EVALUATION

USAID/HEALTH COMMUNICATION CAPACITY COLLABORATIVE (HC3): MIDTERM EVALUATION

AUGUST 2015

This publication was produced for review by the United States Agency for International Development. It was prepared by Lynne Cogswell, Siobhan Green, and Brian Pedersen through the Global Health Program Cycle Improvement Project.

Cover Photo: Lynne Cogswell
Photo description: Lamia Lailaba, a smiling Community Extension Agent on the Health Communication Capacity Collaborative (HC3) Project in Kebbi Province, Nigeria.

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ACRONYMS

BCCP	Bangladesh Center for Communication Programs
CCP	Center for Communication Programs
CS	Capacity strengthening
FBO	Faith-based organization
GHI	Global Health Initiative
GH Tech	Global Health Technical Assistance Project
HC3	Health Communication Capacity Collaborative
HIV	Human immunodeficiency virus
HQ	Headquarters
ICT	Information and communications technology
IR	Interim Result
JAIDS	*Journal of Acquired Immune Deficiency Syndromes*
JHU	Johns Hopkins University
LARC	Long-acting reversible contraceptives
M&E	Monitoring and evaluation
MSH	Management Sciences for Health
NGOs	Nongovernmental organizations
OE	Organizational effectiveness
PEPFAR	President's Emergency Plan for AIDS Relief
PMP	Performance Monitoring Plan
PSI	Population Services International
QA	Quality assurance
QI	Quality improvement
RFA	Request for Applications
RME	Research and monitoring and evaluation
SBCC	Social and behavior change communication
SMS	Small message service
SOW	Scope of Work
TRANSFORM	Translating Effective Practices from Research, Marketing, and Design
USAID	United States Agency for International Development
VLDP	Virtual Leadership Development Program
VOIP	Voice Over Internet Protocol

GLOSSARY

Term	Definition
Capacity strengthening	A multistep collaborative process that improves the ability of a system, organization, or individual to meet objectives and perform better.
Challenges	Any aspect of HC3's work that has hindered effective implementation of activities, thus minimizing successful fulfillment of project objectives.
Change component	Part of a project strategy that focuses specifically on any changes to the original strategy or project design. Often a revised original strategy, it needs to take into account any changes and where the project will go based on emerging change needs.
Digital capacity	The capacity of an individual or an organization to access, use, and create digital tools for internal and external purposes. Includes organizational management tools (such as word processing, accounting, email, Voice Over Internet Protocol [VOIP], messaging, or customer relationship management tools); knowledge management; marketing and sharing (such as storage of digital files, digital archival, organization websites/intranets, internal training, or online research); and service provision (such as webinars, listservs, websites, graphic design, or content development).
Digital tools	Internet and computer-based tools, such as websites, discussion boards, and online toolkits. Digital versions of print materials, webinars, online learning courses, databases and data visualization tools, SMS (small message service) messaging systems, and discussion boards.
Evidence-based	Proven facts, findings, and results that are used to inform, design, refine, and improve interventions or programs.
HC3 staff	All headquarters and country HC3 project staff.
Learning by doing	A four-step cyclical process that moves from capacity assessment to capacity-strengthening plans through implementation, monitoring, and evaluation while encompassing systems reinforcement, direct capacity strengthening, and collaboration throughout the cycle.
Less than successful activities	Any planned activity that was not completed at all or not completed adequately and thus has not yet contributed to the realization of project objectives.
Mission statement	The definition of the purpose of a project, what it does, and how it does it.
Non-HC3 staff	Staff of USAID/DC, Missions, project and implementing partners, and users of HC3 materials who are not HC3 staff.
Overarching patterns	Issues that have recurred in document review and qualitative and quantitative research among the majority of audiences and data sources, across all three evaluation technical areas, and within all three evaluation questions, which have therefore been identified as "overarching." They represent an amalgamation of findings and conclusions. They allow evaluators to focus on the findings that have the highest potential and enable the project evaluated to respond to the improvements that will have the highest impact.
Plan	A description of how a project is to complete its strategy. A plan provides specific details on what, how, where, when, and who will carry out the activities presented in a project strategy. It encompasses tasks, sub-tasks, and to-dos.

Term	Definition
Project strategy	A document detailing where a project wants to go over the project period; it comprises vision statement, goals, objectives, primary audiences, and major activities and corresponding outputs. It should be kept short, 1-2 pages, so that it can be easily revised and adjusted. It should be considered a living document that is reviewed and revised annually. The project strategy also should be infused into all strategic approaches of country-level projects and activities.
Successful Activities	All activities that have contributed to the effective accomplishment of project objectives.
Vision	A single phrase that is a succinct, aspirational definition of the project's desired future, usually the first component in a strategy. A vision should be flexible enough to endure any project changes.

HC3 Resource	Definition
HealthCOMpass	An interactive and highly curated digital repository of high-quality materials and resources for social and behavior change communication (SBCC) from HC3 and SBCC expert partners.
How-to Guides	Short, targeted resources that walk the user through the foundational steps of the SBCC process. They are gateway resources that provide the basic overview for each SBCC activity but also link the user to the wealth of comprehensive resources available in the SBCC community.
Implementation Kits	In-depth, multi-section HC3 resource packages supporting the development of a range of SBCC interventions "from soup to nuts." The iKits include adaptable tools, such as background data, strategic positioning guidance, advocacy briefs, infographics, worksheets, applied activities, case studies, and guidance on indicators and monitoring and evaluation.
P-Process	A step-by-step planning framework, developed by JHU CCP, used to design, implement, monitor, and evaluate communication strategies, materials, and programs.
Springboard	An online peer community for the dissemination and exchange of SBCC knowledge and practices.
VLDP	The HC3 SBCC Virtual Leadership Development Program (SBCC-VLDP), adapted from MSH's 13-week VLDP blended learning program. It uses management and leadership principles, online assignments, and virtual mentoring to assist teams of professionals from around the globe to improve management and SBCC skills in a real-life workplace setting while addressing barriers to actual implementation of a desired SBCC activity in the field.
Webinars	Recorded web-based presentations on a variety of SBCC topics.

EXECUTIVE SUMMARY

OVERVIEW

Launched in 2012, the Health Communication Capacity Collaborative (HC3) is USAID's flagship social and behavior change communication (SBCC) project. HC3 is designed to build up local capacity to implement programs; bolster the body of evidence for SBCC interventions; and provide technical leadership for SBCC practitioners worldwide. Led by the Johns Hopkins Center for Communication Programs (CCP), HC3 is implemented in collaboration with Management Sciences for Health (MSH), NetHope, Population Services International (PSI), Ogilvy PR, and Internews. Informed by the Global Health Initiative (GHI) and USAID Forward agendas, the project seeks to increase the impact and sustainability of USAID-supported SBCC through

- (IR1) Increased capacity of indigenous organizations to design, implement, manage, and evaluate evidence-based health communication interventions; and
- (IR2) Establishment of proven systems for continued development of new and current indigenous implementers.

An evaluation team was tasked to conduct a midterm evaluation of the HC3 project. The purpose was three-fold: (1) review, analyze, and evaluate how well HC3's activities performed against project objectives as described in the Request for Applications (RFA) and the Performance Monitoring Plan (PMP); (2) evaluate HC3's success in building the capacity of developing country individuals and institutions to design, implement, and evaluate high-quality SBCC through resources such as HealthCOMpass, Springboard, and Implementation Kits; and (3) review, analyze, and evaluate the performance of HC3 country programs in Côte d'Ivoire, Nigeria, and Guatemala. It should be noted that the evaluation focused on higher-level project objectives for capacity strengthening (CS), research, and knowledge management; it did not assess the effectiveness of health-specific activities, such as the large core-funded portfolios pertaining to family planning and reproductive health, HIV/AIDS, malaria, and Ebola virus disease.

The evaluation team consisted of Lynne Cogswell, team lead and OE specialist; Siobhan Green, ICT specialist; and Brian Pedersen, SBCC specialist. This evaluation, conducted from June 8 to September 30, 2015, included visits to Guatemala, Nigeria, and Côte d'Ivoire.

The team used nine methods to collect information from 417 persons who comprised seven different types of informants. It also reviewed 222 project documents and other materials. The team employed a two-fold process of triangulation and researcher confirmation to ensure thoroughness and rigor. The analysis examined trends and patterns across all levels, all countries, all data sources, and all technical health units.

SUMMARY OF FINDINGS

This evaluation distilled evidence from document reviews, qualitative interviews and observations, quantitative questionnaires, and surveys. HC3 progress, performance, and successes were examined in terms of three technical areas: organizational effectiveness (OE), SBCC, and information and communications technology (ICT). Overarching patterns were distinguished in a separate narrative section.

Question 1: What progress has been made in achieving project objectives, as described in the project RFA and PMP?

HC3 was found to have succeeded at developing and expanding SBCC technical resources and creating forums for SBCC programming. This finding is illustrated by the more than 200 resources compiled, curated, and disseminated through HC3's HealthCOMpass; its 15 new Implementation Kits and How-to Guides, at least one from each HC3 technical area; and the more than 1,000 participants (an estimated 42% of the total of 2,600), who reported they had applied SBCC information or skills gained during an HC3-sponsored activity.

The majority of findings illustrated that HC3 has been less than successful at developing a strategic and sustainable CS portfolio, establishing a solid evidence base for CS and SBCC, and advancing CS and SBCC globally. Three specific examples typify this lack of success: HC3 has (1) focused on unmeasured and conventional "learning by doing" (more often referred to as experiential or heuristic learning) to accommodate the reduced budget for the CS mandate, but has not offered project-wide alternatives contemporaneously; (2) produced only 4 of the 17 articles planned to provide supporting evidence for CS and SBCC; and (3) conducted only 194 out of 650 planned HC3-sponsored activities.

Challenges to HC3's performance the evaluation identified were its inability to effectively integrate CS into all technical units and to manage its changing CS mandate. Two specific patterns characterize these challenges. HC3 has (1) discouraged integration by encouraging development of individual, technical unit resources, and (2) over-relied on digital tools with no balancing CS approaches or formats. While these two patterns demonstrated that HC3 did not effectively manage its CS challenges, the work it has done on Ebola illustrated that it has the ability to mitigate disruptions to funding and project implementation while continuing to conduct the project activities originally contracted.

The team found that HC3's success was principally related to its SBCC technical strengths. It has a recognized group of competent technical staff, a documented image as an SBCC technical leader, and acknowledged concrete technical plans.

Finally, the evaluation elucidated four predominant recurring factors that undermine HC3's ability to achieve peak performance: (1) insufficiently segmented and studied audiences, (2) lack of a strong project strategy that has a subcomponent for change management, (3) weak project leadership, and (4) lack of clear, actionable research and monitoring and evaluation (RME). All these factors promote less impactful activities and resources and consequently minimize the impact of CS in SBCC and the evolution of SBCC's CS value-added.

Question 2: How successful is HC3 at building capacity to design, implement, and evaluate high-quality regional and country SBCC?

As noted, HC3 has struggled with integrating CS into its activities. The main approach it has taken to global, project-wide CS has been investment in digital tools, such as HealthCOMpass, Springboard, Webinars, and Implementation Kits that can be accessed by SBCC practitioners anywhere. The team was asked to look explicitly at Springboard and how it contributes to SBCC CS at the regional and country levels.

Document review and interviews indicated that HC3 has used digital tools, such as the Springboard and HealthCOMpass, to capture and share SBCC best practices and information globally. These tools are rated very highly by those who are aware of them. However, it is not

clear how they are expected to help improve in-country capacity to design and implement SBCC interventions, i.e., what role they play in project-level CS strategy.

Furthermore, the project has not sufficiently profiled the audiences for its digital tools or considered the digital capacity of local partners in its CS definitions, which is problematic for a project that assumes that key audiences will be using digital tools to build their SBCC capacity. Digital capacity, in this context, would mean the ability to use digital tools to find, access, capture, adapt, and then republish and integrate SBCC content into their own work, as well as using digital tools to improve the operations of their organizations. Also, HC3's digital content has been primarily driven by donor demand and developed at headquarters. HC3's current top-down approach to content development has resulted in less accessibility to and usage by intended beneficiaries. HC3 is also missing an opportunity to build digital and SBCC capacity to source, create, or adapt innovations from country programs for local and global use. As a result, these digital tools have been used only minimally by the in-country audiences who need them most: practitioners in the field, including local Ministry of Health staff.

Springboard, the online and on-the-ground community of practice, has potential to serve a real need for peer-based SBCC capacity strengthening, and many target users see that potential. However, Springboard currently lacks a strategic focus beyond offering a space for this type of interaction. Springboard activities, online and on the ground, are not fully integrated into HC3 activities or CS approaches. As a result, they are not tightly focused on direct user needs; USAID Missions and HC3 country programs and partners see Springboard as a side event or an afterthought. Though it has recently been reoriented to be more focused on country outcomes, until there is a clear strategy to use it for specific CS goals, it remains to be seen whether the new focus will help Springboard achieve its potential.

Question 3: How successful have HC3's country programs been?

In general, USAID Mission respondents in Guatemala, Nigeria, and Côte d'Ivoire were satisfied with HC3's performance against expected outputs, as outlined in country-specific scopes of work (SOWs), annual work plans, and PMPs. However, lack of timely delivery of program outputs in Guatemala and Côte d'Ivoire and inadequate communication in Guatemala and Nigeria were identified as shortcomings that have negatively affected project performance.

Local partners benefit primarily from CS support that is directly linked to program design and implementation. It was reported that because of a lack of country-level funding, CS interventions are not designed to respond to user-specific needs. Where HC3 has a mandate to build the capacity of national and state government coordination bodies, the impact of those activities on the capacity of national bodies has been significant.

Very few field-based respondents were aware of CS tools developed at the global level and HC3 has not conducted capacity analysis to determine how field implementers access and apply these tools.

A reasonable indicator of HC3's impact on the quality of SBCC programs is the quality of its own country-level SBCC activities. The evaluation team's review of programs found that

1. HC3 has demonstrated impressive discipline in situation analyses and applying theory and models to inform program design. Completion and use of original research is lacking, but that may be the result of there being limited funds to conduct program-specific SBCC research.

2. HC3 has applied ecological assumptions and worked at several levels to effect behavior change. Programs have used solid approaches to extend the reach and deepen the impact of activities. Audience segmentation, development and use of audience insight, and prioritization of communication objectives and messages were not sufficient, however, and channel selection and prioritization defaulted to previously used channels with little consideration for program needs, audience access, or cost-effectiveness.

3. HC3 has involved local stakeholders and technical staff both to make tools more accurate and to facilitate local ownership and recognition. Materials and tools were pretested and the feedback used to inform changes. Although interventions and materials development were linked to national communication strategies, programs tended to default to "tried-and-true" models (e.g., wholesale adoption of evidence-based interventions from other contexts, without proper adaptation and contextualization).

4. HC3 has trained outreach staff to implement program activities and trained most other staff to fulfill supporting functions. Supervision systems were robust and provided continuous feedback and coaching to program implementers while contributing to program fidelity. Evaluation activities often focused heavily on changes in knowledge and attitudes instead of actual behavior, which represents a missed opportunity to highlight the important role of SBCC in health programming.

Additional Internal Operational Elements Identified

The evaluation identified four overarching HC3 operational challenges: (1) HC3 has not sufficiently listened to, cultivated, or targeted its understanding to clients and audiences; (2) it did not take rapid or appropriate action with regard to the CS unit; (3) HC3 delayed in replacing the research director and the delay is being felt at global, regional, and country levels and impacting negatively on activities and outputs that fall under this portfolio; and (4) it has not profited from in-house opportunities for exchange between technical units.

Therefore, HC3 has several primary options: (1) advocate for SBCC and for CS in SBCC and advance the field by cultivating new collaborators to infuse as yet untapped intellectual and practical debate and ideas; (2) create a CS and SBCC environment in which practitioners can develop and succeed by seeking out and fostering cutting-edge opportunities; (3) relate to and respond to concerns by listening to its clients and audiences and continually reconfirming comprehension; (4) improve by coordinating big picture and tasks between technical units, not just within units; (5) ensure that client and audience needs are met, while concurrently meeting project needs, maximizing familiarity with its clients, audiences, and staff and identifying mechanisms to bring diverging interests together; (6) establish the validity of CS in SBCC, ensure that the concept is solidly integrated into all technical units and it is effectively shared and promoted by forming a very strong and technically competent CS team lead as well as a supportive team of internal and external experts; (7) advance CS and SBCC and expand the related body of evidence by drawing together a robust and expansive collection of targeted materials that demonstrates the value-added of timely CS and SBCC; (8) and collectively and persuasively advance CS and SBCC by clearly articulating what HC3 is doing and why, so that partners and stakeholders can recognize how, when, and why to contribute and rejoin.

ANALYSIS

Analysis of the findings revealed several overarching and cross-cutting trends and patterns at global, regional, country, and project levels as well as across all HC3 technical areas, such as HIV/AIDS and malaria.

Areas of Success

Four main areas of success, for which HC3 deserves recognition, have enabled HC3 to deliver on project expectations and will enable it to further improve its work:

1. **Strong Technical Staff and Partners** offer a complete array of skills to produce quality outputs when properly supported. They have (1) delivered substantial quality outputs with minimal oversight, regardless of other project constraints; (2) allowed partners to provide resources and expertise that complement those of core HC3 staff, such as deeper experience in CS, media integration, and digital support; and (3) ensured that quality in-country staff are in place and quality technical assistance is provided, so that countries can achieve country plan mandates.

2. **Online Repository of High-Value CS and Technical Resources** has created a needed platform for the dissemination of high-quality resources for SBCC programs. It has (1) assembled, curated, and made available to SBCC practitioners the most effective technical resources that can be used to develop and manage higher-quality SBCC programs; and (2) begun to collect evidence to demonstrate the importance and value-added of SBCC.

3. **Resilient Country Programs** provide the basis for quality programs and activities. They have (1) ensured that programs are implemented despite challenges beyond HC3's control, such as funding interruptions and reorientation of donor priorities; (2) built on existing experience and competence; and (3) capitalized on strong relationships and trust, allowing country programs to achieve impact more quickly.

4. **Solid National-Level Coordination Efforts** have been well-received and highly effective in beginning to build national SBCC capacity. These efforts have (1) created meaningful roles for national SBCC structures; and (2) supported institutionalization of SBCC across technical sector programs.

Areas to Improve

Four areas have undermined HC3's ability to perform effectively; if not rectified, they will continue to reduce the effectiveness and impact of its programs:

1. **HC3's Project Strategy** is inadequate. It needs to be reinforced and expanded at the global, regional, and country levels across all technical health areas. Inadequate project strategy has (1) impeded HC3's ability to respond to requests without disrupting its primary mandate; (2) diminished its ability to deliver on time, especially when changes occur; (3) reduced the potential impact that can result in SBCC and CS by limiting exchange across different health areas; (4) minimized the potential reach of online resources; (5) curtailed the shared understanding of a cohesive, explicit path to project success; and (6) diminished the likelihood that CS, technical leadership, and RME will be strong and sustained.

2. **Internal Leadership** needs to be strategically strengthened. Limited leadership has (1) hindered HC3's ability to staff soundly and assess needed staff competencies; and (2) created unclear communication and project output and work expectations among staff, partners, and stakeholders.

3. **QA and Quality Improvement** (QI) are inadequate and needs to be ensured in all that HC3 produces and implements, especially at the country level. Inadequate QA has (1) diminished HC3's ability to deliver quality products at all levels; (2) undercut CS and SBCC best practices, technical leadership, and RME; (3) weakened the impact of RME and CS in SBCC; and (4) decreased the likelihood that SBCC will be viewed as value-added.

4. **Research, Monitoring, and Evaluation** is incomplete and incoherent, so that it fails to contribute meaningfully to project goals. Incomplete RME has (1) not generated sufficient feedback to inform program improvements and balance supply with demand creation; (2) underrated the need to focus on behavioral outcomes; (3) missed prime opportunities to demonstrate the value-added of SBCC; and, (4) diminished the likelihood of perceived technical leadership.

Conclusions

While HC3 has not as yet strategically integrated the changes it has undergone (i.e., reduced emphasis on CS, push to direct implementation to achieve rapid results, influx of Ebola money, and lack of activities under the TRANSFORM accompaniment); nor has it appropriately exploited these changes. The evaluation found that HC3 has the capacity to improve in its final two years. It has the staff and technical resources needed to achieve its project and country mandates. However, it must be willing to expeditiously implement changes that improve its value to global and in-country audiences and reinvigorate its QA and improvement efforts.

RECOMMENDATIONS

Since the HC3 project has two years remaining, the evaluation team has provided short-term recommendations to guide improvements (see full Recommendations in the report).

Recommendations for HC3 within 3 months
1. Draft a 2-year strategy for HC3 that clearly articulates the project's technical leadership, RME, and CS roles, and how they will together contribute to achievement of project objectives. The strategy must clearly define SBCC CS at different levels, and how it may be promoted, supported, and measured using MSH expertise. Furthermore, it must filter down to the country level and be integrated into all project work.
2. Draft a QA and quality improvement (QA/QI) strategy for HC3-supported in-country projects, with clear indicators based on JHU/CCP's own standards for SBCC design, implementation, and evaluation, to be applied both to global and country-level work. Draw up a complementary plan for roll-out of this strategy, prioritizing countries to be reached in the remaining years of the project.
3. Engage in leadership exercises to ensure close connections between operational and technical activities and to ensure that the strategy and corresponding plans are implemented effectively.
4. Re-examine staffing and replace or train staff as needed to ensure strong, competent technical leads and teams.
5. Finalize the M&E plan and the PMP for the last two years, ensuring that they reflect HC3's technical leadership and RME roles.
6. Create a plan for how CS efforts and RME can be better integrated across all HC3 units and countries, by type, need, and approach.
7. Survey existing programs on how digital tools can be used to promote capacity building, technical leadership, and RME, and identify specific areas where they can be used.
8. Create a formal development model and a two-year strategy for Springboard activity, to make it more impactful, effective, and part of the CS and digital tool survey.

Recommendations for HC3 within 6 months

1. Based on the CS definition and criteria (indicators), revise the work plan for the last year and a half of the project.
2. Audit the RME and SBCC capacity of in-country partners using HC3's SBCC capacity assessment tool and design tailored CS interventions to meet identified needs. Conduct an end-line audit to measure improvements at least six months before project close-out.
3. Assess the digital capacity of local partners in selected countries to help optimize their access to HC3 digital tools.
4. Implement the QA/QI strategy through direct technical support to HC3 country programs to ensure that they meet HC3 quality standards, as identified and measured in the QA/QI strategy. Involve country partners in the QA audits and drafting and implementation of the QI plan to model QA/QI as a form of capacity building.
5. Review HC3 tools, especially digital tools, to see how audiences access and use them, and how they provide feedback to improve them and strengthen content. Use information from the review to improve how the project promotes and disseminates the tools.
6. Institutionalize processes for ICT feedback and country-identified content to make ICT tools and online resources more responsive to the needs of the field.
7. Disseminate "gold standard" behavioral indicators for SBCC programs and ensure that all HC3-supported country programs incorporate indicators into project M&E plans.
8. Moving beyond process indicators, pilot behavioral indicators for CS activities, bringing in experts from such fields as anthropology and psychology, to provide insight.
9. Produce four "letters:" documenting impact of SBCC capacity strengthening, technical leadership and RME on program outcomes to quickly and without huge budget implications, build a more solid evidence base for SBCC globally.

Recommendations for HC3 within 9 months

1. Solicit examples from the field of SBCC capacity strengthening innovations to document and disseminate through the HealthCOMpass website as a way to contribute rapidly to the evidence base for the role of CS and RME in SBCC programming.
2. Create and implement a sustainability plan for HealthCOMpass to ensure that it continues beyond project close-out.

I. BACKGROUND

Launched in 2012, the Health Communication Capacity Collaborative (HC3) is USAID's flagship social and behavior change communication (SBCC) project to build up local capacity to implement programs and to augment the body of evidence for SBCC interventions.[1] Led by Johns Hopkins Center for Communication Programs (CCP), HC3 is implemented in collaboration with Management Sciences for Health (MSH), NetHope, Population Services International (PSI), Ogilvy PR, and Internews.[2] Informed by the Global Health Initiative (GHI) and USAID Forward agendas, the project seeks to increase the impact and sustainability of USAID-supported SBCC through

- (IR1) Increased capacity of indigenous organizations to design, implement, manage, and evaluate evidence-based health communication interventions; and
- (IR2) Establishment of proven systems for continued development of new and current indigenous implementers.[3]

HC3's underlying development hypothesis and results framework can be found in Appendix A.

When the project was awarded, core funds were expected to support (a) evaluations to build the evidence base for SBCC; (b) special studies to examine the impact of capacity strengthening (CS) models; (c) reinforcement and expansion of existing CS tools; and d) organization of knowledge management and exchange meetings. Core funds from USAID's Offices of HIV/AIDS, Population and Reproductive Health, and Health, Infectious Disease, and Nutrition were expected to support development and piloting of interventions to address high-priority behavioral issues specific to each health area. Field support funds were expected to provide tailored coordination and CS for in-country actors, including indigenous implementers, Mission staff, host-country government personnel, and private-sector agencies.[4]

However, since HC3's launch, several contextual changes have affected its work on stated priorities and strategic approaches. Most important has been USAID's reduced emphasis on CS. To achieve more rapid results in health programs, especially in HIV/AIDS, *"USAID has placed greater emphasis on direct implementation over longer-term capacity strengthening."* (USAID DC). HC3's funding landscape also changed radically with an influx of Ebola money in year 3 of the project. Furthermore, HC3 was originally designed to complement USAID's Translating Effective Practices from Research, Marketing and Design (TRANSFORM): Indefinite Delivery/Indefinite Quantity project, which is intended to generate innovations in health communication through the award and implementation of Task Orders that can then be evaluated, disseminated, or scaled-up through HC3; however, *"award of this mechanism has been delayed, only a limited number of task orders have been issued, and no new program innovations identified since the launch of HC3."* (USAID DC).

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[1] JHU/CCP. (June 12, 2012) Technical Application with Amendment #1: RFA SOL-OAA-12-000017. Baltimore, MD: JHU/CCP.
[2] JHU/CCP. Factsheet: About HC3. Retrieved from http://healthcommcapacity.org/wp-content/uploads/2014/03/FINAL-hc3-fact-sheet.pdf.
[3] JHU/CCP. (June 12, 2012) Technical Application with Amendment #1: RFA SOL-OAA-12-000017. Baltimore, MD: JHU/CCP.
[4] USAID. (2012) Request for Applications Number: SOL-OAA-12-000017. Washington, DC: USAID.

As of June 2015, HC3 had received $84 million in core and field support funds and was working in 27 countries on six health areas. Field support buy-ins have required HC3 to focus heavily on direct implementation, while core buy-ins span CS, technical leadership, and research, monitoring, and evaluation (RME).[5]

[5] K. Böse (June 2015). Meet HC3 [PowerPoint slides].

II. EVALUATION PURPOSE

The evaluation team was tasked to conduct a midterm evaluation of the HC3 project. The primary purpose of the evaluation was threefold:

1. Review, analyze, and evaluate the performance of HC3's activities against project objectives as described in the project Request for Applications (RFA) and Performance Monitoring Plan (PMP).
2. Evaluate HC3's success in improving the capacity of developing country individuals and institutions to design, implement, and evaluate high-quality SBCC through resources such as the HealthCOMpass, Springboard, and Implementation Kits.
3. Review, analyze, and evaluate the performance of HC3 country programs in Côte d'Ivoire, Nigeria, and Guatemala.

Specifically, the evaluation examined the following (see Appendix B for the Scope of Work).

HC3'S PROGRESS IN ACHIEVING PROJECT OBJECTIVES

1. What progress has been made in achieving project objectives, as described in the project RFA and PMP?
   - Activities that have been particularly successful in meeting the project's objectives and factors that contributed to these successes
   - Activities that have been less than successful in meeting the project's objectives and factors that contributed to shortfalls in meeting project objectives
   - Challenges that HC3 encountered in achieving project objectives and factors that have mitigated these challenges

HC3'S SUCCESS IN DEVELOPING CAPACITY

2. How successful is HC3 at developing capacity to design, implement, and evaluate high-quality SBCC at the regional and country levels?
   - Responsiveness to felt CS needs among SBCC learners and practitioners in Africa, Asia, and Latin America
   - The extent to which the Springboard, HealthCOMpass, the Virtual Leadership Development Program (VLDP), and the Implementation Kits increased the capacity of SBCC implementers
   - The relative effectiveness of each of HC3's virtual resources (as listed above) in strengthening the capacity of SBCC learners and practitioners
   - Sustainability of the HealthCOMpass and the Springboard virtual platform beyond the project's end date
   - HC3 activities that have successfully contributed to developing the technical or operational capacity of regional Springboard Secretariats to lead CS and knowledge management efforts beyond the project's end date
   - Approaches HC3 may enlist to increase the likelihood of sustainability of its CS resources beyond the project's end date

HC3'S SUCCESS IN COUNTRY PROGRAMS

3. How successful has HC3 been in its country programs in Côte d'Ivoire, Nigeria, and Guatemala?
   - HC3's performance against the objectives described in each country's SOW, PMP, and other planning documents developed in consultation with the USAID Mission, e.g., work plans, life-of-project implementation plans, etc., and factors that contributed to successes and shortcomings
   - The success of HC3's CS interventions in improving the ability of individuals and institutions to design, implement, and evaluate high-quality SBCC
   - The relative effectiveness of each of HC3's CS approaches

III. EVALUATION METHODOLOGY

This evaluation team consisted of Lynne Cogswell, team lead and organizational effectiveness specialist; Siobhan Green, information and communications technology specialist; and Brian Pedersen, social and behavior change communication specialist. This evaluation was conducted from June 8 to September 30, 2015, and included visits to Guatemala, Nigeria, and Côte d'Ivoire (see Appendix C for full calendar).

This evaluation examined three broad technical areas: (1) organizational effectiveness (OE),[6] (2) social and behavior change communication (SBCC), and (3) information and communications technology (ICT) (see Appendix D for protocol specifics). Capacity strengthening (CS) was examined across all technical areas as a core mandate of HC3's work.

The team collected information from 417 persons associated with seven primary data sources (see Appendix E for full contact list). Non-HC3 sources were (1) 10 USAID DC; (2) 26 USAID Missions; (3) 10 project partners; (4) 5 implementing partners, such as CCP Nigeria; (5) 109 country local partners such as local nongovernmental organizations (NGOs) implementing in the states in Nigeria and in Côte d'Ivoire as well as 210 beneficiaries of local activities. HC3 staff consisted of (6) 34 HC3 headquarters (HQ) and (7) 13 HC3 country. The team also examined 222 project documents and materials collected in the field (see Appendices F and G).

The evaluation team employed nine methods: (1) document review; (2) individual/ group interviews; (3) focus group discussions; (4) interactive group activities; (5) program activity observations (see Appendix H for list of activities observed); (6) snapshot surveys; (7) an organizational diagnostic (see Appendix I for Tools); and for online usage, (8) web analytics (Appendix J) and (9) collaborative board analytics (see Appendix K). Not all methods were used to respond to each evaluation question; methods were selected based on their appropriateness to the evaluation question and the data sources available. The sampling was purposive, based on needed sources and types of activities; convenient, based on who was available when the evaluation was conducted; and representative, based on the time available to reach sources.

Quality of findings and analysis was assured by using triangulation. Verification and validation looked at the three sources of data—qualitative, quantitative, and document review. To be considered verified and valid, a finding had to be present in at least two of the three data sources, e.g., "staff skills are strong" was found in qualitative and quantitative sources, "weak strategic planning" was found in all three sources. For all but five interviews, at least two evaluators heard the information or reviewed the documents to cross-check understanding and interpretation. Clear data collection and analysis procedures and centralized data storage ensured that thorough and rigorous process was maintained.

The process of analysis was a direct determination of major trends and patterns across all data sources, using all data collection methods and based on frequency and descriptors. In analyzing the quality of the products and materials produced, the team utilized primarily HC3 (CCP) standards as the metric to review SBCC programs.

[6] For purposes of this evaluation, "organizational" refers to "project."

LIMITATIONS TO THE STUDY

Among the challenges encountered during data collection and analysis were that (1) the number of interviews conducted with active Springboard users was limited; (2) no interviews were conducted with HC3 country offices not visited; and (3) data and findings were disaggregated by funding mechanism type, intervention type, and health area/technical area. However, the team concluded that none of the challenges significantly affected the evaluation results, especially in the case of disaggregation, where no significant differences were identified across countries, funding mechanism type, or health areas or technical topics.

IV. EVALUATION FINDINGS

The findings presented next represent the major trends and patterns identified across levels, countries, technical areas, and data sources. Due to the magnitude of this flagship project, to minimize perceived contextual bias and maximize potential for immediate improvements the team chose to focus on similar overarching global, regional, and country successes across technical health areas as indicators of broad underlying themes within the HC3 project (see Appendices L and M for full qualitative and quantitative syntheses). When findings are specific to only one data source, it is explicitly stated.

RFA and Project PMP objectives against which performance has been compared are

- At the country level, IR1: Increased capacity of indigenous organizations to design, implement, manage, and evaluate evidence-based health communication interventions
  - 1.1 Increased knowledge, attitudes, and skills
  - 1.2 Greater collaboration and exchange
  - 1.3 Increased availability of and exposure to technical information for SBCC
  - 1.4 Increased knowledge of innovative channels and approaches
- At the global level, IR2: Establishing proven systems for professional development in SBCC
  - 2.1 Increased availability of technical information for SBCC programming
  - 2.2 Greater awareness of capacity-strengthening best practices
  - 2.3 Increased availability of technical information for capacity strengthening
  - 2.4 Greater involvement of academic resources

Evaluation Question 1: What progress has been made in achieving project objectives, as described in the project RFA and PMP?

Because Question 1 explores the macro-issues around HC3's performance, it has been compared with project RFA and PMP (1 June 2015) IR 2 (IR 2),[7] establishing proven systems for professional development in SBCC (as stated above). While it would have been significant to evaluate in terms of HC3's additional current mandates that cover not only professional development and CS but also technical leadership and research and M&E (RME), because no documentation detailing those objectives was available, the evaluation could only consider the IR and its sub-IRs.

Activities that have been particularly successful in meeting the project's objectives and factors that contributed to these successes

A significant aggregate of the evaluation research from document review and all data sources indicated that HC3 had been successful in making more technical information for SBCC programming available (IR 2.1). This was exemplified in two main activities: (1) development and

[7] Please note that IR 1 is directed to country-level work and is covered in Questions 3 findings. More on both IR 1 and IR 2 will be found in Question 2 findings.

expansion of SBCC technical resources, and (2) creation of regional forums for SBCC programming.

Strong Technical Staff. HC3's staff at all levels are considered one of its strongest assets. Here a local Nigerian team from Royaume conducts a community dialogue in Kebbi State with local men.

Activity 1: Development and expansion of SBCC technical resources. The majority of USAID DC, Mission, and implementing partner respondents indicated that on its HealthCOMpass website (a digital repository of SBCC materials from HC3 and other SBCC expert partners), HC3 developed and organized an array of over 200 online SBCC materials and design tools, particularly the 15 HC3-created Implementation Kits (in-depth, multi-section toolkits on specific SBCC topics) and guides, with at least one for each technical area. A significant number of these respondents noted that they were encouraged to use the materials in their SBCC work because they had been curated and developed or selected by JHU/CCP, a respected and trusted source. Furthermore, document review uncovered that, of over 60 HC3-produced online materials, at least half were in French and a substantial number were in Spanish, making HealthCOMpass more linguistically accessible than if the materials had been produced only in English.

Activity 2: Creation of forums for SBCC learning and collaboration. The evaluation distinguished activities that stimulated *peer-to-peer exchange and collaboration in SBCC programming*. Most prominent among these were (1) 16 HC3-hosted webinars (recorded web-based presentations on a variety of SBCC topics), including one on Innovations and New Approaches for SBCC capacity strengthening; (2) more than 15 HC3-supported SBCC technical guidance presentations at, for example, the Center for AIDS Research and the African Evaluation Association, after which a reported 50% of participants incorporated presentation information into their work; and (3) HC3 development of Springboard[8] (online peer community for the dissemination and exchange of SBCC knowledge and practices) and its online and face-to-face deployment in more than 22 countries through which have been held a considerable number of discussions of CS needs in SBCC.

Furthermore, the evaluation also identified activities that offered *technical learning and skills-building opportunities on SBCC programming*. Most notable among these were that HC3 provided to more than 60 organizations SBCC technical and leadership training sessions, such as the Virtual Leadership and Development Platform[9] (VLDP; online training for SBCC practitioners). These reached more than 2,000 students and practitioners, with 40% later reporting that they had used the knowledge or skills they learned in their work. Also, HC3 led at least five workshops on, for example, innovative communication approaches that reached another 600 or more practitioners, 37% of whom reported they had used a new channel or approach they had learned.

[8] More specifics on Springboard will be covered in the Question 2 findings.
[9] VLDP will be more fully discussed in the Question 2 findings.

Enabling Factors. A major portion of the evaluation results revealed that IR 2.1 success was due to three main factors: robust staff capabilities, perceived SBCC technical leadership, and clear and concrete technical unit plans.

- ***Robust Staff Capabilities***. The overwhelming majority of respondents agreed that HC3 technical staff were highly qualified: "*staff are HC3's strongest asset*" (USAID Mission). A significant portion of these respondents stated that its strong capabilities enabled HC3 to produce and organize SBCC materials whose content could be trusted. Moreover, 76% of HC3 staff and the majority of non-HC3 staff respondents felt that these capabilities ensured that the SBCC skills taught using these materials would have more impact because the content could be relied on to be accurate and applicable.

- ***Perceived SBCC Technical Leadership.*** 98% of USAID Missions and project and implementing partners indicated that HC3 was a technical leader in the field of SBCC: *"HC3…they have a solid reputation in SBCC."* (Project partner). These same data sources indicated that this perceived leadership role enabled HC3 to assure continued and significant participation by students and practitioners in SBCC sharing and learning opportunities, thus intensifying and strengthening SBCC skills worldwide. Furthermore, a preponderance of USAID Missions and project and implementing partners stated that this perceived leadership role allowed HC3 to ensure that additional technical expertise could be brought to the SBCC discussion worldwide, whereas other SBCC players might not elicit the same kind of attention.

- ***Clear and Concrete Technical Unit Plans***. The evaluation found that regular yearly technical unit plans (what activities technical units will carry out to achieve HC3's mandates) were in place, and that these plans were detailed and clear: *"each technical area…plans their next steps well."* (HC3 Baltimore staff). A majority of HC3 staff interviewed said that these plans guided their work in developing and expanding online resources and creating SBCC discussion forums and ensured that they maintained a focus on sub-IRs. Many project partners and implementing partners said that the technical plans enabled them to engage in discussions on this work and contribute to resource outputs as well as select topics and approaches for SBCC forums. The majority of interviewees also reported that project partner involvement strengthened the outcomes and would not have been possible without the clear technical plans.

Activities that have been less than successful in meeting the project's objectives and factors that contributed to shortfalls in meeting project objectives

A preponderance of the evaluation research findings reveals that HC3 has been less than successful in creating greater awareness of capacity-strengthening best practices (IR 2.2), increasing availability of technical information for capacity strengthening (IR 2.3), and generating greater involvement of academic resources (IR 2.4). This is best illustrated in HC3's lack of progress in three areas: (1) applying effective CS through technical units and country programs; (2) developing an RME agenda for CS and SBCC and establishing a strong corresponding evidence base; and (3) advancing CS and SBCC globally by creating and sharing new approaches.

Activity 1: Application of effective CS through technical units and country programs. A significant number of HC3 staff said they had not been sure how to guarantee that CS was incorporated into their work when the CS mandate was limited and the focus in-country turned to direct implementation. Most also said they had not received sufficient

guidance from the CS technical lead or from project leadership on how to manage the limitations and changes. In-depth examination and discussions with the CS technical team and project partners working on CS made it clear that CS is presently fragmented, with no clear plan for how to bring it into SBCC. It was also revealed that CS was inconsistent with audience needs and there seemed to be no clear indication that audience needs and capacity levels had been taken into consideration when CS approaches and resources were developed. CS (like Springboard[10]) is reportedly separated from the other units rather than integrated and mainstreamed into technical project activities to become an integral part of all technical work. Nor was there any indication that HC3 was advancing new or different CS approaches to SBCC, such as informed-action capacity building. Instead it has stayed with a conventional "learning by doing" CS approach (more often referred to as experiential or heuristic learning), which is a four-step cyclical process that moves from capacity assessment to capacity-strengthening plans through implementation, monitoring, and evaluation while encompassing throughout the cycle systems reinforcement, direct capacity strengthening, and collaboration implementation.

Activity 2: Establishing a strong evidence base for CS and SBCC. Document review found that HC3 has not generated adequate complementary and supportive evidence-based resources; for example, only 4 of 17 planned CS journal articles based on HC3-supported evaluation data have been published. A significant number of HC3 staff also stated that most of these articles had not contributed to the evidence base on the value of SBCC because they had not sufficiently demonstrated SBCC successes. (It should be noted, however, that there were two quality, evidence-based HIV unit exceptions: (1) a package of evidence on how SBCC makes an impact on HIV behavioral outcomes, and (2) the *Journal of Acquired Immune Deficiency Syndrome* [JAIDS] supplement documenting the role of health communication in and its impact on HIV intervention and care.) Most non-HC3 staff reported that HC3 had not been effective in collecting and presenting lessons learned—"*telling their story is weak and unfocused*" (project partner)—citing the lack of SBCC evidentiary documentation after two years. The evaluation team uncovered a draft 2013 M&E plan describing what activities will be tracked and evaluated and how, but there was no evidence that it had been finalized. And while HC3's current mandate was orally acknowledged to now include RME, the team found no RME plan that outlined how HC3 proposed to contribute to new evidence over the life of the project. This lack of an RME plan has reduced how well HC3 has generated and disseminated evidence.

Activity 3: Advancing CS and SBCC globally. Quantitative examination of work to advance CS and SBCC globally showed that only 194 out of 650 projected HC3-sponsored activities have taken place, and only 22 of more than 30 projected documents and materials describing SBCC best practices have been produced. While one global summit is now scheduled for 2016, HC3 has pursued no other large global opportunities, such as outside SBCC technical committees to delineate cutting-edge SBCC approaches or outreach to peer universities to confer on CS and SBCC. Moreover, most HC3 respondents thought that it was unclear how they were to measure HC3's global work and outcomes—*"how we look at our global progress"* (HC3 Baltimore staff)—because lack of a clear RME plan negatively impacts how HC3 advocates for CS and SBCC.

Hindering Factors. The evaluation identified four major factors that have contributed to HC3's less than successful progress on IRs 2.2, 2.3, and 2.4: (1) not enough audience

[10] See more specifics on this under Question 2 and in Appendix N.

segmentation and insight, (2) lack of a project strategy, (3) lack of a change component, and (4) weak project leadership.

- ***Not Enough Audience Segmentation and Insight***. Document review confirmed that for the development of many resources HC3 gathered very little audience insight into how users would use and access CS and SBCC resources and what capacity needed to be strengthened, with the exception of the Commodities and Faith-Based Organization (FBO)-led Breast Feeding Kits, which reportedly underwent significant pretesting. CS staff stated that "*we didn't do audience segmentation [for capacity strengthening] … we just know what they need*" (HC3 Baltimore staff). This lack of segmentation and insight has adversely affected the quality of the evidence-based documentation produced.[11] Without distinguishing audience needs and tailoring materials to them, the likelihood decreases that resources will be used as intended, have the desired outcomes, or even be used at all, further impeding CS and SBCC and minimizing evidence for the field.

- ***Lack of Project Strategy***. A significant proportion of HC3 headquarters and country staff were unable to articulate the difference between a strategy (where HC3 is going over a five-year period) and a plan (how it will get there), often providing a copy of the work plan when asked for a strategy. However, after brief discussions on the intent of strategy versus a plan, the majority of HC3 staff reported that a strategy, while not now clearly articulated, should have been in place early in the project and that it could have reduced some of the misapprehensions experienced: *"we could have benefited from long-range strategizing at the beginning of the project, not just iterative yearly plans*" (HC3 Baltimore staff).

- ***Lack of a Strategic, Sustainable CS Portfolio.*** The vast majority of respondents, including project partners and HC3 staff, and the document review suggested that the CS portfolio is neither strategic nor sustainable. Misapprehensions included HC3 staff uncertainty on how their technical unit work fit into the CS mandate and how this ambiguity influenced the decisions made within their technical units. This lack of strategy diminished CS discussion across technical units, thus minimizing the sustainability of HC3's CS portfolio and its ability to develop a strategic CS portfolio and follow through on activities. The lack of a strategic portfolio hampered integration and cross-fertilization across technical units, which has reduced HC3's ability to demonstrate the value of SBCC CS.

- ***Lack of a Change Component.*** Another element of a strong project strategy is development of a change component (how a project will accommodate, manage, and maximize any changes it might experience, which involves revisions to the original strategy and anticipating unexpected or unusual events that might occur, such as funding cuts or changes in mandate). The evaluation team uncovered no change component to accommodate HC3's shifting priorities. The majority of non-HC3 staff reported that HC3 was not flexible enough in considering alternatives to address project changes. For example, when the CS mandate was reduced, HC3 fell back on its traditional training method of learning by doing. Nor was there clear documentation of the present practical mandates of technical leadership and RME against which HC3 could strategize and manage change. The lack of a change component has inhibited HC3's ability to fulfill its flagship role.

[11] See more on audience segmentation and insight issues in the country programs under Question 3.

Challenges HC3 has encountered in achieving project objectives and factors that have mitigated the challenges

Substantial in-depth research elucidated one challenge that HC3 has successfully mitigated, the influx of Ebola funding in year 3. However, it also identified two challenges that HC3 has experienced that have not yet been successfully resolved: CS integration across technical units and HC3's evolving CS mandate.

Mitigated Challenge: Influx of Ebola Funding. Early in the Ebola outbreak in West Africa, it was evident that a clinical response only would not be sufficient to curtail the epidemic. At the request of USAID, HC3 began working with West African country governments, U.S. government agencies, and international partners to undertake SBCC activities in Liberia, Guinea, and Sierra Leone because many promoted clinical methods require individuals and communities to significantly change their behavior or accept new forms of traditional practices. HC3 has been helping to revive health systems in response to Ebola, prepare for future public health crises, and increase health-seeking behaviors, such as service utilization. It received a significant amount of additional funding to perform these activities. The majority of HC3 staff, USAID/DC, and project partners interviewed stated that the huge influx in Ebola funds, while taxing HC3 human resources and planning for other HC3 activities, had offered an opportunity to demonstrate the impact of SBCC even in emergency circumstances.

A large number of HC3 staff interviewed cited the Ebola work as *"something we are very proud of…we had a significant impact on a global crisis"* (HC3 Baltimore staff). This sentiment was echoed by USAID DC and Mission staff: *"HC3 has been very responsive to the needs of the countries that are facing this crisis"* (USAID Washington). All interviewed appreciated the approach the Ebola team took, stating that they felt the approach had been decisive but quiet: *"we thought that people would be reluctant to work with HC3 since JHU/CCP has a reputation of taking over, but the manner that the HC3 Ebola team used was quiet and inclusive, governments and partners alike responded to this and participated fully"* (USAID Washington). HC3's response was extraordinarily rapid, surprising even HC3 staff. Furthermore, numerous respondents from HC3, implementing partners, and USAID/DC reported that HC3 had been innovative in its approach to using technologies to research issues by working with Mercy Corps to develop a rapid SMS collection system. It was also noted that, based on HealthCOMpass, HC3 had created the extremely useful Ebola Communication Network, which those interviewed highly valued.

The evaluation team identified five factors that mitigated potential disruptions to project activities: (1) rapidly responding to USAID and field needs; (2) bypassing normal JHU budgeting and research processes; (3) contracting with highly qualified people; (4) establishing a strategy, plan, and deliverables; and (5) applying lessons learned effectively to next steps and next countries. HC3 could benefit by replicating the factors cited where possible. It should be noted that these same factors recurred throughout analysis of Questions 1, 2, and 3. Because they relate to the different levels of HC3 performance, they illuminate persistent HC3 strengths and weaknesses.

Unresolved Challenge 1: Integrating CS across technical units. As previously noted in terms of the less than successful Activity 2, HC3 has not been successful in integrating CS across its technical units. Examination of the Implementation Kits and How-to Guides, among other documents, revealed that beyond the learning by doing process, there has been no rigorous effort between technical units to define and detail how CS in SBCC makes a difference, how it should be approached and carried out, or when or how CS in SBCC impacts on the user

audiences and their work. Moreover, it appears that technical teams have viewed this integral component of what HC3 does as a separate activity. The majority of the staff reported that they work in isolation from CS, focusing on the technical work they know well. This isolation has undermined a major aspect of HC3's CS mandate: how CS improves and impacts on the assimilation and application by users of technical information and SBCC skills. Cross-cutting work, which is traditional in health fields, is essential because many health behaviors influence or encourage other health behaviors; however, for HC3 this goes beyond traditional cross-cutting integration. CS integration into technical areas is fundamental to gathering, documenting, and bringing a reliable body of evidence to the global SBCC community on the value added by CS in SBCC. Integration between technical units can ensure that a CS portfolio in SBCC is sustainable by establishing the need for links between CS, SBCC, and technical content.

Unresolved Challenge 2: Evolving CS mandate. In addition to the challenge that arose from lack of CS integration across technical units, the shift in country priorities away from CS to more technical and direct implementation has also diminished the quality of HC3's CS portfolio and of its direct implementation. The majority of HC3 staff, USAID Mission, and project partner respondents indicated that this shift encouraged HC3 to replicate approaches[12] that it had previously used, with no clear indication that an approach was being chosen because there was already a body of evidence proving its effectiveness or because it could be implemented rapidly. Furthermore, the shift encouraged HC3 to rely heavily on learning by doing, again with no documentation of to how well this works for SBCC or in HC3 technical areas.[13] It should be noted that the evaluation also confirmed that the project partner, MSH, has initiated new critical thinking on CS. With a newly seconded staff member in place and better use of such tools as the adapted PROGRES tool, the CS unit is beginning to forge audience-focused, potentially integrated CS aspects. This is best represented by tool development and adaptation by field-centered organizations rather than by headquarters. Furthermore, the evaluation found no evidence that HC3 has assessed whether the virtual platform is the most appropriate method of strengthening SBCC capacity, though it continues to rely heavily on this digital approach.[14]

Potential Mitigating Factors. Respondents and document review identified several factors that could have been used to mitigate the unresolved challenges, but that have not yet been exploited effectively: (1) properly applied audience segmentation and insight, (2) a strong project and change strategy, (3) strengthening of project and CS technical team leadership, and (4) a clear, concrete RME plan. Again, since these factors have recurred throughout these findings, they delineate significant project weaknesses.

Question 1 Conclusions

1. HC3 has been successful at developing and expanding SBCC technical resources and creating forums for SBCC programming. This finding is best illustrated by the more than 200 resources compiled, curated, and disseminated through HC3's HealthCOMpass; its 15 new Implementation Kits and How-to Guides, at least one for each HC3 technical area; and the more than 1,000 participants (an estimated 42% of the total of 2,600) who

[12] More specifics on replication can be found in Question 3.
[13] Harvard Business School has carried out several studies on the effectiveness of learning by doing in business enterprises. All successful endeavors had three factors in common: (1) specific and measurable learning by doing indicators, (2) precise parameters in which work would be carried out, and (3) focused and varied learning-by-doing materials and tools. None of these factors were found for HC3.
[14] Please see Question 2 for more on this aspect of CS.

reported that they had applied SBCC information obtained or skills gained from an HC3-sponsored activity.

2. HC3 has been less than successful at building a strategic and sustainable CS portfolio, establishing a strong evidence base for CS and SBCC, and advancing CS and SBCC globally. For example, HC3 has (1) focused on unmeasured and conventional learning by doing (experiential or heuristic learning) to accommodate the reduced budget for the CS mandate but has not contemporaneously offered project-wide alternatives; (2) produced only 4 of the 17 planned articles to support the evidence for CS and SBCC; and (3) conducted only 194 out of 650 HC3 planned and sponsored activities.

3. Challenges to HC3's performance were its inability to effectively integrate CS across its technical units and to manage its changing CS mandate. Two patterns characterize these challenges: HC3 has (1) dissuaded integration by encouraging resource development by individual technical units; and (2) over-relied on a virtual platform with no balancing CS approaches. While these two patterns demonstrated that HC3 has ineffectively managed its CS challenges, its work on Ebola illustrated that it has the ability to mitigate disruptions to funding and project implementation while continuing to conduct project activities originally contracted.

4. HC3's success was principally related to its SBCC technical strengths. It has a recognized group of competent technical staff, a documented image as an SBCC technical leader, and an acknowledged set of concrete technical plans.

5. Finally, the evaluation identified four predominant and recurring factors that impair HC3's ability to achieve peak performance: (1) insufficient segmentation and examination of audiences; (2) lack of a strong project strategy and sub-component for change management; (3) weak project leadership; and (4) lack of a clear, actionable RME. All these factors encourage activities and resources that have less impact and consequently minimize the impact of CS in SBCC and the evolution of SBCC's CS value-added.

Evaluation Question 2: How successful is HC3 at developing capacity to design, implement, and evaluate high-quality SBCC at the regional and country levels?

This section synthesizes the findings related to Evaluation Question 2. It provides an overview of the successes and the issues related to HC3's digital CS resources, the bulk of its CS work. Based on prioritization by USAID, the evaluation examined in more depth Springboard (the online and on-the-ground community of practice), HealthCOMpass (the digital repository of SBCC materials from both HC3 and other implementing partners), and the Implementation Kits and How-to Guides (digital content on specific SBCC topics—iKits are in depth, multi-section toolkits and How-to Guides are shorter, targeted walk-throughs of key SBCC approaches); it gave less attention to the VLDP (Virtual Leadership Development Program: online training for SBCC practitioners), webinars (recorded web-based presentations of an hour or so on a variety of SBCC topics), other ICT tools, such as short message services (SMS) and social media, and the HC3 project website. All of these were covered in the broad assessment of how digital tools were designed, used, and accessed, but the first three were examined more closely as they were the most often cited.

Responsiveness to the felt capacity-strengthening needs of SBCC learners and practitioners in Africa, Asia, and Latin America

Interviews and document review found that the intended audience for digital CS tools is health professionals implementing SBCC programs, either globally or in-country. When developing CS

resources, respondents indicated, and document review confirmed, that there was very little audience segmentation or profiling. Among HC3 staff respondents, 83% felt that the Implementation Kits and 78% that the How-to Guides that HC3 developed responded to the needs of implementing partners. Although 90% of non-HC3 survey respondents agreed that HC3 produces technical materials relevant to their needs, only 22% reported using HC3 resources in creating their own SBCC interventions or tools—sometimes, according to feedback, because the HC3 tools were too technical for non-SBCC experts. The evaluation team also noted that digital capacity was central to using the digital tools, something that some partners interviewed struggled with.

The extent to which Springboard, HealthCOMpass, the VLDP, and the Implementation Kits increased the capacity of SBCC implementers; and the relative effectiveness of each of these in strengthening the capacity of SBCC learners and practitioners

Among respondents who were familiar with HC3 CS resources, a majority felt they were high-quality tools: "*The technical quality is quite high; when it's great, it's impeccable*" (USAID Washington). HealthCOMpass was reported to be a trusted platform for curated SBCC content, "*HealthCOMpass is done very well as it gets content from lots of resources"* (USAID Washington), and other resources, such as the webinars and How-to Guides, were cited as specific examples of quality resources that promoted opportunities to improve capacity: "*The Webinars are very impactful since they are framed as skills and knowledge building*" (project partner). Highest ratings for being useful to respondents in the two surveys and in interviews were given to HealthCOMpass and the webinars and to specific How-to Guides; Springboard and the iKits were rated lower.

To evaluate how well these resources have contributed to increasing capacity and their relative effectiveness, the evaluation examined each to determine (1) usage by whom, (2) usage for what purpose; and how end-users (3) access, (4) demand, and (5) apply tools.

Usage by whom. Among non-HC3 staff survey respondents, 45% reported they had accessed HealthCOMpass, 26% had used an Implementation Kit, 22% had participated in a webinar, and 75% had attended an HC3 in-person event, which could have been a direct implementation activity or a broader HC3-sponsored activity, such as a Springboard launch. No non-HC3 staff respondents in Côte d'Ivoire reported accessing HealthCOMpass, although 38% in Guatemala had. Web analytics revealed that 37% of sessions on HealthCOMpass originated in North America, 11% in Eastern Africa, 9% in Southern Asia, and 5% in South East Asia; the rest were either from Europe or unregistered. At the time of the evaluation, Springboard had over 3,000 registered accounts, 33% of them individuals affiliated with nongovernment organizations (NGOs), 11% with universities, and 10% with government. Among HC3 staff survey respondents, 88% of country staff and 94% of headquarters staff had a Springboard account and had visited the site at least once. 39% of non-HC3 survey respondents had a Springboard account, and 34% said they had accessed it in the past month. Over half of users stated they were based outside of North America, Europe, or Australia; less than a third were based in North America, Europe, or Australia; and the remainder did not specify. However, web analytics found that 40% of all visitors to the site, new and returning, were based in the US, with Bangladesh at 8% and Nigeria at 5.7% the next two largest sources of non-US-based visitors. According to project reports, 1,003 of 1,594 message posts originated in the US, 169 in Uganda, and 94 in Bangladesh. In Nigeria, the evaluation found that beyond national-level

non-HC3 staff, of whom 50% had used HealthCOMpass, most HC3 country partners were unaware of the tools.

Usage for what purpose. Users turn to the Internet to find SBCC materials for professional development and to stay abreast of what is happening in SBCC, *"I download materials onto my laptop so I can look through them offline*" (local partner). Some stated that they liked to participate in online learning opportunities. Respondents familiar with HealthCOMpass reported that they use the platform to respond to specific technical needs—"*[to find] research to demonstrate to donors, especially USAID, that communication is a smart investment*" (online resource user)—and locate examples of best practices in SBCC programing— "*I have recommended it to people in the field [looking for examples]*" (project partner). Although resource content across technical areas was not analyzed in detail, it was noted that much of the technical content available as digital tools is not topic-specific, such as malaria/HIV, or even health sector-specific. For example, the How-to Guides offer guidance on channel selection that could apply broadly regardless of topic, which indicates potential utility beyond health professionals. HC3 staff reported using Springboard to engage members in discussions linked to specific resource launches and topics, such as the Youth Long-Acting Reversible Contraceptives (LARC) program and Counterfeit Drugs, and to facilitate face-to-face and online collaboration, such as in the Springboard Advisory Council meeting in Tanzania (August 2015). Springboard has also been used to engage subject-matter specialists to share information.

Non-HC3 staff indicated that Springboard facilitates networking, collaboration, and information-sharing among SBCC implementers: *"We have the opportunity of learning first hand as well as having new and innovative information on SBCC*" (local partner). Although a recent HC3 Springboard user survey found that 86% reported that the service was directly useful for their work, some indicated that as a peer-based capacity building platform, Springboard had not been as effective as expected: "*It's something that wanted to be great but it doesn't feel like it's working in the way it was supposed to*" (USAID Washington). In fact, 54% of HC3 staff and 46% of non-HC3 survey respondents gave Springboard the lowest ratings among all the digital tools across all dimensions, such as usage and access.

How end-users access tools: Usability. Some respondents expressed concerns that HC3 digital resources may not be easily accessible to their intended audiences: "*We as Americans can easily navigate these various resources, but our partners want a one-stop shop … we have seen people struggle to navigate the tools that are available*" (HC3 country staff). In interviews digital capacity-building was not explicitly identified as a capacity to be built by HC3 or by MSH: *"[Among our partners], there is a broad range of digital literacy. [Our program] is looking forward to using the App to help overcome some of the challenges"* (HC3 country staff). The evaluation found no indication that HC3, a project that emphasizes digital tools, had examined as part of its CS activities how to improve the digital literacy skills of in-country users. Digital CS is the improvement of the capacity of an organization and individuals to use digital tools effectively in their day-to-day work processes. Digital capacity or literacy includes (1) selection and maintenance of appropriate digital tools for work; (2) skills needed by staff to use these tools in performing their jobs; and (3) strategic planning for how digital tools can improve work performance.

Further, some respondents indicated that the quantity and variety of tools and resources promoted by HC3 causes confusion: *"They have too many channels and too many tools; they need to streamline some of their offerings and make them easier for people to navigate"* (project partner). Interviews with the intended audience for HC3 digital tools indicated that they were unaware of how digital tools were designed and unsure whether they were the intended users, *"attractive, very pretty, but not for us"* (HC3 country staff). Several respondents indicated that a mobile app would improve access: *"People connect more using their phones … so an app would be more appropriate to how people use the Internet in Africa"* (local partner). Some country respondents indicated lack of time for their own professional development as a barrier to Springboard use: *"We are not allowed to use work time to be on Springboard, unless we were being explicitly paid to work on Springboard"* (local partner). Again, a mobile app was cited as a means to overcome this barrier by helping users access Springboard on their own time.

Repository of CS and SBCC Resources. HC3 has both developed new materials and collected and made available previously developed materials. In Nigeria, small malaria posters have been enlarged into banners for use in community dialogues.

How end-users access tools: Digital access—Web analytics show that while desktop access to HealthCOMpass is still most popular, in Kenya access is nearly evenly split between desktop and mobile, 803 to 802 sessions. India's ratio is 40% mobile to desktop usage, 659 to 1,577 sessions. Kenya and India are sometimes considered bellwether states for developing country digital connectivity patterns because they both have high levels of IT capacity and are seen as progressive and tech-savvy cultures, along with having similar issues of poverty, inequality, and uneven infrastructure.

Field visits in Nigeria confirmed that there was enough Internet connectivity to access the digital tools in partner offices in Kebbi and Akwa Ibom State, primarily through a "dongle," a mobile data connection that can be tethered to a laptop. The team observed many members of these community and local partner organizations with smart phones, tablets, and other mobile devices. When asked, partners described their habits of alternating between working on and offline. All those interviewed recognized the importance and value of access to digital materials as part of their work and demonstrated a range of digital capacity (in one case, mainly by one ICT person on staff).

Although connectivity is in general sufficient, many country respondents cited the lack of consistent, affordable, and stable connectivity as a significant barrier to access. For example, during the Springboard event in Nigeria, only one person of about 40 was able to log on to Springboard using the beta-version app, and the event was marred by not having enough connectivity to conduct a live demonstration of the Springboard site and by Skype disconnections with the presenter. Non-HC3 staff respondents from Nigeria, Côte d'Ivoire, and Guatemala reported that their access to HC3 digital tools was neutral or low; HC3 country staff rated it neutral, and HC3 HQ staff rated it high. Based on the observations of Nigeria HC3 staff, the team surmised that its rating of access as low is based on the lack of consistent, affordable, and stable connectivity to use digital tools.

User feedback. Many stated that specific digital tools, such as the Commodities and Breastfeeding Implementation Kits, were field tested before they were finalized "*to make sure [they] worked with the audience*" (USAID Washington). Some HC3 staff remarked that by default digital tools have been designed at headquarters, but others interviewed felt that *"SBCC tools need to be developed in the field, by SBCC practitioners, to make them really impactful."* (project partner). The team found that HC3 regularly used web analytics and user surveys to improve tools, and 56% of HC3 staff survey respondents felt in general digital tools were continuously improved. While HC3 headquarters staff ranked feedback at 62%, country staff ranked it at 31%. However, 74% of HC3 staff survey respondents agreed that HealthCOMpass and 54% agreed that the Implementation Kits had improved since their launch. It was also reported that Springboard had undergone much iteration based on feedback from country group users.

Sustainability of the HealthCOMpass and the Springboard virtual platforms beyond the project's end date

Although the sustainability of digital tools was identified as a goal in the project's original proposal, HC3 presented no explicit sustainability plan for HealthCOMpass. Springboard's sustainability plan has revolved around building regional secretariats to support country-level Springboard activities. The approach builds awareness and usage of Springboard as an online and face-to-face community through in-person events, which are intended to encourage resource mobilization through buy-ins from USAID Missions, other donor agencies, in-kind contributions from country partners, and volunteers.

However, both online and on the ground Springboard has lacked a coherent strategy to directly support building the capacity of SBCC practitioners to implement HC3 activities. Springboard's work is outside of and in addition to on-the-ground SBCC work rather than used strategically as a way to build on and extend the work. Springboard has been used as a way to improve SBCC capacity and approaches, such as HC3's work on Counterfeit Malaria Medications; however, rather than being representative of the broader approach, these examples simply give ideas for how Springboard could be used more strategically.

As a result, to date the resource mobilization approach for Springboard has not been successful. while there are many examples of in-kind contributions, such as meeting space and labor from country partners, only the USAID Mission in Uganda has provided funding, a small amount, to the Africa Secretariat. Many Missions are reluctant to use field support, or even core support, to fund in-country Springboard events; many in fact reported concerns that Springboard events were a distraction from the activities they support, and many did not see a connection between Springboard and the specific needs of their country-level activities.

It was reported that HC3's sustainability approach for Springboard had undergone changes in response to the need to reorient the focus around country-led needs: *"Country context is important; we need to be mapping country context, and not creating general plans"* (project partner). However, some interviewees expressed concern that expectations for the sustainability of Springboard during the term of HC3 were unrealistic: *"Creating Communities of Practice takes time; time needs to be given to the community to endure and flourish"* (project partner). (See Appendix N for a more detailed analysis of Springboard sustainability, including the role of the regional secretariats.)

HC3 activities that have successfully contributed to developing the technical or operational capacity of regional Springboard Secretariats, Bangladesh Center for Communication Programs (BCCP) in Asia and AfriComNet in Africa, to lead capacity strengthening and knowledge management efforts beyond the project's end date

HC3 identified significant weaknesses in AfriComNet's ability to support the Africa Secretariat and provided it with CS support, especially around resource mobilization, through MSH. However, after significant support, HC3 determined that AfriComNet would not be able to deliver the results required in the time available. The project solicited new bids from African regional partners, including AfriComNet, and within three months selected a new secretariat partner, Africa Capacity Alliance. AfriComNet participated in the August Springboard Advisory Council meeting where Africa Capacity Alliance was introduced to country partners.

It was determined that BCCP did not need similar support, possibly due to its longstanding association with CCP and active country SBCC programs. However, BCCP started Secretariat activities later than AfriComNet and activities in Asia generally have been slow to start due to considerable Mission pushback on Springboard launches in the region, including Bangladesh.

Approaches HC3 may enlist to increase the likelihood that its CS resources will be sustained beyond the project end date

There are two potential elements to sustainability: sustainability of the Springboard and HealthCOMpass platforms, which hold the content—the sites are up and available—and sustainability of content that is still available even though the platform on which it was originally published is not. Sustainability also can be physical—the site is paid for, hosted, and updated—or intellectual—the content and concepts are still available to the target users. HC3 has focused on the platform and the physical for Springboard, an issue that is discussed in detail in Appendix N. The content and the intellectual result from HC3's work to market and share its content with the SBCC community to build capacity.

Integration of HC3 CS platforms with other digital platforms was reported as a promising approach to improving the sustainability of project platforms beyond the project end date. RSS feeds have been introduced to improve integration between the HealthCOMpass and Springboard websites, so that about 10% of web traffic to HealthCOMpass was coming from Springboard. Describing their strategy of integrating the two sites, HC3 reported that *"Springboard [is] a place where heavy content can be linked to and discussed"* (HC3 Baltimore staff), while HealthCOMpass would remain a curated inventory for content of substance, such as Implementation Kits, which have their own space on the HC3 website. As to integration into the larger SBCC Community, such as other USAID and international development–funded SBCC and global health partner sites, web analytics found that the four HC3 sites had generated 288 links and 2,853 sessions on HealthCOMpass, whereas 44 external sites, including other CCP programs such as Knowledge for Health, generated only 144 links and 1,217 sessions on HealthCOMpass. Another 112 links from unknown sources matched the criteria for direct linkages rather than search engine referrals.

Question 2 Conclusions

As mentioned in Question 1, HC3 has struggled with integrating CS into its activities. The main approach it has taken to global, project-wide CS has been investment in such digital tools as HealthCOMpass, Springboard, webinars, and Implementation Kits that can be accessed by SBCC practitioners anywhere. The team was asked explicitly to look at Springboard in

particular and how it contributes to the CS of regional and country SBCC. Key conclusions for question 2 are that

1. HC3 has used digital tools, such as the Springboard and HealthCOMpass, to capture and share SBCC best practices and information globally. These tools are rated very highly by those who are aware of them. However, it is not clear how they are expected to help improve in-country capacity to design and implement SBCC interventions, i.e., their role in project-level CS strategy.
2. However, the project has not sufficiently profiled the audiences for its digital tools or included digital capacity of local partners in its CS definitions, which is problematic for a project that assumes that key audiences will be using digital tools to build their SBCC capacity. Digital capacity, in this context, would mean the ability to use digital tools to find, access, capture, adapt, and then republish and integrate SBCC content into their own work, as well as using the tools to improve the operations of their organizations. HC3's digital content has also been driven primarily by donor demand and developed at the headquarters level. HC3's current top-down approach to content development has resulted in lower accessibility and usage by the intended beneficiaries. HC3 is also missing an opportunity to build digital and SBCC capacity to source, create, or adapt innovations from country programs for local and global use. As a result, these digital tools have been used only minimally by the in-country audiences who need them the most—local practitioners in the field, including local Ministry of Health staff.
3. Springboard, the online and on-the-ground community of practice, has the potential to serve a real need for peer-based CS in SBCC, and many target users see that potential. However, Springboard currently lacks a strategic focus beyond offering space for interaction. Its activities, online and on the ground, are not fully integrated into HC3 activities or CS approaches. As a result, its activities are not tightly focused on direct user needs; thus, USAID Missions, and HC3 country programs and partners see Springboard as a side event or an afterthought. Though it has undergone a recent reorientation to be more focused on country outcomes, unless there is a clear strategy to use Springboard for specific CS goals, it remains to be seen whether the new focus will help Springboard achieve its potential.

Evaluation Question 3: How successful has HC3 been in its Country Programs in Côte D'Ivoire, Nigeria, and Guatemala?

The next three sections synthesize the findings on Evaluation Question 3: the success of HC3 country programs, providing an overview of overarching successes and shortcomings.

Because the attributes of HC3-supported country programs are a reasonable indicator of the project's success in improving the quality of SBCC interventions, the evaluation also examined the quality of HC3-implemented SBCC programs and those findings are outlined in the fourth section below. (See Appendix O for more specifics on Country Findings.)

HC3's performance against the objectives described in each country's SOW, PMP, and other planning documents developed in consultation with the USAID Mission, work plans, life-of-project implementation plans, etc., and factors that contributed to successes and shortcomings

Nearly all USAID Mission respondents reported that HC3 was effectively contributing to the goals and objectives outlined in country-level work plans, SOWs, and PMPs. Document review confirmed that HC3 country programs in Côte d'Ivoire, Nigeria, and Guatemala have been mostly successful at delivering the required outputs and contributing to USAID targets. In Guatemala, it was reported, although HC3 has not had sufficient time to perform the full SOW,

its contributions have been well received and have "*helped people to realize that they need to do their communication differently*" (USAID Mission). In both Côte d'Ivoire and Nigeria, Mission respondents indicated that HC3 was one of their best implementing partners: "*They are our strongest prevention and communication partner*" (USAID Mission).

A majority of Mission respondents indicated that among factors contributing to HC3's success are its strong staff, flexibility in responding to USAID's evolving needs, and willingness to provide technical and coordination support to partners. Mission respondents in Côte d'Ivoire and Nigeria also indicated that HC3's previous presence and existing relationships with partners have contributed to its success there.

A shortcoming noted by some Mission respondents was the lack of timely delivery of program outputs. In Guatemala, one problem specified was that "*the research studies that HC3 should be doing haven't moved*" (USAID Mission), and delays in implementation of other activities were reported. In Côte d'Ivoire, respondents indicated that delays in identifying and contracting with implementing partners negatively affected HC3's performance on USAID targets, especially in the project's first year.

Another shortcoming reported by Mission respondents in Nigeria and Guatemala was a lack of communication with Mission staff: *"They haven't provided much feedback to USAID on what they're doing with state-level Advocacy, Communication, and Social Marketing (ACSM) bodies"* (USAID Mission). Respondents suggested this may have prevented USAID from providing more responsive support and advocating for the importance of HC3 project activities with USAID senior managers.

Resilient Country Programs. Country programs are strong, well-staffed, and flexible. In Côte d'Ivoire young women in the popular "SuperGo" program celebrate their successes and their own personal decisions.

The success of HC3's CS interventions in improving the ability of individuals and institutions to design, implement, and evaluate high-quality SBCC

Funding for CS is limited to HC3's core budget and funding levels have not changed significantly across project years. It was reported that tools and other resources developed with core support at the global level are expected to support CS in-country through their use by in-country HC3 staff and partners. However, few field-based respondents, including HC3 in-country staff, were aware of these resources and none indicated they had been used in program design or implementation. Due to the lack of funding for discrete CS interventions at the country level, HC3 staff reported that a learning-by-doing approach had been employed to build specific capacities while implementing program activities.

In both Nigeria and Côte d'Ivoire, it was reported that local partners benefit primarily from CS support that is limited to training in the skills necessary to implement program activities and tools: "*HC3 sent a consultant who trained us on SBCC and how to conduct advocacy within our communities*" (Nigeria local partner). The extent to which HC3 has been able to achieve country-specific program targets may reflect the success of these CS activities. In Guatemala,

where CS activities are planned but have not yet been conducted, some respondents reported concerns about HC3's ability to make technical information more accessible to nonacademic audiences: "*[They] are very technical and theoretical…a little too academic; … using more "layman" terms would be more effective*" (USAID Mission).

The relative effectiveness of each of HC3's CS approaches

Among all respondents who were familiar with the global tools developed by HC3, such as Implementation Kits, How-to Guides, and HealthCOMpass, a majority felt they were of high quality: "*The technical quality is quite high; when it's great, it is impeccable*" (USAID Washington). However, it was reported that these tools have not yet been tested because of limited awareness and follow-up: "*We know the number of downloads but not how they're actually being used*" (HC3 Baltimore staff). Interviews with both HC3 staff and field-based interviewees confirmed that very few were aware of the global tools: "*I haven't had any exposure to the global tools developed by HC3*" (Nigeria local partner). Survey results further support this finding: only 22% of non-HC3 staff indicating that they have consulted HC3's global tools in designing new interventions or programs. As a result, it was not possible to evaluate the relative effectiveness of specific HC3 CS approaches.

In Nigeria, HC3 also has a mandate and funding to build the capacity of national and state government coordination bodies. This support is delivered primarily through coaching by a full-time HC3 in-country staff person; technical workshops to develop resources and tools, such as the communication guidelines toolkit; and discrete capacity-building workshops on technical subjects, such as how to develop audience-specific messaging and radio programs. It was reported that the impact of those activities on the capacity of national bodies has been significant: "*The ACSM of the NMEP was very weak but with HC3 support they have improved their performance, helping to improve the productivity of meetings, training new members on SBCC, and hosting a leadership course*" (USAID Mission). Document reviews confirmed that since HC3 has provided support, the performance of the national body against government targets had improved.

Solid National Coordination and Support. HC3's coordination role in Guatemala and Nigeria has been widely lauded: here Mayan mothers participate in a nutrition education program run by Save the Children, a USAID implementing partner that participates in the integrated Western Highlands project that HC3 coordinates and supports.

Examination of the quality of HC3-supported SBCC programs

According to HC3's theoretical model, by (1) improving and making available global tools and approaches and (2) strengthening technical capacity within programs, the project will contribute to (3) improved global, regional, national, and community practices that result in higher-quality SBCC interventions. Therefore, a reasonable indicator to determine the project's impact on the quality of SBCC interventions would be the attributes of HC3-supported SBCC programs: if HC3-supported programs satisfy its own standards of quality, this would indicate that HC3 is effectively applying and monitoring global tools and approaches at the country level. Programs were examined on four dimensions: (1) use of evidence and theory in planning and design, (2) strategy development, (3) intervention and materials development, and (4) implementation and monitoring. Several elements of each component were examined to determine how well HC3 is

contributing to the development and implementation of quality SBCC programs. Unless otherwise noted, the majority of the country findings pertain to Nigeria and Côte d'Ivoire, where HC3 has designed and is implementing SBCC programs.

Use of evidence and theory in planning and design

Situation Analysis. Most respondents in all informant categories and the document review indicated that situation analyses were regularly conducted and used to inform program strategies and approaches. In Guatemala, HC3 conducted an extensive message consistency analysis and SBCC situation analysis that will be used to develop an integrated SBCC strategy for USAID programs. In Côte d'Ivoire, HC3 supported completion of an MOH situation analysis as part of the national SBCC strategy for HIV. In Nigeria, HC3 completed the 2015 Nigeria Malaria SBCC Situation Analysis, which includes a comprehensive review of previous malaria SBCC programs.

Use of Theories and Models. Most HC3 staff and local implementing partners suggested that theories and models were used to inform SBCC program design. Document review confirmed that theoretical constructs and models, such as CCP's Ideation and Pathways models and the Socio-Ecological Framework, were incorporated into national strategies developed with HC3 support. However, the extent to which theory was used to structure situation analyses was only evident in the 2015 Nigeria Malaria SBCC Situation Analysis, where specific behavioral determinants were explored and documented.

Use of Research Data. Some respondents felt that HC3 did not conduct enough research to fill critical evidence gaps: *"We're still missing an important piece of research … so we've pulled back the strategy development"* (USAID Mission). Document review confirmed that programs rely heavily on existing data or data from HC3 program evaluations, but little new data has been collected to inform strategies and approaches. Several respondents acknowledged, however, that except in Guatemala USAID has not made funding available to support program-specific SBCC research.

Contextualization of Activities (including coordination with other public and private efforts). Some respondents were of the opinion that coordination with other programs has been problematic. In Nigeria, many community interviewees indicated that HC3 generates demand for mosquito nets among populations that cannot easily get them through current distribution channels—*"too much of a good thing"* (Nigeria local partner). In Côte d'Ivoire, some respondents suggested that coordination with HIV testing providers is weak, hindering efficient referral linkages and tracking.

Strategy Development

Audience Segmentation and Insight. In Nigeria and Côte d'Ivoire, according to document review and observations, audience segmentation is mainly limited to basic demographics. In Côte d'Ivoire, audience segmentation largely responded to PEPFAR priorities, which have broad age categories. It was also suggested that use of audience insight to inform program strategies was insufficient. In Nigeria, when asked to describe key audiences, most HC3 staff and local implementing partners could provide only basic descriptors, e.g., pregnant women and caretakers of children under 5, and community activities targeted all audiences irrespective of their priority for net distribution: *"This program is targeting everyone"* (Nigeria local partner). Document review confirmed that very little audience insight was used in the Guidelines for Malaria Advocacy, Communication and Social Marketing Programs, especially those for Kebbi

and Akwa Ibom State, and apparently audience insight was not incorporated into creative briefs. Insufficient audience segmentation and inadequate use of audience insight was also seen in the recruitment and retention challenges: *"Potential participants do not see the relevance of the program to their needs* (Côte d'Ivoire local partner). It was also manifest in the overwhelmingly knowledge-heavy messaging observed in Nigeria, where messaging is not tailored to specific needs because the audience is highly heterogeneous.

Communication Objectives and Messages. Interviews indicated inadequate prioritization of communication objectives and messages. Other research confirmed that program sessions had an overwhelming number of communication objectives and messages. For example, in Nigeria, 9 to 12 messages were observed during community dialogues. In Côte d'Ivoire, it was observed that Activity Two of the SuperGo! session set out 5 communication objectives and delivered 7 diverse messages, and Module Two Brother for Life session had 8 communication objectives and 6 messages: *"Maybe … having one theme per session [would be better] than multiple, especially since the link between messages is not always clear"* (Côte d'Ivoire local partner).

Communication Channels. The evaluation identified a problem with inadequate selection and prioritization of communication channels. In both Nigeria and Côte d'Ivoire, local implementing partners and community leaders reported that many participants were not able to read print materials: "*There are problems with girls being able to read the photo-novella*" (Côte d'Ivoire local partner). Also in Côte d'Ivoire, a June 2014 media exposure survey found very low exposure to HC3's Reseaux TV mini-series. Strategy documents from both Nigeria and Côte d'Ivoire did not provide enough information to determine the extent to which media richness and audience use were considered in channel prioritization or how cost-effectiveness was factored in.

Ecological Assumptions and Approach. It was confirmed that programs worked at several levels to effect behavior change: *"We have national-level activities with mass media and state-level activities through interpersonal communication and mass media as well as capacity building activities"* (HC3 country staff). Programs in both Nigeria and Côte d'Ivoire were found to have targeted audiences at various socio-ecological levels. In Guatemala, respondents noted that HC3 would be implementing population-level activities to complement interpersonal communication activities conducted by other USAID partners.

Strategic Approach. The team's research in Côte d'Ivoire and Nigeria suggested that HC3 programs used strategic approaches to link program elements, including visual branding. In Nigeria, document review confirmed that community dialogues, home visits, mass media, and print activities were designed to work in tandem and a common flipchart is used to standardize messages in community dialogues and home visits. The interviews confirmed that all activities work under the national malaria elimination campaign slogan. In Côte d'Ivoire, messages disseminated through group activities were complemented by mass media and print materials, and HC3 program activities were branded to help audiences link various program tools.

Intervention and Materials Development Processes

Communication Strategy Used to Develop Interventions and Materials. In Nigeria and Côte d'Ivoire, respondents indicated that program activities and materials were linked to national communication strategies. However, interviews, document review, and observations suggested that the programs often default to tried-and-true intervention models rather than being based on updated or local solutions: *"We have tried to push them to think analytically about what's needed rather than what they're most comfortable with; [but they] rely more on program models*

that they're very comfortable with" (USAID Mission). In Côte d'Ivoire, where USAID reported that achieving scale was a clear need, some respondents were concerned that the Brothers for Life and SuperGo! models were not scalable with the funds available. HC3 staff confirmed that cost concerns were a significant challenge to scaling these models up.

Review by Technical Staff and Stakeholders. Interviews with HC3 staff and implementing partners suggested that technical experts and stakeholders were brought in to review program materials and tools: *"We have worked with them to review scripts for their TV series"* (Nigeria local partner). In Nigeria, staff of the state Advocacy, Communication and Social Marketing unit and implementing partners spoke to extensive involvement in adaptation and review of print materials. In Côte d'Ivoire respondents indicated that national technical bodies primarily did the reviewing. Some local implementing partners reported that they provided feedback on existing tools.

Audience Pretesting and Feedback. Respondents in Nigeria and Côte d'Ivoire confirmed that program materials and tools were pretested as part of the development process. HC3 staff interviews agreed that feedback from pretests was used to inform changes to program materials and tools before they were finalized. (It should be noted that the evaluation team did not review pretest reports to confirm the quality of pretest activities.)

Implementation and Monitoring

Staffing and Competencies. It was clear from interviews in Nigeria and Côte d'Ivoire that HC3 staff had trained local implementing partner outreach staff to conduct program activities: *"[HC3's CS] centers on building the capacity of their subs to implement specific programs"* (USAID Mission). In Nigeria, HC3 staff reported, and many local implementing partners confirmed, that HC3 involved partners in some aspects of program conception, such as materials development, as a learn-by-doing approach to build the competencies of individual staff in SBCC program design. In Côte d'Ivoire, the vast majority of country implementing partners reported that HC3 trained their staff to improve financial and project reporting.

Systems for Supervising Field Staff and Activities. It appears from interviews in Nigeria and Côte d'Ivoire that supervision and on-site coaching systems were built into program activities: *"There is constant supervision at the grassroots"* (Nigeria local partner). In both countries, it was reported that HC3 supervisors maintained regular contact with implementing staff and, in Côte d'Ivoire, attended the majority of community sessions. Respondents also reported that HC3 central office staff conducted field visits to complement regular field supervision activities. In Nigeria, it was reported that HC3 supervisory staff also provided direct assistance to state coordination bodies.

Monitoring Systems/Tools and Data Use. HC3 established strong data collection and feedback systems in Nigeria and Côte d'Ivoire: *"HC3 gave us data collection and entry assistance, and we figured out how to do it quickly"* (Nigeria local partner). Local implementing partners also reported, and HC3 staff confirmed, that partners received regular feedback after they submitted required reports. However, some respondents felt that HC3's evaluation was poor: "*They could do better on the evaluation of activities; with the SuperGo! Evaluation … they focused mostly on knowledge and perceptions of risk and less on behavioral outcomes."* (USAID Mission). Document review confirmed that HC3 evaluations tended to focus on changes in knowledge and attitudes.

Question 3 Conclusions

1. In general, USAID Mission respondents in Guatemala, Nigeria, and Côte d'Ivoire were satisfied with HC3's performance against expected results, as outlined in country-specific SOWs, annual work plans, and project monitoring plans. Respondents credited as contributing to HC3's success its strong technical staff, flexibility in responding to USAID's evolving needs, and willingness to provide technical and coordination support to partners. A previously established presence and previous relationships with partners were also indicated as facilitating factors in Côte d'Ivoire and Nigeria. However, lack of timely delivery of program outputs in Guatemala and Côte d'Ivoire and incomplete communication in Guatemala and Nigeria were identified as having negatively affected project performance.

2. Local partners benefit primarily from CS support only in implementing program activities and tools; the extent to which HC3 has been able to achieve country program targets may reflect on the success of these CS activities. Funding for discrete CS is limited to HC3's core budget; resources developed at the global level are expected to support CS in-country. In Nigeria, where HC3 has a mandate to strengthen the capacity of national and state government coordination bodies, the impact of its activities on the capacity of national bodies has been significant.

3. Very few field-based respondents, even HC3 in-country staff, were aware of CS tools developed at the global level, and HC3 has not conducted capacity analysis to determine how field implementers access and apply these tools. Because the evaluation team was not able to locate country implementers who had used HC3's global tools, it was unable to evaluate how effectively these tools have improved the quality of SBCC programs.

4. A reasonable indicator of HC3's impact on the quality of SBCC programs is the quality of its own country-level SBCC activities. In reviewing programs, the evaluation team found that:

    a. HC3 has demonstrated impressive discipline in conducting situation analyses and applying theory and models to inform program design. Although completion and use of original research is lacking, that may be the result of limited funds to support program-specific SBCC research. HC3 has taken into account other programs to ensure complementarity and harmonization, but identified inadequate linkages between demand created by HC3 and service/product delivery in Nigeria and Côte d'Ivoire.

    b. HC3 has demonstrated good application of ecological assumptions and has worked at several levels to effect behavior change. Its programs have used solid approaches to extend the reach and deepen the impact of its activities. Audience segmentation, the development and use of audience insight, and the prioritization of communication objectives and messages, however, were insufficient. Programs inundated broad segments of the population with the same activities and messaging, irrespective of preference, need, or life stage. Channel selection and prioritization defaulted to previously used channels with little consideration for program needs, behavioral determinants, audience access, or cost-effectiveness.

    c. HC3 has involved local stakeholders and technical staff both to make its tools more accurate and to facilitate local ownership and recognition. Materials and tools were pretested and the feedback used to inform changes. But although interventions and materials development were linked to national communication strategies, programs tended to default to tried-and-true models. While not inherently wrong, wholesale adoption of one program by another ignored the opportunity to create program

solutions that might be better suited to audience and program needs and desired outcomes, and provide a more cost-effective means to reaching key audiences.

d. HC3 has trained outreach staff to implement program activities and trained most other staff to fulfill supporting functions. Robust supervision systems provided continuous feedback and coaching to program implementers while contributing to program fidelity. Monitoring systems and tools are strong and key staff have been trained in their application. They are complemented by regular feedback from HC3 staff on program reports. Evaluation often focused heavily on changes in knowledge and attitudes rather than actual behavior; this was a missed opportunity to highlight the important role of SBCC in health programming.

ADDITIONAL INTERNAL OPERATIONAL ELEMENTS

Throughout this evaluation operational elements[15] were identified that did not specifically correspond to any of the three evaluation questions but may also have impacted how effectively HC3 fulfills its mandates. Among these are the following:

Advantageous to Achieving Project Objectives

Staffing: Finance Unit. HC3 addressed some finance staffing issues promptly and its response has ensured that the work can be carried out promptly and efficiently. In the first year of the project, Finance was unable to fulfill its responsibilities; for example, initially the unit had trouble contracting properly to respond to USAID's emerging needs, which resulted in delays in making sub-grants. To mitigate the problem, HC3 hired additional staff experienced with contracting. Two other improvements it made are noteworthy: HC3 has streamlined hiring of country staff and created master service contracts for frequent service providers to speed the contracting process. The majority of USAID and HC3 staff interviewed felt that contractual and funding mechanisms had improved. Furthermore, the evaluation team found that staffing additions and closer adherence to financial procedures had improved HC3's abilities to report effectively and disburse funds more quickly: *"Though things are still sometimes slow, we are getting work done and country programs are moving"* (HC3 Baltimore staff).

Expert Partners. HC3 has gathered together a truly exceptional team of highly skilled partners. Here an implementing partner, Save the Children, in Guatemala works with women to properly protect their bean crops.

Disadvantageous to Achieving Project Objectives

Contacts and Relationships. HC3's outreach to new partners has stagnated. Because HC3 has relied heavily on previous relationships it has not entered into new partnerships that could ignite more critical and creative thinking and broaden the repertoire of approaches to SBCC and to CS in SBCC: *"HC3 … is not searching for new partners, not moving outside of these that they know to expand SBCC capacity reach"* (USAID Mission). If HC3 is to effectively advocate for SBCC

[15] See Appendix D for a full list of operational and organizational effectiveness elements investigated.

and for CS in SBCC and to advance the field, it must cultivate new collaborators to infuse as yet untapped intellectual and practical debate and ideas.

Innovativeness.[16] HC3 has settled for what is familiar but not necessarily most suitable. The majority of respondents stated that HC3 has had difficulty applying new and different approaches to its work: *"Sometimes … it's hard to break out of what we know, shake up our comfort zone"* (HC3 Baltimore staff). A significant number of documents reviewed indicated that HC3 has used what it is familiar with and has employed elsewhere, often replicating programs from one country in another without considering new models based on country context and audience needs. The majority of USAID Missions and implementing partner respondents felt that HC3 has not sufficiently embraced its role in encouraging the exploration and advance of best practices in behavioral programming and in identifying new ways to reach key audiences. To effectively create a CS and SBCC environment in which SBCC practitioners can develop and succeed requires that HC3 seek out cutting-edge opportunities.

Ongoing Assessment, Feedback, and Communication. It appears that HC3 was not tuned into the perceptions of its clients and audiences: Although 61% of its staff think that assessment of project work and feedback to improve has been sufficient—*"continual contact and feedback with the field and our programs is maintained"* (HC3 staff)—79% of USAID Mission and project and implementing partner respondents did not agree. Among their complaints was that feedback, and communication in general, consisted of reacting to requests rather than proactively providing necessary information. Furthermore, while most of the same respondents thought that HC3 kept them informed, they also thought that communication often seemed guarded and ambiguous: *"We are not always sure we have received the full story … it makes us question and be anxious."* (USAID Washington); one such example was the replacement of AfriComNet and another was seconding a new MSH staff member to HC3 headquarters without previously informing USAID/W. To effectively relate to, respond to, and address concerns, HC3 needs to listen to its clients and audiences and continually reconfirm their comprehension.

Project Plan. HC3 has not fostered exchange among project technical units and built on lessons and successes, such as by linking topical worksheets or bundling health behaviors. The vast majority of respondents indicated that HC3 planning across technical areas was no longer evident: "*There really isn't much planning or coordinating across units or at least what is needed."* (HC3 Baltimore staff). To strengthen its work requires that HC3 coordinate the big picture and tasks between, not just within, technical units.

Responsiveness. It appears that HC3 has confounded responsiveness to needs with targeted awareness of the field in general. While HC3 has been responsive to USAID/DC, USAID/Mission, and implementing partner needs, it did not appear from the evaluation that the responsiveness was the result of real insight into field needs and how they affect project or program outcomes—targeted awareness: "*We know that we try to listen to the field, but we are not always sure what our efforts mean for them or for the project mandates"* (HC3 Baltimore staff). To ensure that client and audience needs are met while concurrently meeting project needs requires that HC3 be familiar with its clients, its audiences, and its staff and create mechanisms to harmonize these diverging interests.

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[16] While the team acknowledges that the TRANSFORM project was designed to foster innovation and work alongside HC3, because HC3 itself has used "innovative" as an indicator [Indicator 1.4.1], it was considered reasonable to examine this element.

Weak Project Leadership. While 75.8% of HC3 survey respondents initially stated that they felt their senior management demonstrated positive leadership qualities, upon further investigation and discussion, the majority of HC3 respondents, as well as USAID Mission and implementing partners, affirmed that while most technical unit leaders were strong, project leadership was not providing strategic direction, "*not steering under steam, letting the wind take us*" (HC3 Baltimore staff). When the CS mandate was affected by Mission buy-ins, senior leadership were unable to balance Mission and project needs or were unable to propose proactive strategies. Numerous HC3 staff also thought that senior management had been tentative in dealing with critical staffing issues, which had affected technical work outcomes, especially in the CS portfolio. Furthermore, after funding had been reduced, university engagement had suffered because there was no judicious or creative thinking by project leadership on how to work with and continue to engage universities. Thus the university portfolio stagnated.

Staffing: CS Unit. It appears that HC3 did not take rapid and appropriate action with regard to the CS unit. A significant number of respondents and the document review made it clear that the CS technical lead has not provided concrete and consistent direction to the portfolio. Most data sources felt that CS unit staff could not adequately define the project's vision for CS: "*Is it personal, is it organizational, how do we do it … how does it fit together, how do we accomplish it?*" (HC3 Baltimore staff). Furthermore, it was observed that except for MSH people, HC3 staff did not appear to understand the basics of CS and how fundamental behavior change concepts are to the process. Such concepts affect integration into how programs are conducted, proper feedback cycles, audience segmentation, selection of the right channels, and when and how capacity assessment fits in. Many respondents also stated that they felt the CS unit was technically lacking, and a document review of tools and plans supported the observation. For example, the capacity improvement cycle provides no clear guidance on how to strengthen capacity; and channels, approaches, and linkages to topics or audiences are inconsistent. To establish the validity of CS in SBCC, which includes ensuring that CS is solidly integrated into all technical units and effectively shared and promoted, requires that HC3 have a CS team lead who is technically highly competent and a supportive team of internal and external experts.

Staffing: Research Unit. The delays in hiring a research director significantly delayed essential CS and SBCC research and it will be difficult to make up for the delays. The project lost its research director at the end of year 1 and did not fill the position until month 9 of year 2. While other research specialists within the JHU system, such as Doug Story and Maria Elena Figueroa, contributed their expertise during the interim, their coverage could only be basic, and the project suffered. Research that was necessary to strategy development was delayed, as was vital evidence-based research for SBCC, and the project RME plan was not completed. Although a new research director was hired in June 2015, this long delay has made it very difficult for HC3 to fulfill three of its main mandates by the end of the project: (1) increased availability of technical information for SBCC programming, (2) greater awareness of CS best practices, and (3) increased availability of technical information for CS. To advance CS and SBCC and to expand the CS and SBCC body of evidence requires that HC3 promptly amass a robust and expansive collection of targeted materials that demonstrate the value-added of CS and SBCC.

Vision. HC3 does not have a clearly articulated vision—a succinct, aspirational definition of the project's desired future. Though 73% of the HC3 staff surveyed stated that their project vision was understood and inspirational, none could express it. Meanwhile, the majority of USAID and implementing partners consider HC3's vision to be unclear. Subsequently, many HC3 staff

agreed that a vision was not yet in place and that it was difficult to articulate a vision to non-HC3 staff: *"We are on the verge of visioning"* (HC3 Baltimore staff). When asked by USAID early in Project Year 1 to produce a vision statement—an "elevator speech"—HC3 instead produced a two-page mission statement defining the purpose of project, what it does, and how it does it. While a vision is not indispensable to success, the lack of it suggests larger operational issue: that HC3 HQ staff and HC3 leadership are not in concert, that HQ staff and others are not in agreement; and that the project lacks the cohesiveness it needs to advance CS and SBCC. To collectively and persuasively advance CS and SBCC requires that HC3 clearly articulate what is it doing, and why, so that partners and stakeholders can recognize how, when, and why to contribute and rejoin.

V. ANALYSIS

Analysis of the findings for all three evaluation questions and technical areas (OE, SBCC, and ICT) reveal several overarching trends and patterns. The evaluation team has chosen to focus on these broad issues as areas that HC3 should address to improve not only its performance in the final two years of the project but also to improve the quality of its outcomes.

OVERARCHING AREAS OF SUCCESS

HC3 deserves recognition for its successes in four main areas that have enabled HC3 to deliver on project expectations and will enable it to further improve its work. The successes, which were revealed at global, regional, country, and project levels and across all HC3 technical areas, e.g., HIV/AIDS, malaria, etc., were these:

1. **Strong technical staff and partners,** when properly supported, offer a complete array of skills to produce quality outputs.
2. **The online repository of high-value capacity strengthening and technical resources** has created a needed platform for dissemination of high-quality resources for SBCC programs.
3. **Resilient country programs** provide the basis for quality programs and activities.
4. **Solid national coordination efforts** have been well-received and highly effective in beginning to build national SBCC capacity.

All of these areas of success filter down and across the HC3 project, enabling both HC3's global and country-level impact. In discussing these areas of success during debrief presentations, HC3 stated that *"it is proud of its successes and looks to build on them to the maximum."*

How have these areas of success supported HC3's ability to perform effectively?

- **Strong technical staff and partners** have (1) delivered quality outputs with minimal oversight, regardless of project constraints; (2) allowed partners to provide resources and expertise that complement those of core HC3 staff, such as deeper experience in CS, media integration, and digital support; and (3) assured that quality staff are in place in-country and technical assistance is provided, permitting country programs to fulfill their mandates.
- **The online repository of high-value CS and SBCC Resources** has (1) assembled, curated, and made available to SBCC practitioners the most effective technical resources that can be used to develop and manage higher-quality SBCC programs, and (2) begun to collect evidence to demonstrate the importance and value-added of SBCC.
- **Resilient country programs** have (1) ensured that programs are implemented despite challenges outside HC3's control, such as funding interruptions or reorientation of donor priorities; (2) built on existing experience and know-how; and (3) capitalized on strong relationships and trust, allowing country programs to achieve impact more quickly.
- **Solid national coordination efforts** have (1) created meaningful roles for national SBCC structures; and (2) supported the institutionalization of SBCC across technical programs.

AREAS TO IMPROVE

HC3 needs to improve in four areas where shortfalls have undermined its ability to perform effectively and will continue to reduce the effectiveness and impact of its programs if not quickly rectified. These limitations were found at global, regional, country, and project levels and across all HC3 technical areas, such as HIV/AIDS, and the President's Malaria Initiative. These are the four areas:

1. **HC3's project strategy** needs to be reinforced and expanded at all levels across all technical areas.
2. **Internal leadership** needs to be strategically strengthened.
3. **Quality assurance and quality improvement** are not ensured across all that HC3 produces and implements, especially at the country level.
4. Because **research, monitoring, and evaluation (RME)** is incomplete and incoherent, it fails to contribute meaningfully to project goals.

All of these areas filter down and across the HC3 project, diluting HC3's global and country-level potential impact. In discussing these areas with HC3 during HC3 Midterm Evaluation debrief presentations, HC3 stated that *"if we could use quality assurance as the rubric under which all other work is done, we could tackle these other issues…to assure solid performance and maximize our strengths."*

How have these areas to improve affected HC3's ability to perform effectively?

- **Inadequate project strategy** has (1) undermined HC3's ability to respond to requests without disrupting progress on its primary mandate; (2) diminished its ability to deliver in a timely manner, especially when changes occur; (3) reduced the potential impact of SBCC and CS by limiting exchange across different health areas; (4) minimized the potential reach of online resources; (5) curtailed the shared understanding of a cohesive, explicit path to project success; and (6) diminished the likelihood that CS, technical leadership, and RME will be strong and sustained.
- **Limited leadership** has (1) limited HC3's ability to staff soundly and assess needed staff competencies, and (2) created unclear expectations and communications among staff, partners, and stakeholders.
- **Inadequate QA and QI** have (1) diminished HC3's ability to deliver quality products at all levels; (2) undercut CS and SBCC best practices, technical leadership, and RME; (3) diluted the impact of RME and CS in SBCC; and (4) decreased the likelihood that SBCC will be viewed as value-added.
- **Incomplete RME** has (1) reduced feedback to HC3 and service/product delivery programs, a key feature of HC3's own planning process (the "P" Process) to inform program improvements and to balance supply with demand creation; (2) underrated the need to focus on behavioral outcomes; (3) missed prime opportunities to demonstrate the value-added of SBCC; and (4) diminished the likelihood of perceived technical leadership and timely, targeted RME.

VI. CONCLUSIONS

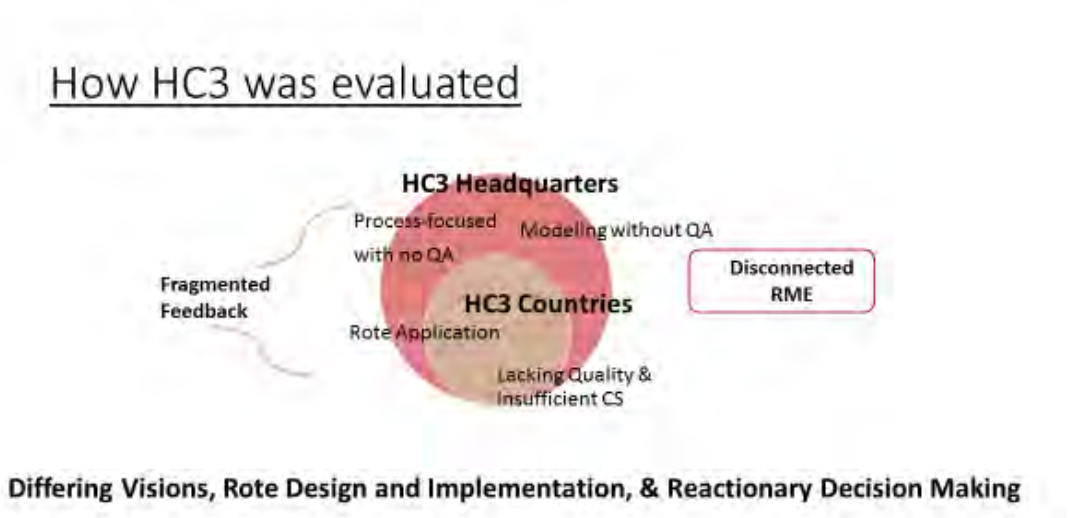
In JHU/CCP's technical application, HC3 was designed around a bold vision of *"a world where health communication is transformative."* This vision assumed that barriers to better health could be best overcome through local engagement and leadership in SBCC programs. It was intended that the HC3 project would contribute to realizing that vision through a learning framework that worked at several levels to strengthen capacity while offering solid tools and approaches and demonstrating models of excellence in SBCC programming. The HC3 project was awarded at a critical moment for SBCC programming worldwide and is uniquely positioned to respond to questions about the role of SBCC in impactful programs.

However, this evaluation has found that weak leadership has limited HC3's ability to advance the cause of SBCC and could impede progress toward its original vision. A lack of strategic direction at all levels and limited application of quality standards also diminish the project's position as a reference point for excellence in SBCC programming. While most partners view HC3 as a technical leader, because it has become a reactive player that develops global tools and country-level interventions without adhering to its own good practices and standards, the HC3 project has not fulfilled its role as a USAID flagship.

Figure 1 depicts what the evaluation team thought to experience based on documents and interviews with HC3 staff and Figure 2 what it actually experienced during the evaluation. Figure 1 shows what HC3 envisioned and where it wanted to be at the end of five years. Figure 2 shows where the evaluation finds it now. With no new apparent vision or revised strategy to manage the changes that all have recognized, HC3's programming has become reactive, minimizing its ability to achieve a shared vision of its desired outcomes and maximizing the likelihood that *"at the end of the day [we] will be in the same place as traditional programs—implementers, not capacity strengtheners and champions of SBCC"* (Project partner).

Figure 1. HC3 "Vision" Past

Figure 2. HC3 "Reality" Present



HC3 has not as yet strategically integrated the changes it has undergone (less emphasis on CS, push to direct implementation for rapid results, influx of Ebola money, and lack of TRANSFORM cooperation); nor has it appropriately exploited these changes. HC3 has the capacity to improve in its final two years, because it has the staff and technical resources necessary to achieve its project and country mandates. However, it must be willing to expeditiously implement changes that improve its value to its global and in-country audiences and reinvigorate its QA and improvement efforts.

VII. RECOMMENDATIONS

Recommendations for how HC3 can improve in the immediate future to maximize its performance and outcomes for the remaining two project years are presented as three-month, six-month, and nine-month tasks. It is hoped that this will enable the HC3 project to move quickly to build on its strengths and minimize its limitations.

Table 1. Recommendations for HC3 within Three Months

RECOMMENDATIONS FOR HC3	CORRESPONDING RECOMMENDATIONS FOR USAID
HC3 should:	**USAID could:**
1. Draft a 2-year strategy for HC3 that, among other things, clearly articulates the project's technical leadership, RME, and CS roles, and how together they will contribute to achievement of project objectives. The strategy must clearly define SBCC CS at different levels, and how it can be promoted, supported, and measured, using MSH expertise. The strategy must filter down to the country level and be integrated into all project work.	1. Select one team member to work as part of HC3's strategy development team to make sure the strategy is aligned with USAID/Global Health's goals for HC3 and with emerging agency priorities. Involve members from different funding units as appropriate. Ask for definitions and criteria and lists of CS indicators at each level to ensure they meet USAID needs.
2. Draft a quality assurance and quality improvement (QA/QI) strategy for HC3-supported in-country projects, with clear indicators based on JHU/CCP's own standards for SBCC design, implementation, and evaluation, to be applied to both global and country-level work. Draft a complementary implementation plan for the roll-out of this strategy, prioritizing countries to be reached in the remaining years of the project.	2. Review and approve the strategy and implementation plan.
3. Engage in leadership exercises to ensure that operational and technical activities are closely connected and that the strategy and corresponding plans are implemented effectively.	3. Participate in exercises as both a method of partnership- building with HC3 and an opportunity for professional development.
4. Re-examine staffing and replace or train staff as needed to ensure strong, competent technical leads and teams.	4. Work closely with HC3 to assess staff strengths and help create clear expectations of outcomes.
5. Finalize the M&E plan and the PMP for the remaining 2 years to ensure that they reflect HC3's technical leadership and RME roles.	5. Work with HC3 to define what USAID wants in the plan and encourage HC3 to finalize it quickly.
6. Create a plan for how CS efforts and RME can be better integrated across all HC3 units and countries, by type, need, and approach.	6. Based on the revised strategy and vision, assess the extent to which CS will be better integrated into HC3, and capture ideas for other SBCC projects.

RECOMMENDATIONS FOR HC3	CORRESPONDING RECOMMENDATIONS FOR USAID
HC3 should:	**USAID could:**
7. Survey how digital tools can be used to promote CS, technical leadership, and RME, and identify specific areas where they can be used.	7. Articulate to Missions why digital tools add value to their local work rather than being a distraction.
8. Create a formalized development model and a 2-year strategy to make Springboard more impactful, effective, and supportive of HC3's CS strategy and on-the-ground implementation work.	8. Review the formal Springboard strategy; if does not meet suggested criteria, end Springboard and create a plan to close out USAID involvement.

Table 2. Recommendations for HC3 within Six Months

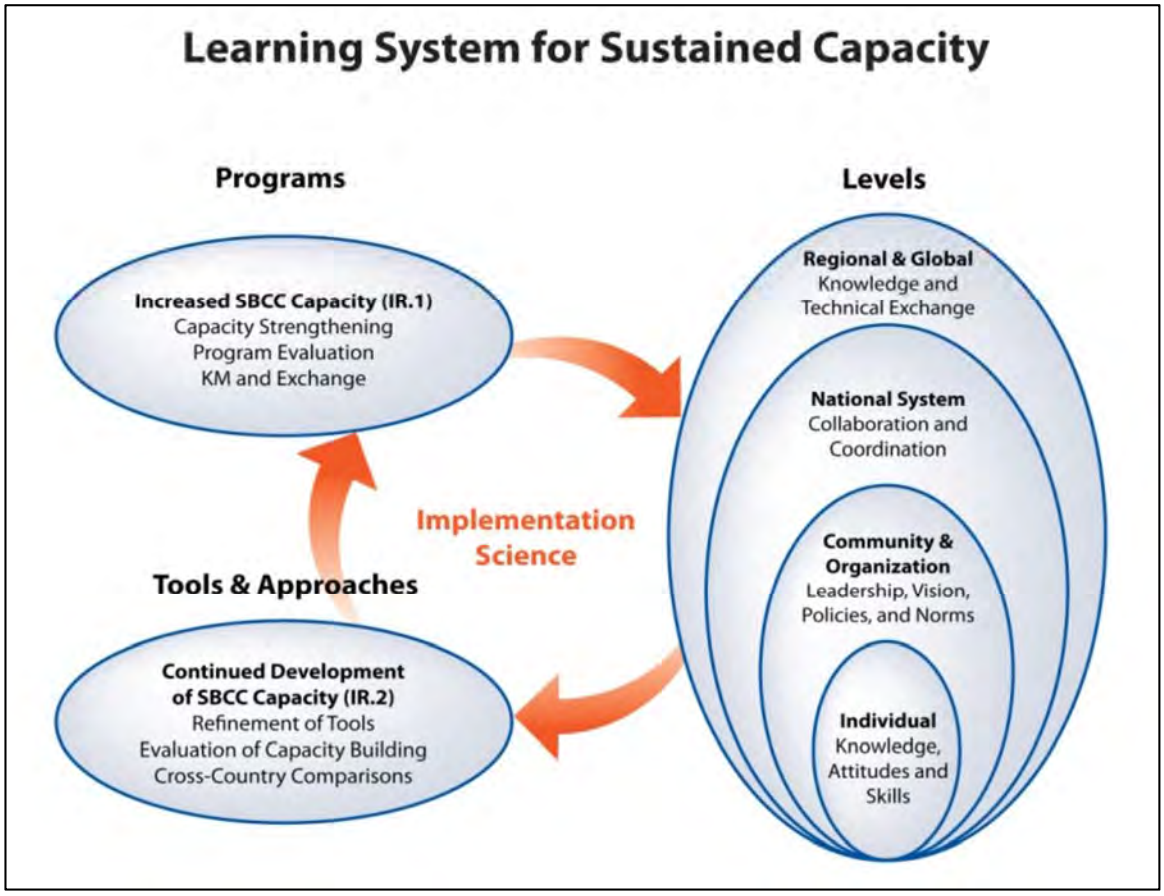
RECOMMENDATIONS FOR HC3	CORRESPONDING RECOMMENDATIONS FOR USAID
HC3 should:	**USAID could:**
1. Based on the CS definition and criteria/indicators being drafted, revise the work plan for the last 1½ years of project.	1. Ensure that MSH is deeply involved in the process and review the work plan, to make sure it is complete and realistic.
2. Audit the RME and SBCC capacity of in-country partners using HC3's SBCC capacity assessment tool and design tailored CS interventions to meet identified needs. Conduct an end-line audit to measure improvements at least six months before project close-out.	2. Ask USAID Missions to share plans developed and costs involved and support the effort.
3. Assess the digital capacity of local partners in selected countries to help optimize their access to HC3 digital tools.	3. Identify target countries and programs, and support digital capacity assessments, involving NetHope.
4. Implement the QA/QI strategy through direct technical support to ensure that country programs meet HC3 quality standards, as identified and measured in the QA/QI strategy. Involve local country partners in these QA audits and QI plan development and implementation to model QA/QI as a form of capacity building.	4. Engage Mission staff in audits, emphasizing how the process improves learning and quality in the long term.
5. Review HC3 tools, especially digital, to see how audiences access and use them, and how they provide feedback to improve them and strengthen content. Use the review results to improve how the HC3 tools are disseminated and promoted.	5. Provide feedback on review of the report and next steps to broaden dissemination.
6. Institutionalize processes for ICT feedback and country-identified content to make ICT tools and online resources more responsive to the needs of the field.	6. Track sources of topics and content, and emphasize to Missions the importance of involving local ICT partners, especially in light of Local Solutions.

RECOMMENDATIONS FOR HC3	CORRESPONDING RECOMMENDATIONS FOR USAID
HC3 should:	**USAID could:**
7. Disseminate "gold standard" behavioral indicators for SBCC programs and ensure that all HC3-supported country programs incorporate relevant indicators in project M&E plans.	7. Monitor and provide feedback.
8. Pilot behavioral indicators for CS activities, moving beyond process indicators by bringing in experts from other fields, e.g., anthropology, business administration, and psychology, to provide insight on appropriate indicators.	8. Encourage HC3 to access technical resources beyond JHU/CCP.
9. Produce four "letters" documenting impact of SBCC capacity strengthening, technical leadership and RME on program outcomes to quickly build, without heavy costs, a more solid evidence base for SBCC globally.	9. Encourage HC3 to ask for letter submissions from the field, especially from non- HC3 projects.

Table 3. Recommendations for HC3 within Nine Months

RECOMMENDATIONS FOR HC3	CORRESPONDING RECOMMENDATIONS FOR USAID
HC3 should:	**USAID could:**
1. Solicit examples from the field of SBCC capacity strengthening innovations to disseminate through the HealthCOMpass website as a way to contribute rapidly to the evidence base for incorporating CS and RME into SBCC programming.	1. Support this effort by working with HC3, and especially MSH, to draw up criteria for selecting SBCC CS innovations.
2. Create and implement a sustainability plan for HealthCOMpass to ensure that it continues beyond project close-out.	2. Prioritize support for HealthCOMpass and its content beyond HC3 close-out. Advise on HC3's sustainability plan for HealthCOMpass based on USAID's commitment to the platform and the resources that reside on it.

APPENDIX A. HC3 THEORETICAL AND RESULTS FRAMEWORKS



HC3 Results Framework

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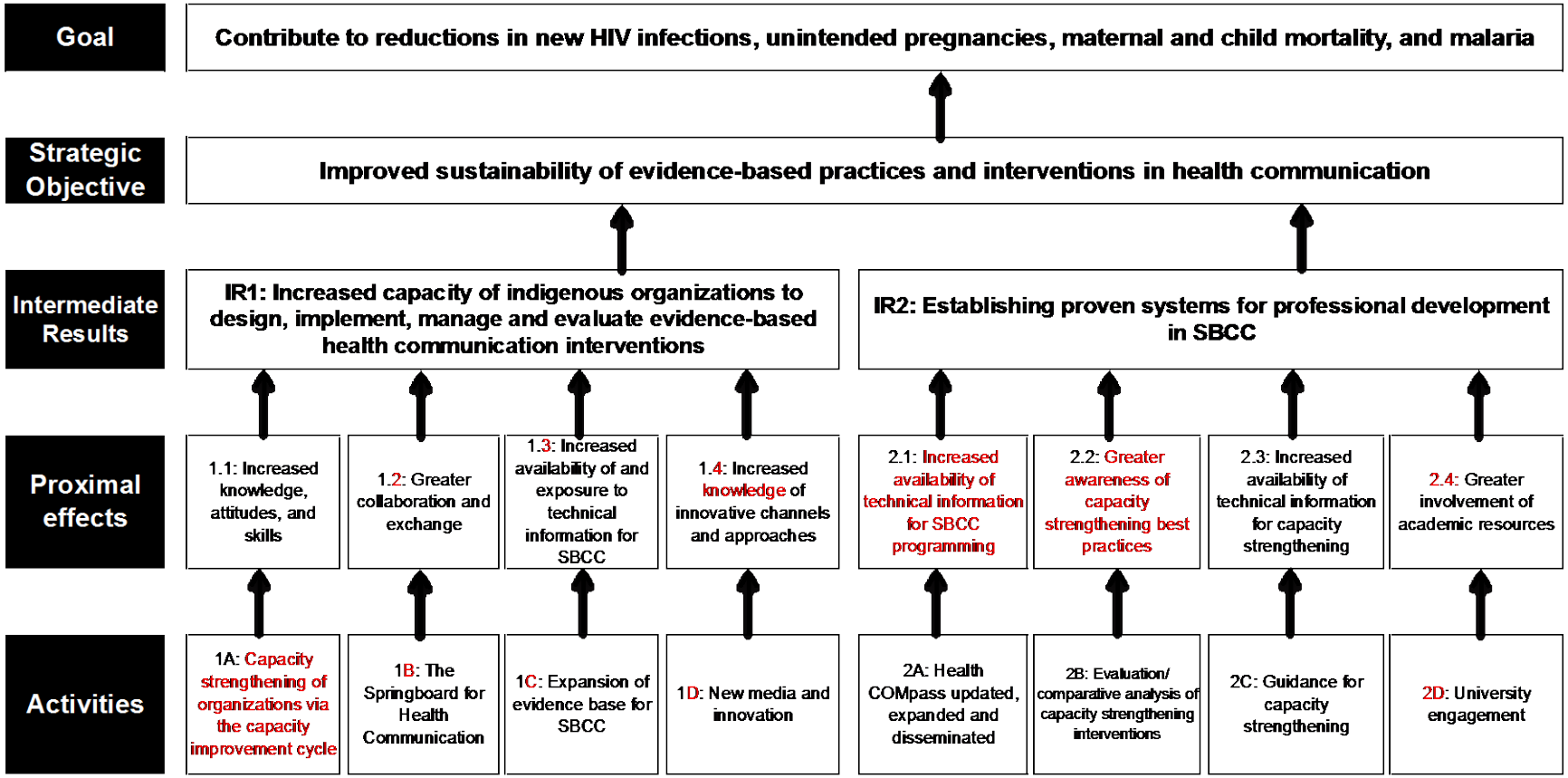


PMP INDICATORS AND DATA: OCTOBER 1, 2013–SEPTEMBER 30, 2014										
Indi-cator ID	Indicator	Revision Notes	Annual Targets		Year 2 Progress					
					Oct 13–Mar 14	Apr 14–Sep 14	Year Total	Total to date	Narrative	Data Source(s)
SO.1	Number of HC3-participating organizations receiving direct funding in the past two years from USAID or other donors for SBCC program design, implementation or evaluation		2014 2016	4 8	N/A	14	14			Ethiopia Capacity Survey
SO.2	Number of indigenous HC3-partner organizations that maintain a level of expert for at least two consecutive surveys		2014 2016	6 12	N/A	N/A	N/A		Baselines were conducted in Ethiopia and Nepal, will be repeated in future project years.	HC3 Capacity Surveys
1.1	Number of indigenous HC3-partner organizations demonstrating improved capacity, relative to baseline	We propose reporting only numbers as this indicator does not have a meaningful denominator.	2013 2014 2015 2016	10 20 30 35	N/A	N/A	N/A		Baselines were conducted in Ethiopia and Nepal, will be repeated in future project years.	HC3 Capacity Surveys
1.2	Number of HC3 project countries with the MOH/SBCC governing body demonstrating improved capacity in the past year, relative to baseline	We propose reporting only numbers as this indicator does not have a meaningful denominator.	2013 2014 2015 2016	2 5 6 8	N/A	N/A	N/A		Baselines were conducted in Ethiopia and Nepal, will be repeated in future project years.	HC3 Capacity Surveys

PMP INDICATORS AND DATA: OCTOBER 1, 2013–SEPTEMBER 30, 2014										
Indi-cator ID	Indicator	Revision Notes	Annual Targets		Year 2 Progress					
					Oct 13–Mar 14	Apr 14–Sep 14	Year Total	Total to date	Narrative	Data Source(s)
2.1	Number of HC3-supported CS tools and approaches incorporated into government-sponsored training curricula in the past year		2013 2014 2015 2016	3 5 8 10	N/A	0	0		No organizations from capacity surveys in Ethiopia or Nepal reported incorporating HC3 tools into training curricula.	HC3 Capacity Surveys/Field staff
2.2	Number of Springboard members that utilize HC3-supported tools in their routine internal training systems		2013 2014 2015 2016	15 35 50 70	N/A	10	10		Ten Springboard members report having incorporated HC3 tools into their internal training systems in the past year.	HC3 user survey
2.3	Percent of operating budget received from non-HC3 sources by the secretariat in the past year to support the functioning of the Springboard		2013 2014 2015 2016	5 10 20 35	N/A	0%	0%		AfriComNet members and partners in various countries have contributed their time and in-kind donations to support Springboard activities. AfriComNet has, however, been unable to raise independent funds during the period under review to support Springboard directly.	Kojo/James/ Africomnet
2.4	Percent of individuals accessing materials through the Health COMpass who report using the information in their work in the past six months		2013 2014 2015 2016	10 10 10 10	N/A	68%	68%		19/28 Health COMpass users report having used HC3 resources in their work.	HC3 user survey

PMP INDICATORS AND DATA: OCTOBER 1, 2013–SEPTEMBER 30, 2014										
Indi-cator ID	Indicator	Revision Notes	Annual Targets		Year 2 Progress					
					Oct 13–Mar 14	Apr 14–Sep 14	Year Total	Total to date	Narrative	Data Source(s)
1.1.1	Number of individuals participating in HC3-sponsored CS activities related to best practices	Formerly: Percent of participants in HC3-sponsored CS activities conducted in the past six months that report a positive change in individual self-assessment index between pre- and post- activity assessments. Activities= any training, workshop, or meeting with a specific meeting objective	2013 2014 2015 2016	70 80 90 95	N/A	2039	2039		2039 total individuals participated in capacity strengthening activities.	Katherine/HC3 field staff
1.1.2	Percent of participants in HC3-sponsored CS activities that report using the knowledge and/or skills learned in training in their work in the past six months		2013 2014 2015 2016	20 30 40 60	N/A	40%	40%		12/30 webinar, event or conference booth attendees report having applied new information gained from those events to their work.	HC3 user survey
1.2.1	Number of Springboard members participating in any south-south technical exchanges in the past year		2013 2014 2015 2016	10 30 60 75	N/A	15	15		Fifteen Springboard members report traveling to another country to exchange technical information in the past year.	HC3 user survey

PMP INDICATORS AND DATA: OCTOBER 1, 2013–SEPTEMBER 30, 2014										
Indi-cator ID	Indicator	Revision Notes	Annual Targets		Year 2 Progress					
					Oct 13–Mar 14	Apr 14–Sep 14	Year Total	Total to date	Narrative	Data Source(s)
1.2.2	Number of Springboard members actively participating in HC3-sponsored online discussion forums in the past six months	Active participation = discussion form posts, discussion views, global activity posts, activity streams, likes and polls	2013 2014 2015 2016	25 75 150 200	N/A	131	131			Springboard web statistics (Soma) (members pivot table spreadsheet: count of emails in column Z)
1.2.3	Number of project materials and documents posted by Springboard members to Springboard website in the past six months		2013 2014 2015 2016	15 50 80 120	N/A	81	81			Springboard web statistics (Soma) (posts spreadsheet: sum PDF and MS attachments ONLY.)
1.2.4	Number of Springboard members reporting successful collaboration with another member facilitated by the Springboard in the past year		2013 2014 2015 2016	5 35 75 100	N/A	7	7		Seven Springboard members who have collaborated with another member report the Springboard to be useful for that collaboration.	HC3 user survey

PMP INDICATORS AND DATA: OCTOBER 1, 2013–SEPTEMBER 30, 2014										
Indi-cator ID	Indicator	Revision Notes	Annual Targets		Year 2 Progress					
					Oct 13–Mar 14	Apr 14–Sep 14	Year Total	Total to date	Narrative	Data Source(s)
1.3.1	Number of peer-reviewed journal articles based on HC3 -supported evaluation data published in the past year	Formerly: Number of journal articles based on HC3 -supported evaluation data published in the past year	2013 2014 2015 2016	4 6 8 10	N/A	3	3		1. SBCC in Malawi—AIDS Care 2. JAIDS Supplement (counted as single item, but contained 13 articles, 8 of which were contributed by HC3-supported R&E staff. nb: these were not program evaluation articles per se, but all cited evaluation results) 3. Joint Communication Survey in Mozambique—AIDS Care	Redcap/Doug
1.3.2	Number of interactions in the past six months with materials summarizing best practices in health communication on the Health COMpass, Springboard virtual platform and HC3 website		2013 2014 2015 2016	500 1500 3000 5000	8,710	14,484	23,194		1,780 Health COMpass downloads 3,373 Health COMpass link clicks 1,897 HC3 site downloads 4,901 HC3 site link clicks 11,243 HC3 site blog reads	Google analytics dashboards

PMP INDICATORS AND DATA: OCTOBER 1, 2013–SEPTEMBER 30, 2014										
Indi-cator ID	Indicator	Revision Notes	Annual Targets		Year 2 Progress					
					Oct 13–Mar 14	Apr 14–Sep 14	Year Total	Total to date	Narrative	Data Source(s)
1.3.3	Number of HC3-supported presentations providing technical guidance for SBCC in the past year		2013 2014 2015 2016	10 15 20 20	8	12	20		Health Communication and HIV webinar Exhibit booth at ICASA 3 Urban Youth SRH/SBCC events AfrEA Presentation NetHope member summit health communication workshop ICASA Presentation - Evidence of Health Communication CFAR JAIDS Panel IAS JAIDS Satellite IAS VMMC Satellite RBM CCoP meeting: Geneva JAIDS USAID brownbag Community level factors webinar Urban youth LeaderNet leadership seminar Innovations & new approaches for SBCC capacity strengthening webinar LARC-Youth Springboard Discussion Measuring outcomes HIV webinar JAIDS supplement press club briefing Rec 7 I-Kit pretest in Uganda	Redcap

PMP INDICATORS AND DATA: OCTOBER 1, 2013–SEPTEMBER 30, 2014										
Indi-cator ID	Indicator	Revision Notes	Annual Targets		Year 2 Progress					
					Oct 13–Mar 14	Apr 14–Sep 14	Year Total	Total to date	Narrative	Data Source(s)
1.3.4	Percent of individuals interacting with SBCC materials who report incorporating the information into their work in the past six months		2013 2014 2015 2016	10 15 20 30	N/A	50%	50%		29/58 HC3 resource users report having used those resources in their work in the past year.	HC3 user survey
1.4.1	Number of interactions in the past six months with documents and materials related to innovative communication channels and approaches on the Health COMpass, Springboard virtual platform and HC3 website		2013 2014 2015 2016	150 750 1500 2500	1,192	4,796	5,988		Health COMpass: 939 HC3 website: 3,287 Springboard: 1,762	Google analytics dashboard
1.4.2	Number of participants attending HC3-sponsored activities related to innovative communication channels and approaches in the past year		2013 2014 2015 2016	60 80 100 40	318	373	691		ICASA VMMC Satellite Session: 100 Youth Campaigns Webinar: 98 Gaming webinar: 120 NetHope member summit health communication workshop CFAR JAIDS Panel: 82 RBM CCoP Meeting: Geneva: 30 Behavioral Economics webinar: 160 Social Drama webinar: 101	Redcap

PMP INDICATORS AND DATA: OCTOBER 1, 2013–SEPTEMBER 30, 2014										
Indi-cator ID	Indicator	Revision Notes	Annual Targets		Year 2 Progress					
					Oct 13–Mar 14	Apr 14–Sep 14	Year Total	Total to date	Narrative	Data Source(s)
1.4.3	Percent of individuals who report attending activities on innovative communication channels and approaches, and intend to use the information in the coming year.	Formerly: Percent of individuals attending activities on innovative communication channels and approaches who report an intention to use the information in their work in the coming year.	2013 2014 2015 2016	10 15 20 30	80%	86%	83%		Gaming webinar: 82% of respondents Youth Campaigns webinar: 78% Behavioral Economics webinar: 75% Social Drama webinar: 96%	Innovation webinar follow-up surveys (Soma)
1.4.4	Percent of Springboard members reporting the use of a new communication channel or approach to disseminate health messages in the past year	Springboard members = people with an online Springboard account	2013 2014 2015 2016	10 15 20 30	N/A	37%	37%		In the first Springboard user survey, 17/46 members report having learned about a new channel from the Springboard in the past year.	HC3 user survey
2.1.1	Number of interactions in the past six months with materials posted on the Health COMpass	Interactions = downloads & link clicks	2013 2014 2015 2016	150 750 1500 2500	2,451	2,702	5,153		1,780 downloads 3,373 link clicks	Google analytics dashboard
2.1.2	Number of Springboard members who report using information from materials posted on the Health COMpass in their work in the past year		2013 2014 2015 2016	15 35 50 70	N/A	16	16		Sixteen Springboard members that have also used the Health COMpass report using those materials in their work in the past year.	HC3 user survey

PMP INDICATORS AND DATA: OCTOBER 1, 2013–SEPTEMBER 30, 2014										
Indi-cator ID	Indicator	Revision Notes	Annual Targets		Year 2 Progress					
					Oct 13–Mar 14	Apr 14–Sep 14	Year Total	Total to date	Narrative	Data Source(s)
2.2.2	Number of journal articles on CS evaluation based on HC3-supported evaluation data published in the past year		2013 2014 2015 2016	0 2 3 3	N/A	1	1		Lettenmaier et al. (2014) in JAIDS supplement. "IV Communication Capacity Strengthening: A Critical View."	Doug/Redcap
2.3.1	Number of interactions in the past six months with capacity strengthening guidance materials on the Health COMpass, Springboard virtual platform or HC3 website		2013 2014 2015 2016	150 750 1500 2500	1,067	1,050	2,117		657 downloads 1,460 link clicks	Google analytics dashboard (Health COMpass only)
2.3.2	Number of capacity strengthening guidance materials posted on the Health COMpass, Springboard virtual platform or HC3 website in the past year		2013 2014 2015 2016	20 25 40 50	N/A	N/A	347		347 total capacity strengthening tools on the Health COMpass.	*Data source: Susan L/Leanne/ website* *Count of SBCC Tools posted*
2.4.1	Number of HC3 project countries with at least one university offering courses covering all elements of the standard SBCC curriculum		2013 2014 2015 2016	1 3 5 6	N/A	5	5		Based on University Needs Assessment. (Nigeria, Ethiopia, Cote d'Ivoire, Tanzania, Bangladesh)	Doug/HC3 field staff

PMP INDICATORS AND DATA: OCTOBER 1, 2013–SEPTEMBER 30, 2014										
Indi-cator ID	Indicator	Revision Notes	Annual Targets		Year 2 Progress					
					Oct 13–Mar 14	Apr 14–Sep 14	Year Total	Total to date	Narrative	Data Source(s)
2.4.2	Number of HC3-supported health communication programs initiated in the past year that involve university-affiliated faculty members in the planning phase of the program		2013 2014 2015 2016	0 1 2 3	N/A	1	1		Jimma University participated in the baseline capacity assessment.	Doug/HC3 field staff
2.4.3	Number of enrollees in SBCC/health communication courses offered by partner universities in the past year		2013 2014 2015 2016	30 60 90 120	N/A	Average of 54 enrollees per university across 21 universities	Average of 54		Based on University Needs Assessment.	Doug/HC3 field staff

PMP INDICATORS AND DATA: OCTOBER 1, 2013–SEPTEMBER 30, 2014										
Indi-cator ID	Indicator	Revision Notes	Annual Targets		Year 2 Progress					
					Oct 13–Mar 14	Apr 14–Sep 14	Year Total	Total to date	Narrative	Data Source(s)
1A.1	Number of countries in which HC3 implemented CS activities in the past year		2013 2014 2015 2016	3 8 10 11	N/A	14	14		Indicator refers to capacity strengthening activities implemented with both core and field support countries. Four of the fourteen countries (India, Afghanistan, Zambia, Kenya) participated in capacity strengthening activities only through Virtual Leadership development program- VLDP). The other ten countries are: Guatemala (core funded), Tanzania (core and field), Pakistan (core), Cote d'Ivoire (core and field), Swaziland (field), Nigeria (field), Nepal (field), Bangladesh (field), Uganda (core [AfriComNet]), Ethiopia (field)	Katherine/Field staff
1A.2	Number of organizations receiving HC3-sponsored CS in the past six months		2013 2014 2015 2016	12 25 35 40	N/A	62	62			Katherine/Field staff

PMP INDICATORS AND DATA: OCTOBER 1, 2013–SEPTEMBER 30, 2014										
Indi-cator ID	Indicator	Revision Notes	Annual Targets		Year 2 Progress					
					Oct 13–Mar 14	Apr 14–Sep 14	Year Total	Total to date	Narrative	Data Source(s)
1A.3	Number of individuals participating in HC3-sponsored training in strategic health communication design, implementation or evaluation in the past six months	Training = conference, seminars, workshops, mentorship programs, eLearning	2013 2014 2015 2016	100 300 500 450	36	158	194			Katherine/Attendance Lists/ James BonTempo/ Field staff/Redcap
1B.1	Number of individuals who join the Springboard	Removed recall period as it is implied by reporting dates Formerly: Number of individuals who join the Springboard in the past 6 months	2013 2014 2015 2016	50 1650 1300 1100	183	1,483	1,666		We will revise the target numbers in the next iteration of the PMP.	Springboard web statistics (Soma) (members spreadsheet: count of emails registered)
1B.2	Proportion of Springboard members who actively participate in a Springboard activity in the past six months	Active participation = discussion form posts, global activity posts, activity streams, likes and polls	2013 2014 2015 2016	50 60 70 80	57% (105/183)	9% (131/1,483)	8% (131/1,666)			Springboard web statistics (Soma) Indicator 1.3.2/1C.1

PMP INDICATORS AND DATA: OCTOBER 1, 2013–SEPTEMBER 30, 2014										
Indi-cator ID	Indicator	Revision Notes	Annual Targets		Year 2 Progress					
					Oct 13–Mar 14	Apr 14–Sep 14	Year Total	Total to date	Narrative	Data Source(s)
1B.3	Number of Springboard activities held in the past six months	Activity = launch events, learning forums, conferences, online discussions, and advisory council meetings, online polls, online campaigns (the last two features to be implemented in near future)	2013 2014 2015 2016	6 12 12 6	6	12	18		Anglophone Africa Advisory Council Meeting HC3 event at ICFP 2013 NetHope member summit health communication workshop ICFP University meeting RBM CCoP Meetings in Washington, DC and Geneva Second Springboard global advisory council meeting LARC-Youth Springboard Discussion Launches in nine countries AfriComNet M&E practicum	Redcap
1C.1	Number of rigorous impact evaluation studies conducted in the past year in partnership with indigenous research institutions		2013 2014 2015 2016	1 1 2 1	N/A	4	4		Tanzania Channels Study Nigeria ESPMIN evaluation Liberia Malaria SBCC Madagascar Malaria SBCC	Doug/Field staff
1C.2	Number of documents and materials describing SBCC best practices developed by HC3 in the past six months		2013 2014 2015 2016	10 20 25 15	9	13	22		HTSP Assessment Report P Process (2014 update) Malaria SBCC indicator reference guide Urban youth DHS secondary analysis report Fact sheet: Global HIV Experts Convene to Review	Redcap

PMP INDICATORS AND DATA: OCTOBER 1, 2013–SEPTEMBER 30, 2014										
Indi-cator ID	Indicator	Revision Notes	Annual Targets		Year 2 Progress					
					Oct 13–Mar 14	Apr 14–Sep 14	Year Total	Total to date	Narrative	Data Source(s)
									the Evidence Urban youth SRH SBCC literature review Demand Generation Implementation Kit: Adaptable communication strategies for 1) contraceptive implants 2) female condoms 3) emergency contraception 4) misoprostol 5) magnesium sulphate 6) chlorhexidine 7) ORS and Zinc 8) amoxicillin Synthesis of evidence for the 13 life-saving underutilized RMNCH commodities Spotlights of the evidence for the 13 commodities Guidelines for Conducting a National Assessment on Demand Generation for Underutilized Commodities Guide on Addressing the Role of Gender in the Demand for RMNCH Commodities Theory-Based Framework for Media Selection in Demand	

PMP INDICATORS AND DATA: OCTOBER 1, 2013–SEPTEMBER 30, 2014										
Indi-cator ID	Indicator	Revision Notes	Annual Targets		Year 2 Progress					
					Oct 13–Mar 14	Apr 14–Sep 14	Year Total	Total to date	Narrative	Data Source(s)
									Generation Programs Utilizing ICT in Demand Generation for RMNCH: Three Case Studies and Recommendations Guide to Public-Private Partnerships in Increasing the Demand for RMNCH Commodities P Process: French translation HCT Fact sheet Health communication and condom use fact sheet Health communication and the HIV Treatment Cascade fact sheet CLF and condom use fact sheet Eight Research 101 Primers	
1C.3	Number of articles and reports included in project-supported searchable database in the past six months		2013 2014 2015 2016	100 100 75 50	N/A	123	123		123 references from the urban youth SBCC literature review included on the "research synthesis" page on the HC3 website.	Doug/Kim/ Keris

PMP INDICATORS AND DATA: OCTOBER 1, 2013–SEPTEMBER 30, 2014										
Indi-cator ID	Indicator	Revision Notes	Annual Targets		Year 2 Progress					
					Oct 13–Mar 14	Apr 14–Sep 14	Year Total	Total to date	Narrative	Data Source(s)
1D.1	Number of HC3 activities promoting new approaches for SBCC conducted in the past six months		2013 2014 2015 2016	6 8 10 4	4	4	8		ICASA VMMC Satellite Session Gaming webinar Youth Campaigns webinar NetHope member summit health communication workshop CFAR JAIDS Panel RBM CCoP Meeting: Geneva Behavioral Economics webinar Social Drama webinar	Redcap
1D.2	Number of Innovation Grants awarded in the past year		2013 2014 2015 2016	3 3 3 3	N/A	N/A	N/A		Funding for this activity was cut per USAID request.	James

PMP INDICATORS AND DATA: OCTOBER 1, 2013–SEPTEMBER 30, 2014										
Indi-cator ID	Indicator	Revision Notes	Annual Targets		Year 2 Progress					
					Oct 13–Mar 14	Apr 14–Sep 14	Year Total	Total to date	Narrative	Data Source(s)
2A.1	Number of CS toolkit modules (implementation kits/guides) developed and/or expanded in the past year		2013 2014 2015 2016	20 15 10 5	9	6	15		Focus package: Counseling Focus package: Malaria Focus package: Faith Based Focus package: LARCs Malaria SBCC Indicator guide Focus package: ICT Focus package: Urban youth Focus package: Gender I-Kit: Demand Generation for underutilized commodities Focus package: Ebola Focus package: Staff picks Focus package: Data visualization Focus package: Measuring HIV SBCC outcomes Focus package: Chlorhexidine I-Kit: Urban adolescent SBCC	Redcap
2A.2	Number of materials posted to the Health COMpass in the past year		2013 2014 2015 2016	40 50 80 100	795	165	960		347 Capacity strengthening tools 613 SBCC project examples	Susan L/Leanne/ website

PMP INDICATORS AND DATA: OCTOBER 1, 2013–SEPTEMBER 30, 2014										
Indi-cator ID	Indicator	Revision Notes	Annual Targets		Year 2 Progress					
					Oct 13–Mar 14	Apr 14–Sep 14	Year Total	Total to date	Narrative	Data Source(s)
2B.1	Number of capacity strengthening interventions evaluated by HC3 in the past year		2013 2014 2015 2016	0 2 3 4	N/A	1	1		Capacity strengthening interventions were not yet mature enough for formal evaluations. Evaluations have been restricted to participant evaluations of individual activities, but not comprehensive enough to meet this indicator.	Doug/ Katherine
2B.2	Number of HC3-sponsored studies comparing the relative effectiveness of CS approaches conducted in the past year		2013 2014 2015 2016	0 1 2 2	N/A	1	1		Evaluation of Tanzania Leadership in Strategic Health Communication initiative at district-level is in progress.	Doug/ Katherine
2C.1	Number of CS guidance documents produced by HC3 in the past year	Targets revised downwards to distinguish them from SBCC programming tools.	2013 2014 2015 2016	0 2 3 3	N/A	0	0		Guidance documents are considered overarching documents that provide instruction on how to assess capacity. Year 3 will see those approaches formalized into capacity assessment documents.	Doug/ Katherine

PMP INDICATORS AND DATA: OCTOBER 1, 2013–SEPTEMBER 30, 2014										
Indi-cator ID	Indicator	Revision Notes	Annual Targets		Year 2 Progress					
					Oct 13–Mar 14	Apr 14–Sep 14	Year Total	Total to date	Narrative	Data Source(s)
2D.1	Number of universities with a formal relationship with HC3 in the past year		2013 2014 2015 2016	2 4 6 8	N/A	7	7		1. NUS (Singapore): Hosted Health Communication Campaigns course 2. Jimma (Ethiopia): Graduate student mentoring 3. MUHAS (Tanzania): Received two capacity strengthening seminars 4. Primary Health Care Institute in Iringa (Tanzania): Received health communication strategic development mentoring training workshops 5. University of Indonesia: provided research support for local K4H project 6. University of Witswatersrand, South Africa 7. University of Houphouët-Boigny, RCI	Doug
2D.2	Number of university-affiliated faculty who join the Springboard in the past year		2013 2014 2015 2016	5 10 15 5	N/A	204	204			Springboard web stats (Soma) (members spreadsheet: count if organization type is university)

PMP INDICATORS AND DATA: OCTOBER 1, 2013–SEPTEMBER 30, 2014										
Indi-cator ID	Indicator	Revision Notes	Annual Targets		Year 2 Progress					
					Oct 13–Mar 14	Apr 14–Sep 14	Year Total	Total to date	Narrative	Data Source(s)
2D.3	Number of Springboard members who report enrolling in an SBCC course offered by a local university in the past year		2013 2014 2015 2016	10 20 30 10	N/A	15	15		Fifteen Springboard members report taking an in person SBCC course at a local university in the past year.	HC3 user survey
2D.4	Number of SBCC/health communication university courses available in HC3 project countries in the past year		2013 2014 2015 2016	4 8 12 16	N/A	Aver-age 1.9 to 2.9 across 6 univer-sities in HC3 focal coun-tries	1.9-2.9		Based on University Needs Assessment.	Doug/Field staff

APPENDIX B. 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)
May 26, 2015

I. TITLE: HEALTH COMMUNICATION CAPACITY COLLABORATIVE (HC3) MIDTERM EVALUATION (066)

II. REQUESTER / CLIENT

■ USAID/Washington
Office/Division: GH / PRH

III. FUNDING ACCOUNT SOURCE(S): (CLICK ON BOX(ES) TO INDICATE SOURCE OF PAYMENT FOR THIS ASSIGNMENT)

☐ 3.1.1 HIV
☐ 3.1.2 TB
☐ 3.1.3 Malaria
☐ 3.1.4 PIOET
☐ 3.1.5 Other public health threats
☐ 3.1.6 MCH
■ 3.1.7 FP/RH
☐ 3.1.8 WSSH
☐ 3.1.9 Nutrition
☐ 3.2.0 Other (specify):

IV. COST ESTIMATE: (NOTE: GH PRO WILL PROVIDE A FINAL BUDGET BASED ON THIS SOW)

V. PERFORMANCE PERIOD

Expected Start Date (on or about): June 1, 2015
Anticipated End Date (on or about): October 31, 2015

VI. LOCATION(S) OF ASSIGNMENT: (INDICATE WHERE WORK WILL BE PERFORMED)

Washington, DC
Baltimore, MD
Nigeria
Cote d'Ivoire
Guatemala
4th country—TBD

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.

VIII. BACKGROUND

Background of project/program/intervention:

Overview

The Health Communication Capacity Collaborative (HC3) is a five-year cooperative agreement primed by the Johns Hopkins Bloomberg School of Public Health's Center for Communication Programs (JHU-CCP). Project partners include PSI, Internews, NetHope, Management Sciences for Health (MSH), and Ogilvy Public Relations. The project, which serves as the Bureau for Global Health's flagship mechanism for social and behavior change communication (SBCC), is mandated to provide technical leadership, capacity strengthening, and research for behavior change programming, while fostering vibrant communities of practice that support improved evidence-based programming and continued innovation.

Priorities Informing the Design of HC3

HC3 was designed to build upon the successes of its predecessor project, C-Change, while responding to outstanding needs in the field of SBCC. Pre-design assessments conducted by USAID clearly identified lack of in-country capacity to design, implement, or evaluate high-quality SBCC as the major challenge to be addressed by HC3. To this end, HC3 was designed to achieve the Strategic Objective (SO) of *improved sustainability of evidence-based practices and interventions in health communication*, through two Intermediate Results (IR):

- *IR1: Increased capacity of indigenous organizations to design, implement, manage, and evaluate evidence-based interventions.*
- *IR2: Establishment of proven systems for continued development of new and existing indigenous implementers.*

The following guiding principles were outlined in design and procurement documents, including the RFA No. SOL-OAA-12-000017, as critical to HC3's success, and should be considered in the evaluation:

- Utilize an implementation science approach, with emphasis on rigorous monitoring and evaluation, documentation, and diffusion of practices;
- Tailor strategies and tools to context, audience, and function;
- Develop and document effective strategies for addressing normative and structural factors that influence behavior;
- Build upon existing resources; and
- Foster active communities of practice spanning a broad range of current and potential partners.

Overview of Investment and Activities to Date

HC3 may accept funds from any USAID operating unit or Mission, but is primarily active in health. The project currently addresses a range of health areas, including:

- Family planning and reproductive health
- HIV and AIDS
- Malaria
- Maternal and child health
- Infectious disease and pandemic threats

To date, HC3 has received approximately $65,000,000 in funding, of which approximately 40% is core funding originating in the Offices of Population and Reproductive Health (PRH), HIV/AIDS (OHA); and Health, Infectious Disease and Nutrition (HIDN) and 60% is field support. Of these core funds, a substantial portion focused on capacity strengthening.

Core-funded activities have focused primarily upon the following cross-cutting and sector-specific activities:

Cross-cutting activities

- Development, testing, and dissemination of capacity strengthening resources for SBCC, with a particular emphasis upon use of virtual platforms for learning and knowledge management; community-building; and academic capacity strengthening.
- Expansion of the evidence base for SBCC through rigorous research and evaluation, including both demonstration of SBCC's behavioral impact and operations research on different capacity strengthening approaches for SBCC implementers (Tanzania, Liberia and Madagascar).

PRH

- Development, testing, and dissemination of behavior change resources for healthy timing and spacing of pregnancy including community dialogue tools for groups outside the health sector (Togo, Niger).
- Development, testing, and dissemination of programmatic resources for the promotion of reproductive health behaviors among urban youth, including demand creation for long-acting methods of contraception (Benin, Madagascar, Malawi, Nigeria).
- Development, testing, and dissemination of resources for provider behavior change (TBD).

HIDN — MCH

- Development, testing, and dissemination of demand creation resources for under-utilized reproductive, maternal, newborn and child health commodities in support of the UN Commission on Life-Saving Commodities for Women and Children (Madagascar, Nepal, Uganda, Bangladesh).
- Development and testing of tools for promotion of exclusive breastfeeding through faith-based organizations (Nigeria).

HIDN — Malaria

- Development, testing, and dissemination of research tools to support PMI malaria control programs, including development of SBCC indicators and a SBCC survey tool (Liberia, Madagascar). Malaria activities focus specifically on promotion of insecticide-treated mosquito nets; indoor residual spraying; intermittent preventive treatment for pregnant women; and prompt use of artemisin-based combination therapies.

OHA

- Development and promotion of materials demonstrating the evidence of SBCC impact on HIV and AIDS programming.
- Implementation of a multi-country assessment of voluntary medical male circumcision (VMMC) communication targeting adolescents (Tanzania, South Africa, and Zimbabwe).
- Facilitation of a VMMC webinar series in support of the USG interagency VMMC technical working group and the broader community of VMMC program implementers.
- Support to UNESCO for comprehensive in-school youth sexuality education in East and Southern Africa, including the development of an online teacher training program to facilitate roll out across the regions (Uganda, Zambia, Tanzania, Lesotho, South Sudan, Malawi, Zimbabwe).

NB: During the first half of Project Year 3, HC3 received a sudden and unexpected infusion of funds related to USAID's Ebola response in West Africa. These funds totaled $7.29 million in GH core, $1 million in Office of Foreign Disaster Assistance (OFDA) core, and $6.5 million in Mission funding approved via the Congressionally-mandated Ebola supplemental. Additional funding—perhaps up to $15 million—is anticipated during the remaining months of Project Year 3. These activities will not be addressed through this evaluation, as they are relatively new and differ substantially from others in HC3's portfolio. It is important, however, that the evaluators consider the influx of Ebola funds and subsequent rapid scale-up of activities as an extenuating circumstance that likely impacted HC3's ability to implement other activities in its portfolio. USAID anticipates that HC3's Ebola-related activities will be reviewed during an end-of-project evaluation, should one be conducted.

At present, HC3 receives field support in the following countries:

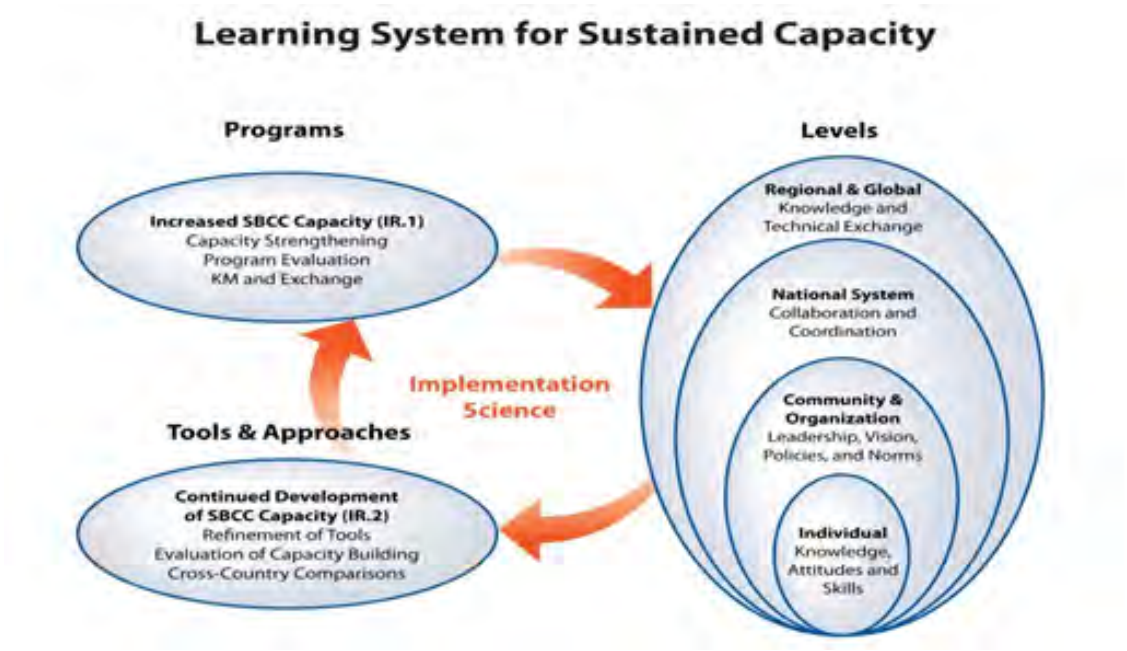
- Angola (Family Planning)
- Bangladesh (Family Planning)
- Cote d'Ivoire (HIV/AIDS)
- Egypt (Family Planning)
- Ethiopia (HIV/AIDS)
- Guatemala (Family Planning, Maternal and Child Health, Nutrition, HIV/AIDS)
- Guinea (MCH, Family Planning, Pandemic Threats)
- Mali (HIV/AIDS)
- Nepal (Family Planning)

- Nigeria (Malaria, Family Planning)
- South Africa (HIV/AIDS)
- Swaziland (HIV/AIDS)
- Madagascar (Malaria)
- Zambia (HIV/AIDS)

Capacity Strengthening Approaches and Activities

Capacity strengthening is central to HC3's work. Many of the project's core-funded activities focus uniquely on capacity strengthening; others emphasize behavior change for a particular health area, but utilize clear and explicit capacity strengthening approaches to maximize sustainability. HC3's capacity strengthening activities are characterized by use of a range of skills-building approaches ("blended learning"). Activities target a wide variety of audiences, including program managers, journalists, video and radio producers, health workers and counselors, health education units and local government staff. HC3 also engages a variety of partners including the private sector, the media and universities. Activities are designed to produce results at the individual, institutional, and "systems" levels, and to balance technical skills-building and organizational development. HC3's capacity strengthening work is premised on the idea that strong and vibrant communities of practice support ongoing and locally-specific skills-building through peer-to-peer exchange. For this reason, community-building - through both virtual and country-level fora - has played a major role in HC3's activities.

The following graphic depicts HC3's approach to SBCC capacity strengthening:



Core-Funded Capacity Strengthening

HC3's primary core-funded capacity strengthening outputs include the following, described in further detail in **Annex 1.**

1. *The Health COMpass:* An interactive and collaborative online collection of high-quality,

curated tools and project examples for SBCC.

2. *The Springboard* [17]*:* A virtual space where practitioners from around the world interact on an online platform, reinforcing and extending the reach of existing communities of practice at local and regional country levels. These on-line conversations are intended to catalyze in-person communities of practice in local and regional spaces and are reinforced by planned HC3 events in the countries and regions.

3. *SBCC Virtual Leadership Development Program (VLDP):* A virtual leadership program for SBCC practitioners that combines face-to-face activities and distance learning to strengthen individual and team leadership and management practices so that participants can anticipate and respond to common programmatic challenges.

4. *Research on Capacity Strengthening:* HC3 is actively implementing a research agenda that seeks to identify effective approaches for strengthening the capacity of organizations to design, implement, and evaluate SBCC activities and the capacity of governmental units to coordinate these activities as part of a national program.

5. *Implementation Kits:* In Years 1 and 2, HC3 developed a series of SBCC Implementation Kits (I-Kits) that provide step-by-step technical guidance around the development of SBCC programs for particular topic area. These resources can be adapted to a local context, without additional technical assistance from an outside party.

6. *Implementation Guides:* Implementation Guides, or How-To Guides, address specific SBCC topics in brief, providing a synthesis of best practices and tips, "how-to" steps, and worksheets.

Capacity Strengthening in the Field

Like its centrally-funded activities, many of HC3's field support-funded portfolios focus heavily upon capacity strengthening for SBCC. HC3's country-level capacity strengthening approach is based on several key pillars:

- *Build on existing capacity*: Through national capacity assessments and mapping approaches, HC3 identifies SBCC capacity already in country and reinforces and extends that capacity.

- *Strengthen individuals and institutions:* Individuals are only as effective as the organizations in which they function. SBCC capacity must be diffused and supported throughout an organization.

- *Focus on the public sector for advocacy and coordination of SBCC*: Ministries of Health and Health Education Units are best positioned to support and extend SBCC efforts in country.

- *Integrate SBCC and organizational development:* Technical expertise and effective organizational systems must both be in place for overall organizational sustainability.

- *Systematic capacity strengthening embedded in collaborative implementation:* Partners "learn by doing" working hand in hand with HC3 teams to design and implement SBCC programs in their countries. Capacity strengthening activities are explicitly woven into the process to prepare for and reinforce hands on activities.

[17] HC3 originally developed the concept of this virtual platform under the name the *Marketplace*. It was subsequently changed to the *Springboard* in April 2014 just prior to the launch. Accordingly, the background documents may include either one of these names.

- *Blend a mix of methods for the most impact:* HC3 utilizes a range of face-to-face, virtual and mobile methods tailored to the unique context.

Two of HC3's most established country programs, focusing on HIV/AIDS and malaria respectively, are in Cote d'Ivoire and Nigeria. These programs, which were launched in 2013 and 2014, are expected to be multi-year buy-ins that will allow for implementation of a range of activities over time. Both programs focus heavily upon capacity strengthening for SBCC within the public sectors. HC3's newer country program in Guatemala is unique among the project's Mission buy-ins insofar as it a) addresses integrated, cross-sectoral behavior change priorities, and b) focuses on capacity strengthening and coordination to a range of USAID implementing partners through a technical assistance model. USAID recommends that these countries serve as case studies for the evaluation. See **Annex 2** for additional information on these country programs.

Background Documents

Documents of interest to the evaluation team may include:

- SOL-OAA-12-000017(RFA for HC3)
- Project Results Framework
- HC3 PRH Work plans: Y1, Y2, Y2 addendum, Y3
- HC3 OHA Work plan: Y1, Y3
- HC3 Malaria Wor plans: Y1, Y2, Y3
- Performance Monitoring Plan and associated data
- Annual and semi-annual reports: Y1, Y2
- Management Review: Y1, Y2
- Project fact sheet and website (including HealthCompass, Implementation Kits, and Springboard)
  - http://www.healthcommcapacity.org/
  - http://www.healthcomspringboard.org/
  - http://www.thehealthcompass.org/
  - http://www.healthcommcapacity.org/implementationkits/
- Capacity-strengthening fact sheet
- Country Matrix summarizing all current in-country activities, including field support buy-ins and core-funded activities
- Staffing Matrix summarizing current headquarters staffing by country/core work stream and level of effort
- HC3/Nigeria Scope of Work and Addendum

- HC3/ Nigeria Work plans: Y1 and Y2
- HC3/ Nigeria Capacity Assessment Reports for partners
- Relevant USAID Nigeria and implementing partner strategies, programs descriptions, and/or other documents
- Relevant Nigeria national documents, including SBCC strategies
- HC3/Cote d'Ivoire Scope of Work
- HC3/Cote d'Ivoire Work plans: Y1 and Y2
- HC3/Cote d'Ivoire Capacity Assessment reports for partners
- Relevant USAID Cote d'Ivoire and implementing partner strategies, programs descriptions, and/or other documents
- Relevant Cote d'Ivoire national documents, including SBCC strategies
- HC3/Guatemala Scope of Work
- HC3/Guatemala Work plan: Y1
- HC/Guatemala Capacity Assessment reports for partners
- Relevant USAID Guatemala and implementing partner strategies, programs descriptions, and/or other documents
- Website analytics for Health COMpass and Springboard.

HC3 will provide these documents, and others as appropriate, to the evaluation team in hard and soft copy at the beginning of the evaluation. Any documents not available to the partner will be provided by the USAID management team.

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

See Learning System for Capacity Strengthening (above) and IRs below.

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

- IR1: Increased capacity of indigenous organizations to design, implement, manage, and evaluate evidence-based interventions.
- IR2: Establishment of proven systems for continued development of new and existing indigenous implementers.

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

Global (see above Background section for more details)

I. 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 primary purpose of this evaluation is threefold:

1. Review, analyze, and evaluate the performance of HC3's activities against project objectives as described in the project RFA and Performance Monitoring Plan.
2. Evaluate HC3's success in improving capacity of developing country individuals and institutions to design, implement, and evaluate high-quality SBCC through resources such as the Health COMpass, Springboard, and Implementation Kits.
3. Review, analyze, and evaluate the performance of HC3 country programs in Cote d'Ivoire, Nigeria, and Guatemala.

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/DC staff working on SBCC, USAID Missions, donors, implementing partners, and others interested in social and behavior change programming

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

The results of this evaluation are expected to provide USAID staff with sufficient information to make recommendations for strengthening HC3's current portfolio of capacity strengthening activities in remaining years of the project, and to inform design of future USAID SBCC mechanisms.

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
Note: All questions should include factors that have facilitated and/or inhibited achievements. The recommendations should follow on these factors, based on evidence from this evaluation.

HC3's approach and performance against project objectives

What progress has been made in achieving project objectives, as described in the project RFA and PMP?

To address this question, consider the following:

- Activities that have been particularly successful in meeting the project's objectives, and factors that contributed to these successes
- Activities that have been less than successful in meeting the project's objectives, and factors that contributed to shortcomings in meeting project objectives
- Challenges that HC3 encountered in achieving project objectives, and factors that have mitigated these challenges

Capacity development

How successful is HC3 at developing capacity to design, implement, and evaluate high-quality SBCC at the regional and country levels?

To address this question, consider the following:

- Responsiveness to felt capacity strengthening needs among SBCC learners and practitioners in Africa, Asia, and Latin America
- The extent to which the Springboard, Health COMpass, the VLDP, and the Implementation Kits served to increase the capacity of SBCC implementers
- The relative effectiveness of each of HC3's virtual resources (the Health COMpass, the Springboard, the VLDP, implementation kits) in strengthening capacity of SBCC learners and practitioners
- Sustainability of the Health COMpass and the Springboard virtual platform beyond the project's end date
- HC3 activities that have successfully contributed to developing the technical or operational capacity of regional Springboard Secretariats (BCCP in Asia and AfriComNet in Africa) to lead capacity strengthening and knowledge management efforts beyond the project's end date
- Approaches HC3 may enlist to increase the likelihood of sustainability of its capacity strengthening resources beyond the project's end date

.. HC3 Country Programs

How successful has HC3 been in their country programs in Cote d'Ivoire, Nigeria, and Guatemala? (These countries selected for their a) maturity and b) diversity in health focus and capacity strengthening approach.)

To address this question, consider the following:

- HC3's performance against the objectives described in each country's scope of work, Performance Monitoring Plan, and other planning documents developed in consultation with the USAID Mission (work plans, life-of-project implementation plans, etc.), and factors that contributed to successes and/or shortcomings
- The success of HC3's capacity strengthening interventions in improving the ability of individuals and institutions to design, implement, and evaluate high-quality SBCC
- The relative effectiveness of each of HC3's capacity strengthening approaches

Other Questions *[OPTIONAL]*

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

Programmatic recommendations on HC3.

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.

Data collection will occur in the US and three target countries: Cote d'Ivoire, Nigeria, and

Guatemala. It is estimated that the evaluation team will visit each country, spending eight working days in Cote d'Ivoire and Nigeria and three in Guatemala.

The ICT consultant will visit two countries to evaluate the use of the various virtual tools. These countries will include Nigeria and a second to be determined during the Team Planning Meeting, based on a review of the web analytics which will help the Team determine the countries that most often access these tools.

The evaluation team may be accompanied by a member of HC3's USAID management team, who can assist with evaluation activities as necessary and appropriate.

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

HC3 and USAID will provide key background documents to the consultants. These documents will include key HC3 program documents, reports and products including, HC3 proposal included in contract, annual work plans, quarterly and annual reports, routine project performance indicator reporting, assessment reports, and other project reports. Key user analytics for HC3 virtual resources will also be reviewed. Additionally, prior to departure to Cote d'Ivoire, Nigeria, and Guatemala, review key country planning documents and SBCC outputs developed by capacity strengthening beneficiaries.

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

Data Source (*existing dataset*)	Description of data	Recommended analysis

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

US based: Using semi-structured interview guides, key informant interviews (KII) will be conducted with HC3 and USAID staff, as well as representatives of key HC3 partner organizations, such as BCCP and AfriComNet. These interviews will be conducted in Washington DC at interviewees' onsite locations or by telephone, whichever is most expedient and cost effective. USAID and HC3 will provide a list of suggested interviewees.

Field visits (Cote d'Ivoire, Nigeria, and Guatemala, and a potential fourth country): KIIs with USAID in-country activity managers and key capacity strengthening beneficiaries (NGOs, Ministries of Health, etc.) will be conducted using a semi-structured question guide, in addition to a broader range of stakeholders, including:

- HC3 staff (from JHU-CCP and key partners)
- CS beneficiaries
- MoHSW
- Mission staff
- USAID/W staff

Other USAID bilateral partners in each of the three focus countries (we can work with HC3 and Missions to identify appropriate partners)

- Springboard and COMpass users (this group may be participants/respondents through FGD and/or group interview instead of KII)

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

Field visits: In countries visited by the Evaluation Team that have users of Springboard Health COMpass, I-Kits, and/or enrollees of VLDP focus group discussions (FDG) will be convened with these users to obtain feedback on the effectiveness and ease of use of these capacity development efforts.

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

Optional: As appropriate, these key informants can be grouped for a group interview, using the same KII semi-structured question guide, both in the US and in country during field visits.

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

Review and analysis of **website analytics**

II. 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.

All analyses will be geared to answer the evaluation questions. Additionally, the evaluation will review both qualitative and quantitative data related to HC3's achievements in relation to the project's objectives and targets. Data will include, but not limited to, qualitative data from interviews focus groups, and project reports; and quantitative data from web analytics (i.e., HealthCOMpass and Springboard website data), and project reports (i.e., HC3 indicator data).

Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age, and location whenever possible. 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 review of qualitative data will be performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances and homogeneity and outliers to better explain what is happening and the perception of those involved. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data do not exist.

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

III. 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 evaluation. These include HC3's proposal, annual work plans, M&E plans, quarterly progress reports, and routine reports of project performance indicator data. This desk review will provide background information for the Evaluation Team, and will also be used as data input and evidence for the evaluation.

Team Planning Meeting (TPM)—A three-day team planning meeting (TPM) will be held at the initiation of this assignment and before the data collection begins. As the methodology within this SOW is meant as a guide for the Evaluation Team, during the TPM the Team will review and finalize these, including the evaluation methods, analytic plan, report, etc. 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;
- Assign drafting/writing responsibilities for the final report; and
- **Finalize counties to be visited**, and assign who will visit what site(s).

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/meeting among the USAID/PRH, GH Pro and the Team Lead to initiate the evaluation activity and review expectations. USAID will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review the initial schedule and review other management issues.
- **In-brief with USAID/PRH**, as part of the TPM. This briefing will be broken into two meetings: a) at the beginning of the TPM, so the Evaluation Team and USAID can discuss

expectations and intended plans; and b) at the end of the TPM when 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 time and place for this in-brief will be determined between the Team Lead and USAID/PRH prior to the TPM.

- **In-brief and Out-brief with USAID Mission** in Cote d'Ivoire, Nigeria, and Guatemala.

  1. Prior to arriving in country, the Evaluation Team will have a field visit evaluation preparation call with Missions to discuss schedules and expectations. Representatives from USAID/PRH who will be going to the field with the Evaluation Team will join this call.

  2. Upon arrival in country the Evaluation Team, including USAID/PRH staff who are participating in the evaluation will meet with relevant USAID Mission staff to discuss in detail the evaluation methods and schedule.

  3. Prior to leaving each country the Evaluation Team will provide a debrief using a PowerPoint presentation, with the USAID Mission with preliminary findings from the county specific evaluation.

- The Team Lead (TL) will brief USAID/PRH **weekly** to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing, and in an email to USAID/PRH.

- A **final debrief** between the Evaluation Team and USAID HC3 management team will be held at the end of the evaluation to present preliminary findings to USAID/PRH. During this meeting a summary of the data will be presented, along with high level findings and draft recommendations. For the debrief, the Evaluation 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. (***Note****: preliminary findings are not final and as more data sources are developed and analyzed these finding may change.*)

- **Stakeholders' debrief/workshop** will be held with HC3 project staff and other stakeholders identified by USAID. This will occur following the final debrief with the Mission, and will not include any information that may be considered procurement sensitive.

Evaluation Report—The Evaluation Team under the leadership of the Team Lead will develop a report with evaluation findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:

1. Team Lead will submit draft evaluation report to GH Pro for review and formatting

2. GH Pro will submit the draft report to USAID

3. USAID will review the draft report in a timely manner, and send their comments and edits back to GH Pro

4. GH Pro will share USAID's comments and edits with the Team Lead, who will then do final edits, as needed, and resubmit to GH Pro

5. GH Pro will review and reformat the final Evaluation Report, as needed, and resubmit to

USAID for approval.

6. Once Evaluation Report is approved, GH Pro will re-format it for 508 compliance and post it to the DEC.

IV. 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 (estimated)
■ Launch briefing	June 2, 2015
■ Work plan with timeline	June 16, 2015
■ Analytic protocol with data collection tools	June 16, 2015
■ In-brief with USAID/PRH and USAID Missions.	USAID/PRH: June 10-12, 2015 USAID Missions: TBD July/August 2015
■ In-brief with target project (HC3)	June 17, 2015 (DC)
■ Routine briefings	Weekly
■ Debrief with Missions and USAID HC3 Management Team or organizing business unit with Power Point presentation	USAID Missions: prior to departure from country USAID HC3 Management Team: not later than August 14, 2015
■ Findings review workshop with stakeholders with Power Point presentation	August 21, 2015
■ Evaluation report	Draft: September 4, 2015 Final Draft: October 2, 2015
☐ Raw data	
■ Posting Evaluation Report to the DEC	October 31, 2015
☐ Dissemination activity	
☐ Other (specify):	

Estimated USAID review time

Average number of business days USAID will need to review deliverables requiring USAID review and/or approval? **10** Business days

V. 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 evaluation team will comprise three - four international consultants and additional in-country consultants. Team composition will likely include a Team Lead, Evaluation Specialist, SBCC Technical Specialist, Capacity Strengthening Specialist, and in-country support staff. This team may be accompanied in their fieldwork by Mission Monitoring and Evaluation staff, as determined by USAID mission capacity and availability. In addition, one full time staff from USAID/Washington may join the evaluation team in the field work conducted in the selected countries and provide assistance in communicating with missions. Together the evaluation team must possess the following skills and qualifications:

- Experience in evaluating SBCC programs in developing country settings.
- Experience implementing SBCC programs in developing country settings.
- Experience in implementing and/or evaluating capacity-strengthening activities within SBCC programs.
- Experience in evaluating virtual and electronic platforms.
- Familiarity with USAID contracting and reporting requirements; policies and initiatives; and tools, such as performance monitoring plans and results frameworks. Familiarity with current GH priorities, including FP2020, EPCMD, PEPFAR, and PMI.
- Experience with USAID mission programming.
- Professional competency in spoken Spanish and/or French (one team member).
- Advanced written and oral communications skills in English.

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

Team Lead: 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 USAID and the evaluation team, and (4) leading briefings and presentations.

Qualifications:

- Minimum of 10 years of experience in public health
- At least 5 years' experience in M&E, preferably on USAID projects/programs
- 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
- Good writing skills
- Familiarity with USAID policies and practices
  - Evaluation policy
  - Results frameworks
  - Performance monitoring plans

Key Staff 1 Title: SBCC Specialist

Roles & Responsibilities: Serve as a member of the evaluation team, providing technical expertise to evaluate SBCC activities and capacity strengthening for SBCC.

Qualifications:

- At least 10 years of experience working with SBCC programs in developing country settings
- Experience should include mass media, community-based interventions, and interpersonal communications (IPC)
- Experience in the following areas is desirable:
  - HIV and PEPFAR programs
  - Malaria and PMI programs
  - FP/RH and FP2020 programs
  - MNCH programs, including EPCMD
  - Gender equity and social/cultural norms transformations (i.e., gender norms transformation)
  - Youth programming
- Experience and knowledgeable on evaluation methodologies related to SBCC
- Experience in implementing and/or evaluating capacity-strengthening activities within SBCC programs
- An advanced degree in public health or related field

- Professional competency in spoken Spanish and/or French is desirable

Number of consultants with this expertise needed: 1-2

Key Staff 2 Title: Evaluation Specialist

Roles & Responsibilities: Serve as a member of the evaluation team, providing quality assurance on evaluation issues, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. S/He will oversee the training of all engaged in data collection, insuring highest level of reliability and validity of data being collected. S/He 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. S/He will participate in all aspects of the evaluation, from planning, data collection, data analysis, to report writing.

Qualifications:

- At least 10 years of experience in USAID M&E procedures and implementation
- At least 5 years managing M&E, including evaluations
- Strong knowledge, skills, and experience in qualitative and quantitative evaluation tools
- Experience in design and implementation of evaluations
- Experience in data management
- Experience using analytic software
- Experience evaluating SBCC programs/activities
- An advanced degree in public health, evaluation or research or related field
- Professional competency in spoken Spanish and/or French is desirable

Number of consultants with this expertise needed: 1

Key Staff 3 Title: Organizational Development Specialist

Roles & Responsibilities: Serve as a member of the evaluation team, providing technical expertise to evaluate organizational capacity strengthening activities and their contribution towards developing sustainable capacity within developing countries for implementing SBCC programs/activities.

Qualifications:

- Background and at least 5 years' experience in organizational capacity development/strengthening.
- Knowledgeable in capacity building assessment (e.g., OCATs) and evaluation methodologies
- Experience working in organizational capacity development/strengthening among governmental and non-governmental entities in developing country settings to strengthen health programs/activities

- Experience working in organizational development for social and behavioral communication programs is desirable
- Professional competency in spoken Spanish and/or French is desirable

Number of consultants with this expertise needed: 1

Key Staff 4 Title: Information Communication Technology (ICT) 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:

- At least 5 years developing, implements and/or evaluating virtual and electronic platforms related to knowledge management and/or capacity strengthening, especially related to health programs in developing country settings
- Experience in evaluating virtual and electronic platforms
- Professional competency in spoken Spanish and/or French is desirable
- Must be fluent in English

Number of consultants with this expertise needed: 1

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

US based: **Program Assistant or Intern** to work part time with the Evaluation Team to arrange interviews, meetings and logistics, and other support duties as needed by the Evaluation Team.

Field visits: In each country (Nigeria, Cote d'Ivoire, and Guatemala) a **Research Assistant/Logistics Coordinator** will be hired to assist the Evaluation Team in setting up and conducting interviews, focus group discussions, and other data collection activities. S/He will arrange any needed logistics and participate in data collection and interpretation.

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:

During Field Visits, USAID/DC staff may accompany the Evaluation Team. They will fully participate in all in-country data collection, preliminary data analysis, and in-country debriefs. Their participation will most likely end once they depart the country where field visit occurred.

Staffing Level of Effort (LOE) Matrix (Optional):

This optional 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.

a) For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.

b) Immediately below each staff title enter the anticipated number of people for each titled position.

c) Enter Row labels for each activity, task and deliverable needed to implement this analytic activity.

d) Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.

e) 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 Team				
		TL: OD Eval Specialist	SBCC Eval Specialist	ICT Eval Specialist	Prog Asst	In-Country Res Asst/Log Coord*
	Number of persons	1	1	1	1	4
1	*Launch Briefing*	1				
2	*Desk review & Data Synthesis*	5	5	5		
3	*Team Planning Meeting*	3	3	3	2	
4	*In-brief with USAID HC3 Management Team*	.5	.5	.5	.5	
5	*Briefing with HC3*	.5	.5	.5	.5	
6	*Data Collection & Data Quality Assurance workshop (protocol orientation for all involved in data collection)*	1	1	1	1	
7	*Prep / Logistics for data collection*				2	
8	*Data collection (US based)*	12	12	12	4	
9	*Preliminary Data analysis*	2	2	2	.5	
10	*Briefing with USAID/PRH with US based prelim findings, prior to field visits, including prep*	1	1	1	.5	
11	*Prep for Field Visits (3 countries + add'l countries that use virtual tools)*	1	1	1	.5	2
12	*Travel to 3 countries for Field Visits**	5	5	4		

Activity / Deliverable		Evaluation Team				
		TL: OD Eval Specialist	SBCC Eval Specialist	ICT Eval Specialist	Prog Asst	In-Country Res Asst/Log Coord*
Number of persons		1	1	1	1	4
13	*Field Visits to 2-3 Countries—activities include: Mission In-brief, preliminary analysis, and exit de-brief*					
13a	*Guatemala*	3	3			2
13b	*Nigeria*	8	8	8		2
13c	*Cote d'Ivoire*	8	8			2
13d	*TBD Country*			5		2
14	*Finalize data analysis (US & Field)*	5	5	5	.5	1
15	*Debrief with USAID/PRH to present prelim findings (US + Field), with prep*	1	1	1	1	1
16	*Stakeholder workshop on prelim findings (US + Field), with prep*	1	1	1	1	1
17	*Draft report*	7	6	5	1	
18	*GH Pro Report QC Review & Formatting*					
19	*Submission of draft report to USAID/PRH*					
20	*USAID Report Review*					
21	*Revise report(s) per USAID comments*	3	2	2		
22	*Finalization and submission of report*					
23	*508 Compliance Review*					
24	*Upload Eval Report(s) to the DEC*					
	Sub-Total LOE	**68**	**65**	**57**	**15**	**13**
	Total LOE	**68**	**65**	**57**	**15**	**52**

** For efficiency, Evaluation Team staff will travel to different countries. Total countries to be visited are 4-6, and each will have an Evaluation/Logistics Assistant. It is estimated that each Key Staff will travel to 2 countries each.*

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

Travel anticipated: List international and local travel anticipated by what team members.
US based: Assumption is that work is based in Washington, DC with travel to Baltimore, MD

Field visits: Nigeria, Cote d'Ivoire, and Guatemala. Additional Location for ICT Consultant TBD during TPM phase, if there is a determination of a critical mass of users.

VI. 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: Eval Team will need meeting space for TPM and other meetings. The will book the space with GH Pro as needed

☐ Travel -other than posting (specify):

☐ Other (specify):

VII. 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.

VIII. 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

USAID will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:

Before Field Work

- SOW.
  - Develop SOW.
  - Peer Review SOW
  - Respond to queries about the SOW and/or the assignment at large.
- Consultant Conflict of Interest (COI). 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.
- Documents. 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.
- Local Consultants. Assist with identification of potential local consultants, including contact information.
- Site Visit Preparations. 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.
- Lodgings and Travel. 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.

IX. ANALYTIC REPORT

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

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, provide recommendations, and identify key questions for future consideration. The report shall follow USAID branding procedures.

An acceptable report will meet the following requirements as per USAID Evaluation Policy ("Criteria to Ensure the Quality of the Evaluation Report"):

- The evaluation report should represent a thoughtful, well-researched and well organized effort to objectively evaluate what worked in the project, what did not and why.
- The evaluation report should address all evaluation questions included in the scope of work.
- The evaluation report should include the scope of work as an Annex. All modifications to the scope of work, whether in technical requirements, evaluation questions, evaluation team composition, methodology or timeline shall be agreed upon in writing.
- Evaluation methodology shall be explained in detail and all tools used in conducting the evaluation such as questionnaires, checklists and discussion guides will be included in an Annex to the final report.
- Evaluation findings will assess outcomes and impacts using gender disaggregated data, if appropriate.
- Limitations to the evaluation shall be disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).
- Evaluation findings should be presented as analyzed facts, evidence and data and not based on anecdotes, hearsay or the compilation of people's opinions.
- Findings should be specific, concise and supported by strong quantitative or qualitative evidence.
- Sources of information need to be properly identified and listed in an Annex, including a list of all individuals interviewed.
- Recommendations need to be supported by findings. Recommendations should be action-oriented, practical and specific, with defined responsibility for the action.
- The evaluation methodology and report will be compliant with the USAID Evaluation Policy and Checklist for Assessing USAID Evaluation Reports.

Reporting Format:

The final report will follow USAID evaluation report guidance. Accordingly, it will not exceed 25 pages and will use the following format:

1. Table of Contents
2. Executive Summary (not more than 5 pages): contain clear, concise summary of the most critical elements of the report, including summary of findings, conclusions and recommendations.
3. Body of the report (not more than 20 pages), which will include:
   - 3.1. Introduction, purpose of evaluation, team composition, scope and methodology, limitations to the evaluation
   - 3.2. Evidence-based findings and conclusions with special attention to technical issues
   - 3.3. Practical and Specific Recommendations for future action and program scale-up based on findings and conclusions.
   - 3.4. Content should be presented in sufficient detail so as to inform subsequent programmatic action to improve program quality and implementation.
4. Annexes (not included in 25 page limit), which will include:
   - 4.1. Evaluation Statement of Work, list of documents reviewed, list of key informants and their contact information, data collection instruments, more-detailed discussion of methodological or technical issues as appropriate, and the PowerPoint presentation from the debrief outlining the evaluation results and recommendations.

The final version of the evaluation report will be submitted to USAID/Washington in hard copy as well as electronically, as both a PDF and a Microsoft Word file. The report will follow USAID branding regulations for type of font and font-size. The report format should be restricted to 1" page margins top/bottom and left/right.

X. USAID CONTACTS

	Primary Contact	Alternate Contact 1	Alternate Contact 2
Name:	Hope Hempstone	Zarnaz Fouladi	Amani Selim
Title:	Senior Behavior Change Advisor	Behavior Change Advisor	Evaluation Advisor
USAID Office	USAID/GH/PRH	USAID/GH/PRH	USAID/GH/PRH
Email:	hhempstone@usaid.gov	zfouladi@usaid.gov	aselim@usaid.gov
Telephone:	571-551-7014	571-551-7329	571-551-7528
Cell Phone (optional)		571-243-7256	571-721-9577

List other contacts [OPTIONAL]

XI. REFERENCE MATERIALS

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

Annex 1: Core-Funded Capacity Strengthening Resources

1. *The Health COMpass:* An interactive and collaborative online collection of high-quality, curated tools and project examples for SBCC. The COMpass builds upon materials databases developed under earlier USAID projects (including JHU-CCP's Media and Materials Clearinghouse and FHI360's C-Hub), providing a stronger focus on "learning by doing" through step-by-step engagement with the user. Officially launched in August 2013, the site was designed in close collaboration with the international SBCC community and field tested with local partners in Pakistan, Nepal, Cote d'Ivoire, Tanzania, and Guatemala. At the end of September 2014, HealthCompass had 550 registered users. While the greatest number of visits came from users in North America (42% total visits), over a quarter (26%) of site visits came from users in Africa, and one in ten (11%) visits came from users in Asia.

2. *The Springboard*[18]*:* Developed collaboratively with several SBCC institutions and an international Advisory Council of SBCC experts, the Springboard is a virtual space where practitioners from around the world interact on an online platform, reinforcing and extending the reach of existing communities of practice at local and regional country levels. These on-line conversations are intended to catalyze in-person communities of practice in local and regional spaces and are reinforced by planned HC3 events in the countries and regions. Two Regional Secretariats were identified to lead the work: AfriComnet in Africa and Bangladesh Center for Communication Programs (BCCP) in Asia. The Springboard was officially launched in May 2014, which was followed by several in-country launches and follow-up activities in the Africa and Asia regions. It is anticipated that by the end of HC3, the Springboard will have launched successfully in 25+ countries, garnered buy-in from in-country partners, and will have sufficient capacity to continue beyond the end of HC3. To date (Sept 2014), Springboard has 1,792 members, with membership spanning North America, Europe, Africa and Asia. Launch activities have taken place in Uganda, Swaziland, Nigeria, Ethiopia, Tanzania, Ghana, and Bangladesh, with anticipated launches in South Africa, Lesotho, Kenya, Rwanda, Sri Lanka, and India in the next several months. In addition, HC3 has been able to garner investments from bilateral projects in South Africa and Uganda to support country level activities.

3. *SBCC Virtual Leadership Development Program (VLDP):* The SBCC VLDP combines face-to-face activities and distance learning to strengthen individual and team leadership and management practices so that participants can anticipate and respond to challenges in behavior change programming. Scheduled to run for thirteen weeks with follow-up activities at two and four months, the program is co-facilitated by MSH and JHU-CCP capacity strengthening experts. To date, 24 learning "teams" (or nearly 300 individuals) from approximately 30 countries have participated.

4. *University-Based Capacity Strengthening:* Based on the findings from a 2013 needs assessment survey from 26 universities in twelve African and Asian countries, HC3 has prioritized the following activities: (i) Host webinars on health communications pedagogy for audiences in sub-Saharan Africa (hosted by AfriComNet) and Asia (hosted by BCCP in Bangladesh); (ii) Work with partners such as AfriComNet and International Communication Association (ICA) to foster national, regional, and international academic networks, including at least one regional health communication conference. (iii) Provide stipends for up to 20 student

[18] HC3 originally developed the concept of this virtual platform under the name the *Marketplace*. It was subsequently changed to the *Springboard* in April 2014 just prior to the launch. Accordingly, the background documents may include either one of these names.

internships annually with local SBCC programs. HC3 is currently cataloguing possible internship opportunities for university students with CCP offices in Bangladesh and Nigeria, with Nepal and Cote D'Ivoire likely to follow.

5. *Research on Capacity Strengthening:* HC3 is actively implementing a research agenda that seeks to identify effective approaches for strengthening the capacity of organizations to design, implement, and evaluate SBCC activities and the capacity of governmental units to coordinate these activities as part of a national program. Based on this framework and the development of a set of research tools, HC3 is guiding a proposed evaluation of a well-recognized capacity-strengthening program implemented by the Tanzania Capacity and Communication Project (TCCP). The evaluation is using a mixed-method, case-control design to explore the combined effects of workshop training and focused mentoring on the capacity strengthening activities and improve our understanding of the measurement of organizational capacity for SBCC. Additional capacity strengthening research is anticipated in the coming years.

6. *Implementation Kits:* In Years 1 and 2, HC3 developed a series of SBCC Implementation Kits (I-Kits) that provide technical guidance around the development of SBCC programs for either dedicated SBCC implementers or implementers with discrete SBCC activities. These are designed as either global or regional-level resources that can be adapted to a local context, without additional technical assistance from an outside party. All I-kits will be pretested in-country to ensure adaptability and usability, and will then be translated to an online format and disseminated through either online or in-person fora. The following implementation kits have either been developed or are being developed by HC3:

   - Demand Generation I-Kit for Under-utilized Commodities: Developed under the UN Commission on Life Saving Commodities for Women and Children, the I-Kit (http://sbccimplementationkits.org/demandrmnch) focuses on underutilized commodities in reproductive, maternal, newborn, and child health. The I-Kit features adaptable communication strategies for a total of nine commodities and several core SBCC resources. The virtual site went live in November 2013 and was pre-tested in Uganda in July 2014, with formal launch scheduled for late 2014. In 2014 and 2015 the activity will focus on dissemination in countries in Africa and Asia, including micro-grants in these targeted countries. In the period of April 2014 through Sept 2014 the I-Kit had 2,801 page views and 1,190 downloads. As the site is still in the pretest phase, the majority of user sessions (56%, or 1,494 sessions) have originated from North America. Sessions originating from Africa constituted almost a quarter (23%) of all sessions, while 17% of sessions originated in Asia.

   - Youth Sexual and Reproductive Health I-Kit: This resource will be pretested in Benin and Madagascar in October 2014. It will be available online in both French and English in 2015. The activity will provide small grants to implementers in Anglophone and francophone countries.

   - Healthy Timing and Spacing: This resource will be pretested in Togo and Niger in 2015. It will be available online in both French and English in 2015.

   - Exclusive Breastfeeding I-Kit for Faith-Based Organizations: This resource was pretested with five Nigerian faith-based organizations in September 2014. It will be available online in English in 2014.

7. *Implementation Guides:* Implementation Guides, or How-To Guides, include the "building blocks" of SBCC and address specific SBCC topics. Guides provide thoughtful synthesis of best practices and tips, "how-to" steps, and worksheets. These Implementation Guides can either be used separately or form part of the Implementation Kits, and will ultimately be made available via the HealthCOMpass. Topics for Implementation Guides include the following SBCC technical and organizational development topics:
   - *SBCC:* Situational Analysis, Audience Analysis, Creative Brief, Media Mix, Message and Materials Development, Pre-testing, Adaptation, Concept Testing, Social Media
   - *Partner Specialty Areas:* Introductory Creativity Guide (Oglivy), Integrating your Creative Platform across all Health Communication (Oglivy), Positioning and Brand Insight (PSI), Organizational Mission (MSH), Organizational Values (MSH), Integrating Gender Awareness (MSH), Developing stories from public health data (Internews), Conducting Audience Research for Health News (Internews)
   - *Research:* Theories of Change, Logic Models, Indicators, Formative Research, M&E Plan
   - *Other proposed topics:* Media buying, Impact Evaluation for Program Managers, Advocacy, Information and Communications Technology, Mass media, Community Mobilization, Adult Learning, Radio, Roadshows.

Annex 2: Capacity Strengthening in the Field

Nigeria

The overall goal of the HC3 Nigeria malaria program (January 2014-September 2017) is to enable the National Malaria Elimination Program (NMEP) and the state level Malaria Elimination Programs to analyze, develop, plan, implement and monitor evidence-based strategic SBCC plans and activities. This will help those organizations reach their goals by improving the demand and use of malaria interventions. In support of this, HC3 Nigeria will develop comprehensive, costed, state-level SBCC programs for malaria prevention and control that address the three principal PMI interventions in Nigeria: IPTp, ITNs and integrated case management at facility, community and among patent medicine vendors (PMVs), as appropriate. By the end of the project, USAID envisions that HC3's efforts will result in maximized SBCC capacity at the state level, and in the existence of high quality and sustainable technical programming, as evidenced by strong technical leadership by the NMEP. Currently HC3 Nigeria is in year 2 of implementation, with year 1 ending in December 2014.

In Year 1 HC3 identified several broad results to achieve its goal. By year 2 HC3 Nigeria had established an on-the-ground presence, and began full-scale implementation. In addition, the broad results were re-aligned to reflect PMI objectives, which included a more focused effort on SBCC implementation.

Result 1: *Evidence-based, high quality SBCC interventions delivered at scale*. To achieve this broad result, HC3 Nigeria is focusing on the following sub- results: (1) Robust research, monitoring, and evaluation utilized to inform design, implementation, and re-planning of SBCC interventions; and (2) Multi-channel interventions promoting IPTP services, ITNs, and integrated case management designed and implemented in collaboration with local creative partners. In

Result 2: *Capacity of NMEP to provide leadership in SBCC increased at the national and in HC3 Focal States.* To achieve this broad result, HC3 Nigeria is focusing on the following sub- result: (1) Capacity of NMEP to coordinate national SBCC efforts increased. For Result 2, HC3 will provide "on-the-job" capacity building technical assistance to the national level ACSM unit and working groups and to the state level Malaria Elimination Programs through TA, capacity strengthening, and training.

Result 3: *Increase the Capacity of the Nigeria Inter-Faith Action Association (NIFAA) to implement and Manage SBCC Malaria Activities.* To achieve this broad result, HC3 Nigeria is focusing on the following sub- result: (1) Organizational Development for NIFAA. The over-all objective of Result 3's capacity-building activities with NIFAA is to make them eligible for direct USAID funding in two years, and to help them to design and implement effective public health communication programs. Based on the result of NIFAA capacity assessment in year 1, the systems identified as for focused capacity strengthening are: procurement and financial management; resource mobilization, including proposal development; and human resource management.

Cote d'Ivoire

The overall goal of the Health Communication Capacity Collaborative/Cote d'Ivoire (HC3 RCI) is to reduce vulnerability to HIV/AIDS among higher-risk populations through communication activities while strengthening the capacity of local partners to address the HIV epidemic through SBCC activities. The project began in October 20013 and will end April 22, 2017. The project

places a special emphasis on strengthening national capacity to provide strategic communication supporting HIV/AIDS prevention, as well as care and treatment services to improve the lives of people living with or affected by HIV/AIDS. HC3 RCI builds on successful activities implemented under a previous bilateral award, reorienting them as appropriate to reflect current data on the epidemic in Côte d'Ivoire.

In year 1 (October 2013-September 2014), HC3 RCI had a relatively heavy emphasis on SBCC capacity strengthening, whereas in year 2 (October 2014-September 2015) the balance has shifted towards a heavier emphasis on implementation and achievement of direct behavior-level outcomes. In addition, at the start of the project interventions addressed HIV prevention, primarily, yet with time have shifted to include behaviors across the HIV/AIDS continuum: from prevention to testing to care and treatment. HC3 RCI achieved a number of first year's broad results, including increased capacity of the Ivorian government in SBCC, increased capacity of local institutions in SBCC, and increased practice of key HIV prevention behaviors among high priority audiences in Cote d'Ivoire.

In year 2, HC3/RCI is designed to achieve the following four broad results:

- Increase practice of key HIV preventive behaviors, risk reduction and service uptake among high-priority audiences (young girls, older men) within Côte d'Ivoire through the planning and implementation of SBCC interventions**.** Recent survey findings from Cote d'Ivoire indicate that the HIV/AIDS epidemic has changed in terms of gender, age, and geographic distribution. As a result, PEPFAR Cote d'Ivoire is shifting its strategy to focus more on treatment and PMTCT, health systems strengthening (HSS), and directing the prevention program toward key populations. For year two, the project will therefore adjust its prevention programs to meet PEPFAR's new priorities for FY 2015.

- *Increase HIV testing uptake and adherence in HIV/AIDS services and retention in care, especially among high priority audiences***.** HC3-RCI will continue to work towards improving the quality and reach of care and support services for the high priority audiences described in the 2014 PEPFAR guidelines by developing new materials to promote HIV testing and counseling with emphasis on couples and families. It will also work to improve the tracking of people living with HIV/AIDS (PLHA) to reduce the number of those who are lost to follow-up before they start on ART, and improve retention of those in care.

- Increase the capacity of the government of Côte d'Ivoire to provide technical leadership in SBCC in Côte d'Ivoire, through strengthened coordination, strategic design, and knowledge management**.** To address the challenge of numerous uncoordinated vertical HIV communication strategies in Cote d'Ivoire, HC3-RCI will continue activities to strengthen local capacity to design, produce, implement, coordinate, evaluate, and scale up high-quality social and behavioral change communication (SBCC) strategies, tools, and materials. A National HIV SBCC Strategy is in the final stages of development. In Year 2, with technical support from HC3-RCI, the strategy will be validated through a collaborative process. This program specific SBCC strategy will then inform all PEPFAR activities and those of the new national HIV/AIDS Program (PNLS).

- *Increase the capacity of local behavior change institutions in Cote d'Ivoire including support to create an Ivorian SBCC NGO***.** Capacity building of local government and NGO partners in SBCC is vital for the SBCC program's sustainability, as it aims to enhance skills and knowledge and

establish plans and processes needed to continue HIV/AIDS activities beyond the HC3 project. Some of the capacity building activities have already begun during year one. For instance, HC3-RCI developed partners' SBCC skills during workshops (using a learning by doing approach), provided on-the-job training, close monitoring, mentorship, and coaching during supervision visits. These processes will require more time to put in place and achieve their desired effects as circumstances change. This results aims to ensure that local partners, including NGOs, have the capacity to continue SBCC activities beyond the life of this project, including the creation of a new NGO specializing in SBCC. In year two the project will continue to strengthen local partners' SBCC knowledge and skills for the period of the project.

Guatemala

USAID Guatemala invests in HC3 for technical assistance in order to achieve the goal of creating synergy and evolving the Western Highlands Integrated Program (WHIP) model in order to achieve the overarching goal of Guatemala's Country Development Cooperation Strategy (CDCS). It is hoped that an integrated SBCC strategy will create a more community-driven, holistic approach for USAID Guatemala's next CDCS. HC3 assistance focuses on creating a WHIP SBCC strategy in order to facilitate complete and comprehensive integration of key elements of development, including income generation, nutrition, education, local governance, water and agriculture. It is expected that the strategy design and implementation processes will serve as a unifying force and prompt momentum for AOR/CORs, implementing partners, key GoG counterparts and other important stakeholders such as private sector and church leaders to collaborate on the reduction of chronic malnutrition in Guatemala. The USAID Guatemala sectors involved in this SBCC venture include Health, Education, Economic Growth, Agriculture, Environment, Democracy and Governance and Food for Peace.

In Guatemala, HC3 is designed to achieve the following broad results:

1. *Increased cross-sectoral SBCC coordination:* Within the 30 target municipalities, many projects are co-located but their messages, materials and activities are neither consistent, nor complementary. Although partners and projects are working across common themes like nutrition, there is not yet standardization of materials, activities, or messages. This appears to cause confusion among target populations and diminish the effectiveness of program efforts.

2. *Strengthened knowledge of audience perceptions and desires through formative research:* USAID Guatemala and its implementing partners require insights into the target audience's information, motivation, capacity to act, influences and norms to properly understand how to motivate people to change their behaviors in sustainable ways.

3. *Increased programmatic reach through utilization of socio-ecological model:* Currently, projects focus primarily on individuals and community, without adequate attention to national or political spheres of influence. Projects tend to focus only on print materials and under-emphasize community mobilization or advocacy, which USAID Guatemala considers essential to enhance program impact. No single project currently integrates these three communications strategies to maximize program results and development impact.

APPENDIX C. CALENDAR OF ACTIVITIES

(REVISED JULY 31, 2015)

June 2015													
		Monday		***Tuesday***		***Wednesday***		***Thursday***		***Friday***		***Saturday***	
		1		**2**		**3**		**4**		**5**		**6**	
7		**8**		**9**		**10**		**11**		**12**		**13**	
14		**15**		**16**		**17**	GH Pro/DC	**18**	GH Pro/DC	**19**	GH Pro/DC	**20**	
						Team Planning Meeting (TPM) 9:00-17:00		TPM 9:00-17:00		TPM 9:00-17:00			
21		**22**		**23**	USAID/DC	**24**	USAID/DC	**25**		**26**		**27**	
		Finalize protocols and US-based evaluation tools 1-4 at GH Pro		Interviews from 9:00-17:00 in Crystal City: - Hope Hempstone - Zarnaz Fouladi - Andrea Ferrand - Rachel Marcus		Interviews from 9:00-17:00 in Crystal City: - Martin Alilio - Andy Tompsett - Kama Garrison - Kim Ahanda		Desktop review of core-funded capacity strengthening outputs Document review		Team meeting on desktop review [Weekly TL Update to USAID/GH Pro]			
28		**29**	HC3 Baltimore	**30**	HC3 Baltimore								
3-5 Team meeting in Baltimore		Presentation by HC3 for Evaluation team Interviews at JHU/CCP offices		Interviews at JHU/CCP offices from 9:00-17:00: - Arzam Ciloglu									

June 2015						
	Monday	***Tuesday***	***Wednesday***	***Thursday***	***Friday***	***Saturday***
	from 9:00-17:00: - Kirsten Bose - Kojo Lokko - Katherine Holmsen - James Bon Tempo - Patricia Pope (G)	- Erin Portillo - Lynn Van Lith - Nan Lewicky - Jane Brown (email/phone)				

July 2015													
Sunday		***Monday***		***Tuesday***		***Wednesday***		***Thursday***		***Friday***		***Saturday***	
						1	HC3 Baltimore	**2**	Springboard	**3**		**4**	
						Interviews at JHU/CCP offices from 9:00-17:00: Alice Payne Merrit (G) Sanjanti Velu Susan Krenn Doug Storey Ian Tweedie		10:00/4:00 Call with Nigeria USAID [Weekly Team Update to TL]		[Weekly TL Update to USAID/GH Pro] (LC unavailable for travel July 3-6)			
5		**6**		**7**		**8**		**9**		**10**	Core Partners	**11**	
						10:30 Tiffany Lillie USAID RCI		8:30: Soma Ghoshal and Fredrik Winsnes (NetHope) 9:45: Stacy Wallick (USAID Guatemala)		8:30: Charles Kakaire (Africomnet) [Weekly TL Update to USAID/GH Pro]			

July 2015													
Sunday		***Monday***		***Tuesday***		***Wednesday***		***Thursday***		***Friday***		***Saturday***	
								14:45: Beth Skorochod (PSI) [Weekly Team Update to TL]					
12	Guatemala	**13**	Guatemala	**14**	Guatemala	**15**	Guatemala	**16**	Guatemala	**17**		**18**	
Travel		Interviews: Wende Duflon (USAID Health Ed Units (TBD)		Field visits to Xela, Western Highlands		SBCC Working Group meeting Debrief		Travel [Weekly Team Update to TL]		[Weekly TL Update to USAID/GH Pro]		(BP unavailable July 18-31) (SG unavailable July 19-25)	
19		**20**		**21**		**22**		**23**		**24**		**25**	
								[Weekly Team Update to TL]		[Weekly TL Update to USAID/GH Pro]			
26		**27**		**28**		**29**		**30**		**31**			Nigeria
		8:00 Tawfigue Jahan BCCP		Cogswell to visit HC3 workshop on Fake Malaria meds in Ghana		9:15 Callie Long Internews 10:30 Regina Traore (HC3, previous RCI now in Mali) 11:45 Judy Seltzer MSH		9:00 Liz McLean MSH 16:00: Lynn Van Lith and Beth Mallalieu (HC3 HIV Team) [Weekly Team Update to TL]		[Weekly TL Update to USAID/GH Pro]		Travel to Nigeria	

August 2015													
Sunday		***Monday***		***Tuesday***		***Wednesday***		***Thursday***		***Friday***		***Saturday***	
												1	Nigeria
												Arrive in Nigeria Lynne and Andy	
2	Nigeria	**3**	Nigeria	**4**	Nigeria	**5**	Nigeria	**6**	Nigeria	**7**	Nigeria	**8**	Nigeria
Arrive in Nigeria Brian and Siobhan 16:00 Meet with Abidemi at hotel		USAID: 9:00-10:30 Group Interview USAID Malaria Team 10:45-12:15 Group Interview USAID FP Team 1:30-2:30 Anna Melstad (HC3) 2:45-4:15 Group Interview HC3 Staff		8:30-9:30 MSH Peter Njoroge 10:00-11:00 Human Network International (ICT) David McAfee 11:15-12:15 CCPN Babafunke Fagbemi 12:30-2:00 ACSM Group Activity-15 members randomly selected (location TBD, hotel conference room)		Abuja to Sokoto DEPARTS 11.25AM Drive from Sokoto to Birnin kebbi Interviews/field visit cont. Interview with John Orok Interview with NGO Director—Kola Oduola FGD with 10 maximum LGAs and Ward Leaders Observe 2-3 SBCC activities		Interviews/field visit cont.		Travel back to Sokoto by vehicle. Sokoto to Abuja 1.05PM ARIK AIR 2:00-5:00 Springboard event		Travel to Akwa Ibom from Abuja 8 AM Flight: Arik Air Arrives 9:15AM Interview with Ahmed Aliyu Interview with Director of NGO—Nsekpong Udoh FGD with 10 maximum LGAs and Ward Leaders Observe 2-3 SBCC activities	

August 2015													
Sunday		***Monday***		***Tuesday***		***Wednesday***		***Thursday***		***Friday***		***Saturday***	
9	Nigeria	10	Nigeria	11	Ivory Coast	12	Ivory Coast	13	Ivory Coast	14	Ivory Coast	15	Ivory Coast
Interviews/Field Visit Cont. FGD with 10 maximum LGAs and Ward Leaders Observe 2-3 SBCC activities Prepare for Debrief		Travel to Abuja from Akwa Ibom 9.45AMFlight: Arik Air Arrives 11 AM Debrief USAID 16:00		Travel to Ivory Coast Arrive 16:20		10:00-11:30 USAID Andrea Halverson & PEPFAR team 13:00-14:00 HC3 Diarra Kaman 14:15-15:45 HC3 Patricia, Ben, Paul Group Interview 16:00-17:00 HC3 Aline Super Go (SG)		8:30-9:30 HC3 Adama Brothers for Life (B4L) 10:00-11:30 MOH All Group Interview 13:00-17:00 2 FGDs with CS Beneficiaries PNLS & LHSC (or observation of activities with same)		AM Visit to GBH (SG) for: 1 interview with LNGO implementing partner 1 FGD with community leaders 1-2 observations of LNGO activities PM Visit to MESSI (SG) for: 1 interview with LNGO implementing partner 1 FGD with community leaders 1-2 observations of LNGO activities		Travel to Abengourou AM Religious holiday ----- PM Visit to UNIVERS SANTE (B4L) for: 1 interview with LNGO implementing partner 1 FGD with community leaders 1-2 observations of LNGO activities (in the evening)	

August 2015 (CONT.)													
Sunday		***Monday***		***Tuesday***		***Wednesday***		***Thursday***		***Friday***		***Saturday***	
16	Ivory Coast	**17**	Ivory Coast	**18**	Ivory Coast	**19**	Ivory Coast	**20**		**21**		**22**	
AM Visit to FEMFECA-R (SG) for: 1 interview with LNGO implementing partner 1 FGD with community leaders 1-2 observations of LNGO activities AM PM Visit to RUBAN ROUGE (SG) for: 1 interview with LNGO implementing partner 1 FGD with community leaders 1-2 observations of LNGO activities		Travel back to Abidjan Start on debrief preparation		AM Visit to SIDALERTE (SG) for: 1 interview with LNGO implementing partner 1 FGD with community leaders 1-2 observations of LNGO activities PM Visit to OASIS (B4L) for: 1 interview with LNGO implementing partner 1 FGD with community leaders 1-2 observations of LNGO activities		9:00-11:00 Group Activity with Strategic Communication Training Participants 11:30-12:30 PEPFAR C&T Dr. N'Gouanma 15:00-16:00 Debrief USAID Travel Home 22:10		[Weekly Team Update to TL]		[Weekly TL Update to USAID/GH Pro]			

August 2015 (CONT.)													
Sunday		***Monday***		***Tuesday***		***Wednesday***		***Thursday***		***Friday***		***Saturday***	
23		**24**		25		**26**		**27**		**28**		**29**	
		13:00 Claudia Vondrasek 14:15 Kama Garrison 15:30 Joseph Munda (Springboard ZM)		13:00 Benji Soro (HC3 Springboard RCI)		16:30 Joanna Skinner Virtual Team Meeting		8:30 Bete Alemu (Springboard ET) [Weekly Team Update to TL]		[LAST Weekly TL Update to USAID/GH Pro]			
30		**31**											
		9:00-11:00 Springboard Discussion with HC3											

September 2015													
Sunday		***Monday***		***Tuesday***		***Wednesday***		***Thursday***		***Friday***		***Saturday***	
				1		**2**		**3**		**4**		**5**	
						Team Meeting in DC		Team Meeting in DC		Team Meeting in DC Submit draft PPT debrief to GH Pro			
6		**7**	GH Pro/DC	**8**	USAID/DC	**9**	GH Pro/DC	**10**	DC	**11**	HC3 Baltimore	**12**	
		Team meeting in DC		9:00-2:00 Preliminary Findings Debrief (at GH Pro)		Team meeting in DC		12:00-4:30 USAID/DC & HC3 Preliminary Findings Debrief (at GH Pro)—included 1-hour with HC3 senior management		11:00-2:00 Presentation of Findings & Q&A/Discussion (in Baltimore)			
13		**14**		**15**		**16**		**17**		**18**		**19**	
										Draft sections of Report from team to TL			
20		**21**		**22**		**23**		**24**		**25**		**26**	
				Return feedback on draft sections—from TL to team									
27		**28**		**29**		**30**							
		Submit finalized report sections to TL				Submit Draft Report from Consultant Team to GH Pro							

APPENDIX D. EVALUATION PROTOCOL

PROTOCOL

This **evaluation team** comprised Lynne Cogswell, Team Lead and Organizational Effectiveness Specialist; Siobhan Green, Information and Communications Technology Specialist; and Brian Pedersen, Social and Behavior Change Communication Specialist.

The team had **three** overarching **evaluation questions** (see Appendix B for full Scope of Work):

1. What progress has been made in achieving project objectives, as described in the project RFA and PMP?
2. How successful is HC3 at developing capacity to design, implement, and evaluate high-quality SBCC at the regional and country levels?
3. How successful has HC3 been in their country programs in Cote d'Ivoire, Nigeria, and Guatemala?

The team did **not** look at **quantity**, didn't "count beans," **but** rather looked at **quality and the outcomes** of the "planted beans."

There were **seven primary data sources** and no secondary data sources[19]: (1) USAID DC, (2) USAID Mission, (3) HC3 Headquarters staff, (4) HC3 Country staff, (5) Project Partners, (6) Country Implementing Partners such as CCPN, (7) Country Local Partners and Players such as Local NGOs implementing in the states in Nigeria and in Cote d'Ivoire, as well as beneficiaries of the local activities. Furthermore, the team looked at Project Documents and Materials collected in the field.

The evaluation team employed **qualitative and quantitative methods** to collect data and information: (1) Document/Desktop Review, (2) Qualitative [Individual/Group Interview (Tool 1), Focus Group Discussions (Tool 2), Interactive Group Activity (Tool 3), and Observation Checklist (Tool 4)]; and (3) Quantitative [Snapshot Survey in French, English and Spanish (Tool 5A, 5B, and 5C), Organizational Diagnostic (Tool 6) (see Appendix I for a full set of tools), and Web and Collaborative Board Analytics (see Appendix J).

This **evaluation** was **conducted** from June 8 to September 30, 2015 and included visits to Guatemala, Nigeria, and Côte d'Ivoire (see Appendix C for full Calendar).

The **sampling methodology** comprised (1) purposive—based on needed audiences and types of activities, (2) convenience—based on who was actually available when the evaluation was conducted, (3) representative—based on time available to reach the primary data sources.

Quality of findings and analysis was **assured** first by using a triangulation methodology. Verification and validation of key findings looked at the three sources of information - qualitative, quantitative and document review—and to be considered a verified and valid finding, it had to be present in a least two of the types of data sources, i.e. staff skills are strong was

[19] Please note that under normal evaluation protocol methodology, documents would be considered a secondary data source. However, as much of what HC3 has done has been document in nature, the team felt it appropriate to use documents as a primary data sources.

reported and/or found in qualitative and quantitative sources, weak strategic planning was reported and/or found in the qualitative, quantitative and document sources. Furthermore, except in five cases, there were always two evaluators present to hear the information and/or review the document to cross-check understanding and interpretation. The clear data collection and analysis procedures and centralized data storage ensured a **thorough and rigorous process was maintained**.

Sample Sizes (see Appendix E for a full list of persons contacted)

Method	Audience							
	USAID DC	USAID Missions	HC3 HQ	HC3 Country	Project Partners	Implement Partners	Country Local Partners & Beneficiaries	TOTAL Persons
Interview	10	26	34	13	10	5	72	170
FGD	-	-	-	-	-	-	21	210
Group Activity	-	-	-	-	-	3	-	37
Observation	-	-	-	-	-	-	25[20]	25
Snapshot	-	4	-	-	5	11	21	41*
Diagnostic	-	-	31	10	-	-	-	41**
Web Analytics	HC3 Website, HealthCOMpass website, Springboard website							
Document Review	222 (see Appendices F and G for full lists)							

*Response rate—138 sent, 62 received, 21 invalid, 41 used = 31%
** Response rate—52 administrated, 41 received, all valid = 79%

The **analysis** process was a simple and straightforward determination of major and in-common trends and patterns across all data sources using all data collection methods based on frequency and descriptors. Furthermore, in analyzing the quality of products and materials produced, the team utilized primarily HC3 (JHU/CCP) standards as the metric to review SBCC programs, complemented by other resources from MSH, PSI, PATH, the CORE group, as well as from Harvard and Wharton Business Schools as a standards for organizational and project effectiveness.

Challenges encountered included: (1) inability to talk virtually to more Springboard users as they were not readily available during the timeframe available to the team, (2) inability to talk to at least two more country offices that were not visited due to the timeframe available to the team, and (3) non-disaggregated data by funding mechanism type, intervention type, and health area/technical area due to the limited amount of time and disaggregation feedback and information available to the team. None of these challenges; however, were felt to impact negatively or reduce the significance of the findings, especially in the case of the disaggregation

[20] See Appendix H for a list of activities observed.

challenge where no significant differences were identified across countries, across health areas or technical topics (except for Ebola where all conditions were outside the norm), or across funding mechanism type.

TECHNICAL AREAS EXAMINED

This **evaluation examined three broad technical areas**: (1) organizational effectiveness, (2) social and behavior change communication, and (3) information and communications technology. Each technical areas and its examined dimensions has been defined in the tables below.

ORGANIZATIONAL EFFECTIVENESS[21]	
Component	**Definition**
Organizational Development	*Organizational Development is comprised of the structures that guide task performance in an organization and the processes used to complete specific tasks. It details the actions and processes carried out by an organization. It examines the process through which these actions are carried out and how these processes could be improved.* Organizational development looks at six broad dimensions: (1) contacts and relationships, (2) assets and finances, (3) strategy and planning, (4) personnel and human resources, (5) staff skills and capabilities, and (6) management structures. The types of aspects that one would expect to find in an organization/project that has been developed and built effectively would include, just to name a few: a wide circle of outside contacts it can leverage for its purposes; solid partnerships; strong contacts in a variety of sectors; good at calling on these contacts when it needs help in a given area; looks to deepen its existing relationships; many assets that are unique from those of other programs; many assets that could be considered sustainable over time things; awareness of assets and actively looks for creative ways to leverage those assets into opportunities; an overarching strategy that allows the vision and mission to succeed, a "life of the project strategy;" a mission that is the focus of the planning process; a goal and objectives that are clear and understood throughout the program; staff that understands its primary clients; decision making that focus on adding value to its clients; decision making on a daily basis that support its objectives; an annual operating work plan; plans developed and revised with input from all levels of staff; staff that understands that long-term strategy; sufficient communication flow that provides all staff with needed program information; hires the right people; staff with the opportunity to evaluation their supervisors; staff who evaluate their own performance; the right people in the right place/job; skills assessment as part of its planning process; and ability to develop needed skills in current staff. As well, a well-developed organization/project would have managers and team leads that set clear goals and objectives; conduct business in an open and inclusive manner; are efficient and productive, focused on outcomes; handle personnel issues in a fair, consistent, and timely fashion; are good role models for the staff; provide sufficient guidance to its staff; and are hired and promoted based on their management and supervisory skills.

[21] This Organizational Effectiveness information and the corresponding tool is the property of Lynne Cogswell and can only be reprinted with permission.

ORGANIZATIONAL EFFECTIVENESS[21]	
Component	**Definition**
Organizational Environment	Organizational Environment encompasses the environment in which an organization functions. The diagnostic assesses the present environment of an organization and compares it to a potentially healthier environment in which the organization could function more effectively. Organizational environment looks at six broad dimensions: (1) vision, (2) leadership, (3) readiness, (4) responsiveness, (5) learning, and (6) innovativeness. The types of features one might expect to see in an organization/project whose environment is "healthy," would include, just to name a few: a single executive that does not have all of the decision-making authority; decisions that are communicated clearly to staff; program managers that manage their own budgets and make spending decisions; there is seldom internal conflict over ideas, decisions; internal stress is minimal; staff at all levels contributes to quality improvement; a formal process is in place to elicit and follow through on new ideas for program changes; a program that integrates client feedback into idea generation; staff that has skills and resources to be successful; there is a formal system for learning and provoking new ideas; senior management that listens to staff concerns and issues; staff that propose solutions to programmatic problems; collaboration and team building play an important role in program development; team across sectors is encouraged; new ideas that are incorporated based on fit with mission; staff that can make changes to the program services and activities based on what they learn; staff that is encouraged to document "lessons learned" and share them with others in their program; staff that is involved in identifying solutions to program challenges; a program that views quality as a competitive advantage; a work environment that stimulates and rewards creativity and passion; a program that is on the cutting-edge; new perspectives are examined and either rejected, substituted, or integrated into current systems; a program that is supportive of pioneering ideas; a program that is able to build on the synergy of its staff; and an environment that supports creative, passionate minds. Furthermore, a healthy project/organizational environment would have a vision that is understood at all levels; has operations and activities that fit with this vision; shows successful efforts to reinforce this vision; that is compelling and inspiring; and can be effectively implemented. Leadership would communicate the vision to the staff; understand what skills staff need to accomplish its program objectives; encourages teamwork across sectors; provide clear and effective lines of authority; not feel pressured to ask others to carry out change they do not fully understand or support themselves; bring the vision to its partners and their communities; listen and lead; set a positive tone for the program; manage the "unexpected" well; make it clear where responsibility for leadership resides; and be proactive in putting forth the vision.
Change Management	*The ability to manage change is critical to the long-term success of an organization or project. Change can be internal, e.g. new policies, new leadership. It can be external, e.g. competitive pressure, funding pressure. Whatever the source of the change, effective organizations/projects learn how to adapt and succeed.* Change management looks at six broad dimensions: (1) change strategy or plan, (2) adaptive policies and procedures, (3) management ability, (4) involvement and cooperation, (5) staff voice, and (6) approach. The types of considerations one would expect to see in a project/organization that manages its change(s) effectively would include: that the organization/project has: a strategy to guide its possible change efforts; policies/procedures that make it possible to change the way things are done; management that effectively monitors

ORGANIZATIONAL EFFECTIVENESS[21]	
Component	**Definition**
	its past change activities; management that can still focus on important change projects when other problems or issues compete for their attention; managed past change well; a history of providing the tools/resources needed to support change initiatives; a history of communicating changes effectively to all levels of the program; a senior leadership team that encourages people to express their opinions about how change affects them; management that can build the support required from staff to complete change initiatives; helped staff understand how specific changes support the overall mission, goals and objectives; kept clients informed of the change efforts and the impact of the change on them; a track record for identifying and resolving problems during change; used a clear decision making process to bring about the change initiatives; the ability to stay on track to achieve its goals; encouraged people to become involved with change initiatives rather than simply being forced to comply with them; a level of cooperation and support among units during change efforts encouraged staff to voice true opinions instead of taking the easier route of "going with the flow;" made an effort to seek change when it is ready, rather than waiting until external factors force the change.
Organizational Outcomes	*Organizational Outcomes are the essence of organizational/project work. They are the reasons, rationale, purpose, and mission for which an organization/project does its work—to make a change or to have a positive impact. The environment and structures of an organization/project affect its organizational/project outcomes.* Organizational Outcomes look at four broad dimensions: (1) ongoing assessment, (2) milestones and indicators, (3) link to knowledge capture, and (4) M&E plan. The types of outcome-related activities or tasks that one would expect to see in an effective project or organization would include: that this organization/project makes a continuous effort to assess the needs of clients through brief surveys and interviews; has integrated methods to continuously gather and use feedback about program activities; has a plan for and method of capturing key learnings and passing them on to staff and other key stakeholders on an ongoing basis; has activities that are connected/linked to the knowledge capture efforts; determines what each operating unit adds to the value of the program and communicates this to staff; calculates the cost of direct and indirect outcomes; uses industry benchmarks to inform and gauge outcomes achieved; resets outcome targets each year and expects to see improvement each year; has an outcome system that uses quality as well as quantity measures; has developed outcome measures that are assessed based on direct input from clients and beneficiaries; measures client satisfaction regularly (at least quarterly); adapts services and activities based on client feedback; has established client satisfaction indicators; links its internal processes to programmatic impact; integrates collection methods that are simple and easy for the clients and stakeholders to use; and has a comprehensive monitoring and evaluation plan.

SOCIAL AND BEHAVIOR CHANGE COMMUNICATION	
Component	**Definition**
Evidence and Theory Use in Planning and Design	The extent to which programs use new and existing evidence (including past experience and lessons learned) and theory to inform the planning and design of program approaches and activities. A comprehensive approach to gather, analyze, document, and use information to inform programs would be demonstrated through a situation analysis, use of theories and models, use of research data, and contextualization of activities, including coordination with other public and private efforts.
Strategy Development	The extent to which programs develop and document a strategic framework that outlines and links key decisions on target audiences, behavior change and communication objectives, priority channels, all based on the situation analysis, and provides a strategic approach that integrates program components. Specifically, a program strategy or communication strategy would include audience segmentation and insight (which can be presented as an audience profile), SMART communication objectives and priority communication channels, ecological assumptions and responses, and a strategic approach that ties all program components together.
Intervention and Materials Development Processes	The extent to which programs employ a process that results in the development of intervention tools and support materials that respond to local context and the program's communication strategy. This process would ensure that intervention tools and support materials respond to the program's communication strategy and would include the review of outputs by technical staff and stakeholders and pretesting with intended audiences prior to finalization.
Implementation and Monitoring	The extent to which programs plan and manage activities to accomplish program objectives. This would include work planning and budgeting, recruitment and training of staff, supervision systems of field staff and activities, and implementation of monitoring systems and tools and data use to inform program improvements.

Source: Adapted from HC3's SBCC-OST Tool (2015), C-Change's SBCC CAT Tool (2011), and O'Sullivan, G.A., et al. *A Field Guide to Designing a Health Communication Strategy*, JHU-CCP (2003).

INFORMATION AND COMMUNICATIONS TECHNOLOGY	
Component	**Definition**
Usage	Who is using the digital tool, and how, for what purpose, and how does this usage link into the broader mandate of HC3? Are these users the same as key users identified by HC3 for the tools?
Integration	How are tools integrated across each other, and how usage is integrated between HC3 tools and programs?
Access/demand	How do users (identified by usage and by HC3 as key users) access the tool (and are there patterns)? Are there different access issues (due to location, literacy, and other factors)? How is demand generated, what is the engagement model?
Feedback	What is the feedback cycle used to iterate towards tools that are more closely aligned with emerging needs and new requirements?

APPENDIX E. PERSONS CONTACTED

(1) USAID DC, (2) USAID Mission, (3) HC3 HQ, (4) HC3 Country, (5) IP—Implementing Partner, (6) PP—Project Partner, (7) CLP—Country Local Partner

##	Name	Data Source	Organization	Title/Work	HC3 Staff	Country	Type of Contact	Contact Information
	Yma Alfaro	USAID Mission	USAID	Health Officer (Support Activity Manager for HC3)	No	Guat	Group Interview	yalfaro@usaid.gov
	Jeff Lehrer	USAID Mission	USAID	Director Program Office	No	Guat	Group Interview	jlehrer@usaid.gov
	Andrew Lucas	USAID Mission	USAID	DGO D&G Officer	No	Guat	Group Interview	alucas@usaid.gov
	William Brands	USAID Mission	USAID	Mission Director	No	Guat	Group Interview	wbrands@usaid.gov
	Tanya Urquieta	USAID Mission	USAID	Mission Deputy Director	No	Guat	Group Interview	turquieta@usaid.gov
	Baudilio López	USAID Mission	USAID	Health Officer	No	Guat	Group Interview	blopez@usaid.gov
	Michelle Dworkin	USAID Mission	USAID	Deputy Director Program Office	No	Guat	Group Interview	mdworkin@usaid.gov
	Julie Boccanera	USAID Mission	USAID	Deputy Health Office	No	Guat	Group Interview	jboccanera@usaid.gov
	Ray Waldron	USAID Mission	USAID	Western Highlands Integrated Program Coordinator	No	Guat	Group Interview	rwaldron@usaid.gov
	Julia María Asturias	USAID Mission	USAID	Western Highlands Integrated Program (WHIP) Senior FSN Coordinator	No	Guat	Group Interview	jmasturia@usaid.gov

##	Name	Data Source	Organization	Title/Work	HC3 Staff	Country	Type of Contact	Contact Information
	Laura Villegas	USAID Mission	USAID	HEO Education Officer	No	Guat	Group Interview	lvillegas@usaid.gov
	Rachael Shenyo	USAID Mission	USAID	WHIP Field Coordinator	No	Guat	Group Interview	rshenyo@usaid.gov
	Wende DuFlon	USAID Mission	USAID	Strategic Communications Officer	No	Guat	Individual & Group Interview	wduflon@usaid.gov
	Stacy Wallick	USAID Mission	USAID	HEO Health Officer	No	Guat	Phone Interview	swallick@usaid.gov
	Abidemi Okechukwu	USAID Mission	USAID	Malaria Program Manager	No	Nigeria	Group Interview	aokechukwu@usaid.gov
	Jessica Kafuko	USAID Mission	USAID	Malaria	No	Nigeria	Group Interview	jkafuko@usaid.gov
	Mounkaila Billo	USAID Mission	USAID	Senior Health Advisor and M&E Team Lead	No	Nigeria	Group Interview	mbillo@usaid.gov
	Uwem Injang	USAID Mission	USAID	M&E	No	Nigeria	Group Interview	uinyang@usaid.gov
	Olubunmi Dili-Ejinaka	USAID Mission	USAID	Malaria	No	Nigeria	Group Interview	odili-ejinaka@usaid.gov
	Uche Ikenyei	USAID Mission	USAID	Malaria	No	Nigeria	Group Interview	uikenyei@usaid.gov
	Andrea Halverson	USAID Mission	USAID	Health Office Director	No	RCI	Individual Interview	ahalverson@usaid.gov
	Tiffany Lillie	USAID Mission	USAID	Activity Manager	No	RCI	Phone Interview	tlillie@usaid.gov
	Dr. Nobah-Bello	USAID Mission	CDC PEPFAR	PMTCT Advisor	No	RCI	Group Interview	xis7@cdc.gov

##	Name	Data Source	Organization	Title/Work	HC3 Staff	Country	Type of Contact	Contact Information
	Doumatey LI	USAID Mission	CDC PEPFAR	Counseling and Testing Advisor	No	RCI	Group Interview	hpl9@cdc.gov
	Stephen Howard	USAID Mission	CDC	HIV/AIDS	No	RCI	Group Interview	xhr9@cdc.gov
	Joseph Trika Beugre	USAID Mission	CDC	HIV/AIDS	No	RCI	Group Interview	jjq1@cdc.gov
	Martin Alilio	USAID DC	USAID	Malaria	No	N/A	Group Interview	malilio@usaid.gov
	Andy Tompsett	USAID DC	USAID	Malaria	No	N/A	Group Interview	atompsett@usaid.gov
	Bhavna Patel	USAID DC	USAID	Malaria	No	N/A	Group Interview	bpatel@usaid.gov
	Hope Hempstone	USAID DC	USAID	PRH, AOR, All FP activities, Mission activities	No	N/A	Individual Interview	hhempstone@usaid.gov
	Zarnaz Fouladi	USAID DC	USAID	PRH Springboard, Youth	No	N/A	Individual Interview	zfouladi@usaid.gov
	Andrea Ferrand	USAID DC	USAID	Contracts	No	N/A	Individual Interview	aferrand@usaid.gov
	Rachel Marcus	USAID DC	USAID	PRH Gender	No	N/A	Individual Interview	rmarcus@usaid.gov
	Stephanie Levy	USAID DC	USAID	SBC Advisor	No	N/A	Individual Interview	slevy@usaid.gov
	Kim Ahanda	USAID DC	USAID	HIV/AIDS activities, RCI	No	N/A	Individual Interview	kahanda@usaid.gov
	Kama Garrison	USAID DC	USAID	Ebola	No	N/A	Phone Interview	kgarrison@usaid.gov
	Beth Skorochod	PP	PSI	Deputy Director HIV & TB	No	N/A	Phone Interview	eskorochod@psi.org

##	Name	Data Source	Organization	Title/Work	HC3 Staff	Country	Type of Contact	Contact Information
	Soma Ghoshal	PP	NetHope	Global Program Manager	Yes, 100%	N/A	Phone Interview	soma.ghoshal@nethope.org
	Frederik Winsnes	PP	NetHope	Director	No	N/A	Phone Interview	fredrik.winsnes@nethope.org
	Liz McLean	PP	MSH	Director of Knowledge Exchange	No	N/A	Phone Interview	elizabeth.d.mclean@gmail.com
	Judy Seltzer	PP	MSH	CS, OD, ID	No, 80%	N/A	Phone Interview	jseltzer@msh.org
	Eliana Monteforte	PP	MSH	CS, OD, ID	Yes, 80%	N/A	Phone Interview	emonteforte@msh.org
	Callie Long	PP	Internews	Media Development	No	N/A	Phone Interview	clong@internews.org
	Dr. Zipporah Kpamor	PP	MSH	Country Representative	No	Nigeria	Group Interview	zkpamor@msh.org
	Peter Njoroge	PP	MSH	Finance & Accounts	No	Nigeria	Group Interview	pnjoroge@msh.org
	Joy Kolin	PP	MSH	Project Director PLAN Health	No	Nigeria	Group Interview	jkolin@msh.org
	Babafunke Fagbemi	IP	CCPN	Director	No	Nigeria	Individual Interview	bfagbemi@ccpnigeria.org
	Anne Udoh	IP	CCPN	Akwa Ibom consultant	No	Nigeria	Individual Interview	anie9395@yahoo.com
	Sammy Olaniru	IP	CCPN	Kebbi consultant	No	Nigeria	Individual Interview	sammylaniru@yahoo.co
	Tawfique Jahan	IP	BCCP Asia	Director	No	Bangla	Phone Interview	tjahan@bangladeshh-ccp.org
	Charles Kakaire	IP	Africomnet	Director	No	Uganda	Phone Interview	ckakaire@africocomnet.org

##	Name	Data Source	Organization	Title/Work	HC3 Staff	Country	Type of Contact	Contact Information
	Alice Payne Merritt	HC3 HQ	JHU/CCP	Director Technical Programs	Yes, 10%	N/A	Group Interview	alicepayne.merritt@jhu.edu
	Doug Storey,	HC3 HQ	JHU/CCP	Director Communication Science and Research	Yes, 25%	N/A	Group Interview	dstorey@jhu.edu
	Maria Elena Figueroa	HC3 HQ	JHU/CCP	Senior Researcher	Yes, 40%	N/A	Group Interview	mefigueroa@jhu.edu
	James BonTempo	HC3 HQ	JHU/CCP	Director HC3 ICT & Innovation	Yes, 50%	N/A	Group Interview	james.bontempo@jhu.edu
	Tilly Gurman	HC3 HQ	JHU/CCP	Director HC3 Research	Yes, 100%	N/A	Group Interview	tagurman@gmail.com
	Katherine Holmsen	HC3 HQ	JHU/CCP	Director HC3 Capacity Strengthening	Yes, 100%	N/A	Group Interview	kholmsen@jhu.edu
	Kim Martin	HC3 HQ	JHU/CCP	Director, HC3 Communications	Yes, 100%	N/A	Group Interview	kim.martin@jhu.edu
	Jane Brown	HC3 HQ	JHU/CCP	Ebola Team Lead	Yes, 100%	N/A	Group Interview	jane.brown@jhu.edu
	Amrita Gill-Bailey	HC3 HQ	JHU/CCP	Senior Program Officer II, Ethiopia Team Lead & Ebola Team	Yes, 100%	N/A	Group Interview	agbailey@jhu.edu
	Nan Lewicky	HC3 HQ	JHU/CCP	Malaria Team Lead	Yes, 100%	N/A	Group Interview	nlewicky@jhu.edu
	Allison Mobley	HC3 HQ	JHU/CCP	FP Team Lead	Yes, 100%	N/A	Group Interview	amobley@jhu.edu
	Patricia Poppe	HC3 HQ	JHU/CCP	Senior Program Officer II, Team Lead Guat	Yes, 60%	N/A	Group Interview	ppoppe@jhu.edu

##	Name	Data Source	Organization	Title/Work	HC3 Staff	Country	Type of Contact	Contact Information
	Gabrielle Hunter	HC3 HQ	JHU/CCP	Program Officer II	Yes, 60%	N/A	Group Interview	gabrielle.hunter@jhu.edu
	Claire Slesinski	HC3 HQ	JHU/CCP	Program Coordinator	Yes, 82%	N/A	Group Interview	claire.slesinski@jhu.edu
	Heather Hancock	HC3 HQ	JHU/CCP	Program Officer CS	Yes, 100%	N/A	Phone Group Interview	hhancock@jhu.edu
	Leanne Wolff	HC3 HQ	JHU/CCP	Senior Program Officer CS	Yes, 50%	N/A	Group Interview	lwolff@jhuccp.org
	Sanjanthi Velu	HC3 HQ	JHU/CCP	Senior Program Officer II, Team Lead	Yes, 90%	N/A	Group Interview	svelu1@jhu.edu
	Mike Toso	HC3 HQ	JHU/CCP	Program Officer, Malaria	Yes, 100%	N/A	Group Interview	mtoso1@jhu.edu
	Corinne Fordham	HC3 HQ	JHU/CCP	Program Specialist	Yes, 100%	N/A	Group Interview	cfordha1@jhu.edu
	Arzum Ciloglu	HC3 HQ	JHU/CCP	Senior Program Officer II, FP Advisor	Yes, 40%	N/A	Group Interview	arzum.ciloglu@jhu.edu
	Erin Portillo	HC3 HQ	JHU/CCP	Program Officer FP	Yes, 100%	N/A	Group Interview	erin.portillo@jhu.edu
	Ian Tweedie,	HC3 HQ	JHU/CCP	Senior Program Officer II, Team Lead, Nigeria	Yes, 30%	N/A	Group Interview	itweedie@jhu.edu
	Grace Awantang	HC3 HQ	JHU/CCP	M&E Advisor	Yes, 100%	N/A	Group Interview	awanta1@jhu.edu
	Anna Helland	HC3 HQ	JHU/CCP	Senior Program Officer	Yes, 100%	N/A	Group Interview	anna.helland@jhu.edu
	Mohamad Sy-Ar	HC3 HQ	JHU/CCP	RCI	Yes, 30%	N/A	Group Interview	msyar@jhu.edu

##	Name	Data Source	Organization	Title/Work	HC3 Staff	Country	Type of Contact	Contact Information
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APPENDIX G. LIST OF IMPLEMENTATION AND SUPPORT MATERIALS VIEWED

	Title	Format
	NIGERIA	
1.	CCPN Activity Form	Monitoring and reporting tool
2.	Every fever must not be Malaria (Akwa Ibom and Kebbi State)	Wall poster
3.	Form 1: HC3 House to House Visit Checklist for Community Volunteers	Monitoring and reporting tool
4.	Form 2: HC3 Follow-up Checklist for Community Volunteers	Monitoring and reporting tool
5.	Form 3: HC3 Monthly Summary Check List for Community Volunteers (CVs)	Monitoring and reporting tool
6.	Form 4: HC3 Monthly Summary Check List for NGOs Activities	Monitoring and reporting tool
7.	Frequently asked Questions on Long Lasting Mosquito Nets (Akwa Ibom and Kebbi State)	Pamphlet
8.	HC3 Activity Form	Monitoring and reporting tool
9.	HC3 Referral Form for Integrated Community Management of Malaria	Referral tracking tool
10.	Health Care Provider: Help Fight Malaria in Pregnancy (Kebbi State)	Wall poster
11.	How to use your net (Kebbi State)	Wall poster
12.	How to use, care for and repair your treated mosquito net (LLIN) (Akwa Ibom and Kebbi State)	Backdrop poster
13.	Learn about Long Lasting Mosquito Nets (Akwa Ibom and Kebbi State)	Pamphlet
14.	Let's Talk about Malaria and Mosquitos: Discussion Guide for Health Workers and Community Volunteers (Akwa Ibom and Kebbi State)	Flipchart
15.	Malaria in Pregnancy (Akwa Ibom and Kebbi State)	Pamphlet
16.	Malaria in Pregnancy: Frequently Asked Questions for Husband (Kebbi State)	Pamphlet
17.	Protect yourself and your unborn baby from malaria (Kebbi State)	Wall poster
18.	Radio—TV Spots: Activity Brief	Creative brief
19.	Radio Magazine Shows: Activity Brief	Creative brief
20.	Show you Care: Help Prevent Malaria in Pregnancy (Akwa Ibom State)	Wall poster
21.	Social Media-ICT: Activity Brief	Creative brief
	CÔTE D'IVOIRE	
22.	Appareil génital de l'homme et de la femme (FPV)	Wall poster
23.	Catégorisation des professions des participants aux activités communautaires de JHU-CCP	Participant selection tool
24.	Ecoutez les conseils de votre bonne grande soeur (SuperGo!)	Wall poster
25.	Evaluation de l'atelier Frères Pour la Vie par les participants	Monitoring and reporting tool

	Title	Format
26.	Evaluation des Activités Frères Pour La Vie: Pré/Post-Test	Monitoring and reporting tool
27.	Evaluation des Sessions par les Facilitateurs	Monitoring and reporting tool
28.	Fais le bon choix: Deviens un home nouveau! (FPV)	Pamphlet
29.	Fiche de Distribution de Préservatifs aux Participants aux Activités FPV	Monitoring and reporting tool
30.	Fiche de Présence des Participantes aux Activités (SuperGo!)	Monitoring and reporting tool
31.	Fiche de Présence des Participants aux Activités	Monitoring and reporting tool
32.	Guide de Mise en Œuvre des Activités Communautaires du Programme SuperGo!	Facilitation guide
33.	Guide du Facilitateur Animation des Activités Communautaires du Programme Frères Pour la Vie	Facilitation guide
34.	Je suis un frère pour la vie et je m'engage (FPV)	Referral tracking tool
35.	La monogamie sérielle (FPV)	Wall poster
36.	Les bons conseils de SuperGo!	Photo comic book
37.	Partenariats multiples et parallèles (FPV)	Wall poster
38.	Questionnaire de recrutement pour le programme Frères Pour la Vie	Participant selection tool
39.	Questionnaire de Recrutement des Participantes aux Activités Communautaires Financées par CCP 2013	Participant selection tool
40.	Rapport de Dépistage (FPV)	Monitoring and reporting tool
41.	Rapport de Suivi des Activités FPV	Monitoring and reporting tool
42.	Rapport Périodique de Suivi des Activités (SuperGo!)	Monitoring and reporting tool
43.	Rapport Périodique de Suivi des Activités et de Supervision des Facilitatrices (SuperGo!)	Monitoring and reporting tool
44.	Réseaux	TV series
45.	Utilisation du préservatif (FPV)	Wall poster

APPENDIX H. LIST OF ACTIVITIES OBSERVED

	Date	Activity	Location	Partner
	Guatemala			
1.	14 July	Nutrition education demonstration	Aldea Varsovia, Xela	Save the Children
2.	14 July	Agriculture education demonstration	Ostumcalco, Xela	Save the Children
3.	14 July	Community-based model farm	Quetzalthenango, Xela	Save the Children
	Nigeria			
4.	5 August	Community dialogue with men	Gorin Dikko Community, Arewa LGA, Kebbi State	Royal Impact Health Care Society
5.	5 August	Community dialogue with women	Gorin Dikko Community, Arewa LGA, Kebbi State	Royal Impact Health Care Society
6.	5 August	Four home visits with community volunteer	Gorin Dikko Community, Arewa LGA, Kebbi State	Royal Impact Health Care Society
7.	6 August	Community dialogue with men	Lailaba Community, Argungu LGA, Kebbi State	Royal Impact Health Care Society
8.	6 August	Community dialogue with women	Lailaba Community, Argungu LGA, Kebbi State	Royal Impact Health Care Society
9.	6 August	Three home visits with community volunteers	Lailaba Community, Argungu LGA, Kebbi State	Royal Impact Health Care Society
10.	7 August	Springboard in-person event	Abuja	CCPN
11.	8 August	Community dialogue with men and women	Ikpa Ibom Ward 3, Mkpat Enin LGA, Awa Igbo State	Community Partners for Development (CPD)
12.	8 August	Four home visits with community volunteers	Ikpa Ibom Ward 3, Mkpat Enin LGA, Awa Igbo State	Community Partners for Development (CPD)
13.	9 August	Two home visits with community volunteers	Urban Ward 1, Ika LGA, Awa Igbo State	Community Partners for Development (CPD)
14.	9 August	Community dialogue with men and women	Urban Ward 1, Ika LGA, Awa Igbo State	Community Partners for Development (CPD)
	Côte d'Ivoire			
15.	14 August	*SuperGo!* group activity	Yopougon, Abidjan	Groupe Biblique des Hôpitaux (GBH)
16.	14 August	*SuperGo!* group activity	Yogougon, Abidjan	Messi

	Date	Activity	Location	Partner
17.	15 August	*Frères pour la Vie* group activity	Abengourou	Universe Santé
18.	16 August	*SuperGo!* group activity	Abengourou	Ruban Rouge
19.	17 August	*Frères pour la Vie* group activity	Yogougon, Abidjan	OASIS
20.	18 August	*SuperGo!* group activity	San Pedro	Charité Vie

APPENDIX I. FULL SET OF TOOLS USED

DATA COLLECTION TOOL 1—INTERVIEW GUIDE

Project:HC3 Midterm Evaluation for USAID
Topic:OE, SBCC, ICT
Method: Interview (Individual and Group)
Data Source: All primary data sources that do not participate in a Group Activity or FGD

INTRODUCTION:

- HC3 midterm evaluation—improve now, inform future—through lens of OE, SBCC, ICT
- All responses confidential
- No right or wrong - Opinions fine
- Might come back with some additional questions later on
- Thank you in advance for your time

Three levels: Performance, Capacity building, Country

QUESTIONS:

Please tell us a bit about how you have been involved with HC3? Role? Length?

1. What is the vision of HC3? (OE)
2. To what extent do you feel the vision of the HC3 project is being fulfilled? How? Why? (OE)
3. What major supportive areas and hindering management issues do you believe exist? How? Why? (OE)
4. What impact do you think these issues have had on HC3's ability to perform? How? Why? (OE)
5. How has HC3 changed? How has HC3 managed its changes? Why? (OE)
6. What impact do you believe this approach to change has had on HC3 capability to build SBCC capacity? Why? (OE)
7. To what extent do you feel HC3 has become a technical leader in the field of S/BCC programming? How? Why? (SBCC)
8. What would you like to see HC3 do differently in its role as technical leader? Why? (SBCC)
9. To what extent do you feel HC3 has successfully promoted the adoption of innovative approaches in S/BCC programming? How? Why? (SBCC)
10. To what extent do USAID programs use SMS and Social Media to implement SBCC? How? Why? (ICT)
11. What approaches do you feel have been most effective in improving the quality of S/BCC interventions in the countries/programs where HC3 provides technical support? Why? (Probe: specific toolkits and guides.) (SBCC)
12. Conversely, what approaches do you feel have been least effective? Why? (SBCC)
13. To what extent do the e-portals (HC3 websites, springboard, etc.) serve the overall purpose of HC3? How? (ICT)
14. To what extent do you believe that these e-portals (compass, iKits, etc.) are serving intended users? How? Why? Broader SBCC community? How? Why? (ICT)
15. What is your understanding of how Springboard supports HC3's work (specifically capacity building)? (ICT)

16. What 2-3 actions could they take to make Springboard more effective in its support? How? Why? (ICT)
17. How do you envision that USAID (DC or Missions) should use Springboard? Why? (ICT)
18. To what extent do you think the internal and external monitoring and evaluation mechanisms are supporting and hindering HC3's ability to meet project expectations? How? Why? (OE)
19. Anything else to add?

CLOSING:

- Might come back for additional questions
- All will be kept in confidence
- Thank you

DATA COLLECTION TOOL 2: FOCUS GROUP DISCUSSION TOPIC GUIDE

Project:HC3 Midterm Evaluation for USAID
Topic:OD, SBCC, ICT
Audience: Country Local Implementing Partner Participants, such as Community Leaders, Facilitators, Past Participants, Supervisors, etc.
Length: 2 hours

INTRODUCTION:

- Introduce team and participants
- Provide purpose of session—HC3 midterm evaluation—improve now, inform future—through lens of OD, SBCC, ICT—discuss: performance, capacity building both at country levels
- All responses confidential
- No right or wrong—Opinions fine
- Thank you in advance for your time

QUESTIONS:

SET 1:

1. Tell us about the work in your community with ORG and TOPIC
2. Why is this work important?
3. What activities are you engaged in? How have you been involved in the development, decision making, and implementation of these activities?
4. What does your community appreciate most about these efforts/activities? Why?
5. What challenges have you experienced? Why?
6. How has ORG been helpful in overcoming these challenges?
7. What successes have you experienced? Why?
8. How has ORG been instrumental in achieving these successes?
9. Anything else to add?

SET 2:

1. Why do you think you were selected to participate in this program?
2. How have you benefited by participating in this program?
3. To what extent have you shared what you learned in this program? With whom? What did you say? How interested were they? Why/why not?
4. How might this program or the approaches be improved? Why?
5. What would you keep the same? Why?
6. Anything else to add?

SET 3:

1. How do you select participants for your program? Why?
2. What tools do you use regularly to carry out your work?
3. What do you think of these tools? Ease of use, appropriateness, acceptable, comprehensibility
4. How might you improve these tools? Why?
5. What have been some of your most challenging experiences working with GROUP? Why?
6. What have been some of your most rewarding/successful moments working with GROUP? Why?
7. How might you improve this program? Why?
8. What would you keep the same? Why?
9. Anything else to add?

SET 4

1. What successes have you had in recruiting and training facilitators? Why?
2. What challenges have you had in recruiting and training facilitators? Why?
3. How have you been implicated in the collection of data? In M&E? Why?
4. How might this role be improved? What might be done differently? Why?
5. How might this program be improved? Why?
6. What would you keep the same? Why?
7. Anything else to add?

CLOSING:

- All will be kept in confidence
- Thank you

DATA COLLECTION TOOL 3: FACILITATION GUIDE FOR GROUP ACTIVITY

Project:HC3 Midterm Evaluation for USAID
Topic:OD, SBCC, ICT
Audience: Country Local Implementing Partner Participants, such as SBCC committee members and players, etc.
Length: 100-120 minutes (depending on the number of people)
Group Size: 15+ (ideal is 15)

Preparation:

1. Put each question on a separate piece of paper (see below)
2. Fold and put all questions in a "bag"
3. Have at least 15 markers (5 sets of 3 colors each) and 15 sheets of flipchart paper (3 sheets per group)
4. On flipchart paper, write the following three questions and post so that all can see:
    a. Part 1: What?
    b. Part 2: How? Why?
    c. Part 3: How improve?

Introduction: *15 min*utes

- Introduce team, introduce participants (name, organization, title)
- Introduce the midterm evaluation goals and objectives
- Explain that need their help to understand what's working, what's not and hear their ideas on how to improve things
- Confidential
- Open and transparent

Group Organization: *10 minutes*

1. Have the large group count off by 2s or 3s (depending on the size of the group) [ideal small group size is 3 persons]—when finished you should have FIVE groups total as all questions needed to be discussed.
2. Have participants move to their number group.
3. Ask one person in each group to be the note taker on the flipchart paper and one to be the reporter when the time comes.
4. Explain that each group will draw one question from the "bag" and that each question has three parts. And that they should write their responses to each part on a separate sheet and post them on the wall side-by-side.
5. Have one person pull from the "bag" one of the questions to be discussed in their small group) [see list of questions below].
6. Have them write their question in CAPS on the first sheet of paper.
7. Tell them they have 20 minutes to answer their questions in their small groups.

Small Group Work: *30 minutes*

As facilitator, circulate to be sure each group is on task and on time

Processing: *50 minutes*

1. Pull the small groups back together
2. Ask each small group reporter to present their three sheets of answers and as time permits/as needed discuss each.
3. Allow each group about 10 minutes to present and discuss

Closing: *5 minutes*

Ask if there are any final questions
Thank the participants

LIST OF QUESTIONS USED IN GUATEMALA AND NIGERIA:

1. To what extent do you feel that HC3 advanced SBCC in your country? How/why? How might HC3 improve its performance in this area?
2. To what extent has HC3 strengthened the SBCC capacity of your organization? How/why? How might HC3 improve its performance in this area?
3. To what extent do the HC3 web materials and e-portals (Health COMpass, Implementation Kits, Implementation Guides, and Springboard) aid you in your work? How/why? How might these be improved?
4. To what extent has HC3 been innovative in implementing its work? How/why? How might HC3 be more innovative?
5. To what extent has HC3 been accessible to you as a partner in the work? How/why? How might HC3 improve its accessibility?

LIST OF QUESTIONS USED IN RCI, as audience was former participants in Strategic Communication Training Workshops

1. To what extent do you feel that HC3/CCP has advanced/is advancing CCSC in your country? How/why? How might they improve their performance in this area?
   Dans quelle mesure vous sentez-vous que le HC3/CCP a avancé/avance le CCSC dans votre pays ? Comment/pourquoi ? Comment est-ce qu'il pourrait améliorer son performance dans ce domaine ?

2. To what extent has HC3/CCP been innovative in implementing its work? How/why? How might they be more innovative?
   Dans quelle mesure le HC3/CCP a été un innovateur dans l'exécution de ses travaux ? Comment/pourquoi ? Comment pourrait-il être plus d'un innovateur ?

3. To what extent has the leadership training made you more effective in your work? How/why? How might it be improved?
   Dans quelle mesure est-ce que la formation en leadership vous a rendu plus efficace dans votre travail? Comment/pourquoi? Comment pourrait-elle être améliorée?

4. To what extent has HC3 CCP provided SBCC leadership in your country? How/why? How might it improve its performance as a leader?
   Dans quelle mesure le HC3/CCP a assuré la direction de CCSC dans votre pays? Comment/pourquoi? Comment pourrait-il améliorer sa performance en tant que leader?

DATA COLLECTION TOOL 4: SBCC OBSERVATION/DISCOVERY CHECKLIST

Project:HC3 Midterm Evaluation for USAID
Topic:OD, SBCC, ICT
Audience: Country Local Implementing Partner Participants, organizations/agencies that have been trained by HC3 in SBCC or participated in HC3 implementing activities as a partner
Length: N/A

Date: _____
Name of Organization: _____

Type of Organization:
☐ INGO ☐ LNGO ☐ CBO ☐ FBO ☐ Government ☐ Private
Type of Activity Observed:

How involved with HC3:
☐ Trained in SBCC ☐ Participated in HC3 implementing activities as a partner

How well do they appear to be able to:

Aspect to Observe/Discover	Not at all well	Somewhat well	Well	Very well	Extremely well	Didn't Observe or Discover
1. Communicate their key message to others	1	2	3	4	5	
2. Develop a key message	1	2	3	4	5	
3. Apply their research to their program, materials, etc.	1	2	3	4	5	
4. Develop a creative brief	1	2	3	4	5	
5. Delineate monitoring and evaluation indicators	1	2	3	4	5	
6. Conduct research for an evidence-based program	1	2	3	4	5	
7. Determine client needs	1	2	3	4	5	
8. Interact effectively with the clients	1	2	3	4	5	
9. Segment audiences appropriately	1	2	3	4	5	
10. Limit messaging appropriately	1	2	3	4	5	
11. Engage the audience	1	2	3	4	5	
12. Use the participatory and interactive approaches	1	2	3	4	5	

Comments/Notes: [indicate what documents examined, what observed, other details that help to put the scoring into perspective]

DATA COLLECTION TOOL 5A: SNAPSHOT SURVEY (ENGLISH)

Project:HC3 Midterm Evaluation for USAID

Topic:OD, SBCC, ICT

Audience: All NON-HC3 staff at any level, in any capacity who has been implicated in HC3 activities

Length: 10-15 minutes

A. Do you work for HC3/Are you HC3-JHU-CCP staff? ☐ YES ☐ NO

B. Gender: ☐ Male ☐ Female

C. Country of Work (type in):

_____

D. Work Title (check the ONE that most accurately depicts your role): ☐ Senior Management, ☐ Technical Support, ☐ Operational Staff, ☐ Other: _____

E. Organization Type: ☐ International NGO, ☐ Local NGO, ☐ CBO, ☐ FBO, ☐ Government, ☐ Private-sector, ☐ Other: _____

F. How long have you worked/collaborated with HC3? ☐ 1-6 months, ☐ 7-12 months, ☐ 13-18 months, ☐ 19-24 months, ☐ more than two years.

Technical Resources	YES	NO
1. Have you ever accessed materials through the HealthCOMpass website?		
2. Have you ever participated in an HC3-sponsored in-person event?		
3. Have you ever used an HC3 Implementation Kit (I-Kit)?		
4. Have you ever participated in an HC3-sponsored webinar?		
5. Do you have a Springboard account?		
6. Have you accessed Springboard in the last three months?		

Social and Behavior Change Communication	*Strongly disagree*	*Disagree*	*Neutral*	*Agree*	*Strongly agree*	*Don't know*
7. HC3 is a technical leader in the field of Social and Behavior Change Communication (SBCC).	1	2	3	4	5	☐
8. HC3 has improved the quality of SBCC technical resources available to me.	1	2	3	4	5	☐
9. The SBCC technical resources promoted by HC3 respond to my technical needs.	1	2	3	4	5	☐
10. The SBCC technical resources promoted by HC3 have introduced me to new approaches.	1	2	3	4	5	☐
11. The SBCC technical resources promoted by HC3 are of high quality.	1	2	3	4	5	☐
12. HC3's SBCC technical resources are easy to apply in my context.	1	2	3	4	5	☐
13. HC3's SBCC technical resources are different from those promoted by other projects.	1	2	3	4	5	☐
14. I consult HC3's websites (Springboard, HealthCOMpass, and Implementation Kits) when I need ideas to help me design a new intervention or tool.	1	2	3	4	5	☐
15. HC3 actively engages other SBCC implementers to contribute to its activities.	1	2	3	4	5	☐
16. HC3 contributes to global evidence by sharing research on the effectiveness of SBCC interventions.	1	2	3	4	5	☐

E-Portals	*Strongly disagree*	*Disagree*	*Neutral*	*Agree*	*Strongly agree*	*Don't know*
17. I have used Springboard to share information or find peers to interact with.	1	2	3	4	5	☐
18. Using Springboard I found at least one answer and/or guidance to a SBCC question I faced.	1	2	3	4	5	☐
19. I find Springboard digital platform easy to use and access from my normal work location to collaborate with peers.	1	2	3	4	5	☐
20. Springboard is able to support the needs of people like me to find peer based support.	1	2	3	4	5	☐
21. HC3's HealthCOMpass is a good source of curated, high-quality SBBC resources.	1	2	3	4	5	☐
22. I use HealthCOMpass to find resources for my job.	1	2	3	4	5	☐
23. I have recommended that others use HealthCOMpass for their work in SBCC.	1	2	3	4	5	☐
24. I find HealthCOMpass easy to access from my normal work location to quickly find SBCC resources.	1	2	3	4	5	☐
25. HealthCOMpass is designed for people like me.	1	2	3	4	5	☐
26. HC3's Implementation Kits (I-Kits) are a good source of high-quality SBBC guidance on specific topics.	1	2	3	4	5	☐
27. I have used at least one I-Kit for my job.	1	2	3	4	5	☐
28. I have recommended others to use at least one of the I-Kits for their work in SBCC.	1	2	3	4	5	☐
29. I find I-Kits easy to access from my normal work location.	1	2	3	4	5	☐
30. I-Kits are designed for people like me.	1	2	3	4	5	☐

Organizational Development[22]	*Strongly disagree*	*Disagree*	*Neutral*	*Agree*	*Strongly agree*	*Don't know*
31. HC3 has strong networks and partners.	1	2	3	4	5	☐
32. HC3 has clear leadership.	1	2	3	4	5	☐
33. HC3 is delivering quality products.	1	2	3	4	5	☐
34. HC3 is creating innovative interventions.	1	2	3	4	5	☐
35. HC3 is accurate in its reporting.	1	2	3	4	5	☐
36. HC3 is responsive to client demands.	1	2	3	4	5	☐
37. HC3 is effective to its responses to on-the-ground needs.	1	2	3	4	5	☐
38. HC3 is timely in its delivery.	1	2	3	4	5	☐
39. HC3 has adapted well to changing priorities.	1	2	3	4	5	☐

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DATA COLLECTION TOOL 5B: SNAPSHOT SURVEY (FRENCH)

Project:HC3 Midterm Evaluation for USAID
Topic:OD, SBCC, ICT
Audience: All NON-HC3 staff at any level, in any capacity who has been implicated in HC3 activities
Length: 10-15 minutes

A. Travaillez-vous pour HC3 / êtes-vous personnel de JHU-HC3-CCP? ☐ Oui ☐ non

B. Sexe : ☐ Male ☐ Femelle

C. Pays de travail : _____

D. Titre de le œuvre (cocher celui qui représente plus exactement votre rôle): ☐de haute direction, ☐ Support technique, ☐ personnel opérationnel

E. Type d'organisation : ☐ ONG internationale, ☐ ONG locale, ☐ CBO, ☐ FBO, ☐ gouvernement, ☐ secteur privé, ☐ autres: ____

F. Combien de temps avez-vous travaillé/collaboré avec HC3? ☐ 1-6 mois, ☐ 7-12 mois, ☐ 13-18 mois, ☐ 19-24 mois, ☐ plus de deux ans.

Ressources techniques	OUI	NON
1. Avez-vous accédé à matériaux via le site web HealthCOMpass?		
2. Avez-vous déjà participé à une manifestation en personne parrainée par HC3?		
3. Avez-vous déjà utilisé un Kit de mise en œuvre du HC3 (I-Kit)?		
4. Avez-vous déjà participé à un webinaire parrainé par HC3?		
5. Avez-vous un compte de Springboard?		
6. Vous avez accédé à Springboard au cours des trois derniers mois?		

Communication sociale et de changement de comportement	***Fortement en désaccord***	***Pas d'accord***	***Neutre***	***Suis d'accord***	***Fortement d'accord***	***Je ne sais pas***
7. HC3 est un leader technique dans le domaine de la Communication sociale et de changement de comportement (SBCC).	1	2	3	4	5	☐
8. HC3 a amélioré la qualité des ressources techniques SBCC disponibles pour moi.	1	2	3	4	5	☐
9. Les ressources techniques SBCC promus par HC3 répondent à mes besoins techniques.	1	2	3	4	5	☐
10. Les ressources techniques SBCC promus par HC3 m'ont présenté à de nouvelles approches.	1	2	3	4	5	☐
11. Les ressources techniques SBCC promus par HC3 sont de haute qualité.	1	2	3	4	5	☐
12. Des ressources techniques SBCC du HC3 sont faciles à appliquer dans mon contexte.	1	2	3	4	5	☐
13. Des ressources techniques SBCC du HC3 sont différentes de ceux promus par d'autres projets.	1	2	3	4	5	☐
14. Je consulte des sites de HC3 (Springboard, HealthCOMpass et les kits de mise en œuvre) quand j'ai besoin d'idées pour m'aider à concevoir un outil ou une nouvelle intervention.	1	2	3	4	5	☐
15. HC3 s'engage activement autres personnes qui implémentent de contribuer à ses activités de SBCC.	1	2	3	4	5	☐
16. HC3 contribue à la preuve globale en partageant la recherche sur l'efficacité des interventions SBCC.	1	2	3	4	5	☐

E-portals	*Fortement en désaccord*	*Pas d'accord*	*Neutre*	*Suis d'accord*	*Fortement d'accord*	*Je ne sais pas*
17. J'ai utilisé le Springboard pour partager de l'information ou de trouver des autres communicateurs avez qui je peux échanger.	1	2	3	4	5	☐
18. A l'aide de Springboard, j'ai trouvé au moins une réponse et/ou d'une orientation à une question de SBCC que j'ai confronté.	1	2	3	4	5	☐
19. Je trouve la plateforme du Springboard facile à utiliser et accéder de mon lieu de travail normal pour collaborer avec mes collègues.	1	2	3	4	5	☐
20. Le Springboard est en mesure de subvenir aux besoins de gens comme moi de trouver le soutien par les pairs.	1	2	3	4	5	☐
21. HealthCOMpass du HC3 est une bonne source de ressources SBCC, organisées et de grande qualité.	1	2	3	4	5	☐
22. J'utilise HealthCOMpass pour trouver des ressources pour mon travail.	1	2	3	4	5	☐
23. J'ai recommandé que d'autres utilisent HealthCOMpass pour leur travail en SBCC.	1	2	3	4	5	☐
24. J'ai trouvé HealthCOMpass facile d'accéder de mon lieu de travail normal pour trouver rapidement les ressources SBCC.	1	2	3	4	5	☐
25. HealthCOMpass est conçu pour des gens comme moi.	1	2	3	4	5	☐
26. Les kits de mise en œuvre du HC3 (I-Kits) sont une bonne source d'orientation de SBCC de haute qualité sur des sujets spécifiques.	1	2	3	4	5	☐
27. J'ai utilisé au moins un I-Kit pour mon travail.	1	2	3	4	5	☐
28. J'ai recommandé aux autres d'utiliser au moins un des I-Kits pour leur travail en SBCC.	1	2	3	4	5	☐
29. je trouve les I-Kits facile d'accéder☐☐ de mon lieu de travail normal.	1	2	3	4	5	☐
30. Les I-Kits sont conçus pour des gens comme moi.	1	2	3	4	5	☐

Développement organisationnel[23]	***Fortement en désaccord***	***Pas d'accord***	***Neutre***	***Suis d'accord***	***Fortement d'accord***	***Je ne sais pas***
31. HC3 a des solides réseaux et partenaires.	1	2	3	4	5	☐
32. HC3 a un « leadership » clair.	1	2	3	4	5	☐
33. HC3 livre des produits de qualité.	1	2	3	4	5	☐
34. HC3 crée des interventions innovatrices.	1	2	3	4	5	☐
35. HC3 est précis dans ses rapports.	1	2	3	4	5	☐
36. HC3 répond aux exigences de client.	1	2	3	4	5	☐
37. HC3 est efficace pour ses réponses aux besoins sur le terrain.	1	2	3	4	5	☐
38. HC3 tombe à point dans son mis en œuvre.	1	2	3	4	5	☐
39. HC3 a bien adapté à des priorités changeantes.	1	2	3	4	5	☐

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DATA COLLECTION TOOL 5C: SNAPSHOT SURVEY (SPANISH)

Project:HC3 Midterm Evaluation for USAID
Topic:OD, SBCC, ICT
Audience: All NON-HC3 staff at any level, in any capacity who has been implicated in HC3 activities
Length: 10-15 minutes

G. ¿Trabaja usted para HC3/Es usted parte del personal de HC3-JHU-CCP? ☐ SI ☐ NO

H. Género: ☐ Masculino ☐ Femenino

I. País en el que trabaja (escríbalo):
_____

J. Título del puesto de trabajo (ponga un cheque en EL cuadro que describa con más precisión el papel que usted desempeña):
☐ Gerente General, ☐ Apoyo Técnico, ☐ Personal Operativo, ☐ Otro: _____

K. Tipo de Organización: ☐ ONG Internacional, ☐ ONG Local, ☐ CBO, ☐ FBO, ☐ Gobierno, ☐ Sector Privado, ☐ Otro: _____

L. ¿Cuánto tiempo ha trabajado con HC3? ☐ 1-6 meses, ☐ 7-12 meses, ☐ 13-18 meses, ☐ 19-24 meses, ☐ más de dos años.

Recursos Técnicos	SI	NO
40. ¿Ha accedido a materiales alguna vez por medio del sitio web HealthCOMpass?		
41. ¿Ha participado alguna vez en un evento patrocinado por HC3 directamente?		
42. ¿Ha utilizado alguna vez un Kit de Implementación (I-Kit) de HC3?		
43. ¿Ha participado alguna vez en un webinario patrocinado por HC3?		
44. ¿Tiene una cuenta Springboard?		
45. ¿Ha ingresado a Springboard en los últimos tres meses?		

Comunicación para el Cambio Social y de la Conducta	***Muy En Desa-cuerdo***	***En Desa-cuerdo***	***Neutro***	***De Acuer-do***	***Muy de Acuerdo***	***No sé***
46. HC3 tiene el liderazgo técnico en el campo de la Comunicación para el Cambio Social y de la Conducta (CCSC).	1	2	3	4	5	☐
47. HC3 ha mejorado la calidad de los recursos técnicos de CCSC disponibles para mí.	1	2	3	4	5	☐
48. Los recursos técnicos de CCSC promovidos por HC3 responden a mis necesidades técnicas.	1	2	3	4	5	☐
49. Los recursos técnicos de CCSC promovidos por HC3 me han introducido a la utilización de nuevos enfoques.	1	2	3	4	5	☐
50. Los recursos técnicos de CCSC promovidos por HC3 son de alta calidad.	1	2	3	4	5	☐
51. Los recursos técnicos de CCSC de HC3 son fáciles de aplicar en mi contexto.	1	2	3	4	5	☐
52. Los recursos técnicos de CCSC de HC3 son diferentes a los que promueven otros proyectos.	1	2	3	4	5	☐
53. Yo consulto los sitios web de HC3 (Springboard, HealthCOMpass y Kits de Implementación) cuando necesito ideas que me ayuden a diseñar una nueva intervención o herramienta.	1	2	3	4	5	☐
54. HC3 se involucra activamente con otros implementadores de CCSC para contribuir con sus actividades.	1	2	3	4	5	☐
55. HC3 contribuye con la evidencia global compartiendo investigación sobre la efectividad de las intervenciones de CCSC.	1	2	3	4	5	☐

Portales Electrónicos	*Muy en Desa-cuerdo*	*En Desa-cuerdo*	*Neutro*	*De Acuer-do*	*Muy de Acuerdo*	*No sé*
56. He utilizado Springboard para compartir información o encontrar pares con quiénes interactuar.	1	2	3	4	5	☐
57. Utilizando Springboard encontré al menos una respuesta y/o direccionamiento para una pregunta sobre CCSC que se me presentó.	1	2	3	4	5	☐
58. Me parece que la plataforma digital de Springboard es de fácil utilización y acceso desde mi ubicación normal de trabajo para colaborar con pares.	1	2	3	4	5	☐
59. Springboard tiene la capacidad de apoyar las necesidades de personas como yo para encontrar apoyo basado en pares.	1	2	3	4	5	☐
60. HealthCOMpass de HC3 es una fuente bien presentada de recursos de CCSC de alta calidad.	1	2	3	4	5	☐
61. Utilizo HealthCOMpass para encontrar recursos para realizar mi trabajo.	1	2	3	4	5	☐
62. He recomendado que otros utilicen HealthCOMpass para su trabajo en CCSC.	1	2	3	4	5	☐
63. Me parece que acceder a HealthCOMpass para encontrar rápidamente recursos sobre CCSC es fácil desde mi ubicación normal de trabajo.	1	2	3	4	5	☐
64. HealthCOMpass está diseñado para personas como yo.	1	2	3	4	5	☐
65. Los Kits de Implementación (I-Kits) de HC3 son una buena fuente de direccionamiento de alta calidad para temas específicos de CCSC.	1	2	3	4	5	☐
66. He utilizado al menos un I-Kit para mi trabajo.	1	2	3	4	5	☐
67. He recomendado a otros utilizar al menos uno de los I-Kits para su trabajo en CCSC.	1	2	3	4	5	☐
68. Me parece fácil acceder a los I-Kits desde mi ubicación normal de trabajo.	1	2	3	4	5	☐
69. Los I-Kits están diseñados para personas como yo.	1	2	3	4	5	☐

Desarrollo Organizacional [24]	***Muy en Desa-cuerdo***	***En Desa-cuerdo***	***Neutro***	***De Acuer-do***	***Muy de Acuerdo***	***No sé***
70. HC3 tiene redes y socios sólidos.	1	2	3	4	5	☐
71. HC3 tiene un liderazgo claro.	1	2	3	4	5	☐
72. HC3 está entregando productos de calidad.	1	2	3	4	5	☐
73. HC3 está creando intervenciones innovadoras.	1	2	3	4	5	☐
74. HC3 tiene precisión en su elaboración de informes.	1	2	3	4	5	☐
75. HC3 muestra receptividad a las demandas de los clientes.	1	2	3	4	5	☐
76. HC3 responde con efectividad a necesidades en el campo.	1	2	3	4	5	☐
77. HC3 es puntual en su entrega.	1	2	3	4	5	☐
78. HC3 se ha adaptado bien a prioridades cambiantes.	1	2	3	4	5	☐

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DATA COLLECTION TOOL 6: ORGANIZATIONAL DIAGNOSTIC[25]

Project: HC3 Midterm Evaluation for USAID
Audience: All HC3 staff at any level, in any capacity who is officially employed by HC3 (not as a sub-contractor, but as a direct employee)
Length: 30-45 minutes

Thank you for taking the time to complete this Internal Diagnostic for HC3!

Your participation in this Diagnostic is essential. It will help the Evaluation team gain a full and balanced picture of the project. Along with the qualitative research and country visits, this will allow them to effectively document lessons learned; provide concrete, specific recommendations for improvement; and inform future programming.

All responses will be kept confidential, so please to not put your name on it. If you would like to put it in an unmarked envelope before returning it, please do so.

THIS DIAGNOSTIC WILL TAKE ABOUT 30-45 MINUTES TO COMPLETE.

Under each question, please check **ONE** response that **BEST** identifies you and your role within the HC3 Project.

A. What is your gender?

1 ☐ Female
2 ☐ Male

B. Where do you work for HC3?

3 ☐ Headquarters (this would be even if you are not physically located in Baltimore)
4 ☐ In-country

C. What is your role in the HC3 Project?

5 ☐ Senior Management
6 ☐ Technical Management
7 ☐ Technical Support
8 ☐ Operations Management
9 ☐ Operations Support
10 ☐ Other:

D. How long have you been with HC3?

11 ☐ Since the beginning
12 ☐ For more than 2 years
13 ☐ Between 1 year and 2 years
14 ☐ For less than 1 year

E. What is your major field of expertise?

15 ☐ Social and Behavior Change Communication
16 ☐ Financial Management
17 ☐ Capacity Strengthening
18 ☐ Research and Evaluation
19 ☐ Information Communications Technology
20 ☐ Organizational Development
21 ☐ Operations Management/Management
22 ☐ Other:

F. How long have you worked in your field of expertise?

23 ☐ 0-5 years
24 ☐ 6-10 years
25 ☐ 11-20 years
26 ☐ 20+ years

G. In which health area do you work most often?

27 ☐ No specific area
28 ☐ Family Planning
29 ☐ Malaria
30 ☐ HIV/AIDS

[25] This Organizational Diagnostic is the property of Lynne Cogswell. A full version can be obtained upon request.

31 ☐ Ebola
32 ☐ Across more than one area
33 ☐ Other:

H. How long have you worked in this health area?

34 ☐ Less than one year
35 ☐ 1-5 years
36 ☐ 6-10 years
37 ☐ 10+ years

I. In which country do you work most often or live?

38 ☐ Angola
39 ☐ Bangladesh
40 ☐ Côte d'Ivoire
41 ☐ Egypt
42 ☐ Ethiopia
43 ☐ Guatemala
44 ☐ Guinea
45 ☐ Madagascar
46 ☐ Mali
47 ☐ Nepal
48 ☐ Nigeria
49 ☐ South Africa
50 ☐ Swaziland
51 ☐ Zambia
52 ☐ Across countries
53 ☐ No country work

J. With which type of funding mechanism are you most often involved?

54 ☐ Core-funded
55 ☐ Country buy-in
56 ☐ Other:

K. What type of activity have you been involved in most often?

57 ☐ Direct implementation
58 ☐ Technical Assistance
59 ☐ Research and evaluation
60 ☐ Other:

Thank you again for your time and participation! Please continue on to the Diagnostic!

APPENDIX J. WEB ANALYTICS PROTOCOL AND SYNTHESIS

BACKGROUND

Client: HC3 Evaluation, Dexis

Purpose of analysis: As part of the overall HC3 evaluation, look at the tools used, by country and other demographics.

CHANGE LOG

Change made	Date	Author
Initial draft	7/9/2015	Siobhan Green
Updates	8/21/2015	Camille Vargas
Final	9/24/2015	Siobhan Green

OVERVIEW

Name of site: HealthCOMpass

URL: http://www.thehealthcompass.org/

Purpose of site: To provide a vetted, curated resources on SBCC for global health

Analytics Sources: GA

Dates Analyzed: September 2015

Period Analyzed: April 1, 2015 – August 31, 2015

ACCESS TO SITE

The following are the web metrics used to measure current audience composition by different factors (demographics/location/language), as well as which technology platforms they use

#	Item	What measuring?	2nd D	Metrics/focus	Source	Results
Ge	**Geography**					
1.	Locations	Audience composition by locations (country, subcontinent	This is a second dimension	*Break out by subcontinent* *Look at country by country* *Top 10 % of audience*	*GA*	35% from North America (33% USA), 14% from Eastern Africa (6% Kenya, 2% Uganda, Tanzanaia), 11% from Southern Asia (7% India, 2% Bangladesh)

#	Item	What measuring?	2nd D	Metrics/focus	Source	Results
Te	**Technology**					
2.	Browser	Most popular browser	Location	Chrome vs FF, vs IE, and version	GA	Chrome (57% global, 22% Kenya, 66% Bangladesh, 44% Tanzania 56% India), Firefox (18% global, 28% Kenya, 34% Bangladesh, 56% Tanzania, 13% India), IE (11% Global, 8% India), Opera mini (6% global, 50% Kenya, 16% India), Safari (8% global)
3.	OS	Most popular OS	Location	Mac vs. PC.	*GA*	Windows (56% Global), Mac (28%), Android (8.87% global, Kenya), iOS (3.6% Global, Nigeria)
4.	Network	% audience within an institution vs. outside	Location	JH Network v. other	GA	Johns Hopkins, PSI network make up less than 5% of all sessions during this period of time.
Mo	**Mobile**					
5.	Devices	Most popular mobile devices	Location	Mobile vs. Desktop	*GA*	Of 930 sessions where type of device was detected, iPad (13%), and iPhone (20%)

DEMAND

The following are the web metrics used to measure where the current audience is coming from, such as organic search, links from other sites, and social media.

#	Item	What measuring?	2nd D	Metrics/focus	Source	
Ac	**Acquisition**					
1.	Channels & Source	How audience finds the site by channel	Location	*SEO, Direct, Social Media, Referrals*	GA	25% are direct, 58% from Google, 9% from referrals (links from other sites).
2.	Referrals	How audience finds the site by URL referrals	Location	*Shows who is linked to HealthCOMpass*	GA	26% of bonafide referrals come from external links (such as other parts of CCPJHU), and 62% are from HC3 sites. The rest of the bonafide links are not set.
SE	**Search Engine Optimization**					
3.	Queries (keywords)		Location		GA	Top keyword: Community radio stations, audience analysis, how write a community brief, situation analysis template, formative research, pregnancy wheel. audience segmentation.
4.	Landing pages	What landing pages are being found with search terms	What search terms are being used		GA	See appendix I
SM	**Social Media**					
5.	Network referrals	Which social media platforms are referring audiences to site	Location		GA	76% of all Social Media referrals are from Facebook (US, India, Nigeria, and Guatemala, Trinidad & Tobago), 16% from twitter (US, Australia, UK, Kenya).
6.	Landing pages	What landing pages are being found with social media	Location		GA	How to Guides (formative research) SBBC spotlights (Good Life Ghana, FP Guatamala) Project examples (comp. feeding wheel) Trending topics (Role SBCC HIV/AIDS, Malaria)

USAGE

The following are the web metrics used to measure how the current audience engages with the site, such as their engagement, common behaviors on the site

#	Item	What measuring?	2nd D	Metrics/focus	Source	
Eg	**Engagement/Stickiness**					
1.	New vs returning	User engagement by repeat visits	Location		GA	New—76%, returning 24% New Bounce: 69% Returning Bounce: 65%
2.	Frequency & recency	User engagement by frequent visits	Location	Types of content	GA	2% visited on the same day 7% in the same week 11% in the same month 13% in the same year, and 87% did not visit in over a year.
3.	Engagement	User engagement by duration by session	Location		GA	68% spend less than 10 seconds on the site. 8% spend more than 10 seconds but less than one minute, and 32% spend more than 1 minute
BF	**Behavior Flow**					
4.	User Pathways	Maps common user pathways	Location		GA	HP->project examples HP->sbcc tools HP->how to guides See appendix 1 for more detailed behavior flow
5.	Site Content	Most popular content	Location		GA	How to guides most popular (25%) SBCC capacity strengthening tool Mostly popular in the US.
6. S E	Site Content: landing pages	Most popular landing pages	Location		GA	Popular landing pages by country: Home page (Bangladesh, India) How to guides (Bangladesh, India, kenya, Nigeria) Project examples (Guatemala, Kenya) SBCC spotlights (Tanzania, Guatemala)
7.	Site Content: exit pages	Where audience members leave.	Location		GA	How to guides (56%). Project examples (78%), SBCC spotlights (54%), SBCC tools (77%), Trending topics (64%)

#	Item	What measuring?	2nd D	Metrics/focus	Source	
SP	**Site performance**					
8.	Site speed	Measures site download speed	Location	Are overseas audiences facing critical slowness in speed?	GA	Page load time seems high for several African countries (in the 30s to 40s).
9.	Page timings	Measures site download speed by page	Location	Are overseas audiences facing critical slowness in speed?	GA	Overall page seems fast, but see appendix 1 for some problematic pages by country,.

TOP LANDING PAGES FOUND IN SEARCH ENGINES

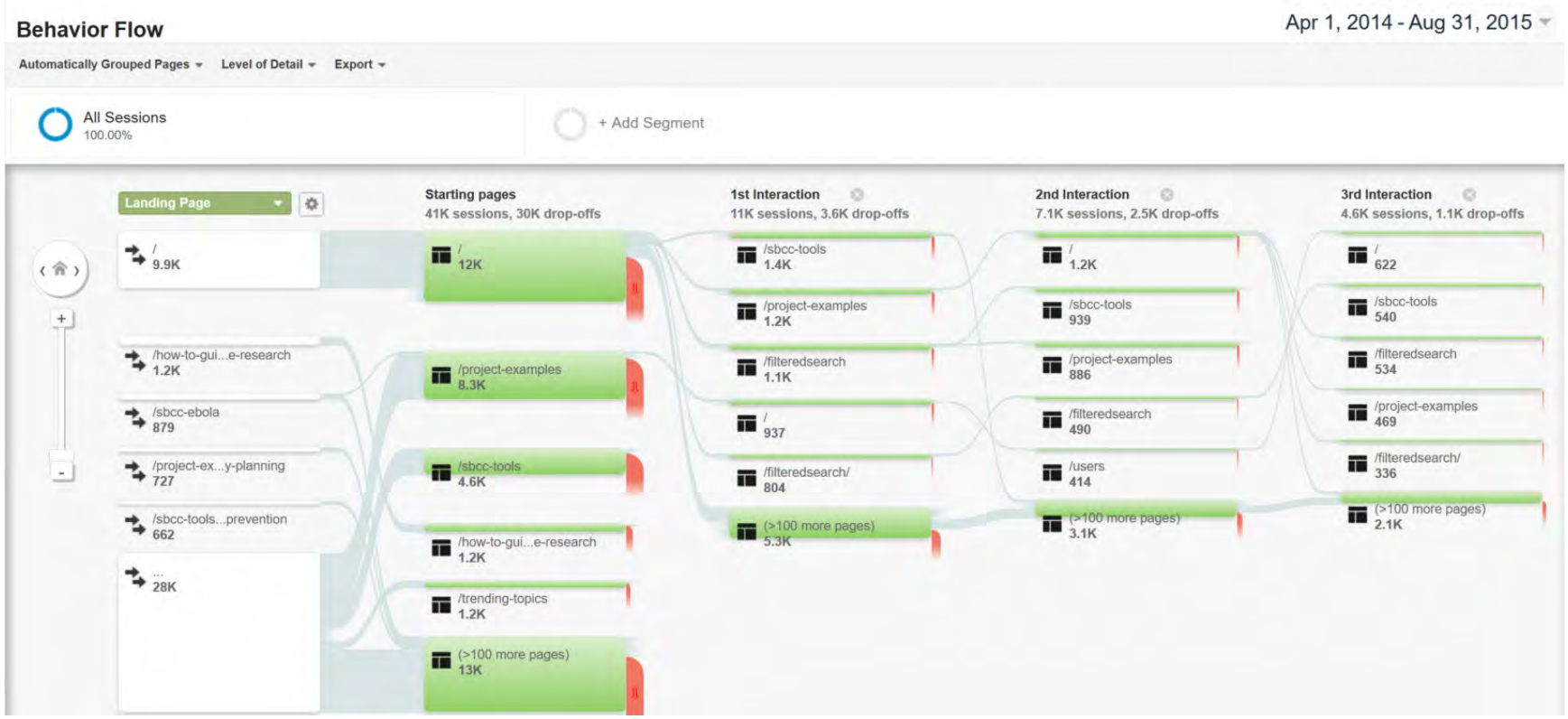
Landing Page	Country	Impressions	Clicks	Average Position	CTR
http://www.thehealthcompass.org/project-examples/growglowgo-healthy-child-feeding-goodlife-flip-chart	Philippines	15000	35	86.51	0.23
http://www.thehealthcompass.org/how-to-guides/how-do-audience-analysis	United States	4500	110	146.11	2.44
http://www.thehealthcompass.org/how-to-guides/how-conduct-qualitative-formative-research	United States	3500	170	75.20	4.86
http://www.thehealthcompass.org/project-examples/circuncisao-medico-o-que-%C3%A9-como-%C3%A9-feita-medical-circumcision-what-it-how-it-done	Brazil	3500	5	124.94	0.14
http://www.thehealthcompass.org/sites/default/files/project_examples/Facilitator's_Guide_%5BSesotho_Language%5D.pdf	South Africa	3000	50	16.27	1.67
http://www.thehealthcompass.org/campaign-kit-or-package/hc3-implementation-kit-demand-generation-life-saving-commodities	India	2500	90	101.49	3.60
http://www.thehealthcompass.org/how-to-guides/how-conduct-situation-analysis	United States	2500	60	109.59	2.40
http://www.thehealthcompass.org/how-to-guides/how-do-audience-segmentation	United States	2500	70	101.67	2.80
http://www.thehealthcompass.org/how-to-guides/how-write-creative-brief	United States	2500	60	86.28	2.40
http://www.thehealthcompass.org/project-examples/se%C3%B1ales-de-peligro-danger-signs-poster	United States	2500	30	83.23	1.20
http://www.thehealthcompass.org/sites/default/files/project_examples/Community%20radio%20technical%20manual%20full.pdf	Brazil	2500	0	21.35	0.00

Landing Page	Country	Impressions	Clicks	Average Position	CTR
http://www.thehealthcompass.org/how-to-guides/how-conduct-pretest	United States	1600	60	137.96	3.75
http://www.thehealthcompass.org/how-to-guides/how-conduct-qualitative-formative-research	India	1600	90	89.15	5.63
http://www.thehealthcompass.org/project-examples/7-pasos-para-la-atenci%C3%B3n-prenatal-personalizada-7-steps-personalized-prenatal-care	India	1600	60	66.68	3.75
http://www.thehealthcompass.org/project-examples/preparemos-en-familia-mi-plan-de-emergencia-lets-prepare-my-emergency-plan-family	Colombia	1600	22	53.33	1.38
http://www.thehealthcompass.org/sites/default/files/project_examples/Facilitator's_Guide_%5BSesotho_Language%5D.pdf	Lesotho	1600	50	8.07	3.13
http://www.thehealthcompass.org/how-to-guides/how-conduct-qualitative-formative-research	Philippines	1300	60	132.42	4.62
http://www.thehealthcompass.org/project-examples/how-use-male-condom	India	1300	16	22.85	1.23
http://www.thehealthcompass.org/project-examples/se%C3%B1ales-de-peligro-danger-signs-poster	India	1300	35	78.45	2.69
http://www.thehealthcompass.org/sites/default/files/project_examples/MSM%20Picture%20Codes%20for%20HIV%20Prevention_optimize.pdf	United States	1300	170	7.63	13.08
http://www.thehealthcompass.org/project-examples/familia-sana-sin-diarreas-con-agua-clorada-latrinas-y-manos-limpias-diarrhea	India	1000	110	24.21	11.00
http://www.thehealthcompass.org/sbcc-spotlights/alive-thrive-viet-nam-talking-babies-media-campaign	United States	1000	22	161.78	2.20
http://www.thehealthcompass.org/sites/default/files/project_examples/SW%20Picture%20Codes%20for%20HIV%20Prevention_optimize.pdf	India	1000	70	12.06	7.00
http://www.thehealthcompass.org/how-to-guides/how-do-audience-analysis	India	900	35	168.54	3.89
http://www.thehealthcompass.org/project-examples/guia-para-tener-una-comunidad-saludable-guide-having-healthy-community	Philippines	900	12	94.55	1.33
http://www.thehealthcompass.org/project-examples/se%C3%B1ales-de-peligro-danger-signs-poster	Philippines	900	22	96.72	2.44

Landing Page	Country	Impressions	Clicks	Average Position	CTR
http://www.thehealthcompass.org/	United States	700	70	33.17	10.00
http://www.thehealthcompass.org/campaign-kit-or-package/letlama	South Africa	700	5	30.83	0.71
http://www.thehealthcompass.org/how-to-guides/how-conduct-qualitative-formative-research	United Kingdom	700	50	91.40	7.14
http://www.thehealthcompass.org/how-to-guides/how-do-audience-analysis	Philippines	700	30	144.67	4.29
http://www.thehealthcompass.org/how-to-guides/how-do-audience-analysis	United Kingdom	700	35	176.19	5.00
http://www.thehealthcompass.org/how-to-guides/how-do-audience-segmentation	India	700	22	143.31	3.14
http://www.thehealthcompass.org/how-to-guides/how-do-audience-segmentation	Philippines	700	35	110.94	5.00
http://www.thehealthcompass.org/project-examples/contraceptive-methods-poster	India	700	16	128.20	2.29
http://www.thehealthcompass.org/project-examples/preparemos-en-familia-mi-plan-de-emergencia-lets-prepare-my-emergency-plan-family	Guatemala	700	250	17.77	35.71
http://www.thehealthcompass.org/project-examples/se%C3%B1ales-de-peligro-danger-signs-poster	South Africa	700	22	66.11	3.14
http://www.thehealthcompass.org/project-examples/se%C3%B1ales-de-peligro-danger-signs-poster	United Kingdom	700	12	87.39	1.71
http://www.thehealthcompass.org/sbcc-spotlights/alive-thrive-viet-nam-talking-babies-media-campaign	India	700	5	122.09	0.71
http://www.thehealthcompass.org/sbcc-spotlights/intersexions	United States	700	22	93.73	3.14
http://www.thehealthcompass.org/sites/default/files/project_examples/Si%20Mchezo%2064%20Jan-Feb%202013%20Low%20Res.pdf	Tanzania	700	12	46.55	1.71
http://www.thehealthcompass.org/campaign-kit-or-package/maternidad-apoyada-familia-feliz	India	600	12	142.82	2.00
http://www.thehealthcompass.org/project-examples/how-use-female-condom	India	600	5	56.39	0.83

Landing Page	Country	Impressions	Clicks	Average Position	CTR
http://www.thehealthcompass.org/project-examples/preparemos-el-plan-de-emergencia-comunitario-lets-prepare-our-community-emergency	Guatemala	600	60	21.09	10.00
http://www.thehealthcompass.org/project-examples/preparemos-en-familia-mi-plan-de-emergencia-lets-prepare-my-emergency-plan-family	Mexico	600	12	40.36	2.00
http://www.thehealthcompass.org/project-examples/take-cover-mosquitoes-spread-malaria-poster-nigeria	India	600	5	135.10	0.83
http://www.thehealthcompass.org/project-examples-malaria-sbcc	India	600	5	193.05	0.83
http://www.thehealthcompass.org/sites/default/files/project_examples/16_Curriculum_Family_Planning.pdf	Ukraine	600	5	71.04	0.83
http://www.thehealthcompass.org/sites/default/files/project_examples/Community%20radio%20technical%20manual%20full.pdf	Philippines	600	16	3.95	2.67
http://www.thehealthcompass.org/tools-reaching-urban-youth	United States	600	5	76.38	0.83
http://www.thehealthcompass.org/campaign-kit-or-package/maternidad-apoyada-familia-feliz	Philippines	500	5	118.50	1.00

BEHAVIOR FLOWS



SITE LOAD AVERAGES BY COUNTRY

Country	Avg. Page Load Time (sec)	Page Views	Bounce Rate	% Exit
Zambia	43.88	161	72.37%	46.58%
Kenya	40.71	1631	71.83%	61.31%
Namibia	40.63	172	50.77%	37.21%
Malaysia	37.01	107	80.49%	75.70%
India	31.30	2093	70.56%	52.94%

Country	Avg. Page Load Time (sec)	Page Views	Bounce Rate	% Exit
Tanzania	21.05	748	59.93%	37.30%
Guatemala	15.87	638	64.66%	36.21%
Nigeria	15.75	1238	61.10%	40.47%
Italy	14.74	267	68.85%	44.57%
Nepal	14.71	331	51.26%	35.05%
United Kingdom	14.48	912	69.00%	60.42%
Sudan	12.37	120	40.91%	18.33%
Philippines	10.38	588	81.46%	69.56%
Liberia	7.82	103	52.94%	48.54%
Uganda	7.71	785	55.40%	44.20%

SITE CONTENT

Page	Country	Pageviews	Unique Pageviews	Avg. Time on Page	Entrances	Bounce Rate	% Exit
/how-it-works	United States	134	111	34.18	5	20.00%	17.16%
/how-it-works Total		134					
/how-to-guides	United States	426	249	49.73	69	34.78%	17.14%
/how-to-guides	Bangladesh	83	68	147.83	58	89.66%	71.08%
/how-to-guides Total		509					
/how-to-guides/how-conduct-pretest	United States	247	148	133.57	84	64.29%	38.87%
/how-to-guides/how-conduct-pretest Total		247					
/how-to-guides/how-conduct-program-analysis	United States	131	13	106.83	3	0.00%	3.05%
/how-to-guides/how-conduct-program-analysis Total		131	2709	0.25			
/how-to-guides/how-conduct-qualitative-formative-research	United States	342	295	290.42	251	81.82%	72.81%

Page	Country	Pageviews	Unique Pageviews	Avg. Time on Page	Entrances	Bounce Rate	% Exit
/how-to-guides/how-conduct-qualitative-formative-research	India	132	118	349.41	114	83.33%	79.55%
/how-to-guides/how-conduct-qualitative-formative-research	Nigeria	73	60	340.27	55	68.42%	69.86%
/how-to-guides/how-conduct-qualitative-formative-research Total		547					
/how-to-guides/how-conduct-situation-analysis	United States	407	229	163.35	100	58.00%	33.91%
/how-to-guides/how-conduct-situation-analysis Total		407					
/how-to-guides/how-develop-channel-mix-plan	United States	67	15	74.83	3	0.00%	11.94%
/how-to-guides/how-develop-channel-mix-plan Total		67					
/how-to-guides/how-develop-sbcc-creative-materials	United States	86	14	107.60	2	50.00%	9.30%
/how-to-guides/how-develop-sbcc-creative-materials Total		86					
/how-to-guides/how-do-audience-analysis	United States	274	203	260.02	135	76.30%	51.09%
/how-to-guides/how-do-audience-analysis Total		274					
/how-to-guides/how-do-audience-segmentation	United States	163	112	185.26	62	53.23%	35.58%
/how-to-guides/how-do-audience-segmentation Total		163					
/how-to-guides/how-write-creative-brief	United States	278	190	137.46	142	60.14%	45.68%
/how-to-guides/how-write-creative-brief Total		278					
/project-examples/individual-birth-planning-antenatal-care-card	Kenya	102	88	336.40	88	81.82%	80.39%

PAGE SPEED

Page	Country	Avg. Page Load Time (sec)	Pageviews	Bounce Rate	% Exit
/project-examples/individual-birth-planning-antenatal-care-card	Kenya	129.98	102	81.82%	80.39%
/	Bangladesh	31.14	75	63.64%	50.67%
/project-examples/preparemos-en-familia-mi-plan-de-emergencia-lets-prepare-my-emergency-plan-family	Guatemala	29.33	78	72.22%	66.67%
/how-to-guides/how-conduct-situation-analysis	United States	26.73	407	58.00%	33.91%
/sbcc-spotlights/family-planning-law-campaign-guatemala	Guatemala	14.58	115	67.61%	56.52%
/how-to-guides	United States	11.91	426	34.78%	17.14%
/how-to-guides	Bangladesh	9.06	83	89.66%	71.08%
/how-to-guides/how-conduct-qualitative-formative-research	United States	9.01	342	81.82%	72.81%
/	United States	6.10	2645	58.08%	52.29%

APPENDIX K. COLLABORATIVE BOARD ANALYTICS PROTOCOL AND SYNTHESIS

BACKGROUND

Client: USAID/GH Pro—HC3 evaluation

Purpose of analysis: To provide insights for USAID (via GHPro) and HC3 on the usage of Springboard online collaboration tool

Change Log

Change made	Date	Author
Created draft	7/13/2015	Siobhan Green
Updated	7/25/2015	Siobhan Green
Finalized	9/22/2015	Siobhan Green

Overview
Name of board: SpringBoard

URL: http://healthcomspringboard.org/
Analytics Sources: SpringBoard, Google Analytics, HC3 User survey, HC3 data reports

Dates Analyzed: April 1 2014 – August 31, 2015

Target audiences: SBCC professionals in developing countries (and those who support those professionals), from NGOs, Government, universities, and private sector.

Purpose of board: Springboard provides online networking and information sharing for SBCC profesionals.

Sources: SB= Springboard site reports, GA= google analytics, US= user survey, N/A = not available.

Access to Board

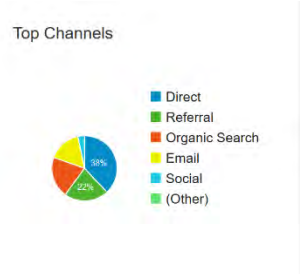
The following are the collaboration board metrics used to measure current audience composition by different factors (demographics/location/language), as well as which technology platforms they use.

#	Item	What measuring?	2nd D	Metrics	Source	Results
De: Demographics						
	Total	Total number of users	Location	Total number of board members	SB	3074 users since launch, starting with approx 437 users as of April 2014
	~~When joined~~	~~Pattern of new users joining~~	~~Location~~	~~When board members joined~~	N/A	N/A
	~~Gender~~	~~Audience composition by gender~~	~~Location~~	~~Board members, M/F~~	N/A	N/A
	~~Age~~	~~Audience composition by age~~	~~Location~~	~~Board members, Child, youth, adult, elderly~~	N/A	N/A
	Org	Audience composition by organization type (e.g. NGO, US Government, etc)	Location	Board members, by org type (also control for institutional partners)	SB, US, SB stata	Of 3074, 314 with JHU or JHUCCP email addresses. (SB) NGO: 998, University: 337, Govt: 327, not specified: 889
	Role/Job position	Audience composition by role (e.g. technical specialist, PM, donor).	Location	Board members, by role	SB stata	Most not stated (not required) PM: 645, Prog Imp: 400, RM&E 236
	~~Years of experience~~		~~Location~~		N/A	N/A
	Focus area	Posts by focus area	Location	Look at where people are posting	SB stata SB	Global (823), Worldwide Meeting (internal): 310, Ebola (109), ICT4Health 101, SBCC campaigns (81) Keywords: Malaria (11), SWIRL (9), Ebola (9), MHealth (7), Social Media (7)
	~~Affiliates/groups~~	~~Audience composition by groups~~	~~Location~~	~~Membership in groups~~	~~SB~~	N/A
Ge: Geography						
	Locations	Audience composition by locations	Is a second dimension	Break down by country	SB, GA, Stata	1611 International, 852 NA, Europe, Aust, 271 not specified (June 2015) *(Stata)* US: 4435 visits, Nigeria 880, India 872, Uganda 856, Zimbabwe 486 *(GA)*
	~~Languages~~	~~Audience composition by language~~	~~Is a second dimension~~		~~N/A~~	N/A
Te: Technology						
	Browser	Most popular browser	Location age	Chrome vs FF, vs IE, and version	GA	Chrome (49%), Firefox (`18%), IE 13%), Safari (10%)
	OS	Most popular OS	Location	Mac vs. PC.	GA	Windows (56.44%), Mac (28.71%), Android (8.87%), iOS (3.6%)

#	Item	What measuring?	2nd D	Metrics	Source	Results
	Network	% audience within an institution vs. outside	Location		GA	10% from JHU network, 1% from PSI network
Mo: Mobile						
	Devices	Most popular mobile devices	Location	Mobile vs. desktop	GA	Of sessions which are registered as coming from Mobiles, 53.87% Not set, 13.04% iPad, 20% iPhone

DEMAND

The following are the web metrics used to measure where the current audience is coming from, such as organic search, links from other boards, and social media.

#	Item	What measuring?	2nd dimension	Look at in particular	Source	Results
Ac: Acquisition						
	Channels	How audience finds the board by channel	Location		GA	19% from Direct, 4.66% from email, 7% from organic search, 11% from links (referrals), 2% from social media 
	Source	How audience finds the board by source/Medium	Location		GA	39% direct or no information, 16% google searches, 12% HC3 SB newsletter
	Referrals	How audience finds the board by URL referrals	Location	Xref with HealthCO Mpass links	GA	20% comes from the HealthCommcapacity.org, 34% of referrals come from HC3 sites (

#	Item	What measuring?	2nd dimension	Look at in particular	Source	Results
Ad: Advertisements						
	~~Campaigns~~		~~Location~~		N/A	N/A
SE: Search Engine Optimization						
	~~Queries (keywords)~~	~~What search terms audience on the board~~	~~Location~~		N/A	N/A
	Organic Keywords	What search terms audience is using to find board			GA	Springboard, mhealth training, health communication, (hotels)
	Landing pages	What landing pages are being found with search terms			GA	See appendix I
SM: Social Media						
	~~Network referrals~~	~~Which social media platforms are referring audiences to board~~	~~Network~~		N/A	N/A
	~~Landing pages~~	~~What landing pages are being found with social media~~			N/A	N/A
	~~User flows~~	~~How audience moves from social network to board~~			N/A	N/A

USAGE OF BOARD

The following are the web metrics used to measure how the current audience engages with the board, such as their engagement, common behaviors on the board

#	Item	What measuring?	2nd D	Look at in particular	Source	
Eg: Engagement						
	New vs returning	User engagement by repeat visits	By location, theme, audience type. Over time	Number of users who are returning. Control for HQ/Moderators	GA	See appendix 1 42,836 sessions, 29,554 were new sessions (meaning the remainder were registered as users returning to the site).
	Frequency & recency	User engagement by frequent visits	~~By location, theme, audience type, over time~~	Frequency of users who are returning to the site. Control for HQ/Moderators	GA	5% (2325 sessions) of users visited daily, 14% (6918 sessions) visited weekly. 20% (9985) visit monthly. 77% (38154) have not returned in a year.
	Engagement	User engagement by duration by session	~~By location, theme, audience type~~	Control for HQ/Moderators	GA	47%(23,399 sessions) visited 1 page, 32% (15922 sessions) + 3 pages. 54% (10,077 sessions) were less than 10 seconds 38% (7126 sessions) were more than one minute
	Posting audience patterns	% of lurkers vs. posters (new and replying)	By thread, location, theme	Who starts new threads? HQ or member? Facilitated discussion?	SB Stata	95% ever active, 5% inactive (meaning never logged in) 91% lurkers, 8% posters US majority of posts (1004) Uganda 168, Bangladesh 94
	Posting topic patterns	Length of threads by topic	By location, theme, audience type	e.g. look for freshness and length	N/A	N/A

#	Item	What measuring?	2nd D	Look at in particular	Source	
	CT : Content and Theme					
	~~User Pathways~~	~~Maps common user pathways~~	~~By location, org, audience type~~	~~How users progress through the site—do they browse, look for specific content, stick with particular themes/groups, view profile information? (feeds into 11&12)~~	N/A	N/A
	Board Content: exit pages	Where audience members leave.	By location, org, audience type	(feeds into 7)	GA	See appendix 1 for full breakdown by country. No real pattern across all countries.
	Board Content	Most popular content	By location, org, audience type	What is the most popular content on the site by the user type? By views, number of users, number of posts. (feeds into 11&12)	GA	Most popular pages: Activity, groups, register, members, jobs See appendix 1 for full breakdown by country
	~~Groups~~	~~Most popular groups~~	~~By location, org, audience type~~	~~For Board Groups (countries), which are the most popular? By views, number of users, number of posts. (feeds into 11&12)~~	N/A	N/A
	Most popular content type	What types of content get the most responses and views by users	By location, org, audience type	Looking at most popular content, pathways and group pages, identify top 10 content types (requests for feedback, new documents, questions, event invitations, etc)	SB, GA	Members, groups, activity Discussions—148 Published (136) Private (7) 5 hidden Topics (within discussions) -599 (published 595)

#	Item	What measuring?	2nd D	Look at in particular	Source	
	Most popular themes			Looking at most popular content, pathways and group pages, identify top 10 themes (country, topic, type of intervention)	SB	Themes (above 40 posts in the group): Capacity Strengthening (49), Ebola (111), Entertainment-education (43), Family Planning (75), Ghana (74), HIV/AIDS(74), ICT and innovation (138), Malaria (61) Media and Messaging (45), Nigeria (57), Social Marketing (81), Springboard (78), Uganda (45), Zimbabwe (77)
SP: Site Performance						
	Board speed	Measures board download speed	By location	Are overseas audiences facing critical slowness in speed?	GA	See appendix 1
	Page timings	Measures board download speed by page	By location	Are overseas audiences facing critical slowness in speed?	GA	See appendix 1
	User timings	Measures board download speed by user (if have profile)	By location	Are overseas audiences facing critical slowness in speed?	GA	See appendix 1

NEW VS RETURNING (APRIL 1, 2014 – AUGUST 31, 2015) GOOGLE ANALYTICS

Total	% new	New users	Bounce	#pages session	Site duration
20K—USA	42%	8657	42	5.30	6:10
4,136—Bangladesh	25%	1074	37	6.06	7:33
3186—Nigeria	34%	1093	44	4.63	7:14
2952—Uganda	23%	690	37	4.81	11:18
1784—India	59%	1054	44	5.24	7:18
1320—Kenya	52%	695	45	4.04	5:50

PAGE TIMINGS BY COUNTRY

Country	Session Duration	Avg. Page Load Time (sec)	Pageviews	Bounce Rate	% Exit
(not set) Average		44.00		98.34%	100.00%
Bangladesh Average		25.42		99.13%	99.42%
Brazil Average		0.00		98.77%	99.39%
Canada Average		5.65		98.86%	100.00%
China Average		0.00		95.40%	100.00%
Côte d'Ivoire Average		0.00		98.08%	100.00%
Ethiopia Average		0.00		96.39%	98.78%
France Average		0.00		99.14%	100.00%
Germany Average		0.00		97.32%	100.00%
India Average		1.85		14.05%	14.79%
Indonesia Average		0.00		98.86%	100.00%
Japan Average		0.00		91.75%	100.00%
Kenya Average		0.00		98.72%	99.15%
Netherlands Average		0.00		100.00%	100.00%
Nigeria Average		0.00		49.64%	49.68%
Pakistan Average		0.00		100.00%	100.00%
Russia Average		69.94		99.45%	98.91%

Country	Session Duration	Avg. Page Load Time (sec)	Pageviews	Bounce Rate	% Exit
Senegal Average		0.00		0.00%	0.39%
South Africa Average		0.00		100.00%	100.00%
Tanzania Average		0.00		99.37%	99.37%
Uganda Average		0.00		49.65%	49.84%
United Kingdom Average		0.00		99.52%	100.00%
United States Average		1.31		8.25%	9.60%
Zimbabwe Average		14.53		97.07%	98.52%
Grand Average		3.98		45.38%	45.85%

Top Landing Page from google searches	Country	Impressions
http://healthcomspringboard.org/	United States	900
http://healthcomspringboard.org/locations/kampala-serena-hotel/	United States	400
http://healthcomspringboard.org/groups/bangladesh-health-communication-springboard/forum/topic/bangladesh-prepares-to-tackle-swine-flu/	India	250
http://healthcomspringboard.org/	India	200
http://healthcomspringboard.org/events/alcohol-and-drug-abuse-day/	India	170
http://healthcomspringboard.org/events/swaziland-face-to-face-leaning-forum/	Italy	170
http://healthcomspringboard.org/groups/bangladesh-bcc-working-group/	United States	170
http://healthcomspringboard.org/groups/bangladesh-bcc-working-group/forum/topic/workshop-for-review-of-hpn-elearning-courses-for-field-workers/	United States	170
http://healthcomspringboard.org/groups/zim-health-communication-forum/forum/topic/can-whatapp-be-used-as-a-formal-means-of-communication/	India	170
http://healthcomspringboard.org/members/hkoenker/friends/	Germany	170
http://healthcomspringboard.org/activity/	United States	150
http://healthcomspringboard.org/discussions/topic/larc-use-among-youth/	United States	150

Top Landing Page from google searches	Country	Impressions
http://healthcomspringboard.org/groups/ethiopia-sbcc-team/forum/topic/u-m-center-launches-first-phase-of-reproductive-health-training-in-ethiopia/	United States	150
http://healthcomspringboard.org/groups/roll-back-malaria-task-force-knowledge-management/	India	150
http://healthcomspringboard.org/groups/roll-back-malaria-task-force-knowledge-management/	United States	150
http://healthcomspringboard.org/groups/zim-health-communication-forum/forum/topic/icasa-2015-zimbabwe-update-2/	Zimbabwe	150
http://healthcomspringboard.org/locations/intercontinental-hotel-nairobi/	United States	150
http://healthcomspringboard.org/members/tofailazad/	Bangladesh	150
http://healthcomspringboard.org/	Unknown Region	110
http://healthcomspringboard.org/discussions/topic/ethiopia-nalias-story-adolescents-who-sell-sex-in-ethiopia/	Ethiopia	110
http://healthcomspringboard.org/discussions/topic/starting-hiv-treatment-at-cd4-count-above-500-reduces-risk-of-serious-illness/	United States	110
http://healthcomspringboard.org/events/global-maternal-newborn-health-conference/	United States	110
http://healthcomspringboard.org/events/integrated-marketing-communication-for-behavioral-impact-imccombi-summer-institute/	United States	110
http://healthcomspringboard.org/events/webinar-review-key-highlights-from-the-march-supplement-to-the-journal-of-acquired-immune-deficiency-syndromes/	India	110
http://healthcomspringboard.org/jobs/	Kenya	110
http://healthcomspringboard.org/members/	United States	110
http://healthcomspringboard.org/members/hkoenker/	Germany	110
http://healthcomspringboard.org/members/lvanlith/friends/	United States	110
http://healthcomspringboard.org/members/mamunul/	Bangladesh	110
http://healthcomspringboard.org/	Russia	90
http://healthcomspringboard.org/discussions/discussion/hivaids/	Italy	90

MOST POPULAR PAGES BY COUNTRY

Page	Country	Pageviews	Unique Pageviews	Avg. Time on Page	Entrances	Bounce Rate	% Exit
/activity/	United States	16468	7723	145.60	3151	30.20%	21.21%
/	United States	11257	8169	106.30	7289	39.44%	34.49%
/groups/	United States	3529	1864	54.30	152	16.45%	8.73%
/register/	United States	3403	1182	87.84	334	26.95%	13.58%
/activity/	Uganda	3242	1526	396.02	853	43.85%	31.96%
/	Bangladesh	2529	1745	172.87	1605	37.38%	32.74%
/activity/	Bangladesh	2506	1480	144.09	390	35.29%	26.46%
/members/	United States	2317	1242	58.00	69	28.57%	9.97%
/register/	Bangladesh	1498	263	100.57	43	20.93%	7.41%
/jobs/	United States	1482	963	95.22	464	55.70%	32.25%
/register/	Nigeria	1326	455	169.77	189	42.33%	16.59%
/worldwide-meeting-2015/	United States	1314	645	95.42	283	17.83%	13.24%
/groups/worldwide-meeting-2015/	United States	1293	590	78.50	162	28.57%	15.24%
/	Nigeria	1165	879	171.17	815	36.56%	33.73%
/activity/	India	1154	506	151.22	260	34.87%	20.10%
/activity/	Nigeria	1149	740	181.42	291	40.34%	25.33%
/	Uganda	1030	874	147.13	792	20.20%	21.36%
/register/	Tanzania	1023	128	127.98	27	22.22%	5.08%
/register/	Uganda	1020	222	126.37	55	38.18%	12.06%
/groups/jobs-and-consultancies-in-health-communication/	United States	927	628	66.46	234	42.74%	22.11%
/events/	United States	913	563	58.03	44	31.82%	8.98%
/	(not set)	898	864	157.71	810	85.28%	84.74%
/content/	United States	832	564	135.13	91	61.54%	28.13%

Page	Country	Pageviews	Unique Pageviews	Avg. Time on Page	Entrances	Bounce Rate	% Exit
/groups/	Bangladesh	797	456	86.37	55	23.64%	10.16%
/register/	Ethiopia	793	177	119.77	44	13.64%	8.45%
/events-3/	United States	764	423	71.69	44	47.73%	12.83%
/activity/	Tanzania	758	362	160.12	140	32.86%	19.92%
/post-a-job/	United States	744	107	83.03	25	4.00%	7.66%
/groups/worldwide-meeting-2015/forum/	United States	718	274	77.58	38	13.16%	6.82%
/members/	Bangladesh	672	410	113.01	41	26.83%	10.12%
/activity/	Ethiopia	660	397	148.81	88	24.44%	18.33%
/	Brazil	628	624	112.73	618	96.93%	96.50%
/register/	Kenya	601	178	133.92	42	33.33%	13.14%
/	Ethiopia	582	453	131.98	430	27.21%	27.32%
/register/	India	574	193	158.66	47	34.04%	13.94%
/	India	547	467	164.68	429	37.91%	36.75%
/groups/ebola-communication/	United States	535	364	92.01	213	54.93%	36.07%
/	Kenya	510	375	125.48	334	30.24%	26.86%
/groups/	Nigeria	489	302	78.35	32	31.25%	13.50%
/members/	Uganda	477	260	260.87	31	25.81%	13.84%
/groups/	Uganda	473	277	94.34	28	7.14%	8.03%
/groups/sbcc-for-family-planning/forum/topic/larc-use-among-youth/	United States	469	315	146.88	217	55.76%	37.31%
/groups/jobs-and-consultancies-in-health-communication/forum/	United States	467	296	59.34	80	46.25%	18.63%
/activity/	Kenya	464	267	117.01	81	29.63%	23.06%
/members/	India	458	132	93.37	18	33.33%	7.64%

Page	Country	Pageviews	Unique Pageviews	Avg. Time on Page	Entrances	Bounce Rate	% Exit
/groups/nigerian-health-and-social-development-communication-practitioners/	Nigeria	457	299	132.49	57	56.14%	20.57%
/register/	Côte d'Ivoire	449	122	155.32	54	18.52%	10.91%
/groups/social-marketing-materials-and-health-communication-campaigns/	United States	444	292	50.16	28	35.71%	13.96%
/register/	Ghana	430	120	136.68	46	21.74%	14.42%
/register/	Zimbabwe	420	127	162.82	26	26.92%	10.71%

APPENDIX L. SYNTHESES OF QUALITATIVE FINDINGS

This appendix contains the full qualitative synthesis of organizational effectiveness, social and behavior change communication, and information and communications technology.

NB Unless otherwise noted, comments listed in this section were heard from/observed by/read in many of the data sources. Quotes are comments given by one data source, but a view shared by several. Also, there might be some overlap with the other two syntheses, but this was kept to ensure that all issues were adequately covered and documented.

QUALITATIVE SYNTHESIS - ORGANIZATIONAL EFFECTIVENESS

ORGANIZATIONAL EFFECTIVENESS			
Area1: Organizational Development	**Area 2: Organizational Environment**	**Area 3: [Change] Management**	**Area 4: Organizational Outcomes**
1. Contacts, Relationships 2. Assets and Finance 3. Strategy and Planning 4. Personnel and Human Resources 5. Staff Skills and Capability 6. Management structures	1. Vision 2. Leadership—Project & Technical 3. Readiness 4. Responsiveness 5. Learning 6. Innovativeness	1. Change Strategy or Plan 2. Adaptive Policies and Procedures 3. Management Ability 4. Involvement and Cooperation 5. Staff Voice 6. Approach	1. Ongoing Assessment 2. Milestones, Benchmarks, Indicators Link to Knowledge Capture 3. M&E Plan

AREA 1: ORGANIZATIONAL DEVELOPMENT

Area 1: Organizational Development		
Dimensions	***Source: USAID DC***	***Source: USAID Country***
1. Contacts, Relationships	• Facilitate strongly in Ebola unit • HIV team effectively dealing with pool of competitors, has reduced tensions • Unclear how/if effectively engaging other partners • Limited cross-fertilization as see others as competition • Rely on old affiliations in-country, not bringing in new, fresh organizations • Don't appear to be collaborative with others sufficiently or well • Work with some CORE group, WHO, UNFPA, PATH, etc. • When engage partners and us strategically can make great strides	• HC3 will project from success of others • HC3 serves as a strong integrator and broker • Strengthened capacity of ACSM committee • How leverage other donors, not really tried • Dismissed, underestimated existing expertise and coordination, not yet really use effectively • Working hard and well with other USAID partners to harmonize and bring together • USAID needs to be involved because implementing with other non-HC3 partners as well • Other partners have not yet been effectively implicated in work, "keep at a distance" • HC3 being used to phase out other unspecialized partners • Generally non-competitive, "always surprise us…"
2. Assets, Finance	• Funding not a given-need to advance field of SBCC and USAID agenda • Finance was opaque, but now getting better • New finance person has made things better, though still slow and somewhat untimely even with templates • Lost Ebola money for Guinea because slow to decide how to run the money	• Slow awarding of sub-award to existing core partner, but slowly getting better • Inability to issue subcontracts, switched to PO and can by-pass Baltimore • Use what works, exists and build out, not establish new financial systems
3. Strategy and Planning	• Use much that has done before, use as fall back—no planning and strategizing • Planning with Implementation Kit within a technical area is good, across technical areas, see no evidence of planning	• Seem very short-sighted, working from work plan to work plan • Not timely in their delivery, important research delayed
4. Personnel and Human Resources	• Not timely in filling gaps, better now, but took very long • Strong staff left, positions finally filled but not as strong and need to get up to speed VERY fast • Slow movement and weak leadership on staff issues and needed changes • Feels not taking staff issues seriously • HR is overstretched, too much juggling, not all full-time • Hard time responding to staff growth needs	• Want someone in country like the team that comes • Team that visits needs to come with all the skills needs, CS and SBCC • Professional and trusted • JHU can draw from all available resources and data effectively

Area 1: Organizational Development		
Dimensions	***Source: USAID DC***	***Source: USAID Country***
5. Staff Skills, Capability	• Some technically strong, but weak pen to paper • Some competent and proactive • Technical capabilities in general quite strong • HIV strong work and team • FP/RH not as strong/weaker • Sometimes less about staff capabilities to perform topic and more about ability to navigate politics • Feel sometimes don't understand audiences well and can't sell project well as a result • Technically sound	• Team highly qualified that visits • High as seen through materials produced—good quality • Strongest SBCC partner in country because apply standards and best practices • Produce high quality materials • Experts with rational and solid reactions • Highly professional and competent
6. Management Structures	• Decision making lags and can't provide information as to why and activities stall • Hold information close and want to control the process • Toom many reviews on products required • Links between units and within some appear to be very weak (staff and management)	• Copyright issues always reduce how and who can use materials, not helpful • Do what asked, but not bring much up first • Sometimes do things without informing USAID, need to be kept informed • Moving ahead on decisions with partners without USAID is not good • Much too slow on the needed research essential to continuing the work

Area 1: Organizational Development			
Dimensions	***Source: HC3 Headquarters***	***Source: HC3 Country***	***Source: Project Partners***
1. Contacts, Relationships	• Drawing on other CCP resources, not as much from project partners • Pre-existing relationships in Liberia allowed Ebola team to move quickly • Specific examination of partners has made HC3 stronger • Use all connections to get buy-ins • HC3 reach is limited, but partners on the ground can reach farther down • MSH team embedded • Worked heavily with old and new partners on Ebola, like Internews and Mercy Corps • Built on strengthens of PSI. MSH and CCP	• Work primarily with Ministries, not much outside • Many coming regionally • Stay with what know • Strong through previous work not HC3	• Strong ties to and work with legacy organizations • Unawareness of interrelationships • Existing connections and ongoing platforms that they build on well • Not on the ground sufficiently, missing opportunities • Doesn't effectively reach out for expertise on the team
2. Assets, Finance	• Lots of CS tools late, Year 2 deliverables a challenge • Field support comes in small bits, had to reach out and to know budgets • Way must report out by funding stream and then by activity is a challenge • Costs a lot to keep redoing staff time • More transparency needed on how much budget is actually available, "hard to contract when don't know how much money you have…"	• Provided training to local partners • Oversight given • Finance mechanisms onerous • Funding comes late, sets all activities behind • Funding streams are slow	• Little support from management • Most time final budget unsure, not know what can afford to actual do the work • Lack of understanding of budgeting for tasks • Lots of resources coming from the field—human, finance, in-kind • Financial reporting is arduous, level of detail not the "norm"
3. Strategy and Planning	• "…because we work within a global framework…should do strategy…"Could have benefited from long-range planning at beginning of project, not just an iterative 1-year plan • No strategy in place for CS, not time, no money • Produced several how-to guides • Fit into global strategy for technical area, only need plan for HC3 • No clear strategy to develop things, just develop lots of generic SBCC I-Kits • Trying to figure out how to disseminate I-Kit now that it is developed and ready • No clear strategy for SpringBoard, just trying activities • Work plan gaps because bundled with all country activities (PEPFAR)	• Not heavily involved, given activities • Plan earlier so funds in place when needed • Putting many plans in place with partners	• Insufficient time given to complete tasks, unreasonable deadlines • Lack of framework for capacity building • Needs solid strategy, work plan and budget—"not buddies"—partners • Not always part of planning process

Area 1: Organizational Development			
Dimensions	***Source: HC3 Headquarters***	***Source: HC3 Country***	***Source: Project Partners***
4. Personnel and Human Resources	• If people would stay longer, it would be better, but lots of unexpected turnover • Staff challenges with major team members leaving, e.g. Research, CS • Most technical team leads are strong • Many staff are not 100% • Team members get poached • Maybe process for hiring consultants can be streamlined • Need to get bold on staff numbers so can get the job done • Created an approved consultant roster so can get high quality	• Sufficient for tasks • Well-trained and competent	• Significant technical capacity and support provided from Headquarters • Most technical staff competent (a few not) • Hired new staff to deal with initial lack of involvement—now better
5. Staff Skills, Capability	• Reported focus on external and internal CS • Experience not audience profile used to develop some I-Kits • CS technical team lead is weak and has insufficient knowledge of CS and its integration to do the job • As staff grows and bulks up and reinforces "we control what can…don't worry about the rest." • Have a conversation with the management team , pay a bit more to get the right people with the right skill sets • Feels team is special because of skills transfer, including with/between project partners • "…would like to have it done right, but time didn't permit…"	• Staff highly capable • Help get from Headquarters technically sound • Transfer skills when come to work from Headquarters	• Highly capable • In charge not qualified • Doesn't understand topic or audience • Highly skills and bring new to table—perspective and capacity
6. Management Structures	• Not much follow-up on dissemination of breastfeeding I-Kit • Lack of time lessens ability to do things 'right' like research and pretesting • Accessing partners in the field for work is laborious, requires lots of paperwork for USAID	• Slow processes administratively • Try to anticipate, but usually still slow • Growing fast, but know place in structure • Little involvement of project partners	• Little or no interaction with local office • Integrated into structure, even as a partner • Well-positioned in Headquarters, not well-positioned in field—too far removed

Area 1: Organizational Development		
Dimensions	***Source: Implementing Partners***	***Source: Local Country Partners—NGO, Government, Beneficiaries***
1. Contacts, Relationships	• Works intimately with many local players • Participates with and includes local SBCC working groups	• Try to tap local knowledge and new partners • Built partnership with "relevant" partners—those stronger and better • Not sharing across projects/NGOs, "could learn much from others to improve…" • Redistributed funds means can't partner as did before
2. Assets, Finance	• Funding delays right when activities were picking up • Resources usually available • Sustainability of funding is questionable if too informal • A few felt funding was supportive	• Access to internet is a challenge—cost and sporadic—would like to access resources but can't easily • Source of funds often delayed, not strong and ongoing • Communication gaps about invoicing • Budget for transport is a problem and repeated challenged • Some materials lacking to make approaches more effective, like microphone • Past participants are the true asset as they work to keep the program "alive" • NGOs expected to chip in 10% of budget, though must invest much more money that the 10% because so many costs are not covered • Equipment to carry out is insufficient or inappropriate and no funds to rectify • Insufficient sets of SBCC materials, must share and "should be 1 per facilitator"
3. Strategy and Planning	• Disagreement about formality of activity organization • Clear plans and expectations • Need to create realistic expectations to reduce frustration • Need strategy to address to gaps, not sure this is in place • Need a strategy that makes people want to take responsibility for themselves "if we can better strengthen at all levels, especially communities, people can take it on…" • Need clearer strategy on CS to understand how to do it at all levels	• Don't feel involved in strategizing or planning • "Beautiful strategy, but unclear how to translate into activities or at the state-level • Need to better align HC3 activities with national work plan • Help to build framework within which work will take place • Scale up plans not in place, just working to complete work plans • Community by community planning, not really strategic • All NGOs working jointly toward same ends

Area 1: Organizational Development		
Dimensions	***Source: Implementing Partners***	***Source: Local Country Partners—NGO, Government, Beneficiaries***
4. Personnel and Human Resources	• Send someone from main office when need help to work • Insufficient for some work and tasks, need more people	• Use previously trained workers as coaches • Good local HC3 office team members "that promote good work" • Team good when here, but not enough "need more bodies…" • No orientation received—just periodic visits to receive information • Respectful staff "always use proper channels…" • One has created own "success checklist" to use monthly, not sure if others do similarly
5. Staff Skills, Capability	• Highly capable • Spent time at main office to learn • Limited BCC experience but lots of strategic planning work	• Need to put all people on the same level of knowledge and know-how "we have strong staff because they were previously trained in techniques…" • Work with staff beyond us, "hard to do our jobs when others don't understand" • Need training on what and how of digital tools available • Build our capacity, providing current practices in and around • Some facilitators not sufficiently trained, can't manage sessions • Unclear how to transfer competencies to the base • Hope to get to the point where state can take on CS without HC3 • NGO does additional follow up training because one shot of CCP is insufficient to actually do jobs well • Would be better if HC3 trained each NGO to do their own thing, then supported, not do or withhold, so can work in communities • Support capabilities in many ways through trainings and coordination meetings • Coaching is ongoing by consultants • "Support now when need, but what happens when project ends and we are still unable and need help?"

Area 1: Organizational Development		
Dimensions	***Source: Implementing Partners***	***Source: Local Country Partners—NGO, Government, Beneficiaries***
6. Management Structures	• Overly complicated layers to get through to do final activities • Country-level mechanisms in place and formalized • Need to connect products with the SBCC work, otherwise "people can't get [it]…and this creates frustrations and they don't want to use…"	• Need organizing entity, every time new project lose everything from before • Program was on hold until HC3 got here, they got things going with good management • Some see HC3 as "too much of a good thing…" create too much demand and think not about the supply • "How can a formal mechanism, one that needs to be formal, evolve 'organically,' then it becomes informal…"

Furthermore for Country Local Players:

Communities really appreciate NGO efforts supported by HC3: brings health, saves their young, makes their girls safe, makes them a strong community, perceived progress in the community, breaks down barriers, though "not yet seen effects in our community…" Common complaint: insufficient commodities.

Program participants highly value SuperGo and Brothers for Life (BFL): learn new things, find new ways, change how/what think, learn to listen, made a difference in their lives, "a boulversé mes attitudes et mes pratiques (turned upside down my attitudes and practices)…" (BFL past participant).

Country local players, in general, feel too many messages, not specific enough audiences "targeting everyone…," fills real need, bolsters community ownership and buy-in, supply is inadequate, some information is too technical for the audiences, and "would like to have more involvement in actual development of materials and approaches, especially if 'we are not the first…'."

AREA 2: ORGANIZATIONAL ENVIRONMENT

Area 2: Organizational Environment		
Dimensions	***Source: USAID DC***	***Source: USAID Country***
1. Vision	• Vision of neutrality, needs to sharpen their focus • Vision unclear and not tailored to the audience • Unclear vision on how will establish global interface and leadership role • Unclear vision for Springboard • Weak visionary lead and for capacity strengthening at a higher level	"Mus have a strategic vision or cannot advance, don't see it…" Especially in SBCC, critical to bring the vision early and clearly or risk people "turning the page…" Willingness and openness to help with vision, but it is coming from USAID and HC3 needs to bring to us
2. Leadership—Project & SBCC Technical	• Often defensive, not taken a hand to improve or have a handle on challenges • No fluidity among top leaders • Senior Management needs to be open and upfront • Technical leaders are strong • Feels leadership is weak, not steering, jut gliding/flowing • Five-year strategic planning seems to be tough for HC3 • In some places (Swaziland) too much leadership, government doesn't feel it's their own • "Appreciate and acknowledge that HC3 is THE SBCC project."	• In-country strong and recognized "people go to JHU for advice…" • "Testament to their technical expertise that others ask them for support…" • Leadership in coordinating and harmonizing, but at USAID's insistence • Been successful as leader, bring framework and SBCC to life • Well-respected as a technical partner
3. Readiness	• Not embraced new style of project, "made things effortful" should experiment more • Can't seem to get out of own way • Decision making process is unclear	• Seem ready to take on the challenge of a new integrated concept • Expectations are high and unrealistic by HC3 • Could have been ready faster, if had picked up on C-Change strategy, good pieces done, and worked with it
4. Responsiveness	• "If leader is good, responsiveness high…" • Responsive to needs of the field but unclear how connects to core mandates • Don't appear to talk to each other • Responsive when pushed • "When great, impeccable…"	• Replaced COP to accommodate • HC3 providing messages and integration opportunities • Supportive consultants and HQ support when looking for COP • Responsive strategically usually, but hard time reaching goals • Sometimes seems only hear what they want and provide "Cadillac version" • Not clear with USAID why things are delayed and when they might happen • COPs very responsive

Area 2: Organizational Environment		
Dimensions	***Source: USAID DC***	***Source: USAID Country***
5. Learning	• Don't seem to be in tune with international trends • Learning from one Implementation Kit applied to the next and they are getting better • "Raising the bar in quality…"	• Should share with Missions what is working else and learn from other countries—evidence is lacking • Have discussed process by layers, very fluid
6. Innovativeness	• Falling back on tried and true, same program models • Should be less about developing models and more about bringing something new • Some Implementation kits are innovative because they have been contextualized • SMS for immediate Ebola data	• "Looking for truly groundbreaking research on how to change our programs…" • Monopolize what do, how helpful is that • Good with traditional approaches at engaging communities stakeholders • Pushing to engage in social media and "they are a little old school…" • Feels innovative suggestions coming from the Missions, HC3 just following along • Picked up on new audiences to investigate, new and innovative to use • Usually seems to be well-adapted contextually when bring innovation for another country

Area 2: Organizational Environment			
Dimensions	***Source: HC3 Headquarters***	***Source: HC3 Country***	***Source: Project Partners***
1. Vision	• Ongoing check-in with vision, "verge of becoming visioning…verge of more explicit diffusion…" • Regardless of whether Missions want CS, HC3 will do it somehow • Core-funded must be linked to country wants and needs • Yes CS, but struggle coming together with lots of the tools • Disconnect between mandate of CS and implementation wants of Missions • Good new reality, CS is there but hard to track and how influence health/behavioral indicators • Early days yet to say "no" can't forage forward • Gold standard will be in follow-on for CS, not yet in this project • "Reality is larger than HC3's vision…" • "Explaining to MOHs what we are all about is difficult, what do we call ourselves…?"	• Lack strategic vision and planning • Orientation and strategy received from Headquarters • Unclear vision, undefined	• No apparent vision—doesn't understand how pieces fit together • How to get focus and stay focused • Vision and expectations for some tools and products unclear, hard to follow through • Many partners unsure of vision, so don't know where they fit and thus how to move • "…if find it doesn't fit, look for a better fit, don't make it fit…"
2. Leadership—Project & SBCC Technical	• Need to articulate new expectations with USAID • Sometimes not enough "energy of leadership" behind CS, so it's now behind • Don't always know funding and framing changes • Slow down and think about it, think about what expected to do and how to do it, "this is often not happening…" • When need leadership it is always there • Good leadership at most technical levels • Need to collect evidence so have a stronger technical voice • Feels seen as technical leader • Useful online and virtual resources • Summit on SBCC coming in 2015 • Working to bridge the divide between behavioral and medical cultural approaches	• Leadership solid and well-informed • Full range of stakeholders involved • Lots of help from Headquarters • Facilitate process with subs	• Lack of clear direction on some product development • Leadership completely lacking (1 unit) • Leadership has avoided making the tough decisions • Global thought leader • Planning SBCC Summit—first of its kind • Brought broader definition to topic • Management gone above and beyond to included partners in process

Area 2: Organizational Environment			
Dimensions	***Source: HC3 Headquarters***	***Source: HC3 Country***	***Source: Project Partners***
3. Readiness	Micro-scrutiny felt from donor, reduces readiness, "ongoing constant discussions, takes time, breaks you down…" • Need fluidity so don't short change bigger picture • Difficult to match CS core to field implementation • Feel time lost in dealing with USAID "rigmarole…"	• Over-reliance on technology difficult for some • No real scale up strategies • Working day-to-day	• Seem unprepared to move forward • Don't understand links between project pieces • Tring to be too much to too many—confusing • Not ready to work with partners with different perspectives
4. Responsiveness	• CS must respond to country, technical and core, must evolve, but slowed down • Feels dancing around things "interferes with creativity and technical leadership" • Feels always very responsive to USAID • Not restrictive and only communicate through a few channels, allows "line managers" to go direct to USAID • Develop generalized responses and approaches so can act faster	• Feel have no voice or input • Not feel fully engaged • Discuss to make changes	• Seldom convenes the team (1 unit) • Senior management responds rapidly and fully • Team building in 1 unit is minimal, rest of the organization is fantastic • No real communication between the team (1 unit) • Participate in internal face-to-face meetings • Reaching out to partners to increase coverage • Internal disagreements disrupt progress and quality
5. Learning	• Impressed with how well the project has internalized how technical help can rapidly advance the goals of HC3 • "Power in the process, not in the product…" • Others don't always "get" SBCC, how to bring them along is our job • Encourage cognitive reflection • "we …demonstrating excellence of products…" • Don't' see CS has behavior change • 'What value is there in an I-Kit if we don't apply our learning to the next kit, so we apply…" • Learning is finally becoming more indigenous • SpringBoard shifting focus to country-led based on first years' experience, learning and feedback	• No real discussions • Not taking sufficient time to "think" • Not much overlap and sharing between the countries	• Using what did elsewhere, improved, taking to the country to learn more • Differing dissemination channels, confusing partners, learning little or nothing • Things process-heavy, hard to work around, need to recognize that format /template is restrictive and change

Area 2: Organizational Environment			
Dimensions	***Source: HC3 Headquarters***	***Source: HC3 Country***	***Source: Project Partners***
6. Innovativeness	• Adaptation of communication tools, provided consistency where merged PSI and P processes • Find innovative ways to fill gaps with self-guides • Want to create an App on SRH issues • Feel work in behavioral economic is exciting • Integration of CS makes HC3 different • SMART client app under development • Feels worksheets are new • "…not sure how to improve/adapt I-its, so useable without us…?" • Webinars new and innovative, not done like this elsewhere • Philosophy of "learning by doing" is process-oriented and new • "Make something easily adaptable, find right people in country, and meet them halfway with something to adapt…" is innovative	• Pulled from previous programs • Adapted minimally, nothing really new • New to us • Demand too high quality so that others can't use easily	• Learning by doing is experiential learning not new • "Innovations happen in the field" how to bring those to Headquarters and global • "HC3 is not where I look for innovations"—just solid what they do well

Area 2: Organizational Environment		
Dimensions	***Source: Implementing Partners***	***Source: Local Country Partners—NGO, Government, Beneficiaries***
1. Vision	• Unclear direction and expectations • Feels brand should be more prominent • Very strategic in timing of materials delivery, increased visibility	• "We urgently need to know vision of HC3, so we know where/how we fit…" • Need to have better idea of what HC3 is here to do, "we think we are going one place and we end up somewhere else…" • No one was able to explain or articulate the vision of HC3 • One said, "Though an HC3 project, it feels like our project…"
2. Leadership—Project & SBCC Technical	• Usually involves others in strategic decision making	• Need to bring integration to the forefront • No leadership within group, not role of HC3 to lead but to support • Understand culture, CCP there since 2000, "we are behind you…" • Really only JHU that has this technical capability • "CCP is a communication leader" • Harmonizing messages, "before too much disagreement…" • "We mass product to ensure quality…"
3. Readiness	• Not ready, didn't understand change actually taking place • Providing technical to field/frontline workers so can keep pace with work	• How to go beyond, not sure HC3 understands what this actually means • Share more information sooner so can prepare and be ready to implement rapidly
4. Responsiveness	• Main Headquarters available when contacted • Different perspective to do things differently	• Some send reports and receive no response back still waiting • One said "Expected to be isolated like with other projects, but HC3 consultant comes all the time…" • A few felt offer great assistance "call and they are there…" • "HC3 supports our work, it's not us that support their program…" • Support is sporadic, HC3 busy with other countries or work • Get support when here, then after long wait for responses • Some said provide assistance on organizational BCC strategy review • Brings things and activities, people, products closer to the community • Provides things and responds when they need things

Area 2: Organizational Environment		
Dimensions	***Source: Implementing Partners***	***Source: Local Country Partners—NGO, Government, Beneficiaries***
5. Learning	• Main office staff came often to help and train • Learn from countries, not "drop down" from global • Strong learning from other parts of the world	• Some approaches insufficiently participatory and interactive • Training materials are not readily accessible or shared • See HC3 as an opportunity to identify and fill gaps • Learned "P" process • Feel sessions are a training and they should distribute a certificate • If could interact with other NGOs to discuss would be able to improve "we share same challenges…" • Need more on how to manage process of behavior change • Some feel offers "step-down" training as CS
6. Innovativeness	• Place to bring SBCC professionals together, not vehicle, but grouping • Not really, pulled concept from previous country project and reduced interventions • New to communities	• "Can't respond to how innovative HC3 is because don't know what here to do." • New concept because new to the country • Some development is contextual and has made work productive • Feel like recreating some work that already exists • Innovative for country because new, but well-adapted? Well-contextualized? that is questionable • Worksheets in materials is new and good, but not enough for us to make good decisions • Use previous participants to recruit and suggest possible recruitees • Use previous participants as ambassadors to encourage communities to participate • Phone SuperGo! Video testimonials put on YouTube • Not really new have done community work like this "a lot" in the past

AREA 3: [CHANGE] MANAGEMENT

Area 3: [Change] Management		
Dimensions	***Source: USAID DC***	***Source: USAID Country***
1. Change Strategy or Plan	• Not moving to reinvigorate and revise Springboard even though not resonating with Mission • Have not dealt well with change, exhibited lots of resistance • Not strategic in how dealt with gaps, finance changes, staff lacks • Change adverse—give impression they think USAID is strict and stringent • "Common tone to guidance and oversight—change adverse."	• Should be building capacity ministries even if not part of behavioral indicators, objectives or tasks
2. Adaptive Policies and Procedures	• Very cumbersome and slow, not flexible	• Shifted well programmatically and strategically with donor shifts • Things are detrimentally slow, don't really understand why
3. Management Ability	• Overcomplicate "feels like selling make work" • Need to streamline • Feel selective information sharing, frustrating • Communication with senior management is felt to be weak • Communication unclear between HC3 team, miss synergies • Management of few technical units very strong (HIV) • Lots of apparent oversight in work, slows work down	• Been very flexible and done a good job under difficult circumstances • Had to write "involve USAID" into SOW, otherwise circumvent USAID • HC3 has given the ability to quickly go to scale, that was an option before • Brought in new staff to handle management challenges quickly • Feel insufficient managing of the process, should be more proactive • Super flexible
4. Involvement and Cooperation	• Often it seems that changes discussed and agreed upon haven't been filtered down to technical staff • Solid HIV team, made work cross-cutting and more acceptable • Frustrating to submit and resubmit products/outputs	Team is always engaged
5. Staff Voice	• Unclear if staff have a voice in changes and in management decisions • Unclear whether staff understand changes	Nothing cited

Area 3: [Change] Management		
Dimensions	***Source: USAID DC***	***Source: USAID Country***
6. Approach	• Neutral, no outreach, don't appear enthusiastic about reaching out to others • If want to be a central partner for SBCC, must be more proactive "be perceived as technical leader" • Ebola—quiet approach, kept people informed, included, involved and engaged	• Suggested essential research than didn't follow through • Seems somewhat fragmented and ad hoc • Very receptive to applying new concepts but don't usually suggest, these come from USAID • Moved country results framework forward • Should be pursuing strategic ways to involve private-sector partners for dollars, expertise, world-wide • Not enough pursuit, always feel like waiting for USAID

Area 3: [Change] Management			
Dimensions	***Source: HC3 Headquarters***	***Source: HC3 Country***	***Source: Project Partners***
1. Change Strategy or Plan	• Year 3 can move preparation and framing to "show how brilliant is is…" • Lots of complexities, lots of agendas, how can we be cohesive and functional • Plan further out that one year, encourage longer term vision and strategy • Feel realistic that it took a while to get up and running • Stress and pressure on team from changes influence quality • Upfront guidance from donor would assist in handling the complexities • Downplay CS, not sure now how to build it in • CS has been put on the back burner • How better to pull together a suite and ensure CS as well as others pull it all together • "…as conditions of program grow, need to get a grip on new things being done…make changes…"	• Ironic, before HC3 built capacity, now as HC3 don't because of funding source • Changed to donor demand • No change plan, decide after the fact • Reorient priorities through deliverables	• No real plan, just adjust as needed and not always well • Feel moved far from capacity strengthening because of Mission buy-in, how to get back • Provide focus and do better job, plan for/communicate on new work and new areas • No flexibility to consider better alternatives
2. Adaptive Policies and Procedures	• HC3 is governed by JHH "conflation at many different levels…" • Set up retrofitted systems to address challenges • Much backend procedural issues with JHU also brings constraints • "to meet global challenges…need to be nimble…" • Requires procedural clarity from donors • Circumspect in communication with USAID, how frame and who says it • Each portfolio is slightly different parameters where funding can go, limits CS • "if USAID management gave proactive guidance…"	• Slow and ridged • Procedures cumbersome and delayed	• Internal controls are in place to manage and operate efficiently • No mechanisms to effectively plead case on supervisor/lead • Processes take a very long time, activities always delayed as a result • "…seemingly ridiculous details slow things down tremendously…"

Area 3: [Change] Management			
Dimensions	***Source: HC3 Headquarters***	***Source: HC3 Country***	***Source: Project Partners***
3. Management Ability	• Ebola preparedness is becoming more like the rest of us now, slower, more procedural • As leaders we are aware what can tap into an organization and as a project • Feels layers of scrutiny from donors burdensome • Open door policy • Team leads are dynamic and positive • Senior management have been proactive in reaching out to USAID/DC • Difficult as feels USAID is micromanaging	• Solid and inclusive • No clear link of what learned to what actually doing	• Hasn't built team or included partners (1 unit) • Lead is difficult hard to communicate with (1 unit) • Hard to get Lead (1 unit) on the same page, appears recalcitrant
4. Involvement and Cooperation	• Feels 'talking points' for all staff on new expectations under the award is a solution • Formed SpringBoard group to align SpringBoard goals with project goals	• Not consulted, just told what/when • Unaware of most project partners • Lots of discussion among staff on way forward	• Not fully involved, received no feedback on how to participate • Have a plan and implement it, not really involved • Not involved in the discussions fully or decision making • Compromises made • Feel supported and included • Not sure what other partners are doing "siloed" and confused
5. Staff Voice	• Need to formalize the discussion about and around CS • Can get to USAID direct to talk to and discuss • Due to lack of information regarding HC3, field staff doesn't understand bigger HC3 picture	• Work imposed "can be brutal"	• Feel have a voice with all but own unit • Communicating changes is not done effectively, staff often confused and don't know how to voice • Offer suggestions but are not listened to • Ideas shut down and "dismissive of our thoughts and ideas" • A few HC staff listen well

Area 3: [Change] Management			
Dimensions	***Source: HC3 Headquarters***	***Source: HC3 Country***	***Source: Project Partners***
6. Approach	• Need to "help" them prioritize, I-Kits not stand alone, need TA to use • Learning by doing for CS, maybe combine it later • "Missions…insist…CS not what they signed up for…" • HC3 global mechanism allowed Ebola team to approach USAID in country and start dialogue	• React to donor demands • When suggest and try to be proactive, just brought back • Not listened to when proactive	• Respond to demands and feedback from USAID only • In responding to USAID direct implementation requests, forget how to be proactive on capacity strengthening mandate

Area 3: [Change] Management		
Dimensions	***Source: Implementing Partners***	***Source: Local Country Partners—NGO, Government, Beneficiaries***
1. Change Strategy or Plan	• Thought understood needs, so no change, then realized coming from two different perspectives • Moving to new technology and thought through elements needed • Organizing functional and harmonized donors and players to avoid duplication and overlaps	• How can HC3 provide support to each regardless of where they are in the process • Need plan to explain what's coming otherwise work in a vacuum • HC3 re-organized work, now don't' know what role is or how to participate • Reorientation of funding thrown them, not sure how to interact with HC3 or request help • Not sharing and discussing changes to recruitment and the difficulties this presents • "Elaborate recruitment challenges, but insufficient response…"
2. Adaptive Policies and Procedures	• Very layered and complicated, reduces what able to do • Can move fast when URGENT, but doesn't happen often	• Progress slow because of process of diagnosis • Procedures in place already, but got some guidance how to adapt somewhat to HC3 needs • Participants are paid in refreshments and transport, how adapt/reduce this • Some with volunteers, must agree on what to give, to set standards
3. Management Ability	• Confusion about purpose and activities, didn't know where to turn • Continue same management styles that people know and are comfortable with • Expectation sometimes unclear and don't realize until told to change it	• Expectations are unclear for many "What are we to do? What is expected?" • Mostly good, but occasionally unsure who to contact to discuss challenges • Feel CCP needs an exit strategy for "How we take over once we feel institutionally skilled"

Area 3: [Change] Management		
Dimensions	***Source: Implementing Partners***	***Source: Local Country Partners—NGO, Government, Beneficiaries***
4. Involvement and Cooperation	• Some discussion in field, some come from them and we do it • Fully involved in discussions and decision making	• Review documents etc. when requested • Don't always feel part of planning process, sometimes just HC3 just makes decisions, needs to work with us • Totally involved by local consultant and implementing partners in process and discussion • Invited leaders to participate so would understand and encourage others • Help select communities and suggest ways to get to appropriate recruitees • "Volunteers come from us, from our communities" participate in discussion and selection • Always sit with traditional leaders and ask their opinions • Ownership by communities, involved since the beginning in discussion, decisions, changes, monitoring 'HC3 is like a communication arm of us…" • Were involved more before PEPFAR, now come into the picture after the fact "we follow from afar…" • Not involved conceptualization, would have like to help "we know communities and potential challenges…"
5. Staff Voice	• Started on a good note, then lost voice as disagreed with direction • Always involved in discussions	• Create a feedback mechanism on the virtual platform so that we can give our opinions and thoughts • Would like to change the criteria for selection, but not listened to, don't know how to proceed • Give feedback, mention in reports, but never hear back, "if rationale for something, just explain…"
6. Approach	• Attempted to suggest different ideas that didn't match apparent desired outcomes, had to revise • Proactive in pursuing, then shot down by USAID/M because needed approval • Feel too ad hoc, not strategic enough	• Proactive, gone door-to-door to recruit and get people involved • Use SMS to maintain contact and follow up once sessions are done • Likes mixed approaches, but feels sometimes hard to do all or use all properly

AREA 4: ORGANIZATIONAL OUTCOMES

Area 4: Organizational Outcomes		
Dimensions	***Source: USAID DC***	***Source: USAID Country***
1. Ongoing Assessment	• Feels communication lacking—be open and honest • Need to be proactive when have challenge, not wait, share, discuss possibilities • Meet regularly to share, but feel don't share all, especially senior management • Some units (HIV) very good sharing • Standing weekly call • Some staff very communicative, others provide no update	• Don't meet regularly, but feel sufficiently informed • Don't feel examine the past to get a sense of what people are thinking • Uneven communication with MOH, needs to be strong and steady • Feels "dial" not moved yet because of link to behavior, want to see it move • Little or no feedback on how state-levels are improving from state or HC3 • Lots of meetings, lots of discussions
2. Milestones, Benchmarks, Indicators	• Too heavy on process, need more behavioral outcomes • Still accountable for showing results, regardless mandate, depending on buy-in • Unclear how will measure global-level work • Don't seem to understand how to be responsive to program outputs • Data that measures Ebola success is questionable, needs to be reexamined	• Able to switch around IRs to include new priorities • Insufficient identification of behavioral outcomes, indicators • No behavioral or CS integration indicators yet • No clear evidence that may be behaviorally successful or sharing of previous successes • Feel HC3 has the capacity to move indicators forward and suggest something new and different, but haven't seen it yet • Need to identify strategic SBCC indicators and incorporate into Mission strategy
3. Link to Knowledge Capture	• Telling of story is weak and unfocused • Focus on lessons learned and be more explicit what want next time • Collection and use of Ebola data fed directly back in to program work	• Significant delays to research activities impacts on learning and strategy development • Much of what they do is too academic, not user friendly • Stick to core content, not be overly academic • Not yet demonstrated direct links between their M&E and knowledge leading to behavior and how integration works • Unclear how to use data to determine focus
4. M&E Plan	• Too much process, not enough results • Theory-driven BCC should be highly measurable, but not evident on PMP • Pulling together an Ebola M&E plan now	• Written in SOW, but not done yet • Pushed to capture PEPFAR indicators and struggling how to capture • Mechanisms unclear • Helped developed one results framework for all—reduced duplication, was proactive • Reinforce HC3's capacity in M&E, get HQ to focus as well on behavioral outcomes

Ebola Success Factors:
Rapid, JHU by-passed normal process, pulled in new people, didn't follow traditional budgeting process, clear mandate, and clear deliverables.

Area 4: Organizational Outcomes			
Dimensions	***Source: HC3 Headquarters***	***Source: HC3 Country***	***Source: Project Partners***
1. Ongoing Assessment	• Encouraging buy-in and ownership at the country-level • Pretested breastfeeding I-Kit with FBOs in webinar • Pretested Commodities I-Kit in Uganda • Heard I-Kits well-received but have to get buy-in in country to get disseminated • Participatory assessments are essential to buy-in • Much pretesting done as part of first use, no indication of changes made afterwards • Need to do more outreach	• Regular meetings to look at direction and needed improvements • Gather but don't feedback to clients/partners	• Share progress through monthly/weekly meetings and reports • Acts as if only USAID client to please (1 unit) • Lots of market research ongoing to see what people want • Springboard could be perfect "promotion and feedback mechanism" • Information doesn't flow up sufficiently (client-country-Headquarters)
2. Milestones, Benchmarks, Indicators	• Determine how to measure CS and CB • No clear way to track CS • Need more guidance on integration across (PMI) "to measure attitudes and beliefs…" • Hard to capture behavior change, didn't appreciate that tension • Though project has changed, IRs haven't • Search for "change metric" is challenge, looking for common denominators • Refine an existing metric to measure CS	• Not representative • Doesn't reflect actual audience needs • Clear indicators in place to track	• Use progress report to improve next phase • No client satisfaction indicators • Results framework presented late, hard to fit into after the fact
3. Link to Knowledge Capture	• Greater visibility is happening • Peer reviewed evidence is vital to PEPFAR • Case studies to come off use of commodities I-Kit • Not enough evidence out there, "but feel good and optimistic…" • To celebrate bigger picture, need to get the story out there • HealthCOMpass is a 'one-stop' shop for knowledge capture • "Creating groundswell of evidence- and theory-based SBCC, raising the profile…" • More effective data mining is needed and needs to be actively used in countries • Retroactively do case study on Ebola to identify successes and replicability	• SMS feedback and follow up to ensure knowledge • Use own research to increase knowledge others • Feed information back in	• Some Implementation kits have very well captured and shared • HealthCOMpass bringing it all together • Needs to encourage more consistent feedback on process and outcomes • Good job documenting processes • Webinars are very good resource well-attended • Ebola—SMS, webinars, etc. fed back immediately and made a difference

Area 4: Organizational Outcomes			
Dimensions	***Source: HC3 Headquarters***	***Source: HC3 Country***	***Source: Project Partners***
4. M&E Plan	• No evaluation of breastfeeding or commodities I-Kits • Once CS tools downloaded, people lost, not sure how to move beyond • Did research concurrently while developing materials • Have made progress • Evolving, doesn't necessarily map on to country progress or serve CS mandate	• No clear application of results beyond filling in the forms • Insufficient research to prove value of SBCC • No self-evaluation • Plans in place with clear indicators	• Clear monitoring plan • Must validate what has been found, insufficient at present • Several six month to one year plans in place for improvement

Area 4: Organizational Outcomes		
Dimensions	***Source: Implementing Partners***	***Source: Local Country Partners—NGO, Government, Beneficiaries***
1. Ongoing Assessment	• Regular meetings and discussions • Always available to listen and help • Share input from other with them • Online conversations with users regular and solid	• Most have monthly or quarterly meetings • 1 consultant engages participants months after to posttest on reported changes • No immediate ending feedback sessions • Don't do enough to evaluate the impact of sessions on lives • Tools need to be more user friendly • Easy/clear accessible channels • Needs for improved feedback mechanisms—not sure when, where, how • Need more low-literate materials • No set review process of progress (except for MSH tool) • Some debrief and discuss regularly when staff comes • Always involve chiefs in initial, interim and outputs discussions • Sometimes HC3 "forgets" to invite or involve partners • One said "HC3 always gives lots of feedback and asks lots of questions"
2. Milestones, Benchmarks, Indicators	• Nothing cited	• Talk a lot about knowledge • Work with consultant, provide information, but have "no input into indicators, have ideas…" • Net use perceived to be high • Pre/posttests only seem to look at knowledge levels, "but we do so much more…" • Working with national level to estimate and understand indicators for all to follow
3. Link to Knowledge Capture	• See no link, not sure how to link • Put on Springboard for others to learn • Work information from every session back into the next session	• HealthCOMpass has successfully offered an "interactive platform" to share SBCC tools • Should build on existing rather than always starting other • Who reviews validity of information passed? • Outputs sometimes "shallow and superficial" not deep enough to have impact • Evidence-based findings still lacking "need it to ensure SBCC funding…"

Area 4: Organizational Outcomes		
Dimensions	***Source: Implementing Partners***	***Source: Local Country Partners—NGO, Government, Beneficiaries***
4. M&E Plan	• Wants to know what doing with all of the information • Need help on how to apply what is learned	• Reviewed and discussed plan once it was in place, very clear • Unclear goals and outcomes for process, need to have this clear • Pre/posttests are cumbersome and difficult for most and only show knowledge • Very hard to track indicators, most don't like to write and record • Collection process sometimes allows for double counting because of the way it is organized, needs to be fixed • A M&E system of collection can be burdensome when so few staff, how can it be simplified

QUALITATIVE SYNTHESIS—SOCIAL AND BEHAVIOR CHANGE COMMUNICATION

Social and Behavior Change Communication			
Evidence and theory use in planning and design	Strategy development	Intervention and materials development processes	Implementation and monitoring
• Situation analysis • Use of theories, models • Use of research data • Contextualization of activities, including coordination with other public and private efforts	• Communication strategy • Audience segmentation and insight • Communication objectives and channels • Ecological assumptions and approach • Strategic approach	• Communication strategy used to develop interventions, materials • Review by technical staff and stakeholders • Audience pretesting and feedback	• Work planning and budgeting • Staffing and competencies • Supervision systems of field staff and activities • Monitoring systems/tools and data use

Component 1: Evidence and theory use in planning and design			
Dimensions	***Source: USAID Headquarters***	***Source: USAID Missions***	***Source: HC3 Headquarters***
Situation analysis	Nothing cited	• Message consistency analysis very extensive and well appreciated (GT)	• Consistency analysis reviewed materials in Guatemala to help partners identify problems with messages • Situation analysis focused on existing SBCC programs in Guatemala
Use of theories and models	• Experts in theory but getting them to link it to programming requires a lot of pushing	• HC3 offers two models but not very intuitive, as the SEF, and more academic and less audience focused • Would like to see blending of best of social marketing and SBCC, including analysis of competing behaviors/products/services • "Ability to act" isn't really addressed in HC3 approach	Nothing cited
Use of research data	Nothing cited	• Using formative assessments and using data to develop materials and messages (CDI) • Completing landscape study to look at mobile phone and social media platform use (GT) • Would like stronger formative research, especially around audience insight (GT)	• Will conduct a baseline in the coming months (NG) • Formative research work will supplement the work done by other projects, fill in the gaps that were identified during reviews (GT)
Contextualization of activities, including coordination with other public and private efforts	Nothing cited	• Would have liked them to build more on work previously completed under C-Change (GT) • Could engage community stakeholders better (CDI) • Link community programs with HTC and providers • Didn't try to build off what had been done before, just assumed that they were starting with nothing • Would be nice to see them find a strategy to better engage private-sector actors	• Promote referrals from community agents for pregnant women and feverish children, but no confirmation system yet in place (NG) • Lots of private sector involvement in Guatemala, USAID hopes HC3 can engage them effectively to access channels

Component 1: Evidence and theory use in planning and design			
Dimensions	***Source: HC3 Country***	***Source: HC3 Partners***	***Source: Country IPs***
Situation analysis	• Situation analysis used as basis for the development of the strategy documents for the project (NG) • Conducted review of all the materials that had been developed and a lit review of programs that were previously implemented (CDI)	Nothing cited	• Helped to recruit a consultant who completed the situation analysis for new communication strategy (CDI)
Use of theories and models	Nothing cited	Nothing cited	• Understand why models are important in SBCC programming
Use of research data	• National Communication Strategy revised was based on the DHS and other research that was done (qualitative) • Idea for BFL program was based on DHS found that age group of older men have higher HIV prevalence	Nothing cited	• Organized workshops to develop strategy, included use of evidence to make decisions (CDI) • With state malaria program, using data and situation analysis; also took into account political situation (NG)
Contextualization of activities, including coordination with other public and private efforts	• Activities are presented to local health facilities and linked to those facilities, especially to provide HIV testing services	Nothing cited	• Decided to plan around life events like market days, which already bring people together (NG) • Ownership of the program by the community, involved in the selection of the CVs (NG) •

Component 1: Evidence and theory use in planning and design		
Dimensions	***Source: Partners/Stakeholders***	***Source: Document review***
Situation analysis	• Key messages analysis, saw that it was positive but they didn't take into account all of the materials, like education and value chains (GT)	• Most strategy documents include situation analysis • Demonstrate discipline in applying analyses • Uneven application of theoretical framework to analyses
Use of theories and models	Nothing cited	• Strategies include discussion of theory and models • Application of SEF • Unclear extent to which theory applied to design in come cases
Use of research data	Nothing cited	• Uses mostly existing research from others and HC3 evaluations • Very little original research, especially around CCP Ideation model
Contextualization of activities, including coordination with other public and private efforts	Nothing cited	• Coordination of other programs taken into consideration • Attempt to include analysis of previous programs

Component 2: Strategy development			
Dimensions	***Source: USAID Headquarters***	***Source: USAID Missions***	***Source: HC3 Headquarters***
Communication strategy	Nothing cited	• Have been leading the national communication strategy revision • Don't seem to have a communication strategy for treatment activities, mostly just respond to requests	• Coordinating the design and implementation of a WHIP S/BCC strategy with those organizations (GT)
Audience segmentation and insight	Nothing cited	• Want to see more focus on audience insight (GT) • SuperGo! needs to be better segmented	• USAID wants communication to take into account the client's view, which is the family; more easily digestible and makes it easier for families to understand the message and make a decision (GT)
Communication objectives and channels	Nothing cited	• Identified need to work more with existing social structures (GT) • Advocating for more radio and mobile phone use (GT) • Proposed the SMS for treatment adherence program (CDI)	Nothing cited
Ecological assumptions and approach	Nothing cited	• Have a high-quality TV and radio series to complement community activities (CDI) • Want to see more advocacy at higher-levels so that they too support comprehensive, strong malaria programming	• Use multiple communication channels to achieve scale and amplify impact (IPC, State/National mass media) (NG) • Will lead some of the mass/radio work in the short-term to support community-level work (GT) • Helped to develop an advocacy plan
Strategic approach	• Seem to default to certain strategies/approaches • Want them to think analytically about what is needed rather than what they are most comfortable falling back on • Tends to be very academic and expensive	• Brought in the importance of using emotional messages (GT) • Reach is not high; how do you get high quality but also reach lots of people (CDI)	Nothing cited

Component 2: Strategy development			
Dimensions	***Source: HC3 Country***	***Source: HC3 Partners***	***Source: Country IPs***
Communication strategy	• Helped PMI to design a BCC strategy around same time that developing strategy for HC3's activities • Drafted communication strategy while waiting for national HIV strategy to be updated, decision was to harmonize afterwards (CDI)	Nothing cited	• Conducted workshop to develop a state-level communication strategy (NG)
Audience segmentation and insight	• Profile of girls targeted by SuperGo!: no longer in school, students, and never attended school • The time required for the activities, currently using four sessions that take 2.5 hours to complete (ten hours total), too much time to give for many participants (participants receive transport allowance for each session)	Nothing cited	• Difficult to recruit older participants since they have things going on (CDI) • Not enough men who meet the education requirement (CDI)
Communication objectives and channels	Nothing cited	Nothing cited	• Would suggest having one theme per session rather than multiple, especially since the link between messages isn't always clear (CDI)
Ecological assumptions and approach	• Community activities supported by mass media activities (NG) • How to get girls to adopt behaviors when they don't have control over the other issues that prevent them from adopting those behaviors (CDI)	Nothing cited	• Have encouraged CVs to act as conduit for communication between health providers and client (NG) • HC3 has already started with radio programs
Strategic approach	• Looking for a program that could be adapted, reached out to South Africa program (CDI)	Nothing cited	Nothing cited

Component 2: Strategy development		
Dimensions	***Source: Partners/Stakeholders***	***Source: Document review***
Communication strategy	• Helped and supported the development of the new ACSM guidelines (NG)	• No specific strategies for HC activities since national strategies serve as default strategies
Audience segmentation and insight	• Mass media programs are not always accessible to lower literate communities (NG) • Need to work in schools since girls can't easily participate (CDI)	• Very little audience segmentation beyond basic demographics, primarily age and gender • No audience insight used to inform program activities; some strategies include more insight than others but basis in evidence not clear
Communication objectives and channels	Nothing cited	• Lots of communication objectives, which means lots of messages • Not indication of why objectives/messages were selected • Channel selection not justified, most channels continued from previous programs • Cost-effectiveness does not seem to have been taken into account
Ecological assumptions and approach	• More work with health care providers to improve quality of services (NG) • Need to reach young men and parents, parents need to encourage girls not to go with old men (CDI)	• Strategies recognize many levels of intervention necessary • Most working at multiple levels to affect change
Strategic approach	• Some tools that we use have to be contextualized, not everything works in every region (GT) • Has brought in contextualized tools, which make them highly productive (NG)	• Attempts to tie activities together • Transmedia approach in Nigeria intended to tie mass and community activities together • Helping with audience linking by working under national or program brands

Component 3: Intervention and materials development processes			
Dimensions	***Source: USAID Headquarters***	***Source: USAID Missions***	***Source: HC3 Headquarters***
Communication strategy used to develop interventions, materials	Nothing cited	Nothing cited	• Provided support to updated ACSM guidelines based on updated malaria strategic plan
Review by technical staff and stakeholders	Nothing cited	• Follow a validation process for materials that they develop (CDI) • CCP holds the copyright for materials they help develop, which means that other partners cannot print them without passing through CCP	Nothing cited
Audience pretesting and feedback	Nothing cited	• Materials are pre-tested (CDI)	• Pretested the guide at the state-level where they are working, Kebbi and Akwa Ibom

Component 3: Intervention and materials development processes			
Dimensions	***Source: HC3 Country***	***Source: HC3 Partners***	***Source: Country IPs***
Communication strategy used to develop interventions, materials	• Existing tools are also in line with new strategy since they were developed based on DHS (CDI)	Nothing cited	• Participants asks for certificates at the end of the sessions (CDI)
Review by technical staff and stakeholders	• All materials and tools are designed under supervision of the PNLS (CDI) • Working with ACSM to build capacity while also producing the materials and tools (NG)	Nothing cited	• Participated in the development of the materials development; corrections that were needed were usually around local language (NG) • Provided feedback on the tools they used in the pilot phase (CDI)
Audience pretesting and feedback	• Conducted a small pilot to see if the adaption was good (CDI)	Nothing cited	Nothing cited

Component 3: Intervention and materials development processes		
Dimensions	***Source: Partners/Stakeholders***	***Source: Document review***
Communication strategy used to develop interventions, materials	Nothing cited	• Most models continued from previous programs or adapted from other countries
Review by technical staff and stakeholders	• HC3 worked with the ACSM to make adaptations (NG)	Nothing cited
Audience pretesting and feedback	Nothing cited	Nothing cited

Component 4: Implementation and monitoring			
Dimensions	***Source: USAID Headquarters***	***Source: USAID Missions***	***Source: HC3 Headquarters***
Work planning and budgeting	Nothing cited	Nothing cited	Nothing cited
Staffing and competencies	Nothing cited	Nothing cited	Nothing cited
Supervision systems of field staff and activities	Nothing cited	Nothing cited	Nothing cited
Monitoring systems/tools and data use	• Developing core indicators to assess quality and impact of the KP work, tools will be used by all partners	• Could do better on the evaluation of activities, not just looking at attitudes but also looking at actual behavior change (CDI) • Have been asking them to look more at behavioral outcomes not just cognitive and knowledge changes • Would like to see HC3/Baltimore provide more support on measurement and leveraging on other donors and projects (NG) • M&E in their scope of work but they haven't done anything on this front (GT) • Not sure how much evidence they have of impact, currently using linkages to measure success	Nothing cited

Component 4: Implementation and monitoring			
Dimensions	***Source: HC3 Country***	***Source: HC3 Partners***	***Source: Country IPs***
Work planning and budgeting	Nothing cited	Nothing cited	• No funding provided to support mobilization and organization activities (CDI)
Staffing and competencies	• Training of those who will implement the program (usually one training per year) (CDI)	Nothing cited	• HC3 state-team provided training, basics of malaria and prevention/treatment actions to take; training on IPC and referral protocols (NG)
Supervision systems of field staff and activities	• CCP staff are also involved in the supervision of field activities • Supervisors are trained; have regular meetings with these supervisors to share what they're having problems with	Nothing cited	• Constant supervision at the grassroots (NG) • Really appreciate supervisors since they provide continuous support and coaching (CDI)
Monitoring systems/tools and data use	• Quarterly monitoring meetings that bring together the various local NGOs to help them exchange lessons and providing some coaching support (CDI)	Nothing cited	• Send data every two weeks with a summary report each month, receive feedback from HC3 (CDI) • Data collection and entry assistance, figured out how to do it quickly; provided with templates that help to summarized data quickly (NG)

Component 4: Implementation and monitoring		
Dimensions	***Source: Partners/Stakeholders***	***Source: Document review***
Work planning and budgeting	• Need to align state-level activities with national ACSM work plan	Nothing cited
Staffing and competencies	• Not enough community volunteers to cover the entire ward, need more (NG)	Nothing cited
Supervision systems of field staff and activities	• Need to involve national ACSM in state-level implementation activities, national body has not been involved in current activities (NG)	Nothing cited
Monitoring systems/tools and data use	• Need an impact evaluation of activities (NG)	• Clear processes for M&E systems • Tools collect required indicators • Evaluations tend to focus on knowledge and attitude change

Other Global Findings			
Dimensions	***Source: USAID Headquarters***	***Source: USAID Missions***	***Source: HC3 Headquarters***
Technical Leadership	• Majority felt that HC3 is viewed as a technical leader • Appreciation within USAID for the technical skills they offer • Have helped to promote best practices through global forums • Hear from others that they are respected by partners • Not always consistent in their technical quality	• Majority reported that leadership at national-level was especially appreciated and seen as important value-add • Other partners, especially non-SBCC, rely on them for technical support • Can sometime overcomplicate SBCC technical issues, which makes their support less accessible	• Invited into international working groups to provide SBCC technical guidance • Brought into Nigeria to provide technical leadership on SBCC
Innovation	• Do not view innovation as their role, role of the TRANSFORM project • On capacity development, have demonstrated some innovation • Tend to fall back on "tried-and-true" approaches over experimenting with new • Tend to require lots of USAID pushing to approach things differently • A bit outside the mainstream, not generating a lot of new ideas	• Have introduced SMS in Côte d'Ivoire programs • Not as innovative as would have liked or expected	• Springboard is an innovative way to build a CoP • Capacity building work has had to be innovative since limited funds available
Technical Resources	• iKits have tested very well but are still untested • Health COMpass a very good curated source of SBCC tools and materials • No sense of how well various tools produced by HC3 are contributing to programs, how they are used • Have struggled to take tools out of the SBCC language and make them accessible to non-SBCC technicians, like youth organizations and providers	• Not aware of the global tools produced by HC3 • Uncertainty of how useful these tools will be for local partners	• Lots of interest in the how-to guides • Have spent lots of time producing, now need to focus on getting them into the hands of those who could benefit from them • Many tools developed without much formative research, based mostly on field experiences of staff • Have not had a chance to evaluate the effectiveness of the tools produced

Other Global Findings			
Dimensions	***Source: HC3 Country***	***Source: HC3 Partners***	***Source: Country IPs***
Technical Leadership	• Helped PMI to design a BCC strategy around the same time that developed strategy for HC3's activities • Used to receive lots of requests, now helping with more strategic things rather than basics	• Innovation webinar series has much more attendance largely because HC3 is being viewed as a technical leader • CCP it brings some integrity, they have a solid reputation in SBCC	Nothing cited
Innovation	Nothing cited	• Using social media and SMS like everyone else does	Nothing cited
Technical Resources	• Have seen people struggle to navigate the tools that are available • HealthCOMpass has been exciting, use it when looking for examples • Have used resources from HC3 website, examples of materials that were developed under other projects • HealthCOMpass is helpful but since it is in English it makes it difficult to access	• Not sure how many grassroots organizations are part of the dissemination • Really like the Health COMpass, it is a great clearinghouse of tools and resources that are out there • Webinars have been very good, especially those that bring in people outside the SBCC field, ex. human-centered design	Nothing cited

Other Global Findings	
Dimensions	***Source: Partners/Stakeholders***
Technical Leadership	• Great technical assistance, very responsive; when we call them they come (NG) • Provided some recommendations to existing strategies (GT) • Have been asked to help with national strategic documents and development of communication materials
Innovation	• Introduced a process that demonstrates the importance of using the situation analysis to make sure programs are research-based (CDI)
Technical Resources	• The electronic platforms but even if we have the information, it has been hard because not everyone has been exposed at the same level (GT)

NOTES FROM OBSERVATION OF COMMUNITY DIALOGUES—NIGERIA

Activity	Community dialogue with men
Date	5 August 2015
Location	Gorin Dikko Community, Arewa LGA, Kebbi State, Nigeria
Implementing partner	Royal Impact Health Care Society

- Approximately 70-100 men present
- Very diverse audience with ages ranging from young children to old men
- Facilitator is a trained male from Royal
- Tools used:
  - Large posters displayed in one location, highlighting how to mount an ITN; facilitator did not refer to the poster during the session
  - Standard flipchart; very limited use by the facilitator who referred to it occasionally when posing questions
  - Pamphlets
- Messages disseminated by facilitator:
  - Benefits of ITN use
  - Signs of malaria
  - Myths about how malaria is transmitted and treated
  - Correct treatment of malaria
  - Importance of removing trash and standing water from environment
  - New drug regimen available in pharmacies
  - Cost/benefit of using an ITN over mosquito coils
- Other topics introduced through questions posed by attendees:
  - Indoor spraying

Note: simultaneously a women's group was being conducted with an equal number of women.

Activity	Community dialogue with men
Date	6 August 2015
Location	Lailaba Community, Argungu LGA, Kebbi State, Nigeria
Implementing partner	Royal Impact Health Care Society

- Approximately 70-80 men
- Very diverse audience with ages ranging from young children to old men
- Facilitator is a trained male from Royal
- Tools used:
  - Large posters displayed at the entrance to the location; no real use of this tool since it was in a separate space (could have been placed here because of the evaluation team's visit)

  - Standard flipchart; very limited use by the facilitator who referred to it occasionally when posing questions
  - Pamphlets
- Messages disseminated by facilitator:
  - How malaria is transmitted
  - Symptoms of malaria
  - Importance of treatment
  - Instructions for using ACT
  - Traditional medicines and malaria
  - Who is at highest risk of malaria
  - Pregnancy and malaria (effects on unborn child)
  - Myths about how malaria is transmitted
- Other topics introduced through questions posed by attendees:
  - Sleeping under ITN to prevent malaria
  - Keeping environment clean
  - Using ITN to socialize
  - Using insecticides
  - Net distribution, how to get them (free distribution or sale)

Note: simultaneously a women's group was being conducted with an equal number of women.

Activity	Community dialogue
Date	8 August 2015
Location	Ikpa Ibom ward 3, Mkpat Enin LGA, Awa Igbo State, Nigeria
Implementing partner	Community Partners for Development

- Approximately 100-125 participants
- Mixed gender and diverse ages, from young children to older men and women
- Trained facilitator from CPD
- Tools used:
  - Large poster with use, care, and repair images
  - Pamphlets and stickers
  - ITN
- Messages disseminated by facilitator:
  - How to hang and use ITN
  - Benefits of ITN use
  - How to care, wash, and repair ITN

  - Malaria and pregnancy
  - Benefits of ANC
  - Partner support for ANC
  - How malaria is transmitted
  - Symptoms of malaria
  - Testing and treatment for malaria
- Other topics introduced through questions posed by attendees:
  - Importance of airing ITN for 24 hours before use
  - Importance of keeping ITN out of the sun
  - Name of medicine
- Session also include a drama presentation that involves a couple that is visited by a community volunteer who convinces them to go to ANC, based on malaria messaging

Overall thoughts:

- Too many messages presented in a very limited timeframe, messaging are very disjointed and are not targeted at all
- Audience is too diverse and large to provide strategic messages; having such a diverse audience (both in terms of age and life stage) lends itself to knowledge-only messaging, nothing emotional in any of the messages
- Very limited "dialogue" since the group is so large (the large size could have been a result of the evaluation team's presence, which local communities and partners often think is an opportunity to increase turnout)
- Tools are very passive and seemingly ineffectual, limited use by facilitator
- If the purpose of the community-level work is to make men supportive of their wives health care decisions (i.e. using an ITN and going for treatment and prophylaxis), why not focus messaging on this action?

Notes from observation of house visits—Nigeria

Activity	House visit with a man
Date	5 August 2015
Location	Gorin Dikko Community, Arewa LGA, Kebbi State, Nigeria
Implementing partner	Royal Impact Health Care Society

- House visit with father of seven children (wife was also being reached by a female community volunteer)
- Male community volunteer trained by HC3 and supervised by Royal
- Tools used:
  - Standard flipchart, which the volunteer used heavily
  - Pamphlets
- Messages disseminated by volunteer:
  - Nearly all the messages contained in the flipchart were covered—from ITN use to the importance of ANC visits
  - Very limited tailoring of messages, only a few questions posed to the participant but nothing that would allow for more effective tailoring of messages

Activity	House visit with a man
Date	9 August 2015
Location	Ika LGA, Awa Ibom State, Nigeria
Implementing partner	CPD

- House visit with father and his one son (has three other children but they were not present)
- Female community volunteer trained by HC3 and supervised by CPD
- Second home visit to this household
- Tools used:
  - Standard flipchart, which the volunteer used heavily; very little correct use, referring to images that did not correspond to the messaging
  - Pamphlets
  - Referral form; very little explanation of why the referral was being made and what the person could expect when arriving at the health center
- Messages disseminated by volunteer:
  - Nearly all the messages contained in the flipchart were covered—from ITN use to the importance of ANC visits
  - No tailoring of messages, very few questions asked beyond those in the screening form, seemingly no tailoring of messages

Notes from observation of SuperGo! activities—Côte d'Ivoire

Activity	SuperGo activity
Date	14 August 2015
Location	Abidjan, Côte d'Ivoire
Implementing partner	GBH

- Approximately 25 participants, 4 with children
- Lots of energy, very upbeat facilitators
- Two facilitators trained by HC3 and supervised by HC3 consultants and GBH
- Tools used:
  - Facilitator's guide, very heavy use by the facilitators, some skipping around but otherwise very good use of the guide
  - Video presentation, served as a trigger for the actual discussion
  - Flipchart paper with session objectives posted around the room, along with group norms
- Messages disseminated by facilitator:
  - Covered all the messages include in the actual session guide

Activity	SuperGo activity
Date	14 August 2015
Location	Abidjan, Côte d'Ivoire
Implementing partner	Messi

- Approximately 28 participants
- Lots of energy, very upbeat facilitators
- Two facilitators trained by HC3 and supervised by HC3 consultants and GBH
- Tools used:
  - Facilitator's guide, very heavy use by the facilitators, some skipping around but otherwise very good use of the guide
  - Photo novel, used at the end to reinforce the message
  - Video presentation, served as a trigger for the actual discussion
  - Flipchart paper with session objectives posted around the room, along with group norms
- Messages disseminated by facilitator:
  - Discussion on fulfilling individual dreams
  - Family planning
  - Trust between couples (as trigger for question on fidelity)
  - Resisting pressure to have sex early
  - HIV testing (advantages, where to find in community, process, experience, how to react to positive results)
  - HIV treatment
  - Condom use (with demonstration)

Overall thoughts:

- Too many messages presented in a very limited timeframe, messaging are very disjointed and are not targeted at all
- TV spots used as trigger are very confusing, lots of mixed messages and some that seem to want to create mis-trust in couples rather than focusing on actual behaviors to promote; also, actors in the spots look nothing like the participants sitting in the room (rich/urban/older vs. poor/young)
- No real conclusions are drawn from discussions, how do participants process all this information and walk away with key calls to action?
- Messaging about fidelity is really confusing, seems to focus on creating mistrust as a way to encourage women to use condoms; but the message of fidelity still comes out at the end

NOTES FROM OBSERVATION OF BROTHERS FOR LIFE ACTIVITIES—CÔTE D'IVOIRE

Activity	Brothers for Life
Date	15 August 2015
Location	Abengourou, Côte d'Ivoire
Implementing partner	Universe Santé

- Module two, which focuses on sexual and reproductive health, family planning, and PMTCT
- Approximately 19 men in the room, aged from 25 to 40s, mix of those with and those without children
- Tools used:
  - Facilitator's guide; which is used heavily by the two facilitators
  - Flipcharts with session objectives, groups norms posted around the room
  - Posters with male and female reproductive system, cut-away graphics with labels
- Messages disseminated by volunteer:
  - Nearly all the messages contained in the guide were covered
- Participants separated into groups and asked to draw and label reproductive systems

Activity	Brothers for Life
Date	17 August 2015
Location	Abidjan, Côte d'Ivoire
Implementing partner	OASIS

- About 27 participants, ranging in age and life stage
- Seems very formal, maybe the ages present require such formality?
- First meeting of the group so they is a very dry process of selecting a group name and explaining the goals of the program
- Tools used:
  - Facilitator's guide; which is used heavily by the facilitator
  - Flipcharts with session objectives, groups norms posted around the room
- They seem to be trying really hard to keep people awake and interested, otherwise a very boring session and only a few participants seem to be interested
- The facilitators are really playing up the HIV angle of the program, rather than overall health, as the program as designed, is this because we're in the room?
- Women present in the room, as supervisors, and the facilitator telling men to ignore the women and treat them like men; if men aren't comfortable with women in the room, why have women supervisors?

Overall thoughts:

- Sessions are way too long and contain too many messages
- The mix of men in different life stages (some married, some not; some with kids, some without) lends itself to knowledge-based messaging
- The size of the group means that the facilitators talk more than anyone else; these sessions feel like trainings rather than opportunities for men to come together and discuss their issues
- Level of detail on some activities (i.e. sexual organs) is really deep while on other sections not deep enough; what exactly are they asking these men to do
- If the purpose of the program is to get men to know their HIV status, then why are they taking time as well to discuss FP; the ultimate goal of these activities seems to be lost under a lot of extra messages that are nice but add to the confusion and may not contribute to the adoption of the actual behavior of interest

QUALITATIVE SYNTHESIS - INFORMATION AND COMMUNICATIONS TECHNOLOGY

Information and Communications Technology				
Usage	**Integration**	**Access/Demand**	**Feedback**	**Sustainability**
• Who is using—Identified Users and/or Others • How are they using • Why are they using • Linkage to broader CS mandate	• Across tools • Between tools and programs	• How access - patters • Access issues—location, literacy, other factors • Demand generation • Engagement model	• Feedback cycle for iteration • Alignment of emerging needs and new requirements	• Resources • beyond project life • Commitment

HealthCOMpass, Implementation Kits (I-Kits), and other Online/virtual Resources		
ICT Model	**USAID DC**	**USAID Missions**
Usage (for Capacity Strengthening)	• I-Kits are good because they have illustrative examples. They are an innovative approach to providing global capacity building support. They do a deep focus on specific areas. For example, they produced an I-Kit on underutilized commodities in partnership with the UN Commission., with the result that it is to date the most widely used I-Kit. The goal is by getting these resources into the right hands, partners would not need additional Technical assistance. • I-Kits. The intended users of I-Kits are in country implementers who are not SBCC specialists, as well as the SBCC specialists in country. This includes Ministry of Health partners as well as local partners, many of whom are not well versed in SBCC nor have local technical access to support in SBCC. • At face value, it seems that most users of HealthCOMpass find it relatively easy to use. When USAID Washington fields requests from Missions, they find it useful to sourcing materials for Mission technical requests. HealthCOMpass is useful as it is hard to get DC/Missions to find and use technical resources, tailored to their needs. It is important to have curated resource, since it is not enough just to have a library of tools, since won't always lead to being applied.	• Not sure, Unaware of the specific tools, but don't see how electronic toolkit, springboard are impacting this country. Not a lot of resources towards them. • HC3 tools are not really used in direct implementation in country. Could be useful to serve as a CoP in country.
Integration (for capacity building)	• I-Kits seem very long and a little complicated (the How To Guides seem more targeted). A counter example is the Youth Toolkit, where CCP partnered with PSI—the resulting I-Kit was great in process and fast in delivery. Finally, not sure how these are being used in country. Are they being disseminated, integrated into on the ground programming? • Where HealthCOMpass and springboard become useful is when they are able to get these resources out so people understand how to use them and implement them in their programs	

HealthCOMpass, Implementation Kits (I-Kits), and other Online/virtual Resources		
ICT Model	**USAID DC**	**USAID Missions**
Access/Demand	• The challenges for HealthCOMpass (and some of the materials on HealthCOMpass) is that sometimes the materials are too technical for non SBCC users. Same issue as I-Kits—how is HealthCOMpass being used on the ground, especially in countries where there is on the ground implementation? • Cannot speak to how users are using tools, but know how HC3 is promoting use. UN Commodities heavily promoted, through K4Health, in the east Africa. • Tested UN commission toolkit in Uganda with the Ministry of Health and local partners, and it was very well received. The users were really excited about resources. I-Kit was designed by UN Commission with a lot of dissemination built in for this capacity building tool. I-Kit walks you thru all steps, including key messages about context/local adaptation and includes illustrative adaptable content. The project shared it widely and reached out to technical resource teams. This digital resource is available online and via flash drive. • Is there duplication between HealthCOMpass and communication initiative (CI) (communication for development)? Are HealthCOMpass/communication initiative different enough to warrant funding both? HC3 platforms provided digestible alterative to CI. CI—end deliverable, thousands of materials, varying quality. HealthCOMpass is more curated, with the intention that users are not BCC experts, many with low connectivity. HealthCOMpass is meant to be more interactive/walk people through key tasks.	• More people from France than from Mission countries accessing materials.
Feedback	• The challenges with the I-Kits and other content include: they take a very long time to produce. There seems to be a lot of iterations needed with USAID involvement (more than anticipated) to get the I-Kits right; sometimes the quality of the writing is not adequate. • Biggest complaint is that it is really long. Suggestions for improvements on I-Kits: document evidence of best practices in creating implementation kits, especially across technical areas, and pull together collections of evidence to make I-Kits stronger. There are lots of SBCC of approaches that are cross cutting and can apply to multiple kits. It feels like HC3 is not building on momentum from one I-Kit to improve/create others.	Nothing cited
Sustainability	Nothing cited	Nothing cited

HealthCOMpass, Implementation Kits (I-Kits), and other Online/virtual Resources		
ICT Model	**HC3 HQ**	**HC3 Country**
Usage (for capacity strengthening)	• Impressed with how well the project internalized role of technology in what we do. Took time to emerge, great team, and great processes in place. Being strategic in the use of technology to increase impact. A, DI/TA, C • Sitting in field, most people do not have background inn SBCC so the How to kits are very helpful, the focus is on ease and clarity of the tool. • Health Compass—library & learning site, with a mix of resources from CHUB and other places. Lots of different types of content. • Users are program managers who don't have SBCC experiences (not the CCP or PSIs) or Professionals at MOH offices, INGOs or local who don't have a lot of SBCC experience. May be the SBCC person sitting in local organization (not necessarily CBO, not beneficiaries). SBCC professionals are looking for specific tools/resources—one stop shop for resources. The How to guides are for people with zero background in SBCC, give you cliff notes of how to do core elements of SBCC. Use in training and workshops. • I-Kits—more for advanced users. How I can improve from before. Offers the structure required for full implementation. Digital tools offer greater interactivity and reinforcement of other channels—glue across/synergies across media. They also offer monitoring and ability access data for formative work. Broader application that can be reused. HealthCOMpass –Spotlights—not just hypothetical, concrete, real life example. VLDP—mixed reviews—inflection points on learning by doing will be really important. • Who is springboard for? The same as the I-Kits—MOH, communication or technical area, health departments, local and INGOs. • Health compass is a set of resources—organized, vetted/curated, and tailored to users—supporting a system. • Using content such as webinars to provide SBCC resources to the broader Health Community. • Housing the Roll Back Malaria resources when they lost their funding	• HealthCOMpass, I-Kits, webinars are all very useful. HealthCOMpass is where you go to get tools, webinars are used for professional development experience, staff using the how to guides. Documents on HealthCOMpass are vetted and curated, and users have high confidence in their quality. It is great for reuse—not reinvent the wheel but can be adapted to suit local needs. HealthCOMpass is a form of advocacy. • HealthCOMpass, especially the how-to guides, to find resources

HealthCOMpass, Implementation Kits (I-Kits), and other Online/virtual Resources		
ICT Model	**HC3 HQ**	**HC3 Country**
Integration (for capacity strengthening)	• Digital advisory group developed to make sure there was a broad representation of different interests/integration of ICTs into development goals. • Have beautiful tools to use and share. Helps a lot with Missions—convincing them of use for capacity building. Brings systematic organization, tools (I-Kit, springboard, HealthCOMpass). Helps bridge the gap. • Strategic health communication training—once people leave training venues—they need additional technical support (offered through Springboard), additional materials to develop (HealthCOMpass)—continuum of capacity building. • Health compass all the time—request from the field (CCP staff and other partners). • Trending topics, JAIDS journal supplement. • Ebola Communication Network was patterned off of HealthCOMpass. • Couldn't work to have one site as they have very different functions. There is deep integration between sites (pulling links and RSS feeds, trending topics, discussions about HealthCOMpass. 10% of referrals to HealthCOMpass are from SpringBoard. • Purpose of the digital tools is dissemination to promote evidence to action (via HealthCOMpass and springboard)	Nothing cited

HealthCOMpass, Implementation Kits (I-Kits), and other Online/virtual Resources		
ICT Model	**HC3 HQ**	**HC3 Country**
Access/Demand	• Now have platforms and tools in place—Springboard/health compass—invest that people know they are there. Vast network, lots of on the ground connections—need to use it to diffusion. • The more face to face opportunities (especially in country) to walk them through what is in Springboard and HealthCOMpass creates opportunity to focus and set aside time to poke around. • Don't go frequently, too much to do. • Health compass, Springboard—make it easier to find information. • Management team meetings—where people are accessing them and where. Lots of people from developing countries. Audiences include INGOs, but focus on capacity strengthening from the field. • Hosted webinars advertise through website and springboard. 100+ people, government staff, local NGOs, Partner organization field offices. Viewing parties. Very successful, keep gaining numbers. • I-Kits pulled together multiple cross cutting guides as core resources. • Digital tools offer technical assistance if people are unable to provide it. • HealthCOMpass is a good platform on SBCC KM/sharing information.	• Connectivity and need for regular presence (engagement model is different for Springboard than for HealthCOMpass—HealthCOMpass can come when you have the need, but springboard you need to check in regularly). • There are some documents in French but most are in English, which is a barrier to use for Francophones. HealthCOMpass is very good tool, but minimal content in French, which makes it difficult to attract Francophones as most resources are in English. There is only one webinar for francophone people. • HC3 relies a lot on technology, but in Africa, ICTs are too difficult. There is not a culture, people are not educated, and they don't have smart phones. Webinars are very interesting, but takes a long time to download. • HealthCOMpass—most people do not know what it is. More marketing and more branding needed. • The digital tools are attractive, very pretty, but not for us.
Feedback	• Idea—I-Kits. Developing an I-Kit builder—tool to allow people to build their own I-Kits. The idea was started in Capacity Strengthening area, and brought in K4Health toolkit development processes. Decided didn't need a kit builder, but rather have templates since only building 10 • HealthCOMpass—tested content from HealthCOMpass in country. • Pre-test with IPs—process to see how search on tools, work with task force, PSI male participation—focused on a tool found on HealthCOMpass – adapted, tested • Re-test with Local partners—selected simple cue card (built in Peru), tested and adapted • Using tools on HealthCOMpass and HC3 website via the partners	Nothing cited
Sustainability	Nothing cited	Nothing cited

HealthCOMpass, Implementation Kits (I-Kits), and other Online/virtual Resources	
ICT Model	**HC3 Project Partners—Non-SpringBoard**
Usage (for capacity strengthening)	• HealthCOMpass is serving the purpose of providing resources, how to kits, capacity how to do stuff, examples. Invaluable and great and recommend to our own staff. • Webinars—opens new technologies and approaches. But if you are in SBCC—methodologies and approaches are already set. People met at HC3 are very open to ideas and approaches. But partnership with internews is way outside standard BCC implementation. • Danger of project with big KM—set up once, and then done. But rather need feedback. HC3 does well, could do more to focus on feedback. • Health compass—people are looking for content, strategies, tools—adapt, not start from scratch. Before, not the one space where can find good strategies (e.g. strategies on malaria). Done very well. Resource done really well. Gets content from lots of resources. Case studies, webinars—very impactful and the case studies, very specific. Need to be better marketed. • Digital tools are good. Technical leader—adoption of digital technology faster than normal. No shyness in using digital technology. E-toolkit. Improve digital capacity. Provided support to MoH to build digital archive, provide input to develop their own resources, training. Maintain websites. By BCCP and partners.
Integration (for capacity strengthening)	• Really like HealthCOMpass—use it a ton and turned other people to it. Great warehouse and get good resources for field • Staff not recreating the wheel—go to HealthCOMpass to find tools to let them do it faster. Countries are most responsive health compass. • Making content more digestible and meaningful, pulling tools to make it easier to do. KM about utilizing the knowledge (better than just storage). Easily found, decision tree. Big thing, needs continual investment, constant feedback, new challenges, • HealthCOMpass—heard good things • HealthCOMpass—well regarded, good work how to organize knowledge base. • There is a lot there—too many places to go—differentiation is not clear (website vs. HealthCOMpass vs Springboard). Need to explain it and get mistaken.
Access/Demand	• I don't know the difference between an I-Kit and a how to guide. Too many tools/channels. What is the difference between an I-Kit and a How To Guide– too subtle? • Partner organized innovation webinar about three months ago that was very successful (100 attendees). Reflects on HC3's "brand" and draws people because HC3 is an authority. Topics: 9 innovation webinars with trending topics in SBCC—behavioral economics, innovative research methodologies, digital storytelling techniques, gender approaches to SBCC. Innovative trending topics. • Johns Hopkins is a global leader in SBCC and we don't see any other organization of that stature. We borrow from others, but most of the technical things come from CCP/Johns Hopkins. • Three different websites for HC3 (Springboard, health compass, HC3 website) needs to be less confusion between them. The tools that are effective, evaluation of tools, are very helpful. • Partner uses local partners- but Partner staff would use the tools, but not share them with their local partners. Not much dissemination with local level, but focused on higher levels. The tools are not going further down without concerted effort to the grassroots organizations, which is a major gap that they have.

HealthCOMpass, Implementation Kits (I-Kits), and other Online/virtual Resources	
ICT Model	**HC3 Project Partners—Non-SpringBoard**
Feedback	Creation of content is very process heavy. For example, partner wrote two How To Guides, submitted 2 years ago. Today got an email from USAID that they would be turned into I-Kits. Not a lot of clear direction from HC3, and lots of changes throughout process. Too many examples, not enough examples, template too confining. Cutting things that are important. Channel issues (short, digestible), asked about links to additional resource? Maybe this isn't the medium—maybe the topic needs to not be presented online. I-Kits for utility for the field—medium put forward—too restrictive. Disappointed with existing ones. Not as good as it could be because cut out so much content. No way to represent otherwise in the format.
Sustainability	Nothing cited

HealthCOMpass, Implementation Kits (I-Kits), and other Online/virtual Resources		
ICT Model	**Country Implementing Partners - CCPN, BCCP, AfriComNet**	**Local Country Partners/Players**
Usage (for capacity strengthening)	• When I was studying my MPH, I picked up a lot of Malaria resources on HealthCOMpass. I sometimes refer people to HealthCOMpass to find resources.	• Responses varied based on who the partner is. ACSM Abuja and its members of the ACSM working group were familiar with the HC3 tools. However, all other partners interviewed had no or minimal knowledge of these tools, and those who had heard of them had not visited or used them. • Core users (CBO partners, local implementers) are not being served because they don't know about it.
Integration (for capacity strengthening)	• Springboard is an evolving initiative but is still too separate from content. It is now pulling in content (HealthCOMpass, library (PMI)—start to use in group discussions.	• **HealthCOMpass** has helped to build the capacity of the ACSM subcommittee members in having current practices in and around the country and internationally. It has also increased members ability to measure behavioral change among target group, i.e. monitoring, supportive supervision, etc. • **IMPLEMENTATION KITS** offer step by step guide to help develop appropriate implementation strategies especially context specific on values, sociocultural beliefs etc. • Examples of some implementation kits are: • (1) The radio content (2) Content design tools (3) National ACSM guideline (4) Social mobilization manual

HealthCOMpass, Implementation Kits (I-Kits), and other Online/virtual Resources		
ICT Model	**Country Implementing Partners - CCPN, BCCP, AfriComNet**	**Local Country Partners/Players**
Access/Demand	• Digital tools are good. HC3 is a technical leader in the adoption of digital technology faster than normal. HC3 has no shyness in using digital technology, such as E-toolkits to Improve digital capacity. We have provided support to MoH to build digital archive, provide input to develop their own resources, training and maintain websites. • We have not lost sight of field workers, piloting two years ago an E-toolkit. Three hundred netbooks for field workers was given to other field workers (NGOs) in the form of an application in android and offline. Target users are Government, NGOs field workers who are capable of using devices (tablets, netbook, phone), and who have download capacity.	• All those interviewed had experience with digital materials and online research. All had internet access of some level. Many had primary internet access via MIFI/Dongles or their phones. Some had participated in online learning • There seemed to be a real desire for more connection between programs and between programs and HQ. There seemed to be a hunger for materials and support, and a familiarity that tools existed on the internet, but they didn't know about them. All organizations had at least one person who had high levels of experience with ICTs and online learning. There was a strong sense that digital literacy was highly important for capacity building and resource mobilization within the CBOs. • When asked about their knowledge of HealthCOMpass and Springboard, all those interviewed asked for links and were excited to get involved. (CCPN Abuja has since send contacts to all those interviewed).
Feedback	Nothing cited	Nothing cited
Sustainability	Nothing cited	Challenges expressed by these audiences included: cost and sporadic nature of connectivity (there was at a minimum cell/edge connectivity in the cities where the local partners were based); lack of familiarity with digital tools/digital literacy (not universal); and a concern for a lack of time to access tools.

Springboard Community of Practice(s) (COP)		
ICT Model	**USAID DC**	**USAID Missions**
Usage (for capacity strengthening) WHO is using it for what purpose	• The approach used is a physical convening and then continue discussions online. • With a fast moving program like PMI it is difficult to measure the impact of those springboard exchanges, may be more beneficial to programs such as diarrhea and MNCH. • Springboard is a venue for practitioners to learn from other practitioners to get real time, tailored feedback, and advance and grow field through peer support. HC3 would serve neutral convening role of BCC experts, by providing space for country based practitioners, offering them broader range of perspectives nationally and globally. There are not a lot of well-trained people who do BCC work, so supporting those who do BCC work is critical. The targeted users should be country level implementers & ministries, most who are not well versed in BCC, as well as those who support them. There is also the goal of growing next generation of practitioners—grad student internships, outreach to junior practitioners/grad students. • Who is using it: USAID has critical concerns that it is not being actively used by non-HC3 staff members or populated by US Grad students). The users are meant to be development practitioners and INGOs.	• Not sure, Unaware of the specific tools, but don't see how electronic toolkit, springboard are impacting this country. Not a lot of resources towards them. • HC3 tools are not really used in direct implementation in country. Could be useful to serve as a CoP in country.

Springboard Community of Practice(s) (COP)		
ICT Model	**USAID DC**	**USAID Missions**
Integration (for capacity strengthening) Integration between online and face-to-face as well as between tool and implementation	• Biggest concern is how Springboard activities "online" and "offline" are reinforcing as well as together directly supporting SBCC on the ground. • SpringBoard activities are mixed between online and in country. Through both, SpringBoard provides a space to convene the universe of BCC practitioners in a country, and beyond (via online platform). It is intended to be—accelerators/multipliers. The purpose is to support capacity strengthening in a way that is more nimble, sustainable, lighter, promoting lateral learning and peer exchange and not top down. • Online and in country activities are not integrated: SpringBoard was supposed to be integrated together to support deep linkages - universities, local partners to create CoPs. In reality, these activities do not seem to be integrated, but instead almost entirely separate. USAID spends a lot to put them together. The management/roll out of the online and the in country seem to roll out in parallel without cross fertilization between the two, but USAID assumed they would built in tandem, even understanding the roll out logistics. USAID is the link in connecting the two parts, requiring closer oversight than expected. It seems that there is never any link between the two parts, and rarely discussion about integration. Appears to USAID as the online and face to face are still separate activities. The in person activities not deemed successful in terms of the LOE requirements.	• Did not know about 2014 events (three in country events) • Not sure, but don't see how electronic toolkit, springboard are impacting RCI. Not a lot of resources towards • Springboard—don't know much about it, lowest priority within • More people from France accessing materials

Springboard Community of Practice(s) (COP)		
ICT Model	**USAID DC**	**USAID Missions**
Access/Demand How they are accessing it? What is the engagement model/marketing?	• USAID Missions have not been enthusiastic about launch events, as they see no perceived need for Springboard and therefore are not willing to put in time or energy (immediate results is the focus). • Communication with USAID: USAID is concerned that HC3 has a history of not communicating with USAID at appropriate times. For example, launching in countries without Mission support (see below), as well as selection of topics for the Webinar series. • Mission reactions mixed: In year one and two, HC3 held several launch events without USAID Mission concurrence which offended many USAID Missions (to spend USAID Washington funds in country, the Mission must concur). As a result, some damage to relationships with Missions over SpringBoard has occurred. For example, in Bangladesh—where BCCP Springboard Secretariat exists, the Mission won't approve any in person SpringBoard activities because some happened without Mission approval. • Since this was discovered, USAID Washington makes requests to the Missions to do these in person events. Some say no, others say maybe but have a negative experience. Some are happy. A common perception of SpringBoard by Mission is of in person activities is that they are not useful. In country work is very close to being killed, and the perception is that for launches, the management burden is huge, and the entire purpose does not resonate with missions. As of June 2015, in Africa, of 15 Missions reached out to, 9 missions gave concurrence, 5 said "not now", and 1 said "never", and in Asia, of 8 reached out to, 1 said yes, 5 said "not now" and 2 said "never". • Online: HC3/UN Commission used Springboard as a dissemination approach for the underutilized commodities I-Kit, to promote the usage of the I-Kit by local communities of practice. The Youth usage of LARCs I-Kit development held an online discussion of country based challenges facing the usage of LARCs by youth. The global interface was good for the youth series, which held conversations on Springboard to discuss the content. It was well attended well facilitated, got many attendees beyond traditional BCC community. • In Country: Springboard has two types of events—Launches and Learning forums. For a Launch, Springboard usually adds to an existing BCC meeting in country—2-3 hour event, showcase, laptops, signup right then and there, work in country and identifies who would be in country volunteer/champion. Usually USAID and Ministry are involved. Learning forums are small technical exchanges, where a topic of interest is discussed. These are usually small event focused on the SBBC community. • Measurement: Wonder how much of the success can be measured by who it is intended to reach.	Unaware of the specific tools.

Springboard Community of Practice(s) (COP)		
ICT Model	**USAID DC**	**USAID Missions**
Feedback What has been the model for improvements and responsiveness to changes	• There have been substantial improvements to platform, especially UX improvements, using an iterative process to identify how users in developing world have different access patterns. • At each levels—where we can get data, use data is different: • View: GA—Anonymized data - # visited, where they went. Don't know quality, how they use, etc. • Login: can track on an individual level—types of users, what are people doing, • Engage: measure posts, shares, interactions/engagement, qualitative analysis • Change: Focused surveys	Nothing cited
Sustainability Look at long term sustainability	• There are also concerns about sustainability with the regional secretariats, both because of Mission push back and now that AfriComNet is no longer the selected partner for Springboard. • Springboard in country activities are not strategic: The roll out to new countries seems to be not based on any strategic approach, or building on past successes. USAID has repeatedly asked HC3 to restrict the number of countries as well as refocus the SOW on realistic goals. In addition, USAID has asked for clarification on how the Learning Forums direct support USAID activities on the ground (either HC3 or other) and are not country specific. • Need continuous on the ground engagement, but very expensive: There was an assumption by USAID/HC3, that once SpringBoard launched, things would start moving organically. But without a champion, timeline, purpose, or driving need, these did not take place. HC3 is still doing some launches, but more learning forums are being done, with more focused areas, and practical/applied topics. However, the cost for these country level events is a large concern, as evidenced by this quote from USAID DC, "*…country-level Springboard activities appear to require a disproportionate level of funding and management from both USAID and HC3, and it is not clear that can be justified. Recommend scaling back country-level activities to countries where a) HC3/CCP has an established, USAID-funded presence, and/or b) the Mission has indicated that they are supportive.*" (Springboard combined comments—USAID feedback on Y4 work plan) • Sustainability Planning: USAID has concerns that the sustainability plan for SpringBoard focuses exclusively on the in country elements, is too vague about the Secretariats, is unrealistic, and is underdeveloped, and seems to be in conflict with the roll out plans for more countries and a new secretariat. There is also concern that lessons learned from earlier years are not being acknowledged or shared. Governance structures are underdeveloped or unclear, and it seems to be late in the project to start developing them. • Role of secretariats: As of the commencement of the evaluation, AfriComNet was to be replaced by another African Partner (as of 8/31- African Capacity Alliance). The role of the secretariats in the long term sustainability of SpringBoard is not clear, nor whether the partners selected are appropriate. In addition, • There needs to be some acknowledgement here of the fact that AfriComNet is being phased out, and a new African secretariat identified and contracted, as that will have serious implications for what the new	Nothing cited

Springboard Community of Practice(s) (COP)		
ICT Model	**USAID DC**	**USAID Missions**
	partner can realistically achieve (and what USAID is willing to fund). • At this point, USAID/PRH needs to minimize its risk around these investments; I am not supportive of funding a new partner to receive the same support that was provided to AfriComNet, when it is not at all clear that the secretariat/in-country community of practice elements of the Springboard model can be successful.	
Recommendations	• In Country: SpringBoard needs to be focused on specific countries, with on the ground presences, where Missions are amenable. Missions get mad when they don't know about events in country. They need to work in partnership with other USAID IPs, local NGOs/Governments. Partners see SpringBoard as CCP agenda being pushed and Missions concerned that these events are threatening or distracting to other partners. At the country level, there must be a local champion, Can often piggy back on technical meeting that is happening—before/during/afterwards (this occurred in Nigeria). • Online: Online platform has been very successful for specific events. Roll back Malaria, for example, able to upload documents and it spurred person to person engagement. USAID would like to see it for other BCC Events (not just HC3 events).	

Springboard Community of Practice(s) (COP)		
Springboard	**HC3 HQ**	**HC3 Country**
Usage (for capacity strengthening)	• Opportunity for SBCC practitioners and organizations to connect. Ability to continue conversations after meetings, easier to reach people and get professional access. Informal environment to get access to experts. Trying to get experts from outside HC3/people working in the field. • Capacity strengthening in ICTs via use of Springboard. • Springboard community—not easy to do, building community, but getting handle. So SBCC community desperately needed • Springboard- used for expert consultations and as private discussion grounds. Nice opportunity to have exchanges and link people. In many countries, there are not a lot of people working in SBCC. Through SpringBoard, can build the community and discover people within country, and bring people together who haven't collaborated in the past. Also allows you to find local community, look for resources,, gain access to them. • Springboard is linked to google translate for French Users.	• Counterfeit pharmaceuticals have a closed group on Springboard after the Ghana meeting to continue and broaden discussion), and designing an I-Kit based on the work and experiences in Nigeria.
Integration (for capacity strengthening)	• A place where light content is hosted but link to heavy content on HealthCOMpass or elsewhere. One site would not work—too different in purpose and goals. • Virtual space that extends the reach for those who cannot meet in person, and provide feedback into the face to face, and make it easy to find people again. Face to face meetings host seminars, workshops at a country/regional level. • Tension between field and core. It is easier to have face to face events when there is an HC3 presence on the ground. Regional secretariats end up hiring consultants to perform support. • Trying to get experts in the field to lead discussions on springboard. • There is a tension between core and field. It is easier to support springboard when there is a local presence; otherwise the regional secretariats are hiring local consultants. Need to get Mission approval in advance. • More discussion groups in Springboard such research methods, theory, and university discussion group. • Resource sharing for Faith based organizations on health topics. • There is a closed space on Springboard to discuss substandard/falsified drugs. They are also working on getting • National ACSM on springboard more formally. • Used Springboard in Madagascar to capture feedback on urban youth work. • Used Springboard to discuss LARCs—shared parts of the finding from literature review, asked participants, sound familiar to your contexts? Validated and focused in on	• Counterfeit pharmaceuticals have a closed group on Springboard after the Ghana meeting to continue and broaden discussion), and designing an I-Kit based on the work and experiences in Nigeria. • They also see it as potentially serving the ACSM working group to allow people to attend meetings "virtually" and encourage them to share activities, and help with collaboration. • Lots of potential usage for specific program implementation but not yet. • Posed the question on Springboard about how they could improve recruitment; one person responded with lots of ideas and examples; idea of sending out SMS that helped people identify risk and allows program to "recruit" those at highest

Springboard Community of Practice(s) (COP)		
Springboard	**HC3 HQ**	**HC3 Country**
	specific barriers, since one of the challenges of the literature review was that most of the literature is not specific to youth & LARCs. • Also, being able to bring in technical experts from host countries to SpringBoard is very valuable. • Replace elements of the Roll back malaria CoP—discussion of M&E and household surveys. • HC3 used Springboard in the world-wide meeting—discussion groups, capture ideas/commitments, take back to home countries, and uploading documents from week. Springboard becomes a space that HC3 can access as a closed group. Invite the country teams to be used as a KM tool for HC3 to be able to participate in the discussions.	risk; also suggested to use TV testimonials to support the programs objectives. • We had planned to use Springboard as an extension after a training to support coaching and mentoring, but USAID cut the program before we could roll it out.
Access/Demand	• Themed discussions every 2 weeks with moderators, who bring content into the discussions. Country groups and pages, where people from those countries can create and curate their own collections for those communities. Increased realization that country lead discussions are key. • Process of creating demand is through launches (10 to date). Let people know about Springboard. Hard to build traction, however, and hard to find activities in country… moved to a "learning forums" approach—Springboard members come together to discuss one topic. • Missions not supportive as they see the face to face as a lot of work without strong benefits (to them). Missions see it in a project mentality—HC3 is coming into the country, Core is upstaging bilateral. In several countries, the local partner said yes, but the Missions said no. Some have changed their minds. • Professional organizations on the ground to have better diffusion and uptake such as Tanzania and Bangladesh. • Day to day interactions are at the country level, not global or regional level. • Not using SpringBoard in Guatemala yet.	• Members of the HC3 team mentioned that they find Springboard very exciting but they do not currently use it directly. They want to make Springboard a central place to go. They want to use it to make it easier to coordinate partners in country (MAPs, etc) to allow peer based sharing of knowledge. • They are looking forward to the App to help improve sharing and access, and want it to be easier to use. One idea is Photo feed like twitter. • Springboard is less easy to use that Facebook. Springboard is mostly in English, which is not a problem for interviewee since he speaks some English; they now have a built-in French translation. • In [Africa], people connect more using their phones; more connection via mobile than via computers in [Africa], so an app would be more appropriate to how people use the

Springboard Community of Practice(s) (COP)		
Springboard	**HC3 HQ**	**HC3 Country**
		Internet in [Africa]. • Language is a barrier: Springboard conversations are almost always in English. • Have presented Springboard to University students, they seemed interested since it was presented as a professional development opportunity, some have created accounts; have found that students seem more interested than professionals, but still low number actually create an account
Feedback	Global advisory council made up of HC3 staff, CORE group, and others.	• I use Springboard to find out what others are doing in other countries and orient my own work around what others are doing. • Our media officer checks Springboard to see if there is anything of interest to show the team.

Springboard Community of Practice(s) (COP)		
Springboard	**HC3 HQ**	**HC3 Country**
Sustainability	• Sustainability model: Global advisory council, bilateral support (USAID), donor support (CDC), regional secretariats, country level champions, CCP commitment, beyond projects. AA, TA, C • Regional secretariat structure, using partners with existing networks and work in capacity strengthening. The secretariats are closer to on the ground needs, support the countries. Countries are meant to come up with own topics. Franchise model—countries can use the Springboard brand but do not require allegiance of an organization to HC3. A Springboard event will have a package (agenda, invitation info, etc) but up to the country to design. • Not mobilizing country level resources the way envisioned– each country looks very different • Regional secretariats are different from each other. BCCP is strong. AfriComNet is weak—had the network but not the infrastructure. HC3 (through MSH) spent a lot of time on capacity building, especial resource mobilization. HC3 ran out of time with AfriComNet—need stronger partner, found a new one. • There has been a struggle to get health areas to support SpringBoard, so most of the funding comes from PRH at the moment. Working on a franchise model. Local organizations mobilizing resources (in kind contributions). CCP is commitment to the development of Springboard beyond the lifecycle of HC3.	• Finalize translation of menus into French • Change the way that notifications are highlights, currently difficult to see what notifications are current • Administrators have created Springboard pages for countries, but better to let users create their own groups based on their interests and the community that they would like to create

Springboard Community of Practice(s) (COP)	
ICT Model	**HC3 Project Partners**
Usage (for capacity strengthening)	• Go to springboard—conversations on—active but peter out. That is the issue with social media platforms. • Work with Kenyan journalists but there is nothing on Springboard for them from a journalism perspective. • When writing blog—sometimes go to springboard to get ideas. • Who is talking to whom on springboard? Are we just talking to ourselves? Background—think facebook, social media. • When contract ends, still make use of springboard. • Content is very supply driven—How to guides—supply driven • Content thoughtful—trying to connect tools with stories, making it user friendly. • Springboard—trying to create groundswell, social networking yet. Local champions, what is unique about this space? Not answered at the time. Could thinking—social network, events locally. • Springboard is not under domain of capacity building.
Integration (for capacity strengthening)	• HC3 is trying to do a lot of different things—Springboard, I-Kits, toolkits—lots and lots of things—at all levels. Not sure if it is strategic. • Since February—on the ground HealthCOMpass - really going gang busters. Marching towards future. • Springboard—not really sprung yet, we will see. • Springboard is the Facebook for communicators. The ideas are very good, but the implementation has not yet meet expectations. • Springboard—not fully realized the vision or mission of the work. Needed more strategic thought and review. • In the beginning, the online and face to face activities as well as Springboard from other project activities were a little siloed, meaning a lack of sharing of goal setting. • The popularity of online springboard is dependent on face to face events. The more HC3 is able to have, more the online will occur. You can see this with spikes around events, which are meant to feed into each other. Face to face gives an opportunity to market the forum and continue the conversation after the event. Recruitment tends to happen after face to face activity. • Springboard has been used to field test, feedback, piloted different tools to engage stakeholders and local champions to use the materials. The process is still immature.
Access/Demand	• HealthCOMpass, and Springboard are leader in the space and go to for resources. • Too confusing? Springboard is a great idea but there seems to be lots of discussion on how to make a COP, which is just another thing people have to do. HC3 has tried to make things easy but not always done. • SpringBoard has local organizations to host launch parties, but it seems like a lot of work for not a lot of reward. So far, most of the regions/countries said no. Myanmar/Thailand, their new staff interested and we worked with HC3 team gathered people together. The event went well, especially getting the conversation/involvement at the grassroots level. But it was a lot of work to invite the people, coordinate everyone. In the busier countries, many organizations are not interested/not enough time.

Springboard Community of Practice(s) (COP)	
ICT Model	**HC3 Project Partners**
Feedback	• HC3 should streamline some of their offerings, unwieldy—where are things posted? Too many choices • Two years—get it out of central office—open source platform. Secretariats, strengthens, operating managers. Governing bodies, figuring out roles and response • There was also pushback: not administrative—ideas being shot down and one perspective being heard only (hindrance), and the tone was dismissive in nature, with team members not being listened to. This was addressed and now improved. • At first, it was very slow getting things done on Springboard—a lot of lines of approval. The team, within HC3, then USAID. Making changes takes a while and is a huge hindrance to Springboard, because cannot iterate through. Also true on the on the ground activities. The approach—create a launch to facilitate in country processes, leading to activities clearly planned at country level, has been undermined by the layers of approval HC3, USAID Washington, Mission. This means the countries and the secretariat don't have powers to organize activities without going through layers of approval. Even holding informal meetings in country needs to be approved. • Asia started later and needed approval from USAID Missions, which was harder. Vietnam/Indonesia the Mission was not on board and blocked activities. Vietnam is starting to be positive. Discussed with Nepal team—agreed to Launch (Feb 2015), India CCP India to explore possibility. Last year—July 2014 attempt to have India springboard launch. This year, after Nepal organized. In New Delhi. CCP Pakistan in about a year. Not really hindrance of management, CCP very proactive in launching in Vietnam and Indonesia—the local situation not ready yet. USAID Mission wasn't ready yet. Philippines—second year plan. Sri Lanka—no connection to the Mission. Secretariat need to explore connection to Missions. USAID Washington has been very proactive, showing lots respect for Mission. • Approvals is a hindering factor on how fast Springboard in country work can be done. The team has done a lot more in terms of forums moving in each country, but the approvals limits how fast the team can move, only been able to do a few countries because of approvals. The in country work also need some seed money to kick start the formalized groups, and ideally this money will be raised from country missions. However, a lot of pushback from missions who don't see benefits or don't know about it, or other issues. The countries who are putting money into it, hold forums on a regular basis. Users want to have forums, ideally once every month. The cost of hosting forums is around ($2000) or $20K per country annually to kick off. • Springboard has held multiple partners meetings and retreats which are helpful in addressing these issues. • The new site has changed, it has new shape, more user friendly website, and that happened over four—five months. HC3 tried to improve the site—almost new website. More organized around countries.

Springboard Community of Practice(s) (COP)	
ICT Model	**HC3 Project Partners**
Sustainability	• HC3 could reach out to partners in countries where CCP does not have a strong presence, but where the partner does. • Concern: how open and publicized is this in country? A launch in country could get free press. Offline/on the ground very important. Face to face will really sell the community. • For sustainability, SpringBoard needs to generate revenue for local events. It needs a governing body to accredit springboard centers (offline—access to coaching and tools). The idea never went anywhere because of lack of urgencies. • Secretariat has new roles, structure of advisory council. The business case needs to be developed. What does SpringBoard offer? In order to generate revenue. Look at shared mission and vision for Springboard, business cases. Tools and process for doing continuously, financial management, pricing strategy. • Need local champions to organize local events, giving specific groups ownership of parts of it (trained in core springboard), but have event including a training on a HealthCOMpass. • Springboard is trying to create groundswell around social networking, but not yet gotten there. Needs local champions to state what is unique about this space? Not answered at the time. • Role of secretariats has changed, giving more freedom with the regional secretariats. Questions about the role of Secretariat in managing online springboard. Currently it is limited because managed in the US, and limited to trying to get members to engage in the platform, by show linkages between face to face forums and the online forums. • The country level activities have been too informally designed by HC3, who is looking for things to evolve informally to pull people together. However, for sustainability and get some funding, these roles and mechanisms need to be formalized. • Regional Secretariat • The secretariats are unclear on their role and not given much guidance on what they were supposed to be doing. Secretariat roles are defined as planning events, finding champions and providing a go to person for support. • Each secretariat is in a different place—BCCP just started, AfriComNet is in transition. • Relationship with the other Regional secretariat - Not established yet—just forming up. Idea to have meeting/advisory council meetings, bringing together different secretariats to hold discussions of how to do things better.

Springboard Community of Practice(s) (COP)		
ICT Model	**Country Implementing Partners -CCPN, BCCP, AfriComNet**	**Local Country Partners/Players**
Usage (for capacity strengthening)	• By utilizing springboard—HC3 is fulfilling mandate for capacity strengthening for health communication. The whole point around springboard is to bring people together to share, learn, network, ask questions of each other. • For AfriComNet—their mandate of strengthening capacity strategic communications ties into HC3 missions. • Define users of Springboard • Precious time to connect with friends. Most users want to download something (rather than connect with people on Springboard). The difference between repository and connections (Springboard can be a link between—not too early to measure). • Are Sammy/Anne (i.e. CCPN regional examples of typical users? • Yes—but—depends on the capacity of the staff. Need to be oriented to the tools. • Need to encourage own staff to use springboard in their jobs. Challenge due to timecard issue • You begin to see trends in the conversations—for example, arguments within discussions, see people to comment on aspects. Level of engagement has increased. However, engagement is linked to face to face activity Topics are often unresolved issues from face to face issues. Clear link between the two. • Springboard at first was too separate from content, but is now pulling in content (HealthCOMpass, library (PMI)—start to use groups to discuss topics.	• Only ACSM national members had heard of SpringBoard • Springboard is a health communication professional forum for sharing communication, knowledge and experiences. At this forum, users have the opportunity of learning first hand as well as having new and innovative information on SBCC (networking).
Integration (for capacity strengthening)	• How do you see the connections/differences between Springboard online and Springboard face2face? • Intentions are different but the outcomes are the same. Creating networks, exchange contacts, interface with others. Connection of networks. Multiplier of experience. • Face to face helps overcome low digital literacy and connectivity issues. • Online helps broaden the community. Face to face is Nigeria/state specific, but online allows it to connect at national, regional or global level. • Face to face element is extremely important.	
Access/Demand	• Challenges of Springboard • Time - need a dedicated staff person to build active engagement online, marketing into the community (face to face as well as online) • Time—of users. Need to work on integrating springboard into how people do their jobs. Right now, a nice to have. Even within CCPN, no time in the timecard for springboard, so has to be done after hours.	• Core users (CBO partners, local implementers) are not being served because they don't know about it. • ACSM Abuja found Springboard and HealthCOMpass to be very

Springboard Community of Practice(s) (COP)		
ICT Model	**Country Implementing Partners -CCPN, BCCP, AfriComNet**	**Local Country Partners/Players**
	• Engagement—working to do so with face to face visits with organizations (Nigerian Medical Association) that have a need for Springboard. • Engagement—email is a powerful trigger for return visits. But email subscription is turned off. • Engagement—need a mobile app so that people can use the tool more ad hoc and not have to remember it when they get to their laptops. Use phone notifications—always on phone. • Growing an online culture requires infrastructure. • Engagement on springboard is still a bit low, due to cultural barriers. A lot of people in Africa use social platform only for social activities. Using online for networking and learning is still not quite there. But the more face 2face forums will be continuing the conversations online. And there are still connectivity issues. Internet links goes down.	good communication mechanisms, the constant reminder on meetings, for example is very encouraging for people to attend. • Challenges expressed by these audiences included: cost and sporadic nature of connectivity (there was at a minimum cell/edge connectivity in the cities where the local partners were based); lack of familiarity with digital tools/digital literacy (not universal); and a concern for a lack of time to access tools.
Feedback	• On the ground, more Springboard launches, more support by Secretariat. • More mapping of country context for everything, and less general. Often times, proposals are too generic, but in order to work, needs to be specific to country, • Event on the ground in each HC3 countries bring on board—every month. Something very specific to motivate people. Also, more virtual events—geared towards countries and specific topics are useful. • Springboard in country needs to be housed someplace—in some place, for sustainability. Currently, it is a USAID/HC3 branded activity but that will end. Back end management needs to start hands of entity.	• For those who are involved in Springboard, there were several suggestions • The Timing Should be Changed: The time for the springboard events mostly coincide with worktime making it a difficult to attend • Create a step by step guide on how to log-into springboard • Need for a mobile App • Training of all subcommittee members on Springboard
Sustainability	• Sustainability - ideas • Institutional home • Allows ownership by a country or state level. Increases visibility • Role of secretariat—the "mother ship"—coordinate meeting, global level perspective. Baltimore cannot support on a country by country basis. • AfriComNet—check in, ability to reply in real time on budget and communications.	Nothing cited

Springboard Community of Practice(s) (COP)		
ICT Model	**Country Implementing Partners -CCPN, BCCP, AfriComNet**	**Local Country Partners/Players**
	• Discussions/topics—need more engagement—national, Africa wide, and then global community • Leverage existing meetings—insert 30 minutes into existing meeting • Finding topics which pull crowds • More networks connected (like Nigerian Medical Association or alumni network)—already have wide reach, looking for something to talk about. • Find evidence—show the connection between SBCC practitioners and improved capacity • Use KM approaches • User surveys • Capacity indicators • Fruitful conversations/meetings attended. • Financing management has been arduous. First, information required is very high, with lots of details and back and forth. • AfriComNet faced a halt in funding for three months where they could not do anything. Depending on role, ranging from annoying to show stopping. • AfriComNet at first envisioned their own online spring board—imbedded in AfriComNet website as an offering of AfriComNet to build on existing members. But springboard turned out stand-alone initiative. It is too separate from core activities. • We have to realize that it takes time to build engagement. Once that is done, foundation of the sustainability will be formed. Each of the country websites will be able to be more proactive, revenue generation, thoughtful about doing so. More innovative bringing about more visitors, other than health communication professionals (Directory). Improvements to the format on the site that attracts people, such as Linked In. High profile member will visit linked in. Take some ideas from linked in. start with engagement. Then can get revenue (paid membership, other revenue sources). Something that is free is not always valued. • It is valuable to the secretariats to have access to resources to plan activities, as well as being involved in strategic decisions. • For resource mobilization, there needs to be a country by country formalized mechanism to seek and receive funding. Each Springboard event costs between $1000–$3000 to host. • Expenses are for the physical costs of meeting up, such as paying for logistics, location, food, and materials. So far, many organizations have been willing to donate space and time, and members have rotated hosting, but as the numbers grow (such as Zimbabwe had 78 people) this is unsustainable and does not scale. • Country level, USAID could put money in. Uganda Mission paid AfriComNet thru the	

Springboard Community of Practice(s) (COP)		
ICT Model	**Country Implementing Partners -CCPN, BCCP, AfriComNet**	**Local Country Partners/Players**
	national communication project for the first two events (venue and snacks) and AfriComNet provided marketing and logistics.	

APPENDIX M. SYNTHESES OF QUANTITATIVE FINDINGS

This appendix contains the full qualitative synthesis of organizational effectiveness, social and behavior change communication, and information and communications technology.

ORGANIZATIONAL DIAGNOSTIC SYNTHESES

Organizational Effectiveness Diagnostic Synthesis

HC3 Self-Assessment N=41 HC3 Staff

Indicates how each segment rated the organizational effectiveness element/issue:
1=Much improvement needed/dissatisfied/strongly disagree
3=Neutral
5=Excellent in this area/satisfied/strongly agree

1 point =20%, e.g. 3.8=76%

Segmented by	Leadership and Vision	%	Change Management	%	Organizational Outcomes	%
Full—no segmentation	3.8	76	3.4	68	3.2	64
Activity type—Direct Implementation	3.6	72	3.7	74	3.3	66
Activity type—Research & Evaluation	3.2	64	3.6	72	2.6	52
Activity type—Technical Assistance	4.1	82	4	80	3.6	72
Country Work—Across Countries	4	80	4.1	82	3.4	68
Country Work—Nigeria	3.9	78	3.5	70	2.8	56
Country Work—Other	3.8	76	3.5	70	3.2	64
Country Work—RCI	3.3	66	3.6	72	3.2	64
Expertise Length—Less than 10 years	3.6	72	3.7	74	3.2	64
Expertise Length—More than 10 years	4.1	82	3.9	78	3.7	74
Health Area Experience Length—Less than 10 years	3.7	74	3.8	76	3.2	64
Health Area Experience Length—More than 10 years	4.1	82	3.7	74	3.6	72
Female	3.8	76	3.3	66	3.2	64
Male	3.8	76	3.6	72	3.2	64
Field of Expertise—CS/OD	3.7	74	3.5	70	4.1	82
Field of Expertise—Finance/Other	4	80	3.7	74	3.5	70

Segmented by	Leadership and Vision	%	Change Management	%	Organizational Outcomes	%
Field of Expertise—ICT	3.8	76	4	80	3.8	76
Field of Expertise—Research & Evaluation	3.2	64	3.4	68	3.4	68
Field of Expertise—SBCC	4.1	82	3.7	74	3.5	70
Funding Mechanisms under which work—Core	4.1	82	3.9	78	3.4	68
Funding Mechanisms under which work—Country buy-ins	3.6	72	3.7	74	3.4	68
Health Area Work in—Across more than 1	3.8	76	3.8	76	3.5	70
Health Area Work in—FP	4.7	94	4.6	92	4.3	86
Health Area Work in—HIV/AIDS	3.7	74	3.8	76	3.3	66
Health Area Work in—Malaria	4.1	82	3.8	76	3.2	64
Length of Time with HC3 - Less than 2 years	3.5	70	3.1	62	2.9	58
Length of Time with HC3—More than 2 years, since beginning	4.1	82	3.7	74	3.5	70
Role—Operations	3.6	72	3.6	72	3.1	62
Role—Senior Management	4.1	82	4.1	82	3.9	78
Role—Technical	3.7	74	2.8	56	2.9	58
Work—At Headquarters	4	80	3.6	72	3.4	68
Work—In country	3.1	62	2.7	54	2.6	52

Segmented by	Organization Development													
	Contacts, Relationships	%	Assets, Finance	%	Planning	%	Personnel, Human Resources	%	Staff Skills, Capability	%	Management Structure	%	TOTAL	%
Full—no segmentation	4	80	3.9	78	3.7	74	3.5	70	3.6	72	3.6	72	3.7	74
Activity type—Direct Implementation	4.1	82	4.1	82	3.8	76	3.4	68	3.4	68	3.6	72	3.7	74
Activity type—Research & Evaluation	3.6	72	3.4	68	3.1	62	2.6	52	3.3	66	3.6	72	3.2	64
Activity type—Technical Assistance	4.4	88	4.1	82	4.2	84	3.7	74	3.9	78	4	80	4.1	82
Country Work—Across Countries	4.3	86	4.2	84	4.2	84	3.7	74	3.9	78	4	80	4	80
Country Work—Nigeria	4	80	3.8	76	4.1	82	3.3	66	3.6	72	3.7	74	3.8	76
Country Work—Other	4.5	90	4.3	86	4	80	3.3	66	3.8	76	3.6	72	3.9	78
Country Work—RCI	3.7	74	3.9	78	3.4	68	2.9	58	3	60	3.6	72	3.4	68
Expertise Length—Less than 10 years	4	80	3.6	72	3.6	72	3.2	64	3.3	66	3.4	68	3.5	70
Expertise Length—More than 10 years	4.3	86	4.3	86	4.2	84	3.7	74	3.9	78	4	80	4.1	82
Health Area Experience Length—Less than 10 years	4.2	84	4	80	3.8	76	3.3	66	3.5	70	3.7	74	3.7	74
Health Area Experience Length—More than 10 years	4.3	86	4.2	84	4.1	82	3.7	74	3.9	78	4	80	4	80
Female	3.9	78	3.8	76	3.7	74	3.4	68	3.5	70	3.6	72	3.6	72
Male	4.3	86	4.2	84	3.8	76	3.7	74	3.8	76	3.8	76	3.9	78
Field of Expertise—CS/OD	4.6	92	4.6	92	4	80	3.6	72	4	80	3.7	74	4.1	82
Field of Expertise—Finance/Other	4.1	82	4.7	94	3.8	76	3.2	64	3.7	74	3.7	74	3.9	78
Field of Expertise—ICT	4.2	84	4.3	86	4	80	3.6	72	3.7	74	3.9	78	3.9	78
Field of Expertise—Research & Evaluation	3.3	66	3.6	72	3.4	68	2.7	54	3.4	68	3.4	68	3.3	66

Segmented by	Organization Development													
	Contacts, Relationships	%	Assets, Finance	%	Planning	%	Personnel, Human Resources	%	Staff Skills, Capability	%	Management Structure	%	TOTAL	%
Field of Expertise—SBCC	4.3	86	4.4	88	4.1	82	3.7	74	3.8	76	4	80	4	80
Funding Mechanisms under which work—Core	4.3	86	4.2	84	4	80	3.6	72	3.9	78	3.9	78	4	80
Funding Mechanisms under which work—Country buy-ins	4.1	82	4	80	3.7	74	3.3	66	3.4	68	3.5	70	3.6	72
Health Area Work in—Across more than 1	4.2	84	4.2	84	3.8	76	3.4	68	3.7	74	3.8	76	3.8	76
Health Area Work in—FP	4.8	96	4.7	94	4.7	94	4.2	84	4.6	92	4.4	88	4.5	90
Health Area Work in—HIV/AIDS	4	80	3.6	72	3.8	76	3.3	66	3.1	62	3.8	76	3.6	72
Health Area Work in—Malaria	4.1	82	4.1	82	4.1	82	3.7	74	4	80	3.9	78	4	80
Length of Time with HC3—Less than 2 years	3.6	72	3.6	72	3.5	70	3.2	64	3.4	68	3.4	68	3.4	68
Length of Time with HC3—More than 2 years, since beginning	4.5	90	4.3	86	4	80	3.8	76	3.9	78	4	80	4.1	82
Role—Operations	3.9	78	3.9	78	3.8	76	3.5	70	3.8	76	3.6	72	3.7	74
Role—Senior Management	4.4	88	4.4	88	4.2	84	3.9	78	4	80	4.2	84	4.2	84
Role—Technical	3.8	76	1.9	38	3.4	68	3.2	64	3.3	66	3.4	68	3.2	64
Work—At Headquarters	4.2	84	4.1	82	3.8	76	3.6	72	3.7	74	3.7	74	3.9	78
Work—In country	3.3	66	3.3	66	3.4	68	3.1	62	3.2	64	3.3	66	3.3	66

Segmented by	Organizational Environment									
	Vision & Leadership	%	Internal Responsiveness	%	Internal Learning	%	Innovativeness	%	TOTAL	%
Full—no segmentation	3.6	72	3.4	68	3.6	72	3.8	76	3.6	72
Activity type—Direct Implementation	3.5	70	3.3	66	3.6	72	3.9	78	3.6	72
Activity type—Research & Evaluation	3.5	70	3.1	62	3.9	78	3.2	64	3.4	68
Activity type—Technical Assistance	4.1	82	3.9	78	4.1	82	4.2	84	4.1	82
Country Work—Across Countries	4	80	4	80	4.1	82	4.2	84	4.1	82
Country Work—Nigeria	3.5	70	3.4	68	3.7	74	3.6	72	3.6	72
Country Work—Other	4.1	82	3.1	62	3.8	76	3.9	78	3.7	74
Country Work—RCI	2.9	58	3.3	66	3.7	74	3.7	74	3.4	68
Expertise Length—Less than 10 years	3.5	70	3.5	70	3.6	72	3.7	74	3.6	72
Expertise Length—More than 10 years	3.9	78	3.7	74	4.2	84	4.2	84	4	80
Health Area Experience Length—Less than 10 years	3.8	76	3.6	72	3.8	76	3.8	76	3.7	74
Health Area Experience Length—More than 10 years	3.9	78	3.7	74	4.2	84	4.2	84	4	80
Female	3.6	72	3.3	66	3.5	70	3.7	74	3.5	70
Male	3.8	76	3.8	76	4.1	82	4.1	82	3.9	78
Field of Expertise—CS/OD	3.8	76	3.8	76	4.3	86	4.2	84	4	80
Field of Expertise—Finance/Other	3.8	76	3.7	74	4	80	4.1	82	3.9	78
Field of Expertise—ICT	4	80	4	80	3.9	78	3.8	76	3.9	78
Field of Expertise—Research & Evaluation	3.4	68	3.7	74	3.6	72	3.2	64	3.5	70
Field of Expertise—SBCC	3.9	78	3.7	74	3.9	78	4.1	82	3.9	78
Funding Mechanisms under which work—Core	4	80	3.8	76	3.9	78	3.9	78	3.9	78

Segmented by	Organizational Environment									
	Vision & Leadership	%	Internal Responsiveness	%	Internal Learning	%	Innovativeness	%	TOTAL	%
Funding Mechanisms under which work—Country buy-ins	3.7	74	3.4	68	3.8	76	3.7	74	3.6	72
Health Area Work in—Across more than 1	3.9	78	3.7	74	3.9	78	3.9	78	3.8	76
Health Area Work in—FP	4.6	92	4.4	88	4.4	88	4.7	94	4.5	90
Health Area Work in—HIV/AIDS	3.2	64	3	60	3.8	76	4	80	3.5	70
Health Area Work in—Malaria	3.8	76	3.8	76	3.8	76	4.1	82	3.9	78
Length of Time with HC3—Less than 2 years	3.4	68	3.2	64	3.4	68	3.6	72	3.4	68
Length of Time with HC3—More than 2 years, since beginning	4	80	3.8	76	4	80	4.1	82	4	80
Role—Operations	3.3	66	3.2	64	3.4	68	3.6	72	3.3	66
Role—Senior Management	4.1	82	4	80	4.2	84	4.3	86	4.1	82
Role—Technical	3.5	70	3.1	62	3.3	66	3.5	70	3.4	68
Work—At Headquarters	3.9	78	3.6	72	3.7	74	4	80	3.8	76
Work—In country	3.1	62	3.3	66	3.7	74	3.6	72	3.4	68

SBCC DIAGNOSTIC SYNTHESIS

Areas Assessed	Strongly agree, Agree	Neutral	Disagree, Strongly disagree	Don't know
A. Technical leadership and engagement				
1. USAID and other donors view our project as a technical leader	38 (98%)	2 (5%)	0 (0%)	1 (2%)
2. Other international and regional implementers	37 (90%)	2 (5%)	0 (0%)	2 (5%)
3. The local governments with which we work view our project as a technical leader	35 (85%)	2 (5%)	0 (0%)	4 (10%)
4. Our project is a leader in creating innovative SBCC interventions	36 (88%)	2 (5%)	0 (0%)	3 (7%)
5. We proactively engage other SBCC implementers	37 (90%)	1 (2%)	1 (2%)	2 (5%)
6. At the country level, our activities effectively, complement the work of other implementers	39 (95%)	0 (0%)	0 (0%)	2 (5%)
7. At the regional level, our activities effectively complement the work of other implementers	34 (83%)	0 (0%)	0 (0%)	7 (17%)
8. At the international level, our activities effectively complement the work of their implementers	35 (85%)	1 (2%)	0 (0%)	5 (12%)
B. Partner SBCC capacity building				
1. Before implementing a SBCC technical capacity building activity, we conduct an assessment to identify the capacity building needs	38 (93%)	2 (5%)	0 (0%)	1 (2%)
2. We have a specific design processes and tools that our local implementing partners use to develop their SBCC activities	37 (90%)	2 (5%)	0 (0%)	2 (5%)
3. Our program design processes and tools are easily applied by our local implementing partners	33 (80%)	3 (7%)	0 (0%)	5 (12%)
4. The in-country SBCC capacity strengthen support we provide has significantly improved the quality of in-country SBCC programming	32 (78%)	1 (2%)	0 (0%)	8 (20%)
C. SBCC Tools and resources				
1. We conduct assessments to identify specific needs before developing new resources	36 (88%)	3 (7%)	0 (0%)	2 (5%)
2. We conduct assessments to understand our end users before developing new resources	36 (88%)	0 (0%)	2 (5%)	3 (7%)

Areas Assessed	Strongly agree, Agree	Neutral	Disagree, Strongly disagree	Don't know
3.End users are consulted throughout the development process for new resources	31 (76%)	4 (10%)	1 (2%)	5 (12%)
4. Our iKits responds to the needs of implementing organizations	31 (76%)	3 (7%)	0 (0%)	7 (17%)
5. Our iKits are easily understood by implementing organizations	23 (56%)	4 (10%)	0 (0%)	13 (32%)
6.Our iKits are easily applied to implementing organizations	22 (54%)	5 (12%)	0 (0%)	14 (34%)
7. Our iKits have contributed significantly to improving the quality of SBCC interventions	22 (54%)	0 (0%)	0 (0%)	19 (46%)
8. Our how-to guides respond to the needs of implementing organizations	30 (73%)	2 (5%)	0 (0%)	9 (22%)
9. Our how-to guides are easily understood by implementing organizations	25 (61%)	1 (2%)	0 (0%)	15 (37%)
10. Our how to guides easily applied by implementing organizations	21 (51%)	2 (5%)	0 (0%)	18 (44%)
11. Our how to guides have contributed significantly to improving the quality of SBCC programs	19 (46%)	0 (0%)	0 (0%)	22 (54%)
12. Where we design and implement SBCC interventions, our programs promote local, original creation over adaptation of intervention models from other countries	25 (61%)	9 (22%)	3 (7%)	4 (10%)
13. Where we design and implement SBCC interventions, our programs include intervention approaches outside our traditional areas of intervention expertise	26 (63%)	8 (20%)	1 (2%)	6 (15%)
D. Research and Evaluation				
1. Our project contributes to the global SBCC evidence base	39 (95%)	1 (2%)	0 (0%)	1 (2%)
2. Our project completes research in a timely matter	25 (61%)	8 (20%)	2 (5%)	6 (15%)
3. Where we design and implement SBCC interventions, we have robust monitoring systems	34 (83%)	4 (10%)	2 (5%)	1 (2%)
4. Where we design and implement SBCC interventions, we use monitoring data to improve the performance of SBCC interventions	33 (80%)	0 (0%)	3 (7%)	5 (12%)
5. Where we design and implement SBCC interventions, we can accurately report our impact on behavior change	32 (78%)	6 (15%)	0 (0%)	3 (7%)

ICT DIAGNOSTIC SYNTHESIS

Indicates how each segment rated the ICT element—by digital tool and by dimensions

- HC: HealthCOMpass
- iKits: Implementation Kits
- SB: SpringBoard
- Mh: MHealth
- OV: Overarching
- USE: Usage
- ACC: Access/Demand
- INT: Integration
- FBK: Feedback
- SUS: Sustainability

Segmented by	HC	%	iKits	%	SB	%	Mh	%	OV	%	USE	%	ACC	%	INT	%	FBK	%	SUS	%
Full—no segmentation	4.4	87%	3.3	67%	2.7	54%	3.7	73%	2.9	58%	3.4	69%	3.5	70%	3.2	63%	2.8	56%	3.1	62%
Activity type—Direct Implementation	3.5	71%	3.3	66%	3.1	62%	2.9	59%	3.6	73%	3.8	76%	4.0	80%	3.4	67%	2.8	56%	3.5	69%
Activity type—Research & Evaluation	2.3	47%	1.8	36%	1.9	38%	1.9	39%	1.9	38%	2.1	41%	2.5	49%	1.8	36%	1.4	27%	1.6	31%
Activity type—Technical Assistance	3.7	74%	3.3	66%	3.5	70%	3.0	60%	3.6	71%	3.9	77%	3.9	78%	3.5	70%	2.7	55%	3.2	64%
Country Work—Across Countries	3.8	76%	3.4	69%	3.6	72%	3.0	61%	3.8	76%	3.7	74%	3.7	75%	3.6	72%	3.2	63%	3.6	73%
Country Work—Nigeria	2.6	52%	1.9	37%	2.4	48%	2.0	40%	1.2	24%	2.4	48%	2.1	43%	1.9	39%	1.4	28%	1.0	20%
Country Work—Other	3.9	78%	3.7	73%	3.5	69%	3.1	62%	3.8	76%	3.7	74%	4.0	80%	3.4	68%	3.6	71%	3.8	76%
Country Work—RCI	2.0	39%	2.0	39%	1.9	38%	2.3	46%	2.1	41%	2.6	52%	2.9	58%	1.9	39%	0.9	18%	1.4	28%
Expertise Length—Less than 10 years	3.0	61%	2.5	50%	2.7	55%	2.0	41%	2.5	51%	2.9	57%	2.9	58%	2.6	52%	2.2	44%	2.6	52%
Expertise Length—More than 10 years	3.8	76%	3.6	72%	3.6	71%	3.5	70%	3.8	77%	3.9	77%	4.0	79%	3.6	73%	3.3	65%	3.5	70%

Segmented by	HC	%	iKits	%	SB	%	Mh	%	OV	%	USE	%	ACC	%	INT	%	FBK	%	SUS	%
Health Area Experience Length—Less than 10 years	3.1	62%	2.7	55%	2.9	57%	2.6	51%	3.0	60%	3.1	62%	3.2	63%	2.8	57%	2.4	47%	2.9	59%
Health Area Experience Length—More than 10 years	4.1	82%	3.8	76%	3.7	75%	3.4	67%	3.8	76%	4.0	79%	4.1	82%	3.8	75%	3.6	71%	3.5	69%
Female	3.6	72%	3.3	65%	3.3	66%	2.8	55%	3.5	71%	3.6	71%	3.6	73%	3.3	66%	2.9	59%	3.5	69%
Male	3.2	64%	2.8	56%	2.9	59%	3.0	61%	2.7	54%	3.1	63%	3.2	65%	2.9	58%	2.5	50%	2.4	48%
Field of Expertise—CS/OD	4.8	96%	4.6	93%	4.1	81%	2.4	48%	4.6	93%	4.6	92%	4.8	95%	4.3	85%	4.5	90%	4.6	93%
Field of Expertise—Finance/Other	2.3	47%	2.3	45%	2.5	50%	2.5	49%	2.5	50%	2.5	49%	2.1	43%	2.5	50%	2.3	46%	2.7	53%
Field of Expertise—ICT	4.3	85%	4.3	86%	4.1	81%	4.1	82%	4.8	95%	4.2	85%	4.3	85%	4.3	85%	4.4	88%	4.8	95%
Field of Expertise—Research & Evaluation	1.7	35%	1.0	20%	1.4	28%	1.1	22%	0.8	17%	1.2	25%	1.6	32%	0.9	19%	0.7	14%	0.8	16%
Field of Expertise—SBCC	3.9	78%	3.5	70%	3.6	71%	3.2	64%	3.7	74%	3.9	79%	4.1	82%	3.6	73%	3.1	62%	3.5	69%
Funding Mechanisms under which work—Core	4.2	85%	3.8	77%	3.8	76%	3.4	67%	4.0	80%	3.9	78%	4.1	82%	3.8	75%	3.7	74%	3.9	78%
Funding Mechanisms under which work—Country buy-ins	3.1	62%	2.8	56%	2.9	57%	2.8	56%	3.2	64%	3.3	66%	3.4	68%	2.9	59%	2.3	46%	3.1	61%
Health Area Work in—Across more than 1	3.7	74%	3.3	67%	3.4	68%	2.9	58%	3.6	73%	3.7	73%	3.8	76%	3.4	69%	3.0	59%	3.5	70%
Health Area Work in—FP	4.9	98%	4.8	97%	4.4	87%	4.3	87%	4.9	98%	4.8	96%	4.9	98%	4.6	91%	4.8	95%	4.9	98%
Health Area Work in—HIV/AIDS	1.8	35%	1.6	33%	1.9	39%	2.0	41%	2.0	40%	1.9	39%	1.9	39%	1.9	37%	1.1	22%	1.7	34%
Health Area Work in—Malaria	3.9	77%	3.2	63%	3.3	66%	3.1	61%	2.6	53%	3.4	69%	3.5	69%	3.0	60%	2.8	56%	2.5	49%
Health Area Work in—Other	2.8	56%	2.6	53%	2.6	51%	2.1	43%	2.7	54%	2.7	55%	2.9	58%	2.5	49%	2.6	52%	2.5	50%
Length of Time with HC3—Less than 2	3.2	64%	2.8	55%	2.9	57%	2.5	51%	2.8	56%	3.2	65%	3.2	64%	2.8	56%	2.3	45%	2.6	52%

Segmented by	HC	%	iKits	%	SB	%	Mh	%	OV	%	USE	%	ACC	%	INT	%	FBK	%	SUS	%
years																				
Length of Time with HC3—More than 2 years, since beginning	3.8	76%	3.6	72%	3.6	72%	3.3	65%	3.9	78%	3.7	73%	3.9	78%	3.6	73%	3.5	70%	3.7	75%
Role—Operations	2.8	56%	2.7	53%	2.7	54%	2.5	50%	2.7	54%	2.8	57%	2.7	54%	2.7	54%	2.5	50%	2.9	58%
Role—Senior Management	4.1	82%	3.9	77%	3.9	79%	3.8	76%	4.4	87%	4.0	79%	4.4	87%	3.9	79%	3.7	74%	4.2	84%
Role—Technical	2.7	54%	2.7	54%	2.6	53%	2.3	47%	2.6	52%	3.4	68%	3.6	72%	3.0	59%	2.1	43%	2.1	43%
Work—At Headquarters	3.7	74%	3.4	68%	3.4	68%	2.9	58%	3.6	73%	3.6	72%	3.7	74%	3.4	68%	3.1	62%	3.5	69%
Work—In country	2.6	52%	2.2	44%	2.4	47%	2.7	53%	2.0	39%	2.7	54%	2.8	55%	2.3	45%	1.6	31%	1.6	33%
Springboard member: YES	3.7	75%	3.4	67%	3.4	69%	3.1	61%	3.5	71%	3.7	74%	3.8	76%	3.4	69%	3.0	61%	3.3	66%
Springboard member: NO	0.2	4%	0.1	2%	0.0	0%	0.1	3%	0.0	0%	0.1	2%	0.2	3%	0.0	0%	0.0	0%	0.0	0%
Attended F2F: YES	4.2	85%	3.8	76%	4.0	80%	3.7	75%	4.0	79%	4.0	80%	4.0	81%	4.0	79%	3.6	73%	3.7	75%
Attended F2F: NO	2.9	59%	2.6	53%	2.6	53%	2.2	45%	2.8	56%	3.0	60%	3.1	63%	2.6	52%	2.2	44%	2.7	53%

Usage

1. HC3's Health Compass is a good source of curated, high quality SBCC materials
1. HC3's iKits are a good source of curated, high quality SBBC guidance on specific topics
7. Using SpringBoard I find guidance to a SBCC question I faced
4. HealthCompass is designed for people like my SBCC partners
4. iKits are designed for people like my SBCC partners
5. SpringBoard is able to support the needs of people like my SBCC partners to find peer based support
5. Our SBCC partners are able to use HealthCompass to find high quality tools they use in their SBCC implementation
5. Our SBCC partners are able to use iKits to improve their SBCC implementation
3. HealthCompass is designed for people like me
3. iKits are designed for people like me
4. SpringBoard is able to support the needs of people like me to find peer based support

ACCESS/DEMAND

2. I find HealthCompass easy to access from my normal work location to quickly find SBCC materials
2. I find iKits easy to access from my normal work location
3. I find SpringBoard digital platform easy to access from my normal work location to collaborate with peers.
4. HC3 online SBCC tools are integrated to allows for user based searching
12. I have recommended others to use HealthCompass for their work in SBCC
8. I have recommended others to use at least on of the iKits for their work in SBCC

INTEGRATION

6. I use SpringBoard to share information or find peers to interact with
11. I use HealthCompass to find materials for my job
7. I use at least on iKit for my job
11. SpringBoard is a useful resource for me for my job at HC3
2. HC3 online SBCC tools are a core element of HC#s capacity building mandate
3. HC3 online SBCC tools are a core element of HC3a direct implementation work
1. HC3 Online SBCC tools are a core element of HC3s technical leadership mandate
10. SpringBoard events are usefulfor providing technical leadership on the ground with our partners
8. SpringBoard on the ground and online events are well integrated
9. SpringBoard on the ground and online events are mutually reinforcing

FEEDBACK

9. Web analytics are reviewed for insight into user behavior
11. Web analytics are reviewed for insight into user behavior
13. I feel the healthCompass has improved in usefulness for SBBC users since I first saw it.
13. I feel the iKits have improved in usefulness for SBCC user since I first saw them.
8. Improvements identified through these recommendations for HealthCompass are made to the site
10. Improvements identified through these recommendations for iKit sare made to them
10. Improvements identified through web analytics for HealthCompass are made to the site
12. Improvements identified through web analytics for iKits aremade them
9. Recommendations for improvements to iKits are sought from users
7. Recommendations for improvements to HealthCompass materials are sought from user
6. HealthCompass has a standard publication improvement process to keep quality at expected levels
6. iKits has a standard publication improvement process to keep their quality at expected levels

Sustainability

5. HC3 online SBCC tools are prioritized by senior management
6. HC3 online SBCC tools are prioritized by USAID
7. HC3 online SBCC tools are given enough resources to fulfill their role
8. HC3 online tools are an important repository of USAID funded SBCC materials created by non HC3 staff

SNAPSHOT SURVEY SYNTHESES

Organizational Effectiveness Snapshot Survey Synthesis (N=41 Non HC3 staff)

Where non-HC3 staff would place HC3 overall on a scale of 1 to 5

Total Scores by Profile	Score	%
Full Results	3.7	74
Female	3.6	72
Male	3	60
Senior Management	3.5	70
Technical Support	3.9	78
Operational Staff	2.9	58
Other Work Title	3.7	74
International NGOs	3.6	72
Local NGOs	4.1	82
Government	3.3	66
Other Org Type	4.4	88
Less than 1 year	3.6	72
More than 1 year	3.8	76
RCI	3.8	76
Guatemala	3.5	70
Nigeria	3.7	74

How non-HC3 staff rated HC3 by Question Asked on a scale of 1 to 5

Totals by Question Asked:	Score	%
HC3 has strong networks and partners.	3.9	77
HC3 has clear leadership.	3.8	77
HC3 is delivering quality products.	4.1	83
HC3 is creating innovative interventions.	3.9	78
HC3 is accurate in its reporting.	3.4	68
HC3 is responsive to client demands.	3.8	77
HC3 is effective to its responses to on-the-ground needs.	3.5	69
HC3 is timely in its delivery.	3.0	61
HC3 has adapted well to changing priorities.	3.7	73

SBCC SNAPSHOT SURVEY SYNTHESIS (N=41 NON-HC3 STAFF)

Questions Asksed	Strongly agree/agree	Neutral	Disagree/Strongly disagree	No response
1. HC3 is a technical leader in the field of Social and Behavior Change Communication (SBCC).	40 (98%)	1 (2%)	0 (0%)	0 (0%)
2. HC3 has improved the quality of SBCC technical resources available to me.	31 (76%)	7 (17%)	1 (2%)	2 (5%)
3. The SBCC technical resources promoted by HC3 respond to my technical needs.	31 (76%)	6 (15%)	0 (0%)	4 (10%)
4. The SBCC technical resources promoted by HC3 have introduced me to new approaches.	35 (85%)	3 (7%)	2 (5%)	1 (2%)
5. The SBCC technical resources promoted by HC3 are of high quality.	37 (90%)	2 (5%)	0 (0%)	2 (5%)
6. HC3's SBCC technical resources are easy to apply in my context.	27 (66%)	8 (20%)	2 (5%)	4 (10%)
7. HC3's SBCC technical resources are different from those promoted by other projects.	22 (54%)	9 (22%)	4 (10%)	6 (15%)
8. I consult HC3's websites (Springboard, HealthCOMpass, Implementation Kits and How-to Guides) when I need ideas to help me design a new intervention or tool.	9 (22%)	16 (39%)	12 (29%)	4 (10%)
9. HC3 actively engages other SBCC implementers to contribute to its activities.	25 (61%)	9 (22%)	3 (7%)	4 (10%)
10. HC3 contributes to global evidence by sharing research on the effectiveness of SBCC interventions.	27 (66%)	9 (22%)	1 (2%)	4 (10%)

ICT Snapshot Survey Synthesis (N=41 non-HC3 staff)

Disaggretation	Gen	Gen %	SB	SB %	HC	HC %	iKit	iKit %	Usage	Usage %	Access	Access %	Integration ave	Integration %
Full	2.6	52%	2.3	46%	2.6	51%	2.4	47%	2.5	50%	2.4	48%	2.8	56%
HC3 staff: No	2.6	52%	2.3	46%	**2.6**	51%	2.4	47%	2.5	50%	2.5	49%	2.8	56%
Gender: Male	2.7	54%	2.6	51%	2.6	52%	2.5	50%	2.6	52%	2.6	51%	3.0	60%
Gender: Female	2.5	50%	2.1	43%	2.5	51%	2.4	48%	2.4	49%	2.3	46%	2.7	54%
Country: Nigeria	2.9	59%	2.9	57%	2.9	58%	2.5	50%	2.9	58%	2.6	53%	3.0	60%
Country: Guatemala	1.9	38%	1.3	25%	1.6	31%	1.7	35%	1.5	30%	1.6	32%	2.2	45%
Country: RCI	2.8	55%	2.3	45%	2.4	48%	2.7	53%	2.3	46%	2.7	53%	2.7	54%
Country: Bangladesh	3.0	60%	4.0	80%	**3.8**	76%	3.4	68%	3.9	77%	3.6	72%	3.4	68%
Country: Other	2.8	57%	2.8	57%	**3.7**	74%	**3.0**	60%	3.5	69%	3.0	61%	3.3	66%
Role: Technical Support	3.1	61%	2.9	58%	2.8	56%	2.5	49%	2.9	59%	2.4	48%	3.0	59%
Role: Operational Staff	2.5	50%	2.1	43%	2.1	42%	2.2	43%	1.9	39%	2.4	47%	2.6	51%
Role: Senior management	2.7	54%	2.2	44%	2.8	55%	2.4	48%	2.5	51%	2.4	47%	2.9	57%
Org: iNGO	2.7	54%	2.3	45%	2.3	47%	2.2	45%	2.2	44%	2.2	45%	2.7	54%
org: local NGO	3.3	65%	3.2	63%	3.1	61%	2.5	51%	3.2	64%	2.7	54%	3.1	63%
org: government	2.2	44%	2.0	41%	2.6	53%	2.2	44%	2.3	46%	2.6	52%	2.6	52%
Org: other	2.0	40%	1.0	20%	0.4	8%	0.4	8%	0.6	11%	0.4	8%	2.6	52%
1-12 months	2.2	44%	1.9	39%	2.3	45%	2.1	42%	2.6	51%	2.1	43%	2.6	51%
13 + months	3.1	62%	2.9	58%	3.2	63%	2.8	56%	2.7	53%	2.8	57%	3.1	62%
used an Ikit—YES	3.3	67%	3.3	66%	3.8	76%	3.0	60%	3.2	63%	2.9	58%	3.0	60%
used an Ikit—NO	2.4	48%	2.0	41%	2.2	44%	2.2	44%	2.4	47%	2.3	45%	2.8	56%
SB account: YES	3.6	71%	3.5	70%	3.5	71%	3.0	59%	3.5	71%	3.2	64%	3.3	66%
SB account: NO	2.0	39%	1.6	31%	1.9	39%	2.0	40%	1.9	37%	1.9	37%	2.5	49%

Disaggretation	Gen	Gen %	SB	SB %	HC	HC %	iKit	iKit %	Usage	Usage %	Access	Access %	Integration ave	Integration %
Accessed HC: Yes	3.3	67%	3.1	62%	3.7	75%	2.9	57%	3.4	68%	3.1	63%	3.3	65%
Accessed HC: No	2.0	39%	3.1	62%	3.7	75%	2.9	57%	1.7	35%	1.8	37%	2.4	48%
Accessed SB Yes	3.5	70%	3.4	68%	3.1	63%	2.6	51%	3.3	66%	2.9	58%	3.1	63%
Accessed SB No	2.1	42%	1.7	35%	2.3	45%	2.3	45%	2.1	42%	2.1	43%	2.6	52%
in-person event? YES	2.5	49%	2.2	44%	2.6	51%	2.3	46%	2.4	49%	2.3	47%	2.8	56%
in-person event? NO	2.9	58%	2.7	55%	2.8	56%	2.8	55%	2.9	58%	2.8	55%	2.8	56%

The above was analyzed in two factors:-by tool and by dimension. Two dimension (feedback and sustainability) were not included in the pocket survey as no questions were asked on these two areas, since users would most likely not have meaningful experience with these elements.

USAGE QUESTIONS

- HC3's HealthCOMpass is a good source of curated, high-quality SBCC resources.
- I consult HC3's websites (Springboard, HealthCOMpass, Implementation Kits and How to Guides) when I need ideas to help me design a new intervention or tool
- Springboard is able to support the needs of people like me to find peer based support.
- Using Springboard I found at least one answer and/or guidance to a SBCC question I faced
- HealthCOMpass is designed for people like me.
- I-Kits are designed for people like me.
- HC3's Implementation Kits (I-Kits) are a good source of high-quality SBCC guidance on specific topics.

ACCESS/DEMAND

- I find HealthCOMpass easy to access from my normal work location to quickly find SBCC resources.
- I find Springboard digital platform easy to use and access from my normal work location to collaborate with peers.
- I have recommended that others use HealthCOMpass for their work in SBCC.
- I find I-Kits easy to access from my normal work location.
- I have recommended others to use at least one of the I-Kits for their work in SBCC.

INTEGRATION

- HC3 actively engages other SBCC implementers to contribute to its activities.
- I have used Springboard to share information or find peers to interact with.
- HC3 contributes to global evidence by sharing research on the effectiveness of SBCC interventions.
- I have used at least one I-Kit for my job.
- I use HealthCOMpass to find resources for my job.

APPENDIX N. SPRINGBOARD SYNTHESIS AND RECOMMENDATIONS

Springboard is a global community of practice (CoP) for SBCC, with the goal of building global SBCC capacity through peer based support. The evaluation team was asked to look specifically at Springboard and provide detailed analysis and recommendations for HC3 and USAID on springboard.

SUMMARY

Building a community of practice takes time, energy, and resources. Springboard position as an online CoP is good. The weaknesses come from the integration with programming, especially of on-the-ground activities. Springboard has a lot of potential and a lot of good will created by existing SBCC practitioners, plus a good basis for membership and engagement. The first three years were focused on building the platform and approach, building community, and processes. Now is the time for more context growth and deepening within the community. There has been confusion between engagement and sustainability. Engagement is about building community and learning patterns. Sustainability is about building commitment, processes, and resources to continue.

Several challenges have been presented by HC3s present approach. A lack of detailed benchmarking of what "success" looks like means that there may be unrealistic expectations by USAID or HC3 or others on what Springboard is capable of in what time period. Springboard is not clearly linked to HC3's capacity building agenda through direct implementation; it doesn't look like a value-add to Missions, but rather a distraction or add on. Not enough depth in CoP development on-the-ground has undermined the ability to deepen and grow in specific countries. Growth to other countries can undermine sustainability in a specific country, by diverting resources and focused attention from the moderator, the secretariats and HC3 HQ staff.

Recommendations include: (1) focus on places where HC3 or its partners have an existing on-the-ground presence and existing springboard community; (2) build specific country level engagement strategies; (3) document the roll out process to build a franchise model, and test to see how effective it is, for sustainability, especially looking at real costs of development and maintaining springboard communities; and (4) look at developing benchmarks as well as designing behavioral outcome indicators in measuring Return on investment (ROI) for a CoP, perhaps using elements of SBCC theory, such as interpersonal communication for in person events.

It should be kept in mind that to effectively build a CoP from scratch requires six steps: (1) inquire, (2) design, (3) prototype, (4) launch, (5) grow, and (6) sustain. The first four have been completed by HC3, while the last two can only occur in a context specific environment.

SPRINGBOARD: DETAILED EVALUATION FINDINGS[26]

Usage

Many field-based interviewees mentioned the need and value for networking and community collaboration in SBCC, and active members shared positive feelings towards Springboard, "*we have the opportunity of learning first hand as well as having new and innovative information on SBCC*" (Country partner). Interviews with local partners showed excitement for such a community and an eagerness to participate. However, many interviewed have also stated that Springboard has not fully realized its potential.

Springboard has experienced rapid growth in the first 24 months of Springboard existence (over 3000 members globally). The primary users of Springboard online and face-to-face seem to be SBCC practitioners and those who are involved in SBCC, communication managers at NGOs, for example, based on observations and Springboard site analysis. Almost 1000 (32%) members self-identify as coming from an NGO, with 327 (11%) from governments. Students and JHU staff are also present (337 or 11% and 314 or 10% respectively[27]). Springboard has a sizable population from or based overseas, such as Nigeria, Uganda, Zimbabwe, and India. While the US leads in terms of number of visits (4435), those four countries alone and together make up almost as many visits (3009), which should be remarked on due to the difference in connectivity, the per capita number of SBCC practitioners, and the early stage of Springboard community development, especially in India.

As of June 2015, Springboard has had launches in nine countries, with five country and two regional forums, representing 364 participants. Four more countries were scheduled for July/August 2015 and a Global SBCC summit is planned for February 2016. The evaluation team attended a Springboard learning forum in Abuja which had 43 attendees, on the topic of Social Media usage for SBCC practitioners.

However, several missions, especially in Asia, have not agreed to requests for launches, expressing concerns over how Springboard supports the work they want HC3 to perform for them in country. "*…the ideal of promoting south-to-south communication and sharing experiences is valued and appreciated… it was not and is not the focus of what the Mission health programming needs from the HC3 project…"* (USAID Mission). Some Missions were additionally concerned that the Springboard "*…activity is a distraction from their SBCC portfolio of work"* (USAID DC). There has been feedback that the launch events seem overly complex for their purpose "*…evening meal for 150 people, seemed at the time to be somewhat excessive…"* (USAID Mission). In country partners mentioned that they need a dedicated staff person on staff to build active engagement online and provide marketing into the community, face-to-face as well as online, but they did not have the budget for such activities. USAID DC mentioned that the launches did not seem to create the organic community development anticipated, and as such, and in light of substantial push back from Bangladesh and Swaziland Missions agreed with HC3's recommendation that Springboard on-the-ground activities should be re-oriented to learning forums.

[26] Some of this text is repeated in the main report and in the syntheses—this is a full report of the findings based on USAID's express need for Springboard analysis.

[27] NGO members or university participants may include JHU staff as different data points were used to count JHU staff.

Integration

According to the HC3 diagnostic survey, 90% of all HC3 staff, 88% of field staff, and 94% of HQ. 39% of Snapshot survey respondents, who were overrepresented by HC3 national partners and insufficiently represented by local partners based on response rates. 47% of HC3 HQ staff have attended a face-to-face SpringBoard event, while 25% of country staff have attended one.[28] An average of 74% of HC3 HQ staff and 54% of HC3 country staff felt satisfied with integration of SpringBoard into HC3s work.[29] HC3 user survey showed 86% of users found SpringBoard directly useful for their work. SpringBoard was used as a discussion platform for the Youth Long-Acting Reversible Contraceptives (LARC) program and Counterfeit Drugs, and the "*advisory council meeting used SpringBoard as a model*" (HC3 Staff) for integration between face-to-face and online collaboration in Tanzania.

Topics discussed on the board are directly relevant to SBCC and USAID health topics. Themes with above 40 posts in the group have been: Capacity Strengthening (49), Ebola (111), Entertainment-education (43), Family Planning (75), Ghana (74), HIV/AIDS (74), ICT and innovation (138), Malaria (61) Media and Messaging (45), Nigeria (57), Social Marketing (81), Springboard (78), Uganda (45), and Zimbabwe (77). Springboard has started developing short "Springboard in Action" documents to show the value on-the-ground to SBCC practitioners. Many non-HC3 respondents expressed the opinion that SpringBoard as a peer-based capacity building platform has potential, but has not been as effective as desired "…*wanted to be great but it doesn't feel like it's working in the way it was supposed to"* (USAID DC) and "*SpringBoard has not sprung yet…"* (HC3 Partner). In quantitative surveys with HC3 staff and external partners, SpringBoard got the lowest ratings across all dimensions, 54% for HC3 staff, and 46% for external partners, of all digital tools. The Nigeria SpringBoard event observed by the team made a presentation about the online discussion board, encouraging sign ups and the installation of the app, but did not walk the users through the site due to limited internet connectivity. There were no follow on activities from the event for SpringBoard online other than posting photos taken at the event.

HealthCOMpass and SpringBoard websites have increased their physical integration through RSS feeds, resulting in approximately 10% of web traffic to HealthCOMpass coming from Springboard. HC3 stated their integration strategy between the two sites as having SpringBoard "*is a place where heavy content can be linked to and discussed*" (HC3 Staff), while HealthCOMpass remains the repository for the 'heavy' content, such as Implementation Kits, "…*SpringBoard is great and links me to a lot of interesting materials, both from HC3 and not…"* (HC3 User survey). In terms of integration into the larger SBCC Community, web analytics showed that the four HC3 sites generated 288 links and 2853 sessions on HealthCOMpass.

Access/Demand

HC3 developed the "Modern Communities of Practice" guide, which has been used to guide Springboard development. For example, the Springboard team has a dedicated moderator, as well as support for regional and country-led programs through the regional secretariats. Early documents on 'Marketplace,' early SpringBoard name, shows audience identification research was performed and directly influenced the original design. A detailed assessment of the needs

[28] Includes staff in countries which have not yet held a SpringBoard event.

[29] Please see Appendices J and K on methodology of integration measurements.

for the, then Marketplace now Springboard, in Anglophone Africa was performed by an independent firm, though no similar document was found for Asia or other parts of Africa.

According to Google analytics, 38% (7126 sessions) were more than one minute long, and 32% (15922 sessions) visited more than 3 pages during one session, indicating that many users are reading content, "lurking." This observation was bolstered by Springboard strata data, which shows 91% of users are lurkers, and 8% posters. Most posts also came from the US, 1004 versus the top two countries of Uganda 168, Bangladesh 94, indicating a large number of Springboard users outside the US are lurkers. 20% of users visited at least monthly, of whom, 14% visit weekly, and 5% of those visit daily.

The evaluation team found that some key audiences, local SBCC practitioners performing direct implementation on-the-ground, were not aware of Springboard, despite having both internet access and digital capacity to use online learning tools. Interviews with country partners indicated that a barrier for them to SpringBoard online use was a lack of time to use it for their own professional development, as they were not allowed to use work time to be on SpringBoard unless they were being explicitly paid to do so. Another barrier mentioned by more than one attendee was connectivity issues. During the SpringBoard event in Nigeria, there were difficulties in logging in to the app, one person out of approximately 40 was able to log on, including members of the evaluation team.

Language issues were cited as a barrier by interviewees. Holding the conversations only in English, interviewees mentioned, makes it less likely for non-Anglophone practitioners will participate.

Several interviewed in Nigeria expressed excitement over the Mobile App. *"[I]n Africa, people connect more using their phones; more connection via mobile than via computers in Africa, so an app would be more appropriate to how people use the Internet in Africa…"* (Country Partner).

FEEDBACK

Springboard online went through multiple iterations in the early days to improve based on user feedback, with the most recent iteration focused around country groups. Springboard advisory council seems to now be focused on country-led activities.

SUSTAINABILITY

Sustainability has been addressed from the initial proposal, with the design of a governance board, resource mobilization, and country led activities. Early design documents show AfriComNet-led community-mobilization strategic thinking process was central to the approach HC3 used for SpringBoard's design and roll out in Africa, based on formative research performed by an independent consulting firm on the potential for a CoP around SBCC in Anglophone Africa. There are no indications; however, that this sort of strategic approach was continued.

To build a CoP from scratch takes several steps, as outlined below, with HC3 actions as discovered by the team in the last column.[30]

Stage	*Step*	*Description*	*HC3 actions*
One	Inquire	Identify audience, purpose goals, and vision	Proposal, early design documents
Two	Design	Define activities, technologies, processes, roles	Proposal, early design documents
Three	Prototype	Pilot community, technology, refine	Early iterations of SpringBoard, first two advisory councils
Four	Launch	Roll out to broader audience	Launch events in country
Five	Grow	Engage members in ways to increase participation	Moderators, program integration, learning forums, , country strategies
Six	Sustain	Cultivate and assess knowledge products to inform new strategies and goals	Third advisory council, learning forums, country strategies

Recently, HC3 has reported the sustainability approach had undergone additional shifts to expand country-led focus reflecting their understanding that, "*Country context is important. We need to be mapping country context, and not creating general plans…"* (HC3 Partner). SpringBoard has also received in-kind contributions from CCP & local partners, such as "*meeting space and labor*" (HC3 staff). HC3 identified that AfriComNet as be unable to deliver the results required, and underwent a rapid selection of new secretariat partner, Africa Capacity Alliance, within three months. Some interviewees expressed concern about unrealistic expectations for sustainability for SpringBoard, commenting, "*Creating CoPs take time, like community mobilization, exchange of information, time needs to be given to the COP to sustain and flourish….*" (HC3 Partner).

ANALYSIS AND CONCLUSIONS

Usage

Communities of practice are valuable and needed as methods of peer-based capacity strengthening. However, creating a global CoP where one has never existed is very hard, and doubly hard in the environments in which HC3 is working due to many factors, such as infrastructure, too few practitioners, digital capacity, and time. Even creating a country-wide CoP is hard; but creating a global CoP that spans multiple regions and continents is even harder. Springboard's 3000 online users in less than 2 years in this context should be looked at as a success.

However, HC3 has not had the same success with in country events, despite a lot of resources being expended and some good strategic approaches, as listed in the original Marketplace design documents. While face-to-face events are highly important to building online communities,[31] HC3's broad, global strategy may be undermining their attempts to build the CoP by not being targeted enough to specific, on-the-ground needs. It seems that resources may be better used

[30] Community of Practice Design Guide, Cambridge, Darren, Soren Kalpan, and VIcki Suter 2005, http://net.educause.edu/ir/library/pdf/nli0531.pdf

[31] The Truly Monumental Guide to Building Online Communities, Mackwebsolutions.com https://s3-us-west-2.amazonaws.com/arthur-assets/The+Monumental+Guide+to+Building+Online+Communties.pdf downloaded September 2015.

on deepening engagement and support for communities in country than on expanding to new countries, especially when faced with significant pushback from Missions.

In addition, while the performance monitoring plan (PMP) has targets for Springboard usage, a clearer situation analysis would help set expectations for what "SpringBoard success" could be. This lack of expectation setting makes successes harder to see and harder to measure, especially when the challenge of building a global CoP is so great. This lack of benchmarking also causes a confusion between quality and quantity, i.e. how to determine how many members, how many/which countries, or how many events. Or should the emphasis be on quality as well, i.e. good community, members, discussion, events, and learning

Springboard seems to confuse marketing with engagement building in on-the-ground events. While a review of early design documents showed clearly that the HC3 team followed best practices around COP development stages one, two and three[32], Springboard seems to be stuck on "launches," i.e. stage four, letting people know it exists; without fully implementing the next two stages focused on deepening usage, i.e. stage five and six, grow and sustain. It is acknowledged that those final two stages need to be deeply connected to community needs in country or in each city and will take a lot of on the ground, focused resources.

Integration

Springboard activities, online and face-to-face, are not integrated fully into "how HC3 works," but too often a side event or afterthought. Instead of Springboard being used as a model and a resource for direct implementation, a "value add" of HC3, it is viewed by many Missions and partners alike as a distraction.

While Springboard online has been used to support program implementation, Springboard face-to-face has been more focused on marketing, launches and learning events. More recently, there has been increased attention on integrating the two, such as the experience of counterfeit Malaria drugs is one of the sole exceptions as a face-to-face workshop was extended through online private discussions after the event. Another example is the advisory council for Springboard where it was used to conduct discussion and activities around SpringBoard itself. These types of events should be the rule, not the exception, for how Springboard online and face-to-face are integrated.

Access/Demand

Not enough attention has been paid to how key audiences currently use the internet and social media for professional development and capacity building or use existing CoPs. It is not clear whether the early work on identification and audience analysis was ever checked and reanalyzed once real users were brought into Springboard. Additionally, there was good data as part of the AfriComNet assessment on how users could potentially use Springboard, but the team was unsure how/if it was used, especially after the design phase. The global nature of Springboard's strategy makes building CoPs harder, as audience usage varies greatly from city/country/region as well as changes over time.

The Springboard website is well designed and has many features that make up a good online CoP. Its branding is appropriate to the perceived audience: professional, friendly, and open. Face-to-face branding is consistent with online branding. The SpringBoard app and website,

[32] please see table above listing the stages of creating a COP

while responsive, have not been mobile-friendly, touch optimized, or reflective of core audience usage. There seem to be significant login challenges with the platform, especially with the App and Facebook integration. This needs to be tested to see if there is an issue to be addressed, as it was reported by several field users as a major barrier to access.

SUSTAINABILITY

Institutionalization of Community of Practice takes time and effort which is not sufficiently reflected in Springboard engagement or sustainability plans. Being able to build a global sustainable CoP from scratch in the five years of the project may have been an unrealistic expectation. The sustainability plan as designed has not worked as anticipated. There has been a weak partner, AfriComNet, some early challenges with funding the partner, and a delay in getting second partner, BCCP, started. Springboard has had underdeveloped "country-led" concepts, just because the work is done in country does not mean it is country-led. In addition, there has been unanticipated pushback from USAID missions because they see Springboard as a distraction and do not clearly perceive its value.

There is confusion over engagement and marketing. Launch parties are about marketing, but do not necessarily lead to engagement. There has been confusion between engagement and sustainability. Engagement is about building community and learning patterns. Sustainability is about building commitment, processes, and resources to continue.

SUGGESTIONS FOR HC3

- Revisit the ***"SpringBoard strategic plan***", focusing on execution for the final two years, plus sustainability beyond:
  - Distinguish between the engagement plan, i.e. building the CoP and getting people involved, and the sustainability plan, i.e. how it will live after USAID HC3 funding ends.
  - The sustainability plan needs to be a business case, including definitions of what sustainable looks like, needed resources to get there. It should also include best, middle and worst case scenarios in terms of resources (i.e. what happens if zero resources are found, vs. some additional resources, vs. dream level of support)
  - Strategic plan may include focusing on places where HC3 or its partners has an existing on-the-ground presence and existing springboard community, and building specific country level engagement strategies.
  - Look at developing benchmarks as well as designing behavioral outcome indicators in measuring ROI for a CoP, perhaps using elements of SBCC theory (such as IPC for in person events).
- Incorporate the following elements into the ***"engagement plan"***:
  - Look at Springboard face-to-face events through the lens of IPC. How do you design an IPC for professionals, where you are trying to improve their ability to deliver and advocate for SBCC?
  - Pulling from other USAID supported CoPs for additional ideas, such as:
    - Working groups around common needs expressed by the community

    - Representation of the CoP in other events by members of the community
    - How did those CoPs get funding from other USAID programs to attend CoP events, participate in leadership roles?
  - Starting with the information provided by the AfriComNet assessment from 2013, perform a detailed audience profile and segmentation analysis, as well as an up to date situation analysis per country for Springboard.
  - Extend the current indicators for Springboard with some benchmarking discovered in the situation analysis.
- Consider including the following in the ***"sustainability plan"***:
  - Come up with concrete ways SpringBoard can be integrated into direct implementation of buy in activities.
  - Come up with a pricing model of how the work that HC3 does on-the-ground can be supported through springboard.
  - Look at using SpringBoard, and other digital tools, as an opportunity for digital capacity building for local partners, including MOH, CBOs, and FBOs.
  - Country ownership may need to be formalized, especially in light of resource mobilization needs.
  - More resources may be required to build country level communities and using resources more effectively, i.e. fewer launch events, more resources to community moderators to support members and create impactful on-the-ground events.
  - If a franchise model is to be followed, a full **detailed business plan** for that franchise needs to be developed. I.e. is it like a membership organization like the Lions club, where new clubs have to be chartered by existing members, or like PriceWaterhouseCoopers with a loose brand affiliation but independently owned and operated.
- **"Website and App"** recommendations
  - For the website:
    - The banner area on some of the pages takes up a lot of real estate, which is especially problematic on smaller screens like tablets.
    - The design, while responsive, does not seem to be highly touch enabled, making using tablets harder.
    - Look at push notifications for responses for web browsers to build engagement.
    - More links to other sites to Springboard would help the reach (the vast majority of referrals to Springboard are from other HC3 sites, with relatively few from other USAID funded sites)
      - If appealing to non-Anglophone audiences, put some time into improving French/Spanish versions. The translation into other languages tool is kind of

odd. Some parts of the site translate and others don't. (for example, the top nav in blue translates but the global nav in line with the logo is in English only). Language was mentioned as a large barrier to non-English speakers, so if reaching out to these audiences is a priority, make the site more multi-lingual.

- For the App:
  - Create full requirements document, identified by the users (use Nigeria as a resource)
  - Create an MVP (minimum viable product) for first iteration focused on top needs
  - Suggested Requirements based on observation:
    - Phone or web-browser based notification of responses to messages.
    - Mobile optimized views of Springboard
    - Email-based message responses enabled
    - Email notifications on by default
    - Reduce banner space on mobile app (takes up a lot of real estate)
    - Improve touch enabled navigation.
  - Perform a comparative analysis of other mobile apps in a similar space, used by core audiences, and pull ideas for UX and features for App.
  - Quora, Linked In, Facebook, Twitter, WeChat, Instagram
  - Create usability testing plan for MVP—both interview/observation and web analytics testing

- Keep in mind the following when ***"framing Springboard"*:**
  - **COPs, virtual and face-to-face, can provide a space for[33],[34]**
    - Professional development at all stages of a career, especially when needing to incorporate emerging practices and technology.
    - Finding people and organizations with expertise through recommendations and "testing" their expertise through their experience in the community.
    - Addressing cross cutting issues, seed innovative ideas outside of traditional siloes, and connect lessons between different topics.
    - Creating community lead standards for best practices, indicators, and how to measure impact.
    - Advocacy for a topic by sharing stories, evidence, research, and moral support.
    - Creating a digital archive of conversations, ideas, and resources that can be used by researchers and other professionals.

[33] http://www.communitysense.nl/papers/hicss04b.pdf
[34] http://www.slideshare.net/sucipto_asan/community-of-practices-best-practice

- **Vibrant and effective COPs require:**[35]
  - Large enough community of perceived expertise to make experts feel they are among peers, and those not yet experts feel that they can both learn and contribute to the community.
  - Self-selection process for individuals based on expertise or passion for a topic
  - Members to have concrete, immediate need for support around the topic.
  - Ways to incorporate the CoP into work life without it being too intrusive or requiring too much time.
  - The community to be responsive to member needs as they arise.
  - The community to be responsive to different ways individuals learn, engage, and contribute.

[35] Ibid.

APPENDIX O. COUNTRY FINDINGS SYNTHESES

BRIEF COUNTRY PROFILES[36]

Profile	Guatemala	Nigeria	Côte d'Ivoire
Length of Time	1 year—2014	1 year—2014	2 years—2013 SuperGo! 1 year—2014 Brothers for Life
Primary Roles	Coordination & Support	Coordination, Direct Implementation & Support	Direct Implementation & Support
Number of Implementing Partners	15 [all USAID implementing partners who are members of the SBCC working group]	4 [2 NGOs + NMEP/SMEP + CCPN]	12 [11 NGOs + PNLS]
Number of Regions/Districts/States Working In	1 region—Western Highlands	2 states Kebbi and Akwa Ibom	3 locations—Abidjan, Abengourou, and San Pedro
Health Topic	Integrated, includes non-health topics	Malaria	HIV/AIDS
Approaches to Date	Coordination & workshops	National-level coordination TV, radio, print (brochures, flipcharts, banners), community-based (house-to-house, community dialogue)	Workshops (4, 2 hours sessions for a total of 10 hours]
Funding Mechanisms	Technical Assistance	Mission Buy-in	Mission Buy-in

[36] This information is as of the time of the Evaluation, August 2015 and is what the team used as a point of reference and comparison. It does not reflect upcoming and potential changes.

SYNTHESIS OF FINDINGS IN GUATEMALA

DATES VISITED July 11 to 16, 2015

CONDUCTED

- 13 (out of 14) interviews with USAID Mission staff
- 2 field visits
- 3 observations of nutrition and agriculture activities[37]
- 1 interactive group research exercise with 10 (out of 21) participating partners
- ## out of ## administered Snapshot Surveys

STRENGTHS IDENTIFIED IN GUATEMALA PROGRAM

Reported Qualities:

- Flexible—*"always willing to listen to new ideas and try things…"*
- Responsive—*"when we call, they are there…"*
- Professional—reportedly treat all with utmost respect and professionalism
- Collaborative—working with 21 organizations to coordinate an integrated USAID program in Western Highlands—an effort reportedly greatly appreciated by the partners and in-country staff
- Trusted—*"we feel that they know their business and we can learn from that…"*

Demonstrated and Reported Competencies:

- Rigorous analysis approach—examined numerous messages and materials to determine overlap, mis-messaging and contradictions. *"It was really impressive to see the results, we had not been aware that we were so together but also so far apart on some things…"*
- Cursory review of existing partners SBCC strategies—some benefited by a review and feedback on their existing SBCC strategy and report that they plan to make changes to it based on this feedback.
- Assistance in reinvigorating SBCC coordination structure—members of this structure felt that the leadership and coordination role being played by HC3 in moving things forward was welcomed, well-placed, and well-handled.
- Appropriate adaptation of some existing tools (Men and Boys Gender and Health Toolkit, and Water Diagnostic Tool)—Though experience with HealthCOMpass was limited, the experience reported was useful and provided adapted tools for the Western Highlands.
- Expertise in M&E, especially indicator development—HC3 apparently has been instructive in looking at and revising indicators for use in an integrated USAID program. It is unique in that it combines indicators for not only the health sector, but other sectors as well such democracy and governance, agriculture, economic development, etc.

[37] All photos in this Guatemala synthesis are of Save the Children's agriculture and nutrition project in Xela, Guatemala. Photos were taken by Lynne Cogswell.

WEAKNESSES REPORTED

Reported Qualities:

- Lack of timeliness—essential studies required to SBCC strategy development have been reportedly delayed with no sure timeframe—*"We can't start without these studies and we see no clear timeline for completion."*
- Inadequate inclusiveness—Though numerous activities have been reportedly conducted, some participating partners feel left out of the process and as such feel they are not really welcome to participate and share ideas, *"we know we don't all do things alike, but we can learn from each other to make a better program…"*
- Insufficiently proactive—In particular, while it is felt that the HC3 team is being incredibly responsive to the demands made to it, it is also felt that the team is not bringing new things to the table, helping the Mission and partners push the envelope, *"while we are making progress, we feel like most of the ideas are coming from us and HC3 is simply reacting to that. As a leader, we expect them to bring things to us…"*

Reported Lack of Competencies:

- Overly technical models—many complained that the models, theories, materials used are *"too academic"* and hard to follow, *"as communicators, they should know how to reach their audiences no matter the subject, not just use it because they have it…"*
- Insufficient tapping of sector and technical expertise—many reported and track-recorded partners are working in Guatemala. While all appear to appreciate the efforts of HC3, most feel that HC3 could better benefit from and utilized their expertise in the partnership and coordination.

- Insufficient audience segmentation—project and beneficiary—There has been no apparent focus given to clearly segmenting the work HC3 is doing with partners or intended beneficiaries, *"one size does not fit all…"*
- Inadequate assessment of level of partner competencies—Most felt, that the effort made initially to examine their SBCC skills was insufficient, didn't allow them to fully participate and respond, and didn't not allow them to provide suggestions.
- Lack of sufficient tailoring—It was felt by many that the programs brought are too generic and have not been sufficiently tailored to the needs of the group and participating partners, *"we feel like they are giving us what they think we need, without confirming whether we need it…"*
- Insufficient follow-up—While it is understood that the HC3 team for Guatemala is small and busy, some felt that follow-up on discussed issues and needed pieces was hindering process. Discussions have been held to improve this and an HC3 staff person and office is being pursued to help with the situation, *"we hope to get another Patricia, but here in Guatemala City, then things will function well…"*

OPPORTUNITIES

Taken

- Leadership role on community facilitators' response—HC3 reported took over the role of leading the effort to get community facilitators working again in a constructive way after a shutdown of the program. This involvement was not only welcomed, but reportedly instrumental in getting things moving again. *"They stepped up and helped us try to fill the gap left by government shutdown of health facilities…"*

- Message consistency analysis—This analysis has been very well received and reportedly an excellent learning lesson for the Mission and participating partners alike. It has pointed out some deficiencies in the materials and a way forward for rectifying the messages. *"I was so shocked to see that some of our messages were so far off, we really thought that all of us were on the same page…"*
- Situation analysis, including identification of new tracks (religious leaders)—This analysis was well-received and needed. It was professionally done and shared. It identified two new tracks for formative research that need to be completion for strategy development.
- Facilitation role in coordinating integration effort—the HC3 teams has reportedly reinvigorated the SBCC working group as well as encouraged SBCC staff of other sectors to join and participate in activities. They have provided leadership in moving forward that has been greatly valued and trusted.

Missed

- Insufficient promotion of global technical resources—There has been little or no promotion of or use of the HC3 e-portals and global resources. The SBCC committee members have even talked of housing their own repository online so that all of the excellent resources from C-Change are not lost. They were unfamiliar with HC3 curated repository and had no idea that it could provide this type of service.
- Inadequate building on good existing documentation and resources—use of C-Change strategy document & existing database of materials—HC3, while nodding to previous work done, has not reportedly taken recommendations and work completed sufficiently into account. Many feel that they are bringing in their models and theories to make it their own, even if something has been done that is good and solid and can be built upon.
- Incomplete review and recommendations on behavioral indicators—though much has been discussed on indicators and partners and the Mission feel that HC3 has the expertise, little has apparently been done (or discussed if indicators are felt to be premature given the status of the work). Most feel this is an oversight that should be rectified as soon as possible so that appropriate indicators can be established and not delayed.
- Inadequate use of existing partner expertise—Many felt that the existing partner expertise could be better identified and tapped, making for *"a true partnership."* Most greatly valued what HC3 brings to the table and hopes to not only benefit by this expertise, but share in return, when appropriate.

CHALLENGES

- Attempted "one size fits all" SBCC capacity strengthening—there is no apparent recognition on the part of HC3 that this is a challenge and thus no apparent fix has yet been suggested.
- Mismatched expectations—expectation of what SBCC can do and will be doing "*Often times we think we're heading in one direction and we end up somewhere else."*
- Unclarified HC3 mandate—it is unclear to most participating partners exactly what HC3's mandate is. It is even questioned at the Mission because they feel the Mission keeps setting the agenda and HC3 has not been proactive enough in helping shape the work.
- Slow pace for essential outputs—It was widely complained that research happens much too slowly. That essential work is delayed, which in this case is strategy development that then delays implementation. In this case both the religious leaders' and family dynamics research was at the time of this visit still on hold with no clear timeline for completing either. *"All want to respect the need for*

good evidence and solid research, but when it slows things down so much, it is hard to place a clear value-added on it."

- Maintaining good momentum—It has been apparently difficult for the HC3 team to keep the momentum going in the field. Though they visit often and their visits are generally viewed as quite productive, it doesn't seem to be enough. HC3 is presently in the process of trying to find a staff in-country to can take the work on and hopefully this will keep the momentum going.

POSSIBLE HC3 IMPROVEMENTS

- Conduct specific, individual, rapid SBCC capacity assessments with local implementing partners, as requested—this will enable all partners to understand how best to benefit by the integrated work, how best to participate, and how best to provide expertise when appropriate.
- Engage stronger SBBC partners to build up less experienced partners—this will allow all partners to utilize their best capacities and enable HC3 to truly be a leader and coordinator.
- Be proactive in aligning HC3 work with appropriate C-Change strategy recommendations and partner work—this will ensure that previous work of excellent quality can be used, disseminated, and acknowledged.
- Clarify HC3 role and objectives with participating partners—this will permit all to understand the direction the work is taking and where they fit in that picture.

- Determine ways that participating partners can better utilize online global technical resources—this will ensure that the excellent resources being put together by HC3 are accessed and used, thus eventually strengthening capacity.
- Create a dedicated spot for a curated Western Highlands Integrated Project repository on the HC3 website—this will ensure that all materials are available to all partners and to others in the region thus expanding HC3's leadership role and the potential impact of capacity strengthening.
- Conduct informal discussions with participating partner headquarters to ensure buy-in on theories, models, approaches—this will ensure that all partners are on the same page and that the theories, etc. are acceptable, appropriate, compatible, and comprehensible to all users and implementers.
- Provide illustrative menu of standard behavioral indicators, including training on difference between and development of process, behavioral/outcome and impact indicators—this will move the M&E agenda forward of not only Guatemala but of HC3 and provide a useful starting point to more unique measurements.
- Formalize SBCC working group—this will ensure that all partners feel part of a cohesive, strong, and integral group, instead of just a *"sometimes we get together when staff come…"*
- Simplify models, theories, and processes—remember the audience—this will ensure again that documents and processes used are acceptable, appropriate, compatible, and comprehensible to all users and implementers.

SUMMARY OF KEY POINTS

- Ability to gain technical leadership trust quickly
- High level of recognized and acknowledged SBCC expertise-----
- Insufficient understanding of and building on existing in-country strengths
- Slow pace of work-----
- Simplify
- Build on what exists that is/was working, avoid replacing with "new and shiny" just because

SYNTHESIS OF FINDINGS IN COTE D'IVOIRE

DATES VISITED: August 12 to 19 2015

CONDUCTED

- 5 (out of 9) interviews with USAID and PEPFAR Mission staff
- 15 individual or group interviews (36+ people)
- 13 focus group discussions with community leaders and former SuperGo! or Frères pour La Vie participants
- 1 interactive group research exercise with 15 participants
- 3 field visits (Yopougon, Abengourou, and San Pedro)
- 7 observations of Frères pour La Vie and SuperGo! Activities

STRENGTHS IDENTIFIED IN HC3'S COTE D'IVOIRE PROGRAM

Reported qualities:

- Responsive to PEPFAR—USAID views HC3 as a very responsive partner that does well to change program course as required by PEPFAR's changing priorities.
- Professional—partners report that HC3 staff treat them with respect and act professionally, which respondents feel further positions HC3 as a good collaborator.
- Trusted—many partners, including those funded by other donors, have sought out advice from HC3/CCP on SBCC issues, "It's a testament when other partners ask them for support."
- Flexible—USAID reports that HC3 is flexible, which allows it to better respond to a changing environment, "They've done really well in being flexible, they've shifted the focus of their IRs [at PEPFAR's request]."

Demonstrated and reported competencies:

- Good partner communication—partners feel that HC3 communicates well with them, keeping them informed of program activities as well as events organized or supported by HC3.
- Clear data collection processes—local partners especially appreciate that HC3 has a clear data collection and reporting process and provides support to ensure proper collection of activity data.
- Learning from experiences and adjusting—HC3 staff report application of lessons learned in implementing program activities, HC3 staff report using these lessons to inform program changes and experiments to maximize the impact of program activities, such as devising strategies to increase the yield of HIV-positive individuals reached by the program.
- Allowing local NGO partners to take the lead in implementation—local partners feel empowered to implement the programs according to local needs and report that HC3 provides appropriate support to give them with helpful guidelines without dictating specific strategies that might vary by location, especially with regards to community engagement and participant recruitment.

WEAKNESSES IDENTIFIED IN HC3'S CÔTE D'IVOIRE PROGRAM

Reported qualities:

- Weak strategic support—HC3/Baltimore provides limited technical support to strengthen the strategies used by the program to achieve PEPFAR objectives. For example, HC3's local staff are experimenting with strategies to increase the program's yield of HIV-positive individuals without input from HC3/Baltimore's HIV technical support team.
- Slow administrative processes—Respondents highlight delays in the finalization of sub-contracts and disbursement of funding, which caused some local NGOs to suspend activities, "JHU is not good at subawards and moving money, which really hurt them in the first year."
- Lack of collaboration—Government partners reported that HC3 does not collaborate with appropriate bodies to design program activities (beyond the identification of implementation sites)

or formulate annual priorities and targets. Respondents conceded that there is also limited collaboration with PEPFAR on annual targets and priorities, which may be affecting HC3's incentive to also collaborate.

Demonstrated and reported competencies:

- Weak evaluation activities—Respondents from USAID especially feel that HC3's evaluation activities are weak and focus too heavily on changes in knowledge and attitudes, "HC3 could do a better on the evaluation of activities, not just looking at attitudes but also looking at actual behavior change."
- Inadequate use of audience insight and segmentation—Respondents from USAID feel that program activities are insufficiently segmented, meaning that critical differences between sub-audiences are not taken into account when designing and implementing program activities, "SuperGo! needs to be revised and better segmented." Additionally, implementing partners reported they struggle to ensure that all participants benefit equally from program activities since some messaging does not apply to some participants, "When the message is relevant to their lives, the girls tend to listen better."
- Lack of strategic design and implementation—Interviews, observation of activities, and reviews of program tools indicate that although linked to the draft national strategy, HC3's program activities are not very strategic in terms of program approaches. For example, Frères pour La Vie sessions require over two hours to complete, which implementing partners report that the length of sessions is a major barrier to participation. The evaluation team felt that the challenge of audience recruitment and engagement was a symptom of insufficiently strategic approaches and is likely the result of limited use of audience insight and segmentation.
- Insufficient prioritization of messaging—Many respondents reported, and observations confirmed, that sessions often include too many messages, ""There's too much information in each session, [we] need to focus on what's essential." During one two-hour session observed by the evaluation team, 7 different messages were disseminated—ranging from family planning and fidelity to delaying sexual debut and HIV testing and treatment.
- Insufficient value-added—As a technical leader, some informants feel that HC3 should do more to generate insights that can be used to improve the performance of program activities, especially with regards to strategies to improve the yield of HIV-positive individuals reached through program activities.
- Inadequate capacity support of local NGO partners—Most local NGO partners reported limited capacity support from HC3, beyond initial training of field agents and supervision to implement program tools. A few partners reported that they had not yet received any capacity support from HC3 to implement even financial and data collection and reporting tools provided by the project.

OPPORTUNITIES

Taken:

- Recruited strong NGO partners—All of the partners visited by the evaluation team demonstrated strong capacity to implement program activities. Additionally, these NGOs have previous, relevant experience that allows them to tailor program activities to their communities. The majority has built extensive networks in their communities and are trusted resources for both community leaders and program audiences.
- Identified and used previously successful program elements—Activities have been built upon previous activities and strategies developed under previous programs, presenting an opportunity to improve on past successes.
- Started process of linkages between care and treatment—"They have done a good job, even without PEPFAR asking, to link community programs with HTC and having providers come to group sessions."
- Initiated innovative SMS program—The Frères pour La Vie program includes a small component of SMS messaging to encourage men who have completed the program to access HIV testing services.

- Provided assistance to sex workers and SMN to report harassment—HC3 worked with other implementing partners to develop an online tool for sex workers to report police harassment.
- Working with clinical partners on SMS to improve adherence—HC3 is working with clinical partners to design, pilot, and evaluate an SMS program to improve adherence among ART patients.

Missed:

- Assistance in reinvigorating CSM coordination structure—Beyond supporting the MOH to revise th national HIV prevention communication strategy, HC3 has provided limited support to MOH to improve the coordination of communication activities. Although PEPFAR support for such activities is limited, some interviewees question is HC3 could provide more information support, "How can HC3 work more with the Ministry to transfer competencies, working with the communication staff that support each service?"
- Engagement of community leaders—"They could engage community stakeholders better; they work through their NGOs and subpartners but we're less sure of how strong their engagement is of community leaders."
- Development a SBCC community of practice—Despite having trained a large cohort of program implementers in SBCC, HC3 has not facilitated the development of a local community of practice.
- Strengthening of local NGO partners to meet targets—Very little support has been provided to local NGO partners to improve organizational effectiveness that would contribute to achievement of annual targets.
- Promotion of global technical resources to meet targets—Very few respondents were aware of and even fewer had ever accessed global technical resources, including Springboard, HealthCOMpass, and the iKits.

CHALLENGES

- Overwhelming messages for audience and time frame—The SuperGo! and Frères pour La Vie program sessions are very long and sometimes include up to a dozen messages. It is unclear how many messages participants retain and the number of messages contributes significantly to the length of individual sessions and the overall programs.
- Reaching higher risk populations—Both programs struggle to reach higher risk individuals within each target audience. As a result, when HIV testing is offered, the yield of newly diagnosed HIV-positive clients is low.
- Electronically collecting and strategically using data—Much data is collected by program implementers and submitted to HC3 on a regular basis. Much of these data is not analyzed by local partners and is not used to inform adjustments to program activities.
- Selecting appropriate techniques/support materials for conditions and capacities—Support materials intended for each program may not be appropriate for audiences (due to illiteracy, especially among SuperGo! participants) or the locations where activities take place (lack of electricity to play TV spots or wall space to hang posters).
- Adapting appropriate models for audience needs and program objectives—The Frères pour La Vie program was adapted from South Africa but very few changes were made to the thematic areas. The context in which Brothers for Life was implemented was very different, especially in terms of program objectives. In Côte d'Ivoire, HC3 has a strong mandate to identify and link into testing HIV-positive individuals. However, the Frères pour La Vie modules include messages on family planning and modern contraceptives, PMTCT, and the function of genital organs. While these are all important themes, to what extent they contribute to the program's measure of success (i.e. getting men tested) is uncertain. Additionally, the number and length of the sessions was reported as a serious barrier to both participant recruitment and scale-up, two things that are required for program success.

- Achieving scale—The time commitment required to complete the program, both for participants and for facilitators, limits the programs ability to achieve scale. "For the investment, the number of people reached is not great."

POSSIBLE HC3 IMPROVEMENTS

- Improve strategies—The current activities are linked to the national SBCC strategy for HIV prevention, which was developed with support from HC3. While this strategy provides a strong foundation, each of the programs require their own strategies outlining the following:
  - Key behaviors—prioritized behaviors for each audience that are clearly linked to donor and MOH expected outcomes
  - Audience insight and segmentation—in-depth understanding of key audiences (in terms of needs, aspirations, life stage, and what they can expect to gain by adopting the promoted behaviors) and more nuanced segmentation of audiences
  - Message prioritization—messages prioritized by what will most affect behavior change
  - Communication channels—communication channels selected based on evidence and cost-effectiveness
  - Recruitment—strategies that use networks to reach those most at-risk (see below)
- Facilitate sharing across local NGOs to exchange and build on lessons learned—Many local NGO partners are experimenting with recruitment strategies and innovative approaches to community engagement. Opportunities should be created to support sharing of approaches and lessons among local NGO partners.
- Involve local NGO partners in all revisions going forward—Local NGOs should be included in future revisions to program tools. They understand best the strengths and challenges of each tool and approach and their inclusion in revisions would further their understanding of the tool and create ownership for the program.
- Consider multi-pronged media approach to increase reach and yield—Communication strategies should include the use of appropriate media channels to reinforce messages disseminated through community- and individual-level activities.
- Use phone-video/media to increase participation of at-risk populations—Some local NGOs have begun to experiment with social media and video testimonials from former participants. These efforts could be promising approaches to increasing use of social networks to recruit new participants and disseminate key messages.
- Explore social network approaches to reach high-risk populations—Much research has been conducted, mostly in the United States, which suggests indicates the potential of social networks to recruit higher risk populations for HIV testing activities. The program should explore adaption of these approaches to the CDI context and key audiences. For more information on these approaches, see http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5424a3.htm and https://effectiveinterventions.cdc.gov/en/HighImpactPrevention/PublicHealthStrategies/SocialNetworkStrategy/resources-and-tools-for-sns.

SUMMARY OF KEY POINTS

- Experiential and iterative learning
- Strong local NGO partners -----
- Limited use of audience insight and segmentation
- Overwhelming messaging -----
- Improve strategies through better audience insight and prioritization of messages
- Encourage more interaction among local NGOs

SYNTHESIS OF FINDINGS IN NIGERIA

DATES VISITED July 1 to 10, 2015

CONDUCTED

- 26 Interviews
- 2 Field Visits and Observations[38] (Kebbi and Akwa Ibom)– 6 community dialogues, 8 house-to-house, 5 focus group discussions, Springboard event (Abuja)
- 1 Interactive group research exercise (Abuja)
- USAID (8 out of 9—88%)
- Implementing Partners (7 out of 8—87%)
- Local beneficiaries

STRENGTHS REPORTED IN NIGERIA

Reported Qualities:

- HC3 is seen as flexible to changing needs by PMI and ASCM
- Responsive –"HC3 has established a clear/easy accessibility channel through emails, phone calls, office visits, participation in ACSM Meetings"[39]
- HC3 has professional staff who are well liked (both HC3 and its partners)/ provide mentoring
- The team is collaborative in its approach, especially in the support to ASCM. "HC3 is in partnership with relevant partners" [40]
- HC3 is trusted as a good partner by ACSM and other partners
- The implementing partners and ACSM felt HC3 was highly supportive of their needs.

Demonstrated and Reported Competencies:

- Assistance in reinvigorating SBCC coordination structure for malaria—this work got top marks by all spoken with.
- Adaptation of some national tools for state-level use (the Guidebook for SBCC)
- Good organizational communication (especially with ACSM)
- Clear sense of ownership of process and materials by local partners (especially ACSM, both national and state).
- Partnership building and inclusion at the national level was noted as well done.
- Clear M&E process and collection processes witnessed in the field.
- Advocacy plan was developed and shared across ACSM.
- HC3 developed and supported mechanisms to review and harmonize messages across the wider SBCC community.

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[38] All photos in this Nigeria synthesis are from focus groups, community dialogues, and house-to-house visits in Kebbi State and Akwa Ibom State, Nigeria with the NGOs Royaume and Community Partners for Development. Photos were taken by Lynne Cogswell.

[39] Group Activity

[40] Ibid

WEAKNESSES REPORTED

Reported Weak Qualities:

- Weak strategic leadership of HC3 in Nigeria—seemed to be more implementing an externally designed program rather than looking critically at how the program meets existing contexts.
- Unpreparedness for scale up/growth, especially moving from two states to 11 in a short period of time

Reported Lack of Competencies:

- **Lack of strategic vision—at all levels—short- and long-term (for immediate implementation as well as for long term scale up)**. This looked like a lack of clarity as to overarching goals and expectations, why activities and audiences were selected, and clear milestones to measure progress. Instead, work plans were developed, which focused on tasks and deliverables, but lacked information on the "why" of the project. A strong strategy would clearly outline and explain the selection of key behaviors to promote, key primary and secondary audiences, communication objectives and key messages, channels and interventions, and the positioning of the promoted behaviors. Importantly, a strong strategy would take into account cost-effectiveness and the appropriateness of prioritized channels/tools to the local context. After reviewing the various "strategic" documents provided by HC3 (i.e. key strategic approaches concept note, work plans, results framework, situation analysis, and creative briefs) the evaluation team was not able to conclude that a clear, evidence-based strategy, as described above, was in place. Developing a strong strategy is one of the important first steps in the development of a new communication program so it would have been expected that effort would have been made at the start of the project to complete this step early and correctly.

- **Insufficient audience insight & segmentation for project and beneficiaries:** None of the documentation we found (either the ACSM Guide or the country situation analysis), had detailed information on audiences, such as why they were selected/prioritized, their demographic/educational/behavioral details, why channels were selected for those audiences, etc. Creative briefs reviewed by the evaluation team did not provide any information about intended audiences beyond basic demographics that would be useful to designers of implementation tools to ensure that they are responsive to intended audiences.
- **Insufficient prioritization of messaging:** During the observed activities, the team saw too many messages delivered in too few channels without audience segmentation and profiling, which leads to inconsistent results. For example, we observed 12 messages being delivered to an audience of men, ranging in age from 2 to 80 during a 45 minute village dialogue. During home visits, no tailoring of messages to individual household situations was done; in one example, a family without any children under five years received messages about the importance of placing children under five under mosquito nets. Additionally, although activities to reach men were explained as efforts to create partner support for pregnant women to access ANC, no specific messaging addressed this behavior. Instead, men received the same messaging as women, which was primarily knowledge-based messaging.

- **Inconsistent application of the process to its full depth:** While several aspects of the P Process were clearly followed and implemented (such as field testing), several elements were either missing (audience segmentation and identification) or produced odd results (the usage of text heavy brochures in a community of high illiteracy in women or the message about female mosquitos being the ones with malaria). In addition, while there was a good M&E process, several quality checks were missing, causing issues such as mixing household visits and village dialogue participants (potentially resulting in double counting), not comparing referrals given with referrals received (when the information was available to the local partner), and not translating the paper based household surveys into digital formats, but rather going straight to aggregated data (missing a quality control and potential data reuse step).
- **Inadequate forum development between different partners**: While HC3 was identified as of high value for its national coordination efforts, they did not do the same either with the broader SBCC community outside ACSM, between levels of the ACSM and partners, or within their own NGO partner community. This observation includes the use of Springboard as a convening mechanism for SBCC capacity building in Nigeria but also providing the opportunity for local partner NGOs to be able to meet each other, state and national ACSM, NIFAA, and other malaria BCC partners.
- **Insufficient value-added by HC3:** Due to the above lacks, it is not clear what value HC3 offers other than selecting very good Nigerian and US staff and partners.

OPPORTUNITIES

Taken:

- **HC3's reinvigoration of ACSM**, at the national- and state-level, was very welcomed and valued by all parties interviewed, and seems to have built a platform for broader SBCC advocacy in Nigeria.
- **HC3's highly skilled staff** are well respected individuals who are highly valued by project partners.
- **HC3's programs** identify and use of previously successful program elements, such as the JPIEGO malaria program in Akwa Ibom.
- **Support for institutional capacity building** of local NGOs was highly appreciated by the local organizations.

Missed:

- **Insufficient promotion of global technical resources**. None of the local partners (CPD, Royal, or Akwa Ibom ACSM) had used or heard of Springboard or HealthCOMpass, despite having access to the internet, having experience in online learning, and being highly motivated to learn more about SBCC. All interviewed were very interested in learning more and asked for links and more information.
- **Inadequate involvement of national-level in state-level activities**. The national ACSM felt they needed more ability to provide technical assistance and oversight themselves to the field, rather than rely on HC3 to provide this oversight. They felt there needed to be additional coordination between State and National level ACSM programs.
- **Insufficient alignment of activities** between HC3 and ACSM in work planning, though this may be an artifact of project timing and therefore, this may be taken care of in the next round of work plan development.
- **Inadequate promotion of best practices** and evidence-based program/strategy development. The lack of discussions between the different parties means not enough

sharing of experiences is occurring. Many common best practices are missed, such as around the use of Springboard/HealthCOMpass with the local implementing partners, as well as what constitutes audience profiling and segmentation, development of interim milestones, appropriate use of behavioral indicators such as referrals received (rather than just given) for performance management, etc. The Nigeria SpringBoard event observed by the team made a presentation about the online discussion board, and encouraging sign ups and the installation of the app, but did not walk the users through the site due to connectivity issues. There was no follow on activities from the Event on SpringBoard online.

CHALLENGES

- A complete strategy with all the necessary elements is not in place. A complete strategy would provide a clear flow down from big picture to individual elements, allowing individual organizations to see their place in the overall approach and how their element contributes to the overall outcomes.

- HC3 seems overly focused on process, with the result of forgetting quality and purpose. An example is the ACSM national guide to help develop state level strategies. The approach is useful but the actual outcome is not very good—the actual strategies developed by it lack essential information on why activities, populations and messages were selected, and does not provide the strategic approach to Malaria Elimination in the state; rather it amounts to a checklist of activities and messages from the larger guide.
- HC3's tendency to want to reach all without audience segmentation and prioritization around risk and vulnerability means that resources are not being adequately prioritized. In addition, there is a clear disconnect between PMI audience priorities (pregnant women/children under 5) and the messaging (all people), resulting in a mismatch between demand generation and commodities provision.
- Springboard, HealthCOMpass and the other digital tools are great resources where there could be clear application in the Nigeria Malaria program (especially in capacity building at the state level, as well as National ACSM partners). However, these tools are not integrated into how HC3 does business but rather as an "add-on" to existing activities. The impact of not utilizing these e-portals and Springboard results in underbuilt community and digital capacity of local NGO partners who really need digital capacity building, especially around using ICTs for resource mobilization, peer support, professional and organizational development, and networking.
- The team seems to have a reactive staffing plan for all levels when addressing scale-up. HC3 is moving from two to 11 states very soon, something that USAID feels they have been aware of for 18 months. The evaluation team did not see or sense that the scale up plan was well formulated or forward thinking enough to meet the needs.
- Health providers are insufficiently engaged in work and process. Several community leaders mentioned that messages were the same for their communities, regardless of the quality of local health services. In addition, many complained that the information they were provided about costs for testing or availability of medications were met with different information

when at the health clinics. Finally, there was an opportunity to use community volunteers to do Rapid testing, avoiding the cost and time of going to a local clinic, something that was identified by local partners as an opportunity but not identified by HC3 as perhaps a country wide opportunity.

- M&E system counting/tabulation process and analytical use has holes that need to be examined. For example, the team suspected double counting of people at village dialogues and house visits. One would assume some overlap between the two audiences. Secondly, the team wondered why the healthcare referral slip was an HC3 template and not based on the Ministry of Health's system, and were concerned of lack of alignment between the systems. Also, while the local partner was reporting to HC3 on the number of referrals given, they were not reporting on the number of referrals received, despite receiving that information from local health care providers. The reason when asked was "HC3's template doesn't ask for it" which implies a focus on completing the form rather than data for project performance.
- In addition, household data was collected on paper surveys and then physically reviewed monthly by HC3 local partners for quality checks (good), but then that data was not transcribed literally into digital formats, but rather transformed into aggregated formats, with the paper copies physically kept in a room. This process is a challenge for several issues: it is starting to cause significant storage concerns for the local NGO, only having aggregated data makes HC3s compliance with the new ADS 579 Data publication requirements highly challenging, as well as losing key opportunities for important data analysis at the household level.

CONSIDERATIONS FOR POSSIBLE HC3 IMPROVEMENT

- Define Nigeria Strategic Plan, including scale up
  - Create a phased implementation plan—multiple terms, scale up plans
  - Before expansion, regroup with active partners and facilitate exchange of and building on lessons learned
- Include digital literacy in capacity building of local and national partners, by using HC3's online tools to deliver high quality, needed tools.
- Perform quality assurance strategies for BCC implementation, especially on the topics of:
  - Audience insight and segmentation
  - Communication objective development
  - Message prioritization
  - Channel selection
- Effectively implicate national-level in state-level activities, and build those relationships for sustainability.
- Consider a larger role for the community volunteers (CVs) (such as rapid testing) and health providers in SBCC programs.

SUMMARY OF KEY POINTS

- Strengthened capacity of ACSMs
- Reported local ownership

- Inadequate strategy
- Insufficient audience understanding

- Improve strategy for use by national- and state-levels
- Move services and commodities to the communities

HEALTH COMMUNICATION CAPACITY COLLABORATIVE

Midterm Evaluation

Response from the Health Communication Capacity Collaborative

February 24, 2016

USAID FROM THE AMERICAN PEOPLE

Thank you for the report

HC3 appreciates the recommendations provide by the evaluation team. Along with our activity managers at USAID, HC3 is pursuing the recommendations contained in the report. We agree that these recommendations will strengthen HC3's outputs and the project's legacy.

The overall negative tone of the report is inconsistent with the day-to-day reality of HC3 and its ongoing achievements. HC3 notes the many positive comments received regarding collaboration with the project from USAID and from project partners. As described in the evaluation report, HC3 is active in six technical areas. It has activities in 30 countries worldwide. USAID Missions have praised local HC3 management teams for their responsiveness and the quality of their work. The project also merited a 43 percent funding ceiling increase to accommodate increased demand for HC3's technical implementation, research and capacity services. HC3 is a vibrant, dynamic and highly active project.

The management and implementation of a global flagship such as HC3 requires balancing many factors to deliver the best possible project solution within time and funding constraints. Thus context is critical to understanding and assessing the circumstances under which HC3 operates.

Several significant changes at USAID have created a very different environment for project implementation than was conceived during the project development period. Many of the issues the evaluators describe reflect the tension that existed during the early years of HC3 between delivering the package of activities described in the project document (with a priority emphasis on capacity strengthening) versus the reality of funding requests, Mission targets and earmark mandates that prioritize and often require quick technical implementation. In many instances these mandates explicitly prohibited or removed overt capacity strengthening activities from HC3's scopes of work and budgets. HC3 is more complex and nuanced in size, financial scale and technical scope than the midterm evaluation was able to describe.

Consideration of the project cycle is also important in understanding and contextualizing HC3's decisions and approach. HC3 is a new project that differs substantially from its predecessor SBCC flagship awards. While HC3 has maintained some legacy resources from the C-Change project, including C-Hub and the online SBCC course, all other aspects of HC3 were initiated from the ground up starting in October 2012. At the time of the evaluation, HC3 had been active for 32 months. Within those 32 months, HC3 had supported country activities through field support for a maximum of 20 months; had operated the Springboard for Health Communication for 15 months; and had been intensively supporting Ebola epidemic response activities for 9 months.

The HC3 midterm evaluation focused on three targeted questions. While these three questions are important to the HC3 mandate, there are many aspects of the project that remain undiscussed and undescribed by the evaluation. The allegory of three blind men touching an elephant's trunk, leg and tail and arguing over the nature of the beast is a fitting analogy to understand the evaluation questions with respect to the overall project. As USAID has stated, HC3 has three main SBCC mandates: technical implementation, capacity strengthening, and research and evaluation. The midterm evaluation team was asked to view HC3 through a capacity lens. As a result, the team had little opportunity to investigate

the approach or impact of the majority of HC3's technical implementation across the different health areas or reflect on the quality and insight gained through HC3's research. Nor was the team able to visit mature country programs with an explicit SBCC capacity strengthening mandate, such as Bangladesh. It is important to contextualize the way in which this capacity-focused evaluation colors, frames and limits the findings of the midterm evaluation report with respect to the overall project.

Question 1: What progress has been made in achieving project objectives as described in the project RFA and PMP?

During the first half of the project cycle, HC3 focused its efforts on building a base of resources that will support greater technical SBCC excellence and improved performance by partners in their programs. Necessarily during the start-up phase, HC3 devoted the majority of its effort to the development of platforms and resources with global access, including the array of resources described in the midterm evaluation report – the Health COMpass, Springboard for Health Communication, Implementation Kits (I-Kit), How-to Guides, research primers and research briefs. While some of these materials were described in the initial project vision in response to the RFA, others grew out of a response to audience needs expressed through key informant interviews and an SBCC needs assessment conducted at the AfriComNet annual meeting in 2013. The data speaks for itself as evidence of the success and importance of these resources. The Life Saving Commodities Demand Generation I-Kit (the first produced by HC3) has been downloaded over 11,900 times. In the first three months after launch, the I-Kit for Urban Adolescent Sexual and Reproductive Health had 547 downloads. Likewise, resources on the Health COMpass have been downloaded over 8,500 times.

While the evaluation question refers to the RFA and PMP, the evaluators do not once discuss HC3 performance against its PMP. The project PMP is the negotiated and agreed-upon standard for program success between HC3 and USAID. HC3 has met or exceeded the majority of its PMP targets; although, it has fallen short on a few – for example, 37 percent of participants in HC3-sponsored capacity strengthening (CS) activities used the knowledge and/or skills learned in the past six months, against a Year 3 PMP target of 40 percent. Examples of targets met or exceeded include:

- Number of countries in which HC3 implemented CS activities in the past six months (Target 13): 15
- Number of organizations that participated in HC3-sponsored CS activities in the past six months (Target 35): 451
- Number of CS activities designed to engage the SBCC/ health communication academic community in the past year (Target 3): 3
- Number of interactions in the past six months with capacity strengthening tools accessed via the Health COMpass or HC3 website (Target 1,500): 16,465
- Proportion of university-affiliated individuals that incorporated HC3-resources in their work in the past year (Target 15 percent): 61 percent
- Number of HC3 activities that disseminated innovative approaches to SBCC in the past six months (Target 10): 59

- Number of HC3-sponsored activities that promoted exchange of technical information related to SBCC/ health communication (Target 2): 30
- Number of participants in HC3-sponsored activities that promoted exchange of technical information related to SBCC/ health communication (Target 700): 1,524
- Number of individuals who joined Springboard in the past six months (Target 650): 782

HC3 takes exception to the following statement from the evaluation report, "*HC3 conducted only 194 out of 650 planned HC3-sponsored activities and only 22 of more than 30 projected documents and materials describing SBCC best practices have been produced.*" HC3 management cannot replicate or verify where the evaluators found that only 194 of 650 planned activities had been completed. The denominator of 650 activities is not a number that is derived from the HC3 PMP. However, by the end of Year 3, HC3 had produced 82 materials describing best practices against our goal of 55 documents (of which 45 had been produced and reported in the Year 2 annual report). These materials are documented in HC3's annual and semi-annual reports and in our PMP reporting. Likewise, HC3 has published 12 articles in peer-reviewed journals through the end of Year 3 (not the four reported in the evaluation report.) Eight articles written by HC3 research staff did appear in a single supplement of the Journal of AIDS. Several additional articles are in the publication process at the time of this writing.

HC3 takes its PMP reporting seriously. As a project we review this data during project team meetings and use the results to inform decision making, improve performance or realign effort to ensure that we are delivering the project that we have promised to our donor.

Question 2: HC3 success at developing capacity to design, implement and evaluate high-quality SBCC at the regional and country level?

As the evaluation team notes, HC3 has developed high quality tools that are highly rated by users. At the midpoint of the project, HC3 has finished the development stage for its key capacity resources and is now devoting time to extending the reach and usability of its key offerings. HC3 appreciates the insight and guidance of the evaluation team on issues of streamlining user navigation of its digital offerings, more in-depth profiling of potential users and greater integration of Springboard into HC3 (and other SBCC partner) project activities. HC3 appreciates the recognition from the evaluation team of the valuable role Springboard can play in supporting peer-based capacity strengthening for SBCC.

As the project has matured, HC3 is devoting more resources to ensure the integration of capacity strengthening and skills building into all country-level programs. HC3 is focusing on this integration both in countries where capacity strengthening is an explicit and monitored program outcome and in environments where the capacity strengthening is framed as a positive result of meeting higher level behavioral targets. To this end, HC3 has now added two positions that are focused on strengthening integration and documenting the use of capacity strengthening approaches in country programs.

The evaluation report stresses the importance of audience segmentation to successful SBCC programs and capacity building. The HC3 team agrees wholeheartedly with the importance of this practice. It is a strategy that HC3 has incorporated from the project's inception. The limited number of conversations between the evaluation team and the project managers apparently did not allow for full discussion of

HC3's approach to formative research at all project levels. All of HC3's activities are designed with the end-user in mind. Stakeholders are involved in the design process from conceptualization through to use testing.

The evaluation report incorrectly states that there was no audience segmentation prior to the development of the Health COMpass or the Springboard. This is not correct. HC3 conducted a user needs and preferences survey among attendees of the AfriComNet annual meeting in Uganda in March 2013. This survey is reported in the HC3 Year 1 Annual Report. The survey was repeated during a Leadership in Strategic Health Communication workshop held in Ghana in April of the same year and also by staff of the Cote d'Ivoire field office among their counterparts. HC3 also conducts an annual user's survey to get feedback on priority needs from among the over 5,400 members of its listserv and 3,450 registered Springboard participants.

HC3 also uses tools such as the revised PROGRES questionnaire to apply "audience insight" to our organizational capacity strengthening work. The enhanced PROGRES tool identifies specific areas for focused capacity strengthening at the organizational level. This adaptation of a tool originally developed by MSH allows HC3 and its partners to prioritize whether capacity strengthening should focus on strategic planning, strengthened SBCC skills or organizational elements such as enhanced finance systems.

Audience segmentation is also a crucial part of all country program design. At the country level, audience segmentation takes place on many levels. Examples include programs such as HC3 Nepal which has developed specific campaigns targeting hard-to-reach audience segments, such as families of migrant workers and members of low-caste groups. HC3 has also developed family planning materials for specific audiences such as urban youth, women of advanced maternal age and high parity women. Other strategies for audience insight and audience profiling include consultative meetings, focus group discussions, participatory ethnographic research techniques (such as free listing, pile sorting, ranking, photo projection, etc) and pretesting and feedback on prototype materials.

Through our user surveys and outreach to partners such as the Core Group, HC3 believes that users find considerable value and use across the suite of our capacity offerings – whether online resources, virtual training or in-country technical assistance. In our review of the data provided in the evaluation report, HC3 finds some of the information provided by the evaluation team misleading. For example, the evaluation report states, "*Although 90% of non-HC3 survey respondents agreed that HC3 produces technical materials relevant to their needs, only 22% reported using HC3 resources in creating their own SBCC interventions or tools – sometimes, according to feedback, because the HC3 tools were too technical for non-SBCC experts*." Looking at the exact survey questions (on page 271), this statement is misleading. The questions for which 90 percent agreed was not about relevance, it was about perceived quality of HC3 materials. Twenty-two percent of respondents said they consult HC3 websites when they need ideas designing a new intervention or tool. During a review of the survey instruments, HC3 cannot find any broader question on use. The finding is further limited by the evaluation's sample size – only 41 non-HC3 staff. Figures from the last HC3 user survey do show better results. Among people who said they learned or gained something new from an HC3 resource, 65 percent had used the

material. Of respondents who said they didn't use the material and didn't intend to, none said it was because the material was too advanced or technical.

Question 3: How successful has HC3 been in its country programs?

At the time of writing, HC3 supports activities in 30 countries globally – ranging from small-scale collaborations to provide technical assistance to a Ministry or pilot testing new materials through to multi-year, multi-million dollar implementation of full-scale campaigns to address critical health issues on a national scale. The country programs that the evaluation team visited represent only a small, but successful, sample of HC3's work in countries. As the midterm evaluation report notes, USAID Missions are strongly positive about their experience working with HC3 and the quality of programs being implemented. "***They are our strongest prevention and communication partner***" (p 21).

HC3 recognizes that all programs have room for improvement. The midterm evaluation report has highlighted issues of strengthening communication between headquarters and all members of the local program team, streamlining the integration of knowledge and learning between headquarters and field offices and ensuring awareness of digital tools and resources. HC3 had identified many of these same issues in our internal reviews. The project appreciates the evaluation team's recommendations for strengthening its implementation in diverse communities globally.

Again, with the countries visited by the evaluation team, context is important.

Guatemala: HC3 is supporting USAID Guatemala's Western Highlands Integrated Program (WHIP) to develop an overarching SBCC strategy that will unify the voice of 18 partners across the health, nutrition, education, democracy and governance, economic development and climate change portfolios under the Presidential Feed the Future Initiative. USAID invited HC3 to join the WHIP partners in September 2014. In the 10 months before the evaluation visit, HC3 carried out a comprehensive situational analysis that included a literature review of over 50 peer-reviewed articles and program documents, an assessment (SWOT analysis) of SBCC field activities, a study on message consistency analysis (first 1,000 days) across 131 materials, the design and implementation of three landscaping studies on the inclusion of religious and indigenous leaders, radio penetration and preferences, and coverage and use of mobile technology and social media. As these activities were moving ahead, HC3 invested effort in revitalizing the WHIP project based Communication Technical Group – hosting three initial meetings with the participation of more than 12 projects, and rallying for their full engagement to make SBCC a catalyst for USAID's integration efforts.

Nigeria: HC3 is supporting Nigeria's Presidents Malaria Initiative response. HC3 began activities with an assessment visit in January 2014. Under the PMI guidance, HC3 was tasked to support strengthening the National Malaria Control Programme's ACSM division (ACSM is an abbreviation for advocacy, communication and social mobilization); implement a model program in two USAID priority states with high targets to justify continued PMI investment in Nigeria; and provide capacity strengthening support to NIFAA, a local implementing partner, to enable this organization to become a USAID direct recipient. The HC3 approach incorporates program elements that have been successful elsewhere and also new approaches, such as tracking intensity and concentration of interpersonal communication activities to

achieve critical mass and the use of transmedia to provide linked, reinforcing messages. On all its deliverables, HC3 has succeeded in meeting or exceeding PMP expectations. In July 2015, Admiral Zeimer commented that HC3's approach was "sophisticated and graduate level." The HC3 program in Nigeria is committed to working with local partners to ensure that Nigeria delivers outreach and use targets defined in the annual Malaria Operating Plan (MOP).

Côte d'Ivoire: The PEPFAR program is a legacy activity that HC3 inherited from earlier projects. The activities in Côte d'Ivoire (RCI) began under the CDC-funded HIV prevention program and transitioned to the USAID portfolio in late 2013. The focus and content of the HC3 portfolio, which began in October 2013, initially focused heavily on capacity strengthening with the RCI government and local partners. The program experienced a dramatic shift a year later under the restructured PEPFAR 3.0. The program budget was cut and all capacity elements were removed. PEPFAR requested a singular focus on implementation of activities geared towards key populations. The local HC3 team has worked hard to refocus the program to the new PEPFAR requirements, while also maintaining good relationships and a commitment to continued capacity strengthening with local SBCC implementing partners who are not as well-versed in the decision-making behind PEPFAR mandates.

While the evaluation team faults HC3 for its lack of innovation in country programs, HC3 is tasked to implement impactful programs based on sound theory and best program practice and principles. Initially, the mandate for innovation was purposely removed from HC3 and placed under the parallel TRANSFORM mechanism. HC3 is designed to deliver programs that will work because they are research-based, theory driven and apply tried and true principles of project implementation. This mandate does not mean, however, that HC3 does not infuse new elements into project programming. Through our global mandate, HC3 is able to share implementation experiences globally and apply them with adaptation in new contexts.

Innovation within the HC3 project is taking place in a variety of formats that span the spectrum from new programming approaches, new understandings of audiences based on research and new applications of digital technology. Brothers for Life and SuperGo were fresh and exciting approaches when first introduced to Cote d'Ivoire from Southern Africa. HC3 is pioneering approaches to improving contraceptive use among families of migrant workers. HC3 is using mobile technology to address gender dynamics in family planning counselling acceptance rates. HC3 is using new survey and mapping techniques to identify priority key populations for HIV services. HC3 is conducting research to improve VMMC counselling services for adolescent males. GeoPoll monitoring techniques first applied in HC3 countries during the response to the Ebola epidemic are being scaled and incorporated into other HC3 country programs for rapid program feedback. Digital resource materials for community health workers piloted in select districts in Bangladesh are being scaled nationwide by the Ministry of Health and the approach is being studied by programs and governments elsewhere. The HC3 implementation teams pride themselves on their ability to blend the best of evidence-based practice with new approaches to deliver results.

In conclusion, the entire HC3 team, including all the implementing partners across the collaborative, stand behind the contributions this project has achieved to date. HC3 is excited to continue to document and describe the impact that high-quality social and behavior change communication programs can deliver to improve health and well-being worldwide. HC3 believes that the SBCC community is more united, energized and articulate about its significant contributions to international development as a result of the collaborative and capacity strengthening nature of this project. With the recommendations from the midterm evaluation report, we look forward to an inspiring conclusion to this project and an enduring legacy of our efforts based on the positive impact of high-quality social and behavior change communication programs.

For more information, please visit
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