EVALUATION

OF THE

POPULATION COMMUNICATION SERVICES (PCS) PROJECT

1995–2002

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ACRONYMS AND ABBREVIATIONS

"A" Frame	"A" Frame for Advocacy
AED	Academy for Educational Development
AWSO	Arab Women Speak Out project
BASICS	Basic Support for Institutionalizing Child Survival
BCC	Behavior change communication
BCCP	Bangladesh Center for Communication Programs
CA	Cooperating agency
CAFS	Center for African Studies
CAP	Change, Access and Control, and Perceptions
CBD	Community-based distribution
CBO	Community-based organization
CCP	Center for Communication Programs
CDC	Centers for Disease Control and Prevention
CEDPA	Centre for Development and Population Activities
CHEST	Community Health Education Skills Toolkit
CMT	Communication, Management, and Training Division
COMET	Communication through Empowering Technologies
COWAD	Community Women and Development (Nigerian NGO)
CPCB	Center for Communication Programs, Bolivia (Centro para Programas de Comunicación en Bolivia)
CPR	Contraceptive prevalence rate
CTO	Cognizant technical officer
CUP	Caring, Understanding Partners initiative
DHS	Demographic and Health Survey
DISH	Delivery of Improved Services for Health project (USAID/Uganda)
EHP	Environmental Health Project
FHI	Family Health International
FP	Family planning
GATHER	Greet, ask, tell, help, explain, and return
G/PHN/POP	Bureau for Global Programs, Field Support and Research, Center for Population and Nutrition, Office of Population
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
ICPD	International Conference on Population and Development
IEC	Information, education and communication
IPC	Interpersonal communication
IPC/C	Interpersonal communication and counseling
IPPF	International Planned Parenthood Federation
IR	Intermediate Result
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
JHU	The Johns Hopkins University
KAP	Knowledge, attitudes, and practice
KSP	Kalusugan Sa Pamilya (in the Philippines)
MAQ	Maximizing access and quality
MCH	Maternal and child health
MSH	Management Sciences for Health
MSI	Management Systems International
NAWOJ	National Association of Women Journalists
NGO	Nongovernmental organization

NID	National Immunization Day
NPC	National Population Council
NPI	National Program on Immunization
NUJ	National Union of Journalists
P Process	Process and Principles of Strategic Communication for Health
PCS	Population Communication Services
PHN	Population, health and nutrition
PIP	Population Information Program
PPAG	Planned Parenthood Association of Ghana
PPFN	Planned Parenthood Federation of Nigeria
PSA	Public service announcement
PSI	Population Services International
RFP	Request for proposal
RH	Reproductive health
SAVE	Save the Children Federation, Inc.
SBC	Steps to Behavior Change
SCOPE	Strategic Communication Planning and Evaluation
SECI	Integrated Community Health Information System (in Peru)
Six Cs	Six Cs for Capacity Building
SO	Strategic Objective
STD	Sexually transmitted disease
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WLDCN	Women, Law and Development Center

PROJECT IDENTIFICATION DATA

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EXECUTIVE SUMMARY

BACKGROUND

The Johns Hopkins University Population Communication Services (JHU/PCS) project has been the Office of Population's leading project for communication and behavior change since 1982. (The Office of Population is in the Center for Population, Health and Nutrition, Bureau for Global Programs, Field Support and Research, U. S. Agency for International Development [USAID/G/PHN/POP].) Now working under its fourth cooperative agreement* with USAID, JHU/PCS and its subcontractors (Academy for Educational Development [AED], the Centre for Development and Population Activities [CEDPA], Prospect Associates, and Save the Children Federation, Inc. [SAVE]) provide technical and financial support for communication projects in all stages of design, implementation, and assessment, including audience identification, message design, determination of appropriate media mix, materials development, and program evaluation.

Previous versions of the PCS project (i.e., those carried out under the first three PCS projects) emphasized production of and training for the development of posters, brochures, flip charts, and other materials for providers and facilities—materials which were largely lacking at that time. The earlier projects also pioneered the use of mass media, music, and drama for family planning and health promotion. The design of the current PCS project recognizes the importance of community mobilization and interpersonal communication and counseling (IPC/C), and incorporates all three elements in a three-pronged strategy wherever possible.

In addition to these planned additional areas of responsibility, PCS IV has become increasingly involved in functional areas that were not anticipated when it was awarded in 1995. These include child survival (including polio eradication), prevention of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), environmental health, and—representing the most obvious departure from the project's traditional orientation—democracy and governance. PCS has assumed responsibility for virtually all of these unanticipated new tasks in response to field support–funded requests from USAID Missions. Indeed, the field support–driven nature of the PCS project is one of its central characteristics. At present, approximately 80 percent of PCS funds are derived from Mission field support funds—a substantial portion of which (approximately 30 percent) has been provided to address communication needs in the areas beyond family planning/reproductive health noted above.

The evaluation presented herein was designed to assess JHU/PCS performance in meeting the objectives set forth in the current cooperative agreement, as well as to examine the project's effectiveness in responding to these new and unforeseen challenges. The evaluation team was asked to review the tools and methodology that JHU/PCS and its partners apply to these tasks, as well as the communication science that underlies PCS's strategic approach.

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*Authorized funding ceiling: $143,868,380 (increased from $108,351,269). Project duration: November 1995–November 2002.

The amount of time allotted for this evaluation was limited (3 weeks of field work, including a literature review; consultations with JHU/Baltimore, subcontractors, and various stakeholders; and visits to Nigeria, Ghana, and Nicaragua). Moreover, the team was not able to visit any Asian countries for reasons beyond the control of PCS and the team—even though PCS has played an active role in the Philippines, Indonesia, Bangladesh, and Nepal throughout this period. Evaluation team findings and recommendations are therefore tentative.

KEY FINDINGS AND RECOMMENDATIONS

JHU/PCS Strategic Approach, Tools, and Evaluation Methodology

Strategic Approach

KEY FINDINGS

- ***PCS maintains an international leadership role in health communication.***
- ***While PCS theory and practice focus predominantly on individual behavior change, PCS has increasingly acknowledged the need to approach individual behavior change in a broader social and cultural context. During the current project, this has led to the development of the Ideation model.***

PCS is widely recognized as a global leader in the development of research-driven health communication. It has sustained this leadership role by its creation and constant renewal of a dynamic synergy between communication theory and practice, most notably in the field of population and family planning.

PCS's strategic approach to the development of communication interventions is derived from the Steps to Behavior Change (SBC) model, which is itself an adaptation of diffusion of innovations theory and the input/output persuasion model, enriched by social marketing experiences and several other theoretical constructs. By its nature, the SBC model leads to a predominant focus on individual behavior change, with less attention given to instances of collective behavior, collective decision-making, or societal and other barriers to behavior change. Recognizing this limitation to the SBC model's application, PCS has recently begun to take broad cultural and societal factors into account. These additional perspectives have contributed to PCS's development of the Ideation model.

The evaluation team concluded that PCS is correct in moving toward a broad theoretical approach to its communication strategy (including work on the development of indicators of social change, which JHU is currently undertaking with the Rockefeller Foundation). That broadened approach could be further enhanced, however, by application of a model that would comprehensively address the complex set of factors that affect behavior change.

PCS is very focused on the demonstration of results, largely in response to USAID's need for measurable outcomes. This results-oriented climate influences PCS's theoretical and methodological approach by encouraging a reliance on successful, time-tested interventions and an avoidance of untested interventions having little or no record of

prior success. PCS practice is to establish as-close-as-possible causal links between its communication interventions and behavior change.

RECOMMENDATIONS

PCS should continue its work in developing a social change communication model. In the process, PCS should broaden its focus from individual behavior change to a more holistic approach that would also address socioeconomic and other factors that often hinder the adoption of sustained health behaviors.

In order to provide a better and deeper understanding of the short-, medium- and long-term impacts of PCS communication interventions, PCS and USAID should continue to explore and apply recent and innovative communication theory.

PCS should increase the role of policy advocacy as a strategy for social change in its communication activities. This can be achieved, inter alia, through greater use of community mobilization and media advocacy.

Tools

KEY FINDING
JHU/PCS has successfully developed and used its SBC conceptual framework and tools such as the P Process and GATHER to respond effectively to audience needs.

JHU/PCS has designed and used a variety of tools to facilitate implementation of its communication interventions. These include the P Process (used for program design and oversight), GATHER (to improve client–provider interaction), SCOPE (for computer-assisted project design), and other tools that facilitate advocacy, gender sensitivity, and community participation. The P Process and GATHER tools were very effective in addressing their intended purposes and were well integrated into the programs of PCS's partners. Other potentially valuable tools of more recent origin, such as the Change, Access and Control, and Perceptions (CAP) gender tool and the "A" Frame for Advocacy tool, were used less frequently. PCS's intentions regarding the development and use of tools in the area of community mobilization are not clear.

JHU/PCS Evaluation Methodology

KEY FINDINGS

- ***PCS has made commendable efforts to establish a cause-effect relationship between communication interventions and individual behavior change.***
- ***PCS's evaluation methods cannot reliably separate out and account for the effects of other messages present in the media environment.***

PCS incorporates a strong evaluation component into each of its communication interventions. Moreover, PCS uses Demographic and Health Surveys (DHS), experimental designs, longitudinal panel studies, household surveys, interviews, epidemiological data, and its own rigorous statistical analyses to assess the impact of its programs. When the findings of these several data sources corroborate each other, PCS claims a cause-effect relationship between its intervention(s) and the observed behavioral change. The evaluation team noted the high quality and methodological rigor of PCS's

approach to evaluation, but that these techniques cannot reliably filter out the effects of other messages to which individuals are exposed at all levels.

PCS emphasizes quantitative methods over qualitative methods in conducting its impact evaluations. It has adopted this approach at least partly in response to USAID's need for demonstrable, measurable results. An overemphasis on quantitative measures can obscure other critical factors in behavior change—factors that might be illuminated by a more balanced use of qualitative techniques of impact evaluation.

RECOMMENDATIONS

PCS should increase the use of its own surveys to include a wider set of variables to assess the impact of its communication programs in the context of other health-related media/interpersonal communication (IPC) messages. Alternate forms of verification and evaluation designs, including qualitative methods, should be used to triangulate findings.

JHU/PCS should increase its combination of qualitative and quantitative techniques of impact evaluation. The use of qualitative techniques has the potential to illuminate elements that might escape quantitative measurements, which tend to focus on knowledge, approval, intention, behavior, and individual advocacy.

Increased use of community norms and social change indicators would be helpful to further understanding of campaign impact beyond the individual. PCS should continue its work on social change evaluations with the Rockefeller Foundation, using units of measurement that extend beyond the individual to include an examination of results at community and societal levels.

Performance Against PCS IV Objectives

The current cooperative agreement sets out four objectives. These include:

- Increased contraceptive use in PCS–assisted countries;
- Improved reproductive health in PCS–supported projects/programs;
- Institutionalization of selected family planning/reproductive health (FP/RH) communication programs in PCS–assisted countries; and
- Improved collaboration among agencies implementing FP/RH programs.

Increased Contraceptive Use

KEY FINDINGS

- ***The contraceptive prevalence rate (CPR) is higher in countries where major PCS programs are being and/or have been implemented.***
- ***While PCS responsibility for CPR changes at the national level cannot be reliably determined, it appears that the coverage, quality, and effectiveness of population programs in several countries are closely related to PCS efforts in those countries.***

- ***PCS programs which are focused on young adults (15 to 25) appear to have contributed to increased contraceptive use among this population group.***

Contraceptive use has increased, sometimes significantly, in countries where PCS has undertaken major programs. Specific examples of such increases, such as in Nigeria (before the cessation of U.S. government assistance), Nicaragua, Nepal, Bangladesh, the Philippines, Tanzania, and Jordan, strongly suggest that the change is caused by PCS communication programs. The sensitivity of analytical methods is still inadequate, however, to determine the extent to which those changes can be attributed to PCS interventions, especially at the national level. The evaluation team observed the positive effects of the project's special focus on meeting the contraceptive and reproductive health needs of youth, and suggested that it is time to replicate these youth-oriented initiatives.

PCS generally dismisses the notion of a gap between knowledge, attitudes, and practice (KAP) (the difference between high levels of contraceptive awareness and lower levels of contraceptive use) as an artifact of flawed mathematics and an inadequate understanding of the communication process. As it examines ways to address genuine elements of the alleged gap, PCS is urged to consider some of the broader societal, cultural, political, legal, and regulatory factors that may impede individual behavior change.

RECOMMENDATIONS

Accurate attribution of *national level* CPR changes to a communication/behavior change communication (BCC) project is not possible—and not reasonable—in view of the many other influences (including service delivery efforts) that affect contraceptive prevalence. In its reporting to USAID, PCS should be asked to identify *specific* behavior changes—including changes in contraceptive practice—which it believes can be attributed to PCS activity (e.g., in PCS project areas and/or among PCS target population groups). Whenever such claims are made, PCS should present the scientific and procedural bases for asserting such attribution.

USAID should use PCS's analytic tools to help establish new, verifiable goals for the follow-on project. USAID should engage the MEASURE project in this task to ensure objectivity and to facilitate stakeholder review of its recommendations.

Drawing on PCS experience in identifying and addressing the special needs of young adults, the follow-on project should support expanded efforts to integrate youth-oriented information and service delivery approaches into broad (public and private) population/reproductive health service delivery systems.

Improve Reproductive Health

KEY FINDING
PCS has successfully applied its communication tools and methodologies to the field of reproductive health.

PCS has met or exceeded the relatively ambiguous goals established under the cooperative agreement. Several of the integrated reproductive health programs carried out by PCS are emblematic of USAID's Strategic Plan (January 1999). These include Bolivia's Las Manitos program, the Green Umbrella in Bangladesh, the Uganda Delivery

of Improved Services for Health (DISH) project, the Tanzania Green Star project, and the Better Health campaign in Zambia. PCS has been successful in reaching youth (e.g., via the Together We Decide campaign with PROFAMILIA in Nicaragua).

Institutionalization of FP/RH Information, Education and Communication (IEC) Programs

KEY FINDING
Throughout its program, PCS has effectively transferred skills in materials development, training, research, and the development of communication campaigns. These capacity-building efforts have reached nongovernmental organizations (NGOs), government entities, advertising/media agencies, and journalists.

By design, the fourth PCS project focuses far more on the transfer and integration of technical communication skills into partners' operations than it does on efforts to help ensure the long-term, institutional sustainability of those partner organizations. PCS compensates for this emphasis by generally selecting partners that have their own record of performance and stability. PCS has been successful in its technical capacity building, having trained more than 1,150 participants at its Advances in Strategic Health Communication workshops over the life of the current project. PCS has helped four of its country offices (Bangladesh, Bolivia, Mexico, and Brazil) become autonomous providers of technical assistance in strategic communication. Similarly, the Center for African Studies (CAFS) (Nairobi and Lome), three regional training centers in Nigeria, and the University of the Philippines have benefited from past PCS assistance to the extent that they are now providing training and technical assistance in communication. These developments augur well for the prospect that host country and/or regional institutions will assume increasing responsibility for the provision of technical assistance in strategic communication.

RECOMMENDATION

PCS should continue and increase its use of the technical capacities it has helped to develop at the country and regional levels. PCS should foster increased use of host country and regional expertise to provide south–south technical assistance and to conduct in-country Advances workshops.

Improve Collaboration among FP/RH Agencies

KEY FINDING
PCS collaborates effectively with host country institutions. PCS collaboration with other (U.S.–based) cooperating agencies has not improved markedly since the previous evaluation.

PCS has collaborated very successfully with scores of host country and regional partners in communication activities over the life of the project. PCS's work in helping to create and support some 23 national IEC working groups or task forces has helped forge essential consensus around national IEC strategies. Evaluation team consultations with PCS partners found that they highly valued the training and technical assistance provided to them under the project. PCS's collaboration with other USAID–funded cooperating

agencies was less substantive, with some exceptions, such as PROQUALI in Brazil, programs in Nepal and Tanzania, and in maximizing access and quality (MAQ). Given the competitiveness among cooperating agencies (CAs), any meaningful collaboration among them would be (and generally is) a function of the extent to which USAID Missions or USAID/Washington insist on the effort and create the conditions for such collaboration.

Special Foci

As noted above, PCS IV includes a large number of new tasks. Some of these, such as community mobilization and IPC/C, are explicit elements of the current cooperative agreement. Others, such as child survival (including polio eradication), HIV/AIDS prevention, environmental health, and democracy and governance, were unforeseen when the cooperating agreement was executed. Time constraints prevented the evaluation team from assessing PCS's impact in most of the new unanticipated areas. The team did, however, examine the appropriateness and effectiveness of PCS's strategy and methodology in approaching these tasks, as well as PCS's ability to access and apply the technical expertise needed to successfully address these hitherto unfamiliar areas of involvement. The team was also asked to assess PCS's success in integrating information technology into its program operation, its performance in adopting and promoting gender considerations in the PCS project portfolio, and the extent to which PCS activities are linked to family planning/reproductive health (FP/RH) service delivery programs.

Beyond FP/RH

KEY FINDINGS

- ***PCS's thematic move beyond FP/RH has primarily been in response to USAID Mission requests. PCS is increasingly developing strategic approaches to these new areas.***
- ***Over the course of PCS IV, PCS has engaged in five new thematic areas. Child survival and HIV/AIDS are the most frequent (number of projects) and largest in dollar value.***
- ***PCS has successfully applied its strategic communication approach, tools, and methodologies in areas beyond family planning and reproductive health.***

Although the PCS project is now working in five new thematic areas, child survival and HIV/AIDS prevention are the most frequent (number of projects) and the largest in dollar value. PCS appears to have applied its strategic communication approach successfully in these new areas—demonstrating that the PCS approach may have significant generic value in responding to communication needs in disparate sectors. With some exceptions (Uganda and Zimbabwe), it is still too early, however, to measure and show substantive project impact in the two newest and largest (child survival and HIV/AIDS) components of its expanded program. With specific regard to HIV/AIDS prevention, moreover, broadening PCS's framework beyond individual behavior to community norms may enhance the achievement of meaningful changes in the audience's sexual practices.

RECOMMENDATION

PCS should closely review global experience in HIV/AIDS communication so that lessons learned from successful interventions can be incorporated into its strategic communication approach.

Community Mobilization

KEY FINDINGS

- ***PCS has substantially expanded its strategies and activities to include community activities.***
- ***PCS community strategies have been predominantly outreach in nature, but increasing experimentation with more participatory approaches is taking place with some success.***
- ***PCS has begun to explore a community mobilization approach involving greater degrees of participation, capacity building, and community empowerment.***
- ***PCS projects make little use of community mobilization to advocate for changes in public policy.***

PCS has substantially expanded its community mobilization activities since the beginning of PCS IV—an increase reflected in the project's funding allocations (22 percent for IPC/C, 36 percent for community mobilization, and 42 percent for mass media). For the most part, PCS's community mobilization strategies are predominantly outreach in nature, that is, awareness-raising events that expose community members to health education messages. Examples include PROQUALI in Brazil and road shows in Ghana. PCS is increasingly experimenting, however, with approaches that involve greater degrees of community participation and empowerment. Examples include work with local government units in the Philippines, the Puentes project in Peru, and the Integrated Community Health Information System (SECI) in Bolivia. The Peru and Bolivia activities have been developed by JHU/PCS's subcontractor Save the Children Federation, Inc. (SAVE), which is helping to mainstream this participatory methodology into PCS theory and practice. PCS projects elsewhere could make more use of communication strategies to advocate for health-related changes in public policy than they do.

RECOMMENDATIONS

Costly one-time outreach projects need to be reevaluated with respect to their cost-effectiveness and long-term impact.

PCS should document the process and impact of participatory community mobilization programs, paying particular attention to the costs and benefits involved from both community and service provider perspectives, the potential for sustainability, replication, and up-scaling. These findings and experiences should be widely disseminated to facilitate greater adoption of such models where appropriate.

PCS should make greater use of community mobilization as a strategy for social change (e.g., by developing community skills in advocacy in general and media advocacy in particular).

Interpersonal Communication and Counseling

KEY FINDING
PCS has responded very constructively to the PCS III evaluation, which called for improvements in the project's approach to IPC/C.

Much of PCS's success in this area derives from its application of the GATHER tool, which PCS has used to improve client–provider interaction in FP/RH programs. GATHER has been successfully integrated into the programs of all PCS partners involved in service delivery and/or provider training, as well as into the programs of third-party organizations, which obtained the tool from PCS partners. PCS's strategic emphasis on client–provider interaction might be usefully expanded, however, by a continued and increased focus on other forms of IPC/C, such as efforts to promote communication among parents, peers, siblings, and families.

RECOMMENDATION

PCS should expand its IPC/C focus beyond client–provider interaction and increase its attention to other forms of interpersonal communication, such as peer education/communication.

Gender

KEY FINDINGS

- ***A significant number of initiatives conducted by PCS IV incorporate a gender focus.***
- ***Many PCS IV evaluations demonstrate significant success in increasing spousal communication and men's approval for family planning and have contributed to an increased utilization of modern contraceptive methods.***
- ***PCS IV has developed tools and workshops to assist in the development of gender-sensitive programs. These are, however, unevenly applied.***
- ***Gender, as a crosscutting issue affecting all areas of PCS's work, is not effectively institutionalized into PCS.***

Commendably, a significant number of PCS initiatives incorporate a gender focus. These are mostly male motivation projects highlighting male approval and shared responsibility. Evaluations of some of the male motivation projects indicate that they are being successful in increasing the use of modern contraceptive methods. Fewer projects focus on women's empowerment and reproductive and sexual rights. While steps have been made to increase the gender-sensitive nature of communication programs (including gender-sensitivity training for health care providers), this needs to be greatly increased.

JHU/PCS subcontractor, the Centre for Development and Population Activities (CEDPA) has developed a Change, Access and Control, and Perceptions (CAP) tool that provides a practical approach for the incorporation of gender issues into all phases of a

communication project cycle. CEDPA has used the CAP tool in its Through the Gender Lens workshops (in Nigeria, Zambia, Ghana, and Nepal). The CAP tool is still the least known of all PCS tools—partly due to its relative newness. However, it would benefit from more rigorous promotion by both CEDPA and PCS. PCS has also begun to focus on gender-based violence as a key barrier to reproductive health through the collection of clearinghouse materials. This should be extended to include a programmatic focus on this issue.

RECOMMENDATIONS

PCS programs should continue to emphasize *shared* responsibility, and to increase emphasis on women's empowerment, gender inequities (including a focus on gender-based violence) and the promotion of sexual and reproductive rights, as called for by the International Conference on Population and Development (ICPD) in Cairo.

PCS should improve its gender focus by

- **encouraging all JHU/PCS staff to undergo training in the Gender Lens workshop;**
- **systematically integrating and acting upon gender analyses in all stages of PCS program cycles; this should include clearly articulated gender-specific goals and objectives, with appropriate process and impact/outcome indicators;**
- **mainstreaming gender into PCS's communication training courses, facilitator manuals, curricula, and counseling tools; and**
- **producing and disseminating a CAP pamphlet and integrating gender more explicitly than it has been into future reprints of P Process, GATHER and "A" Frame tools.**

Integration of Technical Expertise

KEY FINDINGS

- ***PCS has been able to ensure the technical quality of its products and services in new areas. This has been accomplished to a large extent on a reactive basis in response to Mission requests.***
- ***While PCS's ability to design comprehensive strategies is often constrained by Mission directives, increased involvement of stakeholders in the strategic design process could help to enrich the communication strategies selected.***

PCS has generally been able to ensure the technical quality of its products and services by accessing appropriate technical expertise. This has been accomplished to a large extent on a reactive basis (i.e., in response to USAID Mission requests for PCS assistance). PCS has effectively used its university setting to access a significant number of highly qualified professionals and leading experts in the health field, including child survival and HIV/AIDS. PCS has also drawn on the services of host country experts, external consultants, and help from other cooperating agencies, when necessary. In some countries, it has recruited staff having the specialized experience needed to address new program requirements (e.g., democracy and governance staff in Nigeria).

RECOMMENDATION

The follow-on project should include procedures that will ensure rapid, systematic, and reliable access to the technical expertise needed by the project. This expertise needs to be relevant to the specific countries in which the project works.

Use of Information Technology

KEY FINDING
PCS has successfully incorporated information technology into its programs worldwide. PCS uses information technology at four levels: 1) as an operations and management tool, 2) as a technology to enhance program activities, 3) as a tool for training purposes, and 4) as a means to improve and increase dissemination of information, education and communication (IEC) materials, and information regarding project performance and results.

PCS has successfully incorporated information technology into its programs worldwide. PCS uses information technology at all four levels of its operations, including management (electronic mail, video reporting, virtual communities of PCS field offices, and technical assistance provided by JHU/Baltimore via computer/electronic mail) and project operations (hotlines, epidemiological information on CD–ROM); training (the SCOPE tool, CD–ROMs for self-guided and interactive IPC training and for communication materials); and information dissemination (PCS web site, links to 10 other web sites). The evaluation team has recommended that PCS conduct a feasibility study to determine the viability of a proposed hotline strategy in Nigeria, with special attention to public access to and coverage of telephone lines, their functionality as a confidential and anonymous form of counseling, and their sustainability.

Linkages to Service Delivery Programs

KEY FINDING
PCS generally attempts to ensure close linkages between the communication/BCC interventions it supports and the overall population/RH service delivery programs underway in host countries.

PCS has been generally successful in ensuring close linkages between its communication projects and FP/RH service delivery programs. Safeguards include:

- PCS's strong reliance on Mission field support–funds, which by their nature oblige the Missions to promote a degree of integration with other Mission–funded activities;

- PCS's role in the creation and operation of national IEC working groups;

- PCS's promotion of branded services, such as Las Manitos in Bolivia, the Green Umbrella in Bangladesh, DISH in Uganda, Gold Star in Egypt, and the Together We Decide When campaign in Nicaragua; and

- PCS's efforts to promote MAQ components—especially training for health care providers via the GATHER tool—into the IPC/C curricula of PCS partners engaged in service delivery activities. PCS still needs to give additional attention to assuring improved linkage between its community outreach activities and its support for community-level organizations responsible for continued promotion of behavior change and social change messages.

ORGANIZATIONAL AND MANAGEMENT STRUCTURE

Staffing

KEY FINDINGS

- ***JHU/PCS has qualified and competent staff, both at headquarters and in the field.***
- ***PCS is recruiting staff with expertise in child survival, democracy and governance, and HIV/AIDS to respond to its broadened scope. When this expertise is not available inhouse, it recruits technical personnel on an ad hoc basis from other sources.***

PCS has a qualified and competent staff, both at headquarters and in the field. As noted above, PCS recruits additional technical personnel as needed from a variety of sources. The number of staff at the JHU/Baltimore headquarters office is lower today than it was five years ago (86 in 2001 versus 103 in 1996), while the number of field offices and field office staff has increased in response to field support–driven increases in the PCS program. This trend—a drop in costly U.S. personnel and an increase in lower cost host country personnel—has resulted in a decrease in the dollar-to-staff ratio of the project.

Use of Subcontractors

KEY FINDING
PCS subcontractors have not been as fully used as planned under PCS IV.

Relations between JHU/PCS and its four subcontractors are professional and cordial at a personal level, but strained at the institutional level. With the possible exception of Prospect Associates, the subcontractors believe that their considerable technical skills and institutional resources have not been adequately tapped under PCS IV. For its part, JHU/PCS points to difficulties in attracting and holding the sustained interest of its subcontractors, as evidenced by the high turnover rate of subcontractor personnel assigned to the project and these persons' reluctance to commit full time to the project. This kind of dissatisfaction is fairly typical in the larger CA–subcontractor community and does not suggest that any particular party has unusual responsibility for the situation.

USAID Relations

KEY FINDING
USAID field Missions report generally high levels of satisfaction with the PCS project. Project management from USAID/Washington is sound, but USAID needs to ensure more continuity in its project management staff.

USAID field Missions report generally high levels of satisfaction with the PCS project—reflected, perhaps, in the Missions' consistently high funding for PCS programs. Project management by the Communication, Management and Training (CMT) Division in the Office of Population ensures the project's responsiveness to the Agency's Strategic Plan, while generally avoiding unusual intrusion into the project's day-to-day operations. JHU/PCS would prefer more continuity, however, in the division's project support function. The project has had five cognizant technical officers and/or technical advisors over the past five years.

RECOMMENDATION

The CMT Division should ensure, to the extent possible, long-term continuity of division personnel responsible for oversight and management of the PCS project, and should incorporate reporting requirements in the cooperative agreement that would provide USAID with accurate, timely information regarding the performance of subcontractors associated with the project.

Cost Management

KEY FINDING
JHU/PCS appears to be managing its project funds responsibly and prudently.

JHU/PCS is a good steward of the public resources it manages under the PCS IV project. U.S. government audits have been performed periodically on the project; virtually all project acquisitions are executed on a competitive basis. JHU/PCS has been successful in leveraging over $10 million in non–USAID funds to supplement project activities, and JHU/PCS salaries are well within the norms observed in the larger CA community. At the project level, JHU/PCS has conducted cost-effectiveness studies (using a new tool developed for the purpose by Warren Robinson and Gary Lewis) in Egypt and the Philippines. The tool, designed to assess the cost-effectiveness of mass media interventions, is being refined to extend its applicability to other communication activities.

NEW DIRECTIONS

As a summary observation, the PCS IV project has been successful in meeting the objectives—both planned and unforeseen—called for by the USAID–Johns Hopkins University cooperative agreement. The team believes, moreover, that JHU/PCS's 18 years of stewardship of the project has contributed not only to lasting, beneficial changes in health-related behaviors around the world, but also to significant advances in the science and practice of development communication.

This assessment has nonetheless identified a number of aspects of the project's strategy, structure, tools, and performance that might be improved. Many, perhaps most, of the recommendations proposed in this report suggest refinements to an otherwise successful project; they could be implemented under the current PCS IV activity without changes in the terms of the cooperative agreement, or without substantive changes in PCS's strategic approach to its assignment. The adoption of other recommendations, however, would

require one or both such changes. These are noted below primarily for USAID's consideration toward the design of an eventual PCS V project.

- **Expand the project's focus beyond individual behavior change; increase emphasis on factors related to social change.**

- **Expand the project's advocacy role to affect decision-makers and the policy and regulatory environment.**

- **Establish realistic, verifiable objectives, and expect credible evidence of performance.**

- **Intensify the development of communication skills in host countries, for example, in national and regional institutions. Draw on these resources for technical assistance and training support.**

I. INTRODUCTION

PROJECT OVERVIEW

The Johns Hopkins University (JHU) Population Communication Services (PCS) project has been the leading Office of Population project for communication for behavior change since 1982. (The Office of Population is in the Center for Population, Health and Nutrition, Bureau for Global Programs, Field Support and Research, U. S. Agency for International Development [USAID/G/PHN/POP].) In its fourth cooperative agreement with USAID, JHU and its four subcontractors (Academy for Educational Development [AED], Centre for Development and Population Activities [CEDPA], Prospect Associates, and Save the Children Federation, Inc. [SAVE]), provide support for the development of strategic communication programs in population/reproductive health and other sectors in developing countries. The agreement provides technical and financial support for communication projects in all stages of design and implementation, including audience identification, message design, media mix, production of materials, interpersonal communication, and evaluation. PCS seeks to reach women and men, both as individuals as well as family and community members, with communication for behavior change messages that empower them to gain control over their reproductive and general health.

The fourth PCS cooperative agreement has the following objectives:

- Contraceptive use will increase from 1 to 2 percentage points annually in countries where major information, education and communication (IEC) programs are undertaken with PCS guidance and support.

- Reproductive health will improve in PCS–supported pilot projects or integrated programs, as measured by increases in the percentage of people following recommended health practices, such as safer sex (abstinence, condom use, mutual monogamy), seeking prenatal and postpartum care, and extending full breastfeeding.

- In each country where major IEC programs are undertaken, at least one public and several private sector agencies will have developed a sound institutional base for family planning/reproductive health (FP/RH) IEC.

- Collaboration among all agencies carrying out FP/RH IEC will be much improved at the national and selected local levels.

The first three PCS projects emphasized the production of and training for the development of posters, brochures, flip charts, and other materials for providers and facilities—materials that were largely lacking at that time. These earlier projects also were pioneers in the use of mass media, music, and drama for family planning and health promotion. The new design for PCS IV recognized the importance of community

mobilization and interpersonal communication and counseling (IPC/C), and increased the project's focus on these activities.

Another characteristic of the PCS IV project has been a trend toward increased involvement in areas beyond family planning and reproductive health—a shift driven largely by USAID Mission field support funds. During this cooperative agreement, USAID Missions have funded PCS to achieve behavior change results in primary health communication, including human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), child survival, nutrition, infectious disease (polio, malaria, tuberculosis), water and sanitation, and democracy and governance.

PCS IV was designed and is managed by the Communication, Management, and Training (CMT) Division in the Office of Population. The division contributes primarily to USAID's Strategic Objective (SO) 1; however, because of increased demand from Missions, PCS IV contributes in varying degrees to all five SOs.

PCS is a field-driven project, drawing an estimated 80 percent of its total budget from field support funds. As in previous cooperative agreements, field support requests have consistently exceeded its allocated ceiling. The PCS IV funding ceiling has been increased from $108,351,269 to $143,868,380, and the life of the cooperative agreement has been extended two years, to November 2002.

PURPOSE OF THE EVALUATION

PCS was last evaluated in 1993, and covered the period of the PCS III cooperative agreement (1988–93). The current evaluation assesses PCS performance under its PCS IV cooperative agreement (1995–2002), its progress in achieving the four end-of-project results and its effectiveness in integrating community mobilization and interpersonal communication in its range of communication activities. Given the project's expanded scope, the technical competency of PCS's work in areas other than family planning and reproductive health were assessed also.

This evaluation focused primarily on the organization's contributions to Strategic Objective (SO 1), but also addressed certain issues regarding the technical competencies of the project in responding to other SOs beyond PCS's core area (population/reproductive health) of expertise.

The objectives of this evaluation, based on the scope of work (see appendix A), were to

1. assess the extent to which PCS has accomplished the priorities and desired results as set forth in its cooperative agreement;

2. assess how effectively community mobilization and interpersonal communication and counseling (IPC/C) activities were incorporated in the PCS IV project;

3. assess the extent to which PCS has addressed two key issues raised in previous evaluations: 1) bridging the gap between high awareness and positive

attitudes towards family planning and low contraceptive use and 2) fostering coordination with service delivery and other in-country groups when launching an IEC campaign;

4. assess the competencies, effectiveness, and evidence of impact of the current project in areas beyond family planning and reproductive health, such as HIV/AIDS, child survival, and democracy and governance; and

5. assess the effectiveness and efficiency of PCS's organizational and management structures, including any changes that may have resulted from an expanded scope.

The CMT Division is in the early stages of designing a centerwide, follow-on health communication project. In addition to assessing performance under the current project mandate, the evaluation team was asked to identify issues related to the future project design.

EVALUATION METHODOLOGY

The evaluation team consisted of five full-time members, with a sixth member seconded from the CMT Division. Three of the team members were recruited on the basis of their international communication expertise to ensure that the technical aspects of health communication were reflected in the evaluation findings and recommendations.

The evaluation took place from January 8 to February 15, 2001. Data collection and interviews were conducted in the United States in Washington, DC, and Baltimore, Maryland, followed by field visits to PCS country projects in Nigeria, Nicaragua, and Ghana. The evaluation team reviewed project documentation, which included the PCS project cooperative agreement, the 1989 and 1993 evaluations, the 1999 management review, annual work plans, research reports, trip reports, activity evaluations, relevant correspondence, and financial reports. The team conducted extensive interviews with PCS project staff at JHU/Center for Communication Programs (CCP) in Baltimore, and met with its subcontractors and key people in USAID, including the project's cognizant technical officer (CTO) and technical advisor, representatives from child survival, maternal health, HIV/AIDS, democracy and governance, select regional bureaus, and the director of the Office of Population. In the field, the team interviewed PCS country office staff, partner cooperating agencies (CAs) and implementing agencies, USAID Mission staff, and public and private sector partners.

To ensure maximum USAID input into the evaluation, the team drew data from an electronic mail survey of 32 USAID Missions (23 of which responded), which was designed to gather input on PCS's responsiveness and effectiveness in the designated countries. Additional information was collected through telephone interviews with USAID Missions in countries with PCS programs.

Given the constraints imposed by the limited time and geographic coverage of the evaluation's scope of work, the team relied on PCS research and evaluation studies (empirical data) and peer-reviewed articles to assess the impact of project activities. As

part of this exercise, the team assessed the validity of the evaluation tools applied by PCS to measure its impact.

II. THE PCS APPROACH

THE UNDERLYING SCIENCE, TOOLS, AND METHODOLOGY OF THE PCS PROJECT

This section of the report describes the science that PCS applies to the design and implementation of its communication activities and how that science influences the research-driven nature of those activities. The project's explicit scientific paradigm also influences the development of the many tools used by PCS, and guides the project in the design and focus of its evaluation practices—that is, it determines what is relevant to measure, how to measure it, and how PCS assesses the performance of its interventions.

FINDING
PCS maintains an international leadership role in health communication.

Since its inception in 1982, The Johns Hopkins University Population Communication Services project has emerged as one of the foremost practitioners of research-driven health communication in the world. It has maintained this leadership position by creating and sustaining a dynamic synergy between communication theory and practice—most notably in the area of population and family planning.

As discussed below, PCS draws primarily on communication theories that seek to understand and promote individual behavior change. This approach does not reflect recent advances in communication theory and practice that call for holistic approaches to behavior change. In terms of actually *performing* communication work in the field, however, PCS remains unsurpassed in the international arena.

THE STRATEGIC COMMUNICATION FRAMEWORK

FINDING
While PCS theory and practice focus predominantly on individual behavior change, PCS has increasingly acknowledged the need to approach individual behavior change in a broader social and cultural context. During PCS IV, this has led to the development of the Ideation model.

PCS bases its operations on the premise that a strategic approach to communication is required. Everett Rogers identified the need for a strategic approach to communication issues in family planning in the 1970s; since 1982, PCS has responded to this challenge by developing and continuously refining a theory-based strategic framework, termed the Steps to Behavior Change (SBC). SBC is an adaptation of diffusion of innovations theory and the input/output persuasion model, enriched by social marketing experience and a number of other theories, including cognitive theories, social process theories, emotional response theories, and mass media theories. SBC identifies the pathway to behavior change as a process that passes through 5 stages and 16 steps (see below).

STEPS TO BEHAVIOR CHANGE MODEL

To evaluate the impact of communication programs,
you can measure how much the intended audience:

Knowledge:
- Recalls specific messages
- Understands what messages mean
- Can name products, methods, or other practices and/or sources of services/supplies

Approval:
- Responds favorably to messages
- Discusses messages or issues with members of personal networks (family, friends)
- Thinks family, friends, and community approve of practice
- Approves of practice

Intention:
- Recognizes that the specified health practices can meet a personal need
- Intends to consult a provider
- Intends to practice at some time

Practice:
- Goes to a provider of information/supplies/services
- Chooses a method or practice and begins use
- Continues use

Advocacy:
- Experiences and acknowledges the benefits of practice
- Advocates the practice to others
- Supports programs in the community

Source: Processes and Principles of Strategic Communication for Health, The Johns Hopkins School of Public Health, Center for Communication Programs, Population Communication Services, July 1997.

PCS recognizes, however, that this process is not linear and that in many instances, individuals might omit certain steps to adopt a particular behavior. At a conceptual level, PCS has made an important contribution to the field of communication by shifting from traditional demographic audience segmentation techniques to the Unmet Communication Needs approach. This approach identifies where individuals stand along the knowledge–advocacy continuum and helps develop the most appropriate communication intervention to respond to an individual's specific communication need.

By focusing on these communication needs, PCS's SBC provides a framework that helps establish guidelines for program and message designs that target individuals' specific health-related behaviors.

By its nature, SBC leads to a predominant focus on individual behavior change, with less attention given to structural barriers to change and instances of collective behavior or collective decision-making—factors long discussed in the field of communication. In essence, it is argued that in many cultures, individual behavior yields to community or collective behavior, while in other instances, it is argued that certain behaviors, such as

sexual behaviors, are closely tied to cultural practices that demand additional attention to community and cultural values and practices. In recent years PCS has subtly altered its understanding of behavior change, taking into account cultural factors and other forms of decision-making, such as collective action and collective efficacy. These additional perspectives have contributed to the development of what PCS calls the Ideation model.

As defined by PCS, ideation describes a process whereby new ways of thinking diffuse in a society by means of social interaction. Ideation factors include communication networks and cultural and religious norms, in addition to a range of other influences more social in nature than economic. In practice, PCS's development of the Ideation model reflects its systematic consideration of a range of new factors—the ideational forces—in the measurement of behavior change. Rather than viewing change as a process of consecutive steps, the elements of ideation are treated as interdependent, interactive, and simultaneous. Thus, while it is a broader approach (i.e., one that considers a growing number of factors), the roots of the ideation model lie in the SBC approach, and it is essentially a transtheoretical model that focuses on individual behavior change. In practice, PCS takes as many of these factors as possible into consideration, depending on local conditions and constraints.

> ***FINDING***
> ***The joint PCS/Rockefeller attempt to theorize upon and build models and indicators regarding social change–oriented interventions is innovative and potentially groundbreaking for the further development of PCS's strategic communication framework.***

PCS has very recently begun to explore a potential new component of its strategic communication framework. At the request of the Rockefeller Foundation—and thus not an explicit PCS policy and practice at this stage—PCS has developed a model to assess the effectiveness of social change–oriented communication interventions. Based on the model, PCS is in the process of developing indicators to measure the impact of such interventions. A draft version of the model and indicators is found in the handbook, *Guidelines for the Measurement of Process and Outcomes of Social Change Interventions*, currently being assessed by PCS and the Rockefeller Foundation.

This attempt to theorize upon and build models and indicators regarding social change–oriented interventions is innovative and potentially groundbreaking for the further development of PCS's strategic communication framework. It is innovative in the sense that it recognizes the need to strategically and explicitly combine individual behavior change with empowerment and social change. This model's reference to society and the local community as units of change requires it to be a comprehensive and inclusive model (i.e., one that focuses on community dialogue and collective action and on how these processes relate to both individual and social change).

The social change model provides some interesting possibilities of systematically promoting—and subsequently evaluating—social change–oriented interventions in community-oriented projects for health. Contrary to the SBC and the Ideation model, the social change model posits society as the unit of change, and thereby expands the focus of communication interventions. In the future, it may challenge the current theoretical

basis of PCS's communication strategy. The social change model also suggests some innovative methodological approaches to the evaluation of communication interventions. Indeed, PCS plans to apply the social change model to the design of the upcoming evaluation of its environmental health campaign in Nicaragua and to the evaluation of various PCS activities in Indonesia.

FINDING
There is a close relationship between PCS's Research and Evaluation Division and the project's program divisions, resulting in synergies that enrich both theory and practice.

PCS program evaluations are conducted by the PCS Research and Evaluation Division—independent of PCS program divisions—and are carried out in accordance with strict scientific rigor. PCS frequently prepares its findings as articles for submission to peer-reviewed journals—a process that further enhances the rigor and credibility of its program assessments.

PCS evaluations serve two purposes: they provide information about the performance of specific programs in the field (i.e., whether those programs have achieved their objectives) and they contribute to the further theoretical development of PCS's strategic communication framework. PCS assigns a high priority to both objectives—documentation of the outcome of its interventions for USAID and the public and the pursuit of continuous refinement of its program interventions.

PCS applies 10 percent of its project budget to evaluation activities.

FINDING
PCS's determination to show causal links between communication interventions and behavior change may be impeding its readiness to explore new, different, and/or innovative developments in communication science.

PCS is very focused on the demonstration of results, largely in response to USAID's need for measurable outcomes. This results-oriented climate influences PCS's theoretical and methodological approach by encouraging a reliance on successful, time-tested interventions and an avoidance of untested interventions having little or no record of prior success. PCS practice is to establish as-close-as-possible causal links between its communication interventions and behavior change.

Health communicators generally agree, however, that the issue no longer is whether health communication can influence behavior, but how. Moreover, they also agree that it is difficult, if not impossible, to establish causal links between a communication intervention and a particular behavior. Within the scientific paradigm of behavioral sciences, and within the focus on individual behavior change that PCS has set as a priority in its strategic communication framework, many theoretical (e.g., the Ideation model) and methodological innovations are evident in PCS IV. Methodological innovations include "Africa Alive!," the expanded use of sport and sports heroes in Africa as an entertainment strategy to communicate with male audiences, increasingly sophisticated and well-researched radio and television serial dramas, image mapping with respect to characters in entertainment–education dramas, and a survey of religious leaders

so they could serve as advocates in the program. Scientifically and philosophically, however, PCS's strategic approach remains within the behavioral sciences paradigm, reflecting its view, perhaps, that this approach represents the furthermost advance of communication science in operational terms. Alternatively, it may reflect pressure from USAID, implicit or otherwise, to demonstrate results.

As noted above, this pursuit of results has led to creative methodological innovations, but it has also tended to exclude promising lines of scientific enquiry—outside the behavioral sciences paradigm—that have proven successful, thereby simplifying the complex relationships between media uses, knowledge, attitudes, and behavior. Two absent fields of research are of particular relevance for PCS: new media theory, especially reception theory, and audience ethnography, the only relevant example of which was noted in a PCS study in Peru in connection with the Puentes project. These two fields of research offer the following:

- **Reception theory**: A great deal of empirical data has been collected over the last 10–15 years, much of it entertainment–education related, which illuminates in multiple ways the question regarding the meanings which audiences draw from dramas and fictional presentations. This field offers theoretical developments in terms of frameworks to understand processes of identification, emotional engagement, relevance, and recognition of different forms of programming (Fuglsang 1995, Fuenzalida 1997, Gonzalez 1998, Jensen 1986–98, Martin-Barbero 1993, Schroeder 1988).

- **Audience ethnography**: This field, which has grown significantly in the 1990s, provides understanding of the social and cultural uses of media. Given the rapid increase in new technologies and media in general, this is increasingly important. How do different communities, cultures, and societies make use of these media? How does this affect health communication programs? The spread of Western lifestyle programming (e.g., American television series) has undoubted influence on people over time. These factors are not generally taken into consideration by PCS as an important context of PCS communication interventions. Audience ethnography could be very applicable in, for example, sentinel site studies.

Taken together, reception theory and audience ethnography are fields of communication science that provide insights regarding

- the effect of the spread of traditional and new media and communication technologies on audiences in developing countries (exposure to lifestyles, cultures, and symbolic worlds not previously accessible) and assessment of their impact on the promotion of healthy lifestyles;

- an improved understanding of the links between different media and their synergies in campaign design and in evaluation;

- a deeper understanding of the interpersonal interaction around messages, how the messages diffuse into everyday life and are used and discussed, and the changes they articulate, and

- systematic validation of qualitative data. (PCS does not generally attempt to validate the qualitative data it collects and uses in designing, monitoring, and evaluating campaigns. The recent anthropological discussions on reflexivity could be useful in that respect.)

RECOMMENDATIONS

PCS should continue its work in developing a social change communication model. In the process, PCS should broaden its focus from individual behavior change to a more holistic approach that would also address socioeconomic and other factors that often hinder the adoption of sustained health behaviors.

In order to provide a better and deeper understanding of the short-, medium- and long-term impacts of PCS communication interventions, PCS and USAID should continue to explore and apply recent and innovative communication theory.

PCS should increase the role of policy advocacy as a strategy for social change in its communication activities. This can be achieved, inter alia, through greater use of community mobilization and media advocacy. (Strategic communications can contribute to social change through advocacy at both the local and the national levels.) Advocacy should be highlighted in the Process and Principles of Strategic Communication for Health (P Process) menu of choices (which currently focuses on individual behavior change). PCS should work with the POLICY project, where appropriate, to address policy, legal, regulatory, and other factors that bear on social and behavior change.

THE THREE PILLARS OF PCS COMMUNICATION STRATEGIES

PCS communication strategies use a combination of three pillars: mass media, interpersonal communication, and community mobilization activities. This strategy is supported by health communication research demonstrating the enhanced impact of mass media interventions that are linked to support services and mechanisms for interpersonal communication at the community level. Strategies that use multiple channels to reach audiences have also been shown to increase impact.

The three components are used to various degrees in PCS projects, with different pillars dominating more in some strategies than others. National projects make good use of branding and a campaign logo often unites all three components. Examples include Green Umbrella in Bangladesh, Gold Star in Egypt, Blue Star in Nicaragua, and the yellow hand "Stop AIDS. Love Life." in Ghana.

Mass media strategies used by PCS projects tend to focus on entertainment–education programs, such as radio and television dramas and on public service announcements (PSAs) (often jingles). While entertainment–education programs have been shown to have an impact on both individuals and societal norms through complex mechanisms, such as parasocial interaction (where audiences identify with characters intensely and

experience their lives vicariously), PSAs in isolation tend to have little effect. This is why the combination of pillars is vital. PCS should, however, also increase its use of other communication strategies, such as media advocacy, that is, the use of the news media to target policy makers, as espoused by Lawrence Wallack and others.[1]

Interpersonal communication strategies in PCS can be divided into two major categories:

- **Facilitated**: This tends to focus predominantly on client/service provider counseling, but at times includes peer education. Community networks are sometimes used to facilitate this communication, as in the Jiggasha project in Bangladesh.

- **Unfacilitated**: This part of the PCS strategy uses mass media components to stimulate debate and discussion (e.g., campaigns aiming to increase spousal communication).

Both strategies have advantages and disadvantages and are not mutually exclusive. Facilitated interpersonal communication (IPC), if well executed, has the advantage of allowing for interactive participation, specific clarification, and the development of skills necessary to carry out healthy choices (for example, negotiating safer sex), thereby deepening the opportunities for meaningful change. However, it is a more expensive investment and obviously reaches fewer people than the mass media.

Unfacilitated interpersonal communication, which was derived from both facilitated IPC and mass media interventions, is identified by PCS as an important stage in its Steps to Behavior Change model. Discussing with others and advocating positive attitudes or practices serves to extend the range of the intervention as well as to reinforce the impact on the individual. More recently, increased societal discussion has been identified by development communicators as a key component of social change.

Community components of PCS strategies fall into two categories:

- **Community outreach or events**: Entertainment–education is usually central to these events (e.g., "Africa Alive!" music concerts, "Caring, Understanding Partners" soccer matches, and "Stop AIDS. Love Life." road shows in Ghana. In these projects, the community is rarely involved in the intervention design, implementation, or evaluation.

- **Community mobilization projects**, such as Puentes in Peru, Integrated Community Health Information System (SECI) in Bolivia, Kalusugan Sa Pamilya (KSP) in the Philippines, and "Healthy Indonesia 2010," where the focus is on community participation and empowerment. In these instances, the community is the agent rather than the object of change.

[1] Wallack describes how communities themselves can use their collective clout to stage events that will attract the news media and how communities can learn the skills necessary to better access the news media to influence the visibility of issues on the national agenda, and to shape the debate around these issues. In this practice of media advocacy, policy change is the primary objective.

Both of these strategies are discussed in detail in section III. The key argument in favor of community mobilization is its increased likelihood of sustainability and impact—albeit with greater difficulty to scale up. Community outreach, however, reaches more people. Thus, if the objective is to have a large number of people access services (e.g., for national immunization days), mass media and outreach would be appropriate. Long-lasting behavior change through interventions such as road shows and soccer matches alone are highly unlikely, but they do contribute to changes in social norms over time (assuming they are not implemented as one-time activities).

Key influential individuals are often used to help shift social norms and create a supportive climate for change. PCS strategies use popular figures, such as sports and music celebrities, to endorse campaigns. In Jordan and Senegal, PCS successfully persuaded religious leaders to promote the importance of men as caring partners, supportive of modern contraceptive methods. In Ghana, PCS produced AIDS–prevention campaigns with the country's main traditional leaders and persuaded the former first lady to launch its campaign with the now famous campaign slogan, "If it's not on, it's not in."

While the different pillars come with their own specific advantages and disadvantages, the strategy of attempting synergy through the combination of all elements allows for greater reach and mutual reinforcement.

PCS TOOLS

FINDINGS

- ***PCS has successfully developed and used its SBC conceptual framework and tools, such as the P Process and GATHER (greet, ask, tell, help, explain, and return) to respond effectively to audience needs.***
- ***Other tools, such as the "A" Frame, the Six Cs for Capacity, and the Appreciative Inquiry model, are used less frequently—some because of their newness, others because they are not well promoted by PCS. Additional time will be needed to assess the usefulness of these tools.***

PCS has been very successful in designing, developing, and utilizing a variety of tools and models to carry out its communication interventions (see table 1 below).

At the field level, PCS puts its SBC conceptual framework into operation through the P Process. The P Process is a framework for the development of a strategic health communication program. It takes one through the process of situation analysis; strategic design; development, pretesting, and production of communication materials; management implementation and monitoring; and impact evaluation.

Table 1
Main Tools and Models Used by PCS

Tool/Model and Year Developed	Purpose
Steps to Behavior Change (SBC) (1983)	To serve as a conceptual framework for communication interventions focused on individual behavior change
P Process (1983)	To provide a step-by-step process for program design, implementation, and evaluation
GATHER (1987)	To improve client-provider communication in family planning and reproductive health services
SCOPE (1990)	To facilitate training and decision-making in project design
"A" Frame for Advocacy (1999)	To strengthen organizations' capacity to influence policy and media
CAP (1997)	To make communication projects more sensitive to gender issues
Appreciative Inquiry Tool (1998)	To provide guidelines for community participation and decision-making
Ideation Model (1999)	To identify the several forces that influence behavior change
Six Cs for Capacity Building	To assess an organization's capacity in health communication

The P Process is regularly applied by PCS country offices and has become a widely used and appreciated tool among other CAs, nongovernmental organizations (NGOs), and health communication professionals in several countries. In Nicaragua, for example, the P Process was applied to the design, implementation, and evaluation of the successful campaign, Together We Decide When (Juntos Decidimos Cuando). In the Philippines, use of the P Process was instrumental in designing a campaign that changed people's perceptions of family planning as against having children. The P Process was used in a different fashion in Nigeria to advance the democracy and governance strategy. In that case, the use of the P Process led to the identification and selection of 16 NGOs that worked on different areas of democracy and government, from media advocacy to legal training. The evaluation team found broad application of the P Process in several other specific communication activities, including training, development of IEC materials, and program evaluation. Organizations such as PROFAMILIA and the Cooperative for Assistance and Relief Everywhere in Nicaragua, AVSC International in Nigeria, and Ghana's International Planned Parenthood Federation (IPPF) affiliate have adopted the P Process to develop their own IEC materials and other communication products.

It should be noted that future application of the social change–oriented model that PCS is developing in cooperation with the Rockefeller Foundation could have implications for the P Process, as the latter is specifically designed to address individual behavior change and focuses on the SBC model. This focus of the P Process on individual behavior

change should be expanded so that its menu of communication options would include, for example, news media advocacy, social change, policy change, and gender equity.

GATHER (greet, ask, tell, help, explain, and return) was developed to improve client–provider interaction and communication. It is second in popularity and usefulness only to the P Process. GATHER has been institutionalized in several service provider organizations, such as AVSC in Nigeria and Ghana, the Cooperative for Assistance and Relief Everywhere (CARE) and PROFAMILIA in Nicaragua, and the IPPF local affiliate in Ghana, as well as by several other NGOs. In many instances, GATHER has made its way into some local affiliates of other CAs via third parties. Staff members at CARE/Nicaragua, for example, learned about and were trained in the use of GATHER through CARE/Peru and CARE/Bolivia affiliates, which in turn had been trained by JHU in their home countries. This example suggests that dissemination of GATHER goes beyond JHU's own efforts and activities. Data collected in Indonesia and rural Mexico showed that use of GATHER and other facilitative communication interventions, such as peer support groups and self-assessment tools, have had significant impact on quality of care.

SCOPE (Strategic Communication Planning and Evaluation) is a software tool used for training and program design purposes. PCS has developed 22 country versions of SCOPE in several languages and uses it in several training courses, most notably including PCS's annual Advances in Health Communication Workshops. PCS country offices and several NGOs recognize the value and usefulness of SCOPE. The Staywell Foundation in Nigeria highlighted the use of SCOPE in its workshops and in designing its communication programs. Yet, while PCS tries to ensure full use and dissemination of SCOPE, particularly among NGOs and other CAs, it is uncertain whether the tool is in fact widely used by partners, CAs, and NGOs. Evaluation team field visits found that NGOs and CAs spoke more knowledgeably and enthusiastically of the P Process and GATHER than they did about SCOPE. In some cases, SCOPE was perceived to be a highly complex tool, while others suggested that lack of computer facilities might hinder increased use of the tool.

In addition to the P Process, GATHER, and SCOPE, PCS uses a variety of other tools, including the "A" Frame for Advocacy, the Six Cs for Capacity Building, Change, Access and Control, and Perceptions (CAP), and the Appreciative Inquiry Tool. While the P Process, GATHER, and to a certain extent, SCOPE, have been applied very successfully by PCS and are widely recognized by other NGOs and CAs, these other tools do not seem to enjoy the same level of coverage or impact.

The "A" Frame for Advocacy ("A" Frame) and the Six Cs for Capacity Building have been used minimally in PCS–supported programs. The "A" Frame provides a framework for the practice of advocacy to advance policy and other solutions to health issues. One of the few examples where the "A" Frame for Advocacy has been used and was found to be very useful is the democracy and government project in Nigeria. In that instance, the National Union of Journalists (NUJ), Community Women and Development (COWAD), and the Women, Law and Development Center (WLDCN), among other NGOs, applied the "A" Frame with a significant degree of success in advancing the goals of the project, namely to increase the participation of women in Nigerian political discourse. For the

most part, however, the "A" Frame was unknown to most organizations or USAID Missions visited during this evaluation.

The Six Cs for Capacity Building tool seeks to assess an organization's capacity in health communication by facilitating an examination of the organization's competence, commitment, clout, coverage and cost-effectiveness, continuity, and collaboration. PCS also uses the tool to help program managers identify potential partners. The Six Cs tool is currently being tested in the Philippines[2] and, in essence, is still in a development phase. More time, then, will be needed to determine its practical value. PCS might consider the inclusion of additional factors, such as leadership, internal conflict resolution, and elements of organizational culture as PCS refines this tool in a new, more detailed, and quantitative version. If used to evaluate the degree to which PCS has enhanced an organization's capacity, qualitative methods be combined with this tool.

CAP was designed by CEDPA to make strategic communication interventions sensitive to gender issues and has been applied by PCS in a limited number of projects. The tool is meant to help ensure that issues of reproductive health, behavior change theory, and the P Process planning cycle are examined from a gender perspective. In 1997, PCS developed a Gender Lens workshop in Zambia and between 1999 and 2000, conducted country-specific workshops in Nigeria, Ghana, and Nepal. In view of the fact that CAP was developed in 1997, it should have been incorporated into a larger number of projects by the end of 2000 than it has been.

Appreciative Inquiry Methodology was developed by Save the Children Federation, Inc. (SAVE), a subcontractor to JHU/PCS. This methodology draws on principles from the field of organizational development as adapted from previous work by Case Western University in Cleveland. The Appreciative Inquiry Methodology has been used in the Philippines to help integrate local resources into community health activities and to increase access to family planning and child survival services. Preliminary participatory evaluation indicates that there has been a reduction in the number of cases of diarrhea after communities improved and built water pumps. SAVE has identified unintended benefits in the form of additional sources of livelihood for enterprising individuals and communities.

FINDING
PCS tools are designed to address the needs of specific communication interventions. PCS intentions regarding the development and use of tools in the area of community mobilization are less clear. Several community mobilization–related tools are currently being developed, but without the benefit of any unifying strategic vision.

PCS's process of design and development of tools tends to respond to specific aspects of its strategic communication approach. The SBC framework provides a conceptual approach for its communication interventions, which focus on individual behavior change. The SBC framework becomes operational through the P Process, which allows PCS to devise a specific plan of action in order to respond to a particular health problem. The remaining tools tend to respond to the needs of each of PCS's three pillars: mass

[2] Results of the initial pretesting in the Philippines were not very encouraging and suggest that additional work is needed to develop this tool for broader use.

media, community mobilization, and interpersonal communication/counseling. Entertainment–education, for example, is an important component of PCS's mass media strategy. GATHER plays a key role in interpersonal communication and counseling issues, while SCOPE responds to training needs. This pattern is less clear, however, in the area of community mobilization. PCS and some of its subcontractors (AED and SAVE) have developed community mobilization manuals—some in response to an apparent but not explicitly identified strategic objective, and others in response to specific country needs. These manuals are very costly to develop—some requiring up to three years to complete. For reasons of both technical consistency and cost efficiency, their preparation should be closely coordinated.

PCS EVALUATION PRACTICES

FINDING
PCS has made commendable efforts to establish a cause-effect relationship between communication interventions and individual behavior change.

PCS has successfully incorporated a strong evaluation component into each of its communication interventions—a practice consistent with PCS's view of communication as a strategic process. Evaluation activities under the PCS project are carried out on three levels: formative, process, and impact evaluation. Formative evaluation serves as a road map for project design. By using baseline research information and qualitative research methods, such as focus groups, participant observation, and indepth interviews, PCS is able to carefully identify audiences' needs, design and pretest messages, and produce appropriate messages and communication products that best suit the needs of specific populations.

Ongoing, process evaluation or monitoring allows PCS to keep track of audiences' reactions and perceptions to messages and communication interventions, a process that greatly benefits from the use of several forms of qualitative research, including focus groups, indepth interviews, participant observation, and interviews with opinion leaders, among other techniques. Information gathered through monitoring techniques is later used to introduce needed modifications into program interventions.

Finally, impact evaluation is an extremely important component of PCS's communication strategy. PCS uses Demographic and Health Surveys (DHS), experimental designs, longitudinal panel studies, household surveys, interviews, exit interviews, epidemiological data, and its own rigorous statistical analyses, to assess the impact of its communication programs. PCS uses these analytic methods and data sources—when they corroborate each other—to demonstrate a cause-effect relationship between communication interventions and behavior change. As a reflection of its confidence in making these claims, PCS often publishes its evaluation reports in peer-reviewed communication journals and in various journals in the health and family planning fields.

FINDING
PCS evaluation methods cannot reliably separate out and account for the effects of other messages present in the media environment.

As noted previously, PCS impact evaluation practices are characterized by their high quality and good methodological grounding. Multiple regression analyses and dose effects of exposure are used to factor out confounders and establish a significant association with the PCS intervention. Notwithstanding the rigor of PCS's approach, however, it is not always clear that behavior changes reported by PCS can be attributed to PCS's effort. The notion of media environment posits that there are a great number of messages that individuals are exposed to at the mass and interpersonal communication levels—some of them consistent, others contradictory. Any or all of these other messages can influence people's perceptions and potential behaviors. With few exceptions (e.g., some efforts in Mexico and Bangladesh), PCS has not been able to isolate other types of messages which people might have been exposed to in addition to PCS's communication campaign messages. The primary reason for this limitation, as pointed out by PCS, is the constraint imposed by questionnaire length—especially in the case of the DHS, where PCS has little influence over questionnaire design.

Moreover, many of the questions posed in these surveys obscure the nature of the response. For instance, when an individual is asked whether he/she spoke to someone about family planning, a "yes" or "no" response does not provide researchers with a full view of the nature of that communication. Talking to someone about family planning might take the form of a 5–second comment or question to another person—but without any indication as to whether there was any response to the comment/question. Additional effort is needed to fully describe these largely invisible elements of impact evaluation data.

RECOMMENDATION

PCS should increase use of its own surveys to include a wider set of variables to assess the impact of its communication programs in the context of other health-related media/IPC messages. Alternate forms of verification and evaluation designs, including qualitative methods, should be used to triangulate findings.

FINDING
PCS emphasizes quantitative methods over qualitative methods in conducting its impact evaluations.

Commendably, PCS places a high premium on program research and evaluation. With specific regard to its impact evaluations, PCS places special emphasis on quantitative techniques and measurement (i.e., a focus on number of people reached, condoms distributed, individual knowledge, attitude, and behavior change) rather than on changes in community and social norms.[3] Moreover, the trend within PCS is to focus more on evaluations of national campaigns with large outreach components, relying predominantly on quantitative survey methodology.

[3] Illustratively, a document entitled, *Abstracts of Peer-Reviewed or Invited Articles by the Faculty and Staff at The Johns Hopkins University Center for Communication Programs, 1994–2000 (*Kols 2000), reports that the proportion of quantitative to qualitative methodologies used in articles reporting on impact evaluation was 24:6. To the extent that these data represent PCS's evaluation methodology, PCS is likely to use four quantitative techniques for each qualitative measure at each impact evaluation. These data also reflect the preferences of many peer-reviewed journals for strongly quantitative, rather than qualitative, research.

On other, albeit infrequent, occasions, PCS does use some qualitative research techniques (e.g., in its formative evaluations). PCS evaluations of the Puentes, SECI, and KSP projects include a mixture of both qualitative and quantitative methodologies, allowing for an increased depth of understanding of how and why the project works. PCS took the lead in adding a question to the DHS about whether the respondent believes that a majority of the people in her/his community practice (xxx). PCS has also researched the relationship between social networks and interpersonal discussion to understand the mechanisms of change that occur through community projects, such as Jiggasha. The team's observation regarding PCS's emphasis on quantitative methods relates, therefore, more to the issue of balance, and is not intended to suggest that one methodology is better than the other in measuring program impact. Its purpose is instead to point out that there is enough evidence in the communication literature to suggest that qualitative and quantitative methodologies tend to complement each other.

This observation has practical implications at the level of impact evaluation. The use of more indepth, qualitative methodologies can enhance PCS's chances of enriching impact data and qualifying information collected via quantitative techniques. Illustratively, some of PCS's most recent projects, such as Arab Women Speak Out in several Arab countries and the Blue Star campaign in Nicaragua, will rely on qualitative, ethnographic techniques to assess the impact of their communication interventions.

Finally, use of qualitative methodologies might also uncover some unintended consequences of communication campaigns and media messages. PCS has the resources and the capacity to increase its use of qualitative assessments to establish the impact of its communication programs beyond individual behavior change and to make a critical contribution to the field of communication.

PCS has pointed out that its emphasis on quantitative evaluation for impact assessment has been driven to a significant extent by USAID's need for demonstrable, measurable results—that is, a need to display a connection between communication interventions and behavior change. Moreover, qualitative data gathering and analyses can be costly and time-consuming and have not been generally encouraged or valued by USAID. This issue could benefit from more discussion between PCS and USAID—specifically, concerning the importance of qualitative evaluation for better understanding processes of behavior change, community decision-making, social cohesiveness, and other elements that typically cannot be established via quantitative, individual behavior change–oriented measurements alone. PCS's ongoing collaboration with the Rockefeller Foundation, whereby PCS is helping to develop an evaluation framework of social change, might contribute to the further development of PCS's methodology in this area.

RECOMMENDATION

PCS should increase its combination of qualitative and quantitative techniques of impact evaluation. The use of qualitative techniques has the potential to illuminate elements that might escape quantitative measurements, which tend to focus on knowledge, approval, intention, and individual advocacy.

Increased use of community norms and social change indicators would be helpful to further understanding of campaign impact beyond the individual. PCS should continue its work on social change evaluations with the Rockefeller Foundation, using units of measurement that extend beyond the individual to include an examination of results at community and societal levels.

III. PERFORMANCE

In this section of the report, the project's performance is examined against the four objectives set out in the PCS cooperative agreement:

- Increased contraceptive use in PCS–assisted countries;
- Improved reproductive health in PCS–supported projects/programs;
- Institutionalization of selected family planning/reproductive health (FP/RH) information, education and communication (IEC) programs in PCS–assisted countries; and
- Improved collaboration among agencies implementing FP/RH programs.

INCREASED CONTRACEPTIVE USE

OBJECTIVE 1

Contraceptive use will increase from 1 to 2 percentage points annually in countries where major IEC programs are undertaken with PCS guidance and support.

FINDING
The contraceptive prevalence rate (CPR) is higher in countries where major PCS programs are being and/or have been implemented.

The difficulty for this assessment is in determining the extent to which PCS's efforts have contributed to these CPR increases. CPR is increasing, for example, virtually everywhere. The following questions, however, are pertinent to this evaluation. Are contraceptive prevalence rates going up *more* in countries where PCS is most active? Can those increased rates be attributed to more intensive communication efforts under the PCS project? How does PCS separate the effects of its interventions from the effects of other important influences and events (e.g., service delivery, other media, and policy) occurring at the same time in a given country? What, in other words, is the change, or dose effect, that can be attributed to PCS activities?

This task of separating the respective effects of various family planning program interventions has long been one of the key challenges faced by population program managers. Moreover, within this broad area of inquiry, it has been especially difficult to gauge the long-term effect of communication interventions. PCS therefore faces some formidable challenges as it tries to document and verify its achievements against this objective.

PCS reponds to this challenge by reference to DHS data, wherever possible—especially in those instances where PCS is able to insert key, and timely, questions into the DHS questionnaire. Importantly, PCS supplements these overly general DHS data with

surveys of populations reached by PCS interventions (when the project cost of these activities warrants a survey), pre- and posttests among target population groups, increasing use of longitudinal panel studies, and comprehensive statistical analyses designed to elicit the respective effects of other factors that bear on changes in CPR. As a general rule, when PCS undertakes its own survey and analytic work—and if DHS data confirm the results of PCS's analyses—then PCS feels confident in attributing at least a part of the observed CPR change to PCS efforts. PCS cites 11 countries in particular (table 2 below, bold type) where it has made significant program investments and where CPR increases have been especially noteworthy.

PCS further buttresses its analyses and its attribution claims by citing theories of communication and behavior change that specify a causal relationship between information (message) processing, intention, and behavior change. PCS applies these theories to attribute CPR changes to specific campaigns. The theories are less useful, however, when applied to changes in CPR at the national level (e.g., the changes shown on table 2). Thus, while table 2 suggests an important contribution by PCS in attaining CPR increases averaging 1.55 percent per year over the past 10 years in the listed countries, it is not clear how much of that change can be attributed to PCS efforts. Given these ambiguities, it seems reasonable to conclude that PCS has had an important albeit not clearly definable impact on CPR, and that it might have—or might not have—met the CPR target in the cooperative agreement.

This nonspecific level of attribution is probably reasonable considering the daunting nature of the attribution task. The sophistication and objectivity of PCS's evaluation efforts might be obscured by the public image it puts on its findings. In its periodic reporting to USAID, for example, semiannual reports and responses to USAID management review questions, PCS generally cites overall CPR changes in certain countries, identifies the major PCS activities undertaken in those countries, and leaves a presumably unintended impression on the part of the reader that changes in the former are attributable to the effects of the latter. This is unfortunate in the sense that PCS has an important story to tell; it is probably effecting behavior change leading to increased CPR, and PCS's analytic procedures can accurately explain, within bounds, the causes and locus of these changes. This more realistic and useful representation is not visible through the organization's reports following USAID SO frameworks and guidelines.

Two factors may contribute to this miscommunication between PCS's generally conservative self-assessment of its impact and its less restrained representations to USAID. First, there is the wording of the PCS IV objective itself. The CA's requirement that a communication/behavior change communication (BCC) project demonstrate compliance with a number-specific, national-level CPR target probably exceeds the capacity of current evaluation technology to measure reliably. Yet PCS understandably feels compelled to report to USAID in a manner consistent with the language of the CA requirement, to the extent that causality, while never claimed at that level, is sometimes left to the reader to either assume or reject. Secondly, and related to the first point, is the standard of reporting that characterizes virtually all cooperating agency reports to USAID. USAID has created an atmosphere that makes the reporting and documentation of modest or unsuccessful results unwise in a highly competitive environment.

Table 2
Contraceptive Prevalence Rate (CPR) for all Married Women of Reproductive Age (All Methods)

Region	Country	CPR (%): All Methods										Years	Change	Change per Year
		1990	1991	1992	1993	1994	1995	1996	1997	1998	1999			
Africa	Ghana				20.3					22.0				
	Guinea			1.7[a]							6.2			
	Kenya				**32.7**					**39.0**		**5**	**6.3**	**1.26**
	Nigeria	6.0												
	Senegal				7.5				12.9					
	Tanzania			10.4		20.4		**18.4**			**21.7**	**3**	**3.3**	**1.10**
	Uganda						14.8							
	Zambia			**15.2**				**25.9**				**4**	**10.7**	**2.68**
	Zimbabwe					48.1								
Asia	**Bangladesh**		39.9			44.9			**49.8**		**53.8[d]**	**2**	**4.0**	**2.00**
	Indonesia		49.7			**54.7**			**57.4**			**3**	**2.7**	**0.90**
	Nepal		**22.7**					**28.5**				**5**	**5.8**	**1.16**
	Philippines				40.0					**47.8**	**49.3[c]**	**6**	**9.3**	**1.55**
Near East	Egypt			47.1			47.9		54.5					
	Jordan	**40.0**							**52.6**			**7**	**12.6**	**1.80**
	Turkey				62.6					63.9				
Latin America	**Bolivia**					**45.3**			**48.3**			**3**	**3.0**	**1.00**
	Brazil		59.2					76.7						
	Mexico			63.1[b]			67.0			68.7[b]				
	Nicaragua			**48.7**					**60.3**			**5**	**11.6**	**2.32**
	Peru			**59.0**				**64.2**				**4**	**5.2**	**1.30**
	Salvador				53.3									
	AVERAGE											**4.27**	**6.77**	**1.55**

Data Sources: (a) U.S. Bureau of the Census, Official Statistics, March 1999; (b) CONAPO, Mexico, 1999; (c) NSO 1999 National Survey of the Philippines; (d) BDHS Preliminary Report, 1999–2000. Sources of change per year data: Ross, John, Stover, John, and Willard, Amy, 1999, *Profiles for Family Planning and Reproductive Health Program*, The Futures Group International. All other figures come from the DHS web site: www.measuredhs.com/data/indicators/start.cfm
Notes: n = 11

With regard to the first point—some quantifiable standard of performance is obviously needed for the follow-on project, but that standard is not likely to be a specific change in national-level CPR. As noted above, PCS has done a great deal of possibly groundbreaking work in developing the analytic tools and procedures required to establish more meaningful and verifiable measures of impact of BCC activities.

The second point, regarding a need for candor and specificity in CA reporting, goes well beyond the audience of this report. One recommendation is offered, however, that may help USAID and PCS strengthen the good science being applied by PCS to assess its own performance and the reporting of those performance outcomes to USAID.

FINDING
While PCS responsibility for CPR changes at the national level cannot be reliably determined, it appears that the coverage, quality, and effectiveness of population programs in several countries are closely related to PCS efforts in those countries.

USAID and other donors effectively terminated their population assistance to Nigeria in 1994, when a military coup ejected that country's democratically elected government. The PCS program was one of the major casualties of the 1994 shutdown, and the effects of that decision are evident today: the CPR, which was perhaps over 14 percent in 1994, is probably about 8 percent in the year 2000. Interestingly, one of the few population/reproductive health projects which has been able to continue over the past five years (because of its focus on the private, commercial sector) has been a PSI–managed social marketing project. Although the PSI activity markets condoms for HIV prevention as well as contraceptive products for family planning purposes, the project's promotional efforts are devoted almost wholly to the former, condom-related segment of the program. Predictably, condom sales are rising, while contraceptive sales are essentially the same. According to the PSI country representative, the social marketing project's FP component is serving a "customer base that had been created by PCS five years ago."

Contraceptive prevalence in Nicaragua increased from 49 percent in 1993 to 60.3 percent in 1998 (DHS 1998). During that time period, PCS focused its program effort on PROFAMILIA, the country affiliate of IPPF—a period during which PROFAMILIA doubled its market share of all contraceptive users from 5.4 percent to 10.3 percent.

Although contraceptive prevalence is increasing slowly in Nepal (slightly more than half a percentage point per year, from 25.1 percent in 1991 to 28.5 percent in 1996; no national level estimates are available after 1996), the CPR in the four district sites of PCS's radio communication program increased from 36 percent in 1994 to 42.8 percent in 1997 and to 49.2 percent in 1999 (PCS surveys). This represents an increase of 13.2 percentage points over a five-year period, or nearly 3 percentage points per year.

An evaluation of the PCS–supported Men's Participation Program in Jordan found that "intention to use" contraception increased among nonusers exposed to the program from 25 to 38 percent. Contraceptive use among participants in the Bangladesh Jiggasha Project increased by a factor of 5, and contraceptive continuation rates increased from 25.5 to 43 percent.

The contraceptive prevalence rate (modern methods) in Turkey is approximately 35 percent—an extremely low rate when compared with the rates prevailing in virtually every other middle-income country having economic and social indices similar to Turkey's. One significant difference, however, is that Turkey never benefited from any national-level communication efforts to promote family planning.

FINDING
The previous (1994) evaluation of the PCS program called on PCS to help close the large gap that existed between high awareness and positive attitudes toward family planning and low contraceptive use. PCS maintains that the nature of this knowledge, attitudes, and practice (KAP) gap is widely misunderstood, but that it is nonetheless focusing on measures which will help close whatever gap genuinely exists.

According to PCS, the observed difference between knowledge and use (as shown in several surveys) is misleading because

- awareness via mass media is greater than specific, accurate knowledge of various contraceptive methods and service delivery sites;
- knowledge and attitudes almost always change before behavior (except under coercive conditions); and
- measurement and analysis of knowledge is imprecise.

PCS addresses the first factor by improving the public's awareness about the location of clinics and other service sites; by supporting the promotion of branded services, such as PROQUALI in Brazil, Gold Circle in West Africa, Green Umbrella in Bangladesh, and Gold Star in Egypt; and by promoting quality improvements at service sites.

To address the second factor, PCS tries to change the community norms and public perceptions that influence individuals' contraceptive decisions. (It is largely this focus on norms and perceptions that drives PCS's frequent use of television serial dramas, community events, and testimonials from respected national figures.)

Finally, PCS observes that the gap itself is an artifact of some overly simplistic arithmetic procedures. One of these puts all women in the denominator and all women who are aware of or approve of family planning in the numerator. Another approach generates simple percentages of people who know about and/or approve of family planning and use some contraceptive method—but without factoring out women who cannot use contraceptives (i.e., because they are pregnant, breastfeeding,

not fecund). PCS believes that the application of a more comprehensive definition of knowledge—one which includes knowledge about the various methods of contraception, their positive attributes, attitudes regarding the benefits of smaller families, and the norms regarding the social acceptability of contraceptive use—would narrow the gap substantially.[4] This net quantity, in fact, would approximate unmet need—a far more useful measure of the gap and one that recognizes the essential role of service delivery systems (not just communication efforts) in closing that gap.

PCS's analysis serves as a useful commentary on the gap issue—but it is not likely to be the final word on the topic. Persons convinced by PCS's clarification of the gap's true dimensions might still question PCS's choice of programmatic responses to close the remaining gap. At a minimum, PCS's analysis shows that such responses (BCC strategies) should speak directly to clients' needs for practical, useful information. Looking to the future, USAID might want to consider the adoption of a more precise indicator of performance in closing the (redefined) KAP gap. One indicator—which to a considerable extent serves as a proxy for the effectiveness of user-focused communication strategies and their link to service delivery systems—might be "increases in contraceptive continuation rates." PCS evaluations in both the Philippines and Bangladesh have shown that one of the major impacts of communication campaigns is not necessarily the attraction of a large number of new adopters, but rather the reinforcement of the practices of current users—and therefore an increase in contraceptive continuation rates. The added value of this indicator is that increases in contraceptive continuation rates would substantially increase the CPR in most countries.

PCS's definition of the gap also tends to disregard some of the broad societal, cultural, political, legal, and regulatory factors that may impede individual behavior change. Many of these factors are currently being addressed by the POLICY project, but their exclusion from a development communication project such as PCS disrupts prospects for a holistic, strategic response to key influences on behavior change.

RECOMMENDATIONS

Accurate attribution of *national level* CPR changes to a communication/BCC project is not possible—and not reasonable—in view of the many other influences (including service delivery efforts) that affect contraceptive prevalence. In its reporting to USAID, PCS should be asked to identify *specific* behavior changes—including changes in contraceptive practice—which it believes can be attributed to PCS activity (e.g., in PCS project areas and/or among PCS target population groups). Whenever such claims are made, PCS should present the scientific and procedural bases for asserting such attribution.

USAID should use PCS's analytic tools to help establish new, verifiable goals for the follow-on project. USAID should engage the MEASURE project in this task to ensure objectivity and to facilitate stakeholder review of its recommendations.

[4] Survey data from Tanzanian women exposed to the Green Star Family Planning Communication campaign bear out PCS's assertion that the gap dwindles dramatically as the level of knowledge increases.

FINDING
PCS programs that are focused on young adults (15–25) appear to have contributed to increased contraceptive use among this population group.

PCS has implemented over 15 predominately youth-oriented programs in 14 countries. Together, these projects account for approximately one third of PCS's annual budget.

Most of these projects are structured as reproductive health activities, with emphases on sexual responsibility and HIV prevention. They do not recoil, however, from messages and approaches that promote young adults' use of contraceptives for family planning and HIV/AIDS prevention purposes—marking a departure from the timidity that characterized most youth-oriented programs (all donors) until recent years. Precise documentation of PCS's impact on CPR among young adults is not possible, but PCS's own surveys, plus surveys conducted collaboratively with DHS and the Centers for Disease Control and Prevention (CDC), show significant increases in modern contraceptive use among married adults under 25 in countries where PCS has conducted major youth communication interventions (e.g., Kenya, Zambia, Nicaragua, and Peru). Importantly, increases in the CPR for the 15–19 age group in these countries mirror CPR increases in the 20–24 age group.

PCS has clearly embraced the challenge to address the needs of young adults, as indicated by the scope of PCS's interventions and the budgetary resources it commits to the task. Moreover, the data noted above indicate that PCS appears to be producing a genuine impact among this highly vulnerable population age group. A glance at the long list of youth-directed interventions supported by PCS suggests, however, that these results are being extracted from a very labor- and perhaps cost-intensive approach. Most of the projects are discrete, stand-alone activities, such as hotlines, youth-directed radio and television shows, music events and videos, and drama groups. Less apparent are efforts to mainstream youth concerns—and service responses—into national scale information and service delivery networks (often because USAID Missions and/or host country policies have discouraged extensive youth programs). The example of the Juntos Decidimos Quando program in Nicaragua shows, for example, that an entire service delivery system (in this case PROFAMILIA) can be mobilized successfully (with PCS assistance) to serve the needs of young adults—even in a very conservative social environment. Stated differently, PCS has learned a great deal over the past several years regarding the special needs of young adults and the ways these needs can be addressed in a variety of cultural and social settings. It may be time to use this knowledge by scaling up youth-oriented approaches, that is, to support their integration into broad service delivery systems—so that youth-oriented services have a higher likelihood of being institutionalized and continuing once PCS assistance ceases.

RECOMMENDATION

Drawing on PCS experience in identifying and addressing the special needs of young adults, the follow-on project should support expanded efforts to integrate youth-oriented information and service delivery approaches into broad (public and private) population/reproductive health service delivery systems.

IMPROVED REPRODUCTIVE HEALTH

OBJECTIVE 2

Improved reproductive health in PCS–supported pilot projects or integrated programs, as measured by increases in the percentage of people following recommended health practices, such as safe sex, seeking prenatal and postpartum care, and extending full breastfeeding.

FINDING
PCS has successfully applied its communication tools and methodologies to the field of reproductive health.

Over the past several years, USAID Missions have become much more strategic in their planning toward the attainment of health sector objectives. This trend is reflected in Mission SO frameworks that frequently package population/reproductive health/other health initiatives in ways that promote an integrated, mutually reinforcing approach to health issues. As a field support–driven project, these trends are clearly reflected in PCS's project portfolio. Indeed, this post–Cairo aspect of the current PCS project represents one of the major differences between it and the preceding PCS project.

The current project has successfully extended its range and effectiveness beyond population and into reproductive health. PCS has carried out several integrated programs and pilot projects in reproductive health over the life of the current cooperative agreement, and some of these projects are emblematic of the approach reflected in the G/PHN Strategic Plan (January 1999). Examples include the Bolivia Las Manitos program, the Green Umbrella in Bangladesh, the Uganda Delivery of Improved Services for Health (DISH) project, the Tanzania Green Star project, the Better Health campaign in Zambia, and the Zimbabwe Youth Responsibility project. Selected results from these activities—as shown in tables 3 and 4 on pages 29–30 below—indicate that PCS is meeting the somewhat nonspecific achievement targets set forth in PCS IV. Moreover, PCS has consistently exceeded the Intermediate Results that USAID established for this component of the project (see table 5, page 31).

Illustratively, impact results reported for the Bolivia Las Manitos project during the 1994–97 period (as measured by the 1994 and 1997 Bolivia DHS) indicate that prenatal care increased from 52 to 70 percent, women delivering in health facilities increased from 42 to 56 percent, exclusive breastfeeding increased from 53.4 to 60.2 percent, and the CPR (any modern method) increased from 17.8 to 25.2 percent. The Uganda DISH campaign (1994–99) reported similarly impressive results: the proportion of women receiving professional birth delivery assistance increased from 44 to 54 percent; the proportion of women aware of at least three of the four specific obstetrical complications increased from 11 to 18 percent; the proportion of men and women reporting the use of condoms with a nonregular partner increased, respectively, from 42 to 68 percent and from 52 to 71 percent; and the CPR (any modern method) among married women increased from 13 to 22 percent.

As discussed previously, PCS devotes a significant portion of its resources to projects that address the needs of youth and young adults. A relatively recent addition to PCS's reproductive health portfolio is phase II of the successful Juntos Decidimos project in Nicaragua. This latest phase includes the launch of a social marketing campaign aimed at young adults to promote and market a new condom brand, Body Guard. The dual protection initiative—to prevent unwanted pregnancy and HIV/AIDS and sexually transmitted diseases (STDs)—uses a polished media campaign that associates the product with a trendy and modern lifestyle. Body Guard has had a successful start; approximately 1.4 million condoms have been sold—many through nontraditional outlets—since the product was launched 10 months ago.

In Ghana, PCS has updated the Community Health Education Skills Toolkit (CHEST kit) to include management of sexually transmitted infections (STIs) and HIV/AIDS. The integrated IEC kit provides reference information on a wide spectrum of health topics and activities to improve participatory approaches for community health nurses and community health educators. The "Stop AIDS. Love Life." campaign, launched in 2000, has put HIV/AIDS on the national agenda, diffusing both preventive and compassionate messages to decrease risk behavior and reduce stigma towards those living with HIV. With technical assistance from PCS, the Planned Parenthood Association of Ghana (PPAG) developed a youth peer education training curriculum which incorporates GATHER for youth interpersonal counseling. PPAG uses the curriculum for its own inhouse training as well as for training peer educators from other organizations.

Generally speaking, PCS has demonstrated that the skills, tools, models, and methodologies it developed and applied over the years to population/family planning efforts have been effective when applied to reproductive health. For example, PCS uses its Steps to Behavior Change framework, along with formative research among primary audiences, to develop its communication strategies in both population and reproductive health. Similarly, PCS has adapted and applied its GATHER and P Process tools with consistency across both sectors, albeit with less intensity in instances when PCS was required to respond to urgent Mission requests for assistance on a short-term, one-time basis. (See section II, PCS Tools, for a more detailed discussion of how PCS has applied its tools and methodologies to FP/RH).

Table 3
Selected Reproductive Health Outcomes of PCS IV Projects: Integrated RH Programs (Percentages)

Country	Outcome Measure	Year						Years	Change	Change per Year	Difference by Exposure
		1994	1995	1996	1997	1998	1999				
Bolivia Las Manitos	Prenatal Care	52			70			3	18	6	
	Birth Delivery[a]	42			56			3	14	4.7	
	Exclusive Breastfeeding										
	Children 0–3 months	53.4			60.2			3	6.8	2.3	
	Children 4–6 months	21.5			30.1			3	8.6	2.9	
	Exclusive Breastfeeding Mean duration (months)	1.6			2.3			3	1.44	0.5	
	Full Breastfeeding Mean duration (months)	1.9			2.6			3	0.7	0.23	
Bangladesh Green Umbrella	Use Integrated RH Services[b]										
	Exposed						34.6				
	Unexposed						23.1				+ 11.5
Uganda DISH	Birth Delivery[a]				44		54	2	10	5	
	Exclusive Breastfeeding Length is 6 Months				23		41	2	18	9	
	Awareness of 3–4 Obstetrical Complications				11		18	2	7	3.5	
	Condom Use[c]										
	Men				42		68	2	26	13	
	Women				52		71	2	19	9.5	
	Ever HIV Testing										
	Men				16		19	2	3	1.5	
	Women				13		16	2	3	1.5	

Data Sources: Bolivia 1994 and 1997 DHS; Bangladesh, 1998 PCS national representative sample of reproductive age men and women; Uganda, 1997 and 1999 DISH evaluation surveys

[a] For Bolivia, refers to women delivering in health facilities. For Uganda, corresponds to deliveries assisted by a trained nurse or midwife.
[b] Figures correspond to percentages between exposed and unexposed.
[c] Reported condom use with nonregular partner

Table 4
Selected Reproductive Health Outcomes of PCS IV Projects and Other Selected RH Programs (Percentages)

Country	Outcome Measure	Year		Change	Difference by Exposure*
		1999	2000		
Zambia (1999–2000)	Used Condom with Partner	27	40	+ 13	
Tanzania	Used Condom at Last Sex (Men)				
	Exposed	21			+ 12
	Unexposed	9			
	Used Condom at Last Sex (Women)				
	Exposed	12			+7
	Unexposed	5			
	Tested for HIV (Men)				
	Exposed	20			+13
	Unexposed	7			
	Tested for HIV (Women)				
	Exposed	14			+10
	Unexposed	4			
Zimbabwe (1996–99)	Adopted Single Partner				
	Intervention	20			+ 18
	Control	2			
	Started Using Condoms				
	Intervention	11			+ 10
	Control	1			
	Said No to Sex				
	Intervention	53			+21
	Control	32			
	Talked to Partner				
	High Exposure	56			+27
	Low Exposure	29			
	Visited Health Center				
	High Exposure	38			+16
	Low Exposure	22			
	Spoke with Peer Educator				
	High Exposure	32			+ 32
	Low Exposure	0			

*Refers to the difference in percentage points between exposed/intervention and unexposed/control. A positive difference reflects a higher percent in the exposed/intervention group.

Data Sources: Zambia, PCS pre- and postintervention surveys; Tanzania, 1999 DHS; Zimbabwe, PCS pre- and postsurvey data with quasi-experimental study design.

Table 5
PCS IV Outputs According to USAID/Washington Intermediate Results
During October 29, 1996–September 30, 2000

	Expected Outputs 2001	Total to Sept. 2000	Africa	Asia	Europe and Eurasia	Latin America	Near East	Training	Research and Evaluation
1.4 Increased Access, Quality, Demand for FP/RH Services									
Multimedia IEC campaigns	15	44	19	6	7	11	1		
Community mobilization programs	10	48	27	5	5	9	2		
Sets of IEC materials for specific audiences	20	78	26	14	13	16	9	*	
IPC/C training materials	10	43	19	8	6	8	2		
Entertainment–education programs	10	64	25	11	1	25	2		
Technical assistance trips	500	714	288	148	56	139	73	8	2***
1.3 Enhanced Capacity for Sustainable FP/RH Programs									
National IEC task forces established	10–12	24	9	3	3	5	4		
Educational programs and SCOPE workshops:									
a. International	10	8		2					
b. National/regional **	60–70	265	60	62	16	106	14	6*	1
LDC institutions with improved IEC training capacity	5	66	14	3	1	40	8	*	
1.2 Improved Policy, Increased Resources									
National or subnational IEC strategies developed/being implemented	12–15	50	25	9	1	12	2		
IPC/C sections in national medical standards	5	12	4	2		5	1		
1.1 New Improved Technologies, Approaches, Strategies, Knowledge									
Innovations in communication technology, research, training, programs	10	43	11	1	2	15	2	7	5
International/regional specialized conferences/meetings, including JHU	5	17	5	2	2	4	2	1	1
Major publications, articles, reports, working papers, etc.	20	130	10	17	2	17	11	7	66
Professional presentations ****	ND	117							177

* Counted in geographic divisions ** Includes 2–3 day local workshops *** Other trips counted in geographic divisions **** Research and Evaluation Division only

ND = Not Determined

INSTITUTIONALIZATION OF SELECTED FP/RH IEC PROGRAMS

OBJECTIVE 3

In each country where major IEC programs are undertaken, at least one public and several private sector agencies will have developed a sound institutional base for family planning/reproductive health (FP/RH) IEC.

It is not possible under the scope of this evaluation to assess the level of public and private institutionalization in each major PCS country. The objective in itself is problematic, as the phrase "sound institutional base" invites different interpretations, and some countries do not offer viable public sector partners—as in the case of Nigeria, where USAID severed relations with the government. In most cases, the PCS approach to capacity building/institutionalization focuses primarily on an effort to improve partners' technical capacity and much less on development of their long-term institutional viability. In addition, in assessing the PCS approach in this area, the questions of where capacity building ends and institutionalization begins, and who should be responsible for the latter, arise.

The cooperative agreement describes PCS's approach to institutionalization as a process of "empowering institutions to plan, secure funding for, implement, evaluate, and document FP/RH IEC activities on their own." PCS identifies six elements necessary for achieving institutionalization: 1) leadership, 2) a sound institutional base, 3) documented successful experience in FP/RH communication, 4) a clearly identified role in national strategies, 5) adequate financial or community resources, and 6) trained personnel.

Beyond these six elements, institutionalization requires a long-term vision and strategy to effectively transfer technology and build the critical mass of expertise and resources to sustain the leadership for strategic communication and behavior change programs. This is particularly true regarding building capacity within public institutions that are expected to provide the framework for health communication and direct all activities within it.

Most of PCS's efforts are devoted to capacity building through training, workshops, and technical assistance. Several former members of the Ghana IEC committee reported, for example, that their experience with PCS has helped prepare them to develop new campaigns without PCS assistance. In Nigeria, PCS developed the capacity of the country IPPF affiliate to develop communication materials (both print and radio) and to conduct training of counselors. PCS also helped develop the capacity of the Staywell Foundation to develop communication materials (see below).

Institutionalization of capacity, however, is a longer term, more complex process, which is subject to a variety of external factors that cannot always be controlled by PCS. It is important to note that institutional development (i.e., management, administration, and development of financial systems) is not a priority mandate under the PCS cooperative agreement. While not exhaustive, this discussion can highlight examples of where PCS strategies have worked and offer recommendations for the future.

FINDING
Throughout its program, PCS has effectively transferred skills in materials development, training, research, and the development of communication campaigns. These capacity-building efforts have reached NGOs, government entities, advertising/media agencies, and journalists.

PCS works effectively with numerous partners at the country level (see section on collaboration, below). PCS provides technical assistance through its field staff, JHU/Baltimore staff, or one or more of its subcontractors.

One of the principal PCS capacity-building instruments is the Advances in Strategic Health Communication workshop. PCS has trained 1,150 participants through its Advances workshops from 1996 to 2000. Out of a total of 40 workshops, 32 were held in developing countries. In Bangladesh, the Advances training was conducted by the Bangladesh Center for Communication Programs (BCCP). The Gates Leadership Training, although not funded by the PCS project, has benefited key decision-makers in countries where PCS is active. One high-level government official in Ghana described the course as "fantastic" and still uses the material he received during the workshop.

Recognizing the breadth and volume of capacity-building activities conducted by PCS, the following discussion focuses on the institutionalization of that capacity. This question has particular relevance, given the many years of capacity-building assistance PCS has provided in several countries.

FINDING
Institutionalization requires a long-term vision and strategy to effectively transfer technology and build the critical mass of expertise and resources to sustain the leadership for strategic communication programs. The PCS strategy of developing consortia through national IEC strategies and national IEC committees has generally been effective.

FINDING
Four of PCS's field offices (Mexico, Brazil, Bolivia, and Bangladesh) now function as independent national NGOs. Regional institutions, such as the Center for African Studies (CAFS) and three regional training centers in Nigeria, provide training and IEC technical assistance.

PCS has had some notable success with national-level efforts, using its strategy of constituting consortia through national IEC strategies and national IEC committees. In Bolivia, where PCS has been working for over a decade, a dynamic national public/private reproductive health forum with 52 member organizations is in place. The forum is currently implementing its third five-year plan. The process began in 1989, when PCS facilitated a strategic planning exercise. The Center for Communication Programs in Bolivia (Centro para Programas de Comunicación en Bolivia [CPCB]) is another product of this long-term PCS intervention. With support from USAID, the government of Bolivia, and other donors, the PCS country office has been incorporated as a local NGO. The CPCB is directly funded by USAID and is working to diversify its funding base, with PCS providing continued technical assistance.

PCS applied a comparable strategy in Bangladesh, where PCS has an equally mature program. Enlisting the participation of a broad-based coalition of stakeholders and key players, PCS helped develop a national IEC strategy in 1993; it was later revised to incorporate maternal and child health (MCH) activities. PCS phased out its expatriate resident adviser by training a host country national to be his successor. In 1996, the Bangladesh Center for Communication Programs (BCCP) was established as the successor to the JHU field office. Its mandate is to design, manage, implement, and evaluate large-scale strategic communication programs for health and population and other development programs. BCCP serves the communication needs of the Ministry of Health and Family Welfare and its behavior change communication unit, USAID–supported NGOs, and other organizations working in the FP/MCH program. PCS is in the process of replicating its Bolivia and Bangladesh support shift approaches in Nepal.

In Brazil, capacity building for strategic communication planning has been in the forefront of activities with the state Secretariats of Ceara and Bahia as a way of improving the sustainability of family planning service delivery systems. PROQUALI, an accreditation scheme for health centers, is currently being institutionalized across the country. The accreditation criteria target five core areas: clinical services; client counseling, orientation, and information; infection prevention; management systems; and facilities and supplies. PCS joined forces with Management Sciences for Health (MSH) and the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) to provide a comprehensive spectrum of technical assistance for this project.

In Ghana, where PCS had a multiyear involvement, results are not as encouraging. From 1997 to 1998, a PCS adviser was assigned to the National Population Council (NPC) to support the implementation of the revised national population policy. An IEC technical advisory committee was formed and helped develop the strategic framework for reproductive health, child health, and population and development. This framework was intended to guide implementing agencies in developing their action plans using two communication tools: IEC and advocacy. It also identified priorities for capacity building of implementing agencies. This is consistent with the PCS approach for developing sustained technical capacity, whereby capacity building must be an integral element of the development and implementation of national communication strategies. However, internal strife within the NPC, coupled with the diversion of donor funds, derailed the implementation of the strategic plan. The USAID Mission also adjusted its priorities and has not supported any subsequent direct assistance to the NPC. The IEC committee disbanded, and given the leadership vacuum at NPC, no efforts have been made to revitalize it.

In building sound institutional bases in private sector organizations, PCS interventions in Nicaragua have shown impressive results. Over a period of five years, PCS has provided technical assistance to the local family planning association, PROFAMILIA, to improve the quality of and access to reproductive health services. This collaboration has included capacity building of the community-based distribution (CBD) network, training department, IEC department, and research and evaluation department. PCS has also assisted PROFAMILIA's marketing department in the design and implementation of a social marketing campaign for the Body Guard brand condom.

Because of the unsettled political situation that has persisted in Nigeria over recent years, PCS did not apply its national-level approach in that country. There was no public sector partner with which PCS could collaborate, and resources were focused on the private sector. Funding was uncertain given USAID/Nigeria's position, and long-term planning was not possible in this environment. Given these factors, progress toward institutionalization of capacity has been mixed.

A positive example of PCS's institutionalization efforts in Nigeria is the Staywell Foundation—one of the three regional training centers developed in response to USAID/Nigeria's request for the development of an exit strategy. Specifically, USAID asked PCS to develop a strategy that would institutionalize capacity to provide continued IEC support to the health and eventually the democracy and governance sectors. In response to this request, PCS provided substantial technical assistance to the Staywell Foundation during 1997–98. Staff participated in the Advances training in Baltimore, and the P Process is currently well integrated into the work of the foundation. Staywell distributes many PCS materials through its Media Materials Center, and provides access to POPLINE and SCOPE through a dedicated computer. In 1998, PCS and Staywell conducted a Communication Strategy workshop for NGOs in the southeast region of the country; this workshop produced a region-based IEC strategy and an IEC working group. Staywell and the IEC working group continue their collaboration today in coordinating and implementing activities defined under the IEC strategy.

Staywell no longer receives technical assistance or funding from PCS and has successfully attracted funding from the Basic Support for Institutionalizing Child Survival project (BASICS) and the United Nations Population Fund (UNFPA), among others. Staywell believes it has the capacity to conduct Advances workshops and invites such an opportunity when PCS schedules its next in-country workshop. PCS/Lagos should make optimum use of Staywell's strong capabilities, not only within the southeast region, but at the national level as well.

PCS's investment in the IPPF–affiliated Planned Parenthood Federation of Nigeria (PPFN) has not been successful. When PCS identified PPFN as its private sector partner for service delivery, PPFN had an extensive service delivery network and organizational capability. More recently, the institution has been weakened by a lack of strategic vision, poor management practices, and funding cuts. These are clearly developments that escape the control of PCS, but they leave the project with only one very weak partner for the delivery of family planning/reproductive health services in Nigeria.

PCS has made attempts to enlist the participation of universities to further institutionalize health communication skills. PCS trained a core faculty from the University of the Philippines and Development Academy of the Philippines to assume responsibilities for the training of local government IEC personnel. Not only has the core faculty adopted the use of SCOPE for IEC training, but it has expanded the tool's application to other academic courses as well. Some efforts were made to institutionalize the Advances workshops; in Ghana, the University's School of Public Health helped conduct the workshop. However, the change in leadership within the university has made it difficult to pursue this collaboration. PCS works closely with the Gates Foundation and the

Mellon Foundation in developing distance education courses in health communication in Africa (e.g., at Makerere University in Uganda).

PCS has taken some initiatives to capitalize on this body of experience and refine its approach. It has completed, for example, an initial analysis of the factors influencing the success of interagency committees in Latin America. Prospect Associates has taken the lead in preparing a how-to guide for developing national IEC strategies. The revised PCS Six Cs tool for assessing an organization's capacity in health communication is being field tested and used to identify local partners, define needs for technical assistance, and measure progress toward sustainability of communication capacity.

RECOMMENDATION

PCS should continue and increase its use of the technical capacities it has helped to develop at the country and regional levels. PCS should foster increased use of host country and regional expertise to provide south–south technical assistance and to conduct in-country Advances workshops.

IMPROVED COLLABORATION

OBJECTIVE 4

Collaboration among all agencies carrying out FP/RH IEC will be much improved at the national and selected local levels.

FINDING
PCS collaborates effectively with host country institutions. PCS collaboration with other (U.S.–based) cooperating agencies has not improved markedly since the previous evaluation.

PCS could not have achieved an 18–year long record of achievement had it not developed and applied the collaborative skills needed to work constructively with host country governments, NGOs, and commercial agencies. Consultations with PCS's counterpart institutions, subcontractors, and grantees in Nigeria, Ghana, and Nicaragua, for example, found consistently high levels of satisfaction with the substance and style of the PCS relationship. The occasional negative comments (late arrival of funds, delays in PCS/Baltimore approvals for new initiatives) were similar to the complaints common to virtually all CA–supported activities.

Two specific aspects of PCS's role are worth noting. First, PCS does try, whenever possible, to promote the establishment of national IEC working groups or task forces, which include all of the relevant (public, private, commercial, donor) participants in a given country's communication and advocacy activities. At present, some 23 such groups exist in as many countries, although their actual effectiveness varies widely from country to country. Second, for a host country subgrantee, a relationship with PCS almost invariably involves substantive training—via technical assistance, workshop

attendance, or both—in communication theory and application of key tools, such as the P Process and GATHER. The evaluation team observed evidence of such skills transfers in all three of the countries visited (Nigeria, Ghana, and Nicaragua). This training, moreover, was consistently valued by the subgrantees, all of which were found to be using the skills in their own programs.

Substantive collaboration with other cooperating agencies, however, is less frequent. While many good examples of cooperation between PCS and other CAs can be cited (e.g., with BASICS in Nigeria, the Environmental Health Project (EHP) and the Cooperative for Assistance and Relief Everywhere in Nicaragua, MSH and JHPIEGO in support of PROQUALI in Brazil, and work with other CAs through the 23 national IEC committees), such efforts are not the norm and do not generally involve cooperation at a strategic level. The Futures Group/POLICY project reports, for example, that neither the Futures Group nor JHU/PCS has procedures in place to coordinate the two organizations' respective advocacy programs, despite their considerable potential for overlap or duplication with journalist groups, host country decision-makers, and promotion of NGO advocacy/lobbying capacities. Similarly, neither JHU/PCS nor Family Health International (FHI) maintain routine coordinative links (outside of their participation in various maximizing access and quality [MAQ] working groups) despite their involvement in health care provider training and music video initiatives to reach young audiences.

In general, the main factor contributing to CA collaboration—whether at the Washington level or in the field—is usually USAID. In Washington, USAID sometimes attempts to forge CA cooperation around specific issues (again, such as MAQ), or in an effort to share information broadly relevant to several/all cooperating agencies.

These observations are not new, of course. USAID and the CA community are aware of the competitive pressures that obstruct meaningful cooperation—and JHU/PCS is no more responsible for weak cooperation than is any other CA. Given the obstacles, substantive collaboration among the CAs at the country level will continue to be a function of the extent to which USAID Missions are prepared to make it happen.

IV. SPECIAL FOCI

When the PCS IV cooperative agreement was awarded in 1995, its focus was on population and reproductive health. Since then, and largely in response to USAID Mission field support funding, the project has been used to develop communication and behavior change initiatives in other functional areas, such as child survival, HIV/AIDS prevention, environmental health, and democracy and governance.

In addition to these new, unanticipated tasks, the PCS IV cooperative agreement called on JHU/PCS to give increased attention to areas that had not been treated in depth by the prior projects. These included community mobilization, interpersonal communication and counseling (IPC/C), gender issues, and the emergence of new information technologies potentially useful to project implementation.

The evaluation team was asked to examine PCS performance in these new, and in some instances, unforeseen areas of involvement. The team was also asked to review the measures employed by JHU/PCS to ensure the existence of adequate linkages between PCS–supported communication efforts and service delivery programs and the extent to which PCS has integrated the technical expertise needed to respond to its many areas of program activity. The following section examines these issues.

BEYOND FAMILY PLANNING/REPRODUCTIVE HEALTH

FINDING
PCS's thematic move beyond FP/RH has primarily been in response to USAID Mission requests. PCS is increasingly developing strategic approaches to these new areas.

Over the course of PCS IV, the project has moved well beyond family planning and reproductive health and into a broad range of new thematic areas. Virtually all of these new responsibilities were assumed by PCS in response to field support–funded requests from USAID Missions.

The PCS strategic communication framework was originally developed in the context of population and family planning programs; in 1995, when USAID and JHU signed PCS IV, population and family planning were still the near-exclusive focus of the project. At about the same time, however, USAID was increasingly integrating the International Conference on Population and Development (ICPD)/Cairo policy and operational recommendations into its programs at both Washington and field Mission levels. As part of this larger shift, the mandate of PCS IV was broadened in 1995 to include an additional focus on reproductive health.

At the same time, USAID Missions were similarly altering their own portfolios to reflect integrated, strategic approaches to health sector requirements. Their efforts were driven partly by the ICPD, partly by the Agency's managing for results directives, and partly by Mission attempts to minimize and focus their Strategic Objectives on fewer attainable goals. Yet, even as these moves toward greater programmatic consolidation were taking

place, USAID Missions were confronting new challenges that threatened to undercut their attempts to consolidate and focus:

- health reform, and its attendant drive toward decentralization and devolution, was emerging as a political and sectoral priority in several USAID–assisted countries;

- infectious diseases reemerged with unexpected virulence; and

- the HIV/AIDS pandemic showed no sign of abating, but rather was expanding at an alarming rate.

Not surprisingly, many of the USAID Missions' responses to these health sector challenges included communication components. And many of these Missions—staffed by population, health and nutrition (PHN) officers familiar with PCS's successful record in population/family planning—looked to PCS to address those communication tasks.

PCS usually tried to assume these new (beyond FP/RH) responsibilities in a systematic manner. However, due to Mission–propelled urgency and very tight schedules, PCS often conducted its traditional P Process very rapidly or only superficially. As a general rule, PCS launched into its new tasks quickly and developed its strategic approach once the activity was underway. PCS experience in Nigeria (democracy and governance, polio eradication), Ghana (HIV/AIDS prevention), and Nicaragua (EHP) is illustrative. Within several months of project start up, PCS had developed strategic approaches around each of these tasks and had recruited project staff having the technical skills needed to manage the new assignments.

FINDING
Over the course of PCS IV, PCS has engaged in five new thematic areas. Child survival and HIV/AIDS are the most frequent (number of projects) and largest in dollar value.

During the period 1996–2000, PCS involvement beyond FP/RH has included: child survival ($8.6 million), polio eradication ($1.2 million), HIV/AIDS ($5.74 million), democracy and governance ($4.69 million), and environmental health ($2 million) (see appendix C, PCS Funding by Country and Directive, 1996–2000). Overall, child survival projects have been conducted in 11 countries, polio eradication in 1 country (Nigeria), HIV/AIDS prevention in 10 countries (with Ghana, Rwanda, and South Africa being the largest in dollar volume—each costing between $1–1.4 million). Democracy and governance projects are underway in just two countries (Nigeria and Rwanda) and environmental health is in progress in Nicaragua only. Thus, despite the relatively wide range of new thematic areas for PCS, the project's most prominent extension has been into child survival and HIV/AIDS.

FINDING
PCS has successfully applied its strategic communication approach, tools, and methodologies in areas beyond family planning and reproductive health.

PCS's strategic communication framework has demonstrated a generic value in responding to communication needs in the new areas to which it has been applied. PCS has consistently applied its strategic communication framework in these new areas and has built to the degree possible on established approaches to mass media, IPC, and community mobilization.

Polio Eradication

In response to USAID/Nigeria's request that PCS provide support for the Nigerian polio eradication campaign (National Immunization Days [NIDS]), PCS developed a strategy that combined a series of well-established components. These included mobilization of the already established IEC committee; successful steps to coordinate NID mass media campaigns with the efforts of social mobilization committees at national, district, and local levels; and the recruitment of high-level political and religious leaders who publicly endorsed the campaign. The combination of these elements greatly extended the reach of the polio eradication campaign. Despite a slow start and some campaign fatigue, the results have thus far been good. To help develop the social mobilization committee structure, PCS delivered training in IEC, strategic communication, and community mobilization to collaborating partners, including Rotary International, BASICS, CDC, and local NGOs, all of which served on the campaign's interagency coordinating group.

What has been more difficult to achieve has been the establishment and continuity of the social mobilization committees at the community levels. These committees' tendency to dissipate between NIDS campaigns seriously impedes efforts to maintain routine immunization coverage during the periods between the National Immunization Days. Constraints bearing on the committees included a lack of adequate funding, as well as some unclear communication between communication planning and social mobilization activities. USAID/Nigeria has asked PCS to strengthen the linkages between its messages and the work of the community-level committees.

Overall, PCS successfully applied its strategic framework to the Nigerian NIDS campaign, and in the process learned a valuable lesson regarding the need to link its community outreach efforts to the continuing work of community-level organizations. As noted, however, PCS's involvement also revealed some of the difficulties encountered in the building of community support structures in a very short period of time, independent of the thematic approach.

Democracy and Governance

PCS's ability to apply its strategic communication skills to the Nigerian democracy and governance program was largely constrained, at least initially, by USAID Mission imperatives. The Mission stipulated that the campaign's strategic focus was to be on women's empowerment, which was considered to be a less threatening entry point for democracy and governance activities during the turbulent political climate of the time (1997). The objectives of the campaign were also set out by the Mission: to focus on women's political empowerment, fundamental human rights, civic responsibility, and democratic participation. In order to expedite project implementation, the Mission also determined that the campaign should be carried out through the provision of grants to

existing NGOs. The urgency that the Mission attached to the project obviously had an impact on PCS's ability to conduct thorough formative research, including an indepth situational analysis and methodical project design process. Within these constraints, however, PCS eventually developed the following (refined) strategic objectives for the democracy and governance project:

- Increase knowledge of Nigerian women about democratic participation;
- Increase women's political empowerment and participation at the local, state, and national levels;
- Increase knowledge of Nigerian women about the concepts, values, and practices of fundamental human rights and civic responsibility; and
- Increase women's advocacy activities for their fundamental human rights.

PCS's analysis led them to choose a combination of community mobilization and media advocacy as the major thrust of PCS's communication strategy. PCS selected 16 relatively stable NGOs—all of which were already working in community mobilization, legal advocacy, and journalism—as its partners in the program. PCS provided training in project management, BCC, and advocacy to these organizations. Many of PCS's standard techniques were applied; they conducted formative research using focus groups to design messages and materials that were also pretested before distribution. Later phases of the campaign apparently made use of the Ideation model to help develop messages which encouraged women to vote.

PCS's evaluation of phase I of the Nigerian democracy and governance program indicates that it was successful in increasing knowledge of democracy and human rights among participating NGOs, as well as in increasing activities advocating for women's human rights. Exposure to project activities was associated with improved information-seeking behavior and greater likelihood of political involvement. There was also a significant increase in discussion of political views and voting for a woman—from 46 percent of baseline compared with 87 percent in follow up. However, little impact was demonstrated among the general public. (PCS informs that the public was not targeted, although the project outputs included mass media [both through journalists, as well as radio and television soap operas], which were evidently developed and used for general consumption.)

PCS's evaluation methodology was sound, comprising a three-pronged study, before and after quantitative design which examined changes in the attitudes and practices of the NGOs' membership and the public at large.[5] Multivariate regression analysis was used to show significant associations with exposure to the project. However, this does not eliminate the contribution of other sources of information on democracy and governance that must have occurred during this period.

[5] The evaluation measured changes over an extremely short time period, which may affect demonstration of impact. Also, while the results of PCS's evaluation of phase 1 were factored into the design of phase 2, PCS has developed phase 4 of the project without the benefit of the evaluations of phases 2 and 3—apparently due to limited funds.

The major weaknesses of the evaluation were in the institutional analysis (in which only leadership, not ordinary membership, of the NGOs was interviewed) and the assertion of a number of unsubstantiated claims. These include the claim of causal links between the advocacy activities of certain NGOs and a number of specific political appointments, new legislation, and university courses on women and politics. Similarly, claims that the evaluation demonstrated "tried and tested communication strategies for behavior change work in democracy and governance" were not substantiated.

Suggestions for improved design would include the examination of a cross-relationship between the studies; inclusion of qualitative elements to give more depth to the evaluation; interviews of ordinary NGO membership; indepth interviews with key players and independent observers to demonstrate links between advocacy activities, new legislation, and appointments; and the inclusion of media content analysis to evaluate the impact of the media advocacy component of the project.

Environmental Health

PCS's support for the EHP in Nicaragua has focused on the organization of a major mass media campaign (the Blue Star campaign) linked to entertainment-education–focused community mobilization around a Blue Bus scheduled to visit 120 communities in 2001.

One of the issues in the campaign has been the use of entertainment–education in radio and television. As explained elsewhere, entertainment–education is usually an integral element of the PCS strategic communication framework. In this instance, PCS's need to move rapidly collided somewhat with local traditions and conditions for producing radio and television dramas. On one hand, it has been decades since Nicaragua broadcast radionovelas as any significant part of its media panorama. On the other hand, there was no tradition or experience in place for producing television dramas in Nicaragua. The situation was therefore unusual, and the negotiated entertainment–education approach required greater adaptation than PCS usually experienced.

HIV/AIDS Prevention

JHU has progressively increased its work in HIV/AIDS communication. This process has taken several forms, including a dual protection program in Nicaragua (a prominent component of which is the Body Guard social marketing project with PROFAMILIA), comprehensive behavior change campaigns in Kenya (Break the Silence campaign) and Ghana (Stop AIDS. Love Life.), discrete, small-scale programs in Nigeria (telephone hotline and youth call-in radio show) and Nicaragua (human rights and HIV/AIDS), and core-funded activities, such as "Africa Alive!" and the Caring, Understanding Partners (CUP) initiative. To date, PCS has applied its communication expertise to the development and implementation of 21 HIV/AIDS prevention programs.

Generally speaking, PCS has used its models and tools in support of HIV/AIDS prevention activities in two ways. First, PCS has used its P Process to facilitate program design and implementation in countries such as Ghana, Kenya, and Nicaragua. However, with few exceptions (Kenya and Nicaragua), there is not enough evidence available to

determine whether PCS's communication interventions are likely to have a significant effect on behavior. In Kenya, PCS built on the popularity of soccer to develop the Break the Silence campaign. That project has sought to increase knowledge of HIV/AIDS among football players and youth, to increase the number of young men under 20 seeking HIV/AIDS information at available service delivery points, and to increase the number of policy makers supporting youth-oriented approaches to HIV/AIDS prevention. The project has produced some impressive results: over 79 percent of players and 41 percent of fans visited booths for information on HIV/AIDS, and nearly 60 percent of players and fans reported that they planned to discuss HIV/AIDS with someone. Approximately 30 percent of fans plan to seek more information, 17 percent intend to stop premarital sex, 27 percent plan to seek preventive measures against HIV/AIDS, and 7 percent plan to get tested for HIV/AIDS. In Nicaragua, a social marketing approach developed with PROFAMILIA led to sales of over 1.4 million Body Guard condoms in the project's first 10 months. These are promising results for both projects. It is still too early to say, however, whether these trends indicate sustainable changes in HIV/AIDS–related behavior. Given the nature of the HIV epidemic and the obvious difficulties in promoting behavior change in relation to sexual practices, any conclusive judgments regarding the two projects should await PCS's collection, analysis, and reporting of impact data on the interventions.

Second, PCS's approach to HIV/AIDS prevention continues to reflect the project's focus on individual behavior change—an approach that, to date, seems to have failed in most HIV/AIDS communication interventions developed by various organizations around the world. While there is not an easy answer to this question, PCS might capitalize on its academic and field resources to conduct an examination of the elements that might be playing a significant role(s) in sexual behavior. Some successful experiences documented by the Joint United Nations Programme on HIV/AIDS (UNAIDS) show that in some cases, policy issues have been instrumental (Thailand), while in other scenarios, partnering with religious organizations has been a major source of change (Uganda). In both cases, communication continued to play a central role, since it was through communication that policy makers and religious leaders were brought together to promote the necessary changes.

Most of the HIV/AIDS–related interventions supported by PCS focus on prevention. While this must continue to be the highest priority on PCS's HIV/AIDS agenda, USAID and PCS might consider giving more attention to other elements of the HIV/AIDS continuum. These include care and counseling, issues of stigmatization, human rights, and workers' rights.

RECOMMENDATION

PCS should closely review global experience in HIV/AIDS communication so that lessons learned from successful interventions can be incorporated into its strategic communication approach.

COMMUNITY MOBILIZATION[6]

FINDING
PCS has substantially expanded its strategies and activities to include community activities.

The PCS IV project has expanded beyond the predominant focus of the three prior PCS projects on mass media to include community-level activities as one of the three mutually reinforcing pillars (alongside IPC/C and mass media) of its communication approach. This finding is reflected in PCS IV funding allocations: 22 percent to IPC/C related activities, 36 percent to community mobilization, and 42 percent to mass media.

FINDING
PCS community strategies have been predominantly outreach in nature, but increasing experimentation with more participatory approaches is taking place with some success.

Many of the activities included by PCS under the rubric of community mobilization are strictly speaking, community outreach—awareness-raising events exposing community members to health education messages. Such activities can extend the reach and depth of national communication campaigns, reinforce mass media messages, stimulate interpersonal discussion, and direct audiences to services, thereby increasing demand. Projects which appear to make good use of mass media, outreach, and service combinations include the Green Star Reproductive Health project in Tanzania, DISH in Uganda, the Reaching Men campaign in Senegal, the Blue Star campaign in Nicaragua, and Gold Star in Egypt.

Project partners consulted in the course of the evaluation noted some concerns, however, about the level of sustainable impact one could expect of large and expensive community activities that function more as one-time events. The "Africa Alive!" program was mentioned specifically in this regard.

While good linkages between the three components appear to be the norm, instances exist where links to community-level support programs could be improved. The innovative "Stop AIDS. Love Life." program, for example, effectively linked road show events to the campaign's mass media component through strong branding of the yellow hand logo and the inclusion into the road show program of the moving story of an HIV–positive Ghanaian man, who also appears on the television PSAs. There was no linkup, however, to community organizations in the area to provide ongoing support at the local level. PCS needs to strengthen project links between outreach activities and community-based support groups to ensure sustainable impact. A new component—Fleet of Life—is being added to help establish this link.

[6] Save the Children Federation, Inc., informally defines community mobilization as a process through which action is stimulated by a community itself, or by others, that is planned, carried out, and evaluated by a community's individuals, groups, and organizations on a participatory and sustained basis to improve health. In addition to improving health, the community mobilization process also aims to strengthen the community's capacity to address its health and other needs in the future. (Conversation with evaluation team member, January 30, 2001.)

Innovative forms of entertainment–education are often a major feature of PCS's community activities. The "Stop AIDS. Love Life." road shows in Ghana and the Lilac Tent project in Bolivia both draw large audiences to interact with the novelty of a traveling fair (Ghana) or circus-like atmosphere (Bolivia). In the Bolivia case, community radio was effectively used as the project's supportive mass media component.

RECOMMENDATION

Costly one-time outreach projects need to be reevaluated with respect to their cost-effectiveness and long-term impact.

FINDING
PCS has begun to explore a community mobilization approach involving greater degrees of participation, capacity building, and community empowerment.

The term community mobilization implies a greater degree of community participation than the term outreach. Participation can range from meaningful involvement to shared ownership and control of the project itself. In the empowerment model, the process is as important as the outcome, and community members act as agents rather than objects of change.

Global trends towards democratization, decentralization, and the strengthening of civil society are providing greater stimuli for increased client and community participation. Other arguments in favor of this participatory model include increased program relevance and greater use of services and sustainability. MAQ objectives are being increasingly supported when projects become partners with community members and service providers to jointly define quality and develop improvement strategies.

Poor client–provider interaction, despite good IPC/C training, was identified as the major barrier to service utilization in Puno, in rural Peru. Cultural and socioeconomic barriers between service providers and clients were identified as the cause, and the Puentes (Bridges) project was established to increase dialogue and collaboration between the community and service providers. The SECI project to improve maternal and child health in rural areas in Bolivia and the KSP project in the Philippines are two additional examples of community-level, participatory projects where joint service provider/community dialogue and decision-making to improve quality and utilization of services are already showing some measure of success. PCS also reports that local government teams in the Philippines developed their own health communication plans and programs with limited technical assistance from the local PCS staff in Manila. The Healthy Indonesia 2010 Coalition—initiated and supported by PCS—has stimulated the mobilization of local organizations and media at the district level.

These projects were developed by PCS and its subcontractor, Save the Children Federation, Inc. (SAVE). SAVE is helping to mainstream its methodology into PCS practice through a community mobilization task force and the publication of a regular newsletter. Under PCS IV, community mobilization specialists from 10 Latin American countries met to share their experiences in the health sector and to contribute to the development of a how-to manual of best practices.

A community mobilization module is currently in development for SCOPE training, and SAVE plans to work with PCS to develop a CD–ROM dedicated to the topic. Community mobilization is currently a choice of the multitrack session (1.5 hours) of the Advances course. Community mobilization should also be mainstreamed into the Advances course and other PCS training programs, as well as into the P Process and the "A" Frame for Advocacy tools.

RECOMMENDATION

PCS should document the process and impact of participatory community mobilization programs, paying particular attention to the costs and benefits involved from both community and service provider perspectives, the potential for sustainability, replication, and up-scaling. These findings and experiences should be widely disseminated to facilitate greater adoption of such models where appropriate.

FINDING
PCS projects incorporating community elements have contributed to changing behavior and setting new community norms. While evaluations of pilot community mobilization projects using the participatory/empowerment approach are still in process, some up-scaling opportunities are already taking place.

Existing evaluations of PCS projects point to considerable shifts in knowledge, attitude, and at times, behavior change. The evaluation of the Men's Participation program in Jordan, for example, found that spousal communication increased from 48 to 70 percent, and men's approval of contraception increased from 74 to 84 percent. These factors have been shown to be important predictors of service and contraceptive utilization. Intention to use contraception increased among nonusers from 25 to 38 percent, and the number of respondents believing that it was important to have at least one male child decreased from 52 to 44 percent.

Evaluations of the Nigeria democracy and governance project show an increased knowledge of the political process and positive attitudes towards women's political, cultural, and economic empowerment (among the participating NGOs). The program also increased women's voluntary involvement in NGOs, with membership rising by 32 percent and active participation by 48 percent.

In less than one year, the SECI project found more households (compared with controls) in the intervention communities reporting positive health outcomes. Complete child immunization increased from 2.6 to 11.2 percent, vitamin A supplementation increased from 41.9 to 58.6 percent, possession of a health card increased from 27.7 to 44.9 percent, and early postpartum breastfeeding increased from 11.7 to 25.7 percent. Moreover, the project successfully leveraged increased financial resources from the municipal health budget to improve the condition of health services.

A common criticism leveled at community empowerment models is that their impact is felt by a relatively small number of people, and that projects often cannot be replicated on a broad scale. However, the ministries of health in Peru, Bolivia, and the Philippines are

apparently exploring ways to expand the coverage of these projects. In Peru, the MOH has already received alternate donor funding to implement Puentes in other regions.

FINDING
PCS projects make little use of community mobilization to advocate for changes in public policy.

History is full of successful examples of community mobilization to advocate for social change. Such advocacy could affect some of the structural/environmental barriers to health and development, including those related to serving unmet needs.

Media advocacy—the use of the news media by communities to place health and development issues on national agendas to influence policy and key decision-makers—is increasingly recognized as a powerful tool for development communication (Wallack, Dorfman, Ryan). The political influence of communities can be used to pressure elected officials, and training in media advocacy skills can help communities to better access the media and to develop techniques to shape public debate.

PCS made good use of elements of media advocacy in the Nigeria democracy and governance project, which supported the National Association of Women Journalists (NAWOJ) efforts to put women's political empowerment on the public agenda. Media coverage of activities of the community organizations involved in the democracy and governance program took place through networking with NAWOJ. The program could, however, have enhanced the impact of this relationship through training of the participating NGOs in media advocacy skills to enable them to access other journalists and media channels and to shape the debate more effectively.

RECOMMENDATION

PCS should make greater use of community mobilization as a strategy for social change (e.g., by developing community skills in advocacy in general and media advocacy in particular).

INTERPERSONAL COMMUNICATION AND COUNSELING (IPC/C)

FINDING
PCS has responded very constructively to the PCS III evaluation, which called for improvements in the project's approach to IPC/C.

Some specific PCS initiatives since the 1993 evaluation include the development and broad application of the GATHER tool, development of training curricula for health care providers, training of service providers, and facilitation of provider self-assessment tools.

As noted previously, much of PCS's success in this area derives from its application of the GATHER tool, which is used to improve client–provider interaction in family planning and reproductive health programs. GATHER has been effectively applied by several PCS partners, including AVSC in Nigeria, FriendlyCare in the Philippines, and

PROFAMILIA and the Cooperative for Assistance and Relief Everywhere in Nicaragua, Bolivia, and Peru.

PCS reports similar success in Mexico, Indonesia, the Philippines, and Nepal, particularly in the areas of client–provider interaction and provider self-assessment. These latter changes have been stimulated largely via mass media interventions that sensitized clients to expect improved quality of care in clinical settings.

PCS has also developed a number of strategies to enhance the role of interpersonal communication in project implementation. In Nicaragua, PCS has used certain forms of peer communication, via youth clubs, to disseminate reproductive health and adolescent health information among young populations. Also in Nicaragua, PCS has worked closely with PROFAMILIA to establish a network of 900 community health promoters that provide FP/RH information and services to members of their communities (including young adults).

PCS's strategic emphasis on client–provider interaction is not matched, however, by any special focus on other forms of IPC/C, such as peer communication, parent–sibling communication, and family communication. These latter modes of interpersonal communication are explicitly called for in the PCS IV cooperative agreement. With few exceptions (CHEST in Ghana and youth clubs and community health promoters in Nicaragua), there are not many examples of such activities being implemented under the current project. PCS does point out that these forms of interpersonal communication have been incorporated into many of its community mobilization activities. While this is accurate, a more assertive approach to these IPC/C modalities as specific IPC/C interventions might help enhance PCS's IPC/C strategy.

RECOMMENDATION

PCS should expand its IPC/C focus beyond client–provider interaction and increase its attention to other forms of interpersonal communication, such as peer education/communication.

GENDER

FINDING
A significant number of initiatives conducted by PCS IV incorporate a gender focus.

PCS reports cite over 30 gender-sensitive projects in 25 countries. These projects fall into four broad categories:

- male motivation projects—encouraging men to be more supportive of family planning and to share responsibility for sexual, reproductive, and child health;
- projects affecting reproductive health through an explicit focus on women's empowerment;
- training health care providers to offer gender-sensitive services; and

- promoting gender-sensitive communication programs.

Male Motivation Projects

Most of PCS's large projects incorporating gender fall into this category. Examples include the Men's Participation program in Jordan and the Reaching Men campaign in Senegal, both of which targeted men and religious leaders to promote favorable attitudes towards family planning. The CUP initiative in a number of countries in Africa aimed to promote healthy sexual lifestyles among athletes and their fans by building on the mass appeal of sports.

PCS has also contributed to efforts placing men's participation in reproductive health onto national agendas through the cohosting of conferences and targeting of policy makers, donor organizations, and program managers.

PCS has developed various television and radio shows and audiovisual and print materials providing positive role models of caring and responsible men. The diffusion of these images into popular culture has been shown to be a powerful mechanism to shift social norms.

Projects Focusing on Women's Empowerment and Human Rights

The impressive Arab Women Speak Out (AWSO) project made very explicit links between empowerment, women's rights, and reproductive health. Presenting role models of Arab women who have become respected agents of social change in their communities, the AWSO project developed training materials to help build women's self-esteem, skills in decision-making, negotiating, and safeguarding reproductive and general health. Over 21,000 women have been reached by the project to date. Although a full impact evaluation will not be conducted until mid–2001, results from the workshop evaluations point to some success. About one fourth of the participants would participate more actively in decision-making within the family, and nearly one in four asserted that they would encourage other women to be active in their communities. One third of the participants would apply their expanded understanding of women's roles and responsibilities to their own lives. Another measure of the project's success is the interest generated in replicating it elsewhere. A number of country ministries, donor and multilateral agencies, and NGOs plan to incorporate AWSO into national country programs. CEDPA is making extensive use of the AWSO project in Egypt and plans to expand its programs in that country.

The Healthy Futures project, carried out primarily by AED and aimed at reducing barriers to primary school completion among young Kenyan girls, links gender empowerment to health. Evidence of the link between child survival and the education levels of mothers has been well demonstrated. Some hypothesize that the critical factor could be the mother's increased sense of confidence and self-efficacy and exposure to social networks with a diffusion of new ideas. Similarly, the democracy and governance program in Nigeria, designed to increase women's participation in politics and civil society, may well have positive implications for reproductive health. The democracy and governance

project also made direct links to health by enlisting NGO partners' support to mobilize participation in National Immunization Days and World AIDS Day activities. Journalist organizations involved in the democracy and governance project have also been used to promote health issues in the media. Partner NGOs have been involved in activities to improve inheritance rights for women and are pursuing legislation to ban harmful traditional practices that have an impact on health. PCS/Nigeria plans to create greater synergies between democracy and governance and reproductive health under phase IV of its democracy and governance project.

Television series, such as *A Time to Love* in Peru and *Naked Dialogue* in Bolivia, both addressed gender explicitly. The Together We Decide When project in Nicaragua stresses the shared responsibilities of both partners on matters of sexual relations and family planning and reinforces young women's negotiating skills in sexual situations.

FINDING
Many PCS IV evaluations demonstrate significant success in increasing spousal communication and men's approval for family planning and have contributed to an increased utilization of modern contraceptive methods.

PCS's evaluation of the Men's Participation program in Jordan found that spousal communication increased from 48 to 70 percent and men's approval of contraception increased from 74 to 84 percent. Intention to use contraception increased among nonusers from 25 to 38 percent. These indicators have been identified as strong predictors of the utilization of family planning services.

CUP evaluations focus on the number of people exposed to messages, the number of condoms distributed, and the number of men offered counseling services (5,000 at the Kenyan soccer event). Evaluation methodologies make use of KAP surveys, hotline usage, and exit interviews at clinics. In Kenya, 42 percent of players and 45 percent of fans that had seen or heard about the stadium's counseling booths visited them. Seventeen percent planned to cease premarital sex, 27 percent planned to seek preventive measures such as condoms, and 7 percent planned to be tested. Exit interviews at clinics in Uganda found that, of the 41 percent of respondents who had seen the television spots broadcast during the World Cup matches, 6.5 percent reported that the spots influenced them to attend the clinic.

However, men's approval and support for family planning and safe sex does not necessarily translate into women's empowerment nor enhanced autonomy in decision-making related to sexual and reproductive health.

This is well illustrated in the Promotion of Youth Responsibility campaign in Zimbabwe, in which 20 percent of respondents reported remaining faithful to one partner and 11 percent reported using condoms. These changes were much lower in comparison sites. Unfortunately, more than 80 percent of youths still believed that men should make the decisions concerning sex.

RECOMMENDATION

PCS programs should continue to emphasize *shared* responsibility and to increase emphasis on women's empowerment, gender inequities (including a focus on gender-based violence—see below) and the promotion of sexual and reproductive rights, as called for by the ICPD in Cairo.

FINDING
PCS IV has developed tools and workshops to assist in the development of gender-sensitive programs. These are, however, unevenly applied.

FINDING
Gender, as a crosscutting issue affecting all areas of PCS's work, is not effectively institutionalized into PCS.

PCS subcontractor CEDPA has developed the Change, Access and Control, and Perceptions (CAP) tool, which provides a practical approach for the incorporation of gender issues into all phases of a communication project cycle. CEDPA also developed the 5–day Through the Gender Lens workshops, which were conducted in Nigeria, Ghana, Nepal and Zambia (for seven countries). The workshops raise awareness of gender issues and by using the CAP tool, help participants identify and respond to gender considerations throughout the P Process.

Many participants spoke highly of the workshops and the CAP tool. However, the evaluation team found the tool to be unevenly applied. For example, NGOs piloting the Fleet of Hope material—used in Ghana as an innovative education tool on HIV/AIDS—raised concerns that aspects of the materials risked reinforcing stereotypes in the hands of gender-insensitive facilitators. A section on dealing with gender issues in the facilitator's manual and training course would help prevent this.

According to PCS research, health care providers hold the same gender biases and stereotypes as the general public. In response, PCS has integrated the CAP tool into the Latin American regional IPC/C curriculum. The minister of health in Paraguay has selected this curriculum for national IPC/C training.

Very few JHU/PCS staff have received gender training, although some attended CAP presentations and a one-half-day session on use of the gender tool. Although the CAP tool has been incorporated into SCOPE, gender remains one choice out of a number of multitrack sessions within the Advances in Health Communication training courses offered by PCS.

The CAP is probably the least known of all the PCS tools. Although this is partly due to its relative newness, the tool should be more rigorously promoted within PCS and by CEDPA through its networks.

Not surprisingly, the team found uneven application of the tool. When applied, it tends to be used primarily for materials development and to ensure that gender stereotypes are not perpetuated, rather than to inform all stages of program design, implementation, and

evaluation. Of concern was the impression given by some workshop participants that gender was more relevant to the democracy and governance program (dealing with women's empowerment) than to health programs.

PCS has also begun to focus on gender-based violence as a key barrier to reproductive health through the collection of clearinghouse materials. This should be extended to include a programmatic focus on this issue.

RECOMMENDATIONS

PCS should improve its gender focus by

- **encouraging all JHU/PCS staff to undergo training in the Gender Lens workshop;**
- **systematically integrating and acting upon gender analyses in all stages of PCS program cycles; this should include clearly articulated gender-specific goals and objectives, with appropriate process and impact/outcome indicators;**
- **mainstreaming gender into PCS's communication training courses, facilitator manuals, curricula, and counseling tools; and**
- **producing and disseminating a CAP pamphlet and integrating gender more explicitly than it has been into future reprints of the P Process, GATHER, and "A" Frame tools.**

INTEGRATION OF TECHNICAL EXPERTISE

FINDING
PCS has been able to ensure the technical quality of its products and services in new areas. This has been accomplished to a large extent on a reactive basis in response to Mission requests.

Although communication skills are mainly crosscutting, specific issue expertise is needed on two levels: in the strategic planning stage (as different issues may call for different strategies, which in turn may be country specific) and during the development and implementation process to ensure content integrity. Distortions and misinterpretations of content can easily occur during the development of media materials. This is particularly true for entertainment–education projects, where issues are interwoven into stories through characters in a complex way.[7] PCS reports that for this reason, in-country health experts are always involved in workshops to plan entertainment–education programs, and that their priorities and expertise are incorporated into the design document, which forms the basis for all PCS entertainment–education programs.

PCS has accessed its expertise in new areas by drawing on existing inhouse resources and by recruiting new staff when necessary. Most new staff members employed during the

[7] Audience input is as critical as technical expertise and PCS typically incorporates this into the formative research process.

PCS IV period were hired for their expertise in new areas, such as democracy and governance and HIV/AIDS.

As a university-affiliated organization, PCS also has access to a significant number of highly qualified professionals and leading experts in the health field, including child survival and HIV/AIDS. It also draws on the experience of local government and nongovernmental organizations, cooperative agencies, and where necessary, procures the services of external consultants. Internal staff development takes place through seminars and workshops.

In the Nigeria democracy and governance program, PCS recruited Nigerian staff with democracy and governance experience to direct the program and also brought in expertise to JHU/PCS/Baltimore. Management Systems International (MSI) consultants were hired to write the democracy and governance training manuals, and contents of the voter education campaign were derived from Nigeria's independent electoral body in consultation with USAID/Nigeria's Democracy and Governance Division. Regional project advisory committees were set up to oversee materials development. These committees included people and organizations well versed in the field of democracy and governance. In addition, all materials were reviewed by PCS staff having democracy and governance expertise.

In Nigeria's polio eradication campaign, technical expertise was available through the involvement of the Ministry of Health, BASICS, the United Nations Children's Fund (UNICEF), and the World Health Organization (WHO)—all members of the interagency committee responsible for the National Program on Immunization (NPI). Strategy and content were determined by a national IEC committee. The NPI and PCS reviewed and approved the materials.

USAID staff members in the three countries visited during the evaluation (Nigeria, Ghana, and Nicaragua) were uniform and consistent in noting the high professional competence of PCS personnel—including the staff of PCS country offices, as well as technical advisory staff from JHU/PCS Baltimore and the project's participating subcontractors.

In the case of HIV/AIDS prevention and child survival activities, PCS typically brings in HIV/AIDS experts—usually from the faculty of the JHU School of Public Health—to provide technical support and content guidance during the selection of its strategic communication process. However, the extent to which these experts remain engaged through all phases of the communication process is unclear.

In Nicaragua, EHP provided substantial technical input into the development of materials used in the Blue Star campaign.

PCS's response to the need to bring in expertise in new areas (beyond FP/RH) has been largely reactive. As the follow-on communication project will be expected to address needs in these crosscutting sectors in far greater depth and consistency, the new activity will require a more systematic procedure to integrate this expertise into the project's organizational structure and processes.

RECOMMENDATION

The follow-on project should include procedures that will ensure rapid, systematic, and reliable access to the technical expertise needed by the project. This expertise needs to be relevant to the specific countries in which the project works.

FINDING
While PCS's ability to design comprehensive strategies is often constrained by Mission directives, increased involvement of stakeholders in the strategic design process could help to enrich the communication strategies selected.

The inclusion of a broader range of stakeholders would enhance PCS's capacity to respond to complex health problems. In the case of HIV/AIDS, for example, such involvement could help program designers take into account the rapidly changing scenario of the epidemic—its demographics, human rights–related issues, epidemiological trends, treatment advances, access to drugs, treatment compliance, and the impact of the disease at different levels of society.

This involvement would not require the expenditure of significant additional time or money. What is being referred to here are people who are working in the sector, but from different perspectives (e.g., relevant government departments, key researchers, activists, academics, relevant NGOs or community-based organizations [CBOs])—people who could provide input at the early stages of a communication intervention. In some projects, this is achieved through indepth interviews, followed by invitations to specific role players to come together for brainstorming sessions.

USE OF INFORMATION TECHNOLOGY

FINDING
PCS has successfully incorporated information technology into its programs worldwide. PCS uses information technology at four levels: 1) as an operations and management tool, 2) as a technology to enhance program activities, 3) as a tool for training purposes, and 4) as a means to improve and increase dissemination of IEC materials and information regarding project performance and results.

PCS applies its information technology strategy, Communication through Empowering Technologies (COMET), across all four levels of its program.

Operations and Management

PCS uses electronic mail, video reporting, and regional virtual communities of field offices to facilitate internal operations and management. PCS's use of information technology is evidently improving communication between field offices and headquarters. It is used, for example, for field/headquarters communication regarding project performance and problems, to expedite the review and revision of IEC materials, and for the review and clearance of financial reports. PCS also relies on technical assistance provided by JHU/Baltimore via computer/electronic mail to enhance the quality (if not decrease the frequency) of technical assistance visits to the field.

Training and Capacity Building

Information technology represents an important element in training and capacity building activities conducted by PCS. Seven CD–ROMs have either been produced or are being developed by PCS for use in both self-guided and interactive IPC training programs in Latin America (including PROQUALI), and for multimedia training in adolescent RH in Latin America. PCS has also developed CD–ROM collections of communication materials for FP/RH communicators (country-specific and worldwide), and a youth-focused, multiple-choice quiz for Jordanian youth.

PCS's major information technology tool for IEC training purposes is the Strategic Communication Planning and Evaluation (SCOPE) tool, which has been used for training in 22 countries and in 6 languages. SCOPE is a crucial part of the Advances workshops and was developed specifically to increase quality and impact of the training seminars. The evaluation team found that SCOPE users in the field were generally positive, although they seldom used the tool once the training workshops had ended. It appears that additional effort will be needed to ensure the effective use of SCOPE by PCS's partners and collaborators as a planning, rather than a training, tool.

Program Component

PCS applies information technology across several aspects of its program. One application is the use of telephone hotlines—especially as adapted for IPC purposes. PCS has supported the startup or operation of telephone hotlines in Peru, Rwanda, South Africa, the Philippines, and Nicaragua. Three of these projects are focused on youth and one (Rwanda) is focused on men.

PCS is currently in the process of developing a new telephone hotline project in Nigeria. Building on an existing hotline for HIV/AIDS counseling, PCS is engaging two of its subcontractors (Prospect Associates and AED) to help launch the hotline and train the staff of the Lagos–based service. Evaluation team inquiries regarding the feasibility of this initiative were inconclusive. Moreover, as HIV/AIDS prevention is a new program area for PCS/Nigeria, the team suggested that further analysis of the proposal (using the P Process) would be helpful prior to launching the service in Nigeria. This analysis would pay special attention to public access to and coverage of telephone lines, their functionality as a confidential and anonymous form of counseling, and their sustainability. The USAID Mission was very enthusiastic about the hotline, referred to the success of a hotline in South Africa, and apparently had no doubts about the project's likely success.

PCS is using information technology to develop a participatory epidemiological information management tool to support the activities of SECI/Peru. PCS has also distributed CD–ROM training tools (ISABEL) to 150 Ministry of Health clinics in Peru to improve health care providers' skills in client counseling.

Dissemination

PCS effectively uses information technology to broadly disseminate IEC materials and the results of PCS–supported activities. The JHU/PCS web site, with its access to Photoshare and Netlinks, is an important instrument in these dissemination efforts. PCS is currently linked to 10 web sites, including those managed for or by "Africa Alive!," MAQ, the Nigeria CAs, the Jordan National Population Commission, and the Communication initiative. The evaluation team believes that PCS could extend its impact further by increasing its dissemination of communication materials to non–English speaking audiences (e.g., along the lines of the Spanish language web site PCS is currently setting up for Latin American youth). PCS should also publish its project results and evaluations in non–English language academic and nonacademic journals.

LINKAGES TO SERVICE DELIVERY PROGRAMS

> ***FINDING***
> ***PCS generally attempts to ensure close linkages between the communication/BCC interventions it supports and the overall population/RH service delivery programs underway in host countries.***

An oft-heard observation within USAID is that communication/BCC programs are not sufficiently coordinated with service delivery (or even other communication) activities in-country. This view reflects a broader view within USAID that communication efforts are sometimes self-indulgent and episodic—focusing on the artfulness of a particular information campaign, television drama, or series of radio spots, but with insufficient regard for the specific information needs of clients—information such as the location of clinics, identification of FP methods or discussion of side effects.

Some miscommunication has occurred from time to time under the PCS program. In Nicaragua, the USAID Mission objected to the slow development of the Blue Star campaign, which was intended to support broader elements of the EHP program launched 6 months earlier. USAID Missions in Eastern Europe report that PCS insistence on repeating the developmental process in each country—despite cross-country cultural similarities that would have enabled faster adaptation of existing regional messages—caused lengthy and costly delays in launching communication activities in the Europe and Eurasia region. Finally, some of PCS's community outreach programs ("Stop AIDS. Love Life." in Ghana, NIDS–related campaigns in Nigeria) were not adequately linked to community-level organizations, which might have contributed to the long-term sustainability of the campaigns.

It should also be noted that USAID Missions' occasional insistence on immediate action sometimes impedes PCS's ability to touch all bases and thereby develop a solid foundation for program action.

Broadly speaking, however, the PCS approach to country-level programming is structured in ways that minimize miscommunication between message and service delivery.

Most obvious of these safeguards is the PCS program's reliance on Mission field support funds for the bulk of its activities in-country. PCS is essentially responding to Mission directions in most countries, such that the Missions themselves must bear significant responsibility for the quality and specificity of the instructions they give to PCS and for overseeing the implementation of PCS–supported activities. This is not to absolve PCS of any responsibility, however, for ensuring close coordination with other activities in-country; overstretched Mission PHN officers depend on PCS to do so. This responsibility extends especially to PCS's long-established practice of seeking out new program opportunities even as it designs and/or implements previously agreed-upon field support–funded activities. These exploratory efforts should be approved by Missions prior to PCS's initiation of substantive contacts with prospective partners in-country.

PCS also helps ensure synchronization of communication and service delivery efforts via its key role in creating and supporting national IEC working groups or task forces in countries where PCS is active. These committees generally include representatives from the host country's health ministry, other government bodies having a stake in population/reproductive health programs, donor agencies, other cooperating agencies, the NGO sector, and partners in the private/commercial sector. Such committees exist in about 23 countries, although it is not clear how many of them exercise substantive roles in coordinating the several parties' communication needs and interventions.

The concept of branding is central to PCS's approach to communication and is a very effective device for facilitating client awareness and knowledge regarding population/reproductive health services. Examples include Las Manitos in Bolivia, Green Umbrella in Bangladesh, DISH in Uganda, the Juntos Decidemos campaign in Nicaragua, Gold Star in Egypt, PROQUALI in Brazil, and the Blue Star in Indonesia. PCS is often the originator of these brands and structures its communication materials and campaigns with program managers to strengthen public awareness of the brands and what they represent, and to educate the public regarding the services available at branded sites.

PCS has been vigorous in its efforts to integrate MAQ components into its communication/BCC programs—and especially in incorporating the GATHER tool into the IPC/C training curricula of PCS's partners. In Nicaragua, PCS has successfully grafted GATHER into the training regimes of PROFAMILIA, the Cooperative for Assistance and Relief Everywhere/Nicaragua, and several other NGOs assisting in the youth-oriented Juntos Decidimos program. In Nigeria, AVSC acknowledged PCS's role in developing training materials used by health care providers in AVSC–assisted facilities. PCS points out that a major objective of this focus on provider training is to improve providers' responsiveness to the information needs of clients—including concerns over side effects and broad health issues. Meanwhile, PCS support for mass media and community mobilization activities is designed, inter alia, to help educate consumers (clients) to expect and demand high quality care at service sites.

Most importantly, USAID Missions report that PCS linkages to service delivery organizations are generally sound. In their responses to a USAID/Washington survey conducted in association with this assessment, 15 Missions (approximately 70 percent of

those responding) ranked PCS's collaborative efforts with service delivery organizations to be outstanding (14 percent) or very good (55 percent).

V. ORGANIZATIONAL AND MANAGEMENT STRUCTURE

Time constraints limited the evaluation team's ability to conduct a close examination of the management aspects of the PCS project. On the basis of brief observation, however, some selected findings and recommendations are offered regarding the project's staffing, use of subcontractors, relations with USAID, and JHU/PCS efforts at cost containment.

STAFFING

FINDING
JHU/PCS has qualified and competent staff, both at headquarters and in the field.

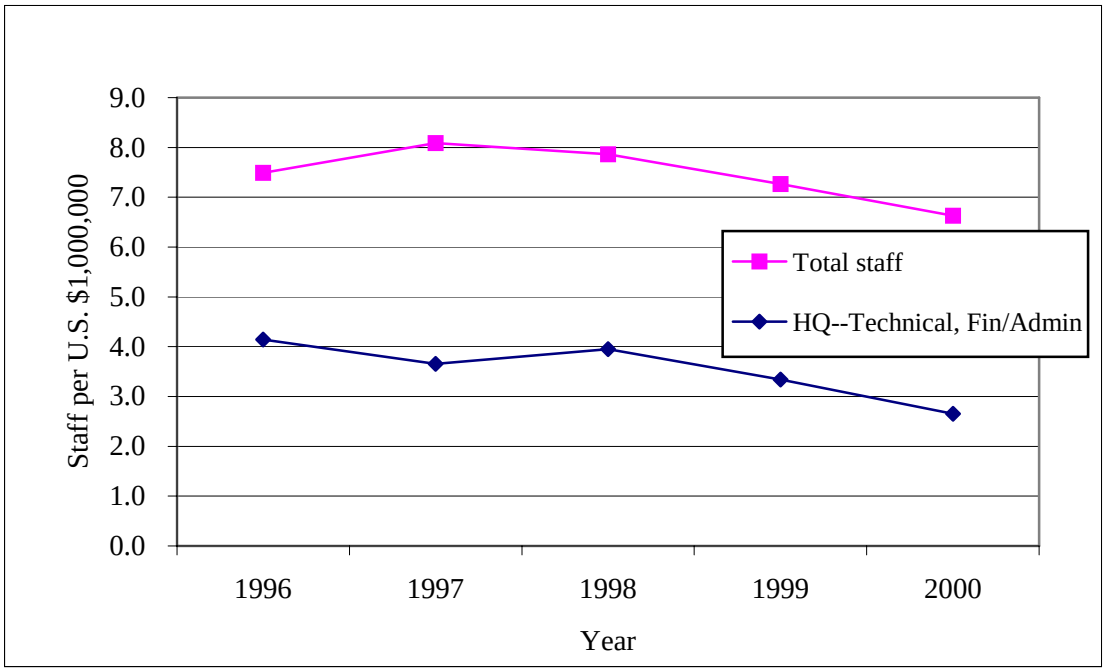
FINDING
PCS is recruiting staff with expertise in child survival, democracy and governance, and HIV/AIDS to respond to its broadened scope. When this expertise is not available inhouse, it recruits technical personnel on an ad hoc basis from other sources.

JHU/PCS is endowed with a committed, enthusiastic, and technically competent staff, both at headquarters and in the field. The quality of the staff in Nigeria, Ghana, and Nicaragua is impressive and the USAID Missions in those countries clearly value the responsiveness and collaboration of PCS field staff. Of the 23 Missions that responded to the electronic mail survey, 86.4 percent described the qualifications and technical competencies of resident advisors and headquarters staff as either "very good" or "outstanding." Thirty percent of the headquarters senior staff has been with PCS for over 10 years. This staff continuity is a testimony to the challenging and rewarding work environment provided by the project. There is a strong research and evaluation culture, complemented by a systematic approach at all levels.

The PCS management structure consists of a management group, a programs division that houses the five regional subdivisions, a finance and administration division, and a technical division that houses research and evaluation, training, dissemination, and technical advisors. PCS continues to maintain geographical divisions in Baltimore to save overhead costs, such as rent and equipment. The tradeoff is higher travel costs for technical assistance and program monitoring.

The number of staff at headquarters is at its lowest level since 1996. More specifically, Baltimore staff levels have decreased from 103 in 1996 to 86 in 2001. Concurrently, and as field support funding has increased, the number of field offices has increased from 15 in 1996 to 30 today. Field office staff increased from 83 in 1996 to 129 in 2000 (this figure excludes CPCB [Bolivia] and BCCP [Bangladesh] staff). Of the 18 resident advisors, 4 are expatriates. Table 6 below illustrates trends in the dollar-to-staff ratio over the past five years.

Table 6
Number of Staff per U.S. $1 Million Budgeted



New staff hires, both at headquarters and in the field, have been recruited on the basis of their experience in the new technical fields (democracy and governance, child survival, and HIV/AIDS) that are now being addressed by the project. In Nigeria, where democracy and governance is an important part of the PCS country portfolio, an entire democracy and governance unit is in place. One member of this unit was recently recruited by the USAID/Lagos democracy and governance office. A recently recruited senior technical advisor in Baltimore brings substantial HIV/AIDS experience from Eastern Africa. When the technical expertise is not available on staff, PCS obtains technical personnel from partner organizations, through recruitment of individual consultants or through committees, as in the case of the polio campaign in Nigeria (see section III, Integration of Technical Expertise). Referring again to the USAID Mission survey, some 70 percent of responding Missions judged PCS's use of in-country or regional expertise to be either "very good" or "outstanding."

USE OF SUBCONTRACTORS

FINDING
PCS subcontractors have not been as fully used as planned under PCS IV.

PCS and its subcontractors (AED, CEDPA, Prospect Associates and SAVE) have good, open, and candid relations at the personal and professional levels. As primary contractor and subcontractors, however, they hold very different institutional views regarding the effectiveness, and ultimately, the success, of their collaboration on the PCS project. Among the subcontractors, these views vary widely—from relative satisfaction on the

part of Prospect Associates, to a high level of frustration at CEDPA, whose staff believes that its association with the project has been largely unproductive. Staff at SAVE and AED believe that the partnership has produced some excellent, albeit fewer than expected outcomes, and that JHU's inability or refusal to draw on these subcontractors' skills and capacities has resulted in some major lost opportunities for creative problem-solving.

JHU has generally maintained throughout the period of the cooperative agreement that its subcontractors were successfully pursuing the objectives set forth in the PCS IV agreement. More recently, JHU has identified some strains in its relations with the subcontractors, pointing specifically to subcontractor behaviors that impede the organizations' effectiveness. These include high turnover of subcontractor personnel assigned to the PCS project; refusal of subcontractor staff to work at PCS/Baltimore on a 100 percent, dedicated-time basis; refusal of subcontractor staff to present themselves as PCS personnel while on overseas assignment for the project (thereby confusing project—and USAID—counterparts regarding their tasks and objectives); and a contractual environment that expects full-time competitors to work together constructively as occasional collaborators.

To be sure, the subcontractors have brought some noteworthy successes to the project:

- Prospect Associates is strengthening the strategic approach and marketing skills of several advertising agencies subcontracted by PCS;

- SAVE is successfully integrating its community mobilization approach into PCS–supported programs in Bolivia, Peru, and the Philippines;

- AED will soon begin a major technical support role for PCS's democracy and governance initiative in Rwanda; and

- CEDPA has provided training in gender-sensitive programming to PCS partners in Ghana, Nigeria, Zambia, and Nepal.

None of the subcontractors, however, has come close to applying the personnel, skills, or budgetary resources originally envisioned under PCS IV. In consequence, the outcomes planned for the contractor/subcontractor arrangement under PCS IV have fallen short of expectations.

These shortcomings are known to USAID, to JHU, and to the four subcontractors. Indeed, JHU's tendency to marginalize its subcontractors was noted in the USAID evaluations of the two prior PCS projects. The apparent patience of these parties with such a long running and unresolved situation probably reflects their understanding that unhappy prime contractor/subcontractor relations are normal in the broad world of USAID contracting. Absent any substantive change in the way USAID designs its projects and develops its requests for proposals—RFPs which sometimes encourage the formation of cumbersome partnerships—it is unlikely that the situation will change markedly in the future.

USAID RELATIONS

FINDING
USAID field Missions report generally high levels of satisfaction with the PCS project. Project management from USAID/Washington is sound, but USAID needs to ensure more continuity in its project management staff.

USAID Field Missions

One of the hallmarks of the PCS project is its responsiveness to USAID requirements. The unanticipated growth of the project—both in terms of its cost as well as its extension into hitherto unfamiliar territory (environmental health, polio eradication, democracy and governance) was not sought by PCS so much as it was thrust upon it by USAID field Missions. USAID Missions' reasons for engaging PCS vary, of course. Many Missions (e.g., Nicaragua) identified roles for PCS in recognition of PCS's strong record of achievement in communication/behavior change over the past two decades. Others were perhaps confronted with few choices at a time when they were trying to reduce the absolute number of CAs working in-country (e.g., the Nigeria democracy and governance initiative).

Whatever their specific reasons for selecting PCS, the Missions do appear to be generally satisfied with its performance. In their responses to an electronic mail survey conducted by USAID/Washington as part of this assessment, 22 Missions ranked PCS across 10 performance areas on a scale ranking that included "outstanding," "very good," "satisfactory," and "unsatisfactory." Approximately 70 percent of these rankings were in the "very good" to "outstanding" category, and less than 10 percent were in the "unsatisfactory" category—the latter score driven largely by reporting from Missions in the Europe and Eurasia region. Rankings in the "satisfactory" and "unsatisfactory" categories help identify some areas of improvement for PCS. From the Missions' perspective, these include observations that PCS resident advisors lack sufficient decision-making authority and concerns regarding the relatively high cost of PCS assistance. (Evaluation team observations echo these concerns: PCS country offices refer most technical and almost all financial decisions to JHU/PCS/Baltimore for review; Missions are only gradually accommodating to the requirement that they add indirect costs to their field support budgets.)

USAID/Washington

The G/PHN/POP/CMT Division manages the PCS project in a constructive and professional manner—using the collaborative aspects of the cooperative agreement to ensure project responsiveness to the Agency's Strategic Objectives (SOs), while maintaining the appropriate distance from PCS's day-to-day project operations. Moreover, CMT's stewardship of the project's limited core funds has enabled PCS to explore several innovative aspects of communication theory and practice.

PCS is evidently pleased with the nature and substance of its relations with USAID/Washington, but has noted the disruptive effects of the high turnover of project cognizant technical officers and technical advisors in the CMT Division (up to five staff

changes in the past five years.) The evaluation team cannot comment knowledgeably about USAID's internal personnel procedures; it agrees with PCS, however, that a complex and costly flagship project, such as PCS, deserves more stability in USAID management and oversight than it has experienced to date.

With the exception of Prospect Associates, all of JHU/PCS's subcontractors expressed some frustration at not being able to present their strategies (and concerns) directly to CMT project managers. This is not in fact a management shortcoming, as U.S. government contracting policy strongly discourages direct contact between government project managers and subcontractors. It does suggest, however, that CMT and JHU/PCS need to examine the project's reporting system to ensure that JHU/PCS is adequately communicating subcontractor issues to CMT.[8]

RECOMMENDATION

The CMT Division should ensure, to the extent possible, long-term continuity of division personnel responsible for oversight and management of the PCS project, and should incorporate reporting requirements in the cooperative agreement that would provide USAID with accurate, timely information regarding the performance of subcontractors associated with the project.

COST MANAGEMENT

FINDING
PCS appears to be managing its project funds responsibly and prudently.

PCS observes normal cost accounting methods (as audited periodically by U.S. government agencies) designed to help ensure that project funds are managed responsibly. Virtually all project procurement is executed on a competitive basis; PCS does try to secure/leverage additional, non–USAID funds to supplement project costs (see table 7 below); and the salary scale in Baltimore is well within the norms observed by the larger CA community.

As pointed out above, the size of the staff at JHU/Baltimore has remained constant even as the size of the overall project has grown. While the number of field office staff has increased significantly to keep up with that growth, most of these additional staff members are relatively inexpensive local hire employees. Absent any growth in expatriate or U.S. hire staff, the staff-per-project dollar ratio of the PCS project has actually declined under PCS IV (see table 6 above).

At the project level, PCS points to considerable success in leveraging over $10 million (summary figures are shown in table 7) from other donors, commercial firms, NGOs, and

[8] The subcontractors made a similar point regarding PCS field office communications with USAID Missions, that is, that PCS field staff does not adequately inform PHN officers about the roles of the subcontractors under the PCS project, such that Mission staff is often confused—even resentful—when subcontractors attempt to carry out their subcontractual commitments in host countries. The subcontractors point to this impeded access as a key reason for their very modest impact under PCS IV.

host governments over the life of PCS IV. These contributions appear to be real net additions to project-funded resources provided under the PCS project.[9]

Table 7
PCS IV Evaluation
1995–2000 Leveraging of Funds Summary*

Africa: $2,437,958
Behavior change communication activities ranged from television and radio spots/interviews, CDs of African musicians, to launches of campaigns, to production of printed materials, and to a three-year project in Northern Nigeria promoting access to reproductive health services for young adults through radio and community events.

Asia: $3,950,435
These activities varied from television and radio spots/interviews, to launches of campaigns, print media, to office space, and a three-year youth-centered communication project in Pakistan that links a television social drama for young people on the benefits of birth spacing and prevention of HIV/AIDS/STDs to sites and facilities serving young people.

Europe and Eurasia: $581,600
Behavior change activities included television and radio spots/interviews, promotional materials, advertising space, and modern contraceptives (IUDs, condoms, oral contraceptives).

Latin America: $2,231,761
These activities ranged from television and radio spots, to other media coverage, to advertising space, and to design and implementation of the Arcandina School Network in Ecuador.

Near East: $423,645
Behavior change communication activities varied from television spots, to promotional materials, to prizes for a contest, to seminars, and to workshops.

Global (Core): $682,924
These activities cover media/advocacy, development of social change indicators, and leadership and management training in reproductive health.

Research and Evaluation: $100,000
These activities involved working with organizations, such as Macro International, UNICEF, etc. on research and evaluation.

Total PCS IV Funds Leveraged in Regions: **$10,408,323**

*Does not include PCS IV project leveraging of USAID bilateral funds in about 12 countries worldwide.

[9] Missing from these additional contributions are any significant payments by commercial sponsors of PCS–developed entertainment–education programs (i.e., radio or television serial dramas). Only three such programs have been able to attract commercial sponsorship for radio or television air time.

At the analytic level, PCS has conducted cost-effectiveness studies of PCS–supported communication campaigns in Egypt and the Philippines. These studies tend to reinforce the intuitive notion that mass media—because of their extensive geographic and population coverage—are extremely cost-effective tools to effect behavior change. Indeed, PCS maintains that current indicators of effect underestimate the total effect of communication (and therefore understate its cost-effectiveness) because estimates based on national surveys of married women of reproductive age omit the effect of communication on men, single women, elders, and children and omit the impact of indirect communication (e.g., communication about media interventions by nonlisteners/nonviewers). PCS would add that survey-based data also miss the effects of communication on continuation rates of contraceptive use. PCS is in the process of refining its draft tool for measuring cost-effectiveness (Warren Robinson and Gary Lewis, 2000) to extend its applicability beyond mass media to other communication interventions.

VI. NEW DIRECTIONS

The PCS IV project has been generally successful in meeting the objectives—both planned and unforeseen—called for by the USAID–Johns Hopkins University cooperative agreement. The team believes, moreover, that JHU's 18 years of stewardship of the PCS project has contributed not only to lasting, beneficial changes in health-related behaviors around the world, but also to significant advances in the science and practice of development communication.

This assessment has nonetheless identified a number of aspects of the project's strategy, structure, tools, and performance that might be improved. Many, perhaps most, of the recommendations proposed in this report suggest refinements to an otherwise successful project; they could be implemented under the current PCS IV activity without changes in the terms of the cooperative agreement or without substantive changes in PCS's strategic approach to its assignment. The adoption of other recommendations, however, would require one or both such changes. These are noted below primarily for USAID's consideration toward the design of an eventual PCS V project.

- **Expand the project's focus beyond individual behavior change; increase emphasis on factors related to social change.** The project's current strategic approach can overlook key cultural and societal factors that contribute to or impede behavior change. Indeed, much of the experience to date in the field of HIV/AIDS prevention is suggesting that a focus on individual behavior change has been largely unsuccessful. The current project is taking steps to broaden its perspective, but a more explicit embrace of social change theory and practice could enhance the project's effectiveness.

- **Expand the project's advocacy role to affect decision-makers and the policy and regulatory environment.** While the current project is not explicitly enjoined from such advocacy work (it works in Nigeria, for example, with journalist groups and NGOs to promote health-related policy changes), it defers most efforts in this area to the POLICY project. The absence of this component hinders the development and implementation of a more complete, coherent approach to social and behavior change communication—an approach which takes into account the larger array of factors (including the policy, legal and regulatory environment) that affect behavior. This expanded focus should also address some of the new issues arising through decentralized programs that will depend on community advocacy.

- **Establish realistic, verifiable objectives, and expect credible evidence of performance.** The effects of communication activities are difficult at best to verify. Better, however, to establish meaningful and measurable standards of performance than to introduce ambiguous goals that invite ambiguous or misleading performance reports or skepticism surrounding the project's real achievements.

- **Intensify the development of communication skills in host countries, for example, in national and regional institutions. Draw on these resources for technical assistance and training support.** The long-term sustainability of communication interventions will be assured, at least in part, by the emergence of host country and regional capacities to design, implement, and assess communication programs. Development of this capacity should be a priority of the new project. Meanwhile, PCS IV and the prior PCS projects have trained hundreds of communication managers, technicians, and academics over the past 18 years. It is time to capitalize on that investment by drawing more heavily on these individual and institutional resources to provide south–south technical assistance and training in their own countries and/or regions. The follow-on project should include indicators measuring grantee performance in mobilizing and using these resources.

APPENDICES

A: SCOPE OF WORK

B: PERSONS CONTACTED

C: PCS FUNDING BY COUNTRY AND DIRECTIVE

D: SUMMARY OF PCS STRATEGIC HEALTH COMMUNICATION INTERVENTIONS, 1995–2000

E: REFERENCES

APPENDIX A

SCOPE OF WORK

Scope of Work
Population Communication Services (PCS) Evaluation

I. PROGRAM INFORMATION

Project Name:	Family Planning Information, Education and Communication (IEC) Field Support Project
Cooperative Agreement Number:	CCP-A-00-96-90001-00
Agreement Value:	$108,938,714.00
Obligation to Date:	$119,000,000.00

II. BACKGROUND

A. Project Overview

The Population Communication Services (PCS) project has been the leading Office of Population project for communication for behavior change since 1982. In its fourth cooperative agreement with USAID, PCS and its four subcontractors (Academy for Educational Development, Center for Development and Population Activities (CEDPA), Prospect Associates, and Save the Children), provide support for the effective delivery of appropriate information on family planning to developing countries. The agreement provides technical and financial support for communication projects in all stages of design and implementation, including audience identification, message design, media mix, production of materials, interpersonal communication, and evaluation. PCS seeks to reach women and men, both as individuals as well as family and community members, with communication for behavior change messages that empower them to gain control over their reproductive and general health. PCS will contribute to the reduction in the level of fertility in developing countries by making family planning an informed choice, a household word, and a community norm.

PCS I, II, and III primarily focused on mass media communication activities. The new design for PCS IV recognized the importance of community mobilization and interpersonal communication and counseling and increased the project's focus on these activities.

Another characteristic of the PCS IV project has been a trend of increased field support funds beyond family planning and reproductive health into other PHN areas. During this cooperative agreement, USAID Missions have funded PCS to achieve behavior change results in primary health communication, including HIV/AIDS, child survival, nutrition, infectious disease (polio, malaria, TB), water and sanitation, and democracy and governance.

B. USAID's Population, Health and Nutrition Center

The Population, Health, and Nutrition Center at USAID works towards five strategic objectives that support the Agency's goal of stabilizing world population and protecting human health. These objectives, which represent an integrated approach to reproductive health, are as follows:

SO1: Increased use by women and men of voluntary practices that contribute to reduced fertility
SO2: Increased use of key maternal health and nutrition interventions
SO3: Increased use of key child health and nutrition interventions
SO4: Increased use of improved, effective and sustainable responses to reduce HIV transmission and to mitigate the impact of the HIV/AIDS pandemic
SO5: Increased use of proven interventions to reduce the threat of infectious diseases of major public health importance

PCS IV was designed and is managed by the Communication, Management, and Training (CMT) Division in the Office of Population. The division primarily contributes to SO1, however, because of increased demand from Missions, PCS contributes in varying degrees to all five SOs. This evaluation should primarily focus on the organization's contributions to SO1, but should also address certain issues regarding the technical competencies of the project to extend to other SOs and PCS's field performance and management of non-SO1 funding.

C. Communication Management and Training Division: Communications Portfolio

The CMT Division supports two IEC projects: Population Communication Services, the CMT Division's flagship project, and Population Information Project (PIP). Through the work carried out under these two projects, the division strives to change the knowledge, attitudes, and behavior towards family planning and reproductive health services and improve local IEC capacity.

III. PURPOSE OF THE EVALUATION

PCS was last evaluated in 1993 at which time several issues were identified and recommendations for improved performance were made. The current evaluation should principally look at PCS's performance under its current agreement—its progress in achieving the four end-of-project results (see attachment) and how it has addressed two key issues raised by the last evaluation team. Evaluators should also consider the technical competency of PCS's work in areas other than family planning and reproductive health. Additionally, the Center is in the early stages of designing a center wide, follow-on Health Communication project. Through its field observation, and using the data collected from Mission surveys, the team should also flag issues related to the future project design that would be important for the Health Communication Results Package Team to consider.

The objectives of this evaluation are:

1. To assess the extent to which PCS has accomplished the priorities and desired results as set forth in their Cooperative Agreement.

2. To assess how effectively community mobilization and interpersonal communication and counseling (IPC/C) activities were incorporated in the PCS IV project.

3. To assess the extent to which PCS has addressed two key issues raised in previous evaluations, 1) bridging the gap between high awareness and positive attitudes towards family planning and low contraceptive use, and 2) fostering coordination with service delivery and other in-country groups when launching an IEC campaign.

4. To assess the competencies, effectiveness, and evidence of impact of the current project in areas beyond family planning and reproductive health such as HIV/AIDS, child survival, and democracy and governance.

5. To assess the effectiveness and efficiency of PCS's organizational and management structures including any changes that may have resulted from an expanded scope.

IV. STATEMENT OF WORK

To reach the above stated objectives, the following section outlines specific questions or issues to be addressed under this evaluation. Questions in italics will be answered by the PCS project prior to the start of the evaluation while questions with an asterisk (*****) will be addressed in a field survey; the evaluation team should use these answers as background information for the subsequent questions within each section.

<u>1. To what extent has the project accomplished the priorities and desired results set out in its Cooperative Agreement?</u>

A. Major Results and Accomplishments of the Project

What progress has the project made in achieving the four end-of-project results outlined in the cooperative agreement? How appropriate are the indicators PCS is using to measure progress towards these results?

Currently, about 30 percent of PCS's field support funding is for non-population activities. How has this expanded focus affected PCS's ability to achieve the expected results outlined in their cooperative agreement?

B. Meeting Unmet Communication Needs

How has the conceptual framework "Steps to Behavior Change (SBC)" and the other tools that PCS created and uses[10] provided flexibility to respond to various target audiences' needs? Are so many tools necessary/additive? *

[10] (P Process, A for Advocacy, GATHER, 6 Cs for Capacity, SCOPE—see annex for description of each)

How effective have the strategies and tools PCS has developed and applied been in changing behavior?* What evidence supports this? How applicable are they to other technical areas such as HIV/AIDS, and child survival? How are other partners and CAs institutionalizing these tools?

The majority of PCS communication strategies target young couples (under 25) as their primary audience. How was it decided to focus on this audience? What interventions have been successful with this audience? *How is PCS gauging whether this group is moving from awareness to behavior change?*

How has the project's support of gender specific activities and initiatives improved the provision of accurate FP/RH information, access, and community support? How are these activities being evaluated? What has been the evidence of impact of these activities?

How is PCS using information technology in its activities? How has the integration of IT changed the way they work? Discuss the benefits and challenges related to IT activities.

C. Collaboration with Counterparts in Communication Activities

How have the four subcontractors been utilized under the current cooperative agreement? Are the subcontractors' expertise being fully exploited? What role have the subcontractors played in work plan development and other planning exercises? Do the subcontractors bring the right expertise to the project? *What could USAID and PCS do to improve the partnership?*

How has PCS collaborated with cooperating agencies and other partners in the field when developing communications interventions in family planning and reproductive health as well as HIV/AIDS, child survival and democracy and governance?*

D. Applied Research and Evaluation

How successful has PCS been at developing and applying tools to measure cost efficiencies and effectiveness of communication interventions? What have we learned about cost efficiencies and effectiveness from the tools? How have they disseminated the tools and related research findings to the USAID and CA community? Are CAs and other communications projects using these tools?

Are PCS projects evaluated at various stages of implementation to allow for mid-term corrections in strategy and message adjustments? Is PCS amenable to making mid-term corrections and adjustments requested by Missions or other partners?*

E. Building Capacity for Sustainability

At the country level, how effective has PCS been at institutionalizing IEC skills and empowering institutions, both public and private, to conduct IEC work with minimum expatriate support?* What accounted for achieving this institutionalization/empowerment when it was achieved?

What has been the evidence of impact of PCS's work in the policy and advocacy arena?

Is PCS making appropriate use of in-country or regional expertise in implementing the project?*

2. To assess how effectively community mobilization and interpersonal communication and counseling (IPC/C) activities were incorporated in the PCS IV project.

How did PCS respond to USAID's request to expand their strategies and activities to include Community Mobilization and Interpersonal Communication and Counseling?

Community Mobilization: How is PCS evaluating its community mobilization activities? What has been the strength of these interventions for changing individual behavior and setting new community norms?

Interpersonal Communication and Counseling: What has been the evidence of impact of PCS's work in IPC/C?

3. To what extent has PCS addressed two key issues raised in previous evaluations, 1) bridging the gap between high awareness and positive attitudes towards family planning and low contraceptive use, and 2) fostering coordination with service delivery and other in-country groups when launching an IEC campaign.

During this Cooperative Agreement, what evidence shows that PCS is bridging the gap between high awareness and positive attitudes towards family planning and low contraceptive use?

How has PCS addressed the issue of improving coordination with service delivery, policy and advocacy, and other in-country groups when developing and launching an IEC strategy?

4. What are the competencies, effectiveness, and evidence of impact of the current project in areas beyond family planning and reproductive health, such as HIV/AIDS, child survival, and democracy and governance?

Given that the current Cooperative Agreement does not outline specific results for work outside of family planning and reproductive health, what do Missions cite as the advantages of using PCS for work in HIV/AIDS, child survival, and democracy and governance? What have been the disadvantages?*

How is the project measuring its impact in these other technical areas? Are the indicators they are using appropriate? Are they measuring their progress at the right intervals?

How does PCS ensure the technical quality of its products and services in non-family planning/reproductive health areas?

How relevant is the family planning communication experience to these other technical areas?

When implementing projects in the field, are the communication strategies that PCS applies appropriate, effective, and, best suited for areas other than family planning? What proof is there of the effectiveness in these areas?

5. How effective is the organizational and management structure of PCS particularly given their expansion into other technical areas?

Structure and Staffing

How do the organization and management of the PCS Project at the prime as well as the subcontractor level contribute to or detract from the functioning of the project? *How does management from USAID affect the functioning of the project?*

Given PCS's continued growth and expansion into other technical areas, does the current geographical structure create duplication in technical expertise? Please comment on the competence and expertise of the headquarters and field staff.

Since the 1993 evaluation, PCS has expanded the number of resident advisors in countries where the project serves as the major IEC in-country coordinating agency. Please comment on the ratio of staff at the headquarters versus field level and assess the effectiveness.

V. RESOURCES AND PROCEDURES

A. Data Sources

The evaluation team will review all project documentation, including but not limited to the following: the PCS Project Cooperative Agreement, the 1989 and 1993 evaluations, the 1999 management review, annual workplans, research reports, trip reports, activity evaluations, relevant correspondence, and financial reports. The team will conduct interviews with the PCS Project staff at JHU/CCP Baltimore, at AED and CEDPA in Washington, at Prospect Associates in Maryland, and Save the Children in Connecticut (by phone). A select number of CAs working in service delivery, child survival, and HIV/AIDS will also be interviewed. The team will meet with key people in USAID including the project's CTO and Technical Advisor, representatives from Child Survival, Maternal Health, HIV/AIDS, Democracy and Governance, and the Office of Population's Director. In addition, USAID Missions who have worked with PCS under the current cooperative agreement will be surveyed.

For questions relating to evidence the project's impact, the team will use PCS research studies (empirical data) and be asked to weigh these self-reported data. To assess the competencies, effectiveness and evidence of PCS's work in other technical areas, the team will ask technical experts at USAID and elsewhere to comment on project activities.

B. Methods of Data Collection

Prior to the evaluation team's arrival in Washington, G/PHN/POP/CMT will contact selected USAID field missions (approximately 30) to gather input into this evaluation (see questions above with asterisk). An analysis of the responses will be provided to the team in advance. Based on the review responses, the team will follow up by telephone with mission staff in key countries (4-5) where site visits will not be made.

Prior to the team's arrival, PCS will respond to a series of questions that are part of the team's statement of work (questions above in italics). Answers to these questions will be provided to the team in advance and should be used as background information for answering subsequent questions within the statement of work.

Following the U.S-based data collection, members of the team will visit two countries where the PCS project has been active: Nicaragua and Ghana. While in country, the team will meet with USAID mission staff, PCS's local counterparts, other CAs working in country and government officials when appropriate.

C. Duration and Timing of the Evaluation

The evaluation will begin in early January. A total of six weeks is estimated for data collection and drafting the report. Once the team leader receives comments on the first draft (Week 8), s(he) will require additional time to incorporate them into the report. A time line is outlined below:

Week 1:	3 days in Washington (POPTECH/USAID)
	2 days in Baltimore
Week 2-3:	Field Visits
Week 4:	4 days in Washington DC (phone interviews with Missions and subcontractors)
	1 day team visit PCS headquarters
Week 5:	Prepare debriefing
Week 6:	1 day debrief to USAID
	1 day debrief to PCS
	3 days draft report preparations
Week 7:	First draft received at POPTECH and copies distributed to team members, USAID CTO, CA and assessment manager for comments
Week 10:	Comments received by POPTECH and sent to team leader
Week 12:	Team leader turns in second draft with comments incorporated
Week 15:	Final report distribution begins

A detailed outline of the key findings and recommendations should be provided to G/PHN/POP and Project staff after the fieldwork is completed and should be done with the project's Technical Advisor, the CMT division staff and HN communications staff no later than February 15.

D. Team Composition

The evaluation team will consist of five members with technical expertise and experience as described below. In addition to the right combination of technical skills, the team should also be diverse and balanced in terms of gender, language (Spanish), and culture (North vs. South). A sixth team member may be necessary to achieve the ideal team composition.

1. A Chief of Party who knows PHN Center programs and has experience in design, implementation and evaluation of FP/RH and other health programs, including HIV/AIDS, Child Survival and Safe Motherhood. The person should have both field experience and knowledge of the PHN Center strategic objectives, especially SO1.

2. A Health Communications Research/Evaluation specialist who has worked internationally and has experience in developing monitoring and evaluation systems for behavior change.

3-4. Two Development Communications specialists who are abreast of current trends and issues in Health Communications. Experience in community mobilization activities, working with adolescents, and gender issues is also important.

5. Dr. Scott Ratzan of USAID's CMT Division. Dr. Ratzan is leading the Health Communication Results Package Team for the PHN Center and also is familiar with the PCS project. Dr. Ratzan will be primarily concerned with the implications this evaluation has for the follow-on design.

E. Funding and Logistical Support

All funding and logistical support for the PCS Project evaluation will be provided through the POPTECH Project of the Office of Population. Activities that will be covered include recruiting and supporting the evaluation team, assisting with the compilation and analysis of the Mission survey, funding all expenses related to the evaluation, providing logistical support including setting up meetings for the team both in Washington and in the countries visited, and producing and disseminating the draft and final reports.

APPENDIX B

PERSONS CONTACTED

PERSONS CONTACTED

GHANA

USAID
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Joseph K. Amuzu, SO 3 Deputy Team Leader
Lawrence Aduonum-Darko, Population Specialist

Johns Hopkins University (JHU) Population Communication Services (PCS)
Ian Tweedie, Resident Advisor

Government of Ghana
Ben Eghan, Chief Director, Ministry of Communications
Issah Yahaya, Deputy Director, Ministry of Communications
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Mary Arday-Kotei, Head of Unit, Ministry of Health/Health Education Unit

Lintas
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Wisdom PLWHA Association
Emmanuel Agbo, President
Douglas Sem, Spokesperson

Planned Parenthood Association of Ghana
Joanna Nerquaye-Tetteh, Executive Director

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Kojo Lokko, Deputy Managing Director

Phillip Foundation - Peer Education Project
Boateng Mensah, Director

Group Africa
Stephen Stapelberg, General Manager

GHANET (Ghana HIV/AIDS NGO Network)
Alice Lamptey, President

AVSC International
Nick Kanlisi, Country Director

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Cynthia Eledu, Country Programme Advisor

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Gifty Alema-Mensah

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Momentum Exp.
Ron Boon, Chief Executive Officer

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Canal TV #2
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American Red Cross
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APPENDIX C

PCS FUNDING BY COUNTRY AND DIRECTIVE

1996–2000

PCS Funding by Country and Directive, 1996–2000

		Field Support									
Country	**Core**	**Pop**	**CHS**	**CSP**	**HEA**	**HIV**	**INF**	**CSMN**	**DG**	**MAARDS**	**Country Total**
AFR											
Africa Region*	$603,000	$510,000				$350,000		$100,000			$1,563,000
Ethiopia		$905,000	$88,000			$113,000					$1,106,000
Ghana	$65,000	$2,699,000	$1,086,000			$1,441,000				$270,500	$5,561,500
Kenya	$782,000	$1,100,000	$40,000			$60,000	$150,000				$2,132,000
Nigeria	$190,000	$2,824,000	$1,670,000	$1,200,000		$375,000			$4,444,233		$10,703,233
REDSO/ESA			$375,000								$375,000
Rwanda						$1,300,000	$300,000			$846,600	$2,446,600
Senegal		$375,000	$325,000								$700,000
South Africa		$300,000				$1,000,000					$1,300,000
Tanzania		$1,690,000	$655,000			$335,000					$2,680,000
Uganda		$1,145,000	$404,000		$150,000	$350,000					$2,049,000
Zambia	$270,000	$1,700,000	$200,000					$225,000			$2,425,000
Zimbabwe		$1,330,000				$150,000				$137,000	$1,617,000
Total for AFR	**$1,910,000**	**$14,578,000**	**$4,843,000**	**$1,200,000**	**$150,000**	**$5,474,000**	**$450,000**	**$355,000**	**$4,444,233**	**$1,254,100**	**$34,658,333**
ANE											
ANE Region		$14,000							$250,000		$264,000
Bangladesh		$5,350,000	$850,000								$6,200,000
India		$2,240,000									$2,240,000
Indonesia	$83,000	$1,697,000								$2,000,000	$3,780,000
Jordan		$5,907,906									$5,907,906
Nepal	$568,000	$4,350,000									$4,918,000
Philippines		$12,552,000									$12,552,000
Total for ANE	**$651,000**	**$32,110,906**	**$850,000**	**$0**	**$0**	**$0**	**$0**	**$0**	**$250,000**	**$2,000,000**	**$35,861,906**
E&E											
Armenia		$1,350,000									$1,350,000
E&E Bureau		$169,000									$169,000
Georgia		$1,355,000									$1,355,000
Moldova		$675,000									$675,000
Romania		$1,700,000									$1,700,000
Turkey	$155,000	$820,000									$975,000
Ukraine		$1,550,000									$1,550,000
Total for E&E	**$155,000**	**$7,619,000**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$7,774,000**
LAC											
Bolivia	$341,000	$3,009,000									$3,350,000
Brazil		$2,000,000									$2,000,000
Dominican Rep.		$492,000									$492,000
Ecuador	$280,000	$395,000	$144,000								$819,000
Honduras		$523,000								$400,000	$923,000
Mexico		$632,000									$632,000
Nicaragua		$3,243,289	$2,484,000			$500,000					$6,227,289
Paraguay		$900,000									$900,000
Peru		$1,050,000									$1,050,000
Total for LAC	**$621,000**	**$12,244,289**	**$2,628,000**	**$0**	**$0**	**$500,000**	**$0**	**$0**	**$0**	**$400,000**	**$16,393,289**
Total for Worldwide	**$23,162,800**										**$23,162,800**
Total for All	**$26,499,800**	**$66,552,195**	**$8,321,000**	**$1,200,000**	**$150,000**	**$5,974,000**	**$450,000**	**$355,000**	**$4,694,233**	**$3,654,100**	**$117,850,328**

*Core money for AFR Region includes $350,000 in HN Core for Africa Live

APPENDIX D

SUMMARY OF PCS STRATEGIC HEALTH COMMUNICATION INTERVENTIONS

1995–2000

Summary of PCS Strategic Health Communication Interventions, 1995–2000

	Child Surv.	D&G	Dom. Viol.	Env/ Pop.	HIV/ AIDS	Malaria	Mat. Mort.	Nutr.	Immu.	Water	Health Ref.
Bang							X				
Brazil					X						X
Ecua	X			X			X				
Ethio	X										
Ghan	X				X						
Hond					X		X				
Indon				X			X				X
Nica	X				X					X	
Nigeri	X	X			X	X			X		
Philip	X			X	X			X			
Rom			X								
Rwan		X			X	X					
Seneg	X										
S. Afr					X						
Tanz	X				X						
Ugan	X							X			
Ukra					X						
Zimb					X						

APPENDIX E

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REFERENCES

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POPTECH

POPULATION TECHNICAL ASSISTANCE PROJECT

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Welcome to POPTECH

The Population Technical Assistance Project (POPTECH) provides short-term technical assistance in support of the population and reproductive health program of the U.S. Agency for International Development (USAID).

POPTECH is supported by the Bureau for Global Programs, Field Support and Research, Center for Population, Health and Nutrition, Office of Population (G/PHN/POP).

POPTECH fields technical assistance teams who work with USAID and host country counterparts to improve the effectiveness of USAID's population program.

This web site contains resource and background information for USAID staff, consultants, and those interested in population, health, and nutrition issues. Follow the links at left to access the relevant information sources. E-mail questions and comments to: admin@poptechproject.com

All files on this site are property of the U.S. government, and are under its auspices and ultimate disposition.

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Population Technical Assistance Project

POPTECH

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POPTECH identifies and recruits consultant teams to assist USAID/Washington and its Missions in program design, development, evaluation, and related services. The resources listed here will assist in organizing an effective and meaningful assignment.

Users' Guide	It is vital that Missions first review the POPTECH Users' Guide, a critical resource that details how to utilize POPTECH's services. A step-by-step checklist for use in planning an assignment is included in the guide.
POPTECH Services	An overview of the range of services provided by the POPTECH project is provided here.
Roles and Responsibilities	Who is responsible for which aspects of an assignment? This page outlines the roles of relevant offices, Missions, consultants, staff, and others.
Assignment Management Documents	These guidelines and checklists are designed to facilitate preparing for and implementing an assignment. They summarize and organize the various steps to consider and resolve before an assignment can be implemented, and note issues to keep in mind while an assignment is underway.
Sample Scopes of Work	To facilitate assignment management, Missions may wish to review some sample scopes of work.

Tool Series	The POPTECH Tool Series comprises several analytical tools designed to support and enhance the expertise of POPTECH consultants, promote consistency and quality across reports, and provide assistance to the Bureau for Global Programs, Field Support and Research (Global Bureau) and Mission staff.
SOTA Workshop CD	This resource CD-ROM was produced in conjunction with the ANE-SOTA Workshop held in Chiang Mai, Thailand in September 1997. It is intended for use by USAID PHN officers and other interested parties worldwide.
Contact Us	Contact the USAID cognizant technical officer (CTO) for details, or send a message directly to the POPTECH office.

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