

# C-CHANGE FINAL REPORT

March 2013

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## ACRONYMS

<b>ABMP</b>	African Broadcast Media Partnership	<b>FGD</b>	focus group discussion
<b>ACT</b>	artemisinin-based combination therapy	<b>FP/RH</b>	family planning/reproductive health
<b>ANC</b>	antenatal care	<b>GBV</b>	gender-based violence
<b>ART</b>	anti-retroviral therapy	<b>GEM</b>	Gender Equitable Men
<b>ARV</b>	anti-retrovirals	<b>GOK</b>	Government of Kenya
<b>CA</b>	cooperating agency	<b>GSC</b>	Gender Scales Compendium
<b>CACOC</b>	Constituency AIDS Coordinating Committee	<b>GTZ</b>	Deutsche Gesellschaft für Technische Zusammenarbeit
<b>CBD</b>	community-based distribution	<b>HEP</b>	Health Extension Program
<b>CBO</b>	community-based organization	<b>HEU</b>	Health Education Unit
<b>C-Change</b>	Communication for Change	<b>HEW</b>	health extension worker
<b>CCT</b>	Community Conversation Toolkit for HIV Prevention	<b>HF</b>	health facility
<b>CGR</b>	cross generational relationships	<b>HIP</b>	Hygiene Improvement Project
<b>CHW</b>	community health worker	<b>IDI</b>	in-depth interview
<b>CLTS</b>	community-led total sanitation	<b>IPC</b>	interpersonal communication
<b>CoE</b>	center of excellence	<b>IPTp</b>	intermittent preventive treatment in pregnancy
<b>COP</b>	community of practice	<b>IRS</b>	Indoor residual spraying
<b>CS</b>	capacity strengthening	<b>JHUCCP</b>	Johns Hopkins University Center for Communication Programs
<b>CSO</b>	civil society organization	<b>LLIN</b>	long lasting insecticide-treated net
<b>CTMP</b>	Comité Technique Multisectoriel Permanent	<b>MARP</b>	most-at-risk populations
<b>DHS</b>	Demographic and Health Survey	<b>MCH</b>	maternal and child health
<b>DRC</b>	Democratic Republic of the Congo	<b>MCM</b>	Modern contraceptive methods
<b>DRH</b>	Division of Reproductive Health	<b>MCP</b>	Malaria Communities Program
<b>E&amp;E</b>	USAID Europe and Eurasia Bureau	<b>MOH</b>	Ministry of Health
<b>EMA</b>	Essential Malaria Action	<b>MOHSS</b>	Ministry of Health and Social Services
<b>FBO</b>	faith-based organization	<b>MOHSW</b>	Ministry of Health and Social Welfare

<b>MOPHS</b>	Ministry of Public Health and Sanitation	<b>SAT</b>	South African Aids Trust
<b>MSM</b>	men who have sex with men	<b>SAT</b>	Southern Africa AIDS Trust
<b>NERCHA</b>	National Emergency Response Council for HIV and AIDS	<b>SBCC</b>	Social and behavior change communication
<b>NGO</b>	non-governmental organization	<b>SBCC CAT</b>	SBCC Capacity Assessment Tool
<b>NMCP</b>	National Malaria Control Programs	<b>SDM</b>	Standard Days Method®
<b>NSC</b>	national steering committee	<b>SOTA</b>	state of the art
<b>ORS</b>	oral rehydration salts	<b>SRGBV</b>	school-related gender-based violence
<b>PHDP</b>	positive health, dignity and prevention	<b>SSO</b>	social service organization
<b>PIRCOM</b>	Programa Inter-Religious Contra a Malaria	<b>STI</b>	sexually transmitted infections
<b>PLHIV</b>	person living with HIV	<b>SW</b>	sex workers
<b>PMI</b>	President's Malaria Initiative	<b>TA</b>	technical assistance
<b>PMTCT</b>	prevention of mother-to-child transmission of HIV	<b>TAC</b>	technical advisory committee
<b>PNCPS</b>	Programme National de Communication pour la Promotion de la Santé	<b>TAG</b>	technical advisory group
<b>PNLP</b>	Programme National de Lutte contre le Paludisme	<b>TOT</b>	training of trainers
<b>PNLS</b>	Programme National de Lutte contre le SIDA	<b>TWG</b>	technical working group
<b>PNSA</b>	Programme National de Santé des Adolescents	<b>UNFPA</b>	United Nations Population Fund
<b>PNSR</b>	Programme National de Santé de la Reproduction	<b>USAID</b>	United States Agency for International Development
<b>PSA</b>	public service announcement	<b>VCT</b>	voluntary counseling and testing
<b>PSI</b>	Population Services International	<b>VIPP</b>	Visualization in Participatory Programs
<b>PwP</b>	prevention with positives	<b>VMMC</b>	voluntary medical male circumcision
<b>RACOC</b>	Regional AIDS Coordinating Committee	<b>WASH</b>	water, sanitation, and hygiene
<b>RH</b>	reproductive health	<b>WHO</b>	World Health Organization
<b>RHC</b>	rural health center		
<b>S &amp; D</b>	stigma and discrimination		



# THE C-Change Story

The field of health and development communication has evolved over time. Programming in this area encompasses a broad range of activities and approaches which focus on the individual, community, and environmental influences on behavior and social change. Projects spanning three decades in various sectors have worked to reduce fertility; decrease morbidity and mortality of women, infants and children; reduce risky behaviors; improve agricultural production; promote democracy and civil society; and protect the environment.

Terms such as information, education and communication (IEC), health education, behavior change communication (BCC), social marketing, health communication, communication for social change (CFSC), and **social and behavior change communication (SBCC)** have been used to describe this field. It defines the art and practice of informing, influencing, and motivating individuals, communities, institutional and public audiences about important health and development issues.

As a key component of public health and other development areas, the field has evolved to use measurable objectives and evaluation methods, and is fed by multiple disciplines. As part of this evolution, behavior change has moved away from the linear expert-learner or sender-receiver paradigm to transfer information, and seeks to engage audiences in ongoing and meaningful dialogue where influence flows in both directions. Popular BCC methodologies emphasize persuasion and negotiation with the individual or community for changes affecting knowledge, attitudes, behaviors, and practices. An alternate framework for intervention, CFSC emphasizes focusing on empowerment of community members through dialogue and problem-solving. This approach locates individual behavioral risks and vulnerabilities within the broader community and social context.<sup>1</sup> As a combination of both approaches, **SBCC** makes a conscious and consistent effort to address social factors that influence health and development within a socio-ecological framework. While change often starts with an individual, it needs to be manifested in social norm change, group change, policy or structural change in order to be sustainable. This is achieved through communication oriented towards advocacy in the political and cultural domain, social and community mobilization to expand participation and foster collaboration, and communicating in relation to individual risk and vulnerability.<sup>2</sup>

For the past five years, the C-Change Project has been a key partner in USAID's efforts to provide leadership across sectors in the field of **SBCC**. C-Change has articulated and promoted this approach which recognizes that the determinants of behavior and social change exist on multiple levels and extend beyond the

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1 Figueroa, M E; D L Kincaid; M Rani; & G Lewis. 2002. *Communication for Social Change: An Integrated Model for Measuring the Process and Its Outcomes*. New York: The Rockefeller Foundation.

2 C-Change. 2012. *C-Modules: A Learning Package for Social and Behavior Change Communication (SBCC)*. Washington DC: C-Change/FHI 360.

## WHAT IS

# Social and Behavior Change Communication (SBCC)?

SBCC is the systematic application of interactive, theory-based, and research-driven communication processes and strategies to address tipping points for change at individual, community, and social levels. It does this by:

- **Using an interactive, planned and strategic process**
- **Applying a socio-ecological model—examining social, cultural, economic and legislative factors as well as concepts relating to individual behavior change**
- **Operating through three key strategies—advocacy, social and community mobilization, and behavior change communication (BCC).**

Because it is based on a socio-ecological model, SBCC uses theories and models from various disciplines to provide road maps for understanding and addressing barriers to change, and clarifies assumptions on which interventions are based. SBCC theories and models also help to identify indicators that can be used to measure success.

By using an SBCC approach, practitioners can begin to understand their intended audiences, the contexts in which they live, and their needs as adult learners.

## C-CHANGE FUNDING (as of 12/31/12)

### LEADER AWARD

Total Obligated Amount: \$67,606,830

Core: \$29,958,022

Field Support: \$37,648,808

### ASSOCIATE AWARDS

Total number of Associate Awards: 10

Total Estimated Funding: \$125,003,774

Total Obligated Amount: \$57,408,770

individual to the macro-influencers of behavior. This report details these research, implementation, and capacity strengthening activities and interventions in Africa, Latin America and the Caribbean, Eastern Europe, and Asia that have resulted in improved systems and processes to facilitate the application of SBCC and ensure its sustainability post-C-Change.

### BACKGROUND AND RESULTS

The C-Change Project was designed by USAID to provide state-of-the-art support to USAID Missions and their partners in designing, planning, implementing and evaluating communication activities and ensuring that communication innovations, best practices and lessons learned were developed and disseminated. A five-year USAID Bureau for Global Health-funded Leader with Associates (LWA) cooperative agreement was awarded to AED<sup>3</sup> on September 25, 2007<sup>4</sup> with a total funding ceiling of \$173,764.03 (see box to left for total funding picture, including core and field support accumulated under the leader award and total estimated funding and obligations as of 12/31/12 for ten associate awards).

<sup>3</sup> AED's programs and assets were acquired in full on June 30, 2010 by FHI; henceforth the project has been under the management of FHI 360.

<sup>4</sup> Scheduled to end on September 30, 2012, the project received a no-cost extension through December 31, 2012.

### Objectives of the C-Change Project, by intermediate result, were:

**Intermediate Result 1:** Evidence-based scaled-up health and development communication programs implemented and best practices of behavior change applied, using state-of-the-art communication practices as well as participatory and community-led programming

**Intermediate Result 2:** Health and development communication skills and knowledge transferred to developing country institutions in both the public and private sectors focusing on institutional capacity to plan, implement and evaluate comprehensive health and development communication programs

**Intermediate Result 3:** Health and development communication integrated within the wider public health and development agendas

**Intermediate Result 4:** Effective social and behavior change communication knowledge generated and shared to address emerging health and development issues by providing technical leadership, strengthening global learning and establishing an innovative knowledge agenda for health and development communication.

## C-CHANGE BY THE NUMBERS

**3,627** people and **287** local organizations trained in SBCC

**4** countries with **5** established Centers of Excellence

**4** regional networks (comprising **212** member organizations) with expanded SBCC capacity

**415** SBCC materials developed for use in national or sub-national programs

**28,471** external downloads of C-Modules from C-Change website and...

**5,008** external downloads of SBCC Capacity Assessment Tools

**62,577** downloads of C-Change tools, briefs and reports from C-Change website

**283** records comprising **2,233** media and document files uploaded to C-Hub repository

**170** organizations with one or more parts of C-Change framework incorporated into SBCC activity or intervention

**97** government-run programs by technical area with incorporated or strengthened SBCC capabilities

**75** national or lower-level technical working groups or task forces with developed or revised SBCC strategies and **82** with coordination strategy documents

**79** global, national or regional SBCC advocacy conferences, meetings or summits held

Over a five-year period, C-Change employed the following SBCC strategic approaches:

- **Improved the quality of SBCC interventions and developed streamlined approaches and tools**
- **Built the capacity of regional networks and local institutions, including NGOs, CBOs, and FBOs** to plan, coordinate, manage, implement, and evaluate SBCC programs and interventions
- **Conducted research and improved monitoring and evaluation that informed program development and implementation**, by identifying and examining how programs utilize key social determinants of behavior—social norms and social networks—that influence and reach beyond the individual
- **Achieved scale and sustainability** by engaging and strengthening existing institutions and social networks and building strong coalitions to support programs
- **Identified and influenced the social determinants of behaviors** to bring about positive behavior change by shifting social norms that required addressing gender roles and other cultural practices
- **Set up and tested different models for engaging the media as full partners** in the process of social change

C-Change, in most cases, exceeded its targets and in the end 97 government-run programs, 287 local organizations, and countless individuals benefited from C-Change’s contributions.<sup>5</sup>

This end-of-project report captures C-Change’s accomplishments, results and lessons learned—from formative research and monitoring and evaluation, to implementation of integrated communication programs, to capacity building and forging and maintaining partnerships in its field-supported and core-supported activities. All of these accomplishments would not have been possible without the generous support of USAID.

## LESSONS LEARNED

How did C-Change advance the field of health communication? What questions loom as C-Change ends five years of capacity strengthening work with governments, NGOs, universities, regional networks and individuals?

C-Change learned important lessons that will continue to inform the work of SBCC as the field evolves. Ten key lessons are highlighted here (an expanded set of lessons are reported in each Section according to the individual IRs).

- 1** Overall, SBCC capacity strengthening is the best way to create permanent, sustainable institutionalization and use of the SBCC approach.
- 2** Capacity strengthening activities, tools, and resources have been the crucial backbone of the program. In addition to building the capacity of southern hemisphere institutions and partners, they have increasingly strengthened USAID’s country implementation programs, as well as played a major part in the program design of C-Change’s operations research. These tools, and the practices they engender, are one of the strongest outcomes of the project and a lasting legacy to the field of SBCC.
- 3** Achieving wide-scale and sustainable capacity in SBCC requires considerable time, resources, and mentoring.

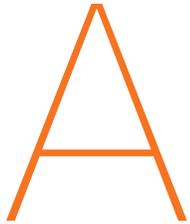
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<sup>5</sup> See Appendix 3 for overall achievements in the Program Monitoring Plan (PMP).

- 4** Partnerships with key stakeholders and groupings of organizations are crucial to embedding SBCC into global, national, sub-national government sectoral structures, NGOs, and their institutional and individual mindsets. Working with such groupings creates communities of practice and results in shared strategies and visions for coordinated, multi-partner implementation; joint SBCC strategies lead to better quality interventions.
- 5** For a regional network cascading model to be successful in building capacity, it is essential to monitor that those trained at the regional level go beyond their own organizations to transfer skills and be linked to others in their countries carrying out SBCC. This helps ensure that they continue to develop and apply their skills and tap into the support network necessary to provide capacity building services to other partners.
- 6** More work is needed to promote country ownership of SBCC tools and materials and to sustain the capacity built. Skills transfer and sustained capacity requires ongoing training, mentoring and application, including at district levels, as well as a systematic capacity strengthening process with adequate budgets and reasonable time frames.
- 7** Because SBCC is often undervalued and equated with IEC and public relations (PR) by governments and some donor officials, as well as other key actors in development programs, more efforts are needed to promote SBCC as an important concept with specific tools that benefit health and development programs.
- 8** C-Change critically challenged the tendency of health communicators to think only in terms of individual behavior change by combining behavior change and social change thinking. This represents a real advance in the state-of-the-art of health communication in developing country contexts. The project also demonstrated how the same concepts and tools could be applied to change in other fields, such as democracy and governance.
- 9** C-Change combined and operationalized development communication approaches, social change concepts and behavior change methods for capacity strengthening, program design and implementation. In the process it made behavioral and social science theory application to strategy development more accessible for learners and practitioners.
- 10** The project developed innovative operations research in HIV prevention demonstrating that health communication needs renewal away from one-way messaging to addressing community social norms and collective efficacy with approaches focused on dialogue and community action.

During the project's final dissemination meeting with USAID and other key stakeholders in September 2012, USAID challenged the gathering of distinguished health communicators to address important questions facing health communication in the future. These questions acknowledged that while we, the health communication community, are committed to capacity strengthening in the field of health communication there are important issues to answer: "What is the impact of capacity strengthening of health communication and how do we more adequately measure it?" "What is the impact of capacity strengthening in health programs themselves?" "How is it making them better, stronger?" "What is the impact of SBCC on health outcomes?" "What is the impact of country ownership of communication programs?" These and other questions inspire thoughtful reflection for the future of health communication.





## Tailoring SBCC Capacity Strengthening at Multiple Levels

C-Change developed sustainable systems in SBCC programming through training, technical assistance (TA), mentoring, and knowledge generation activities to share and institutionalize state-of-the-art theory and “best practices” thereby contributing to the project’s *Intermediate Result 2: Strengthen and Transfer Skills and Knowledge to Developing Country Institutions*. With USAID global and mission funding, the project worked to strengthen the capacity of national governments, partner organizations, regional institutions, NGOs, and other key stakeholders in comprehensive planning and coordination, management, implementation, and monitoring and evaluation of SBCC programs and activities. C-Change worked to strengthen Southern partners through all of these endeavors. Developing and sharing tools and methods to assess, plan, implement, and evaluate effective SBCC programming in resource-constrained settings was a top priority. Success was measured by the degree to which SBCC competencies were demonstrated, institutionalized, and mainstreamed by developing country institutions and partners.

C-Change took several approaches to sustainable SBCC capacity building on multiple levels. The program created tools and sustainable channels for SBCC training, including creating certificate and degree programs in five universities in four countries (**Albania, Guatemala, Nigeria, and South Africa**); worked across regions through regional institutions and networks in **Africa**; and strengthened SBCC capacity at the country level in 15 countries, seven of which (**The Bahamas, DRC, Guatemala, Jamaica, Kenya, Namibia, and Swaziland**) are detailed here. See below for descriptions and results of these capacity building efforts.

## 1 SBCC CAPACITY STRENGTHENING AT GLOBAL LEVEL—TOOLS AND CHANNELS



Capacity Strengthening Toolkit launch postcard

C-Change aimed to expand the depth and supply of communication expertise in USAID intervention countries through creating tools and developing sustainable channels for continued SBCC training in-country. This included development of the *Capacity Strengthening Toolkit for SBCC* ([www.c-changeproject.org/focus-areas/capacity-strengthening/SBCC-Toolkit](http://www.c-changeproject.org/focus-areas/capacity-strengthening/SBCC-Toolkit)), which comprises a Capacity Assessment Tool in three versions, an SBCC framework, the *C-Modules Learning Package* ([www.c-changeproject.org/resources/c-modules](http://www.c-changeproject.org/resources/c-modules)), online SBCC courses, and the *C-Bulletins* ([www.c-changeproject.org/resources/c-bulletins](http://www.c-changeproject.org/resources/c-bulletins)), a series of guides on developing and adapting materials for low literacy audiences. In addition, C-Change fostered the development of certificate and degree programs in communication at universities to ensure a sustainable cadre of skilled public health and other development professionals knowledgeable about and able to implement effective health communication programs. Previously, the only options in Africa for SBCC training were non-accredited and stand-alone courses and workshops.

### CAPACITY STRENGTHENING TOOLKIT

The Capacity Strengthening (CS) Toolkit's components were designed for providers and practitioners of capacity strengthening for SBCC to improve their individual skills/competencies and to address organizational or contextual factors that influence how these skills are used. The CS Toolkit helps to maintain flexible and adaptable training and supporting resources. It allows for tailoring for group or individual learning, provides alternatives to face-to-face training through online courses, and allows capacity strengthening providers to measure core SBCC competencies. At the close of the C-Change Project, over 19 countries had used the components of the toolkit to support capacity strengthening efforts and service providers, practitioners, students, and organizations had downloaded elements of the toolkit from the C-Change website and C-Hub 33,113 times.



### ONLINE LEARNING: FACILITATED AND SELF-PACED FLEXIBLE COURSES

The online courses, adapted from the C-Modules and other pieces in the C-Change CS Toolkit, incorporate cross-cutting content on the state of the art in applying SBCC theories and concepts, and information on SBCC for advocacy and social mobilization. Advantages of the online course include lower instructional costs, the potential to reach many learners, and the convenience of learning at home or at work, at times that suit the learner's schedule. Conversely, factors that need to be considered are design costs, technical access, and the challenge of continuing to engage and motivate learners who never meet their facilitator or each other.

CS TOOLKIT FOR SBCC	DESCRIPTION
Social and Behavior Change Communication (SBCC) Framework	The <b>SBCC Framework</b> ( <a href="http://www.c-changeproject.org/focus-areas/capacity-strengthening#framework">www.c-changeproject.org/focus-areas/capacity-strengthening#framework</a> ) identifies a planned and researched approach, a socio-ecological model to identify “tipping points” or critical leverage factors for change, and three key strategies to employ in addressing them for use by implementers in guiding programs.
SBCC M&E Measurement Tools and Framework—SBCC Capacity Assessment Tools (SBCC-CAT)	The <b>SBCC Capacity Assessment Tool (SBCC-CAT)</b> ( <a href="http://www.c-changeproject.org/resources/sbcc-capacity-assessment-tool">www.c-changeproject.org/resources/sbcc-capacity-assessment-tool</a> ) assists organizations, networks, and individuals to assess and measure capacity in SBCC. C-Change developed the SBCC-CAT in three versions—one for organizations to measure their technical capacity and needs in SBCC, another for donors and networks to assess their own capacity and that of the partners they support and manage, and an additional one to measure individual SBCC knowledge and competencies.
C-Modules: A Learning Package for SBCC (including health worker and supplemental facilitator guides)	The <b>C-Modules: A Learning Package for SBCC</b> ( <a href="http://www.c-changeproject.org/focus-areas/capacity-strengthening/sbcc-modules">www.c-changeproject.org/focus-areas/capacity-strengthening/sbcc-modules</a> ) is designed for facilitated, face-to-face workshops with program staff of small and medium-sized health and development organizations with varying levels of experience in planning or implementing SBCC programs. Also included, is additional content to focus trainings on the application of SBCC theories and models, SBCC for advocacy, social mobilization, and training of trainers.
Online C-Modules: A Learning Package for SBCC	<p>Online C-Modules, adapted from the face-to-face versions:</p> <ul style="list-style-type: none"> <li>• The instructor-led online course was available for groups/organizations interested the C-Modules with extensive support from a facilitator. Each module was scheduled for four or six weeks, with a fixed start and end date, and consisted of several topical units. There was a set fee for each module.</li> <li>• The self-paced online course was available at no cost. Participants completed the training and coursework at their own pace.</li> </ul>
Centers of Excellence Courses	Masters and certificate courses at centers of excellence. C-Change supported the development of centers of excellence in South Africa, Nigeria, Albania, and Guatemala. More information on the centers is available below.
C-Capacity Online Resource Center (CSORC) and Newsletter)	The CSORC offers resources, practical tools, and dialogue opportunities to strengthen capacity in the field of health and development communication, focusing on SBCC. The CSORC contains supplemental training resources, exchange, and mentoring opportunities that support the C-Change learning package and selected listings of opportunities for SBCC support and dialogue. A bi-monthly newsletter was produced that kept readers updated on new resources and training opportunities.
C-Bulletins: Guidance on participatory materials development	10 <b>C-Bulletins</b> ( <a href="http://www.c-changeproject.org/resources/c-bulletins">www.c-changeproject.org/resources/c-bulletins</a> ) for communication practitioners who develop and adapt SBCC materials and activities for audiences with lower literacy skills. Each of these offers practical, how-to assistance and a list of additional resources. C-Bulletin topics draw on field experiences of C-Change and partners creating and adapting materials and activities for this audience. They also respond to the limited information available on issues such as whether readability formulas work for local languages, how interactivity relates to literacy, and how audiences with lower literacy skills can be mobilized to identify and advocate for local solutions to local problems.

## RESULTS AND LESSONS LEARNED

C-Change's experience in developing and facilitating the online C-Modules courses suggest that it is an effective tool and strategy for building capacity of stakeholders—practitioners, government officials, and others—in designing, implementing and evaluating SBCC programs in the field. In addition, online courses require a flexible, easy-to-use learning platform for participants who have to balance their studies with their work and other aspects of their lives. These participants must be eager to engage in online discussions with other participants and facilitators who adopt a participatory, non-didactic pedagogy. As of end of December 2012, 158 people had completed at least one online (either facilitated or self-paced) module of the C-Module training.

## CENTERS OF EXCELLENCE AND COMMUNITIES OF PRACTICE AT UNIVERSITIES

C-Change established four Centers of Excellence (CoE) to raise the profile of SBCC and create a more viable and visible environment for SBCC work. Educational institutions in South Africa, Albania, Guatemala, and Nigeria incorporated SBCC theory and practice into their communication and/or public health curricula to strengthen institutional capacity and to build and sustain a new cadre of SBCC professionals. (Further information about each CoE is below).

The establishment of communities of practice (COP) took different forms in each country. A COP was formally established at the CoE in South Africa with an interactive web page to facilitate exchanges among students and graduates of SBCC courses. An informal COP was developed after face-to-face trainings of partners in Nigeria using an email list. In Jamaica, a Facebook page to share resources and information was developed to facilitate further involvement by participants who had embarked on SBCC training. C-Change developed an online COP in Guatemala that is hosted by the CoE in Guatemala. This online COP has a chat space as well as links to organizations of interest in planning SBCC activities in Guatemala.

*(Following is a description of each CoE with their Results; see the Lessons Learned at the end of this section, which draws on the experiences of all four CoEs.)*

**University of Witwatersrand (Wits), South Africa.** C-Change, with substantive contributions from other funders, including DFID, CDC, the private sector, Wits University itself, and the Soul City Institute for Health and Development Communication, facilitated the development of a world-class program to address the need for SBCC professionals in Africa. Through a consultative process, C-Change ensured that local and international experts and university administrative and academic leadership were involved in the design and establishment of the CoE. Early in the process, consultative meetings were held to ensure that courses were formalized within Wits. During a regional consultative meeting held in May 2009, consensus was reached among stakeholders using C-Change's competency-based framework for SBCC which elucidates the key functions, purpose, elements, and units of competencies for the planned program's curricula. Based on feedback received during this meeting, the content for specialized courses was developed and field-tested and the structure for an MPH program was developed. After consultation and course design, Wits launched its first-ever MPH degree that allowed students to concentrate in SBCC. In addition, eight week-long certificate courses for SBCC practitioners (see graphic) were designed and are now offered.

## RESULTS

By the end of the project, 156 participants from 25 countries representing government bodies, UN agencies, NGOs, and donor and research institutions were enrolled in short courses, and 23 students from seven African

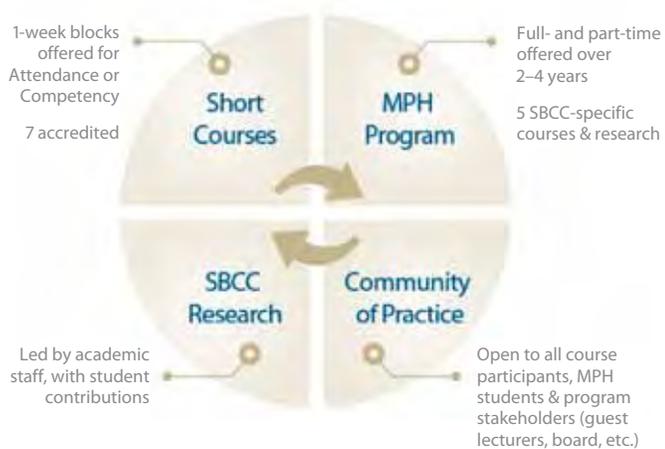
# SBCC courses and structure for University of Witswatersrand CoE

## SBCC Courses Developed:

1. Introduction to Health Promotion
2. Introduction to SBCC
3. SBCC Approaches\*
4. Applying Social Behavior Change Theory to Practice\*
5. Planning and Implementing SBCC\*
6. Communication, Media, and Society\*
7. Entertainment Education
8. Research and Monitoring and Evaluation for SBCC\*

\*Required MPH SBCC field of specialization courses

## Structure of the CoE at Wits:



Source: Nieuwoudy, Christofides & Usdin, 2012

countries were enrolled in the MPH program in SBCC, with its first graduate in December 2011. Currently, the program is preparing to accept the third cohort of MPH students. Since establishing the CoE, Wits has served as a resource for the development of SBCC courses at other institutions.

**University of Tirana, Albania.** In 2009, C-Change established informal contacts with the University of Tirana (UOT). Many of the faculty members at UOT had been involved with the C-Change Family Planning Peer Education (FP/PE) program as master trainers and coordinators during the 2009-2011 country program and had participated in several SBCC short-term trainings at that time. This was a significant factor in their interest in pursuing the development of a CoE in SBCC. Positive and strong support from the University authorities at department, faculty and vice-chancellor levels assisted a rapidly-moving process for development of this CoE. C-Change assisted with preparations to host six university representatives to participate in exchange visits with Wits and with Swedish universities in Malmo and Roskilde to ensure that the program being developed met international standards for quality. The project also provided training of UOT staff and NGO representatives in SBCC.

## RESULTS

By the spring of 2010, the MA in SBCC was developed and the first group of 14 master's degree students began study in October 2011. A second cohort began in October 2012. Recruitment of students strengthened ties to civil society organizations (CSOs) for which SBCC competencies are very relevant. This network of CSOs has ensured a recruitment base for continued viability of the program and has provided links to potential jobs in the marketplace.

**Universidad de Valle, Guatemala.** At the Universidad de Valle, "off-the-shelf" courses were selected for SBCC training as a less-risky option than a master's program for which demand was considered uncertain. C-Change provided TA to the University by assessing technical support and other resource needs for online and classroom instruction and helped to build an online SBCC course using the University's Sakai platform. The C-Modules, along with case studies, tools, and tables were adapted for the Latin American context, and curricula for SBCC courses were tailored for tertiary-level institutions.

## RESULTS

Sixteen faculty members were trained in SBCC to lead SBCC courses. With that training, faculty organized two face-to-face SBCC trainings for students and community leaders at regional campuses and faculty from three of the university's campuses coordinated and facilitated a pilot online six-week SBCC course for working professionals and academics. C-Change also led a study tour of UVG faculty and administrative staff to the Universidad del Norte (UNINORTE) in Barranquilla, Colombia, the country's premier University in the Northern Region and a potential future site as an SBCC Center of Excellence. In addition, a market study that considered multi-level academic offerings (from online short courses to a master's degree in communication program) was carried out in the Western Highlands. The CoE continuation plan for 2013 was developed, based on the market study results and a promotional strategy for the online community of practice ([www.comunicacionparaelcambio.org](http://www.comunicacionparaelcambio.org)).

**Cross River State University of Technology and University of Calabar, Nigeria.** C-Change engaged with universities in Cross River State—University of Calabar (UNICAL) and Cross River State University of Technology (CRUTECH) to develop CoEs. After initial orientation with the leadership of both universities, C-Change conducted a series of Nigeria-based trainings for the core communications department faculty from both institutions. In-country trainings were followed by a three-week certificate course on curricular and syllabi development at the University of Witwatersrand in Johannesburg. All trainings were led by C-Change CoE partners from Ohio University and the University of Witwatersrand.

## RESULTS

UNICAL and CRUTECH now offer graduate-level SBCC courses supported and supervised by Ohio University partners, and a short-term course on SBCC will begin March 2013, which is funded under the ongoing Nigeria Associate Award. There is also a short-term goal of initiating an online SBCC course to expand SBCC educational opportunities to the rest of the country. The National University Commission has accredited these courses and approved their curricula.

*C-Change continues work in Nigeria through an Associate Award that ends April 30, 2014.*

### **LESSONS LEARNED—CENTERS OF EXCELLENCE IN FOUR COUNTRIES**

Lessons learned by C-Change in the development of CoEs for SBCC within university structures include the following:

- It is critical to secure and build/maintain relationships with key stakeholders and to obtain buy-in from the outset and throughout the process;
- It is important to house SBCC within an existing public health or other relevant social program context;
- It is also important to use an applied approach when developing the coursework for hands-on skills building; and
- It is crucial to have high-quality trained staff and quality assurance by a multi-disciplinary advisory board.

## 2 SBCC CAPACITY STRENGTHENING THROUGH INSTITUTIONS AND COUNTRY AFFILIATES AT REGIONAL LEVEL

Another approach C-Change used to build capacity was to work with selected regional networks to embed SBCC into their programs and to train a group of master trainers to serve as resources in their own organizations and regions. C-Change used this model to improve the amount, quality, availability, coordination, and harmonization of SBCC programming; to achieve large geographic reach; and to reduce costs. C-Change partnered with three regional networks—**Southern Africa AIDS Trust (SAT)**, **African Broadcast Media Partnership (ABMP)**, and **African Network for Strategic Communication in Health and Development (AfriComNet)**—to strengthen SBCC capacity. This work and lessons learned overall are described below.

### SOUTHERN AFRICA AIDS TRUST COUNTRY NETWORKS

C-Change received funding for a special regional initiative (Regional SBCC Capacity Strengthening with SAT) to prepare master trainers to cascade SBCC skills within their country networks. C-Change used the SBCC-CAT to carry out a baseline assessment of the SBCC level of the SAT offices and their partners. Results were used to tailor the C-Change SBCC trainings to the identified capacities and needs. Five trainings were conducted for members of 23 SAT network organizations in five countries (**Malawi, Mozambique, Tanzania, Zambia, and Zimbabwe**). Trainings included Visualization in Participatory Programs (VIPP) and the C-Modules, along with refresher training and a training of trainers (TOT).

Following the trainings, C-Change developed tailored assignments for participants to apply knowledge learned from the workshops and provided TA and guidance on the assignments submitted by the trainees.

### RESULTS

Results showed that all SAT SBCC partners in four<sup>1</sup> of the countries improved SBCC knowledge and competencies and are using the SBCC tools from the C-Modules. By close of the collaboration with SAT, C-Change had trained 30 people from 23 organizations in Southern Africa countries to plan an SBCC intervention. Of the SAT partners trained, 86% were able to provide TA and training to others in an SBCC topical area.

<sup>1</sup> Mozambique discontinued its work with the organizations after the third training, so did not participate in the final evaluation.



SBCC Capacity Assessment Tool (SBCC-CAT) for use with organizations

“The organization’s programming is more focused after undergoing the SBCC capacity development process. Interventions that the organization has developed are now more evidenced-based as such; it makes the process of tracking behavior trends among the organization’s target group even easier. In this respect, the organization has developed relevant tools, including an M&E plan, to inform and guide the collection and use of data.”

“It was important to create materials and activities during planning in order to reach the people. The knowledge on SBCC C-Planning partly enabled CHISWEA to set the project goal, select the audience, identify the desired change, barriers to change and communication objectives.”

—Feedback from survey participant



Guide on PMTCT developed for ABMP broadcasters by C-Change, available at [www.c-hubonline.org/resources/make-it-possible-it-begins-you](http://www.c-hubonline.org/resources/make-it-possible-it-begins-you)

## AFRICAN BROADCAST MEDIA PARTNERSHIP (ABMP)

ABMP's broadcast platform reaches approximately 400 million people via 66 broadcasting companies with sustained public service campaigns on radio and television and through localized programming. C-Change worked with this member network of 68 radio and television media companies representing **38 African countries** to increase the amount, quality, as well as the entertainment and informational value of HIV/AIDS and reproductive health-related broadcast programming across Africa. The benefit of working with such a large network as ABMP was the ability to have widespread coordination, harmonization and impact across Africa. An example is the work C-Change accomplished in the creative development arena: by building on the platform established by the YOU campaign, C-Change helped ABMP members to design and produce two pan-African radio and television campaigns on prevention of mother-to-child transmission of HIV (PMTCT) and integrated reproductive health and HIV prevention.

C-Change also worked with ABMP members to increase their technical capacity in up-to-date HIV/AIDS and reproductive health issues, SBCC principles and techniques, TV and radio production and broadcast trends, creative strategies and message development, social media, measurement of impact, and production of local programming. Technical assistance in these areas included mentoring, trainings, development of production guides/manuals, research that identified reproductive health priority issues, and support to improve quality and appropriateness of programming from conception through design, pre-testing and final production.

## RESULTS

With C-Change support, ABMP transitioned from a fledgling organization funded and supported technically through Kaiser Family Foundation to an independent organization capable of moving forward independently, opening opportunities to pursue other funders and partners in the future. C-Change oriented 79 high-level media practitioners (network owners, producers and/or editors) in SBCC approaches. They, in turn, showed evidence of incorporating SBCC into their programming, having either aired the ABMP public service announcements or produced and aired original programming. With TA from C-Change, ABMP also established, among its individual member companies, stronger capacity to produce and broadcast socially-relevant programming with higher production and entertainment value.

## AFRICOMNET

AfriComNet, comprised of organizations from **56 countries** and 1,459 individuals, works in HIV and AIDS and health and development communication in Africa. It collaborated with C-Change to promote capacity strengthening in SBCC with its partners at **10 universities in eight countries**. C-Change introduced the Capacity Strengthening Toolkit at a regional meeting in March 2011 to AfriComNet university partners. Based on feedback from the meeting, discussions ensued regarding training university members to be facilitators of online C-Modules. As a result, an eight-day workshop was conducted for selected university faculty members. The workshop aimed to provide participants with general insight into and understanding of key schools of thought, theories, and concepts that inform the practice of SBCC, in order to connect theory and concepts with the process of designing curricula on SBCC, and to give participants opportunities to develop and share online training tools and methods for adapting their existing and new courses for online delivery in their own institutions. For the purposes of this training, a wiki was created which participants and facilitators used as a tool to practice some skills related to online learning, including embedding video, posting files, and generating discussions.

## RESULTS

As follow-on to the training, C-Change organized a practicum for the university professors. After the training, participants went back to their universities and recruited students to take an online course set up on the wiki. The university professors facilitated the course with support from C-Change. Two professors completed the course and are now considered to be trained facilitators of the online C-Modules.

### LESSONS LEARNED—CAPACITY STRENGTHENING THROUGH REGIONAL NETWORKS

Work with these networks (SAT, ABMP, and AfriComNet) yielded important overall lessons. One is to invest the necessary time up front to identify and partner with existing, robust networks and organizations, which have their own resources to complement an additional investment of TA and resources. Another is to carefully select members for capacity strengthening within the network who have similar interests in creating a community of practice and can facilitate transfer of capacity strengthening skills to other members. Finally, it is important to build the capacity of not only the members/member organizations themselves, but to build their capacity to function as a network in order to sustain network activities.

## 3 SBCC CAPACITY STRENGTHENING AT COUNTRY LEVEL

C-Change supported the strengthening of SBCC capacities at national, regional, and local levels in several countries and across multiple health areas. In **Namibia**, C-Change's longest-running capacity strengthening program, the project initially focused on HIV prevention and later added programs in malaria, TB, maternal and child health, social welfare, and disabilities in support of the Namibia primary care program. In **Kenya**, the project worked with family planning, malaria, and Voluntary Medical Male Circumcision (VMMC) programs; in **Swaziland**, the project focused on HIV prevention; and in **Guatemala**, the **DRC**, **Jamaica**, and **The Bahamas**, the project worked with national government ministries, departments, committees and technical working groups to ensure that the practice of SBCC was incorporated into government planning, policies and program design and implementation.

### USING A SYSTEMATIC MULTI-LEVEL APPROACH TO SBCC CAPACITY STRENGTHENING IN NAMIBIA

A rapid assessment of SBCC for HIV prevention in Namibia in mid-2008 showed over 90% of the population in both urban and rural areas had high rates of HIV prevention-related knowledge<sup>2</sup>. Yet risky behaviors such as concurrent sexual partnerships, inconsistent condom use, inter-generational and transactional sex, low levels of HIV testing, and low levels of male circumcision continued to fuel the epidemic. Weaknesses in SBCC coordination and programming for behavioral and normative change were revealed among both NGO implementing partners and government institutions, and opportunities for SBCC capacity strengthening were identified.

As a result, C-Change implemented a multi-level program of SBCC capacity strengthening with NGOs and government on national and regional levels. With government, C-Change worked at the national level to design and establish coordinating structures; guiding policies, strategies and quality standards; and developing SBCC campaigns and complementary interpersonal communication (IPC) materials to strengthen HIV prevention. With 16 leading NGOs and private sector partners, C-Change undertook a systematic 10-step process of baseline capacity assessments, program-specific SBCC strategy development, SBCC training and mentoring, ongoing TA, quality improvement (QI) during field implementation and support to follow-on data collection, analysis and report writing.

Rather than work with each government entity or NGO partner separately, C-Change assisted national HIV prevention task forces comprised of government, NGOs and development partners to develop IPC tools that gained the approval of all partners and stakeholders and carried the government logo. Some materials were linked to mass media in national SBCC campaigns, while others were stand-alone cross-cutting materials for specific age or population groups such as men who have sex with men (MSM) and sex workers. For example, C-Change facilitated the development of IPC materials linked to mass media in the national SBCC *Break the Chain* campaign on HIV and concurrent partnerships and the national SBCC *Stand Up* campaign on HIV

2 Demographic and Health Surveys, 2006-07.

and alcohol. These new materials helped civil society organizations (CSO) become important partners in implementing national campaigns at the community level, by assisting individuals/communities to discuss risky behaviors and find workable solutions for their own lives. These communication initiatives and others were the result of lengthy and targeted C-Change stakeholder engagement.

At the national level, C-Change supported improved coordination of HIV prevention activities across line ministries, NGOs and development partners. Technical assistance was provided to the Ministry of Health's Secretariat to the National AIDS Executive Committee in the design and formation of the National Prevention Technical Advisory Committee (TAC). Multiple technical working groups focused on specific populations or on specific drivers of the epidemic. During this process, the project advocated for and achieved expanded participation of NGOs in the TAC and working groups. As a result of C-Change advocacy and technical support, stakeholders working in HIV prevention are now able to come together under one national coordinating body.

In 2010, the Ministry of Health and Social Services (MOHSS) asked C-Change to expand its capacity strengthening support to other technical areas. This resulted in the development of four national SBCC strategies for the Expanded Program on Immunization, Food and Nutrition, Primary Health Care, and the Communication for Behavioral Impact (COMBI) program focusing on HIV/AIDS, malaria, and TB.

At the regional level, C-Change worked with the Ministry of Regional and Local Government, Housing and Rural Development to develop and implement the first capacity assessment of Regional and Constituency AIDS Coordinating Committees (RACOCs and CACOCs). The assessment was undertaken in Omaheke Region at the request of the Regional Health Management Team. This resulted in the participatory development of the first regional SBCC strategy for HIV prevention. As part of the initial assessment and strategy process, C-Change worked with RACOC and its CACOCs to review current data on HIV prevention for the region and to construct a regional baseline and map the Omaheke Region in order to identify HIV transmission hot spots, highest risk populations, and the HIV Prevention Programs' coverage.

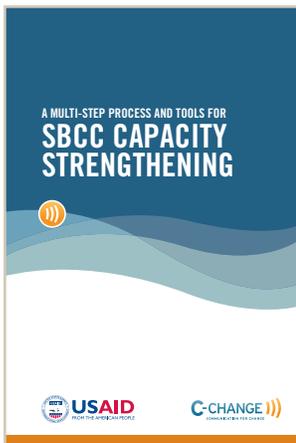
A distinct outgrowth of C-Change's work in Namibia was a request in by the national MOHSS/Primary Health Care Directorate to assist the Ministry to design and implement a new community-based health program pilot in collaboration with UNICEF. Called the Health Extension Program (HEP),



From the *Stand Up* campaign on HIV prevention and alcohol developed by C-Change Namibia, available at [www.c-hubonline.org/resources/stand-against-alcohol-abuse-and-hiv-prevention-namibia](http://www.c-hubonline.org/resources/stand-against-alcohol-abuse-and-hiv-prevention-namibia)



From the *Break the Chain* campaign on HIV prevention and MCP developed by C-Change Namibia, [www.c-hubonline.org/resources/break-chain-national-sbcc-campaign](http://www.c-hubonline.org/resources/break-chain-national-sbcc-campaign)



*A Multi-Step Process and Tools for SBCC Capacity Strengthening*, available at [www.c-hubonline.org/resources/sbcc-capacity-strengthening-namibia-process-and-tools](http://www.c-hubonline.org/resources/sbcc-capacity-strengthening-namibia-process-and-tools)

it is designed to train community health workers to provide primary care to remote rural communities. C-Change acted as the principal advisor to the MOHSS HEP National Steering Committee (NSC) in the design of the program including the contents of the standard service package and Health Extension Worker (HEW) kit, terms of reference for the HEWs and community, and HEW selection criteria and methods, all of which were approved by the NSC. C-Change also led the development of all HEW training and field materials, including the M&E system and forms, and worked with the National Health Training Center to train the HEWs. By project end, 34 HEWs had graduated and were providing integrated primary care to over 10,400 persons in remote rural communities.

### LESSONS LEARNED

Overall, as a result of C-Change's work in Namibia, capacity strengthening resulted in 24 stronger SBCC HIV prevention programs among 16 local NGOs, new government coordinating structures on the national level, new or updated SBCC policies, and SBCC strategies at both the national and regional levels, new national IPC materials and quality improvement tools for partner use, greater government collaboration with NGOs, and a new pilot community-based primary care program reaching remote communities and integrating HIV prevention.

Several important takeaways from the Namibia program are: 1) the systematic 10-step capacity strengthening process and linked tools used in NGO capacity strengthening was participatory and a simple method by which to apply SBCC theory and evidence to strengthen SBCC programs and focus efforts on behavior and normative change; 2) it is critical that national structures and sub-structures are in place and that NGOs and government jointly plan, develop and implement policies and strategies, including SBCC campaigns to strengthen the national and regional environment for SBCC; 3) the simultaneous assessment and strengthening of multiple NGOs with government is an effective way to reduce the financial burden of materials development, ensure consistency of messages across communities and organizations, and provide interpersonal communication and dialogue for behavior change through NGOs in support of national level mass media; and 4) the success of a local pilot (e.g., such as the HEP) requires the full support of MOHSS regional and district staff, as well as supervisory staff from the facilities, so that ownership is built at all stages.

*C-Change continues work in Namibia through an Associate Award that ends September 30, 2014.*

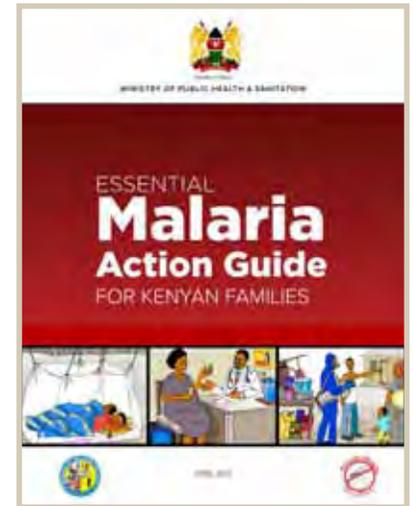
## BUILDING SBCC CAPACITY OF THE GOVERNMENT AND LOCAL AND INTERNATIONAL NGOS IN KENYA

C-Change worked with agencies of the Government of Kenya's (GOK) Division of Reproductive Health (DRH), Department of Health Promotion and Department of Disease Prevention and Control in the Ministry of Public Health and Sanitation (MoPHS), and local and international NGOs to strengthen and improve SBCC capacity and advocacy and ensure that tools and resources built upon and complemented partners' work while reinforcing messages across programs of FP/RH, malaria prevention and control, and HIV prevention.

The C-Change team conducted SBCC training for government officials and local NGOs. Experts in the MoPHS were trained on media outreach to enable them to serve as key resource persons during interviews and listener call-in shows. The DRH was assisted to develop a quarterly newsletter and provided training so that they could independently manage subsequent issues. They were also assisted in an assessment process that helped to chart a path forward to better collaborate and share knowledge with different departments, ministries and development partners. A group of champion journalists was trained by Internews, a C-Change partner, to increase the amount and accuracy of media coverage on FP/RH. More than 22 news segments resulted from the training. For HealthRight International/Kenya, C-Change organized a four-month TOT SBCC program for malaria control, which incorporated classroom instruction, student teaching and professional mentorship, to ensure that the organization's provincial staff could develop and lead internal SBCC trainings for district and community-based program staff.

## RESULTS

C-Change assisted development of a National Malaria Communication Strategy and Essential Malaria Action Guide for Kenyan Families to harmonize malaria communication approaches. C-Changes' work with malaria partners in the Advocacy, Communication and Social Mobilization Working Group and its contributions to the country's Global Fund proposal increased the SBCC capacity of the Division of Malaria Control, other government entities and partner NGOs. Capacity strengthening efforts including small grants to three malaria NGOs—PATH, Merlin and World Vision—led to increases in the use of long-lasting insecticide treated nets (LLINs) and uptake of malaria treatment. In Kisii District between 2009 and 2010, the proportion, of pregnant women and children under 5, who slept under an LLIN the previous night increased from 23% to 84.2% and from 25% to 77.9%, respectively.



*Essential Malaria Guide  
for Kenyan Families,*  
[www.c-hubonline.org/  
resources/essential-malaria-  
action-guide-kenyan-families](http://www.c-hubonline.org/resources/essential-malaria-action-guide-kenyan-families)

In HIV prevention, C-Change worked with partners and the National Task Force on a voluntary medical male circumcision (VMMC) communication guide for Nyanza Province that operationalized the national VMMC Communication Strategy. C-Change developed 14 VMMC materials following formative research, adapted them to three other regions in Kenya, and provided capacity strengthening on SBCC for government and local staff who are now using the materials. The process of working through Regional and National Task Forces, as well as the participatory materials development and adaptation process based on audience consultations, has been documented in a case study and used by other VMMC country programs.

C-Change used the SBCC-CAT in Kenya, which had been developed as part of capacity strengthening efforts in other countries, to assess various organizations' core competencies before and after trainings. One measure of successful results in the increase in application of skills in SBCC was the inclusion of such assessments in work plans, communication strategies, M&E plans and SBCC materials. Pre- and post-tests during trainings and workshops were also used to monitor capacity strengthening results.

### **STRENGTHENING LEADERSHIP AND COORDINATION OF NATIONAL HIV PREVENTION PRIORITIES IN SWAZILAND**

Over a three-year period, C-Change worked to strengthen systems and procedures for coordinating a sustained multi-sectoral, multi-level national HIV prevention response, including national policy for HIV prevention and quality standards for HIV communication activities undertaken by broadcast media. The project worked to improve capacity to design and implement evidence-informed SBCC at all levels.

A first priority for USAID in Swaziland was for C-Change to work directly with the National Emergency Response Council for HIV and AIDS (NERCHA) and their subsidiary, the Public Sector HIV/AIDS Coordinating Committee (PSHACC), to strengthen their capacities to respond to the HIV/AIDS pandemic with effective SBCC strategies and monitoring and evaluation plans. C-Change assisted NERCHA to refine the National HIV Prevention Action Plan and reconvene the HIV Prevention Working Group. The project also developed supporting tools and contributed to a program monitoring plan and estimations of implementation costs. The project conducted training of NERCHA staff in all four regions of the country.

C-Change worked to strengthen the role of media in their response to HIV and AIDS by facilitating a media sector review and training journalists and media managers on minimum standards for stigma-free reporting. Training was provided to news editors of media houses on the role of media in reporting acts of violence against women. The training stimulated dialogue on gender-based violence, how it is perceived in the country, and how over-zealous reporting can adversely affect the ability of government prosecutors to litigate and win gender-based court cases.

### **RESULTS**

The project-facilitated self assessments of SBCC capacity with six large private sector companies and 24 public sector employers. C-Change conducted "strategic information sessions" to address gaps identified during the assessments and initial sensitization training on HIV and gender-based issues for Human Resource Coordinators. Master trainers were selected for more intensive SBCC training to enable them to cascade training to colleagues

throughout their organizations. Five master trainers from the private sector and 24 ministry-appointed health and wellness coordinators from the public sector were chosen for this SBCC TOT. At the request of USAID/Swaziland, C-Change partnered with the Swaziland Business Coalition on HIV and AIDS to assess the roles and performance of their wellness coordinators.

C-Change also strengthened the organizational and technical capacity of Lusweti Institute for Health and Development Communication, a local organization known for its mass media campaigns focused on the risks of concurrent sexual partnerships.

Finally, C-Change collaborated with PSI and local NGOs—Khulisa Umnftwana and Bantwana—to provide peer education training for 150 young women attending the Reed Dance so that they could in turn work with other young women to increase their negotiation skills and provide information about risk behaviors, including risks associated with early sexual debut. C-Change provided training for 30 male security personnel or Tindvunas, who are stationed at bathing streams, sleeping tents, and camp gates to guard the young women for the duration of the ceremony. Ultimately all training and dialogues supported HIV prevention and changing social norms and behaviors around gender-based inequities and violence.

## LESSONS LEARNED

During its work in Swaziland, C-Change found that embedding core staff within the offices of NERCHA deepened the acceptance of C-Change staff as part of the NERCHA HIV Prevention team and enabled seamless planning, implementation and evaluation of activities to achieve the overall project goals and objectives. C-Change adopted a similar model in working with its local NGO partners through Lusweti. Both NERCHA and Lusweti staff cascaded these trainings downstream to PSHACC and NERCHA regional personnel.

The training that C-Change offered to news editors and their journalists proved effective in moderating their tendency towards tabloid and sensational approaches to sensitive issues such as rape and intimate partner violence. The media specifically requested that C-Change staff act as local watchdogs to alert them of tendencies to support the patriarchal values of Swazi culture.

## THOUSANDS OF YOUNG WOMEN REACHED AT THE ANNUAL REED DANCE

Each year, more than 50,000 maidens—young, unmarried, childless women—travel to the Eludzidzini Royal Residence in the Kingdom of Swaziland’s traditional capital to attend the annual Umhlanga Reed Dance. They come from across the kingdom and nearby South African provinces to participate in the ceremony, when they cut new reeds to protect the residence from wind, present them to the Queen Mother, and dance. The traditional ceremony honors the young women’s chastity, builds solidarity between them, and pays tribute to femininity and the female monarch.

Most of these young women come with minimal resources. Many sleep in camps supervised by male police and security forces, but they remain vulnerable to rape, abuse, and gender-based violence.



Trained by C-Change, this peer educator worked with young women attending the Reed Dance.

## BUILDING A COMMON UNDERSTANDING AND LANGUAGE AROUND SBCC PROGRAMMING IN GUATEMALA

In Guatemala, C-Change worked with USAID's Health and Education Office (HEO) implementing partners and Government of Guatemala Ministries of Health and Education staff to establish a common understanding and language around SBCC programming, improve SBCC skills at all levels, improve USAID HEO Technical Officers' abilities to manage SBCC components of their portfolios, and strengthen coordination of USAID implementing partners' SBCC activities. This was accomplished by the establishment and support of an SBCC Technical Working Group (TWG) composed of all key stakeholders.

The TWG helped to forge a joint vision for an overarching SBCC strategy and key content for an accompanying SBCC implementation guide. It enabled all members to improve SBCC skills by collaborating in a concentrated geographic area, and provided a forum for bringing SBCC into the forefront of project planning.

C-Change developed a face-to-face and a web-based SBCC community of practice (COP) that electronically linked SBCC practitioners throughout the country at: ([www.comunicacionparaelcambio.org](http://www.comunicacionparaelcambio.org)). The website contains over 500 documents and samples of SBCC materials, a Spanish version of the C-Change Capacity Strengthening Toolkit for SBCC, and products developed by C-Change specifically for the Guatemalan project, which include an overarching SBCC Strategy, Implementation Guide, and SBCC evaluation indicator bank. The website was tested with the Guatemala City-based COP, USAID implementing partners, and field-based representatives in the Western Highlands. The website is hosted by the University del Valle with oversight by USAID implementing partners, the Ministries of Health and Education and the private sector.

The C-Change SBCC-CAT was applied to the Health Promotion Unit of the Ministry of Health (PROEDUSA) as part of their internal planning as well as to several USAID implementing partners. Following assessments, capacity strengthening plans were developed and subsequent training provided in the C-Modules along with tailored TA to each organization. C-Change held a week-long M&E training in SBCC, worked with organizations to develop an SBCC M&E indicator bank, and refined indicators during a series of meetings.

## RESULTS

The integrated approach to capacity strengthening (combining USAID implementing partners with government counterparts) strengthened a shared vision for SBCC implementation in the Western Highlands of Guatemala. Specific results included that 90% of participants in the University CoE SBCC courses exhibited an increase in SBCC knowledge.



C-Change Guatemala CoP webpage, [www.comunicacionparaelcambio.org](http://www.comunicacionparaelcambio.org)

## IMPROVING COORDINATION OF SBCC PROGRAMMING BETWEEN MINISTRY OF HEALTH AND CIVIL SOCIETY IN JAMAICA AND THE BAHAMAS

During the more than two-year program in Jamaica and The Bahamas, C-Change aimed to improve capacity of, coordination between, and quality of public and private sector SBCC programs for most-at-risk populations (MARP) and to accelerate scale, reach and momentum of programs, and improve social mobilization and facilitation techniques.

C-Change conducted trainings in SBCC and provided ongoing TA and mentoring to partners (see box) to increase the quality of implementation and documentation of programs in the national response. Trainings and SBCC tools developed by C-Change ensured that an SBCC approach was adopted and used by partners in their MARP communication programs for sex workers and MSM.

C-Change participated in and provided TA to the MARP Technical Working Group (TWG) and to the Monitoring and Evaluation Research Group. The project advocated for a National Strategic Communication Plan for MARPs to serve as a guiding document for both government and civil society partners. C-Change also participated in the regional Sex Worker and HIV TWG and attended and presented at meetings in Trinidad and Guyana. The project trained representatives of the MARP TWG in Visualization in Participatory Programs (VIPP) techniques and others on using social media.

### RESULTS

C-Change provided TA to the finalization of 14 partner organizations' strategic documents (e.g., communication strategies, implementation plans, and M&E plans) and developed a Global Best Practices Research Report on communication programming for MSM and sex workers, which was distributed widely.



Global Best Practices Research Report, [www.c-changeprogram.org/sites/default/files/Global-Best-Practices-Report-FINAL.pdf](http://www.c-changeprogram.org/sites/default/files/Global-Best-Practices-Report-FINAL.pdf)

## LIST OF PARTNERS

### JAMAICA

National HIV/AIDS Programme	Jamaica Forum for Lesbians	Kingston and St. Andrew Parish AIDS Committee
ASHE Performing Arts Company	All-Sexuals & Gays	Peer Counseling Association of Jamaica
Children First	Jamaica Network of Seropositives	Grata Foundation
Caribbean HIV/AIDS Alliance	Jamaica Red Cross	Pride in Action
Caribbean Vulnerable Communities Coalition	Jamaica Youth Advocacy Network	Sankofa Arts and Facilitation
Eve for Life	Joy Town Community Development Foundation	Sex Workers Association of Jamaica
Jamaica AIDS Support for Life	Junior Chamber International	

### THE BAHAMAS

Society Against STIs and HIV	Bahamas Association for Social Health AIDS Foundation
Bahamas Red Cross	Advanced Family Medicine and Medi-Spa
Civil Society Bahamas	Lignum Vitae Centre of Hope
Urban Youth Development Centre	Ministry of Sports Youth and Culture
Ministry of Health	
Youth Ambassadors for Positive Living	
HIV Centre	
Bahamas Family Planning Association	



EMA Guide—Democratic Republic of Congo, available at [www.c-hubonline.org/resources/essential-malaria-action-guide-drc](http://www.c-hubonline.org/resources/essential-malaria-action-guide-drc)

### BOLSTERING MULTI-SECTORAL TECHNICAL COMMITTEES IN THE DEMOCRATIC REPUBLIC OF CONGO

In the DRC, C-Change revitalized national-level working groups/technical committees of numerous government sectors focused on malaria, HIV/AIDS, water/sanitation, tuberculosis, maternal/newborn/child health, gender-based violence and family planning. C-Change provided technical and administrative support to enhance their organizational structures and increase their functionality. In early 2012, the National Communication Strategy and Implementation Plan for Family Planning was finalized by the staff of the PNSR and then endorsed by the Ministry of Health. C-Change anticipates that the Communication Strategies and Implementation Plans for PNLs, PNLp and PNSA will be finalized and endorsed by the Government.

C-Change provided SBCC TA to government staff and partners through a university-level course and SBCC trainings. The project conducted training on SBCC for Reproductive Health with the government and interested partners and co-facilitated training on HIV/AIDS with ProVIC (the integrated HIV/AIDS project led by PATH). In addition, C-Change held a capacity building workshop at central level for the PNLs and a second one for provincial-level government personnel and their local partners to strengthen their implementation plans in SBCC and HIV.

C-Change provided ongoing support to the Provincial Malaria Task Force on how to use the Essential Malaria Action Guidelines and other behavior change materials. These were distributed by trained health agents to communities. C-Change also provided the Government with technical support during international events, such as Woman’s Day, Earth Day, World Malaria Day, HIV/AIDS’s Day, Reproductive Health Day, and others.

## COMMUNICATION STRATEGIES AND IMPLEMENTATION PLANS DEVELOPED IN DRC

<p><b>Development of Tools and Communication/ Advocacy Briefs</b> for:</p> <p>The Multi-sectoral Technical Permanent Committee in FP</p>	<p><b>Development of Anti-Tuberculosis Communication Strategy, Advocacy Plan and other support materials</b> for:</p> <p>LAT (The Anti-Tuberculosis League)</p>	<p><b>Development of Communication Strategy and Implementation Plan</b> for the following agencies:</p> <ul style="list-style-type: none"> <li>• PNSR (National Program on Reproductive Health)</li> <li>• PNLs (National Program on HIV/AIDS)</li> <li>• PNLp (National Program against Malaria)</li> <li>• PNSA (National Program of the Adolescents’ Health)</li> </ul>
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## Scaling Up Best Practices in Social and Behavior Change Communication

C-Change focused on strengthening the capacity of existing institutions to carry out SBCC, which contributed to *Intermediate Result 1: Scaling Up Best Practices in Social and Behavior Change Communication* across technical areas that included FP/RH, malaria prevention and control, and HIV prevention. A small segment of this work included direct implementation of SBCC programs with specific populations.

C-Change engaged with government ministries and agencies in several countries—**DRC, Kenya, Malawi, and Albania**—to reinvigorate FP programming and budgeting and incorporate best practices in SBCC, following a period of minimal support and funding.

In its work on scaling up best practices in SBCC for malaria prevention, C-Change provided TA or implemented programs in **DRC, Ethiopia, Ghana, Kenya, Liberia, Malawi, Mozambique, Nigeria, and São Tomé and Príncipe**. C-Change strengthened the President's Malaria Initiative (PMI) including leading a collaboration of national malaria control programs and partners in **15 countries** to develop a strategic framework for malaria communication and launch harmonized regional and country-level malaria prevention communication programming.

C-Change partnered with national and district governments and local NGOs using participatory approaches for the development of the *Voluntary Medical Male Circumcision (VMMC) Toolkit* in Kenya and the *Community Conversation Toolkit for HIV Prevention* in **Lesotho, Swaziland, Malawi, Namibia, Nigeria, Zambia, and Zimbabwe**. C-Change also developed a web-based tool, the *Gender Scales Compendium*, for researchers and implementers. The following details this work.

## 1 Re-Launching and Launching Family Planning: Country Experiences

Beginning in the 1990s, FP and RH programming began to live in the shadow of HIV and AIDS. The urgency of the HIV epidemic forced a shift in focus for national health programs and decreased funding for modern contraceptive programs. Only in the last few years has the pendulum swung back toward a focus on the importance of FP and RH for the health of individuals, couples, and families. When older girls and women have access to modern contraceptives as well as education, they acquire the skills to take charge of their own RH choices and to contribute significantly to their families' communities' and nation's well-being.

As part of strategic efforts to reinvigorate FP and RH programs, USAID engaged C-Change to apply SBCC methodologies to the critical task of repositioning and re-launching FP as part of national health strategies. C-Change scaled up SBCC best practices in the **Democratic Republic of Congo (DRC)**, **Kenya**, and **Malawi**, and initiated an SBCC effort in **Albania** to change social norms for greater acceptance of modern contraceptive methods.

### RE-LAUNCHING FAMILY PLANNING IN THE DEMOCRATIC REPUBLIC OF CONGO (DRC)

From mid-2009 through July 2012, C-Change conducted SBCC activities to assist the Government of the DRC to reposition FP as a high priority in its national health strategy. C-Change worked with the DRC Ministry of Health providing TA to the *Programme National de Santé de la Reproduction* (PNSR) and the *Programme National de Communication pour la Promotion de la Santé* (PNCPS) staff to develop their skills in SBCC to promote FP.

C-Change's focus on advocacy fostered increased attention and action on FP and targeted influential decision-makers in the government and donor agencies. C-Change worked closely with the *Programme National de Santé des Adolescents* (PNSA) to conduct a research study on attitudes surrounding FP, the use of FP health services, and the use of modern contraceptive methods (MCM). C-Change provided technical support to PNSR to develop a national FP campaign. C-Change drafted a national SBCC strategy for FP in partnership with PNSR, PNCPS, PNSA, and several NGOs.

**Launch of renewed focus on family planning.** In December 2009, C-Change supported a two-day meeting to expand FP/RH and launch cross-sectoral efforts by government, donor agencies, and civil society to elevate programming and policy and increase resources. The meeting brought together more than 150 government leaders (including the First Lady Mme. Marie Olive Lembe Kabila), donors, UN agencies, FP experts, and NGOs to advocate for renewed programs and address the decline in use of modern contraceptives—less than 7% in 2007 (DHS 2007) compared to 16% in 1990.

A second FP advocacy conference was held in June 2012 in collaboration with the Bill and Melinda Gates Foundation, Tulane University and the World Bank and over 130 attendees advocated for improving governance and strengthening leadership to implement FP, strengthening operations to achieve measurable results, disseminating information on FP benefits and services, and funding to ensure universal access to FP. The conference concluded with a call for the MOH to move forward on establishing a budget

line item for this critical area. Two C-Change-supported committees grew out of this event to follow up on the recommendations made during the meeting: the *Comité Technique Multisectoriel Permanent* (CTMP) and the Policy and Advocacy Committee. C-Change partnered with Tulane University to create an FP website for the DRC ([www.familyplanning-drc.net](http://www.familyplanning-drc.net)) that shared ideas, experiences and products on FP.

**Advocacy and policies.** C-Change supported the PNSR, which advocated for a revision to remove taxes on FP supplies and successfully led the inclusion of a specific FP line item in the MOH budget. C-Change collaborated with the PNSR to develop a FP SBCC National Strategic Plan and an annual Family Planning Operational Plan. As part of this intervention, C-Change partnered with UNFPA to design data collection tools, which focused on collecting provincial data from donors and implementing partners through a series of one-day meetings in each province. C-Change also worked with UNFPA to create a mapping tool to assess the adequacy of existing materials and the need for new materials to fit the new SBCC strategy.

**Training workshops.** C-Change trained 3,000 *relais communautaire* (community health workers) in East Kasai, West Kasai, and Katanga provinces to use the C-Change developed *Family Planning Dialogue Guide* ([www.c-hubonline.org/resources/family-planning-dialogue-guide-community-health-volunteers-drc](http://www.c-hubonline.org/resources/family-planning-dialogue-guide-community-health-volunteers-drc)), a health workers' guide for use during home visits and group discussions. The guide covers topics such as the importance of spacing pregnancies for the health of mothers and children, the importance of visiting health clinics for FP/RH counseling and antenatal care, and the use and benefits of modern contraceptives. C-Change printed and helped to distribute 1,000 copies of the *Dialogue Guide* for community health workers.

**Working with the media.** C-Change carried out an FP capacity building workshop for 32 journalists in the DRC and established a journalists' FP Club. C-Change worked with partner Search for Common Ground (SFCG) to create eight episodes of a radio series *Mopila* on the daily experiences in the life of a taxi driver, and four episodes of a television program *L'Equipe* ([www.c-hubonline.org/resources/l'equipe-team-drc](http://www.c-hubonline.org/resources/l'equipe-team-drc)) about a women's soccer team. Both programs developed and promoted FP messages as part of their storylines, which integrated health messaging into these entertainment shows. The programs were broadcast nationwide in several local languages, with a particular focus on languages of Kasai Occidental, Kasai Oriental, South Kivu and Katanga provinces.



First Lady Mme Kabila presents at FP conference in December 2009



*L'Equipe* is a TV show about a women's soccer team that incorporates health messages.

## RESULTS AND LESSONS LEARNED

Through its advocacy work, C-Change has contributed to re-launching FP by elevating FP on the agenda of the government of DRC as well as that of local and international NGOs.

The work of C-Change has facilitated the establishment and institutionalization of a coordinating and decision-making structure, the CTMP. The CTMP consists of all major actors working in FP and convenes every few months with the active participation of the Ministers of Health, of Gender, and of Planning. C-Change is also providing technical leadership to the CTMP's Technical Communication Group, which supports the PNSR.

The high fertility rate of women in the DRC (average of 6.5 children) in a context of strong pronatalist sentiments puts advocacy at the heart of all activities related to the promotion of FP. The PNSR must be strengthened and its capacity improved to lead and coordinate FP activities.

The great challenge in the DRC lies in the very limited supply of services in the face of high unmet need in FP. A recent donor-funded study (USAID, UNFPA, and the Bill & Melinda Gates Foundation) showed that current service offerings are quite weak, both in terms of number of service facilities and offerings, as well as their quality.

*C-Change continues work in DRC through an Associate Award that began August 1, 2012 and ends July 31, 2015.*

## RE-LAUNCHING FAMILY PLANNING IN KENYA

C-Change conducted SBCC activities to reposition FP/RH in Kenya from October 2008 to January 2011. It supported the government's rollout of its National Reproductive Health Communication Strategy and ensured coordinated SBCC in reproductive health programming throughout the country at the district, regional, and national levels. C-Change worked with more than 1,000 national, regional, district, and local leaders, decision-makers, and implementers in Kenya.

**High-level advocacy.** C-Change worked with the National Coordinating Agency for Population and Development (NCAPD) and the Division of Reproductive Health (DRH) in Kenya to design advocacy approaches for FP/RH on multiple levels.

In April 2010, the Government of Kenya launched its national reproductive health strategy and guideline documents at the high-level National Leaders' Population Conference attended by more than 1,000 national and international leaders, to discuss FP/RH issues and their importance to the economic and social health of Kenya. The meeting marked Kenya's national recommitment to FP efforts. USAID, WHO, GTZ, and Liverpool VCT provided support. C-Change coordinated media outreach for the meeting, including a series of live national television programs where health ministry experts were interviewed, and assisted in designing technical presentations and managing partner coordination. In addition, C-Change created materials for district-level leaders on FP/RH and its implications for other development outcomes, and conducted more than 25 advocacy and strategy development meetings with these leaders to develop action plans.

**Implementation guide for RH strategy.** C-Change worked closely with the Government of Kenya to develop the *Reproductive Health Communication Strategy Implementation Guide* ([www.c-hubonline.org/resources/reproductive-health-communication-strategy-implementation-guide-2010-2012](http://www.c-hubonline.org/resources/reproductive-health-communication-strategy-implementation-guide-2010-2012)) to operationalize the National RH Communication Strategy. A major component included a detailed mapping of implementing partners' work that was captured during several stakeholder meetings. The guide assisted implementers in rolling out the communication strategy at national, regional, and district levels and ensured FP/RH programs are supported by coordinated SBCC.

**Mass media intervention.** C-Change also collaborated with the DRH to produce media materials for the 2010-2011 *Plan for Yourself a Good Life* ([www.c-hubonline.org/resources/plan-yourself-good-life-fprh-health-campaign-kenya](http://www.c-hubonline.org/resources/plan-yourself-good-life-fprh-health-campaign-kenya)), a six-month campaign that targeted peri-urban and rural men and women aged 25–35 in areas with low contraceptive prevalence rates, including Kenya's Eastern, Central, Western, Northeastern, and Coast provinces. Materials for radio, print, and billboards in Kiswahili and local languages promoted informed choice on use of modern contraceptives and child spacing. Campaign objectives included an increase in the number of couples visiting health facilities for information on modern FP methods, an increase in the uptake of FP services, and an increased understanding of the safety and reliability of MCM among men and women.

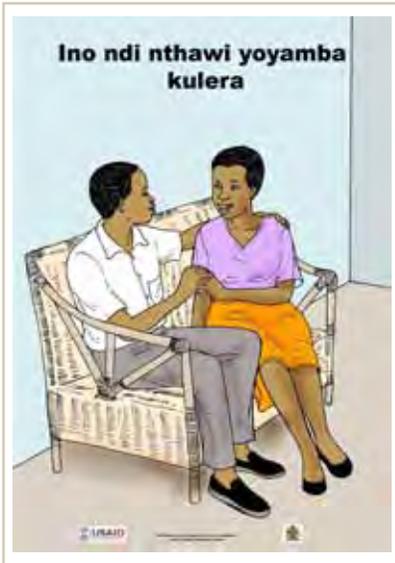
A total of 84 radio spots, 17 presenter mentions and three interviews were aired through four radio stations through January 2011. Ministry of Public Health and Sanitation (MOPHS)/DRH Reproductive Health experts participated as key resource persons during the listener call-in shows. C-Change printed and distributed 6,000 FP posters ([www.c-hubonline.org/resources/plan-yourself-good-life-fprh-health-campaign-kenya](http://www.c-hubonline.org/resources/plan-yourself-good-life-fprh-health-campaign-kenya)) promoting child spacing and encouraging clients to visit health facilities for advice on use of FP methods. C-Change also developed a “minimum package for post-partum care” as a quick reference manual to guide health care service providers on the services the newborn baby and the mother should receive within specified periods.

## LESSONS LEARNED

The Kenya program began as an implementation of an SBCC program. When USAID shifted the emphasis mid-stream, C-Change readjusted and played a coordinating and capacity strengthening role. C-Change conducted advocacy at the national,



Poster for the *Plan for Yourself a Good Life* FP campaign, [www.c-hubonline.org/resources/plan-yourself-good-life-fprh-health-campaign-kenya](http://www.c-hubonline.org/resources/plan-yourself-good-life-fprh-health-campaign-kenya)



Revised IPC materials for FP, available at [www.c-hubonline.org/resources/guidelines-family-planning-communication-malawi](http://www.c-hubonline.org/resources/guidelines-family-planning-communication-malawi)

“C-Change staff has taught us the process of developing Guidelines for Family Planning communication, capacity building on social behavior change communication and rolling out of the Guidelines at all levels i.e., zonal and district.”

“It was good to introduce new concepts in communication; SBCC especially on Family Planning remains a big gap and needs more such projects.”

“It was good to see traditional authorities (Chiefs) working together with other people because this encouraged sense of ownership.”

—HEU staff comments

regional, and district levels as a critical first step in the process to refocus FP efforts in Kenya. Advocacy at each of these levels created the important enabling environment for men and women at the household level such that the subsequent mass media campaign could be as effective as possible.

## RE-LAUNCHING FAMILY PLANNING IN MALAWI

From April 2010 to August 2011, C-Change worked with the Government of Malawi’s MOH Health Education Unit (HEU) to increase demand for and uptake of FP/RH services nationwide. Strategies included institutionalizing a systematic planning process for FP/RH communication, developing FP communication guidelines and rolling them out to districts, and building government and local NGO staff capacity in SBCC.

C-Change worked with the MOH’s HEU to set up the Task Force on Family Planning Communication, which brought together all key stakeholders, thus ensuring consistency of messages, a synergy of approaches, and effective use of all financial and technical resources. Two working groups were formed—one to oversee the development of the Government of Malawi’s *Guidelines for Family Planning Communication* ([www.c-hubonline.org/resources/guidelines-family-planning-communication-malawi](http://www.c-hubonline.org/resources/guidelines-family-planning-communication-malawi)), and the other to review existing FP communication materials to support development of the guidelines.

The HEU led a participatory process with technical support from C-Change to develop the *Guidelines*. This key document is based on formative research regarding perceived benefits and barriers to improved practices in FP and provides the framework for improved programming in Malawi. It also supports the major objectives of the Government of Malawi’s National Reproductive Health Strategy, which are to promote safe FP/RH practices by men, women, and young people through informed choice and to increase the use of high-quality, accessible FP/RH services. C-Change assisted the HEU with rollout of the *Guidelines* in districts throughout Malawi.

## RESULTS AND LESSONS LEARNED

The FP Communication Materials Working Group, comprised of eight national and international organizations, reviewed and adapted more than 18 FP materials (method choice, a man’s responsibility in planning the family, decisions for a couple around family size, using condoms, access to accurate FP information, etc). Revised materials were printed and sent to the districts for further distribution to beneficiaries.

During rollout of the *Guidelines*, C-Change carried out SBCC training, using the C-Modules, for 250 MOH and NGO staff to increase their skills for implementing SBCC

programming related to FP practices. The Malawi experience serves as a model for operationalizing national strategies at district and local levels that can be implemented elsewhere.

National government buy-in was critical to the sustainability of national communication guidelines and major health initiatives. C-Change obtained this buy-in as a priority by immediately engaging with the MOH, collaborating with a wide range of stakeholders and actively seeking their input to build trust, and establishing the Taskforce on FP Communication. Institutionalizing a planning process for the MOH, including modeling an annual work plan process and guiding its implementation, was also important to the success of this process.

## LAUNCHING FAMILY PLANNING IN ALBANIA

USAID sought C-Change assistance in supporting the Government of Albania to change social norms for greater acceptance and use of MCMs. From 2008 to 2011, C-Change conducted SBCC activities to facilitate changing social norms in Albania. In 2008, the use of modern contraceptives in Albania was among the lowest in Europe. People relied heavily on traditional FP, such as withdrawal (51%), and it is widely believed that low FP use has resulted in high abortion rates. Use of MCMs had increased from around eight percent in 2002 to only 15 percent in 2008 (DHS 2002; PRO Shëndetit 2005; DHS 2009).

Objectives of the Albania activity, which was the only FP/RH program that C-Change implemented directly with a population, were to:

- Increase awareness of the FP products available in the private and public sectors, counter misconceptions, and improve informed choice for contraceptives;
- Increase use of MCMs and decrease reliance on withdrawal and other traditional approaches to FP; and
- Create a positive environment for the discussion, choice, and use of MCMs among young men and women in Albania.

Albania's MOH, the Social Sciences Department of the University of Tirana, and international and local NGOs interested in FP were partners in this effort. The project targeted urban, educated young adults, ages 18–35 years, in the cities of Tirana, Durres, Vlora, Elbazan, and Korca.

C-Change's major strategies included long-term mass media campaigns, community-based approaches that included interventions with pharmacists and peer education for university students, training of journalists to enable accurate and knowledgeable reporting about FP, and creation of a Center of Excellence (CoE) in SBCC at the University of Tirana.

**Mass media campaigns at national level.** Two mass media campaigns were launched. The first campaign promoted the theme "Enjoy life, enjoy love. Use modern contraceptives... for happy moments" and was aimed at 18- to 35-year-old females and males in urban areas, particularly university students. The theme was featured on a 40-second TV spot, three radio spots, and print materials (a poster, newspaper ad, and an outdoor billboard). Messages promoted the safety and reliability of modern contraceptives and corrected common misperceptions that came to light in the baseline survey. The second mass media campaign had the theme, "Happy Life," emphasizing the benefits of MCMs and



Enjoy Life, Enjoy Love Media Campaign,  
[www.c-hubonline.org/resources/happy-moments](http://www.c-hubonline.org/resources/happy-moments)

countering misconceptions about side effects. The project sponsored several music concerts that promoted the use of MCMs and attracted two to three thousand students in Tirana, Durres, and Vlora.

**Peer education with university students.** C-Change developed a peer education program for university students by adapting existing peer counseling manuals from similar programs from other countries and also developed supporting FP/SBCC materials. C-Change trained 1095 peer educators as master trainers, who in turn worked with students and helped clarify concerns about the use of MCMs. A total of 29,862 students (21,671 females and 8,191 males) from the cities of Tirana, Vlora, Elbazan, Korca benefitted from this intervention.

#### **Interpersonal communication for pharmacists and pharmacy staff.**

Pharmacies are the main source of modern contraceptives for urban consumers in Albania. To reach these clients, C-Change identified about 120 pharmacies selling contraceptives in Tirana and about 30 each in Elbasan, Vlora, Korca, and Durres. The project conducted a “scientific meeting” to improve pharmacists’ knowledge and attitudes about the different methods, improve their effectiveness in counseling, and enhance the purchasing environment for consumers interested in using hormonal contraceptives. Pharmacies also received training in one-on-one counseling sessions, which included tools and support materials to assist them to guide and counsel their clients.

**Journalists.** The C-Change Albania Multimedia Initiative trained a dozen journalists from Albanian newspaper, radio, and television on facts about MCMs, explained current data on sexual behaviors and beliefs in Albania, and supplied links to a variety of websites where they could obtain a global perspective on contraceptive usage. The third year of the project focused on scaling up work with both previously trained journalists as well as a new cohort of about ten journalists. Project-sponsored activities included education-entertainment events, round tables, debates, and interviews.

## **RESULTS AND LESSONS LEARNED**

Following the second mass media campaign, evaluation findings showed that exposure to FP messages was strongly associated with increase in knowledge about MCMs (90% of women at endline were able to spontaneously name three or more MCM compared to 21% at baseline); and the use of those methods (53% of women at endline reported use of MCM compared to 30% at baseline). Exposure was also associated with more positive attitudes towards joint decision

making or willingness to talk with sexual partners, parents, and health providers (52% of endline respondents reported discussing avoiding pregnancy with a sexual partner compared to 36% at baseline).

The C-Change Albania program used multiple channels to achieve its results; different channels are preferred by different audience segments, are complementary, and have different roles. The channels, which, in addition to mass media, included one-to-one counseling, peer education, discussions among small groups of homogeneous people, and home visits by trained personnel, reinforced one another. This approach also increased the numbers of trained people, “doers” or “adopters,” who became advocates or role models within the society, leading to desired social norm changes.

C-Change’s intervention is showing signs of positive social norm changes in Albania on the use of MCM, but challenges remain that will require additional time and resources. Subsequent interventions will want to consider the following:

- How to encourage young consumers to increase uptake of modern contraception;
- How to involve media leaders to advocate for FP and modern contraception;
- How to involve the government so that reproductive health becomes a priority;
- How to change the mentality of the “long time” health professionals;
- How to motivate medical doctors to advocate for modern contraception; and
- How to reach rural populations.

## 2 SUPPORTING PMI WITH BEST PRACTICES IN SBCC

From 2008 through 2012, C-Change collaborated with the President’s Malaria Initiative (PMI) to engage missions, country-level malaria control programs, NGO partners, and the USAID-funded Malaria Communities Program (MCP) grantees to plan and make strategic use of SBCC to promote life-saving behaviors and provide innovative SBCC solutions to prevent and control malaria in Africa. C-Change implemented programs or provided TA in **DRC, Ethiopia, Ghana, Kenya, Liberia, Malawi, Mozambique, Nigeria, and São Tomé and Príncipe.**

Two major communication efforts by C-Change—development and launch of *The Strategic Framework for Malaria Communication at the Country Level* (a collaboration that included NMCPs and partners in **15 countries**) and the development of Essential Malaria Actions frameworks and guides in several countries—have codified the current state-of-the-art in malaria communication and harmonized malaria communication interventions, best practices, and technical support across communities, countries, and regions.

## STRATEGIC FRAMEWORK FOR MALARIA COMMUNICATION AT COUNTRY LEVEL

The *Strategic Framework for Malaria Communication at the Country Level* ([www.c-changeproject.org/resources/strategic-framework-malaria-communication-country-level](http://www.c-changeproject.org/resources/strategic-framework-malaria-communication-country-level)) is a product of more than 18 months of engagement with 15 NMCPs, 12 communication-oriented organizations, and the Roll Back Malaria Partnership Secretariat. Working collaboratively, C-Change organized and led three major international consultative meetings to examine the current state of the art in health communication for malaria prevention, harmonize regional and country-level malaria prevention communication programming, and chart a path for integrating current best practices into national malaria communication strategies.

These three consultations led to the creation of the first-ever global reference document for malaria communication. *The Strategic Framework* focuses on six challenges for malaria control, as stated in the *RBM Global Malaria Action Plan* (2008):

- Improve acceptance and use of long-lasting insecticide treated bednets (LLINs), particularly for children under five and pregnant women
- Accelerate access to and demand for intermittent preventive treatment in pregnancy (IPTp)
- Improve early treatment seeking and compliance with drug therapy, e.g., artemisinin-based combination therapy (ACTs)
- Increase acceptance of indoor residual spraying (IRS) as a tool for vector control
- Strengthen a culture of malaria prevention and treatment seeking behavior
- Mobilize political commitment and resources for malaria and for country-level communication efforts

The five-year time frame for the *Strategic Framework*, launched in August of 2012 with the participation of the Tanzanian Minister of Health, describes complementary processes needed to improve the contribution of communication to malaria control and mobilizes partners to take action. These processes include the following:

- Advocate for systems and programs that ensure communication is positioned appropriately within the global RBM Partnership;
- Ensure all national malaria control program communication strategies are context-appropriate, evidence based, and results driven;
- Foster capacity building in communication planning, management, and evaluation at the global, regional, national, and sub-national levels;
- Invest adequate resources to ensure communication interventions achieve measurable results at the country level;
- Expand the evidence demonstrating the impact of communication interventions on social and behavioral change and thus contribute to the reduction of the burden of malaria.

(See **RESULTS—Strategic Framework and EMAs** below.)

## ESSENTIAL MALARIA ACTIONS IN ETHIOPIA, KENYA AND DRC

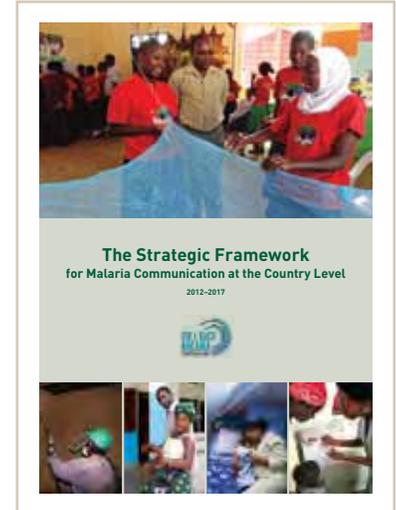
The second C-Change-led effort was the development of Essential Malaria Actions (EMA), which sought to shift the discourse on malaria control away from reliance on awareness raising interventions to action-oriented messages that promote practices that are easy for people to adopt and carry out. Based on lessons learned from developing the EMAs in Ethiopia, C-Change gained unprecedented political commitment in Kenya and the DRC, not only to support the development of EMAs, but also to integrate EMAs into malaria control policy to be followed by both public and private sector marketing agencies and communication organizations involved in malaria prevention and control.

To develop these EMAs, C-Change engaged district health managers and in-country NGO partners in designing, testing and implementing malaria SBCC activities at the national, regional and community level. In DRC and Kenya, C-Change led a series of workshops to define the desired action, field test the messages and ensure widespread integration of the EMAs into existing and future SBCC interventions by partners, community health workers and health promotion officers. The guides are unique, as they ensure harmonization of communication approaches and promote essential malaria actions that fall into four categories: use of LLINs, malaria case management, indoor residual spraying, and prevention of malaria during pregnancy.

### RESULTS—STRATEGIC FRAMEWORK AND EMAS

Development of the *Strategic Framework for Malaria Communication at the Country Level* and the EMAs served as significant project accomplishments by establishing the first-ever international standards for malaria communication interventions and spearheaded the revival of harmonized, action-oriented messaging in country communication programs.

On the TA and capacity building side, C-Change undertook more than 22 missions to train more than 235 people in SBCC design and evaluation protocols. C-Change worked with MOHs/NMCPs in nine countries (DRC, Ethiopia, Ghana, Kenya, Liberia, Malawi, Mozambique, Nigeria, and São Tomé and Príncipe) to assess and design or modernize their national communication strategies, and contributed to the development of robust communication components for Kenya's and Nigeria's successful Global Fund country applications. C-Change's accomplishments, achieved with relatively modest funding, represent significant value for money as new international standards in malaria communication were established, NMCP communication policies and strategies were updated to reflect changing state of the art in health communications, and a new cadre of trained communication professionals was equipped with the skills and knowledge necessary to develop, implement and evaluate communication interventions.



*Strategic Framework for Malaria Communication at the Country Level*, [www.c-hubonline.org/resources/strategic-framework-malaria-communication-country-level-2012-2017](http://www.c-hubonline.org/resources/strategic-framework-malaria-communication-country-level-2012-2017)



EMA Message Tool—Ethiopia, [www.c-hubonline.org/resources/essential-malaria-actions-ethiopian-families](http://www.c-hubonline.org/resources/essential-malaria-actions-ethiopian-families)

## MALARIA PREVENTION AT COUNTRY LEVEL

Following are descriptions and results of C-Change's implementation of malaria prevention activities in DRC, Kenya, Mozambique, and Nigeria.

**DRC Country Program.** In DRC, C-Change provided expert counsel for development and implementation of a national SBCC strategy for the DRC's National Malaria Control Program (PNLP) and working groups at the national and provincial levels and supported the development of integrated work plans and cross-partner collaboration in East Kasai, West Kasai, South Kivu, and Katanga provinces. Communication materials on malaria prevention and control were revised with C-Change's assistance to ensure that they were consistent with the national policy and current best practices. Background papers and frequently asked questions were drafted to support high-level political commitment and accurate, timely coverage of malaria projects and activities.

### RESULTS

C-Change conducted six SBCC training workshops and trained 27 provincial-based health and communication staff in SBCC using the C-Modules. These trainings sought to build the capacity of provincial-based staff in malaria communication in advance of a ramp up of PMI-funded bednet and IPTp distributions in these provinces scheduled for 2013. C-Change developed, printed and distributed more than 12,000 EMA-based job aids, flip-charts and other low literacy materials and worked with the provincial health officers in East and West Kasai, Katanga, and South Kivu to develop four provincial-specific malaria communication strategies and work plans.

**Mozambique Country Program.** In post-conflict Mozambique, government services are not yet able to fully address the health needs of all citizens, especially the prevention and treatment of malaria and water-borne diseases. Faith-based organizations throughout Mozambique representing all major faiths were interested in working with C-Change to fill this gap by creating a network to leverage their social status and geographic reach to engage their communities about malaria prevention and control. Working in collaboration with the MOH, and PMI-Mozambique, C-Change helped to transform this faith-based network into a self-supportive NGO—Programa Inter-Religious Contra a Malaria (PIRCOM).

C-Change developed a mentoring relationship with PIRCOM where C-Change and PIRCOM staff worked side-by-side to develop the organizational, managerial, implementation and technical expertise of PIRCOM with the ultimate goal of creating a self-sustaining indigenous NGO.

### RESULTS

The project trained 867 participants in at least three of the six C-Modules, which was an important step toward strengthening the SBCC capacity in Mozambique.

Furthermore, C-Change's intervention led to positive changes in malaria prevention behaviors as evidenced by the changes between the baseline and the endline studies. For example, women of reproductive age who sought treatment for their children under five with fever, increased from 57% at baseline to 78% at endline; and the proportion of respondents who believed fellow community members were seeking treatment for malaria at a health facility increased from 80% to 89%.

Over the course of two years, C-Change built PRICOM into an effective SBCC-centered organization working in four high malaria-prevalence provinces (Zambezia, Nampula, Sofala, and Inhambane) to improve the skills of provincial, district, and community faith-based staff to implement effective SBCC programs for malaria prevention and treatment.

**Nigeria Country Program.** Nigeria has experienced a large drop-out rate in the number of pregnant women seeking IPTp. In the Cross River and Bauchi states, C-Change conducted a qualitative study of behavioral barriers and social determinants that can influence women’s decisions to seek IPTp services. The findings detailed the knowledge, practices, and behaviors of the population and the implications these factors have on the targeted audiences and their social support networks.

## RESULTS

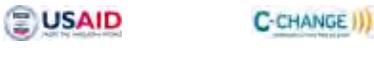
Results from the qualitative study indicated that providers are often reluctant to use job aids, like a patient brochure, for fear of appearing to lack knowledge on IPTp. The study showed, however, that a patient brochure used for counseling and given to the pregnant woman to take home had great receptivity among focus group discussants. Discussants even recommended revisions to the brochure to clarify the pictorial instructions regarding how/why the woman should take IPTp and when she should return for her next dose.

Another finding was that women’s trust of providers affects their willingness to take unfamiliar medicines. Lack of both provider training on IPC and provision of services in a respectful manner was repeatedly mentioned as a barrier to the likelihood that women comply with their instructions to take medicines, especially if they find the side effects unpleasant.

An important conclusion of the FGDs was the realization that community-level activities to reduce barriers or to reinforce existing beliefs and behaviors that facilitate appropriate prevention and management of malaria in pregnancy must target not only pregnant women but also their husbands, families, and influential community members. Though FGD participants indicated they had received information about malaria during ANC visits and from community health workers, they also had some misconceptions about causes, signs and symptoms and particularly the risks of malaria in pregnancy. Husbands play an important role in deciding whether their wives access health care, but FGD participants in Cross River expressed a willingness to counter their husband’s wishes if necessary to benefit the health of their baby. Women and men suggested that husbands are more supportive of their wives’ health care when it protects the fetus. CHWs are a trusted source of information and are underutilized as promoters of IPTp and prompt use of ACTs for malaria during pregnancy. Results from the study will be published in a forthcoming journal article.

The Nigerian NMCP has begun work with partners to amend the national communication strategy to address the results of the survey.

**Kenya Country Program.** In addition to implementing the EMAs (described above), C-Change also strengthened Kenya’s community malaria SBCC programs through the awarding of 18-month sub-grants and provision of TA to three NGOs—PATH, Merlin, and World Vision—to design, develop, implement and evaluate community SBCC malaria control interventions in 12 endemic and epidemic-prone districts in Nyanza and Western provinces.



*success story*

**C-Change and PMI assist communities in efforts to prevent malaria**

**Challenge**  
 Myths and misconceptions about the causes of malaria kept pregnant women from seeking malaria treatment in western Kenya. And many women doubted that community health workers (CHWs) and health clinics could help them to prevent malaria.

One such doubter was Selina Auma Opiyo, a mother from Khamulaya village. "I would ask for medicine from the neighbors and administer it blindly, not really knowing what I was doing," explains Opiyo, sitting in the one-room, mud-walled house she shares with her husband and three children. She gratefully points to Regina Ombira, the CHW who encouraged her to visit the health facility.

Ombira recalled how difficult that task was—a challenge that many CHWs face. "Selina was absolutely anything. It was more than not liking hospitals; she was influenced by traditional beliefs that say revealing a pregnancy early on [by visiting an external clinic] would expose her and her fetus to witchcraft. Such as the myths doing the rounds here," Ombira says. "I found her seven months pregnant and not having visited a health facility once. She did not want to see me at first, let alone listen, but I was able to convince her," she adds.

**Response**  
 C-Change, with funding from the U.S. President's Malaria Initiative (PMI), has provided the curriculum and training in social and behavior change communication (SBCC) to district-based NGO staff charged with implementing activities to combat malaria in the western part of Kenya. In turn, these NGOs trained villagers to serve as community health workers (CHWs) to work in health facilities and educate people about malaria.

"The CHWs' assistance has been immense," says Nursing Officer Hilda Wairui at the Bulungu Dispensary in Bunyala District. "Since the CHWs came, they have helped combat the many myths and misconceptions about malaria prevention that kept some pregnant women from seeking malaria treatment."

Opiyo now recognizes the symptoms of malaria. "When my child develops fever, loses appetite, throws up, looks lethargic, complains of headache and develops a running stomach, I know I must rush them to hospital because malaria is a killer," she says.

She notes, however, that her family does not go to hospital as frequently as before because they now sleep under long-lasting insecticide-treated nets (LLINs). They also know that they can take actions to prevent malaria based on the information that C-Change has provided.

CHW communication training is complemented with radio spots that spread information about malaria



Selina Auma Opiyo, a mother who benefited from the C-Change malaria program

Kenya Malaria and SBCC Success Story,  
[www.c-changeproject.org/resources/success-story-c-change-and-pmi-assist-communities-efforts-prevent-malaria](http://www.c-changeproject.org/resources/success-story-c-change-and-pmi-assist-communities-efforts-prevent-malaria)

## RESULTS

C-Change's support to the three NGOs enabled them to build the capacity of CHW to be "behavior change agents" in their communities and implement integrated, community-level SBCC activities. Comprehensive community SBCC interventions led to increased use of LLINs and increased uptake of malaria treatment according to data from quantitative baseline and endline studies. For example, the proportion of pregnant women in Bunyala District who slept under an LLIN the previous night increased between September 2009 and September 2010 from 28% to 68%, and the proportion of children under 5 who slept under an LLIN increased from 60% to 85%. In Teso Region, the number of pregnant women obtaining IPTp doubled from 200 to nearly 400, and the number receiving IPTp increased from about 150 to 250.

## LESSONS LEARNED—PMI PORTFOLIO OVERALL

The four years of C-Change's PMI work created opportunities to leverage resources and apply lessons learned across countries and programs. C-Change's SBCC strategic guidance helped to enhance the capacity of NMCPs to develop and implement robust national malaria communication strategies. C-Change TA to capacity building and materials development helped local organizations and community health workers to more effectively communicate action-oriented messaging and programming to motivate targeted audiences to adopt and regularly practice malaria prevention behaviors.

C-Change's products—the *Strategic Framework for Malaria Communication* and the *Essential Malaria Actions* frameworks and guides—helped to codify SBCC best practices and establish standards for action-oriented programming and messaging. The guides were practical in approach and designed to be easily adapted to a country's specific communication needs while promoting proven SBCC methodologies. More importantly, these products were developed consensually by engaging multiple stakeholders, which facilitated their integration and adoption as key reference documents for malaria communication at national level while providing a roadmap for how to engage for future collaborative efforts.

## 3 DEVELOPING SBCC TOOLKITS AND METHODS FOR NATIONAL, REGIONAL, AND GLOBAL APPLICATION

C-Change forged a path to meet the challenges of materials and tools development to facilitate social and behavior change. The project engaged participatory approaches in working with low literacy audiences in development of the **Community Conversation Toolkit for HIV Prevention**. Additionally, C-Change promoted the importance of community ownership and the inclusion of gatekeepers, including religious and business leaders and the media in the development of the **Voluntary Medical Male Circumcision (VMMC) Communication Toolkit** and media campaign in Kenya. The project incorporated the **Action Media Methodology** to inform its work on HIV prevention with key affected populations and populations with low literacy. C-Change led development of the **Gender Scales Compendium** in partnership with other USAID partners as a tool to assess gender attitudes and beliefs and evaluate program interventions. C-Change also led development of USAID's **Facts for Family Planning** booklet.

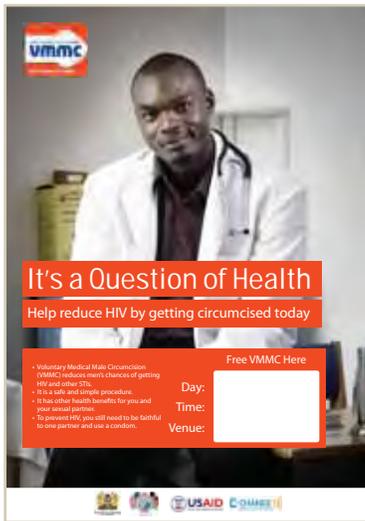
### VOLUNTARY MEDICAL MALE CIRCUMCISION COMMUNICATION TOOLKIT IN KENYA

Findings from randomized control trials in Kenya, Uganda, and South Africa indicated that voluntary medical male circumcision (VMMC) provides up to 60 percent protection for men against heterosexually-acquired HIV infections. These findings influenced the GOK to take the lead in rolling out VMMC services, based on technical guidance from UNAIDS and the WHO. The National Male Circumcision (MC) Task Force was set up under the MOPHS in 2007.

From 2009–2011, C-Change supported the rollout of the GOK's VMMC program in Nyanza Province and other provinces as part of a comprehensive HIV prevention strategy. This activity developed innovative communication materials, tools, and guiding documents on VMMC that emphasize its benefits and safe healing, and reinforce that, although VMMC reduces risk for men, it does not completely prevent HIV transmission and must be combined with other prevention behaviors, especially the use of condoms.

A key outcome of this effort was the development of the *VMMC Communication Guide* ([www.c-changeproject.org/resources/vmmc-communication-toolkit-kenya](http://www.c-changeproject.org/resources/vmmc-communication-toolkit-kenya)) for Nyanza Province that operationalized the National Male Circumcision (MC) Communication Strategy, and the *Voluntary Medical Male Circumcision Communication Toolkit* ([www.c-hubonline.org/resources/voluntary-medical-male-circumcision-vmmc-communication-toolkit-kenya-english](http://www.c-hubonline.org/resources/voluntary-medical-male-circumcision-vmmc-communication-toolkit-kenya-english)), a set of advocacy and educational materials in print and audio formats that support the strategy. The strategy was developed to raise awareness of VMMC, identify barriers to uptake of VMMC services, counter perceptions that circumcised men and their sexual partners are fully protected from HIV, and address the risk behaviors that may follow from this mistaken belief.

C-Change worked with the communication sub-committees of the National MC Task Force and the Nyanza Provincial MC Task Force to hold consultations and planning meetings with stakeholders, including the communication managers and directors of four VMMC implementing partners—Catholic Medical Missions Board, Family AIDS Care and Education Services, Impact Research and Development Organization, and



VMMC Toolkit poster, available at [www.c-hubonline.org/resources/voluntary-medical-male-circumcision-vmmc-communication-toolkit-kenya-english](http://www.c-hubonline.org/resources/voluntary-medical-male-circumcision-vmmc-communication-toolkit-kenya-english)

“The VMMC Communication Toolkit set the trend and pace for other countries [and] significantly contributed to the increased demand for VMMC, especially among unreached adult males and their partners.... Implementing partners have taken it upon themselves to print the materials. What excites me is the C-Change adaptation guide... a resource [to] scale up implementation in other regions and outside Kenya.”

—Isaac Oguma, Secretary  
Nyanza VMMC Task Force

Nyanza Reproductive Health Society. These stakeholders were trained to harmonize messages and use the toolkit and also took the lead in printing and using the materials in the toolkit. Materials reflect the recommendations of the Nyanza VMMC Communication Guide as well as feedback from extensive concept testing and pretesting with audience members: males ages 12–17 and 18–49, young boys and their parents, males in discordant sexual relationships with women, circumcised and uncircumcised men and their female partners, business owners, Luo elders, health providers, community mobilizers, and faith-based leaders. Interviews and discussions sought to determine their perceptions of the benefits of VMMC services, their views on other VMMC issues, and barriers to uptake. All materials were developed in English and the majority of materials were adapted into Kiswahili, Luo, Teso, and Turkana.

C-Change supported the development of a model strategic planning process and an overarching operational plan to coordinate VMMC communication that led to the incorporation of SBBC into the communication activities of the National MC Task Force, four provincial MC task forces, and four implementing partners. Materials in the VMMC Communication Toolkit are being used by the four implementing partners, who leveraged USAID’s investment in C-Change by using their own funds to print the materials.

## RESULTS AND LESSONS LEARNED

**Ownership of the rollout by the MOPHS and communities was key.** The MOPHS and partners owned the rollout process and its outcome, with support from gatekeepers and influential persons. Communities were involved in planning and implementing the process and were mobilized for VMMC services.

**VMMC task forces played a critical leadership role.** The task forces served as national and provincial champions for VMMC, with well-coordinated leadership and strong government support. The synergy contributed to effective VMMC programming.

**High-level advocacy and partnerships overcame resistance and opposition to VMMC.** The MOPHS and the National MC Task Force partnered with the media and political leaders to neutralize opposition to VMMC.

**Detailed implementation guidance was needed for the communication strategy.** The detailed implementation guide that C-Change developed for Nyanza was important to assist implementers with information on how to implement the government’s VMMC Communication Strategy. The guide’s systematic approach, based on a socio-ecological model, detailed in C-Module 0, guided the rollout of culturally appropriate and effective communication approaches and materials.

## COMMUNITY CONVERSATION TOOLKIT FOR HIV PREVENTION IN AFRICA

Developed during a two-year C-Change activity (October 2010–August 2012), the *Community Conversation Toolkit (CCT)*, available at [www.c-hubonline.org/resources/community-conversation-toolkit-hiv-prevention-english](http://www.c-hubonline.org/resources/community-conversation-toolkit-hiv-prevention-english), highlights key HIV epidemic drivers including concurrent partnerships, cross-generational sex, alcohol abuse, and gender-based violence. Tools in the kit include “throw-boxes” and buttons with proverbs and idioms in local languages, playing cards that pose prevention-related questions instead of passive messaging, and thematic picture codes for role plays with tips for discussion (concerning reasons, risks, rights, and responsibilities), as well as finger puppets.

All of these tools can be used to enable in-depth discussions on HIV-related topics. The community mobilizer’s guide helps identify key issues and challenges, outlines stakeholder consultation processes, and illustrates the steps to develop and implement action plans. Following concept testing, partner Soul City and their regional partners led the pre-testing and adaptation process in Malawi, Zambia and Zimbabwe with adults ages 20 and older.

An evaluation of the toolkit was carried out in Malawi and Zambia. Several groups participated in the evaluation, including bicycle taxi operators, Muslim women who are HIV positive, community leaders, and ex-sexual cleansers.

C-Change supported four partner organizations (Friends of AIDS Trust, Hope for Life, Contact Youth Trust Association, and Kuba Lusa) from the SAT network in Malawi and Zambia to carry out a series of dialogues using the CCT. Forty peer educators from the four partners were trained to facilitate the dialogues with 23 community groups. Each group met a minimum of four times. Both individual and group actions that resulted from the dialogues were recorded.

## RESULTS AND LESSONS LEARNED

The CCT has been adapted in seven countries (Lesotho, Swaziland, Malawi, Namibia, Nigeria, Zambia, and Zimbabwe) and was used by a total of 41 NGOs. Toolkit training was given to 224 partners and peer educators. C-Change directly supported over 80 dialogue sessions in Malawi and Zambia. The toolkit triggered dialogue and locally-driven actions around gender-based violence, access to services and HIV testing, multiple and concurrent sexual partnerships, couple dialogue, HIV discordancy and condom use, alcohol abuse and sexual risk taking, and harmful traditional practices (sexual cleansing).



Community Conversation Toolkit Case Study, showing components, [www.c-changeproject.org/sites/default/files/C-Change\\_CaseStudy\\_CCT.pdf](http://www.c-changeproject.org/sites/default/files/C-Change_CaseStudy_CCT.pdf)



Community Conversation Toolkit, available at [www.c-hubonline.org/resources/community-conversation-toolkit-hiv-prevention-english](http://www.c-hubonline.org/resources/community-conversation-toolkit-hiv-prevention-english)

“If I had this toolkit years ago, the chief would have discussed HIV with me and not thrown me out of his house.”

—NGO director, Malawi

“It brings the dialogue. It makes people start talking. I have observed tools like this are lacking in our communities.”

—Peer educator, Malawi

“The tools enhance the flow of discussion within a group; bring about full participation from the audience and give room for experience sharing.”

—NGO partner, Nigeria

An external evaluation of the toolkit focused on the outputs and outcomes of the implementation of the CCT in Zambia and Malawi. This focus included understanding how the dialogues improved HIV prevention knowledge, reduced risky sexual behaviors and relationship practices, changed attitudes related to HIV prevention, and led to activities related to HIV prevention at community level.

The CCT demonstrated that communication tools can generate individual, interpersonal, and social-change actions to address HIV risk in sexual relationships and the risk embedded in harmful traditional practices. The many positive lessons learned include:

- Participatory development and testing led to relevant and valued communication tools.
- The interactive, game-like approach promoted dialogue.
- The CCT is most effective with continual training in facilitation, observation, and note-taking.
- The established relationships between CBOs and community stakeholders fostered group actions and follow-up.
- Although dialogues and specific actions prompted are grounded in a given community and culture, the application of the CCT can be taken to scale in any country and community.
- Participants supported changes they discussed beyond the dialogues, and implementing organizations worked to secure funding for continued implementation.
- The evaluation validates the need for non-traditional communication approaches that spur home-grown solutions, focus on relationships, and foster critical group thinking.

### **ACTION MEDIA METHODOLOGY IN SOUTHERN AFRICA, JAMAICA AND THE BAHAMAS**

The Action Media Methodology emerged in the mid-1990s in South Africa as an alternative approach to top-down communication development processes typically led by practitioners from socio-economic and knowledge contexts far different from the communities they sought to reach. As a result, materials produced often did not resonate with their audiences. The Action Media methodology engages audience members through active participation in a series of workshops that explore communication needs, perspectives on communication products, and concepts that speak to members’ experiences and their social, cultural and economic environments. SBCC practitioners who use this methodology can gather rich qualitative data that inform strategies and interventions. C-Change used the methodology to address HIV prevention with low-literate audiences.

## RESULTS

In 2009, C-Change conducted Action Media workshops with a group of 20 low- and semi-literate adult participants (age 20–62) in Elandsdoorn, a rural community in the Limpopo Province of **South Africa** to explore issues related to HIV/AIDS and communication. From the workshops, C-Change developed a participatory Community Conversation Toolkit for HIV Prevention for audiences with lower literacy. It has been successfully adapted for use in seven countries: **Lesotho, Malawi, Namibia, Nigeria, Swaziland, Zambia, and Zimbabwe**. (See further information above in section on *Community Conversation Toolkit for Prevention in Africa*.)

In November 2010, C-Change hosted an Action Media workshop with HIV-affected populations in **Jamaica**—groups of 15 to 20 sex workers, men who have sex with men (MSM), and community educators and outreach workers. Findings—which were also shared with government, UN and donor stakeholders—informed materials development and effective harmonization of messages, resulting in the development of counseling cards, discussion and proverb cubes, a peer educator handbook and a services leaflet, cell phone screen savers and ring tones, as well as arm bands and carry bags.

Action Media workshops were also conducted in **The Bahamas** in September 2011 to inform communication for persons living with HIV (PLHIV), sex workers, and MSM. A briefing and a sharing of the findings by other countries that have key affected populations was held with 13 Bahamian stakeholders. Based on this participatory approach, mobile phone messaging, phone images and desktop screensavers, websites, and social networking resources such as Facebook and Twitter emerged as tools and formats that were used in The Bahamas in programs developed for key affected population.

## GENDER SCALES COMPENDIUM

Gender has been posited as a gateway factor to behaviors that affect health outcomes and health status. While gender norms and power dynamics between men and women have been studied in the context of HIV and gender-based violence, less is known about their role in contraceptive use and their influence on reproductive health behaviors. C-Change has been exploring the impact of gender on FP and the validity of current gender scales in predicting contraceptive use.

A scale is a numerical score aggregating multiple indicators believed to reflect an underlying concept. Because there is no single “gold standard” for measuring gender norms, gender attitudes, women’s empowerment,



Role play during Action Media workshop with lower literacy participants in South Africa



*Gender Scales Compendium,*  
[www.c-changeproject.org/content/gender-scales-compendium/](http://www.c-changeproject.org/content/gender-scales-compendium/)

and other aspects of gender, researchers often use multiple measures. Using a single measure is not possible because gender operates in multiple spheres and has many facets. When a single measure is preferred, a scale combining several items creates a more valid measure than any single scale item used alone.

In March 2010, C-Change convened a working group of researchers with expert knowledge of gender scales to review those scales in current use. The participants identified scales that measure adherence to gender norms and reviewed how they have been used to measure the success of interventions in changing these norms.

The working group supported the creation of an online compendium of gender scales. They saw the value of making it easily accessible by health and development practitioners who may want to use these tools to assess gender-related attitudes and beliefs and evaluate their interventions. Scales selected for the compendium have all been tested for their ability to measure gender attitudes and predict behaviors of interest, such as gender-based violence and partner reduction. The scales include those developed by working group participants as well as other scales they identified.

The compendium is not exhaustive. It does not encompass all scales appropriate for studying gender and health outcomes, and it does not identify which scale is best for a specific study or evaluation. The gender scales included are the Couple Communication on Sex Scale, Women's Empowerment Scale, Gender Beliefs Scale, Gender Equitable Men (GEM) Scale, Gender Norm Attitudes Scale, Gender Relations Scale, Household Decision-Making Scale, and the Sexual Relationship Power Scale (SRPS).

Each gender scale in this compendium includes the following information, where applicable:

- Scale objective: The purpose of the scale
- Type(s) of behavior or outcomes predicted: Behaviors or outcomes the scale aims to predict (such as gender-based violence)
- Types of items the scale includes: Domains for the items in the scale
- Number of items and subscales: Number of items in the scale and number of subscales, if any
- Scoring procedures: Procedures followed for scoring response options to scale items

- Psychometrics used: Types of statistical approaches used to construct the items in the scale, such as internal consistency (the extent to which items in a scale are correlated with one another or measure the same thing) and factor analysis (a method that reduces a large number of variables or factor to a smaller number of most important factors.)
- Type(s) of statistics used to test predictive validity: Which statistics, if any, are used to test how well the scale predicts the behavior it aims to predict
- Used with women / used with men: Whether the scale has been used with one or both genders
- Country/countries where tested or applied: Locations where the scale was tested or adapted
- Lessons learned: Describes lessons learned, particularly for program implementers, on the application of the scale.
- Additional information: Relevant information not otherwise covered, including definitions and more information on the construction of the scale

*Source:* Citations on the development of the scale and/or its adaptation or modification

## RESULTS

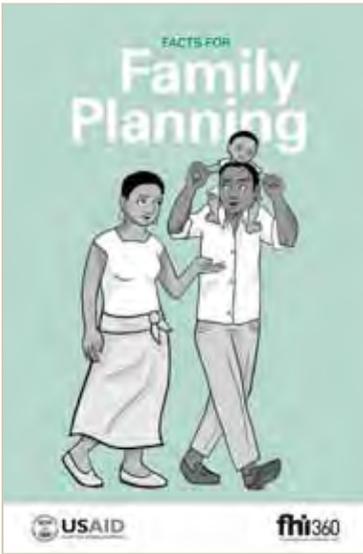
The *Gender Scales Compendium* (GSC) was specifically designed for web access on the C-Change website. The GSC includes a home page and eight subpages (for each of the eight unique scales). Web statistics indicate that the GSC or one of its eight scales was accessed 17,262 times since going online in late 2010. To promote the GSC, C-Change Knowledge Management sent out information and updates several times per year via the Project's e-newsletters. A dissemination postcard describing the Compendium with the URL was distributed at USAID and other relevant local and international events and meetings.

## FACTS FOR FAMILY PLANNING

From 2009–2012, USAID's Office of Population and Reproductive Health commissioned C-Change to research and produce *Facts for Family Planning* to present the rationale for FP and RH and provide a comprehensive collection of evidence-based key facts and supporting information written in an accessible style. Although it was initially envisioned as being similar to early versions of UNICEF's *Facts for Life*—a simple, successful book that aided consistent communication on child survival—it eventually took on a broader mandate and became more detailed.

The publication was developed by C-Change and reviewed by a wide variety of stakeholders—the WHO, Georgetown University/Institute for Reproductive Health, Population Council, and the Population Reference Bureau (PRB)—as well as experts in the field of FP, including Amy Tsui of Johns Hopkins University, Jane Bertrand of Tulane University, Rhonda Smith of PRB, and independent consultants Elaine Murphy and Ward Rinehart. Illustrations and diagrams were designed and tailored to the text.

The final publication provides key information for those who communicate about voluntary FP and RH in developing country settings, and is intended to help in developing materials and messages about FP. Principal audiences for the publication include:



*Facts for Family Planning*,  
[www.fphandbook.org/sites/default/files/familyplanning\\_web.pdf](http://www.fphandbook.org/sites/default/files/familyplanning_web.pdf)

- Program directors and managers who use the book to guide the development of communication and training materials for program activities;
- Counselors, social workers, community health outreach workers, teachers, religious leaders, and others who help individuals and couples make informed decisions on FP;
- Journalists and media outlets, which use the information as a basis for television, radio, and other mass media programming and for use in social media applications such as websites or on cell phones; and
- Other stakeholders who may use this resource to develop targeted advocacy messages and materials for politicians and decision-makers who influence policy and funding for FP services, or create comprehensive communication campaigns designed to promote healthy behaviors overall.

### **NEXT STEPS**

Following the end of the C-Change project in December 2012, the publication is being disseminated by Knowledge for Health (K4Health) at [www.fphandbook.org/sites/default/files/familyplanning\\_web.pdf](http://www.fphandbook.org/sites/default/files/familyplanning_web.pdf).  
*(K4Health is a project led by JHU-CCP on which FHI 360 is a partner.)*

The booklet will be disseminated 1) as a companion volume of the *Family Planning Global Handbook*, which is targeted to providers; and 2) to non-FP sectors, including projects working in areas such as food security, environment, and development that would benefit from basic information on FP.



## Generating and Disseminating Knowledge for Improving SBCC

C-Change achieved *Intermediate Result 4: Generating and Disseminating Knowledge for Improving SBCC* through the project's research studies and knowledge management (KM) activities. Research results furthered SBCC state-of-the-art knowledge and were incorporated into capacity strengthening tools, resources, and guidance for immediate and ongoing use by developing country health ministries, NGO staff, and SBCC practitioners. The project's approaches, interventions and implementation activities were described and the information disseminated through the project's KM and communication channels. These channels assisted the project's goals of disseminating knowledge and building the capacity and competencies in SBCC of the staff and workers of government ministries and programs, local NGOs, and USAID partners seeking to incorporate C-Change's findings and lessons learned into their ongoing work.

Research studies were carried out in FP/RH, HIV prevention, and malaria prevention and control. The FP/RH studies looked at the role of gender equity in **Guatemala** and **Tanzania**; contraceptive side effects in **Kenya**; use of the Standards Days Method® (SDM) as a contraceptive method in **Benin**; FP and HIV prevention integration in **Zambia**; and barriers to FP use in **Malawi**. HIV prevention studies examined high rates of HIV among adult women in **Ethiopia**, **Namibia**, and **South Africa**; HIV prevention and the views of PLHIV in **Ethiopia**, **Mozambique**, and **Uganda**; sexual partner concurrency (or concurrency) in **Lesotho**; and HIV prevention solutions for at-risk populations, including MSM and sex workers, in **Jamaica** and **The Bahamas**. Malaria prevention research assessed bed net uses in **Ethiopia**.

Knowledge dissemination was carried out via several channels. They included the project's website at [www.c-changeproject.org](http://www.c-changeproject.org); C-Hub, the web-based repository of health and development communication materials, at [www.c-hubonline.org](http://www.c-hubonline.org); several e-newsletters; presentations at meetings and conferences; and blogs and use of social media (in particular Twitter). The following is a summary of C-Change's research activities and a description of C-Change's knowledge sharing, information dissemination, and promotion activities.

# 1 STUDIES ON FAMILY PLANNING/REPRODUCTIVE HEALTH AND GENDER

Short descriptions and results of six studies carried out in FP/RH and gender follow.

## USING INTERACTIVE WORKSHOPS TO PROMOTE GENDER EQUITY AND FAMILY PLANNING IN RURAL GUATEMALAN AND TANZANIAN COMMUNITIES

In many countries, inequitable gender norms contribute to high fertility, short spacing between pregnancies, and non-use of modern contraceptives, particularly among rural, indigenous populations, thereby limiting women's ability to make decisions about their own reproduction. In light of this reality, these studies were designed to test a strategy—interactive community-based workshops—to increase gender equitable attitudes and promote the practice of FP in rural communities.<sup>1</sup> They were inspired in part by the work of *Instituto Promundo*, based in Brazil, which has shown success in reducing HIV risk behaviors by holding interactive workshops in which young men are encouraged to examine and question prevailing norms of masculinity.

Interventions consisted of a series of six interactive workshop sessions—two for men, two for women and two for couples. C-Change developed a manual that workshop facilitators used, which incorporated games, role plays, and other exercises to raise awareness of gender inequality and the gender issues that function as barriers to FP, and to encourage gender-equitable attitudes and interest in FP. In both countries, C-Change worked with partners who were providing mobile reproductive health services and where community-based workers provided FP information, condoms and pills, and referrals.

Baseline and follow-up surveys were used to measure FP knowledge and use and gender attitudes. Gender attitudes were measured using the Gender and FP Equity Scale, developed by C-Change.

## RESULTS

In both countries, differences in the levels of change in gender equity scores between intervention and comparison groups were significant, both for men and for women, and there was a large, statistically significant effect of the workshops on knowledge of contraceptive methods. For example, in Tanzania, women in the intervention group scored 13.2 on the Gender and Family Planning Scale at baseline and 15.9 at endline, which was significant, compared to women in the control group who scored 14.3 at baseline and 15.1 at end line. In Guatemala, men in the intervention group scored 13.5 at baseline and 14.6 at endline, while men in the control group scored 14.7 at both baseline and endline.

Modern contraceptive use also increased but fell short of statistical significance, suggesting that the workshops may have influenced modern contraceptive use, but in an environment where there were already overall increasing rates of contraceptive use.

The significant effects of this intervention on gender attitudes and contraceptive knowledge, and the findings regarding contraceptive use, suggest that it is possible to influence inequitable gender norms and reproductive

<sup>1</sup> 30 rural communities in predominantly Mayan Western Highlands in Guatemala and 24 rural communities in the Lake Zone area in Tanzania.

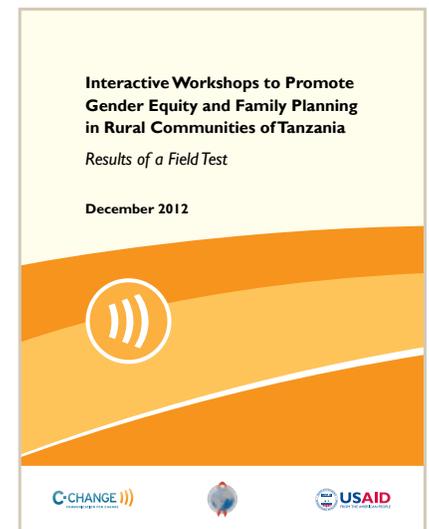
health behaviors in a short span of time using appropriately designed communication interventions that engage communities in re-thinking gender norms that act as barriers to health. A longer term study would be useful to determine whether the results of the workshops eventually spread beyond the participants to influence gender norms and FP among others in these communities. Tests of this intervention in a variety of contexts could provide a better idea of the replicability of these results across cultures.

### TESTING FAMILY PLANNING INTERVENTIONS USING RADIO AND GENDER TRAINING IN TANZANIA

Until recently, the preponderance of health-related literature on gender norms in developing countries has focused on women and interventions designed to empower women. Recent exceptions have emerged in the form of evaluations of male-focused interventions to reduce HIV/AIDS risk behaviors or increase use of contraception by addressing norms associated with masculinity, including the Men as Partners program, Program H, and the Male Motivators Program in Malawi. However, there is still a gap in knowledge concerning affordable, scalable communication interventions that address the norms that influence both men and women's roles in health decision-making. Short, intensive community dialogues facilitated by community-based workers, is one potential intervention (see section above—*Using Interactive Workshops to Promote Gender Equity and Family Planning in Rural Guatemalan and Tanzanian Communities*). Radio promotion is another.

C-Change tested a potential radio intervention in this study by developing six “gender-themed” and six “generic” FP radio spots to be broadcast over local radio stations in two regions of Tanzania where T-MARC, a Tanzanian NGO, is implementing a community-based distribution (CBD) program in partnership with local clinics. In T-MARC's program, community-based distributors (*washauri*) provide health education talks to community members and sell socially marketed health products, including oral contraceptives and male and female condoms, at subsidized prices.

The radio spots were broadcast over two sixteen-week periods spaced about one year apart. In the region where gender-themed radio spots were broadcast, *washauri* also received a three-day training on gender norms. In the region where generic radio spots were broadcast, no additional gender training was provided, but all *washauri* received 10 days of initial technical training using a curriculum developed by the Tanzania Ministry of Health and Social Welfare.



*Interactive Workshops to Promote Gender Equity and FP in Tanzania Report*, [www.c-changeproject.org/sites/default/files/Gender-Equity-FP-Tanzania.pdf](http://www.c-changeproject.org/sites/default/files/Gender-Equity-FP-Tanzania.pdf)

## RESULTS

Service statistics collected by the *washauri* were used to compare contraceptive sales between the two regions. Additionally, three cross-sectional surveys were administered to measure changes in men's and women's gender attitudes, contraceptive knowledge and use before and after each period of radio broadcasts. The sales data showed dramatic increases in sales in both regions for the first three months, but subsequently there was no effect from generic or gendered interventions on contraceptive sales in either region. The survey showed no significant associations between gender attitudes, FP use, FP knowledge, or spousal communication about FP at midline (after the first phase of radio broadcasts) or endline (after the second phase of radio broadcasts) in either the gender-themed or generic regions.

Despite the lack of significant survey findings or service statistic results, radio may still be an effective supportive medium when used in conjunction with other media in interventions that address gender norms that function as barriers to FP uptake. During the study period, due to logistical and contractual problems, the gap between the two radio broadcast periods from that originally planned was nearly a year, diluting any cumulative effects that may have been observed after the second broadcast period. Additionally, there were gaps in the service statistic records due to problems with supervision of the *washauri* at the clinic-level, which affect the reliability of the service statistic findings. Radio interventions should be tested under more controlled conditions than were available for this evaluation.

## ADDRESSING FEARS OF CONTRACEPTIVE SIDE EFFECTS IN KENYA

Unmet need for FP is high in Nyanza and Coast Provinces of Kenya. In order to better understand why, C-Change conducted a study of the barriers to modern contraceptive use in these two provinces. Qualitative research, specifically FGD and IDI, was conducted with men and women of reproductive age (18-35; users and non-users) to learn their fears, misconceptions, and misinformation, and the perceived side effects of the use of modern contraception. Outcomes of this research were used to provide decision-makers within the DRH in the MOPHS and other collaborators in Kenya with the evidence base to enable the design and use of strategic SBCC communication interventions to overcome these barriers and increase the uptake of MCM.

Phase I of the study documented barriers and Phase II examined the characteristics, decision-making factors, and processes among current users of modern contraception.

## RESULTS

Phase I results indicated that overall use of modern contraceptive methods in Kenya is limited due in part to documented fears, misconceptions, and side effects. For all methods, commonly-cited problems were heavy bleeding, reduced sexual activity, high blood pressure, and lethargy. For modern contraceptive methods, fears and misconceptions included birth defects, infertility, spousal rejection, reduced libido, and contraceptive failure. Phase II findings about decision-making processes among users of modern contraception demonstrated that significant emphasis was placed on using FP in general because of economic struggles, i.e., parents wanted to be able to provide for their children. The choice of particular methods relied heavily on advice from health providers, peer recommendations, and spousal preferences.

## POPULARIZING STANDARD DAYS METHOD® IN BENIN

A third of Beninese women with unmet need for FP do not intend to use FP in the future due in large part to the fear of side effects. By providing women with a contraceptive choice that is both natural and effective, the Standard Days Method® (SDM) has the potential to contribute to reducing that unmet need. SDM helps women to identify “fertile windows” when they are likely to become pregnant. This study was designed to increase awareness and availability of SDM by widely distributing directly to the consumer a paper-based version. Phase I tested the interpretation of messages and images included in initial prototypes; Phase II assessed the successful and correct use of the revised versions; and Phase III assessed the uptake of the final paper SDM.

The study was done in urban and peri-urban neighborhoods of Cotonou, Benin. Several data collection methods were employed across the three phases, including monitoring of service statistics, FGD, intercept interviews, and IDI with potential users and health providers.

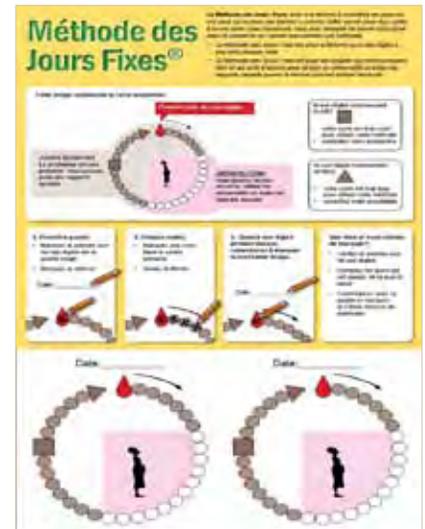
Kiosks and salons disseminated nearly 1,800 paper SDM posters over a two-month period; salons averaged slightly higher distribution than kiosks. Data showed that sales of CycleBeads®<sup>2</sup> increased and that healthcare providers received more enquiries about SDM and modern FP methods during this time period.

### RESULTS AND LESSONS LEARNED

Study findings indicated that the paper SDM poster was well accepted by potential users and health care providers because it was natural and simple and had no cost. Respondents liked the colors and understood the images, messages, instructions, and diagrams.

Over three-quarters of potential users reported that they would use SDM (either the paper SDM or CycleBeads) in the future.

Religious reasons and partner disapproval were the most common reasons cited for not using the SDM method. Top concerns expressed were method failure and eligibility for SDM use. While there was recognition that a certain level of literacy is needed to understand the paper SDM, both providers and potential users commented throughout all three phases that the paper SDM is acceptable even for lower-literacy groups, due to its simplicity and clarity.



Paper SDM used in Benin, [www.c-changeproject.org/sites/default/files/Standard-Days-Method-Report-Benin.pdf](http://www.c-changeproject.org/sites/default/files/Standard-Days-Method-Report-Benin.pdf)

### SDM STUDY COMMENTS

“It is a well-conceived card. It speaks for itself. It has diagrams, pictures, and words. Women can use it without a provider.”

—Potential User FGD 1

“It is the problems with their husband; if their husband will accept; or other women want to do it behind their husband’s back, but we refuse. You don’t do that, so it is necessary for them to inform their husband.”

—Provider Interview

“Yes, I will use this tool in the future [paper SDM] because for a long time I wanted a natural method but had no opportunity to get the information.”

—Female, Intercept Interview

<sup>2</sup> CycleBeads®, a string of colored beads developed by the Institute for Reproductive Health, is a low-cost visual tool that assists women to use SDM.

These findings confirm that SDM requires concerted promotion efforts geared toward providers and women of reproductive age to ensure its inclusion in the FP method mix in Benin. The paper SDM can be used as a promotional tool to increase awareness of SDM, fertility awareness, and FP in general. The low production cost of this tool facilitates wide dissemination beyond traditional service delivery points.

### **INTEGRATING FP AND HIV PREVENTION IN ZAMBIA**

This study took place within an integrated FP/HIV program in Mwase Zonal Rural Health Center (Mwase RHC) in Zambia's Eastern Province to determine the effects of community-informed and community-based communication strategies on FP uptake and to identify social norms that influence FP acceptance and uptake, particularly among PLHIV.

The program strengthened FP screening and referral systems within the Mwase RHC (including VCT, outpatient and ARV clinics, and FP services offered within MCH). Trained community volunteers facilitated a series of SBCC activities designed to address barriers to FP, including FP myths/misconceptions, gender roles, and community norms about ideal family size. Data were collected at baseline, midline and endline using service records, community-based surveys and FGD. Study participants included HIV-infected and non-infected persons randomly selected from VCT and ART registers at Mwase RHC.

### **RESULTS AND LESSONS LEARNED**

Results indicate that both acceptance and use of FP increased over the life of the project. Use of modern FP by women increased from 43% at baseline to 54% at endline. Male approval for FP remained fairly constant, but larger proportions of women at endline reported that their husband or partner approved of FP than at baseline. This change was more notable among HIV-negative female respondents than HIV-positive respondents. Analyses also suggested that perceived norms of ideal family size shifted downwards for both male and female respondents.

Findings from this study suggest that the SBCC activities appear to have influenced key community norms that influence FP, especially ideal family size. Further, there was evidence of significant changes in proximate determinants of FP such as exposure to FP information, comfort in discussing FP, women's approval of FP, and women's perceived approval of FP by husbands/partners. It is possible that some increases in FP uptake by women were limited by FP supply issues.

### **STUDYING BARRIERS TO FAMILY PLANNING USE IN MALAWI: OPPORTUNITIES FOR SBCC**

This study delved into the socio-cultural context for women's and men's FP decisions and fertility behaviors in Malawi. It was conducted to generate evidence to inform the development of effective SBCC strategies and interventions for improved sexual and reproductive health and the uptake of modern FP methods. Specifically, the study identified factors that facilitate or constrain the use of modern FP methods and assessed the extent to which SBCC materials available in health facilities addressed barriers to FP use.

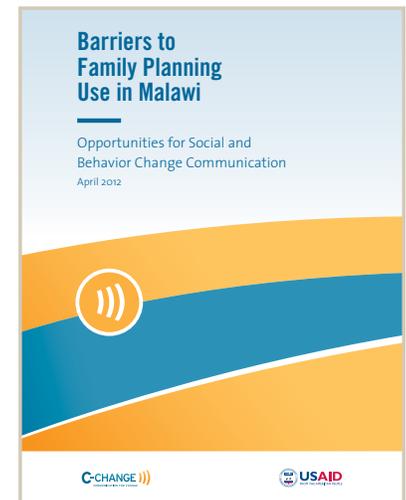
Several methods were employed. Focus groups were held with men and women of reproductive age (18–24 and > 25) in Lilongwe, Mzimba, Dedza, Machinga and Thyolo Districts. Three separate surveys were conducted in 30 health facilities. Interviews were conducted with clients and health workers and an inventory and assessment of available SBCC materials was undertaken.

## RESULTS AND LESSONS LEARNED

An interesting study finding was that although most married couples believed the ideal number of children to be four, they confessed to receiving pressure from older relatives and community members to have larger families. Participants noted that male disapproval is a major barrier to FP use, often based on misconceptions about the perceived effects of FP on sexual desire and performance. It was also reported that field staff at health facilities often fail to discuss potential side effects of FP use. Around 20% of interview participants reported that they “do not like” FP. Non-use of FP was more prevalent among Muslim women and those with less education. Distance to health facilities was also noted as a barrier.

With respect to availability of SBCC materials, the study found that posters and charts were the most widely available in health facilities with brochures, videos, and audiotapes in short supply or hidden in storage. Health providers and facility clients indicated that they believe videos are effective for conveying FP messages. Another finding of note was that low literacy rates make existing written SBCC materials ineffective in communicating FP messages.

Some implications of this study for the design of appropriate communication interventions include the following: 1) an SBCC strategy should focus on people who influence FP decisions including relatives and community members and male partners; 2) messages should be culturally sensitive, highlight the benefits of FP and child spacing, address cultural preferences for large family size, address gaps in knowledge of FP, and for those messages that target men, should address their role in FP and misconceptions around sexual desire and performance and other side effects of FP use; 3) FP campaigns should address barriers to access and utilization of FP, highlight the benefits of FP use; include messages for Muslim women and women with less education; and should be designed for specific target audiences (rural, urban); 4) health providers should be adequately trained to discuss the side effects of FP; 5) a mechanism should be established to monitor how health personnel address FP side effects; 6) an adequate supply of FP methods at health facilities should be available with trained health facility staff who understand how to estimate supply need and an engaged MOH and other stakeholders to ensure availability; 7) outreach programs should use community health workers to disseminate FP methods and SBCC materials to communities who do not live close to health facilities; and 8) the Government of Malawi should increase the number of health facilities so clients do not have to travel long distances to reach them.



*Barriers to FP Use in Malawi* Report,  
[www.c-changeproject.org/resources/barriers-family-planning-use-malawi-sbcc](http://www.c-changeproject.org/resources/barriers-family-planning-use-malawi-sbcc)

## 2 STUDIES ON HIV PREVENTION WITH ADULT POPULATIONS

Several research studies, some of which were multi-country studies, were completed on HIV prevention with adult populations, including adult women, PLHIV, and at-risk populations (MSM and sex workers) and the role of communication. Short descriptions, results, and recommendations follow.

### HIV PREVENTION AMONG ADULT WOMEN IN ETHIOPIA, NAMIBIA, AND SOUTH AFRICA: OPPORTUNITIES FOR SBCC

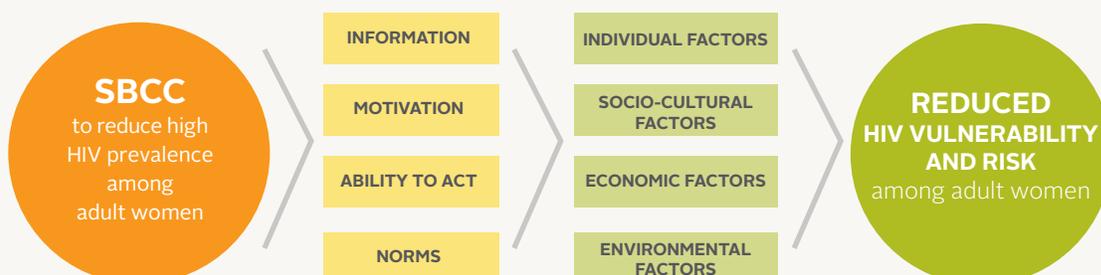
Factors underpinning high HIV prevalence among adult women are complex and appear to be intractable. In order to design strategic HIV prevention responses through appropriate SBCC interventions, this multi-country qualitative study (**Ethiopia, Namibia, and South Africa**) set out to look at rural and urban adult women's perceptions of their own vulnerability, what they consider risky sexual behaviors, and whether there were any emerging concepts from them that would provide insight into reducing that vulnerability and risk.

FGDs with women and men and IDIs with community leaders and stakeholders were held in 16 communities across the three countries. The analysis drew on the C-Change socio-ecological model by using the four cross-cutting elements relevant to SBCC for HIV prevention (information, motivation, ability to act, and norms) and adapted the ecological levels into individual, socio-cultural, economic, and environmental factors (see socio-ecological model below).

### RESULTS AND RECOMMENDATIONS

Across communities, common factors underpinning HIV vulnerability were largely related to economic inequality and exposure to alcohol consumption, with gender being a related issue. Shifts in gender empowerment, including changes in women's access to education and employment and avoidance of early marriage have not led to an equivalent transformation in HIV risk among adult women.

Participants in this study already had high levels of knowledge about HIV and AIDS. It was their narratives that provided insights into ways to address HIV vulnerability and risk and highlighted what individual and community-level HIV prevention actions could be taken. These included acknowledging and internalizing HIV risk and being motivated through self-respect, self-care, and self-efficacy, to have sexually responsible relationships, and greater levels of



A socio-ecological approach to addressing HIV prevention through SBCC

community engagement, including involvement in problem-solving. Men voiced concerns about the impact of HIV on the women in their lives and the community in general, highlighting that they had not been adequately drawn into processes for addressing the disease.

These findings suggest that solutions to reducing HIV vulnerability and risk must be integrated and build on “emerging” indigenous strategies across the four elements of change (information, motivation, ability to act, and norms). A focus on sexual relationships and relationship contexts, horizontal systems of response through involving community members in problem-solving, and promoting contextually relevant solutions led ‘from the ground’ were mentioned. While shifts in program approaches are urgent, they can only succeed if M&E systems are adapted to understand the dynamics of change beyond “message delivery.”

### **PERSPECTIVES OF PLHIV ON HIV PREVENTION IN AFRICA: OPPORTUNITIES AND CHALLENGES FOR STRENGTHENING THE RESPONSE**

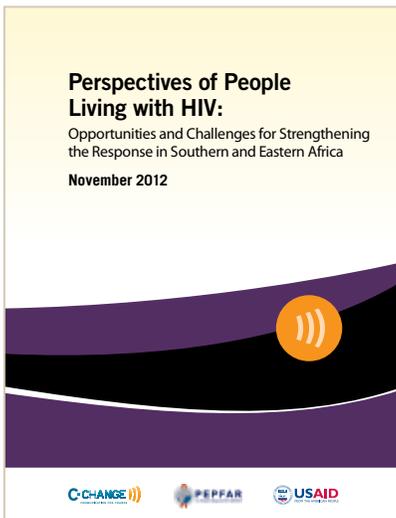
A multi-country study (Ethiopia, Mozambique, and Uganda) was conducted to increase understanding of HIV prevention in relation to living with HIV and to inform regional and global policies and strategies. The study focused on perceptions of PLHIV on issues of prevention as well as exploring the availability and relevant activities and services at community levels. C-Change worked with three local partners to implement the study: School of Social Sciences, Makerere University, Uganda; Synovate Kenya, Mozambique; and Yeroam Consultancy, Ethiopia.

The study used mixed-methods and was conducted in three to four selected communities in each country. Methods included: 1) a questionnaire-based survey among 862 PLHIV 18-49 to assess knowledge of what PwP/PHDP entails as well as the extent to which PLHIV are engaged in practices that promote PwP/PHDP; 2) FGDs and IDIs conducted among 348 PLHIV and non-PLHIV (home-based care providers, support group members, religious leaders, community leaders and staff of NGO/CBO) to assess understanding of what PwP/PHDP entails, perceptions of availability of PwP/PHDP services/activities, and the adequacy of these services/activities to meet the needs of PLHIV to prevent re-infection, co-infection, and transmission of HIV and other STI; and 3) a modified situation analysis conducted with 79 organizations to map and describe PWP/PHDP interventions implemented at the community and health facility levels.

### **RESULTS AND RECOMMENDATIONS**

Results of the study varied by gender, age and country. The overall findings are summarized here. Knowledge and information access: Understanding of the components of HIV prevention for PLHIV was high, however the concept of PHDP was not widely known. Most rated their HIV/AIDS knowledge as adequate or very good. Gaps to providing basic information to marginalized PLHIV (sex workers and MSM) existed.

**Physical and mental health.** Most were on anti-retroviral therapy (ART), adherent, had lived with HIV for more than three years, and reported to be in good health and able to perform daily activities. Barriers to ART adherence included lack of transport, inadequate food to take medications, side effects, and stock-outs. A majority worried about future supplies of free ART. The majority reported they had not felt sad or depressed about their HIV status in the past month and the majority reported that religion was very important in coping with HIV. Alcohol consumption was reportedly low although around a third who drank alcohol had been drunk in the last month.



A multi-country study on PLHIV in Ethiopia, Mozambique, and Uganda, [www.c-changeproject.org/resources/perspectives-plhiv-hiv-prevention-study-three-african-countries](http://www.c-changeproject.org/resources/perspectives-plhiv-hiv-prevention-study-three-african-countries)

**Disclosure, stigma and discrimination.** Most had disclosed their status to someone, although only two-thirds had disclosed to a spouse or partner. Some experienced negative consequences of disclosure including relationship break-ups, rejection by friends, physical violence, ejection from their home, and loss of rental accommodation or of a job, as well as some discrimination among PLHIV women in labor in healthcare settings. Two-fifths reported they worked hard to keep their HIV status a secret.

**Sexuality and PLHIV.** More than a third had not had sex in the last year, but among those sexually active, most had had one partner. Most reported preferring a partner who was HIV-positive and most used condoms to prevent HIV infection or reinfection, although others used other protective methods or no protection based on either having a positive partner or considering their viral load low due to being on ART.

**HIV discordancy.** Discordant relationships were reportedly difficult to manage. When partners remained together, relationships often remained ambiguous, with outside partners being sought, difficulties sustaining condom use, and reduced sexual frequency or abstinence.

**Contraception, fertility and PMTCT.** More than two thirds used condoms as a contraceptive method. One in five had experienced the death of a child from AIDS but desire to have children remained high. Nearly a third of women had had a child since knowing their status with a majority having taken steps to prevent HIV via PMTCT measures.

**Support groups and associations, volunteerism.** Most reported being in PLHIV associations, about a third were members of support groups, and nearly half did volunteer work. Several benefits were reportedly associated with membership or volunteer work while constraints for these activities centered around accessing funding support, lack of support from local authorities, insufficient integration into processes to allow them to lead a response in their communities, all of which undermined long-term sustainability of activities.

**Service providers and PLHIV.** Formal service providers addressed a broad range of services related to PHDP, although services were uneven across organizations with limited support for some services/activities. While communication materials helped guide and support, there were also gaps in addressing marginalized PLHIV.

The report summarized several implications for policy and programs to improve the response to PHDP in southern and eastern Africa. They include strengthening support for disclosure and promotion of PLHIV rights; supporting safer sexual relationships for PLHIV and their sexuality needs; reinforcing economic support programs; and enhancing the engagement in PHDP of PLHIV associations, support groups, and volunteerism.

## EVALUATION OF COMMUNITY DIALOGUES TO REDUCE CONCURRENCY IN LESOTHO

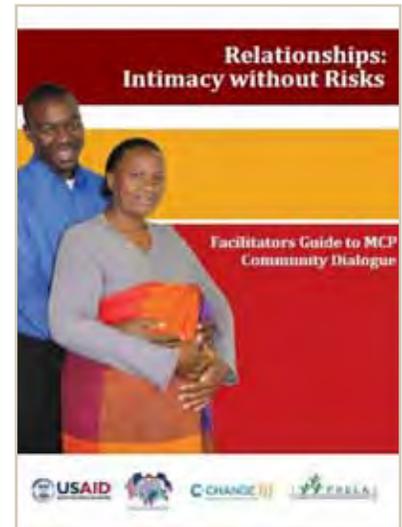
The National AIDS Commission (NAC) and the Ministry of Health and Social Welfare (MOHSW) in Lesotho worked with C-Change to reduce the prevalence of sexual partner concurrency through SBCC interventions. To effect changes in social norms around an issue as complex as concurrency, C-Change implemented a community dialogue intervention entitled, *Relationships: Intimacy Without Risk*, in five districts of Lesotho. Community dialogues took place in facilitator-led, informal, participatory groups that were provided with open space for group members to become comfortable with discussing sexual relationship issues, to identify the drivers of HIV within their wider social and cultural contexts, and to address their own attitudes in order to make positive individual and collective decisions and plans to further reduce HIV infection.

The primary objective of the study was to assess whether the community dialogues had been effective in improving communication on topics of concurrency, cross-generational and transactional sex and had a positive effect—or potential effect—in reducing these risk behaviors. The evaluation also gathered suggestions from participants on how future community dialogue interventions could be improved. A secondary research objective was to explore the role of concurrency in contributing to the spread of HIV and to identify other issues seen as problematic in communities, such as poverty and substance abuse.

## RESULTS AND RECOMMENDATIONS

From the study seven major issues facing communities were identified: substance abuse, HIV and AIDS, poverty and unemployment, physical infrastructure challenges, teenage pregnancy, crime, and community apathy. Most study participants viewed concurrency as a driver of HIV and identified several reasons: the ripple effect of concurrency and its widening sexual networks; the practice of unprotected sex; transactional sex as a means of survival; lack of information on HIV; lack of knowledge of one's own HIV status and the status and sexual history of others; the drive for self-gratification; the perceived norm of concurrency as an acceptable common practice; and ignorance of the HIV risk of concurrency, or dismissive attitudes toward this risk.

Almost all participants perceived the community dialogues as an overwhelmingly positive contribution to their communities and their relationships with partners. Positive effects reported included: improved sexual behaviors (reduction in concurrency practices, increased practice of protected sex, and reduction of transactional sex); more open communication about sex and other sensitive issues with sexual partners, spouses, children, parents, families, and peers and



*Relationships: Intimacy without Risk* Facilitator's Guide, available at [www.c-changeproject.org/sites/default/files/Facilitator's\\_Guide\\_\[English\\_Language\].pdf](http://www.c-changeproject.org/sites/default/files/Facilitator's_Guide_[English_Language].pdf)

within communities; improved relationships with sexual partners, including strengthened emotional ties, trust, and commitment, improved sexual techniques, and altered gender norms relating to women taking the initiative in sexual relationships; increased information dissemination and knowledge about HIV and AIDS; improved health-seeking behavior, including increased uptake of HIV testing; increased acceptance of one's own HIV status; and increased sense of personal contribution and empowerment in the community.

A minority of participants expressed critical views about the community dialogues and open discussions of sexual practices and concurrency, some charging that this was culturally unacceptable. A few said community dialogues did not lead to social and behavior change, while others said the dialogues had instigated community and interpersonal conflicts by undermining trust in sexual partnerships.

Based on perceptions and testimonies of participants, the study provides anecdotal evidence of the positive effect of the community dialogues. While behavior change is unlikely after such a short intervention and conclusions cannot be drawn about impact on concurrency, the evaluation suggests that community dialogues, in combination with campaigns that promote VMMC, condom use, alcohol reduction, and other targeted risk-reduction behaviors, should be more rigorously evaluated to determine the efficacy of broader prevention approaches in the response to HIV and AIDS.

## **STUDIES EXPLORING SOLUTIONS TO PREVENTION FOR MARPS IN JAMAICA AND THE BAHAMAS**

Several studies were undertaken seeking solutions to HIV prevention for MARPs in Jamaica and The Bahamas.

**1. Cross-Generational Relationships: Perceived Norms and Practices in Jamaica.** In this study, C-Change explored the dynamics of cross-generational sex in Jamaica by focusing on males and females who self-identified as having participated in cross-generational sexual relationships (CGR). A further aim of the assessment was to inform existing programs working to decrease cross-generational sexual practices and their related risks, including gender-based violence (GBV) and HIV.

FGD were held with males and females, ages 16-20, who had sex with older males and 69 IDI with various relationship dyad participants (older male/younger male, older female/younger male, and older male/younger female).

Participants' motivations and practices mirrored the perceived norms they reported. This was particularly true for motivations for involvement in CGRs, infidelity, and concurrent sexual partnerships. Participants did not believe that CGRs were rare in their community—instead they mainly believed the community was indifferent to these relationships or approved of them for the material gain they offered. Participants believed marriage was less common among their peers than other types of relationships. Most marriages were thought to end in divorce as a result of infidelity. Participants also held the opinion that concurrency was common among their peers and most reported that they had more than one sexual partner. High frequency of partners was most commonly reported by men (25+) involved in relationships with younger females.

Despite these findings, most participants reported high levels of satisfaction with their CGR. Common areas of reported dissatisfaction included arguments fueled by jealousy, infidelity and control factors. Instances of physical and sexual abuse were also cited. Most participants placed importance on HIV testing and in many cases, condom use.

## RESULTS AND RECOMMENDATIONS

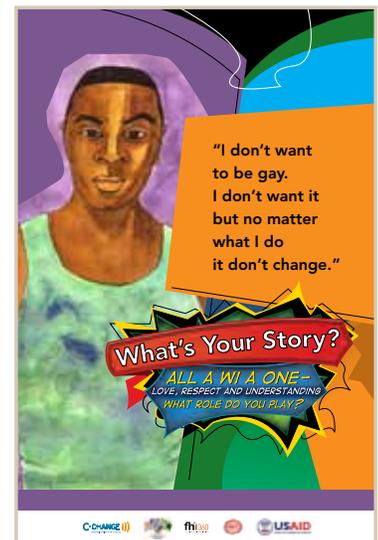
This study has many implications for HIV-prevention programming in Jamaica around gender and STI/HIV risk reduction. While respondents' participation in HIV testing was high, issues emerged related to power and sexual control, infidelity, stigmatization of homosexuality, abuse, economic needs and younger participants' trust in their older partners' guidance and support. Focusing only on the financial/material motivations for cross-generational relationships is not enough. Other motivators, such as the desire for emotional support and sexual pleasure, also need to be addressed by communication programming. Programs must also address the extreme power inequities that exist within these types of relationships for younger participants and the wider community norms. Addressing individual level behavior change in the absence of larger complementary efforts to address social norms, or their perception, would be insufficient.

**2. Layered Stigma among Health Facility and Social Services Staff toward Most-At-Risk Populations in Jamaica.** MSM have been the target of verbal, nonverbal, and physical stigma and discrimination (S&D) and abuse where negative labels, stereotypes, insults and physical attacks are perpetrated against MSM individuals or groups to deny them their dignity, respect and basic human rights. The purpose of this quantitative study was to understand the degree of stigma and discrimination that sex workers (SW) and MSM encounter when seeking health-related and social services to better inform SBCC programming for MARPs. Key informants included 165 health facility (HF) workers, 63 social service organizations (SSO), and 450 male and female SW.

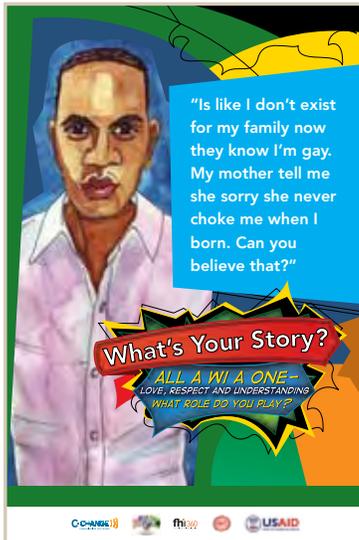
Findings for HF workers and SSOs revealed an overall positive relationship between training and reduced stigma. Although the majority of staff in HF and SSOs had not received HIV- or MARP-related training, those who had, reported no HIV transmission fears; no desire for avoidance of sweat/saliva of PLHIV, MSM, SW; no discomfort in sharing a bathroom with an MSM or HIV-positive colleague; and no fear of performing medical procedures like giving an injection/IV and dressing wounds of PLHIV. Significantly, more trained than untrained HF staff agreed that MSM and SW deserved the same level of care as other clients; disagreed that HIV/AIDS spread due to immoral behavior; and disagreed that homosexuality and SW was immoral.

“Provided that the person is of a statutory legal age then they're OK with it [CGR] as long as they're old enough. It seems to be encouraged in some cases, especially in heterosexual relationships because of the advantages for the female being with an older male, that is, monetary gains, primarily. Ostensibly, she could gain experience and wisdom from the older partner, but practically speaking that's not necessarily what she wants.”

—Interview  
Male, aged 25+



Poster addressing discrimination concerns of MSM in Jamaica, [www.c-hubonline.org/resources/jamaica-sbcc-materials-men-who-have-sex-men-whats-your-story-0](http://www.c-hubonline.org/resources/jamaica-sbcc-materials-men-who-have-sex-men-whats-your-story-0)



Poster developed to address S&D experienced by MSM in Jamaica, [www.c-hubonline.org/resources/jamaica-sbcc-materials-men-who-have-sex-men-whats-your-story-0](http://www.c-hubonline.org/resources/jamaica-sbcc-materials-men-who-have-sex-men-whats-your-story-0)

One ethnographer reported that his mother said:

*"If I ever find out that you are gay, I will poison you to death myself."*

Another ethnographer reported overhearing a man say to another man that he would "... pour kerosene oil all over his son and light him on fire personally, if he ever found out his son was gay..."

SW reported a number of S&D experiences with health services, for example, being gossiped about when seeking health care, receiving poorer quality care or denied services and/or feeling rushed by health staff during their exam. Those who had disclosed their SW status were significantly more likely, than those who had not, to report being denied services, etc. Across nearly all stigma measures among sex workers, males reported experiencing higher S&D within the last six months when seeking health care than females.

## RESULTS AND RECOMMENDATIONS

Findings supported past research on stigma, i.e., that there is widespread layered stigma toward PLHIV, MSM, and SW in clinical and non-clinical settings. MARPs experience with layered stigma in Jamaica threatens their quality of care and services, thereby increasing their vulnerability to HIV infection. Results support the need for HIV prevention and IPC training with a focus on stigma and discrimination toward MARPs and more MARP-friendly providers. The study showed that 62.5% of staff trained reported "no fear of giving an injection/IV drip" compared with 32% of untrained staff. Results also support the need for national health services strengthening, established standards of care and a more favorable policy/legislative environment related to MARPs.

### 3. Experiences of Stigma and Discrimination among Men Who Have Sex with Men in Jamaica.

The purpose of this qualitative study was to put S&D in Jamaica into the words, actions and experiences of MSM in order to develop materials for anti-stigma and anti-homophobia SBCC and advocacy campaigns. The study was carried out in five parishes by 24 ethnographers, who put a face to the percentages and data produced by quantitative surveys.

An ethnographic approach entitled "hearsay ethnography" was used to collect data among self-identified MSM, ages 18–35, in five parishes in Jamaica. Ethnographers were given journals and asked to identify and record, over a three-week period, any conversations and situations within which they observed or experienced stigma and/or discrimination (i.e., actions, deeds, words, behaviors, and attitudes) or had conversations where others had observed or experienced stigma and/or discrimination. Weekly debriefs were conducted with ethnographers and transcripts were also analyzed.

## RESULTS AND RECOMMENDATIONS

Results show that S&D incidents were pervasive and occurred daily. Frequent forms of S&D included verbal insults (primarily name-calling) and negative

non-verbal communication. There were few reported incidents of physical attacks. S&D was usually directed at a specific individual in seven out of ten instances and most cases occurred when the MSM was alone. Most S&D was perpetuated by other males. Using a socio-ecological model for analysis, three domains of S&D were examined: 1) interpersonal; 2) community-level; and 3) institutional.

*Interpersonal:* MSM experienced the largest degree of fear and anxiety over their sexuality being discovered by family members. Common feelings that emerged were depression and suicidal thoughts, fear, frustration and anger/desire for retribution. The study also revealed a dynamic of discrimination within the MSM population such that some of those gay-identified discriminated against individuals who were non-gay identified.

*Community-Level:* The study found that much of the reported S&D occurred in very public spaces or retail establishments, which at times afforded the perpetrator an audience. S&D was also reported by MSM when seeking housing services.

*Institutional:* Educational institutions were the third most popular environment where S&D was experienced. Ethnographers were sometimes reluctant to use health services due to the S&D displayed by some staff. The study found that in some instances churches functioned as a direct source of S&D, both in the doctrine preached and in their treatment of known or suspected MSM.

Study findings were consistent with previously published studies showing that MSM are the target of verbal, nonverbal, and physical S&D and abuse. Evidence of family, community and institutional hostility toward MSM, heighten the need for a multi-layered approach to address S&D. Interventions to address S&D are necessary at various layers of society and not just focused on individual behavior but also on overlapping influences, such as social and environmental factors.

**4. Use of Social Media among Sex Workers and Men Who Have Sex with Men in Jamaica.** Social media sites and mobile phone-based platforms have the potential for enabling communication programs to reach marginalized populations in Jamaica at scale. The purpose of this study was to explore the frequency and type of social media used by MARPs to inform communication programs working with these populations. The examination of social media use included cell phones, the internet, and preferences for receiving health information. C-Change developed a cell phone-based survey administered to 787 SW and MSM.

## **RESULTS AND RECOMMENDATIONS**

Findings from this assessment reinforced literature that shows a high penetration of cell phones in Jamaica and use and preference of social media among MSM and SW and variations among differing MARP populations. For example, the study found that Facebook was the most popular social media site visited by all populations (91.2%), followed by YouTube (66.9%), Tagged (46.3), and Twitter (40.6%). Social media use was one the most frequently cited reasons for Internet use among MSM (75.8%) as well as accessing email (77.7%) and viewing entertainment sites (60.4%), pornography (42.5%) and seeking casual sexual partners (13.2%). Social media can be an effective channel for sexual health and personal safety information for SW and their clients. Study findings imply that using social media sites and mobile phone-based platforms and segmenting MARP message dissemination, interaction and intervention recruitment has the potential for enabling communication programs to reach marginalized populations at scale.



Social media materials developed for use by sex workers in Jamaica, [www.c-hubonline.org/resources/jamaica-hiv-prevention-sbcc-media-materials-sex-workers](http://www.c-hubonline.org/resources/jamaica-hiv-prevention-sbcc-media-materials-sex-workers)

### 5. Stigma and Discrimination among Health and Social Service Providers in The Bahamas.

MSM and SW do not come forward and identify their sexuality and their sexual experiences and do not receive the support that they need to reduce their risks and prevent the spread of HIV. This is of strong concern within The Bahamas where SW and MSM are believed to be among key affected populations of the HIV and AIDS epidemic with an estimated general prevalence rate of three percent and 14 percent prevalence rate among MSM. In light of this, C-Change conducted two studies in The Bahamas. The first study assessed the level of S&D toward PLHIV, MSM, and SW in health and social service settings.

### RESULTS AND RECOMMENDATIONS

This study found a significant training gap among health care workers. Not only was training exposure very low, but when it was present, it was not significantly linked with decreased S&D toward PLHIV, MSM and SW. There was a dearth of providers considered to be friendly to key affected populations (37% of HF staff reported a desire to avoid sharing a bathroom with an MSM colleague, and 50% of HF workers feared HIV transmission from coming into contact with the sweat or saliva of someone who was HIV positive); a lack of services available outside of the island of New Providence (where 70% of the population lives); and an environment of S&D that was fueled by fear and moral judgments toward each of these groups, especially toward those living with HIV and AIDS (39% of social service workers believed that people living with HIV should be ashamed of themselves). These findings were reported by SW and MSM and were corroborated by data reported by HF and social service organization workers themselves using direct questions and case vignettes as a way to triangulate social desirability biases.

As a result, C-Change recommended that a training assessment, examining the level and quality of services, be conducted with health facilities and social service organizations and their clinical and nonclinical staff in HIV prevention/basic transmission, S&D, interpersonal communication, and considerations for working with key affected populations. Scale up of prevention efforts, especially social services outside of New Providence, was advocated with the recommendation to include greater involvement of key affected populations in these initiatives as a way to increase reach. Lastly, it was recommended to increase comprehensive SBCC interventions that provide a supportive environment for key affected populations.

### 6. Social Media Usage by Key Affected Populations in The Bahamas.

This study was a formative assessment, which looked at the level of social media use among key affected populations toward the objective of

better informing SBCC interventions and services with these audiences. Specifically, this study looked at social media use, one platform that has been shown to be an effective way to expand reach, foster engagement, and increase access to credible, science-based health messages among harder-to-reach audiences. The study found that the use of cell phones and the Internet, including social media, was high among MSM and SW. The most popular social media sites were Facebook, YouTube, Tagged, Twitter, and Adam for Adam. Most respondents used these sites to make new friends, for entertainment, and to stay in touch with friends and family. Male and female SWs also used these platforms to look for casual sexual partners.

## RESULTS AND RECOMMENDATIONS

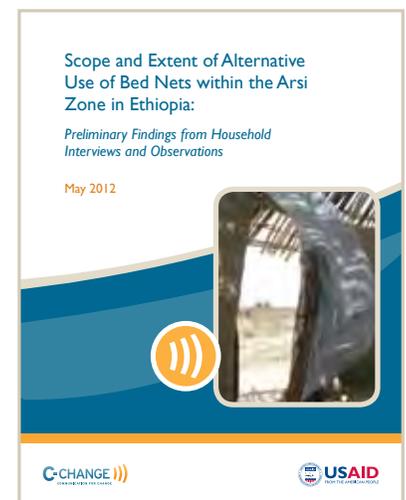
The study found varying degrees of online health-seeking behavior and desire to receive tailored health messages and dialogue via electronic and mobile means. The study concluded that while social media can be an effective way to extend or reinforce interpersonal SBCC activities and reach marginalized populations, it is not always the most trusted or preferred channel for MSM and SW. C-Change therefore, recommended that interventions for these audiences take into account their technology preferences, that social media use be integrated into existing programming via opt-in program options, and that key affected populations are involved directly in the development of any social media interventions to ensure that communication is relevant, valuable, appealing, and appropriately tailored. A final recommendation was to ensure that any communication via these media are multi-directional, ensure privacy and confidentiality, and are complemented by other trusted communication channels.

# 3

## STUDY ON MALARIA PREVENTION

### MALARIA PREVENTION STUDY ON BED NETS IN ETHIOPIA

In May 2011, C-Change conducted a pilot study in the Arsi Zone in Ethiopia to assess intended and alternative use of bed nets and develop methods for future studies. The primary objective of the pilot study was to provide data on the scope and extent of alternative use of bed nets in intervention and comparison communities and to identify barriers and facilitators for intended and alternative uses. A secondary objective was to provide recommendations on future monitoring studies and the design of SBCC programs that promote LLIN use and malaria prevention and control. A cross-sectional survey was used to measure the scope and extent of



*Alternative Uses for Bed Nets in Ethiopia Report*, available at [www.c-changeproject.org/sites/default/files/alternative-use-of-bed-nets-ethiopia.pdf](http://www.c-changeproject.org/sites/default/files/alternative-use-of-bed-nets-ethiopia.pdf)

alternative and intended use of bed nets at the household level. Qualitative methods were used to explore barriers and facilitators for intended and alternative use. C-Change had carried out SBCC activities accompanied by LLIN distribution in the intervention communities. Comparison communities had received LLINs, but no C-Change SBCC activities. This report includes findings from the household survey.

## RESULTS

The results of the cross-sectional survey provided insights into alternative uses of bed nets with similarities and differences between intervention and comparison communities. There was little difference between the mean number of bed nets that households reported that they owned and the mean number of bed nets they reported they had received, suggesting high retention of distributed bed nets in both communities. However, among intervention communities, 46% of households used a bed net for malaria prevention the night before the survey, compared to 20% of households in comparison communities. And, in intervention communities, 37% of households used bed nets for alternative purposes, compared to 56% of the households in comparison communities.

## 4 KNOWLEDGE DISSEMINATION

The knowledge dissemination activities of the C-Change project focused on disseminating information about the project's capacity strengthening approaches and achievements and its research and country implementation activities, and the promotion of the resources and tools developed by the project. Major dissemination vehicles were the project website ([www.c-changeproject.org](http://www.c-changeproject.org)) and C-Hub ([www.c-hubonline.org](http://www.c-hubonline.org)), a database of health and development communication materials. Traditional approaches were also employed, including presentations on C-Change tools, research, and approaches at meetings and conferences. KM produced and disseminated three different electronic newsletters that met identified information needs for the project.

### C-CHANGE WEBSITE

The website was the major dissemination vehicle for information about C-Change and its activities and project outputs. The site was developed using a Drupal-based content management system, which afforded maximum flexibility and easy updating. The website includes a *Home, About Us, Focus Areas, Where We Work, Resources, and News* pages. Two additional pages were added in 2012 to highlight C-Change's major end-of-project meetings in South Africa and Washington DC. A community feature associated with the Resources and News tabs invites comments by users for further discussion. As the project grew and changed, the website was redesigned to better highlight the project's capacity strengthening activities; the redesign also included a slideshow generator on the home page to visually highlight project accomplishments and provide quick links to project results. The search feature on the Resources page was enhanced to facilitate searching for documents by type.



C-Change website, [www.c-changeproject.org](http://www.c-changeproject.org)

## RESULTS

Google Analytics and AWSTATS analytics were used to track the website's downloads and views and to document the reach and geographic location of website users. From June 2009 through December 31, 2012, there were 307,817 page views and over 62,577 downloads of reports, tools and communication materials. The most frequently downloaded documents were the C-Modules, a central product of the project. Social media used evolved considerably during the life of the C-Change project. A C-Change Twitter account was actively used during the final year and a half and provided another dissemination mechanism for C-Change tools and reports. Tweets were also used to highlight presentations at conferences, including the International AIDS conference in July 2012.

## C-HUB — ONLINE REPOSITORY OF COMMUNICATION MATERIALS

C-Hub ([www.c-hubonline.org](http://www.c-hubonline.org)) is an online repository of evidence-based health and development communication materials. USAID cooperating agencies and developing country organizations are encouraged to upload their health communication materials and associated documents. C-Hub is an accessible global platform for health and development professionals seeking resources and was designed with features to foster a community of health communication practitioners who share, contribute and discuss resources and issues.



C-Change branded and launched C-Hub initially in June 2010 with materials transferred from the predecessor project, JHU/CCP Media/Materials Clearinghouse ([www.m-mc.org](http://www.m-mc.org)). New materials from other USAID-funded and other donor-funded projects were solicited and added. They include materials in print, audio, and video formats, such as posters, pamphlets, flip charts and other print materials used in communication campaigns; training materials, and IPC materials; audio files and scripts of radio spots and shows; video files for television spots and shows; and supporting documentation such as communication strategies, formative research, concept testing and pre-testing reports, baseline and endline evaluations, and final program evaluations and reports.

Following user testing, C-Hub was redesigned, using the Drupal content management system technology, as a more accessible system with user-friendly upload capability and community features including blogging to foster community interactions. C-Change launched the redesigned C-Hub in February 2012. C-Hub now includes a robust search functionality to facilitate quick browsing of resources; simplified uploading of resources; a community of health and development communication practitioners; an associated YouTube account to host videos; and social media tools (Twitter, a blog, and Facebook) to facilitate sharing and dissemination of resources. Users join the C-Hub community, upload and download materials; provide comments or initiate conversations with the C-Hub community; and comment on C-Hub blog postings. *C-Hub Update*, a monthly e-newsletter was initiated in 2012 to showcase new materials uploaded to the repository and highlight news and events.

## RESULTS

Since 2010, C-Change has added 283 records comprising 2,233 materials and tools to the database, available in multiple media, languages and health areas. The C-Hub audience grew steadily with over 20,000 visitors since June 2010. User downloads of communication materials numbered over 40,000. The most downloaded communication materials included the *C-Modules*, the *Community Conversation Toolkit for HIV Prevention*, and *Voluntary Medical Male Circumcision Communication Toolkit*.

## E-NEWSLETTERS

KM developed and coordinated two e-newsletters—**C-Channel** and **C-Picks**.



**C-Channel.** *C-Channel* was developed to provide SBCC implementers and researchers access to peer-reviewed articles on aspects of health communication, with particular focus on developing country subscribers, and as a dissemination vehicle for the project's tools, training materials, and reports. FHI 360 Satellife staff partnered in this effort providing the technology and IT software to manage the subscriptions and mailings, while C-Change research staff provided quality control regarding the technical substance of the article abstracts highlighted in the newsletter. Subscribers in Africa, Asia, the Caribbean and Latin America could download, free-of-charge, peer-reviewed articles that were summarized and grouped around themes relevant to SBCC and health with each month focusing on different topics. The "Introduction" paragraph and the "Of Interest" sections of the newsletter provided links to C-Change tools and reports on the C-Change website and C-Hub, and highlighted the work of partners and other USAID-funded programs, such as AIDSTAR-One.

*C-Channel* had a mailing list that grew to 2,500 subscribers, with 80% from the developing world; it was also distributed to four listservs—HIPNET, Core Group, AfroNets, and AfriComNet, reaching an additional 14,000 subscribers. *C-Channel* issues are archived on the C-Change website. Over the four-year period, 44 issues of *C-Channel* were disseminated, from which developing world subscribers retrieved 2,433 peer-reviewed articles.

**C-Picks and the CI Partnership.** C-Change engaged in a resource partnership with Communication Initiative (CI) for development and dissemination of the bimonthly e-newsletter *C-Picks*. *C-Picks* provided summaries of project and their reports, tools, and training materials in SBCC in relevant technical areas, particularly FP/RH, HIV and AIDS, and malaria prevention and gender equity. This partnership leveraged the strengths of CI—a well-known website that included a large database of summaries of health and development communication reports and tools from USAID, Gates and other foundations, UN organizations, and other country development agencies and a well-developed subscriber base throughout the developing and developed world. The SBCC implementation and research expertise of C-Change technical staff was critical to validating the quality of the content. As the project matured, the newsletter also served as a dissemination mechanism for C-Change tools and reports, with links to the C-Change website and C-Hub.



## RESULTS

*C-Picks* was disseminated to over 8,900 subscribers. Traffic to the C-Change website was positively impacted by publication of *C-Picks*, as evidenced by an uptick in downloads of materials and page views in the two weeks following each newsletter's dissemination. *C-Picks* also positively impacted links to and views of C-Change website pages and resources. There were 24,032 "click-throughs" from the *C-Picks* e-newsletter and *C-Picks* website to any page on the C-Change website from November 2008 to mid-June 2012 (the last issue of *C-Picks* was May 2012).



# D

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## Integrating SBCC within Wider Health and Development Agendas

C-Change was a strong advocate for bringing SBCC onto national and international agendas in the areas of health, particularly HIV prevention, family planning and reproductive health, malaria prevention and control, and water and sanitation; and beyond health to gender equity, education, democracy and governance, and youth. C-Change used core, field and other direct support to achieve *Intermediate Result 3: Integrating SBCC within Wider Health and Development Agendas*.

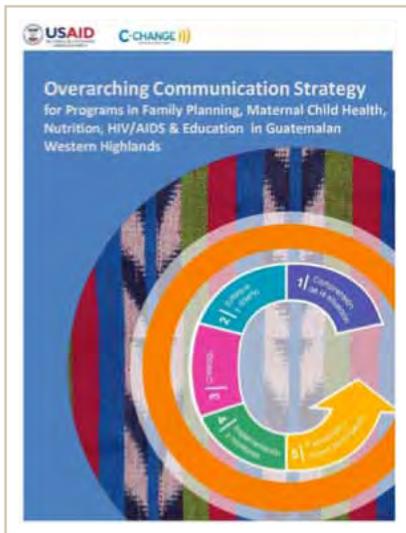
In **Guatemala**, C-Change responded to USAID's request for an integrated approach across the health and education sector, in light of the Global Health Initiative (GHI) and the Feed the Future (FTF) strategic frameworks, aiming to expand and deepen the impact of development programs through SBCC. In the **DRC**, C-Change implemented a broad multi-sector health program and addressed gender-based violence (GBV) in schools and their communities.

Programs in **Ethiopia, Kenya** and **Madagascar** brought an SBCC approach to water and sanitation programs in the context of HIV prevention, antenatal care, and newborn/child health.

C-Change brought SBCC approaches to its work with the media. This included a partnership with the Half the Sky Movement for women's and girls' empowerment, in which C-Change provided TA for a series of videos and mobile phone games developed for use in **India** and **Africa**; and work with MTV in **Kenya** on the "Shuga" TV drama series geared to young people confronting the realities of HIV. Smaller SBCC interventions in **Indonesia, North Africa**, and **Europe and Eurasia** are also detailed.

# 1

## MULTI-SECTORAL SBCC PROGRAMS



*Overarching Communication Strategy,*  
[www.c-hubonline.org/resources/sbcc-strategy-and-implementation-guide-guatemala](http://www.c-hubonline.org/resources/sbcc-strategy-and-implementation-guide-guatemala)

### DEVELOPING A HEALTH AND EDUCATION SBCC FRAMEWORK IN GUATEMALA

USAID/Guatemala’s Health and Education Office (HEO) requested C-Change TA to develop an overarching HEO SBCC strategy that would align its SBCC activities and improve the quality and impact of SBCC programming. A major objective was providing a systematic roadmap and implementation guide for HEO technical officers, government counterparts in the MOH, the Ministry of Education (MOE), and implementing partners to enable development of integrated SBCC messages and materials across the health and education sectors; and creating links and improving coordination of SBCC activities for better utilization of health services, using a participatory consultative process. In preparation for the development of the overarching strategy, C-Change drafted individual SBCC strategies for nutrition, maternal and child health, reproductive health/family planning, and HIV and AIDS. The overarching strategy provided the framework for the development of an Implementation Guide.

The SBCC Strategy and Implementation Guide oriented SBCC planners to use a “convergence approach” that seeks opportunities for integration of key health issues that affect individuals and groups, using life-stages as an organizing principle. This approach recognized that specific health information and services are needed at different times, based on an individual’s particular stage of life and lifestyle. To that end, these two documents outlined interventions around health needs of the audiences via four life stages-- young parents, mature families, children 6-13, and adolescents—which were identified as openings for a comprehensive social change process. Communication was organized around households and communities, rather than public health categories, as has been done in the past. The “convergence approach” is grounded in three main principles: 1) families and communities are the drivers of their health; 2) SBCC programs, messages, and materials must address social, environmental, and structural issues; and 3) systems that support healthy outcomes must be strengthened.

The Implementation Guide was developed and field tested for content (including suitability and clarity of drawings and photos), structure, and intercultural and cultural appropriateness with MOH staff responsible for health promotion programming or implementation in the departmental and district health offices, as well as with local and international NGO staff,

including those in the Western Highlands. Language used in key health messages was tested for relevancy and the degree to which it provided motivation for positive behavior change in Mayan communities. Once finalized, the Guide was rolled out to key stakeholders. Training in the implementation guide was provided to 98 Ministry of Health staff, which is responsible for health promotion programming and implementation.

## **RESULTS AND LESSONS LEARNED**

This integrated approach to capacity strengthening (combining USAID implementing partners with government counterparts) is supporting a shared vision for SBCC implementation in the Western Highlands of Guatemala. In addition, the core of health professionals who were trained in SBCC are facilitating the further development of implementation plans to complement the overarching SBCC strategy recently rolled out.

Three important lessons were learned: 1) C-Change's neutral position as technical advisor, not implementer, was a critical success factor in the process (C-Change was seen as not holding a vested and/or competing interest); 2) the convergence approach that USAID/Guatemala promoted requires focused Mission backing and resources to support the organizational changes required for the approach to work and be sustained; and 3) health messages that are developed must be concept tested with Mayan populations in their contexts.

## **INCORPORATING FAMILY PLANNING, HIV AND AIDS, MATERNAL AND CHILD HEALTH, MALARIA, TB, AND WATER AND SANITATION: A MULTI-SECTOR PROGRAM IN DRC**

In the DRC, C-Change responded to the country's need to increase positive health behaviors and norms through multi-sectoral, evidence-based SBCC programs. C-Change employed three specific strategies: 1) support national-level coordination; 2) build government and partner SBCC skills; and 3) develop evidence-based supportive interventions and materials. C-Change responded to specific needs in each of the sectoral domains based on detailed assessments. For example, C-Change took a leading role in the repositioning of FP/RH by engaging the staff of the PNSR in the development of a national communication strategy and work plan. C-Change also provided key assistance for convening the December 2009 and June 2012 conferences. (*See Section B for additional information.*) C-Change also worked with the *Programme National de Lutte contre le SIDA* (PNLS) to strengthen their re-engagement of SBCC working groups at the provincial level to harmonize HIV SBCC messages.

C-Change provided SBCC capacity strengthening to the National Malaria Control Program at national, provincial, and community levels to promote malaria prevention and control communication activities and planned and supported several activities to celebrate World Malaria Day in May 2012 in Lubumbashi, Katanga Province, at which high-level authorities and partners launched a multimedia campaign for malaria prevention and control.

C-Change also developed SBCC support materials for maternal, newborn, and child health (MNCH), water and sanitation, TB, and gender-based violence (GBV), which ensured consistent and harmonized messages between sectors. These support materials have been used and distributed by partners in five health zones in both Katanga and South Kivu provinces.

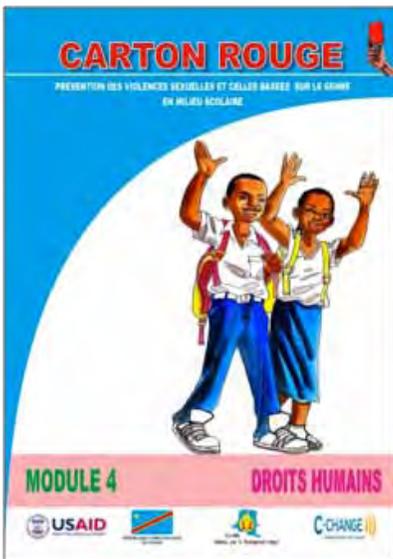
*C-Change continues work in DRC through an Associate Award that began August 1, 2012 and ends July 31, 2015.*

## COMBATING SCHOOL-RELATED GENDER-BASED VIOLENCE IN DRC

In 2010, C-Change began a new initiative in the DRC promoting positive social and gender norms to prevent and mitigate school-related gender-based violence (SRGBV) among school-aged children in Katanga Province.

The project was jointly implemented with the Congolese NGO *Initiatives pour le Développement Intégrale* (IDI) in 31 schools and neighboring communities in three districts of Katanga (Lubumbashi, Kasumbalesa and Likasi). The aim was to create a safe environment for students in schools and challenge prevailing social norms that perpetuate SRGBV in the students' communities. The project used the tested USAID Safe Schools Doorways I & III curricula for teachers and students to promote positive changes in students, teachers, school administrators, parents, and community members on attitudes and knowledge concerning GBV.

Based on formative research, C-Change developed community media campaigns utilizing radio, television, educational comic books, and other community channels to create awareness of the issues related to SRGBV and youth. These messages focused on improving attitudes and behaviors that contribute to hostile environments for students, teachers, administrators, and parents. Findings are informing future program design and enhancing the strategic approach for future interventions combating SRGBV.



Comic Book to create awareness of GBV, [www.c-hubonline.org/resources/preventing-school-related-gender-based-violence-katanga-province-drc](http://www.c-hubonline.org/resources/preventing-school-related-gender-based-violence-katanga-province-drc)

## RESULTS

As the result of C-Change work, 31 target schools have now become known as “Ecoles sans violence” (schools without violence); over 700 teachers have been trained in recognizing and combating SRGBV; 65 SRGBV focal teachers have been identified in each school to act as first responders in cases of SRGBV; 35 social service providers have been identified and built into the SRGBV referral system; 154 youth club leaders have been trained in SRGBV prevention peer mentoring techniques; 123 parents' committee members were trained on SRGBV prevention; 200 Teacher SRGBV Training Manuals were developed, printed, and distributed; three comic book editions based on SRGBV were developed and 6,000 copies were printed and distributed in the target schools; five community radio stations carried over 2,750 radio spots and over 70 in-depth radio shows to raise awareness and combat SRGBV; four television programs, bringing together teachers, parents and students to discuss SRGBV were developed and broadcast throughout Katanga Province via two local television stations; 450 Student SRGBV Training Manuals were developed, printed and distributed; 31 SRGBV Oversight Committees were established (one in each target school) comprised of teachers and parents that meet regularly to examine instances of SRGBV and report them to the appropriate authorities; and the 31 target

schools have established SRGBV local referral systems and teachers' codes of conduct explicitly addressing SRGBV.

An endline evaluation in May 2012 revealed changes in knowledge, awareness, and attitudes about SRGBV among students, teachers, school administrators, and parents. Post-project 95% of teachers and 90% of students reported being aware of how to prevent SRGBV, compared to 33% of students and 56% of teachers pre-project. The most dramatic change was a 66% reduction in violent forms of corporal punishment (striking students or using whip or canes) by teachers.

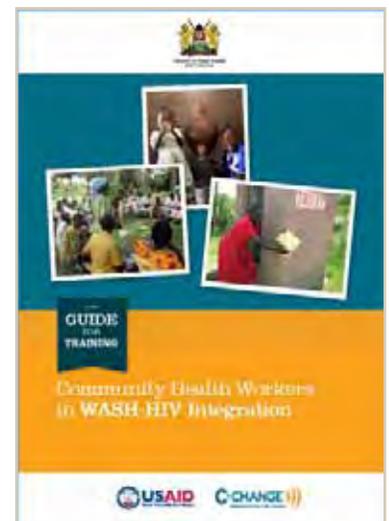
## 2 WATER, SANITATION, AND HYGIENE PROGRAMS AT COUNTRY LEVEL

### INTEGRATING WASH AND HIV/AIDS CARE AND SUPPORT IN KENYA

Begun under the Hygiene Improvement Project (HIP), the WASH-HIV Integration program in Kenya enabled partners and stakeholders to integrate WASH practices into existing training and program implementation. The WASH-HIV Integration approach identifies feasible actions that users can take to move them closer to ideal practices in washing hands properly and at critical times; treating drinking water and storing it safely; and constructing and using latrines and latrine supports, or developing alternative sanitation options for people who are too weak to use a latrine. By negotiating with people to improve WASH practices incrementally, they can take actions that improve health—actions that are possible for households to take although they may not be the ideal practice.

Based on these identified and field-tested, small doable actions, C-Change developed a training curriculum and job aids for community health workers (CHW) and supported implementing organizations in WASH-HIV integration. The project initially worked in three provinces—Coast, Nyanza, and Western—training 80 district public health officers in WASH-HIV Integration.

The second phase focused on scaling up activities to the remaining five provinces and supporting the initial three provinces to move activities deeper to reach community health workers. A truly integrated approach was used to engage district AIDS and STI officers as well as public health officers. C-Change targeted USAID's bilateral APHIA+ programs as partners to bring efforts to the community level. Phase three will continue activities under USAID's WASHplus Project, implemented by FHI 360, and will integrate CDC and Department of Defense partners as well.



*CHW Trainers Guide in WASH-HIV Integration*, available at [www.c-hubonline.org/resources/guide-training-community-health-workers-wash-hiv-integration](http://www.c-hubonline.org/resources/guide-training-community-health-workers-wash-hiv-integration)

## RESULTS

C-Change trained over 250 district public health and AIDS/STI and community strategy officers in WASH-HIV integration. Each province developed a WASH-HIV integration work plan. C-Change supported six inter-ministerial coordinating committee (ICC) meetings for WASH in four provinces and three national WASH ICC meetings to bring attention to WASH activities around the country. C-Change printed 1,000 training manuals and 10,000 job aids in English and translated the materials into Kiswahili.

At the policy level, C-Change was a member of the core team that developed the *National Environmental and Sanitation Strategy—2010–2015* and contributed to improvements in the nutrition and HIV guidelines and the sanitation guidelines by strengthening WASH language. C-Change also provided input to the WASH and HIV sections of the CHW training curriculum.

## IMPROVING WATER, SANITATION AND HYGIENE IN MADAGASCAR

At the close of the USAID-funded HIP project in Madagascar in September 2010, USAID/Madagascar continued its investment in the program through C-Change. HIP had focused on promoting improvements to three key hygiene practices (handwashing with soap, using improved latrines, and drinking safe water) and operated at scale in four regions using “WASH Everywhere” as a key approach. Building on the work and approaches started by HIP, C-Change organized community mobilization and training as well as mass media message dissemination on the importance of improving hygiene practices. Key goals were to help schools, churches, markets and other public spaces become “WASH friendly”<sup>1</sup> and to provide access for households with modest incomes to small loans to purchase sanitation products and services.

An innovative feature was the public-private partnership model for “blocs sanitaires”— pay-for-use toilet and shower blocks owned by the municipality but managed by private contractors on a for-profit basis. These have become widely imitated as one feasible solution to sanitation challenges faced by residents and passers-by in densely populated urban areas. Up to 11,000 monthly users were clocked at one bloc site.

In more rural areas, a subsidy-free sanitation initiative called “community-led total sanitation” (CLTS) was carried out. CLTS is a participatory methodology that ignites enough disgust by members of a community in their own open defecation practices in order that the community becomes galvanized to solve their own poor practices without outside assistance. C-Change worked with a wide range of partners, including the Malagasy Red Cross, the Scouting Federation of Madagascar, and World Wildlife Youth Clubs. As the U.S. Government banned any support to the government of Madagascar when C-Change began its intervention, the Project worked in creative ways to reach households and communities while assuring sustainability through partnerships with and capacity building of established organizations.

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1 “WASH friendly” means that the people managing the institution agreed to attain a level of enabling technology and promotional practices that could be certified.

## RESULTS

Combined results of HIP/C-Change technical assistance were outstanding—315,000 people were exposed to hygiene improvement messages through various channels; 1,670 community agents were trained and functional; 81 local organizations were trained; 19 local entrepreneurs were trained in latrine slab construction and were operational; 125 villages were motivated to become Open Defecation Free; 424 new latrines were constructed; and 109 people were trained in operations and maintenance of water/sanitation points.

## INTEGRATING HANDWASHING AS AN ESSENTIAL ANTENATAL CARE ACTION IN ETHIOPIA

Acting on important new evidence linking birth attendant and caretaker handwashing to a significant 43% decrease in neonatal death<sup>2</sup>, C-Change worked in collaboration with Ethiopia’s Ministry of Health and the Amhara Regional Health Bureau to integrate handwashing as a sixth essential antenatal care (ANC) action. Together they developed and tested key messaging for family actions, following the pattern set out in the *ANC Essential Action Handbook* used by HEW with families in Amhara. The key messages encouraged all family members to wash hands with soap before handling a newborn, and incorporated the “small doable action” approach to make handwashing more feasible, even when running water and soap are scarce. The key action promoted in materials and related training for HEW is construction of a simple *tippy tap* handwashing station, which reminds and facilitates handwashing. C-Change also developed a one-day training course supplementing the existing ANC training for HEW, which covered comprehensive WASH practices—handwashing, safe water, and safe feces disposal, with an emphasis on negotiating improved practices by caretakers for newborn survival and family resiliency.

## RESULTS

C-Change updated and enhanced the *ANC Essential Action Handbook* and trained 50 health extension workers/trainers in the WASH training course, with a government commitment to cascade the training down to the *kebele* (village) in at least 50 *kebeles*.

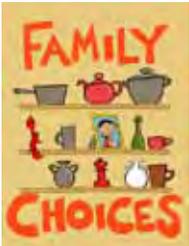
2 Rhee V. et al. 2008. “Maternal and Birth Attendant Hand Washing and Neonatal Mortality in Southern Nepal.” *Archives of Pediatrics & Adolescent Medicine*. Vol. 162 (No. 7), pp 603-608. July 2008.

## 3 SBCC PROGRAMMING WITH THE MEDIA, PRIVATE SECTOR, AND OTHERS

### SUPPORTING THE HALF THE SKY MOVEMENT FOR GIRLS AND WOMEN

C-Change supported the development of games and videos through its partner, Show of Force, as part of the Half the Sky Movement, to foster awareness about and build advocacy for gender equality and social, economic, and educational empowerment of women and girls. This global, multi-donor, multimedia, public affairs initiative is inspired by, and carried out in collaboration with, Nicholas Kristof and Sheryl WuDunn, authors of the best-selling book *Half the Sky: Turning Oppression into Opportunity for Women Worldwide*. Three mobile games and 18 short educational and advocacy videos were developed as tools for use by NGOs, governments, and other partners to help increase global awareness and bring about social change for critical health, gender equality, and empowerment topics including FP/RH, girl's education, maternal and child health, sex trafficking, women's economic empowerment, and domestic violence. A centerpiece of the multimedia initiative was a four-hour PBS television series, which premiered on October 1–2, 2012. All videos are available on C-Hub at [www.c-hubonline.org/resources/half-sky-movement-multimedia-initiative](http://www.c-hubonline.org/resources/half-sky-movement-multimedia-initiative).

Descriptions of the games<sup>3</sup> and six of the videos follow:



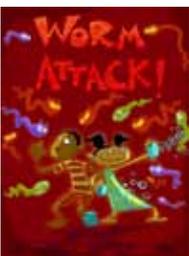
#### Game: Family Choices

*Family Choices* aims to enhance the perception of girls' place in and value to families, with an emphasis on keeping girls in school. The 'choose your own adventure' game allows players to explore the outcomes of a family's choices related to girls' education, early marriage, and family planning. Players decide whether Anu (in **India**) or Mercy (in **Kenya**) will ultimately achieve their dreams of someday becoming financially independent nurses.



#### Game: 9-Minutes

In the *9-Minutes* game, players experience the adventures of 9 months of pregnancy in just 9 minutes. The game aims to introduce players to the key do's and don'ts of pregnancy by presenting them with a series of life choices (physical, medical, and social), working against the clock and using a simple, iconic format. The players' choices determine the health and well-being of both the mother and her baby.



#### Game: Worm Attack!

*Worm Attack!* aims to keep girls and boys healthy by defeating the yucky worms inside their stomachs. Young players, their teachers, and their families work to rid themselves and their communities of infestation with intestinal worms in this fast-paced, fun game through the strategic use of deworming pills.

<sup>3</sup> Mobile games are available in India and East Africa for use on phones in English, Hindi, and Kiswahili.

### Video: Girls' Education and Delayed Marriage in India – Pooja's Story

This video complements the Half the Sky Movement's mobile game, *Family Choices*, in **India**. The video centers on an eighth-grader named Pooja who does not want to get married at age 13, which would lead her to follow the footsteps of her mother and other girls in her village. Pooja's parents and grandparents support her as they believe that delaying marriage and pursuing education is good for Pooja and the entire family.



### Video: Domestic Violence in Liberia

A candid and moving discussion about domestic violence that includes the viewpoints of both men and women in **Liberia** is documented in this film. The video aims to make the viewer see that domestic violence is not a private 'boyfriend/girlfriend' matter but a public health issue that needs discussion and ultimately to be stopped.



### Video: Comprehensive Sexual Education in India

This short video, in the style of a public service announcement, stresses the importance of comprehensive sexual education in **India**. It highlights the problems that lack of such education can cause and argues that education empowers young people to make informed decisions about their bodies, relationships, and health.



### Video: Midwifery in Somaliland – Become a Midwife!

Edna Adan, head of the only maternity hospital in **Somaliland**, encourages women to become midwives through her midwife training program. In the video, Edna describes the program, and women who participate in the training tell their stories. Pregnancy-related morbidity and mortality are extremely high in the region and Edna and her trainees are determined to change that.



### Video: Girls' Education and Female Circumcision in Kenya – Maggie the Maasai

This video complements the Half the Sky Movement's mobile game, *Family Choices*, in **Kenya**. It tells the inspiring story of one Maasai family who cast aside community judgment and chose not to circumcise their daughters. The film focuses on Maggie, the second daughter who serves in her community as a government health worker. Through the powerful example of this family, many other parents decided to abandon the harmful tradition of female circumcision and early marriage in favor of educating their daughters.



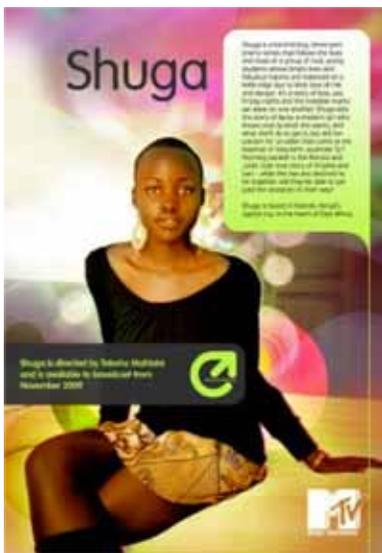


### Video: Women's Empowerment in India

The collective power of women's self-help groups in **India** is demonstrated in this video. The film highlights the individual, family, and community benefits of women joining together, creating solutions, and talks with men about treating their sons and daughters equally, about financial savings and contributing positively to their communities.

The other 12 Half the Sky Movement videos developed focused on the following topics:

INDIA	KENYA	LIBERIA
<ul style="list-style-type: none"> <li>• Family planning</li> <li>• Sex trafficking</li> <li>• Economic empowerment</li> <li>• Pregnancy health</li> <li>• Deworming</li> </ul>	<ul style="list-style-type: none"> <li>• Family planning/reproductive health</li> <li>• Economic empowerment</li> <li>• Pregnancy health</li> <li>• Deworming</li> </ul>	<ul style="list-style-type: none"> <li>• Business training</li> <li>• Reproductive health</li> </ul>
		SOMALILAND
		<ul style="list-style-type: none"> <li>• Gender norms</li> </ul>



Shuga materials available at [www.c-hubonline.org/resources/shuga-hiv-prevention-through-mtv-drama](http://www.c-hubonline.org/resources/shuga-hiv-prevention-through-mtv-drama)

### SHUGA: USING EDUTAINMENT FOR HIV PREVENTION AMONG YOUTH IN KENYA: A PUBLIC-PRIVATE PARTNERSHIP

C-Change provided TA to MTV Networks International and MTV's Staying Alive Foundation on an 'edutainment' series for young people on HIV prevention and stigma. As a result, "Shuga," a three-part, fast-moving drama was developed and filmed in Nairobi. It focuses on the lives of several young adults and university students as they confront the realities of love, jobs, and families. The series addresses sexual networks, multiple concurrent partnerships, substance abuse, and living with HIV, in the context of cultural norms.

C-Change provided additional TA to the program's online component—an innovative feature for interviews and issues discussions with cast members, Q&A, and blogging, where youth discuss issues and comment on a "question of the week." C-Change provided input on pretesting the programs and for training local broadcasters in order to strengthen their capacity to produce local programming and contributed to a training of trainers and educational toolkit for youth organizations carrying out peer education.

### RESULTS AND LESSONS LEARNED

C-Change's efforts enabled MTV to incorporate social learning theory, feature positive characters as role models and promote self-efficacy. C-Change TA also helped to increase knowledge and address misconceptions about HIV, HIV testing and treatment, and positive health behaviors. In a

program evaluation, carried out by JHU/CCP (available at [www.c-hubonline.org/sites/default/files/resources/research-testing/MTV-EVALUATION-SUMMARY.pdf](http://www.c-hubonline.org/sites/default/files/resources/research-testing/MTV-EVALUATION-SUMMARY.pdf)), more than 90% of participants said the program had an impact on their thinking with regard to HIV testing, concurrent relationships, and stigma. More than half (52%) of the participants said they had talked with a close friend and at least 10% said they had talked with a parent or guardian about the program's characters or messages. This public-private partnership with MTV had great return on investment but proved time-consuming for C-Change due to many different organizational cultures and priorities involved in the production.

## SCALING UP ORS AND ZINC TREATMENT IN INDONESIA

In Indonesia, C-Change provided a one-year follow up to the POUZN project<sup>4</sup> to build on the project's achievements. POUZN was deliberately designed to engage the private sector in the development, marketing, sale and local acceptance of zinc treatment for diarrheal episodes. POUZN created interest for zinc treatment production and marketing with the pharmaceutical industry, which led to the launch of zinc treatment in Indonesia in December 2007. Although zinc treatment had the support of top-level opinion leaders and pediatricians, support from general practitioners and midwives lagged. Therefore, C-Change was charged with applying the SBCC approach to institutionalize the promotion of zinc treatment "LINTAS Diare"<sup>5</sup> for children under five years of age by general practitioners and midwives. Objectives included getting zinc marketing into the product mix of additional sales forces that target general practitioners and midwives in the public and private sectors; including zinc in the Essential Drug List; and promoting MOH ownership of public relations and communication on oral rehydration salts (ORS). The project also included an M&E component.

## RESULTS

An evaluation carried out after four months of intense promotion in four major cities revealed the following results in change of practice among covered general practitioners and midwives, compared to baseline.

GENERAL PRACTITIONERS		
	BASELINE (%)	ENDLINE (%)
Who prescribed zinc	60	76
Most popular zinc brand prescribed	28	43
Who gave ORS	94	99
MIDWIVES		
	BASELINE (%)	ENDLINE (%)
Who dispensed zinc	39	61
Most popular zinc brand dispensed	52	54
Who gave ORS	77	83

4 The Point-of-Use Water Disinfection and Zinc Treatment project (POUZN) in Indonesia began in 2008 and ended in October 2010.

5 LINTAS Diare (lima langkah tuntaskan diare) or Five Steps to Treat Diarrhea consists of 1) giving ORALIT right away when the child gets diarrhea, for treatment or prevention of dehydration; 2) giving Zinc for 10 consecutive days, 3) continued breastfeeding and child feeding as if the child were healthy, 4) no antibiotics unless it is for bloody diarrhea or cholera, and 5) advice to the caregiver: Go back to the health provider if the child has fever, bloody feces, vomiting, no appetite for food or drink, is very thirsty, or the child's diarrhea is worsening or not improving within three days.

Sales of zinc treatment increased by 140% compared to the previous year. Zinc products were available in 86% of pharmacies nationwide. Zinc treatment was included in the National Essential Drug List and can now be procured by any Provincial Health Office and District Health Office. Finally, the MOH assumed full ownership of the public relations and the communications campaign of all “Lintas Diare” material developed by C-Change: TV, radio spots, flipcharts, pocket book, poster, banner, etc. All materials have been branded with the logo of the MOH and are available on their website.

### **INCORPORATING SOCIAL PARTICIPATION AS A “PILLAR” FOR HEALTH SYSTEMS STRENGTHENING**

C-Change was asked by USAID to develop a document that would outline the factors that support and hinder participation in health systems strengthening. The concept paper, *“Social Participation in Health Systems: Considerations for Implementation”* showcased the ways in which social participation is critical for an integrated, primary health system. The paper provided examples of policies and structures that support social participation at the national, regional and community levels. The paper highlighted some important factors for a strengthened primary health care system: 1) more attention and effort to develop intersectoral and civil society organizational alliances; 2) addressing social determinants of health; and 3) efficient allocation of funds.

#### **RESULTS**

The paper was used as the basis for an interactive session at the USAID Latin America and Caribbean (LAC) SOTA meeting on “Advocating for better health care, citizen participation and oversight” in Miami, Florida, on March 11, 2010. The paper was shared with WHO’s internal advisory group, and as a result, WHO developed a handbook for country-level implementers on how to incorporate community involvement and social participation into WHO’s health system strengthening approach “Pillar.”

### **EMPOWERING HEALTH CARE CONSUMERS IN EUROPE AND EURASIA**

C-Change was tasked by USAID’s Europe and Eurasia Bureau (E&E) to conduct a literature review and an assessment that would document the experience of three E&E countries (Albania, Armenia, Kyrgyzstan) in motivating health care consumers to take more responsibility for their health and the health of their families. The assessment team made recommendations for how the E&E Bureau and other donors could make their assistance more effective in this regard. The findings were presented at two important meetings in October 2008: 1) the USAID Central Asian Regional (CAR) Mission Workshop on Collaborative Strategies in Primary Health Care; and 2) International Conference on Primary Health Care. Recommendations from the report were highlighted in the closing charter of the International Conference on Primary Health Care.

## RESULTS

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The assessment pointed out one very important “take-away”: Empowering health care consumers to take more responsibility for their own and their family’s health cannot be achieved by a single intervention alone, but through adequate reforms and long-term SBCC interventions supported by an enabling environment of supportive structures, programs and policies.

### WORKING WITH THE HIV/AIDS ALLIANCE INTERNATIONAL IN NORTH AFRICA

USAID’s Asia and Near East (ANE) Bureau, as part of its broader program to address sexual health needs and the specific vulnerabilities of MSM in North Africa and the Middle East, provided funding for C-Change to conduct SBCC capacity strengthening workshops, focused on the C-Modules. C-Change worked in coordination with the HIV/AIDS Alliance International and targeted Alliance NGOs working with MSM projects in four countries: **Algeria, Lebanon, Morocco, and Tunisia**. The two-part training workshops were held in Tunisia and Morocco.

The first part was hosted by the *Association de Lutte Contre le Sida* in Tunisia and covered C-Modules 0 and 1. The workshop included a field trip to a project working with PLHIV, which allowed the participants to meet implementers and direct beneficiaries. The second workshop was hosted in Morocco by the *Association Marocaine pour la Santé et le Développement* and included a review of C-Modules 2-5. At this workshop, participants were given the opportunity to develop support materials and a communication work plan for a social and behavior change project.



# APPENDICES

## 1 C-CHANGE LEADER WITH ASSOCIATE AWARDS

NO.	PILLAR OFFICE/COUNTRY	AGREEMENT NO.	EFFECTIVE DATE
A.	PRH (Leader Award)	GPO-AA-00-07-00004-00	9/25/2007
Associate Awards			
1.	Ethiopia	663-A-00-08-00432-00	9/26/2008
2.	Madagascar	687-A-09-00021-00	3/3/2009
3.	Nigeria	620-A-00-09-00003-00	4/21/2009
4.	RDMA/Greater Mekong Subregion	AID-486-A-09-00006	9/15/2009
5.	HIDN/PREVENT	GHN-A-00-09-00002-00	9/30/2009
6.	Albania	182-A-00-10-00102-00	5/1/2010
7.	Peru	AID-527-LA-10-00002	7/1/2010
8.	Nicaragua	AID-524-LA-10-00001	7/9/2010
9.	Democratic Republic of Congo	AID-660-LA-12-00001	7/31/2012
10.	Namibia	AID-673-LA-12-00002	9/28/2012
<b>Total Associate Awards</b>			
<b>Total Leader and Associate Awards</b>			

PERIOD OF PERFORMANCE	TOTAL ESTIMATED AMOUNT	OBLIGATED AMOUNT	STATUS
9/25/2007 - 12/31/2012	\$ 173,764,030	\$ 67,606,830	On-going
10/01/2008 - 9/27/2013	9,839,900	9,839,900	On-going
3/03/2009 - 9/30/2009	183,983	183,983	Closed
5/01/2009 - 4/30/2014	9,306,000	7,142,826	On-going
9/16/2009 - 10/31/2012	4,200,000	3,498,322	On-going
9/30/2009 - 9/29/2015	70,000,000	16,880,000	On-going
5/01/2010 - 7/31/2010	59,600	59,600	Closed
5/18/2010 - 5/31/2012	5,314,291	5,255,000	Closed
7/12/2010 - 7/12/2013	3,000,000	2,253,181	On-going
8/01/2012 - 7/31/2015	21,500,000	5,781,380	On-going
10/01/2012 - 9/30/2014	1,600,000	957,600	On-going
	<b>125,003,774</b>	<b>51,851,792</b>	
	<b>\$ 298,767,804</b>	<b>\$ 119,458,622</b>	

## 2 PEER-REVIEWED ARTICLES

TITLE	AUTHORS	STATUS	CITATION AND URL
Gender norms and family planning decision-making in Tanzania: A qualitative study.	S Schuler, B Rottach	Published: <i>Journal of Public Health in Africa</i>	Schuler, S., E. Rottach. 2011. Gender Norms and Family Planning Decision-making in Tanzania: A qualitative study. <i>Journal of Public Health in Africa</i> 2:e25 <a href="http://www.publichealthinafrica.org/index.php/jphia/article/view/jphia.2011.e25/pdf_1">http://www.publichealthinafrica.org/index.php/jphia/article/view/jphia.2011.e25/pdf_1</a>
Influence of communication on gender attitudes on contraceptive use in Tanzania: New evidence using husbands' and wives' survey data.	G Nanda, S Schuler, R Lenzi	Published: <i>Journal of Biosocial Science</i>	Nanda, G., S. Schuler, R. Lenzi. 2013. Influence of Communication on Gender Attitudes on Contraceptive Use in Tanzania: New Evidence Using Husbands' and Wives' Survey Data. <i>Journal of Biosocial Science</i> DOI: 10.1017/S0021932012000855. <a href="http://journals.cambridge.org/action/displayAbstract?fromPage=online&amp;aid=8819685">http://journals.cambridge.org/action/displayAbstract?fromPage=online&amp;aid=8819685</a>
Developing women's empowerment scales and predicting contraceptive use: a study of 12 countries' DHS data.	F Leon	Submitted: <i>Journal of Biosocial Science</i>	
Assessment of levels of stigma and discrimination among clinic and social service agency staff in Jamaica and The Bahamas.	S Rogers, K Tureski, A Cushnie	Submitted: <i>AIDS Care</i>	
A Community Conversation Toolkit (CCT) for HIV prevention: Fostering dialogue and critical reflection for change.	W Parker, S Meyanathan, C Diala, A Becker-Benton	Submitted: <i>Journal of Health Communication</i>	
Effectiveness of peer education and mass media to effect knowledge and use of modern contraceptive methods in Albania.	G Nanda, B de Negri	To be submitted: <i>Studies in Family Planning</i>	
Fears, misconceptions, and side effects of modern contraception in Kenya.	G Nanda, J Alaii, C Ramirez	To be submitted: TBD	

TITLE	AUTHORS	STATUS	CITATION AND URL
Validation of the C-Change Gender and Family Planning Equity Scale for Measuring Effects Of SBCC.	S Schuler, G Nanda	To be submitted: <i>Journal of Sexual and Reproductive Health</i>	
Exploratory assessment of alternative use of bed nets within the Arsi Zone in Ethiopia: Findings from a household survey and observations.	H Astatke, C Marin, C Ramirez, E Tenaw, S Girma, T Pennas	To be submitted: <i>Malaria Journal</i>	
Interactive workshops to promote gender equity and family planning in rural communities of Guatemala and Tanzania: Results of a community randomized study.	S Schuler, G Nanda	To be submitted: <i>Culture, Health, and Sexuality</i>	
From vertical to horizontal: Reshaping HIV prevention communication to address sustained vulnerability among adult women in hyper-endemic epidemic contexts.	W Parker, R Borwankar, A Becker-Benton	To be submitted: TBD	
Perspectives of PLHIV on HIV prevention: Opportunities and challenges for strengthening response in Africa.	W Parker, S Rogers, A Haile, E Walakira & C Njihia	To be submitted: <i>AIDS Care</i>	
Determinants of adherence to anti-retroviral therapy in Southern and Eastern Africa: A mixed-method study.	S. Rogers, Warren Parker, S Field, A Haile, E Walakira, C Njihia	To be submitted: <i>BioMed Central Public Health</i>	



# 3 PROGRAM MONITORING PLAN — SEPTEMBER 2007 TO DECEMBER 31, 2012

## C-CHANGE PROGRAM MONITORING PLAN (PMP)

This PMP reflects the project's results management framework since inception. Most of these indicators were included in the illustrative PMP, and thus guided the project's M&E and data collection approach. During the first two years emphasis was placed on startup of activities. This current PMP includes all current activities as well as those from years 1 and 2 which were continued but does not include those which were developed and later discontinued. It reflects the critical expansion of country and core activities and is the revised management tool for the project.

The C-Change Project develops sustainable systems in social and behavior change communication (SBCC) programming, involving capacity building of Southern Partners, comprehensive planning and coordination, as well as leading core-funded knowledge generation activities to arrive at "best practices." The C-Change approach to **Social and Behavior Change Communication (SBCC)** is a researched and planned process that takes program planners and implementers through a 5 stage process: 1) Understanding the Situation, 2) Focusing and Designing, 3) Creating, 4) Implementing and Monitoring, and 5) Evaluation and Re-planning.



SOURCE: Adapted from Health Communication Partnership, P-Process Structure, COP at JHU (2003); M. Koo, Macneil, Olin, Carrigan, ACADA Model (2009); Parker, Dalrymple, and Dunlop, The Integrated Strategy Wheel (1998); AED, Tool Box for Building Health Communication Capacity (1995); National Cancer Institute, Health Communication Program Cycle (2009).

SBCC operates through three main strategies considered to be crucial for social transformation: **advocacy** to raise resources and political and social leadership commitment for development goals; **social mobilization** for wider participation and ownership, including community mobilization; and **Behavior change communication** for changes in knowledge, attitudes and practices of specific participants/audiences in programs.

When combined with strategies for the development of appropriate skills and capacities, and the provision of an enabling environment, communication plays a central role in positive social and behavior change. SBCC uses a socio ecological model which examines several levels of influence to find the "tipping point" for change. This model, used in the *C-Modules*, is a combination of socio-ecological models and psychosocial factors that can be used for analysis and planning.

This model has two parts:

- I. **Levels of analysis** are represented by the rings. The rings represent both domains of influence as well as the people representing them at each level.
- II. **Cross-cutting factors** in the triangle influence each of the actors in the rings.

The **levels of analysis** (represented by the rings) are:

1. The individual **“self”** most affected by the issue
2. Direct influencers represented by two rings:
  - a. One including **partners, family, and peers**
  - b. Another including **local community (members and leaders), services and products and providers** associated with them; all of them may shape community and gender norms, access to and demand for community resources and existing services.
3. Indirect influences which make up the outer **enabling environment**. Components of this ring may facilitate or hinder change and would include: government policies and regulations, political forces, prevailing economic conditions, the private sector, religion, technology and the natural environment. Actors in this ring, such as national government, business, faith and movement leaders, are often targets for advocacy and social mobilization activities.

Each level and the actors therein are influenced by several **cross cutting factors** (represented in the triangle) which SBCC interventions may be able to modify to generate change. These factors may act in isolation or in combination. To help identify these factors we put them into four large categories: information, motivation, ability to act, and norms:



People need **information** that is timely, accessible and relevant. When looking at information consider the level of **knowledge** held by that person or group, e.g., about modern contraceptives and their side effects. With such information, some individuals, groups, or communities may be empowered to act. For most people, however, information is not enough to change.

They require **motivation** often represented by **attitudes and beliefs** about the issues they are trying to change, e.g., attitudes towards condom use or beliefs about the benefit of FP. Motivation can be affected by SBCC, such as effective counseling, peer education, entertaining radio, or TV programs. If done well, such communication can foster individual attitudinal and behavioral change, as well as social norm change.

However, even motivation may not be enough. For instance, few women and girls in the countries hardest hit by HIV and AIDS have power in negotiating the time and conditions for having sex, including the use of condoms. Or they may lack the funds to buy condoms. They need the **ability to act** in particular circumstances that pose a threat, look at the actual skills and efficacy of the actors:

- a. Skills** include psychosocial life skills: problem-solving, decision-making, negotiation, critical and creative thinking, interpersonal communication, and other relationship skills, such as empathy;
- b. Efficacy** looks at the confidence of individuals (self-efficacy) and groups in their own skills to affect change.
- c. Access** includes financial and geographical issues such as access to health services, ability to buy products, overcome transport issues etc.

Finally, **norms**—as expressed in perceived norms, socio-cultural, and gender norms have considerable influence. Norms reflect the values of the group and specify those actions that are expected of the individual by its surrounding society. Perceived norms are those that an individual believes others are holding and therefore are expected of him or herself. Socio-cultural norms are those that the community as a whole is following because of social status or cultural conventions. Gender norms shape the society's view on what is expected of males and females.

This ecological model supports the multi-pronged approach to creating sustainable SBCC activities that C-Change has been developed to undertake. Furthermore, this approach allows C-Change to address multiple needs and issues and bring about results that all lead to the success of a sustainable SBCC program. C-Change's intermediate results reach across levels of analysis of the socio-ecological model.

Ultimately C-Change's holistic and robust approach to SBCC strengthens the chances of success as measured against the original project Intermediate Results (IRs) and expected results in SBCC: **IR1** – scale up evidence-based SBCC programs and apply best practices; **IR2** – strengthening and transfer SBCC skills and knowledge to developing country institutions; **IR3** – integrate SBCC within wider public health and development agendas; and **IR4** – generate and share effective SBCC knowledge to address emerging health and development issues.

## PMP INTRODUCTION

The purpose of any PMP is to provide a framework for the set of indicators to be used by a program to monitor that program's progress and results. This PMP is designed to do just that. The intention is that C-Change and USAID will be able to tell the story of the C-Change experience and explain not only what happened along the way but also how much of it happened, who was involved, and what were the successes, challenges and results of all that C-Change has carried out with USAID support.

The data are being systematically gathered by in-country staff and Washington, DC based Project and Activity Leaders and then stored in one of the C-Change databases (see descriptions below). Once entered into the proper database, progress towards achieving targets will be monitored on a quarterly basis. Each database has the capability of combining data points to calculate indicator results on a quarterly, annual and life of project basis. Most indicators and data collection tools are designed to be analyzed by gender, health topic, type of partner agency, and other relevant variables on the specific activity. C-Change will be able to report on how many women attended trainings and how many men attended trainings by the topic of the training, the country, and type of agency the person comes from. This type of analysis will allow C-Change to describe, in detail, who participated and to what degree they participated.

The main accomplishments to be shared through telling the story of C-change will primarily focus on two things: 1) the use of a comprehensive capacity strengthening system to effect organizational change in conducting SBCC, and 2) the benefit of increasing networking and coordination of the players in a locale to improve health promotion through a coordinated and comprehensive SBCC campaign.

Furthermore, it is important to keep in mind that we learn a great deal from our challenges and failures. To that end, this PMP will help C-Change identify where things went well or did not go well and will help us to describe that process and make informed decisions on how to make improvements. Because the IRs and expected results are key to measuring success, the C-Change PMP is organized by IR:

- The first indicators to be presented in each IR are those indicators that are global in scope, cut across multiple sites, are considered to be cross-cutting, and can be either core or field Supported.
- The second set is the indicators for the country specific field and core activities for each IR.

Each performance indicator is presented with an indicator target, the definition and unit of measurement, the data collection methods/approaches, the data compilation: frequency/responsibility, the country applications and the funding source (Core or field support). The person(s) identified in the column marked "Responsible" is either the technical activity leader, the program leader or one of the research team members responsible for data collection for that activity. The people responsible will ensure that the indicators are being measured and reported on in a timely manner. Ultimately the responsibility lies with the C-Change Director, Neill McKee and the Research Director to ensure that C-Change measures and reports on the indicators in this PMP.

Within the two groupings (Cross-cutting Indicators and Country Specific Filed and Core Activities), the PMP includes outcome, output, and process level indicators designed to assess progress for PRH and

OHA-funded activities. The indicators reflect the breadth and complexity of C-Change’s activities included in the project’s work plans. They are designed to capture the effects of the project’s efforts in multiple, cross-cutting topic areas, using a range of delivery methods. They also reflect performance monitoring and evaluation measures, and data are captured across the project in a consistent manner with responsibilities for collection and reporting spread across project staff so that implementation, research, and evaluation staff work together to fulfill PMP requirements.

The data from all projects will be collected through the Project Officers and Activity Leaders and stored in one of several databases. The databases are centrally located and can be used to describe the C-Change results disaggregated by key elements including gender, cadre, type of activity, and date of activity. The databases to store this information are:

- **Key Indicator Database** – This database stores the bulk of the indicators listed in this PMP. As projects and research activities are completed their results are reported to the central offices in DC and their relevant information is entered into this core database.
- **An Assessment Tool Database** – this keeps track of organizational scores on the CAT from baseline through follow-up
- **A Capacity Strengthening Database** – Here is where all of the training, TA, Mentoring and other forms of capacity strengthening activities are captured and counted by type of TA, topic of TA, Cadre, Gender, completion of homework (if any), etc.<sup>1</sup>
- **Knowledge Generation and Sharing Database** – Tracks all downloads, “click-throughs,” etc., and keeps track of article writing and conference presentations.

In addition to the data that will be stored in the above mentioned databases, C-Change will undertake a series of qualitative assessments and case studies of several critical areas of contribution that have been made by the Project. In order to fully explain and share the successes and failures of the program, C-change will develop four thematic cases studies and several activity-specific cases studies which will be intended to illustrate best practices and lessons learned. The four thematic areas are:

- How to conduct a comprehensive package of capacity strengthening activities (indicators 1.2, 1.2, 2.2 – 2.7, 2.18 and 2.19)
- How to organize and ensure in-country harmony and ownership of the SBCC approach (indicators 1.3, 1.4, 3.1-3.6)
- How to develop a Master’s level program on SBCC via a Center of Excellence (indicators 2.1, 2.4, 2.11, 2.16, and 2.17)
- How to use innovative and advanced technology such as eLearning and distance learning to improve SBCC (indicators 2.2, 2.3, 2.4, 2.13, and 2.14).

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<sup>1</sup> Note that for the capacity strengthening database, CS data is collected for the trainings done by C-Change and not by partners. Partner data will be captured in a limited way using the results from the individual CAT.

Additional case studies will be conducted on several of the activities that C-Change carried out over the five years of the Project. The activities considered most useful to be presented in this manner are:

- Extended use and national ownership of male circumcision materials developed through the SBCC process in Kenya
- Use of Peer Educators to influence acceptance of modern contraceptive methods in Albania
- Use of low literacy materials in a pilot program for HIV prevention amongst adults in Southern Africa

Finally, a great number of research activities have been carried out by C-Change that measure various SBCC strategies to effect change. These activities will each have their own report and distribution process. The final reports will not only be shared with USAID/Washington and USAID Missions, they will be widely disseminated through the Project website, local partners, local governments, journal articles and conference presentations.

All research activities are designed specifically to contribute to the state-of-the-art of SBCC knowledge. In all cases the intention is to use this learning directly in country programs to enhance knowledge, build skills, and improve upon health promotion programs. In addition, all C-Change activities meet federal compliance on restrictions on the use of FP/RH and HIV/AIDS funds, as well as other regulations; such as, FP/FH legislation for compliance found in Tiaht, DeConcini, Livingston, Kemp-Kasten and the Helms Amendments, the Mexico City Policy, and the Siljander and Biden requirements, as well as the HIV/AIDS legislation found in U.S. Leadership Against HIV/AIDS, TB and Malaria Act of 2003, and AAPD 05-04.

The comprehensive PMP report is available in the online version of the C-Change Final Report at [www.c-changeproject.org/sites/default/files/C-Change-Final-Report.March2013.pdf](http://www.c-changeproject.org/sites/default/files/C-Change-Final-Report.March2013.pdf)

## C-Change Performance Monitoring Plan (PMP)

### IR1: Scale Up Evidence-Based SBCC Programs and Apply Best Practices

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related indicator target
			Frequency / Responsibility	Country/ Program Applications		
<b>IR1 CROSS-CUTTING INDICATORS</b>						
1.2) # of collaborating organizations that have incorporated one or more parts of the C-Change framework into an SBCC activity or intervention	<b>Def:</b> # of collaborating organizations (gov't, entities or sub-entities, NGO/CBO/FBOs or organizations within networks working on discrete activities and receiving training or TA from C-Change for SBCC implementation) that use at least one of the following parts from C-Change's SBCC framework: 1) C-Planning; 2) Socio-Ecological Model for Change; or 3) Three Key Strategies in their activity design or implementation	Information included in work plans, protocols, and final reports	End of project data	Albania Bahamas Jamaica Kenya – malaria Kenya – RH Malawi Mozambique Namibia Swaziland PMI Core		Albania 11 (target: 15) Bahamas 1 (target: 5) Jamaica 12 (target: 4) Kenya – malaria 6 (target: 4) Kenya – RH 2 (target: 2) Malawi 1 (target: 1) Mozambique 4 (target: 3) Namibia 108 (target: 61) PMI Core 19 (target: 20) Swaziland 6 (target: 3)
	Note: for details on individual SBCC interventions within collaborating organizations, see indicator 3.				Core and Field Support	<b>Achievement: 170</b> <b>Overall target: 118</b>
	<b>Unit:</b> Collaborating organizations.					

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Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related indicator target
			Frequency / Responsibility	Country/ Program Applications		
1.3) # of government-run programs by area where the SBCC approach has been incorporated or strengthened due to C-Change country-level involvement	Def: # of government-run programs by area (e.g. Family Planning, HIV, PMTCT, ARV, MCH, malaria, TB, GBV school, GBV workplace, GBV and HIV, water and sanitation ) where the SBCC approach (evidence based and planned) is incorporated or strengthened in at least one of the following: strategic plans, program designs, program development, program implementation or program evaluation due to C-Change involvement	Information included in work plans, protocols, and final reports Case study	End of project data  Responsibility : Hibist Astatke / Program and Activity Leaders	DRC – HIV DRC – malaria DRC – RH Kenya – malaria Kenya – RH Malawi – RH Namibia PMI Core Sao Tome – malaria Swaziland		DRC – HIV 13 (target:1) DRC – malaria 8 (target:2) DRC – RH 4 (target:1) Kenya – malaria 5 (target: 4) Kenya – RH 3 (target: 2) Malawi – RH 1 (target: 1) Namibia 53 (target: 31) PMI Core 1 (target: 1) Sao Tome 4 (target: 4) Swaziland 5 (target: 1)
<i>Outcome</i>	Note: This does not include non-governmental organizations - avoid double-counting with indicator 1.2 above  Unit: Number of government program areas				Core and Field Support	Achievement: 97 Overall target: 48



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Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related indicator target
			Frequency / Responsibility	Country/ Program Applications		
1.6) % of target population reached – via media by program area  PEPFAR 8.6.D <i>Output</i>	<p><b>Def:</b> # of people in targeted areas estimated to have been reached with SBCC media messages (radio and TV) <b>divided</b> by the estimated size of the target population</p> <p><b>Unit:</b> Number of target population members</p>	Estimates will be conducted by local media partners via formal documentation methods.	<p>Bi-annual PEPFAR reporting</p> <p><b>Responsibility:</b> Susan Rogers/ Program and Activity Leaders</p>	DRC – HIV Lesotho	Field Support	<p>DRC – HIV (target: 65%) 59% (26,001,300/ 44,070,000)</p> <p>Lesotho: Indicator has been dropped due to difficulty validating data submitted by the radio station using the prescribed method.</p> <p><b>Achievement: 59%</b> (26M/44M)</p> <p><b>Overall target: 65%</b></p>
<b>IR1 COUNTRY SPECIFIC FIELD AND CORE ACTIVITY INDICATORS</b>						
1.7) % of target population with awareness of 3 or more modern contraceptive methods  <i>Outcome</i>	<p><b>Def:</b> # of university students surveyed, in targeted intervention areas, with spontaneous awareness of 3 or more modern contraceptive methods <b>divided</b> by all university student surveyed in targeted intervention areas</p> <p><b>Unit:</b> University students</p>	Program evaluation surveys	<p>Data collected at baseline and end line</p> <p><b>Responsibility:</b> Geeta Nanda</p>	Albania	Core and Field Support	<p>Albania total – 16% at baseline to 75% at end line (p&lt;.001)</p> <p>(target is significant increase between baseline and end line; p&lt;.05)</p>
1.8) % of target population who use modern contraception (CPR)  <i>Outcome</i>	<p><b>Def:</b> # of university students surveyed, in targeted intervention areas, using some form of modern contraception at last sex <b>divided</b> by all university student surveyed in targeted intervention areas</p> <p><b>Unit:</b> University students</p>	Program evaluation surveys	<p>Data collected at baseline and end line</p> <p><b>Responsibility:</b> Geeta Nanda</p>	Albania	Core and Field Support	<p>Albania total – 31% at baseline to 47% at end line (p&lt;.001)</p> <p>(target is significant increase between baseline and end line; p&lt;.05)</p>

## C-Change Performance Monitoring Plan (PMP) IR1: Scale Up Evidence-Based SBCC Programs and Apply Best Practices

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related indicator target
			Frequency / Responsibility	Country/ Program Applications		
<b>IR1 COUNTRY SPECIFIC FIELD AND CORE ACTIVITY INDICATORS</b>						
1.9) % of target population who recall hearing or seeing a specific message  <i>Output</i>	<b>Def:</b> % of target population surveyed that has seen or heard at least one message within a single health area (i.e., HIV Prevention, FP/RH or Malaria) disseminated by C-CHANGE through any channel <b>divided</b> by total target population surveyed, disaggregated by health area  <b>Unit:</b> target population surveyed	Baseline survey	End of project data  <b>Responsibility:</b> Hibist Astatke/ Activity Leaders	DRC – malaria  Mozambique	Field Support	DRC-malaria Baseline 72%/a (550/763)  Mozambique Baseline 50% (183/366)  <b>Mozambique:</b> End line data compromised due to collection method  (end line target: 15% increase from baseline)  (end line target: 5% increase from baseline)
1.10a) # of BCC/IEC activities to promote ITN use  <b>PMI Indicator</b> <i>Process</i>	<b>Def:</b> # of community health or information activities such as, outreach or group meetings that promote ITN use  <b>Unit:</b> BCC/IEC Activities	Quarterly Reports	End of project data  <b>Responsibility:</b> Hibist Astatke/ Thad Pennas/ Activity Leaders	DRC – malaria  Mozambique	Field Support	DRC-malaria 579,827 (target: 81,000)  Mozambique 11,663 (target: 10,000)  <b>Achievement: 591,490</b> <b>Overall target: 91,000</b>
1.10b) # of BCC/IEC activities to promote IPTp uptake  <b>PMI Indicator</b> <i>Process</i>	<b>Def:</b> # of community health or information activities such as, outreach or group meetings that promote IPTp uptake  <b>Unit:</b> BCC/IEC Activities	Quarterly Reports	End of project data  <b>Responsibility:</b> Hibist Astatke/ Thad Pennas/ Activity Leaders	DRC – malaria  Mozambique	Field Support	DRC-malaria 29,827 (target: 81,000)  Mozambique 7,017 (target: 10,000)  <b>Achievement: 36,844</b> <b>Overall target: 91,000</b>

## C-Change Performance Monitoring Plan (PMP) IR1: Scale Up Evidence-Based SBCC Programs and Apply Best Practices

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related indicator target
			Frequency / Responsibility	Country/ Program Applications		
1.11) % of target population who believe that nets should be used nightly to prevent Malaria	Def: # of target population surveyed who list sleeping under bed nets as a way to prevent Malaria <b>divided by</b> total target population surveyed  Unit: Target population surveyed	Baseline survey	End of project data  <b>Responsibility:</b> Hibist Astatke/ Thad Pennas/ Activity Leaders	DRC – malaria	Field Support	DRC-malaria Baseline 96% (730/758)  Mozambique Baseline 99% (355/359)  Mozambique End line 97.1% (161/166)
<b>PMI Indicator</b> Outcome						
1.12) % of household heads who believe indoor residual spraying is an effective means of malaria prevention and control	Def: # of household heads surveyed who state that IRS is an effective way to prevent malaria <b>divided by</b> total # of Household heads interviewed  Unit: Household heads surveyed	Baseline survey	End of project data  <b>Responsibility:</b> Hibist Astatke/ Thad Pennas/ Activity Leaders	Mozambique	Field Support	Mozambique Baseline 91% (327/359)  Mozambique End line 84.9% (141/166)
<b>PMI Indicator</b> Outcome						
1.13) % of target population who believe it is important to seek treatment for fever within 24 hours from a qualified provider	Def: # of target population surveyed who state it is important or very important to seek treatment for fever within 24 hours from a qualified provider <b>divided by</b> total target population surveyed  Unit: Target population surveyed	Baseline survey	End of project data  <b>Responsibility:</b> Hibist Astatke/ Thad Pennas/ Activity Leaders	DRC – malaria	Field Support	DRC-malaria Baseline 91% (695/764)  Mozambique Baseline 97% (350/359)  Mozambique End line 99.2% (165/166)
<b>PMI Indicator</b> Outcome						

## C-Change Performance Monitoring Plan (PMP) IR1: Scale Up Evidence-Based SBCC Programs and Apply Best Practices

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related indicator target
			Frequency / Responsibility	Country/ Program Applications		
1.14) % of pregnant women who have received two or more doses of IPTp during pregnancy in the last two years	<b>Def:</b> # of women surveyed who received two or more doses of a recommended anti-malarial drug treatment during ANC visits to prevent malaria during their last pregnancy that led to a live birth within the last two years <b>divided by</b> total number of women surveyed who had a live birth in the last two years <b>Unit:</b> Pregnant women surveyed	Baseline survey	End of project data  <b>Responsibility:</b> Hibist Astatke/ Thad Pennas/ Activity Leaders	DRC – malaria	Field Support	DRC-malaria (target 10% increase from baseline) Baseline 37% (144/394)
<b>PMI Indicator Outcome</b>						
<b>4.1.1 SBCC Low Literacy Material and Tools – Adult Prevention Program</b>						
<b>4.1.2 Increased Use of Community-Based Methods</b>						
1.15a) # of collaborating organizations that participated in the adaptation of the community conversation tools for adult HIV prevention	<b>Def:</b> # of collaborating organizations (gov't, NGO/CBO/FBOs or organizations within networks receiving training or TA from C-Change for SBCC implementation) that have participated in the adaptation of the community conversation tools for adult HIV prevention activities through meetings, workshops and field testing <b>Unit:</b> Number of organizations/partners	Quarterly Reports  Case Study of pilot project	End of project data  <b>Responsibility:</b> Hibist Astatke/ Sarah Meyanathan	Low Lit OHA Program Lesotho Malawi Namibia Nigeria Swaziland Zambia Zimbabwe	Core Funding	(Global PMP target: 17) Lesotho 11 Malawi 12 Namibia 16 Nigeria 23 Swaziland 13 Zambia 20 Zimbabwe 4
<b>Outcome</b>						<b>Achievement:</b> 99 <b>Overall target:</b> 17

C-Change Performance Monitoring Plan (PMP)						
IR1: Scale Up Evidence-Based SBCC Programs and Apply Best Practices						
Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related indicator target
			Frequency / Responsibility	Country/ Program Applications		
1.15b) # of collaborating organizations that have used the community conversation tools in their adult HIV prevention activities	<p><b>Def:</b> # of collaborating organizations (gov't, NGO/CBO/FBOs or organizations within Change for SBCC implementation) that have used the community conversation tools in their adult HIV prevention activities</p> <p><b>Unit:</b> Number of collaborating organizations</p>	<p>Quarterly Reports</p> <p>Case Study of pilot project</p>	<p>End of project data</p> <p><b>Responsibility:</b> Hibist Astatke/Sarah Meyanathan</p>	<p>Low Lit OHA Program</p> <p>Lesotho</p> <p>Malawi</p> <p>Namibia</p> <p>Nigeria</p> <p>Swaziland</p> <p>Zambia</p> <p>Zimbabwe</p>	<p>Core Funding</p>	<p>(Global PMP target=18)</p> <p>Lesotho 2</p> <p>Malawi 4</p> <p>Namibia 11</p> <p>Nigeria 5</p> <p>Swaziland 14</p> <p>Zambia 4</p> <p>Zimbabwe 2</p> <p><b>Achievement: 42</b></p> <p><b>Overall target: 18</b></p>
1.15c) # of national level working groups or task forces that have facilitated the use of community conversation tools for adult HIV prevention activities	<p><b>Def:</b> # of working groups or task forces that have facilitated the use of the community conversation tools for adult HIV prevention activities</p> <p><b>Unit:</b> Number of working groups or task forces</p>	<p>Quarterly Reports</p> <p>Case Study of pilot project</p>	<p>End of project data</p> <p><b>Responsibility:</b> Hibist Astatke/Sarah Meyanathan</p>	<p>Low Lit OHA Program</p> <p>Lesotho</p> <p>Malawi</p> <p>Namibia</p> <p>Nigeria</p> <p>Swaziland</p>	<p>Core Funding</p>	<p>(Global PMP target=4)</p> <p>Lesotho 0</p> <p>Malawi 1</p> <p>Namibia 2</p> <p>Nigeria 2</p> <p>Swaziland 1</p> <p><b>Achievement: 6</b></p> <p><b>Overall target: 4</b></p>
<i>Outcome</i>						
<i>Outcome</i>						

## C-Change Performance Monitoring Plan (PMP)

### IR1: Scale Up Evidence-Based SBCC Programs and Apply Best Practices

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related indicator target
			Frequency / Responsibility	Country/ Program Applications		
<b>4.1.3 Development of Voluntary Medical Male Circumcision (VMMC) Communication materials in Kenya</b>						
1.16) # of collaborating organizations using final prototypes of Male Circumcision (MC) communication materials	<b>Def:</b> Collaborating organizations here refers broadly to C-Change collaborating organizations (gov't, NGO/CBO/FBOs or organizations within networks receiving training or TA from C-Change for SBCC implementation), cooperating agencies, other national or sub-national government agencies, or NGOs. Final prototypes here refer to versions of C-Change communication materials on male circumcision that are ready to be adapted/used by others in different settings (interpersonal, community and mass media tools)	Quarterly Reports Case Study	End of project data <b>Responsibility:</b> Susan Rogers /Sarah Mcyanathan	Kenya – voluntary medical male circumcision	Core Funding	Kenya - VMMC 4 (target: 4) <b>Achievement: 4</b> <b>Overall target: 4</b>
<b>4.1.4 Technical support provided for MTV programming in Kenya</b>						
1.17) # of MTV materials for which C-Change provides technical input consistent with evidence-based approach	<b>Def:</b> MTV materials that were developed with technical assistance from C-Change (Specifically TV segments of 'Shuga' or 'Behind the Scenes' and a peer education toolkit) <b>Unit:</b> Number of materials developed	Quarterly Reports	End of project data <b>Responsibility:</b> Susan Rogers	Kenya - HIV	Core Funding	Kenya – HIV 12 (target: 12) <b>Achievement: 12</b> <b>Overall target: 12</b>
Process						

## IR2: Strengthening and Transfer SBCC Skills and Knowledge to Developing Country Institutions

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of March 31, 2012 and related indicator target
			Frequency / Responsibility	Country/ Program Applications		
<b>IR2 CROSS-CUTTING INDICATORS</b>						
2.1) # of academic institutions that are able to provide training in SBCC following 3 of C-Change's pre-determined criteria <i>Outcome</i>	<p><b>Def:</b> # of academic institutions that are able to provide training in SBCC following 3 of C-Change's pre-determined criteria</p> <p><b>Unit:</b> Number of academic institutions that meet those criteria</p>	<p>Assessment of institutions using pre-determined criteria</p> <p>Case study of COE design, set up, and assessment; work plans, protocols, final reports on successes and failures</p>	<p>End of project data</p> <p><b>Responsibility:</b> Susan Rogers/ Emily Bockh and Phillis Kim</p>	<p>Albania</p> <p>Guatemala</p> <p>South Africa</p>	<p>Core and Field Support</p>	<p>Albania 1 (target: 1)</p> <p>Guatemala 1 (target: 1)</p> <p>South Africa 1 (target: 1)</p> <p><b>Achievement: 3</b></p> <p><b>Overall target: 3</b></p>
2.2) % of agencies, organizations and work groups that increase SBCC competencies <i>Outcome</i>	<p><b>Def:</b> # of agencies, organizations, and work groups whose post-training /TA scores on SBCC competencies exceed their pre-training scores <b>divided</b> by the total number organizations receiving training and TA from C-Change</p> <p><b>Unit:</b> Trained organizations</p>	<p>Capacity Assessment Tool Database (baseline and follow-up data)</p>	<p>End of project data</p> <p><b>Responsibility:</b> Susan Rogers/ Emily Bockh and Activity Leaders</p>	<p>Albania</p> <p>Bahamas</p> <p>Guatemala</p> <p>Jamaica</p> <p>Kenya – malaria</p> <p>Kenya – RH</p> <p>Mozambique</p> <p>PMI Core</p> <p>SAT Network</p> <p>Swaziland</p>	<p>Core and Field Support</p>	<p>Albania 60% (target: 100%) (3/5)</p> <p>Bahamas 67% (target: 50%) (6/9)</p> <p>Guatemala 70% (7/10) (target: 90%) (target: 60%)</p> <p>Jamaica 93% (13/14)</p> <p>Kenya-malaria 100% (target: 100%) (7/7)</p> <p>Kenya - RH 100% (target: 100%) (2/2)</p> <p>Mozambique 100% (target: 100%) (2/2)</p> <p>PMI Core 100% (target: 100%) (21/21)</p> <p>SAT Network 100% (15/15) (target: 80%)</p> <p>Swaziland 100% (target: 100%) (2/2)</p> <p><b>Achievement: 90% (78/87)</b></p> <p><b>Overall target: 88%</b></p>

## IR2: Strengthening and Transfer SBCC Skills and Knowledge to Developing Country Institutions

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related indicator target
			Frequency / Responsibility	Country/ Program Applications		
2.3) % of people trained who exhibit application of SBCC knowledge and skills	Def: # of participants who applied the knowledge and skills they gained during training into their work <b>divided by</b> the number of participants who attended trainings covering topics in at least 3 out of the 6 C-Modules	Application survey monkey questions from Individual CAT 6 month post training	End of project data	Albania		Albania 67% (target: 100%) (14/21)
<i>Outcome</i>	'Applied knowledge and skills' can be shown by participants using at least one of the following criteria: 1. Successfully completing post-training homework assignments Producing other products (such as journalists' articles) or providing evidence of implementing SBCC in participant's own program (i.e., reaching target population with SBCC activities) 2. Demonstrating application of SBCC learnings/skills in the Individual CAT 3-6 month training follow-up survey If individual has data/information related to more than one criteria, use the data that are higher/show the most progress <b>Unit:</b> Number of participants	Post training assessment of work plans, strategies, journalist's articles	<b>Responsibility</b> : Susan Rogers/ Emily Bockh and activity leaders	Bahamas Guatemala Jamaica Kenya - malaria Kenya - RH Namibia PMI Core SAT Network Swaziland	Core and Field Support	Bahamas 43% (target: 10%) (6/14) Guatemala 56% (target: 6%) (61/108) Jamaica 24% (target: 40%) (14/59) Kenya - malaria 100% (target: 80%) (54/54) Kenya - RH 100% (target: 80%) (17/17) Namibia 100% (target: 100%) (1421/1421) PMI Core 94% (target: 100%) (66/70) SAT Network 81% (target: 80%) (21/26) Swaziland 100% (target: 100%) (14/14)
						<b>Achievement: 94%</b> <b>(1,694/1,810)</b> <b>Overall target: 75%</b>  The low percentages reflected in the Bahamas & Jamaica data are due in part to the fact that individuals trained typically do not have organizational support to complete the post-training homework assignments.

## IR2: Strengthening and Transfer SBCC Skills and Knowledge to Developing Country Institutions

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related indicator target
			Frequency / Responsibility	Country/ Program Applications		
<p>2.4) % of participants in SBCC courses with increased knowledge after completion of an SBCC Center of Excellence course</p> <p><i>Outcome</i></p>	<p><b>Def:</b> # of participants in SBCC courses at the Center of Excellence, who receive a passing grade for at least one course <b>divided by</b> the total number of students who attended at least one full course at a center of excellence</p> <p><b>Unit:</b> SBCC course participants</p>	<p>Student records for each participant with data pass/fail marks from Centers of Excellence</p>	<p>End of project</p> <p><b>Responsibility:</b> Susan Rogers &amp; Emily Bockh &amp; Phillis Kim</p>	<p>Guatemala</p> <p>Southern African countries</p>	<p>Core and Field Support</p>	<p>Guatemala <b>90%</b> (47/52) (target: 70%)</p> <p>Southern African countries <b>96%</b> (153/157) (target: 90%)</p> <p><b>Achievement: 96%</b> <b>(200/209)</b></p> <p><b>Overall target: 80%</b></p>

## IR2: Strengthening and Transfer SBCC Skills and Knowledge to Developing Country Institutions

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related indicator target
			Frequency / Responsibility	Country/ Program Applications		
<p>2.5a) # of people trained who were able to plan an SBCC intervention</p> <p><i>Outcome</i></p>	<p><b>Def:</b> # of participants who have been trained in SBCC concepts in at least 3 of 5 C-Modules (0-4) who have done at least one of the following:</p> <ol style="list-style-type: none"> <li>1) successfully completed in-training SBCC templates and/or post-training homework assignments, developed an SBCC strategy for their program, and/or other planning activities that are based on concepts in at least 3 of 5 C-Modules (0-4);</li> <li>2) completed pre and post knowledge assessments and demonstrate overall increased knowledge related to concepts in at least 3 of 5 C-Modules (0-4);</li> <li>3) completed the Individual CAT knowledge pre and post assessment and demonstrated overall increased knowledge related to concepts in at least 3 of 5 C-Modules (0-4).</li> </ol> <p>If individual has data/information for more than one of the criteria above, take the data that are higher/show the most progress</p> <p><b>Unit:</b> Number of people trained</p>	<p>Assessment of trainees documents related to the three criteria listed (i.e., quality of planning documents, pre and post test scores of surveys)</p> <p>Attendance sheets from all C-Change funded SBCC trainings to determine if attended training that covered concepts in at least 3 of 5 C-Modules (0-4) (if not available check ERs, quarterly reports, imprest)</p>	<p>End of project data</p> <p><b>Responsibility:</b> Susan Rogers/ Emily Boeckh and activity leaders</p>	<p>Bahamas Guatemala Jamaica Kenya – malaria Kenya – RH Mozambique Namibia PMI Core SAT Network Swaziland</p>	<p>Core and Field Support</p>	<p>Bahamas 14 (target: 14) Guatemala 126 (target: 82) Jamaica 24 (target: 24) Kenya - malaria 35 (target: 105) Kenya – RH 14 (target: 14) Mozambique 861 (target: 39) Namibia 1,393 (target: 1,183) PMI Core 68 (target: 75) SAT Network 23 (target: 15) Swaziland 14 (target: 14)</p> <p><b>Achievement: 2,572</b> <b>Overall target: 1,565</b></p>



## IR2: Strengthening and Transfer SBCC Skills and Knowledge to Developing Country Institutions

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related indicator target
			Frequency / Responsibility	Country/ Program Applications		
2.6) # of people trained in SBCC  <i>Output</i>	Def: # of participants who complete an SBCC training that covers topics in at least 3 out of the 6 C-Modules	Capacity assessment reports  Attendance sheets from all C-Change funded SBCC trainings (if not available check expense reimbursements, quarterly reports, imprest)	End of project data  <b>Responsibility:</b> Susan Rogers/ Emily Bockh and activity leaders	Albania Bahamas DRC Guatemala Jamaica Kenya – malaria Kenya – RH Malawi	Core and Field Support	21 (target: 21) 14 (target: 14) 430 (target: 275) 204 (target: 100) 50 (target: 50) 54 (target: 105) 17 (target: 17) 250 (target: 250)
	Unit: Number of people trained			Mozambique Namibia Nigeria PMI Core Sao Tome – malaria SAT Network Swaziland		867 (target: 26) 1,433 (target: 1,253) 119 (target: 12) 70 (target: 75) 58 (target: 50) 26 (target: 15) 14 (target: 14)
						<b>Achievement: 3,627</b> <b>Overall target: 2,227</b>

## IR2: Strengthening and Transfer SBCC Skills and Knowledge to Developing Country Institutions

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related indicator target
			Frequency / Responsibility	Country/ Program Applications		
2.7) # of local organizations with which C-Change engages in SBCC capacity strengthening activities  <i>Output</i>	<p><b>Def:</b> # of local organizations (indigenous government or non-governmental organization within country receiving training or technical assistance for implementation of SBCC from C-Change) that C-Change has partnered with to provide SBCC training and/or technical assistance</p> <p><b>Unit:</b> Number of collaborating indigenous organizations</p>	<p>CS event form (if not available use Trip Reports, Quarterly reports)</p> <p>Case Study to include indicators 2.2 – 2.7</p>	<p>End of project data</p> <p>Responsibility: Susan Rogers/ Emily Bockh and activity leaders</p>	<p>Albania Bahamas DRC Guatemala Jamaica Kenya – malaria Kenya –VMMC Kenya – RH Malawi</p>	<p>Core and Field Support</p>	<p>4 (target: 6) 15 (target: 10) 43 (target: 19) 19 (target: 8) 26 (target: 18) 2 (target: 5) 4 (target: 4) 2 (target: 2) 2 (target: 2)  2 5 (target: 3) 86 (target: 63) 25 (target: 1) 22 (target: 20) 23 (target: 10) 3 (target: 3) 6 (target: 6)</p>
<b>IR2 COUNTRY SPECIFIC FIELD AND CORE ACTIVITY INDICATORS</b>						
2.8) % of C-Change trained trainers who provide trainings/technical assistance to others in at least one SBCC topic area	<p><b>Def:</b> # C-Change trained trainers who provide trainings/technical assistance to others in at least one SBCC topic area covered in any of the C-Modules <b>divided by</b> total number of people participating in trainer of trainers workshops</p> <p><b>Unit:</b> Number of C-Change trainers of trainers</p>		<p>End of project data</p> <p><b>Responsibility:</b> Susan Rogers/ Antje Becker and activity leaders</p>	<p>Mozambique SAT Network Swaziland</p>	<p>Core and Field Support</p>	<p>80% (target: 100%) 86% (target: 80%) 100% (18/18) (target: 100%) <b>Achievement: 92%</b> <b>(34/37)</b> <b>Overall target: 93%</b></p>
<i>Outcome</i>						<p><b>Achievement: 287</b> <b>Overall target: 180</b></p>

## *IR2: Strengthening and Transfer SBCC Skills and Knowledge to Developing Country Institutions*

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related indicator target
			Frequency / Responsibility	Country/ Program Applications		
2.9a) # of peer educators who successfully complete a RH peer education training <i>Output</i>	<b>Def:</b> # of peers who successfully complete the RH peer education training <b>Unit:</b> Peer Educators	Project Capacity Strengthening Database	End of project data <b>Responsibility:</b> Susan Rogers / Antje Becker and activity leaders	Albania	Core and Field Support	Albania 1,095 (target: 900) <b>Achievement: 1,095</b> <b>Overall target: 900</b>
2.9b) # of peer educators who successfully complete a HIV peer education training <i>Output</i>	<b>Def:</b> # of peers who successfully complete the HIV peer educator training <b>Unit:</b> # of Peer Educators	Project Capacity Strengthening Database	End of project data <b>Responsibility:</b> Susan Rogers / Sarah Meyanathan activity leaders	Lesotho	Core and Field Support	Lesotho 350 (target: 350) <b>Achievement: 350</b> <b>Overall target: 350</b>

## IR2: Strengthening and Transfer SBCC Skills and Knowledge to Developing Country Institutions

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related indicator target
			Frequency / Responsibility	Country/ Program Applications		
<b>1.2.1 and 4.2.1 Support to Capacity Strengthening</b>						
2.10a) # of external downloads of C-Change's C-Modules  <i>Output</i>	<p><b>Def:</b> Downloads refers to copying and sending data from C-Change's website to a user's data storage space, one or all modules; it does not reflect the number of people who have downloaded, but downloads themselves</p> <p><b>Unit:</b> # of external downloads of C-Change's C-Modules</p>	Web Activity Database	<p>Quarterly</p> <p><b>Responsibility:</b> Susan Rogers/ Emily Bockh</p>	Worldwide	Core Funding	<p>Worldwide <b>28,471</b> (target: 100/month on average)</p> <p><b>Achievement: 28,471</b> <b>Total target: 3,300</b></p>
2.10b) # of external downloads of C-Change SBCC Capacity Assessment Tools  <i>Output</i>	<p><b>Def:</b> Downloads refers to copying and sending data from C-Change's website to a user's data storage space, one or all modules; it does not reflect the number of people who have downloaded, but downloads themselves</p> <p><b>Unit:</b> # of external downloads of C-Change's SBCC Capacity Assessment Tools</p>	Web Activity Database	<p>Quarterly</p> <p><b>Responsibility:</b> Susan Rogers/ Emily Bockh</p>	Worldwide	Core Funding	<p>Worldwide <b>5,008</b> (target: 40/month on average)</p> <p><b>Achievement: 5,008</b> <b>Total target: 1,320</b></p>

## *IR2: Strengthening and Transfer SBCC Skills and Knowledge to Developing Country Institutions*

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related indicator target
			Frequency / Responsibility	Country/ Program Applications		
2.10c) # of external downloads of C-Change Adaptation Bulletins <i>Output</i>	<p><b>Def:</b> Downloads refers to copying and sending data from C-Change's website to a user's data storage space, one or all modules; it does not reflect the number of people who have downloaded, but downloads themselves</p> <p><b>Unit:</b> # of External downloads of C-Change's Adaptation Bulletins</p>	Web Activity Database	<p>Quarterly</p> <p><b>Responsibility:</b> Susan Rogers/ Emily Bockh</p>	Worldwide	Core Funding	<p>Worldwide 457 (target: 40/month on average)</p> <p><b>Achievement: 457</b> <b>Total target: 400</b></p>
2.10d) # of external downloads of C-Change SBCC Framework and other CS Toolkit components <i>Output</i>	<p><b>Def:</b> Downloads refers to copying and sending components of the CS Toolkit from C-Change's website to a user's data storage space; it does not reflect the number of people who have downloaded, but downloads themselves</p> <p><b>Unit:</b> # of External downloads of C-Change SBCC Framework and/or other CS Toolkit components</p>	Web Activity Database	<p>Quarterly</p> <p><b>Responsibility:</b> Susan Rogers/ Emily Bockh</p>	Worldwide	Core Funding	<p>Worldwide 1,099 (target: 10/month on average)</p> <p><b>Achievement: 1,099</b> <b>Total target: 330</b></p>

## IR2: Strengthening and Transfer SBCC Skills and Knowledge to Developing Country Institutions

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related indicator target
			Frequency / Responsibility	Country/ Program Applications		
2.11) # of participants from local collaborating organizations and/or host national staff participants from international organizations attending an SBCC course by the Center of Excellence  <i>Output</i>	<b>Def:</b> # of individuals from local collaborating organizations (gov't, NGO/CBO/FBOs or organizations within networks receiving training or TA from C-Change for SBCC implementation) and/or host national staff from international organizations (locally based organization with a headquarter office outside of the country) who are enrolled in SBCC course(s) conducted by a Center of Excellence  <b>Unit:</b> Number of participants	University student records	End of project data  <b>Responsibility:</b> Susan Rogers/ Emily Bockh and activity leaders	Africa C-Change implementation countries Guatemala	Core Funding	Africa C-Change implementation countries (target: 20) <b>34</b> Guatemala <b>15</b> (target: 5) <b>Achievement: 49</b> <b>Overall target: 25</b>
2.12) # of developing country readers subscribed to C-Capacity e-magazine  <i>Output</i>	<b>Def:</b> Individuals (distinct from the C-Change list-serve subscribers) from countries of Africa, Asia and South America who register to have access to e-magazine of C-Change  <b>Unit:</b> Number of developing country readers	Web Activity Database	Quarterly  <b>Responsibility:</b> Susan Rogers/ Sarah Mcyanathan	Worldwide	Core Funding	Worldwide <b>9,357</b> (target: 1,000/year) <b>Achievement: 9,357</b> <b>Total target: 2,750</b>

## IR2: Strengthening and Transfer SBCC Skills and Knowledge to Developing Country Institutions

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related indicator target
			Frequency / Responsibility	Country/ Program/ Applications		
2.13) # of people completing at least one online C-Module course <i>Output</i>	<b>Def:</b> # of people completing online trainings that are facilitated by an Ohio University instructor or are self-paced <b>Unit:</b> Number of people completing online trainings	Quarterly Reports, Ohio University – student records by log-in and participant name	End of project data <b>Responsibility:</b> Susan Rogers/ Emily Bockh	Worldwide	Core Funding	Worldwide 158 (target: 270/year) <b>Achievement: 156</b> <b>Total target: 202</b> <i>(target adjusted for a 9-month activity period)</i>
2.14) # of people trained to facilitate online C-Modules courses <i>Process</i>	<b>Def:</b> # of people trained to facilitate instructor- led online C-Module courses <b>Unit:</b> # of people trained	Quarterly Reports Ohio University – student records by log-in and participant name	End of project data <b>Responsibility:</b> Susan Rogers/ Emily Bockh	AfriComNet	Core Funding	AfriComNet 9 (target: 6) <b>Achievement: 9</b> <b>Overall target: 6</b>
<b>1.2.1 and 4.2.1 Support to Capacity Strengthening, 1.2.3 Guatemala: Support to Develop a Center of Excellence</b>						
2.15) # online communities of practice established <i>Outcome</i>	<b>Def:</b> # of online communities of practice established based on predetermined criteria <b>Unit:</b> Number of communities established	Quarterly Reports	End of project data <b>Responsibility:</b> Susan Rogers/ Sarah Meyanathan	Jamaica SAT Network South Africa	Core Funding	Jamaica 3 (target: 1) SAT Network 2 (target: 1) South Africa 1 (target: 1) <b>Achievement: 6</b> <b>Overall target: 3</b>
2.16) # students who attended a course in SBCC at the centers of excellence <i>Output</i>	<b>Def:</b> # of students who attended a full course at a center of excellence <b>Unit:</b> Student	Quarterly Reports University student records	End of project data <b>Responsibility:</b> Susan Rogers/ Emily Bockh and Phyllis Kim	Southern African countries	Core Funding	Southern African countries 156 (target: 100) <b>Achievement: 156</b> <b>Overall target: 100</b>

## IR2: Strengthening and Transfer SBCC Skills and Knowledge to Developing Country Institutions

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related indicator target
			Frequency / Responsibility	Country/ Program Applications		
2.17) # of SBCC courses or workshops implemented by a center of excellence  <i>Process</i>	<b>Def:</b> # of SBCC courses or workshops implemented at a center of excellence  <b>Unit:</b> # of SBCC courses or workshops	Quarterly Reports from University student records	End of project data  <b>Responsibility:</b> Susan Rogers/ Emily Bockh and Phillis Kim	Guatemala South Africa	Core Funding	Guatemala 4 (target: 4) South Africa 10 (target: 5/year) <b>Achievement: 14</b> <b>Total target: 14</b>
2.18) % of collaborating organizations within SAT using SBCC tools  <i>Outcome</i>	<b>Def:</b> # collaborating organizations within SAT (gov't, NGO/CBO/FBOs or organizations within networks receiving training or TA from C-Change for SBCC implementation) using worksheets, checklists, and templates from the C-Modules for training and/or SBCC program design <b>divided by</b> all collaborating organizations within SAT  <b>Unit:</b> Collaborating organizations	Assessment of organizations trained/ Capacity Assessment Tool  Case Study	End of project data  <b>Responsibility:</b> Susan Rogers/ Emily Bockh	SAT Network	Core Funding	SAT Network 100% (15/15) (target: 100%) <b>Achievement: 100%</b> <b>(15/15)</b> <b>Overall target: 100%</b>

## IR2: Strengthening and Transfer SBCC Skills and Knowledge to Developing Country Institutions

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related indicator target
			Frequency / Responsibility	Country/ Program Applications		
<p><b>4.2.2 Regional SBCC capacity strengthening with SAT Network</b></p> <p>2.19) % of participants from collaborating organizations within SAT who exhibit increased knowledge after participation in an SBCC training</p> <p><i>Output</i></p>	<p><b>Def:</b> # of training participants within the SAT network who have done at least one of the criteria listed below <b>divided by</b> all SAT training participants who have been trained in SBCC concepts related to at least 3 of the 6 C-Change Modules.</p> <p><b>Criteria:</b></p> <ol style="list-style-type: none"> <li>1) successfully completed in-training SBCC templates and/or post-training homework assignments related to concepts in at least 3 of 6 C-Change modules;</li> <li>2) completed pre and post knowledge assessments and demonstrate overall increased knowledge related to concepts in at least 3 of the 6 C-Change modules;</li> <li>3) completed the Individual CAT knowledge pre and post assessment and demonstrated overall increased knowledge related to concepts in at least 3 of the 6 C-Change modules</li> </ol> <p>If individual has data/information for more than one of the criteria listed above, use data that demonstrate the most progress</p> <p><b>Unit:</b> Number of participants</p>	<p>Project Capacity Strengthening Database</p>	<p>Find of project data</p> <p><b>Responsibility:</b> Susan Rogers/ Emily Bockh</p>	<p>SAT Network</p>	<p>Core Funding</p>	<p>SAT Network 92% (24/26) (target: 75%)</p> <p><b>Achievement: 92% (24/26)</b></p> <p><b>Overall target: 75%</b></p>

## IR3: Integrate SBCC Within Wider Public Health and Development Agendas

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related indicator target
			Frequency / Responsibility	Country / Program Applications		
<b>IR3 CROSS-CUTTING INDICATORS</b>						
3.2a) # of national or lower level technical working groups or task forces that develop or revise SBCC strategies with support from C-Change	<p><b>Def:</b> # of national or lower level technical working groups or task forces that develop new or revise existing SBCC strategies with technical assistance from C-Change</p> <p><b>Unit:</b> # of technical working groups or task forces</p>	Quarterly Reports	End of project data	DRC – FP DRC – HIV DRC – malaria Guatemala Jamaica Kenya – malaria Kenya –VMMC Kenya – RH Malawi Mozambique Namibia Nigeria Swaziland	Field Support	DRC – FP 2 (target: 3) DRC – HIV 3 (target: 1) DRC – malaria 9 (target: 5) Guatemala 2 (target: 1) Jamaica 2 (target: 2) Kenya – malaria 5 (target: 2) Kenya –VMMC 2 (target: 2) Kenya – RH 2 (target: 1) Malawi 3 (target: 3) Mozambique 2 (target: 2) Namibia 34 (target: 34) Nigeria 7 (target: 2) Swaziland 2 (target: 1)
3.3) # of C-Change led global, national or regional conferences, meetings or summits to advocate or strategize on the use and importance of SBCC	<p><b>Def:</b> # C-Change led Global, National or regional SBCC Conferences, Meetings (does not include on-going working groups and task force meetings) or Summits to strategize or advocate on the use and importance of SBCC</p> <p><b>Unit:</b> # of C-Change led conferences, meetings or summits</p>	Quarterly Reports	End of project data	DRC - HIV DRC - malaria DRC-WATSAN Kenya – malaria Kenya –VMMC Kenya – RH Malawi Namibia Nigeria Swaziland	Field Support	DRC – HIV 2 (target: 1) DRC - malaria 1 (target: 8) DRC - WATS 2 (target: 1) Kenya - malaria 4 (target: 2) Kenya –VMMC 1 (target: 1) Kenya – RH 1 (target: 2) Malawi 11 (target: 11) Namibia 46 (target: 44) Nigeria 9 (target: 2) Swaziland 2 (target: 2)
<p><b>Achievement: 75</b> <b>Overall target: 59</b></p>						79 74

## IR3: Integrate SBCC Within Wider Public Health and Development Agendas

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation Frequency / Responsibility	Country / Program Applications	Funding Source	Value reported as of December 31, 2012 and related indicator target
3.4a) # SBCC coordination strategy documents developed by national or lower level technical working groups or task forces with support from C-Change	<p><b>Def:</b> # of SBCC coordination strategy documents ( plans, guidelines or any other written materials) developed by national or lower level technical working groups or task forces with support by C-Change (for a more coordinated approach to SBCC or to spell out how to carry out coordinated SBCC programming)</p> <p><b>Unit:</b> # of coordination strategy documents</p>	Quarterly Reports	<p>End of project data</p> <p><b>Responsibility:</b> Hibist Astatke/ Antje Becker /Program and activity leaders</p>	<p>DRC – FP</p> <p>DRC – malaria</p> <p>Guatemala</p> <p>Jamaica</p> <p>Kenya – malaria</p> <p>Kenya –VMMC</p> <p>Malawi</p> <p>Mozambique</p> <p>Namibia</p> <p>Nigeria</p> <p>Swaziland</p>	Field Support	<p>DRC – FP 14 (target: 6)</p> <p>DRC – malaria 1 (target: 4)</p> <p>Guatemala 9 (target: 6)</p> <p>Jamaica 5 (target: 6)</p> <p>Kenya – malaria 2 (target: 1)</p> <p>Kenya –VMMC 1 (target: 1)</p> <p>Malawi 1 (target: 1)</p> <p>Mozambique 3 (target: 2)</p> <p>Namibia 42 (target: 41)</p> <p>Nigeria 12 (target: 1)</p> <p>Swaziland 1 (target: 1)</p> <p><b>Achievement: 91</b></p> <p><b>Overall target: 70</b></p>
3.4b) # of SBCC materials developed with support from C-Change for use in national or sub-national programs	<p><b>Def:</b> SBCC materials for mass media, group, and/or individual interventions (does not include C-change Community Conversation Toolkit) for national or sub-national programs (any government or non-government programs)</p> <p><b>Unit:</b> Number of SBCC materials</p>	Quarterly Reports	<p>End of project data</p> <p><b>Responsibility:</b> Hibist Astatke/ Antje Becker /Program and activity leaders</p>	<p>DRC – FP</p> <p>DRC – GBV</p> <p>DRC – HIV</p> <p>DRC – malaria</p> <p>DRC – MCH</p> <p>DRC-WATSAN</p> <p>DRC-TB</p> <p>Half the Sky</p> <p>Jamaica</p> <p>Kenya – malaria</p> <p>Kenya –VMMC</p> <p>Malawi</p> <p>Mozambique</p> <p>Namibia</p> <p>Sao Tome – malaria</p> <p>Swaziland</p>	<p>Core &amp; Field Support</p>	<p>DRC – FP 25 (target: 26)</p> <p>DRC – GBV 20 (target: 25)</p> <p>DRC – HIV 70 (target: 81)</p> <p>DRC – malaria 49 (target: 58)</p> <p>DRC – MCH 25 (target: 31)</p> <p>DRC – WATSAN 30 (target: 50)</p> <p>DRC – TB 7 (target:15)</p> <p>Half the Sky 24 (target: 20)</p> <p>Jamaica 22 (target: 6)</p> <p>Kenya-malaria 1 (target: 1)</p> <p>Kenya –VMMC 53 (target: 14)</p> <p>Malawi 13 (target: 13)</p> <p>Mozambique 11 (target: 2)</p> <p>Namibia 50 (target: 39)</p> <p>Sao Tome 10 (target: 10)</p> <p>Swaziland 5 (target: 5)</p> <p><b>Achievement: 413</b></p> <p><b>Overall target: 386</b></p>

### IR3: Integrate SBCC Within Wider Public Health and Development Agendas

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation Frequency / Responsibility	Country / Program Applications	Funding Source	Value reported as of December 31, 2012 and related indicator target
<b>4.3.2 USAID e-Learning module on SBCC</b>						
3.9) # of individuals completing the final E-learning module <i>Output</i>	<p><b>Def:</b> # of individuals, that have worked through the E-learning modules on the design and implementation of their various health and development programs</p> <p><b>Unit:</b> Individuals completing the final E-learning module</p>	USAID website	<p>End of project data</p> <p><b>Responsibility:</b> Hibist Astatke/Emily Bockh</p>	Worldwide	Core Funding	<p>Worldwide {activity not yet completed} (target: 15/month)</p> <p>The C-Change project will not be reporting on this indicator as the course is to be approved by USAID in late December and will not be available to users before December 31, 2012.</p>
<b>4.3.3 Collaboration with the African Broadcast Media Partnership (AMP)</b>						
3.10a) # of high level media practitioners (network owners, producers or editors) oriented in SBCC approaches <i>Output</i>	<p><b>Def:</b> # of high level media practitioners (network owners, producers or editors) oriented in SBCC approaches (attended a basic SBCC orientation meeting at an ABMP meeting)</p> <p><b>Unit:</b> Number of high level media practitioners</p>	<p>Project Capacity Strengthening Database</p> <p>eSurvey to measure SBCC incorporation</p>	<p>End of project data</p> <p><b>Responsibility:</b> Susan Rogers/ Thad Pennas</p>	AMP countries	Core Funding	<p>ABMP 79 (target: 55) Sao Tome – malaria 3 (target: 3)</p> <p><b>Achievement: 82</b> <b>Overall target: 55</b></p>
3.10b) # of high level media practitioners that show evidence of incorporating SBCC into their programming <i>Outcome</i>	<p><b>Def:</b> # of high level media practitioners (network owners, producers or editors) who show evidence of incorporating SBCC into their programming (have either aired the ABMP PSA on HIV or RH and/or have produced and aired their own program on HIV or RH)</p> <p><b>Unit:</b> Number of high level media practitioners</p>	<p>Project Capacity Strengthening Database</p> <p>eSurvey to measure SBCC incorporation</p>	<p>End of project data</p> <p><b>Responsibility:</b> Susan Rogers/ Thad Pennas</p>	ABMP countries	Core Funding	<p>ABMP 79 (target: 55)</p> <p><b>Achievement: 79</b> <b>Overall target: 55</b></p>

## IR4: Generate and Share Effective SBCC Knowledge to Address Emerging Health and Development Issues

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation Frequency/ Responsibility	Country Applications	Funding Source	Value reported as of December 31, 2012 and related indicator target
<b>IR4 CROSS-CUTTING INDICATORS</b>						
4.1) # of peer reviewed articles submitted or published in academic journals	<p><b>Def:</b> Articles written by C-Change staff and “partners” that have been accepted by peer review journals for publication</p> <p><b>Unit:</b> Number of Papers</p>	Journal database	Upon submission	All relevant study countries	Core and Field Support	3 (target: 8) <b>Achievement: 3</b> <b>Overall target: 8</b>
<i>Outcome</i>			<b>Responsibility:</b> Susan Rogers/Geeta Nanda			
4.2a) # of Professional Conferences where C-Change results are presented	<p><b>Def:</b> Presenting study results in conferences as either posters, abstracts, round table discussions, or oral presentations</p> <p><b>Unit:</b> Number of studies presented</p>	Conference tracking database	Upon submission	All relevant study countries	Core and Field Support	9 (target: 5) <b>Achievement: 9</b> <b>Overall target: 5</b>
<i>Outcome</i>			<b>Responsibility:</b> Susan Rogers/Geeta Nanda			
4.2b) # of C-Change presentations made at Professional Conferences	<p><b>Def:</b> # of presentations made at the same Professional Conference or across different conferences.</p> <p><b>Unit:</b> Number of presentations</p>	Conference tracking database	Upon submission	All relevant study countries	Core and Field Support	20 (target: 10) <b>Achievement: 20</b> <b>Overall target: 10</b>
<i>Process</i>			<b>Responsibility:</b> Susan Rogers/Geeta Nanda			

## IR4: Generate and Share Effective SBCC Knowledge to Address Emerging Health and Development Issues

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/Approaches		Data Compilation Frequency/Responsibility		Country Applications	Funding Source	Value reported as of December 31, 2012 and related indicator target
<b>IR4 CROSS-CUTTING INDICATORS</b>								
4.3) # of research studies from which findings are disseminated to key audiences through multiple channels  <i>Process</i>	<p><b>Def:</b> # of research studies (those conducted directly by C-change or its contractors) from which findings (learning from research studies) are disseminated to key audiences through multiple channels (via formal communication channels with USAID and implementation partners; technical briefs disseminated via website and listserves and e-journals; and in-country workshops held to discuss study findings and develop recommendations for incorporating results into communication programs)</p> <p><b>Unit:</b> Number of research studies</p>	Quarterly Reports	End of project data	All relevant study countries	Core and Field Support	17 (target: 8)		<p><b>Achievement: 17</b></p> <p><b>Overall target: 8</b></p>

## IR4: Generate and Share Effective SBCC Knowledge to Address Emerging Health and Development Issues

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related indicator target
			Frequency/ Responsibility	Country Applications		
<b>IR4 COUNTRY SPECIFIC FIELD AND CORE ACTIVITY INDICATORS</b>						
<b>1.4.3 Tanzania: Family Planning (FP) Gender Norms Intervention Research</b>						
4.4) # of pills and condoms sold in site  <i>Outcome</i>	Def: # of pills and male and female condoms sold through community based distributors (CBDs) in the intervention (communities where gendered FP radio spots are aired and CBDs receive training) site  Unit: Pills and condoms	CBD service statistics	End of project data  Responsibility: Hibist Astatke/Sidney Schuler	Tanzania	Core Funding	# of pills sold: approximately 400 pill cycles in the one month before a radio intervention and 160 in the one month after  # of male condoms sold: approximately 340 in the one month before a radio intervention and 110 in the one month after  # of female condoms sold: approximately 100 in the one month before a radio intervention and 15 in the one month after
4.6) Average gender equity score disaggregated by gender  <i>Outcome</i>	Def: Sum of survey respondents' score on each item in the Gender Equitable Men (GEM) Scale divided by the total number of survey respondents disaggregated by gender  Unit: Average Score on GEM Scale	GEM Scales	End of project data  Responsibility: Hibist Astatke/Sidney Schuler	Tanzania	Core Funding	Males 7.6 at baseline and 7.8 at end line (NS);  Females 7.8 at baseline and 10.0 at end line (p <.01)  (target: statistically significant increase over baseline in intervention site, p<.05)

## IR4: Generate and Share Effective SBCC Knowledge to Address Emerging Health and Development Issues

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation Frequency/ Responsibility	Country Applications	Funding Source	Value reported as of December 31, 2012 and related indicator target
<b>1.4.4 Albania: Evaluation of University Student Modern Contraceptive Intervention and Clinic-Based Capacity Strengthening</b>						
4.7) % of target population using modern contraception disaggregated by gender	Def: # of all university students surveyed, in targeted intervention areas, using some form of modern contraception at last sex <b>divided by</b> all university student surveyed in targeted intervention areas disaggregated by gender	Endline –baseline comparison	Data collected at baseline and end line <b>Responsibility:</b> Hibist Astatke/Geeta Nanda	Albania	Core Funding	Males 53% at baseline to 72% at end line (p<.05); Females 18% at baseline to 23% at end line (NS) (target: significant increase between baseline and end line, p<.05)
<b>1.4.5 Benin: A Paper Version for Tracking the Menstrual Cycle for Standard Days Method (SDM) Users</b>						
4.9) # of CycleBeads sold in the intervention area	Def: # of CycleBeads sold in the intervention area  Unit: CycleBeads sold	Before and after comparison of sales data	End of project data (process monitoring available)  <b>Responsibility:</b> Hibist Astatke/Geeta Nanda	Benin	Core Funding	20 (target: 45) <b>Achievement: 20</b> <b>Overall target: 45</b>
<b>1.4.6 Zambia: Enhancing SBCC in FP/HIV Integration</b>						
4.10) % of HIV-infected and uninfected individuals in project area using modern methods of contraception	Def: # of surveyed respondents using modern contraception methods divided by all surveyed respondents disaggregated by HIV-status  Unit: HIV-infected and uninfected individuals	Baseline and endline surveys and program statistics	End of project data  <b>Responsibility:</b> Hibist Astatke/Bamikal Feysieran	Zambia	Core Funding	HIV infected women-44% at baseline and 58% at end line (p<.05)  HIV non-infected women-42% at baseline and 52% at end line (p<.05) (target: significant increase between baseline and end line, p<.05)

## IR4: Generate and Share Effective SBCC Knowledge to Address Emerging Health and Development Issues

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related indicator target
			Frequency/ Responsibility	Country Applications		
<b>IR4 COUNTRY SPECIFIC FIELD AND CORE ACTIVITY INDICATORS</b>						
<b>1.4.7 PRH &amp; 4.4.4 OHA SBCC Information Dissemination</b>						
4.11a) # of new records (a record is a database term for a collection of files) approved for upload to C-Hub (See also 4.11c)	<p><b>Def:</b> A record is a database term for a collection of files. The indicator measures the upload of a new record (approved set of materials) to the database</p> <p><b>Unit:</b> one record</p>	Web Activity Database	Quarterly	Worldwide	Core Funding	<p>283 (target: 40 annually)</p> <p><b>Achievement: 283</b></p> <p><b>Total target: 110</b></p>
4.11b) # of unique pageviews of C-Hub records	<p><b>Def:</b> Unique pageviews refers to a user clicking on a record on the C-Hub website to view its contents and is measured under Google Analytics; (it is not a count of the number of people who have viewed, but unique views of records themselves)</p> <p><b>Unit:</b> one unique pageview</p>	Web Activity Database	Quarterly	Worldwide	Core Funding	<p>70,575 (target: 250 quarterly)</p> <p><b>Achievement: 70,575</b></p> <p><b>Total target: 688</b></p>
4.11c) # of materials and tools (electronic files) that comprise a record -(See also 4.11a)	<p><b>Def:</b> # of files in total (files can include health communication materials such as instruments and reports, surveys, videos, PSAs, posters, presentations etc.) for all records uploaded during the time period</p> <p><b>Unit:</b> one electronic file</p>	Web Activity Database	Quarterly	Worldwide	Core Funding	<p>2,233 (target: 400 annually)</p> <p><b>Achievement: 2,233</b></p> <p><b>Total target: 1,100</b></p>

## IR4: Generate and Share Effective SBCC Knowledge to Address Emerging Health and Development Issues

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related indicator target
			Frequency/ Responsibility	Country Applications		
4.12) # of downloads of C-Change tools, briefs, and reports from C-Change website  <i>Output</i>	<b>Def:</b> Downloads refers to a user clicking on a link on the C-Change website to download a document; (it is not a count of the number of people who have downloaded, but downloads themselves)- using Awstats  <b>Unit:</b> one download	Web Activity Database	Quarterly  <b>Responsibility:</b> Susan Rogers/ Sandra Kalscheur	Worldwide	Core Funding	62,577 (target: 45 quarterly)  <b>Achievement: 62,577</b> <b>Total target: 495</b>
4.13a) # of “click-throughs” from CI’s website to the C-Change website (any page)  <i>Output</i>	<b>Def:</b> Click-through is a click on a link on any page of the Communication Initiative (CI) website to a page in the C-Change website; (it does not reflect the number of people who have clicked-through, but click-throughs themselves)  <b>Unit:</b> One click-through	Web Activity Database	Quarterly  <b>Responsibility:</b> Susan Rogers/ Sandra Kalscheur, Sarah Meyanathan	Worldwide	Core Funding	8,539 (target: 75 quarterly)  <b>Achievement: 8,539</b> <b>Total target: 825</b>
4.13b) # of “click-throughs” from CI’s website to C Hub (any page)	<b>Def:</b> Click-through is a click on a link on any page of the Communication Initiative (CI) website to a page in the C-Hub website; (it does not reflect the number of people who have clicked-through, but click-throughs themselves)  <b>Unit:</b> One click-through	Web Activity Database	Quarterly  <b>Responsibility:</b> Susan Rogers/ Sandra Kalscheur, Sarah Meyanathan	Worldwide	Core Funding	2,859 (target: 75 quarterly)  <b>Achievement: 2,859</b> <b>Total target: 825</b>

## IR4: Generate and Share Effective SBCC Knowledge to Address Emerging Health and Development Issues

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related Indicator target
			Frequency/ Responsibility	Country Applications		
<b>IR4 COUNTRY SPECIFIC FIELD AND CORE ACTIVITY INDICATORS</b>						
4.14) # of retrievals of peer-reviewed articles by C-Channel-developing world subscribers	Def: Retrievals refers to the subscribers clicking on the link in the emailed e-newsletter; (it does not reflect the number of people who have clicked-through, but click-throughs themselves)  Unit: one retrieval	Web Activity Database	Quarterly	Worldwide		2,433 (target: 90 quarterly) <b>Achievement: 2,433</b> <b>Total target: 990</b>
<i>Output</i>			Responsibility: Susan Rogers/ Sandra Kalscheur		Core Funding	
<b>1.4.11 The Democratic Republic of the Congo: Prevention of School-Related Gender-Based Violence</b>						
4.17) % of students who feel more secure at school than they did in previous school years	Def: # of students who indicate on a survey that they feel more secure in school than they did in previous school years divided by all students completing the survey  Unit: Percent of students feeling more secure in school than they did in previous school years	Baseline and end line surveys	End of project data Responsibility: Susan Rogers/Sid Schuler/Eugene Katzin	DRC		46% (227/497)
<i>Outcome</i>					Core Funding	
4.18) # of girls and boys who have reported incidences of SRGBV	Def: Measures count of individuals reporting abuse to parents, teachers, focal persons or others in a position to help, by gender  Unit: Cases of SRGBV violence reported by students	Baseline and end line surveys School focal person's records	End of project data Responsibility: Susan Rogers/ Sid Schuler / Eugene Katzin	DRC		1,138 (574 Girls, 564 Boys)
<i>Output</i>					Core Funding	

## IR4: Generate and Share Effective SBCC Knowledge to Address Emerging Health and Development Issues

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation Frequency/ Responsibility	Country Applications	Funding Source	Value reported as of December 31, 2012 and related indicator target
4.19) % of schools that have procedures to take action on reported cases of sexual abuse	Def: # of schools that have procedures to take action (policies, regulations, rules) on reported cases of sexual abuse divided by all schools  Unit: Percent of schools	NGO reports of interviews with principals	Monthly  Responsible: Susan Rogers/Sid Schuler	DRC	Core Funded	100% (31/31)  (target: increase between baseline and end line, $p < .05$ )
<i>Output (CMEI)</i>						
<b>1.4.13 Social Networking EGAT/PRH</b>						
4.20) # of strategic FP activities carried out by health organizations	Def: # Strategic FP activities such as meetings & group discussions and information / education sessions, implemented with target populations by health Organizations that have worked with C-Change within the "whole system in the room" planning approach  Unit: Strategic FP activities	Quarterly Reports	Quarterly	Mali	Core Funding	28 (target: 28)  Achievement: 28 Overall target: 28
<i>Outcome</i>						

## IR4: Generate and Share Effective SBCC Knowledge to Address Emerging Health and Development Issues

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related indicator target
			Frequency/ Responsibility	Country Applications		
4.21) # of strategic FP activities carried out by Natural Resource Management (NRM)  <i>Outcome</i>	<b>Def:</b> #of strategic FP activities such as meetings & group discussions, information /education sessions, referral to FP services carried out using Natural Resource Management (NRM) to increase the amount of interaction between target population and NRM organizations concerning family planning  <b>Unit:</b> # of strategic FP activities	Quarterly Reports	Quarterly <b>Responsibility:</b> Hibist Astarke/Geeta Nanda/ Center for Environmental Strategies	Mali	Core Funding	23 (target: 23) <b>Achievement: 23</b> <b>Overall target: 23</b>
<b>1.4.14 Predictive Validity and Face Validity of Gender Scales</b>						
4.22) # of clicks on gender scales compendium links (home page and any of the eight scales subpages)  <i>Output</i>	<b>Def:</b> Measures the total number of times the gender compendium links (home page and eight subpages) are clicked; (it does not reflect the number of people who have clicked-through, but click-throughs themselves)  <b>Unit:</b> one click through	Web Activity Database	Quarterly <b>Responsibility:</b> Susan Rogers/Sandra Kalscheur	Worldwide	Core Funding	17,262 (target: 30-45 quarterly) <b>Achievement: 17,262</b> <b>Total target: 495</b>

## IR4: Generate and Share Effective SBCC Knowledge to Address Emerging Health and Development Issues

Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation Frequency/ Responsibility	Country Applications	Funding Source	Value reported as of December 31, 2012 and related indicator target
<b>1.4.16 Evaluating the Effects of Gender Norms/FP Interventions in Two Countries</b>						
4.24) Average score on Gender and Family Planning Scale disaggregated by gender	Def: Average score on Gender and Family Planning Scale disaggregated by gender  Unit: Average Score on GEM Scale	GEM Scales	End of Project	Tanzania Guatemala	Core Funding	Guatemala:  <i>Men</i> 13.5 at baseline, 14.6 at end line in intervention group, 14.7 at both baseline and end line in control group (difference in differences significant at $p < .002$ .)  <i>Women</i> 14.7 at baseline, 14.9 at end line in intervention group; 15.3 at baseline, 14.5 at end line in control group. (difference in differences significant at $p < .003$ .)  Tanzania:  <i>Men</i> 13.1 at baseline, 16.0 at end line in intervention group; 14.6 at baseline, 15.2 at end line in control group. (difference in differences significant at $p < .002$ .)  <i>Women</i> 13.2 at baseline, 15.9 at end line in intervention group; 14.3 at baseline and 13.1 at end line in control group. (difference in differences significant at $p < .001$ )  (target: significant difference between baseline and end line in the intervention group relative to the control group, $p < .05$ )
Outcome			Responsibility: Hibist Astatke/Sidney Schuler			

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Performance Indicator	Definition and Unit of Measurement	Data Collection Methods/ Approaches	Data Compilation		Funding Source	Value reported as of December 31, 2012 and related indicator target
			Frequency/ Responsibility	Country Applications		
4.25) # of contraceptives provided disaggregated by short and long acting methods  <i>Outcome</i>	<p><b>Def:</b> : # of different types of modern contraceptive methods (Pill, Emergency Contraceptive Pill, IUD, Injectables, and Long Acting &amp; Permanent Methods such as insertion of implant, completion of voluntary sterilization etc) provided through service delivery sites (promoters, health facility and/or mobile clinics) in the intervention site C-Change SBCC intervention that uses group discussions</p> <p><b>Unit:</b> # of methods provided</p>	Service statistics	<p>End of project data</p> <p><b>Responsibility:</b> Hibist Astarke/Sidney Schuler</p>	Tanzania and Guatemala	<p>Guatemala:</p> <p>Total number of modern contraceptive methods provided in a single mobile clinic ranged from a high of approximately 35 pre-intervention to approximately 40 post-intervention.(NS)</p> <p>Tanzania:</p> <p>The mean number of modern contraceptive methods provided per clinic ranged from 23 to 83 pre-intervention and from 30 to 52 post intervention. (NS)</p> <p>(target=significant increase between baseline and end line in the intervention site, <math>p &lt; .05</math>)</p>	

