MONITORING, EVALUATION, AND LEARNING PLAN (MELP)

Communication for Healthy Communities (CHC)

Cooperative Agreement No: AID-617-A-13-00003

Submitted by

FHI 360

Initial submission date: September 30, 2013;

First USAID feedback date: April 2014
Second feedback date: July 2014
Third feedback date: late January 2015
Fourth Feedback (with QED): March 2015
Consensus feedback: late April 2015
Current revision date: June 19, 2015

Approved by USAID: _____

Table of Contents

ACRONYMS

ANC	Antenatal Care
BCC WG	Behavior Change Communication Work Group
AIDS	Acquired Immune Deficiency Syndrome
BCC	Behavior Change Communication
CAT	Capacity Assessment Tool
C-Change	*Communication for Change*
CDCS	Country Development and Cooperation Strategy
CDO	Community Development Officer
CHC	*Communication for Healthy Communities*
CLA	Collaboration, Learning, Adapting
COP	Chief of Party
CS	Capacity Strengthening
DCOP	Deputy Chief of Party
DHE	District Health Educator
DHT	District Health Team
DO3	Development Objective 3
FHI 360	Family Health International
FP	Family Planning
GOU	Government of Uganda
HC	Health Communication
HCP	*Health Communication Partnership*
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HQ	Headquarters
IP	Implementing Partner
IPC	Interpersonal Communication
IR	Intermediate Result
ITN/LLIN	Insecticide-Treated Net/Long Lasting Insecticidal Net
KM	Knowledge Management
LOP	Life of Project
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation
MARP	Most-at-Risk Population
MCH	Maternal and Child Health
MEEPP	Monitoring & Evaluation of the Emergency Plan Process
MER	Monitoring, Evaluation and Research
MIS	Malaria Indicator Survey
MOGLSD	Ministry of Gender, Labor and Social Development
MOH	Ministry of Health
PAC	Project Advisory Committee
PEPFAR	President's Emergency Plan for AIDS Relief
MELP	Monitoring, Evaluation and Learning Plan
PMT	Project Management Team
PMTCT	Prevention of Mother-to-Child Transmission
RTO	Regional Technical Officer
SBCC	Social and Behavior Change Communication
SDS	*Strengthening Decentralization for Sustainability*
SEM	Socio-Ecological Model
SO	Strategic Objective
SOPs	Standard Operating Procedures
STA	Senior Technical Advisor

TA	Technical Assistance
TB	Tuberculosis
TOR	Terms of Reference
UAC	Uganda AIDS Commission
UAIS	Uganda AIDS Indicator Survey
UDHS	Uganda Demographic and Health Survey
USAID	United States Agency for International Development
USG	United States Government
VHT	Village Health Team
VMMC	Voluntary Medical Male Circumcision

1. **BACKGROUND**

1.1 Overview of the Communication for Healthy Communities (CHC) Program

On 21st June 2013, the U.S. Agency for International Development (USAID)/Uganda entered into a Cooperative Agreement with Family Health International (FHI 360) to provide support for the Communication for Health Communities (CHC) program.

CHC builds on previous work by GOU, HCP and other IPs which focused on developing tools and strategies for social and behavior change, motivating individuals, households and communities to adopt practices that improve health, providing a supportive environment to embrace positive practices and capacity building. CHC aims to bring these efforts to fruition through 6 broad themes outlined in the CHC work plan: coordination and collaboration, capacity strengthening, integration, use of innovative and participatory health communication approaches, shifting social norms and gender analysis, and knowledge management and dissemination of research results and high impact practices.

1.2. Goals and results

The goal of CHC is to contribute to a reduction in HIV infections, total fertility, maternal and child mortality, malnutrition, malaria, and tuberculosis (TB). The strategic objective is to increase adoption of health behaviors reflected in the uptake, initiation and seeking of critical service and non-service related healthy behaviors – through strengthened integrated health communication. Three Intermediate Results (IRs) have been identified to support measurement of effectiveness of CHC:

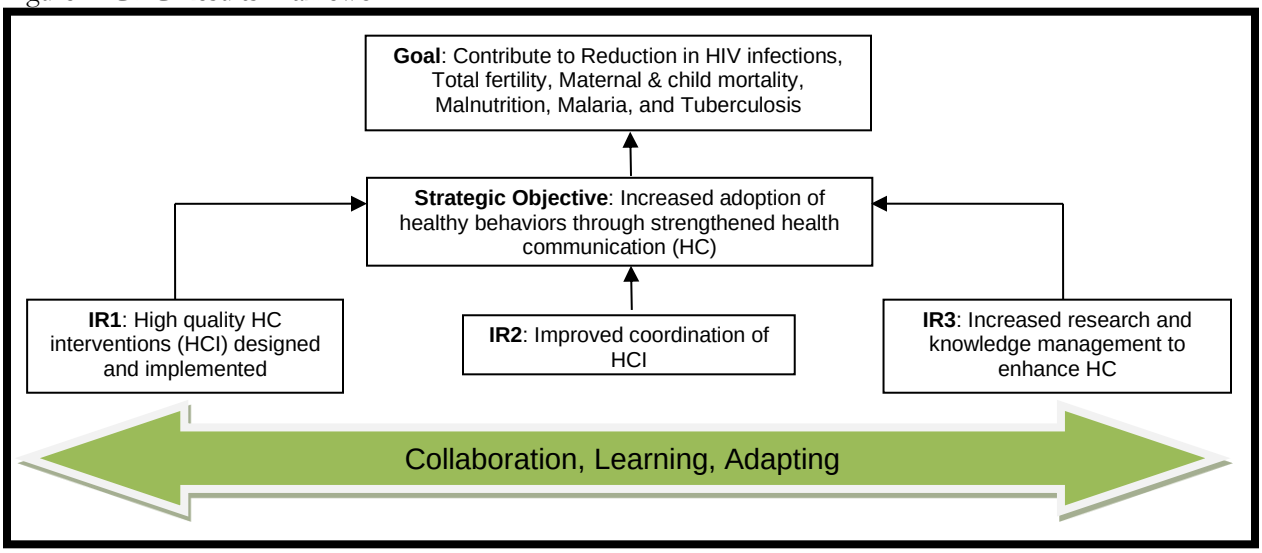
- IR1: High quality health communication interventions designed and implemented;
- IR2: Improved coordination of health communication intervention; and
- IR3: Increased research and knowledge management to enhance health communication.

1.3 CHC Results Framework

The development hypothesis underlying the design of CHC is that high quality, well-coordinated health communication interventions that are conducted based on research and evidence relevant to Uganda's context will result in increased adoption of healthy behaviors. The integrated health communication platform – grounded in the proven C-Change SBCC Framework and its Socio-Ecological Model – are expected to result in improved health status for Ugandans in geographic and programmatic areas where campaigns and other

communication efforts are implemented* by: 1) increasing their relevant comprehensive correct health knowledge; 2) addressing dominant social and gender norms that negatively affect health; 3) shifting motivation and ability to act; and 4) translating these elements of change into health-promoting actions, including utilization of critical, high-impact services in six priority areas (HIV/AIDS, FP, MCH, nutrition, malaria and TB); illustrated in in the CHC Results Framework in Figure 1 below and the audience-focused Results Matrix in Table 1.

Figure 1: CHC Results Framework



In this framework, the intermediate results are understood to have a reciprocal relationship. It links current research with opportunities to guide policy, programs, and practice decisions. Similarly, it facilitates the application of experience from programs, policies, and practice to inform new research. This research utilization relationship enhances and is by itself dependent on a system that supports all phases of the process, including coordination to ensure standardization for maximal effect. CHC will carefully track, verify, or adjust implementation based on this development hypothesis for maximal outcomes. Also, CHC will inform USAID of appropriate opportunities for adjustment depending on emerging changing needs, in order to modify direction as needed to ensure achievement of the results that will impact the HIV epidemic and other health problems.

* CHC SBCC interventions are modelled on the presumption that demand creation works best when supported by availability of health services, hence a particular focus on areas where USG service IPs are providing health systems strengthening support.

Table 1: CHC Results Matrix for Behavioral Variables

A. Uptake of healthy behaviors and/or utilization of critical high impact services in six priority areas (HIV/AIDS, FP, MCH, Nutrition, Malaria, and TB)

Young adults in relationships; 18 – 30y	Pregnant couple; 15 – 49y	Caregivers of children 0 – <5y	Adolescent boys and girls; 10 – 19y
1. Adopt behaviors and/or services that reduce risk exposure to HIV/AIDS (condoms, partner reduction, and ART adherence) and unintended pregnancy.	1. Adopt behaviors and/or services that reduce their risk to HIV/AIDS (condoms, partner reduction, and ART adherence) and unintended/ un-spaced pregnancies. 2. Adopt behaviors and/or services that enhance pregnancy safety and a healthy baby (nutrition, ANC plus eMTCT and IPTp, LLIN use, test and treat malaria, and deliver child at HF).	1. Adopt behaviors and/or services that enhance child health outcomes (EBF, initiate/complete child vaccinations, child LLIN use) 2. Recognize symptoms of childhood illness/ fever and seek prompt advice/ treatment.	1. If HIV positive, enroll into and adhere to ART 2. If sexually active, adopt behaviors and/or services that reduce HIV risk (condoms, partner reduction) and prevent pregnancy before age 18y

CROSS CUTTING ISSUES FOR HIV AND PREGNANCY PREVENTION AMONG KEY POPULATIONS

Female Sex Workers	Fisherfolk (female)	Truckers and Fisherfolk (male)
1. Adopt behaviors and/or health services that reduce HIV risk (condoms, ART adherence) and prevent unintended pregnancy	1. Adopt behaviors and/or health services that reduce risk exposure to HIV/AIDS (condoms, ART adherence, partner reduction) and prevent unintended pregnancy	1. Adopt behaviors and/or health services that reduce risk exposure to HIV/AIDS (condoms, ART adherence, partner reduction)

B. Demonstrated comprehensive health knowledge in six priority areas (HIV/AIDS, FP, MCH, Nutrition, Malaria, and TB

Young adults in relationships; 18 – 30y	Pregnant couple; 15 – 49y	Caregivers of children 0 – <5y	Adolescent boys and girls; 10 – 19y
1. Demonstrate comprehensive correct knowledge in a range of health issues (HIV/AIDS, condom use, SMC, contraception, malaria, TB) plus where to obtain services	1. Demonstrate comprehensive correct knowledge in health issues (HIV/AIDS, ANC, eMTCT, IPTp, LLINs, EIB/EBF, post-natal contraception, condom use, TB) & where to and services.	1. Demonstrate comprehensive correct knowledge in a range of child health issues (EBF, dietary diversity, recognition and management of child fever, TB, ART adherence, LLINs, contraception) plus where to obtain services.	1. Demonstrate comprehensive knowledge in health issues (HIV/AIDS, condom use, contraception, SMC for HIV prevention, malaria, TB) plus where to obtain services.

C. Demonstrated favorable shift in dominant attitudes that affect health

Young adults in relationships; 18 – 30y	Pregnant couple; 15 – 49y	Caregivers of children 0 – <5y	Adolescent boys and girls; 10 – 19y
1. Demonstrate approval of behaviors and/or services that reduce risk exposure to HIV/AIDS (condoms, partner reduction, and ART adherence) and unintended pregnancy.	1. Demonstrate approval of behaviors and/or services that reduce their risk to HIV/AIDS (condoms, partner reduction, and ART adherence) and unintended/ un-spaced pregnancies.	1. Demonstrate approval of behaviors and/or services that enhance child health outcomes (EBF, initiate/complete child vaccinations, child LLIN use)	1. Demonstrate approval of a. HIV positive youth enrolling into and adhering to ART b. Sexually active adolescents adopting behaviors and/or services that reduce HIV risk (condoms, partner reduction) and preventing pregnancy before age 18y

1.4 CHC Theory of Change[♠]

CHC's overall programming perspective is based on Communication for Change's (C-Change) Socio-Ecological Model (SEM) that looks beyond individuals to their social context, addressing gender and other social norms that prevent people from taking up healthy behaviors. CHC will apply the SEM's cross cutting factors to the analysis and design of interventions. These include selected theoretical concepts, namely knowledge, motivation: *attitudes and beliefs*; ability to act: *skills, self-efficacy, access*; and norms: *perceived, socio-cultural and gender norms*. These constructs are summarized in Figure 2: CHC Theory of Change (see Annexes).

Using the Social Ecological Model (SEM) CHC will embed theories targeting individual, inter-personal, community, and social environment levels to design, implement, monitor and evaluate health programs, aligned with the intermediate result areas, outlined below.

1.4.1 IR1: Effective health communication interventions designed and implemented

Individual and interpersonal level: At the individual level, CHC approach is based on the extended parallel process model (EPPM). This model conceptualizes individual behavior change as being (a) motivated by people's desires to reduce their risk—health, interpersonal and socio-economic--and (b) facilitated by enhancement of personal efficacy and trust in the efficacy of practices and services to bring about change. Interventions are then tailored around this knowledge to maximize acceptability and sustainability.

Community level: CHC will incorporate the Positive Deviance Approach[1] in customized research to identify positive "deviants" (a minority in a given community who practice the desired behavior) and integrate those insights into effective HC planning. The theory of Normative Social Behavior[2], which conceptualizes behavior change as being determined by interpersonal and social network influences, will be used to analyze social norms, gender norms, descriptive and perceived norms and how they affect adoption of desired behaviors such as using a condom, sleeping under a treated mosquito net, attending ANC, delivering at a health facility, seeking TB testing and treatment, among others.

Capacity strengthening: CHC will borrow from the concepts of Participation, Application and Transfer from C-Change's SBCC capacity assessment tool for individuals. Action Media Methodology based on participatory action research and learning processes will be used to foster participatory design of communication strategies and materials and allow for meaningful participation, mentoring and capacity strengthening of individuals, communities and institutions.

♠ The theory of change provided here is a summary to highlight the main theories overarching the overall CHC activity, and specific intermediate result area activities. CHC is developing a separate detailed booklet to document the scope and complementarities to which these theories will be deployed.

1 Zeitlin et al. 1990; Pascale & Sternin 2005

2 Jones, 1994

1.4.2 IR2: Improved coordination of health communication interventions

CHC will use the Social Network and Social Support Theory.[3] The Social Network and Social Support Theory focus on a web of social relationships that surround and influence individuals and or networks. The theory posits that human behavior does not exist in isolation and the fact that certain network characteristics, network functions and types of support make a network effective in attaining common goals. This can be effectively deployed to partner collaboration. Structural characteristics refer to the degree of homogeneity among members of a given network/group, resource exchange, formal roles, and knowledge and interaction among members. Where these structural characteristics are stronger, the ability of the network to influence each other is higher.

1.4.3 IR3: Increased research and knowledge management to enhance health communication

CHC will adopt an appropriate research utilization model borrowing from FHI 360's vast research utilization experience. While the exact model is yet to be determined, CHC will plan its monitoring and evaluation research from a research utilization perspective. In this regard, CHC will take cognizance of the uses and context in which the findings are to be applied, hence use of strategies such as stakeholder engagement and collaborative research, continuous assessment and adjustment (as may be appropriate), and timely dissemination of monitoring and research output to improve outcomes.

1.5 Relationship with USAID/Uganda's Development Objective (DO3)

The Communication for Healthy Communities (CHC) program will contribute to the achievement of USAID/Uganda's Health, HIV/AIDS and Education Office's Development Objective 3 (DO3): "*Improved health and nutrition status in focus areas and population groups*," under USAID/Uganda's new 2011-2015 Country Development and Cooperation Strategy (CDCS).

The intermediate result (IR) towards achievement of DO3 is *more effective use of sustainable health services* i.e. using services when appropriate, for better health outcomes. This, in turn, is to be achieved through four critical results including increased health seeking behaviors, improved quality of health services, increased availability of health services, and increased accessibility of health services. CHC's strategic objective derives from the first result: increased health seeking behaviors, defined as *the ability of individuals and/or communities to make 'healthy choices' in either their lifestyle behaviors or their use of health care and treatment to positively impact their health*. USAID implementing partners and other programs working to strengthen the delivery of health services at the community level will need supportive high quality health communication activities, including demand creation. CHC will support partners implementation by developing and adapting evidence-based communication approaches and materials. Further, USAID/Uganda's Collaborating Learning and Adapting (CLA) methodology underscores that progress towards outcomes is improved when efforts are coordinated and collaborative, informed by testing new approaches in a continuous search for improvement, and build on what works while eliminating ineffective strategies. Coordination seeks to foster a harmonized approach, thus

[3] Mckee, Manoncourt, Yoon & Carnegie 2000; Glanz & Viswanath 2008

contributing towards reduced duplication of effort and elimination of working at cross-purposes. A strengthened monitoring and evaluation as well as a research utilization agenda are critical to this process. CHC's Results Framework reflects this in the recognition of a reciprocal dynamic relationship between the three intermediate results. CHC will advance a cyclic evidence-based approach in which HC programming provides questions for research while research provides direction for HC. Underlying these is a system for dissemination and application of new knowledge in programming. Altogether, these enhance opportunities for learning, coordination, and standardization of approaches.

2. THE MONITORING, EVALUATION, AND LEARNING (MEL) PLAN

2.1 Purpose of the MEL Plan

This MEL Plan provides a framework for the set of indicators to be used by CHC program to monitor progress and results. The MEL Plan recognizes indicators at two levels:

1. Context Indicators: These indicators are part of the DO3 hypothesis. We recognize that CHC only makes a contribution to them, thus the program level targets are not required for this level of indicators. The data for these indicators is collected through the UDHS, and relevant lessons applied in program review.
2. Outcome Indicators: These indicators relate to CHC performance in the three inter-mediate results areas.

The MEL Plan facilitates documentation of experience to reflect what happened, the intensity of specific activities, parties involved, and detailing the results in terms of what works (in what situation, and why), what does not seem to work (in what situation, and why) and the specific challenges. These combinations of documentation processes will facilitate informed decisions on how to enhance effective areas and make improvements in less effective areas (see Performance indicator matrix, M&E work plan matrix, M&E timeline projections, and Assessment of risks and unexpected outcomes matrix.

2.2 How the MEL Plan is organized

Intermediate Results (IR) are key to measuring success, thus, the performance indicator tracking table in the MEL Plan is organized by IR. Each performance indicator is presented with an indicator target, the numerator and denominator (as may be appropriate), the unit of measurement, the data sources, frequency and responsible persons, disaggregation parameters, and progressive data compilation from baseline through the life of the project.

2.3 Limitations in the current MEL Pan

CHC is using the UDHS 2011, UAIS 2011, and UMIS 2009[4] surveys as reference points for strategic objective indicators (Outcome Indicators) and intermediate outcome indicators (comprehensive knowledge and health behaviors) until the CHC baseline is conducted in selected 16 evaluation districts in April/May 2015, following which CHC will revise indicators targets in consultation with USAID. However, targets are suggested, informed by the Hierarchy of Communication Effects Model (see Annexes, Figure 3). The model is based on a combination of the stages of change model and wider communication effects research/debate by Prochaska & Diclemente et al (1984, 1998), and recent work by Thomas W. Valente (2002) on evaluation of health communication. Essentially, at least a health communication reach of 80% is required to facilitate a shift and/or improvement in knowledge and behavioral response. Exposure will be measured as Moderate 40%; High 60%; Very High 80%. The target is at least 80% exposure level for any given message delivered via IPC or mass media. The targets set at these indicator levels will be reviewed once appropriate baselines have been established from CHC's baseline survey (Timeline 1) projected for April/May 2015.

3. MANAGING RISKS AND ASSUMPTIONS

It is anticipated that by increasing clients' knowledge and demand, HC interventions will put pressure on the health system to provide better quality services. The success of USAID implementing partners and GOU working to strengthen the delivery of health services at the community level in assuring accessibility to quality health services is thus equally critical to the success of CHC.

CHC's M&E system will proactively collect and review data and program output as a measure to closely monitor key risks and assumptions that may impact the achievement of CHC's goal (see Table 2). The monitoring and evaluation system will be primed to project/anticipate and troubleshoot key risks and assumptions that could hamper progress and achievements in CHC OBULAMU campaign and capacity strengthening goals and targets. Managing critical risks and assumptions is a core component of the learning agenda. Risks and assumptions will be monitored through judicious intervention and key indicators tracking, and timely analysis of data and reporting to project teams, USAID, and key partners such as the MOH and USG IPs. The status of risks and assumptions will be critically reviewed in MER and key staff updates (monthly), general staff review meetings and work-planning (quarterly and annually), and in reporting to USAID and stakeholders (by reporting periods).

[4] These national data set reference points will be updated with new data. For instance, CHC contributed to review of the UMIS 2014 survey questionnaire, and will use the survey findings/report to replace UMIS 2009 as a reference point.

Table 2: Risks and Assumptions

Potential risk	Means of Verification	Actions to mitigate
Limited access to relevant, timely and disaggregated monitoring data (*especially service data***) from implementing partners (IPs).**	• Extent that DHEs and IPs are equipped and skilled to use databases such as HMIS for decision-making and not just reporting purposes • Extent that USAID facilitates CHC access to service data collated in PEPFAR databases such as HIBRID and DATIM. •	• Continuously access and analyze HMIS data to troubleshoot intervention rollout effects, and to triangulate its evidence base generated through intervention tracking and evaluative surveys. • Use periodic national data reports such as UDHS, UMIS, and UAIS whenever available to triangulate project data.

Lack of commitment by partners to support intervention rollout and monitoring.	• Partner HC plans and funding status of HC activities in partner programs
	• Extent that IPs monitoring tools can accommodate OBULAMU rollout monitoring, especially in Champions/VHT IPC activities
		• Action plans drafted and consensus reached with IPs to support intervention rollout and monitoring following CHC capacity strengthening and/or technical assistance to partners
		  ○ CHC and partners explore how to accommodate monitoring in existing partner mechanisms
		  ○ CHC regional staff conduct random site quality improvement visits and complete a quality checklist with DHEs, IPs and/or Champions

Limited capacities of local partners and counterparts to implement HC activities	• Partner mapping, organization capacity assessments, and intervention quality rating scores during random field visits highlight capacity gaps	• CHC capacity strengthening plan for partners designed to give tailored CS and continuous TA during the rollout and monitoring of OBULAMU campaign

Frequent inaccessibility and/or unavailability of services: *commodity stock outs, irregular IPC support shaped by IPs arrangements with Champions/VHTs, prevailing provider attitudes/prejudices*	• DHEs service status logs
	• VHT feedback logs
	• Random community feedback logs/listening survey reports
		• Closely monitor intervention rollout and trends in service uptake to troubleshoot any dips and/or unchanged patterns.
		  ○ Regular discussions with DHE to review service status and troubleshoot district actions
		  ○ Random reviews with partners/ champions
		• Service status shared with AOR for necessary action through USG-GOU mechanisms

Shifting donor priorities and funding envelopes.	• Donor policy and strategy documents • Routine donor feedback with project teams	• Work closely with AOR for timely feedback • Negotiate and document critical changes to the work-plan and targets • M&E data analyzed timely to inform decision-making and re-planning

Potential Assumptions	Means of Verification	Actions to support
Planned activities implemented on schedule	• Intervention tracking database • Quarterly and annual reports vis-à-vis work plan schedule	• Timely plot and track implementation according to annual work plan and OBULAMU implementation guide schedules: clearly marking planned versus actual process/results • Timely communicate progress to implementation teams/ managers.
People will change attitudes and behaviors	• Demonstrated in changes in the HMIS data trends, and validated in project-led evaluative survey reports/publications and supplementary national survey reports such as UDHS, UMIS, and UAIS whenever available	• Anchor interventions on evidence and theory-based approaches o Clearly defined objectives distinguishing communication objectives versus behavior change objectives o Formative and evaluative studies designed cognizant of the context of implementation
Partners work plans and budgets have an HC component that accommodates and support CHC OBULAMU rollout and capacity strengthening activities.	• Existence of action plans (plus budgets, where applicable) for partner TA and collaboration in key rollout steps.	• Action plans drafted and consensus reached with IPs during orientation on implementation guides in order to secure support for intervention rollout and monitoring following CHC capacity strengthening and/or technical assistance to partners • Intervention quality rating tools will be randomly deployed during field support visits to monitor status.
USAID recognizes effect of shifting donor priorities and funding on implementation, timelines, targets, and measurable outcomes	• Review meeting reports • Documented feedback on quarterly and annual reports	• CHC will maintain close work and updates with the AOR to timely discuss changing priorities/ contexts with the donor, and secure consensus on the subsequent effect/ changes to the work plan
Political stability and MOH support	• Status feedback from the field, general news, security alerts	• Advocacy with MoH organs to facilitate possible support, particularly in planning activities around election years/periods.

Overall, the CHC plan to manage the risk that GoU affiliates and implementing partners fail to commit to an integrated approach that is characterized by use of evidence to inform implementation comprises of the following consultative and review measures:

3.1 Project Management Team (PMT)

The PMT, led by the Chief of Party (COP) meets weekly to provide updates, conduct detailed project planning, identify and troubleshoot challenges, ensure that available resources are being used as effectively and efficiently, and make regarding strategies and implementation. The PMT is also responsible for setting up a coordination system between the Kampala and regional teams such that there are regular, effective lines of communication between the two levels to discuss activities, ensure integration of approaches and strengthen coordination. The PMT meets periodically with USAID to review project work plans and progress and resolve any issues; present performance management reports; provide lessons learned and success stories; channel feedback from the GOU and partners on implementation, among others. See more detail in Communication Matrix (annexes).

3.2 National-level coordination

CHC will coordinate roll-out of the campaign through the BCC Working Group, and the M&E and Research/Knowledge Management (MER/KM) Task Force, in both of which it is also a regular participant and technical lead. Selected CHC staff also participate in other national thematic working groups such as the MCH Cluster, the FP, Malaria, and Nutrition, the UAC M&E TWG, and the combined national ART/PMTCT Advisory Committee. See more in Communication and Dissemination Plan (section 5.6).

3.3 District and village-level coordination

CHC will coordinate its district-level activities closely with DHTs and VHTs in order to facilitate the coordination of HC activities with service delivery. Specifically, CHC will incorporate the management of activities into DHT/DHE and VHT agendas and SDS District Operational Plans (where relevant) and work with a CHC coordination team composed of the District Health Education office, and Community Development Officers (CDO), among others. See more in Communication Matrix (annexes).

3.4 Notes on baselines and targets

CHC has made attempts to be more specific about its social and behavior change communication (SBCC) contribution (reflected in an excerpt from the CHC outcome evaluation protocol – see Annexes, Table 4). The minimum detectable effect sizes (MDES) summarized in Table 4 (annexes) measure feasible CHC contribution, based on a calculation of the current national reference data, national target projections, and total number of expected evaluation districts for a given indicator. Based on continuous review of data, CHC will make

consultations with USAID as needed to highlight any needs for revision of targets currently projected in the MELP.

4. CHC PERFORMANCE INDICATORS MATRICES

4.1 High Level Context indicators[5,6]

Performance Indicator	Indicator Definition and Unit of Measurement	Data Source/ FREQUENCY	Disaggregated by	Reference Point before CHC	2015		2016		2017	
					Target	Actual				
SO Context Indicator 1. Percent of men age 15-49 who are circumcised	**Numerator**: Number of men aged 15-49 who have been circumcised **Denominator**: Number of men aged 15-49 in survey **Unit of Measurement**: Percent	UDHS/ UAIS reports **FREQUENCY**: whenever available	Region, Age, Residence (rural/urban)	UAIS 2011 **26.4% MC prevalence among 15-49** 15-24- 26.3% 15-19 -23.4% 20-24 -30.7% 25-29 -29.7% 30-39 -26.8% 40-49 -23.3%	80% DO3 50% HSSP III					
SO Context Indicator 2. Percent of women age 15-49 who were tested for HIV and received the results during antenatal care	**Numerator**: Number of women who gave birth in the two years preceding the survey who report that they took an HIV test and received their results during antenatal care **Denominator**: Number of women who gave birth two years before the survey and report attending ANC **Unit of Measurement:** Percent	UAIS **FREQUENCY**: whenever available	Region, Age, Residence (rural/urban)	UAIS 2011 72%	100% HSSP III					
SO Context Indicator 3. Proportion of children exclusively breastfed for the first 6 months	**Numerator:** Number of children aged two years who were only fed breast milk for the first six months (*counting up to the last day of the fifth month of life*) **Denominator:** Number of children 6-24 months in survey **Unit of Measurement**: Percent	UDHS **FREQUENCY**: whenever available	Child sex, Mother's age, education, residence, region, and wealth quintile	UDHS 2011 62%	80% HSSP III					
SO Context Indicator 4 Percentage of children under 5y classified as malnourished.	**Numerator**: Number of children under 5 years classified as malnourished according to three anthropometric indices of nutritional status.	UDHS **FREQUENCY**: whenever available	Age in months, Child sex, residence, region, Mother's education Mother's interview status,	UDHS 2011 Height-for-age <-2SD = 33%	Unavailable					

[5] These indicators are part of the DO3 hypothesis. CHC is one of USAID's interventions that contribute to the achievement of high level results represented by these indicators. While performance targets are not set for CHC as a single intervention, CHC will use these indicators and national targets to discuss its performance. Data sources include UDHS, UAIS or UMIS as may be appropriate. CHC tracks national performance in these indicators to guide design, targeting and focusing of communication interventions.

[6] Targets are available up to 2015. SOURCES INCLUDE: Health Sector Strategic Plan (HSSP) III and USAID DO3

Performance Indicator	Indicator Definition and Unit of Measurement	Data Source/ FREQUENCY	Disaggregated by	Reference Point before CHC	2015		2016		2017	
					Target	Actual				
	Denominator: Total number of children under 5 years in surveyed households *Anthropometric indices of nutritional status:* height-for-age, weight-for-height, and weight-for-age **Unit of measurement:** Percent			Weight-for-height <-2SD = 5% Weight-for-age <-2SD = 14%						
SO Context Indicator 5. Proportion of women who took 2 or more doses of IPTp	**Numerator**: Number 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 **Denominator**: Total number of women surveyed who had a live birth in the last two years **Unit of Measurement:** Proportion	UDHS/ UMIS **FREQUENCY**: whenever available	Mother's age, education, number of children, residence, region, and wealth quintile	UDHS 2011 25%	85% PMI 80% HSSP III					
SO Context Indicator 6. Contraceptive prevalence rate (CPR)	**Numerator**: Number of sexually active women aged 15-49y who are currently using any modern method of family planning. *Modern contraceptive methods include* Pill, IUCD, Injectable, Implant, Voluntary sterilization, Condoms **Denominator:** Total number of sexually active women aged 15-49 years in the survey **Unit of Measurement:** Percent	UDHS **FREQUENCY**: whenever available	Region, Age, Marital status, FP Method, Residence	UDHS 2011 26%	38% DO3 35% HSSP III					

4.2 Strategic Objective Level Outcome Indicators

Performance Indicator	Indicator Definition and Unit of Measurement	Source of Information[7] & FREQUENCY	Information compilation		Reference data before CHC HC[8]	2014[9]		2015[10]		2016		2018	
			Responsibility	Disaggregated by		Target	Actual	Target	Actual	Target	Actual	Target	Actual
Goal: Contribute to Reduction in HIV Infections, Unmet Need for Family Planning, Maternal and Child Mortality, Malnutrition, Malaria, and Tuberculosis [Indicators developed after impact feasibility study (linked to outcome evaluation) will determine what disease/condition biomarkers can be feasibly measured over time]													
Strategic Objective (SO): Increase adoption of healthy behaviors through strengthened health communication													
SO Outcome Indicator 1. Percentage of individuals who used a condom at last higher risk sex	**Numerator**: Number of individuals who used a condom the last time they had sexual intercourse with a non-marital or non-cohabiting partner in last 12 months. **Denominator:** Number of individuals who had higher risk sex in last 12 months **Unit of Measurement:** Percent	CHC evaluative survey reports – **FREQUENCY:** early 2015, late 2016, early 2018	Data/ M&E Managers assisted by Program Activity Leaders	Sex, Age, Cluster of USG IPs	UAIS 2011 Men 14.8%, Women 15.8%	N/A	N/A	20% - General pop. 30% MARPS		57% General pop. 60% MARPs		80% General population 85% MARPs	
SO Outcome Indicator 2. Percentage of mothers of children 0-11 months who delivered their last baby in a health facility	**Numerator:** Number of mothers of children 0-11 months who delivered their last baby in a health facility **Denominator:** Number of mothers of children 0-11 months in the survey **Health facility includes:** 1) Hospital, 2)Health Centre II, III or IV, 3) Clinic (ACCREDITED Private, Government CLINIC) **Unit of Measurement:** Percent	CHC evaluative survey reports – Triangulated with UDHS and LQAS **FREQUENCY:** early 2015, late 2016, early 2018	Data/ M&E Managers assisted by Program Activity Leaders	Mother's age, education, number of children, wealth quintile, and cluster of USG IPs	UDHS 2011 57.4%	N/A	N/A	60%		65%		72%	
SO Outcome Indicator 3. Proportion of pregnant women who slept under an ITN/LLIN last night	**Numerator:** Number of pregnant women who slept under an ITN/LLIN the night before the survey	CHC evaluative survey reports –	Data/ M&E Managers assisted by Program Activity Leaders	Age, education, HH ITN coverage ratio,	UDHS 2011 47% all HH	N/A	N/A	75%		85%		85%	

[7] **COMPLEMENTARY DATA**: CHC survey data interpretation to be triangulated with either LQAS, HMIS sources, UDHS, UAIS, UMIS reports WHENEVER AVAILABLE.
[8] **BASELINE**: Reference data serves as baseline until updated with CHC survey 1 findings. CHC survey 1 is projected for April/May 2015. For Malaria indicators, survey findings from UMIS 2014 will be used to triangulate CHC survey data.
[9] **2014 TARGETS**: CHC HC campaign just recently rolled out through the OBULAMU campaign (late 2014). Thus, it is deemed inappropriate to have targets for 2014. However, CHC is using service data trends from HMIS and LQAS 2014 to inform targeted rollout of the OBULAMU campaign with IPs.
10 **2015-2018 TARGETS**: CHC evaluative survey design estimates 5% - 18% minimum detectable effect sizes for CHC HC contribution across health indicators; i.e. calculations based on current national data (UDHS 2011/UAIS 2011/UMIS 2009) and target projections in HSSP III 2010/11-2014/15. CHC has thus set modest targets to be revised after CHC survey 1.

Performance Indicator	Indicator Definition and Unit of Measurement	Source of Information[7] & FREQUENCY	Information compilation		Reference data before CHC HC[8]	2014[9]		2015[10]		2016		2018	
			Responsibility	Disaggregated by		Target	Actual	Target	Actual	Target	Actual	Target	Actual
	Denominator: Number of pregnant women surveyed in HH with ITN **Unit of Measurement:** Percent	**FREQUENCY:** early 2015, late 2016, early 2018		Cluster of USG IPs	71% HH with ITN								
SO Outcome Indicator 4. Proportion of children under five years old with fever in the last two weeks for whom advice or treatment was sought	**Numerator**: Number of children under five years old who had a fever in the previous two weeks for whom advice or treatment was sought **Denominator**: Total number of children under five years old who had a fever in the previous two weeks **Unit of measurement**: Proportion	CHC evaluative survey reports – **FREQUENCY:** early 2015, late 2016, early 2018	Data/ M&E Managers assisted by Program Activity Leaders	Mother's age, education, residence, and wealth quintile, type of provider, Cluster of USG IPs	UDHS 2011 30%	N/A	N/A	35%		55%		72%	
SO Outcome Indicator 5. Percent of individuals with a persistent cough lasting two or more weeks who sought TB screening and testing services	**Numerator**: Number of individuals (adults and/or children) with a persistent cough lasting two or more weeks who sought (or for whom the caregiver sought) TB screening and testing services **Denominator**: Total number of individuals for whom a cough lasting 2/more weeks is reported in surveyed households **Unit of measurement** Percent	CHC evaluative survey reports – **FREQUENCY:** early 2015, late 2016, early 2018	Data/ M&E Managers assisted by Program Activity Leaders	Age, sex, HH wealth quintile, type of provider sought	National TB Program 2014: 65%	N/A	N/A	70%		75%		75%	

4.3 IR Level Indicators: CHC Capacity Strengthening (CS)and Technical Assistance (TA)

Performance Indicator	Indicator Definition and Unit of Measurement	Data Source	Information compilation		Baseline: Qualitative Insight from audit of HC 2014 report	2015[11]		2016		2017/2018	
			Frequency/ Responsibility	Disaggregated by		Target	Actual	Target	Actual	Target	Actual
Intermediate Result 1: High quality health communication interventions designed and implemented											
IR 1.1 Number of collaborating partners staff that increased their HC competencies	Number of GOUs and IPs staff who accessed CHC CS opportunities that increased their HC competencies, based on selected criteria/tools **Unit of Measurement**: Number	HC Capacity Strengthening database [12]	Per CHC reporting periods: quarterly, annually, end of project **Responsibility**: Data/ M&E Managers assisted by Program Activity Leaders	Health focus, region	IPs did not have staff with SBCC skills. A few outsourced IEC from partners such as UHMG and CDFU. Others simply distributed whatever IEC materials they could access from MoH, or what remained from the HCP. Others used what was available from sources such as UNICEF.	IPs 30 DHE 50 National level (BCC WG Secretariat and GOU TWGs) 20		IPs 30 DHE 50 National level (BCC WG Secretariat and GOU TWGs) 20		IPs 30 DHE 50 National level (BCC WG Secretariat and GOU TWGs) 20	
IR1.2 Number of collaborating partners that adopt one or more components of the integrated HC strategy	**Numerator**: Number of GOU/USG IPs - who received SBCC technical assistance from CHC - that deploy at least one of six key components of the integrated HC strategy in the program activities. NB: Also a proxy for HC interventions with improved quality. *Components include:* 1) Audience identification and segmentation, 2) Adaptation and localization of HC to partners' program context 3) Maximize reach and exposure (saturation) of HC interventions, 4) Monitor, document, and provide feedback, 5) Use of data/evidence for planning and implementation, and 6) Continuous training, orientation, mentoring, and supervision of health workers and champions to implement quality HC interventions. **Unit**: Number	HC Capacity Strengthening database	Per CHC reporting periods: quarterly, annually, end of project **Responsibility**: Data/ M&E Managers assisted by Program Activity Leaders	Health focus, region	IPs IEC activities were mainly concentrated around community outreach services. There was little (if any) follow-up IEC until the next outreach week.	IPs 30 DHE 50 National level (BCC WG Secretariat and GOU TWGs) 20		IPs 30 DHE 50 National level (BCC WG Secretariat and GOU TWGs) 20		IPs 30 DHE 50 National level (BCC WG Secretariat and GOU TWGs) 20	

[11] **TARGETS**: 2015 Targets based on existing USG IPs (estimated at 30), and or target projections in the CHC YR2 workplan. Targets for 2016 and 2018 to be refined after experience in 2015. For DHE level, Capacity Strengthening/ Technical Assistance will prioritize data use for decision making. CHC expects to track 50 DHEs (based on old districts) as case studies of CHC TA. At BCC WG and thematic area TWGs CHC will only count the secretariats in order to avoid double counting of partners represented. The

[12] **DATA BASE**: The HC Capacity Strengthening Database keeps track of IP/organizational and individual scores on the 1) HC capacity assessment tools; 2) implementation quality rating tools used to assess the integrity of implementation according to essential elements of HC design, implementation, and monitoring; and 3) HC program related training, Technical Assistance (TA), Mentoring.

Performance Indicator	Indicator Definition and Unit of Measurement	Data Source	Information compilation		Baseline: Qualitative Insight from audit of HC 2014 report	2015[11]		2016		2017/2018	
			Frequency/ Responsibility	Disaggregated by		Target	Actual	Target	Actual	Target	Actual
Intermediate Result 2: Improved coordination of health communication interventions											
IR 2.1 Percent of HC materials disseminated that have gone through the national standardization process	**Numerator**: Number of materials standardized through the national process **Denominator**: Number of materials disseminated through CHC-led systems **Unit of measurement**: Percent	HC Products and Knowledge Management databases	Per CHC reporting periods: quarterly, annually, end of project **Responsibility**: Data/ M&E Managers assisted by Program Activity Leaders	Type of material, target audience	The audit of HC suggested that although HC coordination platforms existed including the UAC IEC Committee and the BCC WG, materials were produced with negligible considerations for standardization of messages.	100%		100%		100%	
2.2 Number of collaborating IPs that disseminate nationally harmonized and standardized resources through their own communication activities	Number of GOU and IPs programs receiving CHC TA that use nationally standardized HC resources in their activities **Unit**: Number	HC Products and Capacity Strengthening databases	Per CHC reporting periods: quarterly, annually, end of project **Responsibility**: Data/ M&E Managers assisted by Program Activity Leaders	Type of resource, target audience for resource, health area	The audit suggested that IPs were generally pro materials bearing MoH/Govt logo as indication of working within Govt. Strategies. They used what was available, some outdated. In the absence of MoH materials, IPs used available resources from HC3 website and UNICEF.	IPs 30 DHE 50 BCC WG Secretariat Thematic TWGs		30 DHE 50 BCC WG Secretariat Thematic TWGs		DHE 50 BCC WG Secretariat Thematic TWGs	
Intermediate Result 3: Increased research and knowledge management to enhance health communication											
3.1A Percent of CHC HC interventions (includes HC designs, target populations and implementation approaches) that are informed by research. NB: This indicator measures CHC track record in using evidence in its HC interventions	**Numerator**: Number of CHC HC interventions that meet minimum criteria including use of research evidence for design, audience targeting, and implementation. *Minimum criteria* for this indicator are based on the Communication for Change (C-Change) Program's *Steps of a Planning Process for SBCC* (***C-Modules: A Learning Package for Social and Behavior Change Communication, May 2012***). The C-Planning Model for HC interventions contains five steps including 1. Understanding the situation (*Problem identification and priority setting through formative research*)	HC Products and Knowledge Management databases	Per CHC reporting periods: quarterly, annually, end of project **Responsibility**: Research Associate/ KM Manager assisted by Program Activity	HC intervention, health focus	N/A	100%		100%		100%	

Performance Indicator	Indicator Definition and Unit of Measurement	Data Source	Information compilation		Baseline: Qualitative Insight from audit of HC 2014 report	2015[11]		2016		2017/2018	
			Frequency/ Responsibility	Disaggregated by		Target	Actual	Target	Actual	Target	Actual
	2. Focusing and designing (*Formulation of research questions, Concept development, Baseline*) 3. Creating (*Formative research*) 4. Implementing and monitoring (*Monitoring program rollout and generating information for review*) 5. Evaluative assessment and re-planning (*Assessment of outcome indicators and generating information for program review*) **Denominator**: Number of HC interventions developed and rolled out by CHC and/or partners receiving CHC TA **Unit of measurement**: Percent										
3.1B Number of collaborating institutions that contribute to at least one step of development of SBCC research through CHC TA. NB: This indicator tracks CHC efforts for increasing partner's capacity for SBCC research and/or evidence-based HC intervention planning and implementation	**Definition**: Number of local collaborating institutions that – through CHC TA – contribute to learning in at least one of five steps of planning and executing SBCC. *Domains* for this indicator are based on the Communication for Change (C-Change) Program's *Steps of a Planning Process for SBCC* (*C-Modules: A Learning Package for Social and Behavior Change Communication, May 2012*). The C-Planning Model contains five steps including 1. Understanding the situation (*Problem identification and priority setting through formative research*) 2. Focusing and designing (*Formulation of research questions, Concept development*) 3. Creating (*Protocol development*) 4. Implementing and monitoring (*Monitoring program rollout and generating information for review*) 5. Evaluative assessment and re-planning (*Assessment of outcome*	HC Capacity Strengthening Database Knowledge Management database	Per CHC reporting periods: quarterly, annually, end of project **Responsibility**: Research Associate/ KM Managers assisted by Program Activity Leaders	Type of research i.e. based on the five steps of SBCC planning Health area Region	Research institutions are well equipped and have skilled faculty to undertake various types of research. SBCC research has been limited because it is not well funded. Discussions with faculty indicated interest to collaborate mainly through student fellowships in which Masters students who have completed term work obtain internship on CHC program to develop dissertation research.	5		10		10	

Performance Indicator	Indicator Definition and Unit of Measurement	Data Source	Information compilation		Baseline: Qualitative Insight from audit of HC 2014 report	2015[11]		2016		2017/2018	
			Frequency/ Responsibility	Disaggregated by		Target	Actual	Target	Actual	Target	Actual
	indicators and generating information for program review) **NOTE**: To avoid double-counting, knowledge products are counted under Indicator # 3.1 above *Local institutions* include universities or health programs/projects collaborating with CHC. *Eligible output* include those undertaken by IPs program staff, University faculty staff, and/or through interns/fellows attached to collaborating IPs programs/CHC. **Unit of Measurement**: Number										
3.1 Number of knowledge events implemented through CHC support/Oversight	**Definition:** Number of knowledge sharing/ dissemination/ learning events implemented by CHC and/or IPs through CHC TA. *Domains include:* data dissemination and interpretation events, brainstorming workshops, materials development and feedback sessions with IPs. **Unit**: Number	Knowledge Management database	Per CHC reporting periods: quarterly, annually, end of project **Responsibility**: Research Associate/ KM Manager assisted by Program Activity Leaders	Type of event, health focus, region	Knowledge was mainly shared through the Technical WGs, BCC WG, or partner dissemination events. The practice appeared more for IP credit as opposed to engendering a systematic learning agenda.	At least 5 regional * 8 regions **20 national** (6 BCC WG, 6 Thematic TWG, 12 other)		At least 5 regional * 8 regions **20 national** (6 BCC WG, 6 Thematic TWG, 12 other)		At least 5 regional * 8 regions **20 national** (6 BCC WG, 6 Thematic TWG, 12 other)	
3.2 Number of external downloads of evidence-based knowledge products from CHC-moderated website or cloud based knowledge repository platform	**Definition**: Number of external downloads of evidence-based HC products from CHC-moderated website or cloud based knowledge repository platform **Unit**: Number	Knowledge Management database	Per CHC reporting periods: quarterly, annually, end of project **Responsibility**: Research Associate & KM Manager assisted by Program Activity Leaders	Type of product; health area	Knowledge was not necessarily available on demand. Distribution circled around the BCC WG meeting sessions. The HCP knowledge repository comprised of an external drive that an officer carried to BCC WG meetings.	50		TBD after set up of Data visualization platform in 2015		TBD	

4.4 CHC SBCC Intermediate Outcome Level Indicators: Communication Effects

Demonstrated scores 1) Comprehensive knowledge♣, 2) Approval of behaviors/services, 3) Intention

Performance Indicator	Health Area/ BCC domains covered in indicator	Data source[13]/ Disaggregation	FREQUENCY/ Responsibility	Reference data before CHC[14]	2015[15]		2016		2018	
					Target	Actual	Target	Actual	Target	Actual
Goal: Contribute to Reduction in HIV Infections, Unmet Need for Family Planning, Maternal and Child Mortality, Malnutrition, Malaria, and Tuberculosis [Indicators developed after impact feasibility study (linked to outcome evaluation) will determine what disease/condition biomarkers can be feasibly measured over time]										
Intermediate Result 1: High quality health communication interventions designed and implemented										
1.1 Demonstrated comprehensive knowledge across health areas										
Percent of target audience who demonstrate comprehensive correct knowledge across selected health areas **Numerator**: Individuals 15-49y whose average score on a range of related questions indicate they have comprehensive correct knowledge in specific components of health areas covered in OBULAMU messages	**HIV**	CHC evaluative survey reports – Age, sex, General population, Key populations (MSM, FSW, Fisherfolk, Truckers)	**FREQUENCY:** early 2015, late 2016, early 2018 **RESPONSIBILITY**: Research Associate and data manager	UAIS 2011 36% women 43% men	40% Women 48% men		50% Women 58% men		60% Women 68% men	
	FP	CHC evaluative survey reports – Age, sex	**FREQUENCY:** early 2015, late 2016, early 2018 **RESPONSIBILITY**: Research Associate and data manager	Not available	40%		50%		60%	

♣ COMPREHENSIVE KNOWLEDGE

HIV/AIDS: Heard of HIV/AIDS, and can name the three recommended behaviors for prevention of HIV; and reject two misconceptions about HIV/AIDS transmission *(ref UDHS 2011).*

FP: 1) Can name at least 3 modern methods, 2) knows that FP can help to delay pregnancy, space children, or limit births, 3) knows where to obtain modern FP, and 4) rejects at least 2 two misconceptions about FP.

ANC: Awareness about full ANC coverage (plus eMTCT, IPTp 1-2, LLIN use), iron-rich foods during pregnancy, HF delivery, post-partum care. (*THE MCH BEHAVIOR CHANGE ENABLER, USAID, April 2014)*

Malaria: Have heard of malaria, name the cause of malaria, the main symptom of malaria, the correct treatment for malaria, the preventive measures *(Malaria BCC Indicator Reference Guide. Feb 2014)*

TB: Knows at least 2 signs and symptoms of TB, how TB is transmitted, that TB is a curable disease, the risk of not completing TB treatment *(USAID LQAS 2013)*

[13] CHC survey data interpretation to be triangulated with either LQAS, HMIS sources, UDHS, UAIS, UMIS reports WHENEVER AVAILABLE.

[14] Reference data serves as baseline until updated with CHC survey 1 projected for April/May 2015. For Malaria indicators, survey findings from UMIS 2014 will be used to triangulate CHC survey data.

[15] CHC surveys are estimated to occur 1½ years apart. There will be no CHC survey in 2017.

Performance Indicator	Health Area/ BCC domains covered in indicator		Data source[13]/ Disaggregation	FREQUENCY/ Responsibility	Reference data before CHC[14]	2015[15]		2016		2018	
						Target	Actual	Target	Actual	Target	Actual
Domains under comprehensive knowledge: See specific breakdown in column 3 **Denominator**: Individuals in the CHC evaluative survey who are reached with OBULAMU messages at least twice through any/ combination of channels used by the project	**ANC**		CHC evaluative survey reports – Age, HH with/without <5y	**FREQUENCY:** early 2015, late 2016, early 2018 **RESPONSIBILITY**: Research Associate and data manager	Not available	50%		60%		70%	
	Malaria		CHC evaluative survey reports – Age, HH with/without <5y	**FREQUENCY:** early 2015, late 2016, early 2018 **RESPONSIBILITY**: Research Associate and data manager	Not available	50%		60%		70%	
	TB		CHC evaluative survey reports – Age, sex, District	**FREQUENCY:** early 2015, late 2016, early 2018 **RESPONSIBILITY**: Research Associate and data manager	Not available	60%		70%		80%	
1.2 Approval of desired behaviors and/or health services across health areas[16]											
Percent of individuals who approve of health behaviors and/or health services promoted in OBULAMU messages **Numerator**:	**HIV**	Testing for HIV	CHC evaluative survey reports – Age, sex, General population, Key populations (CSW, Fisherfolk, Truckers, MSM)	**FREQUENCY:** early 2015, late 2016, early 2018 **RESPONSIBILITY**: Research Associate and data manager	Not available	40%		50%		60%	
		Always using condoms during high risk sex (esp. Key Populations)				40%		50%		60%	
		Enrolling for eMTCT if HIV positive				40%		50%		60%	
		Obtaining SMC				40%		50%		60%	

[16] Targets in this set of indicators are based on the hierarchy of communication effects (see Figure 3 at the end of the document). The assumption in this cascade of effects is that if CHC HC reaches 80% of the population that have not adopted the desired behaviors, at least 60% will understand the message, and about 40% will approve of the message. The subsequent targets assume a 10 percent increase with cumulative reach and frequency impact of HC interventions. In other words, the threshold of effectiveness is attained with at least 3 exposures. Exposures ranging between 4 and 9 qualify for reinforcement of effectiveness, and above 10 exposures result in excessive exposure and risk of information overload and ineffectiveness. See http://www.slideshare.net/Laisekhadir/reach-frequency-impact and http://renaissance000.blogspot.com/2012/11/chapter10mediaplanningandstrategy.html

Performance Indicator	Health Area/ BCC domains covered in indicator		Data source[13]/ Disaggregation	FREQUENCY/ Responsibility	Reference data before CHC[14]	2015[15]		2016		2018	
						Target	Actual	Target	Actual	Target	Actual
Eligible individuals 15-49 who approve of specific health behaviors and/or health services promoted in OBULAMU messages *Domains under approve:* See specific breakdown in column 3. **Denominator**: Individuals in the CHC evaluative survey who are reached with OBULAMU messages at least twice through any or a combination of channels used by the project, but are not adopters a specific behavior/or health service at the time of survey	**Modern FP**	Taking up FP use either to -Delay pregnancy -Space births -Limit births	CHC evaluative survey reports – Age, sex, CHC enumeration cluster	**FREQUENCY:** early 2015, late 2016, early 2018 **RESPONSIBILITY**: Research Associate and data manager	Not available	40%		50%		60%	
	MCHN	Exclusively breastfeeding baby (including EIB) up to 6 months of age	CHC evaluative survey reports – Age, sex (where applicable), CHC enumeration cluster	**FREQUENCY:** early 2015, late 2016, early 2018 **RESPONSIBILITY**: Research Associate and data manager	Not available	40%		50%		60%	
								50%		60%	
								50%		60%	
		Initiating and completing full course of timely vaccinations for infants				40%		50%		60%	
								50%		60%	
		Pregnant women initiating and completing 4 ANC visits (1st - 4th)				40%		50%		60%	
		Delivering child at a Health Facility				40%		50%		60%	
	Malaria	Using LLIN every night	CHC evaluative survey reports – Age, HH with/without <5y, district	**FREQUENCY:** early 2015, late 2016, early 2018 **RESPONSIBILITY**: Research Associate and data manager	Not available	40%		50%		60%	
		Pregnant women attending ANC, and initiating and completing full course of IPTp (2 or more)				40%		50%		60%	
		Caregivers seeking prompt diagnosis and appropriate care for children upon recognizing symptoms of malaria.				40%		50%		60%	
		IRS spraying of households				40%		50%		60%	
	TB	TB screening and testing	CHC evaluative survey reports – Age, sex, District	**FREQUENCY:** early 2015, late 2016, early 2018 **RESPONSIBILITY**: Research Associate and data manager	Not available	40%		50%		60%	
		TB treatment adherence				40%					

Performance Indicator	Health Area/ BCC domains covered in indicator		Data source[13]/ Disaggregation	FREQUENCY/ Responsibility	Reference data before CHC[14]	2015[15]		2016		2018	
						Target	Actual	Target	Actual	Target	Actual
1.3 Intention to initiate and/or adopt desired behaviors and/or health services across health areas[17]											
Percent of individuals who intend to adopt health behaviors and/or health services promoted in OBULAMU messages **Numerator**: Eligible individuals 15-49 who report that they intend – in the next six months – to adopt at least one of the specific health behaviors and/or health services promoted in OBULAMU messages *Domains under intend:* See specific breakdown in column 3. **Denominator**: Individuals in the CHC evaluative survey who are reached with OBULAMU messages at least twice through any or a combination of channels used by the project, but are not adopters of a specific behavior/or health service at the time of survey	**HIV**	Testing for HIV	CHC evaluative survey reports Age, sex, General population, Key populations (CSW, Fisherfolk, Truckers, MSM)	**FREQUENCY:** early 2015, late 2016, early 2018 **RESPONSIBILITY**: Research Associate and data manager	Not available	20%		30%		40%	
		Always using condoms during high risk sex (esp. Key Populations)				20%		30%		40%	
		Enrolling for eMTCT if HIV positive				20%		30%		40%	
		Obtaining SMC				20%		30%		40%	
		Adhering to ART				20%		30%		40%	
	Modern FP	Taking up FP use either to -Delay pregnancy -Space births -Limit births	CHC evaluative survey reports Age, sex, CHC enumeration cluster	**FREQUENCY:** early 2015, late 2016, early 2018 **RESPONSIBILITY**: Research Associate and data manager	Not available	20%		30%		40%	
	MCHN	Exclusively breastfeeding baby (including EIB) up to 6 months of age	CHC evaluative survey reports Age, sex (where applicable), CHC enumeration cluster	**FREQUENCY:** early 2015, late 2016, early 2018 **RESPONSIBILITY**: Research Associate and data manager	Not available	20%		30%		40%	
								30%		40%	
								30%		40%	
		Initiating and completing full course of timely vaccinations for infants				20%		30%		40%	
								30%		40%	
		If pregnant, initiating and completing 4 ANC visits (1st - 4th)				20%		30%		40%	
		Delivering child at a Health Facility				20%		30%		40%	
	Malaria	Using LLIN every night	CHC evaluative survey reports Age, HH with/without <5y, district	**FREQUENCY:** early 2015, late 2016, early 2018 **RESPONSIBILITY**: Research Associate and data manager	Not available	20%		30%		40%	
		If pregnant, attending ANC, and initiating and completing full course of IPTp (2 or more)				20%		30%		40%	
		If caregivers, seeking prompt diagnosis and appropriate care for children upon recognizing symptoms of malaria.				20%		30%		40%	
		IRS spraying of households				20%		30%		40%	

[17] Targets in this set of indicators are based on the hierarchy of communication effects (see Figure 3 at the end of the document). The assumption in this cascade of effects is that if CHC HC reaches 80% of the population that have not adopted the desired behaviors, at least 60% will understand the message, and about 40% will approve of the behavior being promoted, and a least 20 percent will develop intention to adopt the behavior. The subsequent targets assume a 10 percent increase with cumulative reach and frequency impact of HC interventions. In other words, the threshold of effectiveness is attained with at least 3 exposures. Exposures ranging between 4 and 9 qualify for reinforcement of effectiveness, and above 10 exposures result in excessive exposure and risk of information overload and ineffectiveness. See http://www.slideshare.net/Laisekhadir/reach-frequency-impact and http://renaissance000.blogspot.com/2012/11/chapter10mediaplanningandstrategy.html

Performance Indicator	Health Area/ BCC domains covered in indicator		Data source[13]/ Disaggregation	FREQUENCY/ Responsibility	Reference data before CHC[14]	2015[15]		2016		2018	
						Target	Actual	Target	Actual	Target	Actual
	TB	If gets a persistent cough lasting 2 or more weeks, screen and test for TB	CHC evaluative survey reports Age, sex, District	**FREQUENCY:** early 2015, late 2016, early 2018 **RESPONSIBILITY**: Research Associate and data manager	Not available	20%		30%		40%	
		If tested positive for TB, adhere to treatment				20%		30%		40%	

4.5 CHC Indicators Reference Sheets

4.5.1 Reference Sheets: Strategic Objective Indicators (CONTEXT)

Indicator Reference Sheet			
Strategic Objective (SO): Increase adoption of healthy behaviors through strengthened health communication			
SO CONTEXT Indicator 1: Percent of men aged 15-49y who are circumcised			
Date Established:		**Date Last Reviewed:**	
a. Description			
Precise Definition(s): The increase in percent of men aged 15-49y circumcised **Unit of Measure:** Percent **Numerator:** Number of men aged 15-49 who are circumcised **Denominator:** Number of men aged 15-49 in UDHS/UAIS who were circumcised **Disaggregation:** Per UDHS/UAIS disaggregation **Justification/Management Utility:** Estimation of changing rates of male circumcision among adult men aged 15-49. Serves as a proxy indicator for potential demand for male circumcision.			
b. Plan for Data Collection			
Data Collection Method: Mainly UDHS/UAIS whenever available. **Method of Measurement:** Per UDHS/UAIS questionnaires. Supplementary data generated using CHC evaluative surveys. In a CHC survey, all respondents are asked their age, and all men are asked about their circumcision status. All circumcised men are asked whether their circumcision occurred in the last 6 months. Men circumcised in the last 6 months are asked what prompted their decision to obtain circumcision. Data is recorded in non-prompted response categories of which some are about CHC HC. **Data Source(s):** UDHS/UAIS reports when available. Supplementary data to come from periodic reports of CHC cross-sectional surveys across 16 evaluation districts at Timeline 1 (baseline), midline, and endline. **Timing / Frequency of Data Collection:** Periodic by UDHS/UAIS calendars. In CHC evaluative surveys: Baseline early 2015; Midline late 2016, Endline early 2018. **Estimated Cost of Data Collection:** No cost for data extraction from UDHS/UAIS. Periodic CHC surveys estimated at US$ 150,000 each. **Responsible Individual(s):** CHC Research and M&E officers.			
c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)			
Data Analysis: Per UDHS/UAIS report format. Supplementary data from CHC evaluative surveys estimates uptake in the last 6 months to facilitate analysis of attribution to CHC HC interventions in a given period. Supplementary CHC data will be analyzed using Univariate and bivariate statistics and compared with trends in national surveys including UDHS and UAIS. **Presentation of Data:** Frequency tables/graphs/trend lines as may be appropriate. **Review of Data:** Periodic by survey timelines. In CHC survey every 1½ years **Reporting of Data:** CHC evaluative survey reports for supplementary data.			
d. Data Quality Issues			
Initial Data Quality Assessment: None **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:**			
e. Other Notes			
Notes on Baselines/Targets: Baselines for this indicator draw from UAIS 2011. No targets are set for context indicators. Notably, CHC only makes a contribution to this indicator.			
Location of Data Storage: CHC M&E and Research data bases, FHI360, Kampala.			
Other notes:			
e. 1 Performance Tracking Data Table			
	Target	**Actual**	**Comments**
Reference point– UDHS 2011: 26.4%			
2014	N/A		
2015	N/A		
2016	N/A		
2017	N/A		
THIS SHEET LAST UPDATED ON: February 2015			

Indicator Reference Sheet			
Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication			
SO CONTEXT Indicator 2: Percent of women aged 15-49 who were tested for HIV and received their test results during antenatal care.			
Date Established: Date Last Reviewed:			
a. Description			
Precise Definition(s): The change in percent of women 15-49 who gave birth in the two years preceding the survey who report that they took an HIV test and received their results during antenatal care **Unit of Measure:** Percent **Numerator:** Number of women 15-49 who gave birth in the two years preceding the survey who report that they took an HIV test and received their results during antenatal care **Denominator:** Number of women 15-49 who gave birth two years before the survey and report attending ANC **Disaggregation:** Per UDHS/UAIS report **Justification/Management Utility:** Proxy indicator for active use and demand at household level for identification/treatment of all HIV-infected pregnant women.			
b. Plan for Data Collection			
Data Collection Method: Mainly UDHS/UAIS whenever available. **Method of Measurement:** Per UDHS/UAIS questionnaires. Supplementary data generated using CHC evaluative surveys. In CHC survey, currently pregnant women and/or mothers with a live birth 0-11 months before the survey are asked if they obtained an HIV test during their pregnancy. If yes, (I do not want to know the test result, BUT) did you receive the results of the HIV test? **Data Source(s):** UDHS/UAIS reports when available. CHC evaluative surveys: Observation 1 early 2015; Observation 2 late 2016; Observation 3 early 2018. **Timing / Frequency of Data Collection:** By UDHS/UAIS calendar. CHC Observation 1 early 2015; Observation 2 late 2016; Observation 3 early 2018, **Estimated Cost of Data Collection:** Periodic CHC evaluations estimated at US$ 150,000 each covering 16 districts **Responsible Individual(s):** Research and M&E Officers			
c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)			
Data Analysis: None for UDHS/UAIS. Univariate and bivariate statistics for supplementary CHC surveys **Presentation of Data:** Frequency tables **Review of Data:** By survey timelines **Reporting of Data:** CHC evaluative surveys reports for supplementary data.			
d. Data Quality Issues			
Initial Data Quality Assessment: None **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:**			
e. Other Notes			
Notes on Baselines/Targets: Baselines for this indicator draw from UAIS 2011. No targets are set for context indicators. Notably, CHC only makes a contribution to this indicator.			
Location of Data Storage: CHC M&E and Research databases, FHI360, Kampala.			
Other notes:			
e. 1 Performance Data Table			
	Target	**Actual**	**Comments**
Reference point: UAIS 2011; 72%			
2014	N/A		
2015	N/A		
2016	N/A		
2017	N/A		
THIS SHEET LAST UPDATED ON: February 2015			

Indicator Reference Sheet			
Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication			
SO CONTEXT Indicator 3: Percent of exclusively breastfed for the first 6 months			
Date Established:		**Date Last Reviewed:**	
a. Description			
Precise Definition(s): The prevalence of exclusive breastfeeding of children **Unit of Measure:** Percent **Numerator:** Number of children aged two years who were only breastfed milk for the first six months (counting up to the last day of the fifth month of life) **Denominator:** Number of children 0-24 months in the national survey **Disaggregation:** Per UDHS report **Justification/Management Utility:** Assessing existing behaviors around breastfeeding for the first six months of life.			
b. Plan for Data Collection			
Data Collection Method: Mainly UDHS whenever available. **Method of Measurement:** Per UDHS questionnaire for women. Supplementary data generated using CHC evaluative surveys. In CHC survey, a caregiver of a child 0-<6 months will be asked to list all possible things the child was fed in the last 24 hours, besides breast milk. **Data Source(s):** UDHS/UAIS reports when available. CHC evaluative surveys: Observation 1 early 2015; Observation 2 late 2016; Observation 3 early 2018. **Timing / Frequency of Data Collection:** By UDHS calendar. CHC Observation 1 early 2015; Observation 2 late 2016; Observation 3 early 2018, **Estimated Cost of Data Collection:** Periodic CHC evaluations estimated at US$ 150,000 each covering 16 districts **Responsible Individual(s):** Research and M&E Officers			
c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)			
Data Analysis: None for UDHS. Univariate and bivariate statistics for supplementary CHC surveys **Presentation of Data:** Frequency tables **Review of Data:** By survey timelines **Reporting of Data:** CHC evaluative surveys reports for supplementary data.			
d. Data Quality Issues			
Initial Data Quality Assessment: None **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:**			
e. Other Notes			
Notes on Baselines/Targets: Baselines for this indicator draw from UAIS 2011. No targets are set for context indicators. Notably, CHC only makes a contribution to this indicator.			
Location of Data Storage: CHC M&E and Research databases, FHI360, Kampala.			
Other notes:			
e. 1 Performance Data Table			
	Target	**Actual**	**Comments**
Reference point: UAIS 2011; 62%			
2014	N/A		
2015	N/A		
2016	N/A		
2017	N/A		
THIS SHEET LAST UPDATED ON: February 2015			

Indicator Reference Sheet			
Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication			
SO CONTEXT Indicator 4: Percent of children under 5 years classified as malnourished			
Date Established:		**Date Last Reviewed:**	
a. Description			
Precise Definition(s): Prevalence of malnutrition in children <5y **Unit of Measure:** Percent **Numerator:** Number of children under 5 years classified as malnourished according to three anthropometric indices of nutritional status **Denominator:** Total number of children under 5 years old in UDHS survey. **Disaggregation:** By UDHS report format **Justification/Management Utility:** A proxy for dietary diversity of foods fed to children			
b. Plan for Data Collection			
Data Collection Method: UDHS whenever available **Method of Measurement:** Per UDHS questionnaire. Supplementary data in a CHC survey: Caregivers of children 6-23 months are asked about liquids or foods that the children aged 6-23 months have had in the last 24 hours. Prompted answers are aligned with the following domains: 1) Energy foods: Cereals and products, roots/tubers and products, 2) Growth foods: Legumes, meats, fish, poultry eggs, milk and products, 3) Protective foods: Fruits and vegetables. A related question asks for the number of times the child was fed in the last 24 hours. **Data Source(s):** UDHS/UAIS reports when available. CHC evaluative surveys: Observation 1 early 2015; Observation 2 late 2016; Observation 3 early 2018. **Timing / Frequency of Data Collection:** By UDHS calendar. CHC Observation 1 early 2015; Observation 2 late 2016; Observation 3 early 2018, **Estimated Cost of Data Collection:** Periodic CHC evaluations estimated at US$ 150,000 each covering 16 districts **Responsible Individual(s):** Research and M&E Officers			
c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)			
Data Analysis: Per UDHS report format. Supplementary CHC survey data analysis includes univariate and bivariate statistics Illustrative ways to calculate this indicate include the following two fractions: Breastfed children 6–23 months of age who received solid , semi-solid or soft foods the minimum number of times or more during the previous day / Breastfed children 6–23 months of age **AND** Non-breastfed children 6–23 months of age who received solid , semi-solid or soft foods or milk feeds the minimum number of times or more during the previous day / Non-breastfed children 6–23 months of age **Presentation of Data:** Frequency tables **Review of Data:** By survey timelines **Reporting of Data:** CHC evaluative surveys reports for supplementary data.			
d. Data Quality Issues			
Initial Data Quality Assessment: None **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:**			
e. Other Notes			
Notes on Baselines/Targets: Baselines for this indicator draw from UAIS 2011. No targets are set for context indicators. Notably, CHC only makes a contribution to this indicator.			
Location of Data Storage: CHC M&E and Research databases, FHI360, Kampala.			
Other notes:			
e. 1 Performance Tracking Data Table			
	Target	**Actual**	**Comments**
Reference point: UDHS 2011 Height-for-age <-2SD = 33% Weight-for-height <-2SD = 5% Weight-for-age <-2SD = 14%			
2014	N/A		
2015	N/A		
2016	N/A		
2017	N/A		
THIS SHEET LAST UPDATED ON: February 2015			

Indicator Reference Sheet			
Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication			
SO CONTEXT Indicator 5: Proportion of women who took 2 or more doses of IPTp			
Date Established:		**Date Last Reviewed:**	
a. Description			
Precise Definition(s): The change in the percentage of mothers of children 0-11 months who received 2 or more doses of IPTp during ANC visits during their last pregnancy as a result of exposure to CHC messages **Unit of Measure:** Proportion **Numerator:** Number of women surveyed who received two or more doses of a recommended prophylactic anti-malarial drug during ANC visits to prevent malaria during their last pregnancy that led to a live birth within the last two years **Denominator:** Total number of women surveyed who had a live birth in the last two years **Disaggregation:** Per UMIS/UDHS report format. **Justification/Management Utility:** Proxy indicator for active use and demand at household level for ANC services including IPTp to prevent malaria in pregnancy.			
b. Plan for Data Collection			
Data Collection Method: Mainly UMIS/UDHS when available. **Method of Measurement:** Per UMIS/UDHS questionnaire. Supplementary data generated through CHC evaluative surveys: During this/your most recent pregnancy did you take any drugs in order to prevent you from getting malaria? How many times did you take medicine to prevent malaria during this/your last pregnancy? IF CURRENTLY PREGNANT How likely or unlikely are you to obtain any drugs during this pregnancy to prevent malaria? Where do you intend to obtain the drugs to prevent malaria? **Data Source(s):** UMIS/UDHS reports when available. CHC evaluative surveys: Observations 1, 2, 3. **Timing / Frequency of Data Collection:** By UMIS/UDHS calendar. CHC Observation 1 early 2015; Observation 2 late 2016; Observation 3 early 2018 **Estimated Cost of Data Collection:** Periodic CHC evaluations estimated at US$ 150,000 each covering 16 districts **Responsible Individual(s):** Research and M&E Officers			
c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)			
Data Analysis: None for UMIS/UDHS. Univariate and bivariate statistics for supplementary CHC surveys **Presentation of Data:** Frequency tables **Review of Data:** By survey timelines **Reporting of Data:** CHC evaluative surveys reports for supplementary data.			
d. Data Quality Issues			
Initial Data Quality Assessment: None **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:**			
e. Other Notes			
Notes on Baselines/Targets: Baselines for this indicator draw from UAIS 2011. No targets are set for context indicators. Notably, CHC only makes a contribution to this indicator.			
Location of Data Storage: CHC M&E and Research databases, FHI360, Kampala.			
Other notes:			
e. 1 Performance Data Table			
	Target	**Actual**	**Comments**
Reference point: UMIS 2009 32%; UDHS 2011 25%			
2014	N/A		
2015	N/A		
2016	N/A		
2017	N/A		
THIS SHEET LAST UPDATED ON: February 2015			

Indicator Reference Sheet			
Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication			
SO CONTEXT Indicator 6: Percent of sexually active women aged 15-49y who are currently using any modern method of family planning in response to CHC messages			
Date Established:		**Date Last Reviewed:**	
a. Description			
Precise Definition(s): Percent of women aged 15-49 years or their partners who report using any modern contraceptive method (Pill, IUCD, Injectable, Implant, Voluntary sterilization, Condoms) in response to CHC messages **Unit of Measure:** Percent **Numerator:** Number of sexually active women aged 15-49y who are currently using any modern method of family planning. *Modern contraceptive methods include* Pill, IUCD, Injectable, Implant, Voluntary sterilization, Condoms **Denominator:** Total number of sexually active women aged 15-49 years in the survey **Disaggregation:** Per UMIS/UDHS report format **Justification/Management Utility:** Modern contraceptive methods are being promoted as part of a strategy to address high fertility rate and improve maternal health outcomes. This indicator measures progress in mobilizing contraceptive demand/ uptake.			
b. Plan for Data Collection			
Data Collection Method: Mainly UDHS when available. **Method of Measurement:** UDHS questionnaire. Supplementary CHC evaluative survey: Sexually active male and female respondents are asked: Are you or your partner currently using a method to prevent pregnancy? Which methods are you or your partner currently using? (E.g. voluntary sterilization, pills, IUD, injectable, implants, calendar/cycle beads, and condoms). **Data Source(s):** UMIS/UDHS reports when available. CHC evaluative surveys: Observations 1, 2, 3. **Frequency of Data Collection:** By UDHS calendar. CHC Observation 1 early 2015; Observation 2 late 2016; Observation 3 early 2018 **Estimated Cost of Data Collection:** Periodic CHC evaluations estimated at US$ 150,000 each covering 16 districts **Responsible Individual(s):** Research and M&E Officers			
c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)			
Data Analysis: None for UDHS. Univariate and bivariate statistics for supplementary CHC surveys **Presentation of Data:** Frequency tables **Review of Data:** By survey timelines **Reporting of Data:** CHC evaluative surveys reports for supplementary data.			
d. Data Quality Issues			
Initial Data Quality Assessment: None **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:**			
e. Other Notes			
Notes on Baselines/Targets: Baselines for this indicator draw from UAIS 2011. No targets are set for context indicators. Notably, CHC only makes a contribution to this indicator.			
Location of Data Storage: CHC M&E and Research databases, FHI360, Kampala.			
Other notes:			
e. 1 Performance Data Table			
	Target	**Actual**	**Comments**
Reference point: UDHS 2011 26%			
2014	N/A		
2015	N/A		
2016	N/A		
2017	N/A		
THIS SHEET LAST UPDATED ON: February 2015			

4.5.2 Reference Sheets: Strategic Objective Indicators (OUTCOME)

Indicator Reference Sheet			
Strategic Objective*:* Increase adoption of healthy behaviors through strengthened health communication			
SO OUTCOME Indicator 1: Percentage of individuals who engaged in higher risk sex in the last 6 months			
Date Established: **Date Last Reviewed:**			
a. Description			
Precise Definition(s): The change in percent of individuals who did not engage in higher risk sex in the last 6 months **Unit of Measure:** Percent **Numerator:** Number of individuals who had sex with a non-marital, non-cohabiting partner in the last 6 months. **Denominator:** Number of individuals who had sex in the last 6 months **Disaggregation:** Region, Age, Residence (rural/urban) **Justification/Management Utility:** Estimation of trends in decline in high risk sex behaviors in the last six months.			
b. Plan for Data Collection			
Data Collection Method: CHC evaluative survey questionnaire. **Method of Measurement:** In a survey, men and women 15-49y who have been sexually active in the last 6 months, are asked: I would like to ask you some questions about your relationship with your last sexual partner. [IF MORE THAN ONE SEXUAL PARTNER] I will then ask the same questions about other sexual partners that you have had in the last 6 months. In total, with how many different people have you had sexual intercourse in the last 6 months? What was your relationship to this person with whom you had sexual intercourse? **Data Source(s):** CHC evaluative survey reports: Observations 1, 2, 3. **Frequency of Data Collection:** CHC Observation 1 early 2015; Observation 2 late 2016; Observation 3 early 2018 **Estimated Cost of Data Collection:** Periodic CHC evaluations estimated at US$ 150,000 each covering 16 districts **Responsible Individual(s):** Research and M&E Officers			
c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)			
Data Analysis: Univariate and bivariate statistics. CHC evaluative survey data will be compared with trends in GOU/USG IP data drawn from HMIS. **Presentation of Data:** Frequency tables/ graphs/trend lines **Review of Data:** By survey periods **Reporting of Data:** CHC survey reports, presentations			
d. Data Quality Issues			
Initial Data Quality Assessment: None **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:**			
e. Other Notes			
Notes on Baselines/Targets: CHC Observation one covering 16 districts (one peri-urban and one rural per region) is scheduled for April-May 2015. CHC evaluative survey protocol attempts to measure CHC contribution to selected variables/indicators (see – Annex 2). Notably, the minimum detectable effect sizes measure feasible CHC contribution, based on a calculation of UDHS 2011 data, current national target projections as reflected in HSSP III, and total number of expected evaluation districts for a given indicator (all 16 for HIV behaviors since USG IP HIV prevention activities exist country-wide). CHC survey data will be supplemented with HMIS trend data six months back from the survey point. CHC 2014 targets for this indicator draw from UAIS 2011 indication that at least 25% and as little as 4% of men and women respectively engaged in high risk sex and national targets that aim to reduce these numbers by half. However, CHC hypothesizes that women's responses to the UAIS 2011 may reflect social desirability. Thus, CHC prefers to estimate post 2014 targets based on CHC baseline and other data from HMIS in 2015.			
Location of Data Storage: CHC M&E and Research data bases, FHI360, Kampala.			
e. 1 Performance Data Table			
	Target	**Actual**	**Comments**
Reference point: UAIS 2011-74.6% men; 96% women			
2014	38% men; Women 2%		
2015	TBD May/June 2015 after CHC Observation 1		
2016	TBD		
2017	TBD		
2018	TBD		
THIS SHEET LAST UPDATED ON: February 2015			

Indicator Reference Sheet			
Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication			
SO OUTCOME Indicator 2: Percent of individuals who used a condom at last higher risk sex			
Date Established: **Date Last Reviewed:**			
a. Description			
Precise Definition(s): The change in the percentage of individuals who used a condom the last time they had sexual intercourse with a non-marital or non-cohabiting partner in the last six months. **Unit of Measure:** Percent **Numerator:** Number of individuals who used a condom the last time they had sexual intercourse with a non-marital or non-cohabiting partner in last 6 months. **Denominator:** Number of individuals who had higher risk sex in last 12 months **Disaggregation:** Region, Sex, Age (15-19, 20-24, 25-49), Residence (rural/urban) **Justification/Management Utility:** Estimation of changes in risky sex behaviors, i.e. progress specifically towards preventing exposure to HIV through unprotected sex with non-regular sexual partners. The trend in condom use during the most recent sex act is assumed to generally reflect the trend in consistent condom use. Disaggregation by patterns across regions, age, sex, and residence facilitates targeted HC intervention. Measurement in the last six months facilitates analysis to estimate attribution to CHC messages.			
b. Plan for Data Collection			
Data Collection Method: CHC evaluative survey questionnaire **Method of Measurement:** I would like to ask you some questions about your relationship with your last sexual partner. [IF MORE THAN ONE SEXUAL PARTNER] I will then ask the same questions about other sexual partners that you have had in the last 6 months. The last time you had sexual intercourse with this person was a condom used? What was your relationship to this person with whom you had sexual intercourse? IF BOYFRIEND/ GIRLFRIEND: Were you living together as if married? **Data Source(s):** CHC evaluative survey reports: Observations 1, 2, 3. **Frequency of Data Collection:** CHC Observation 1 early 2015; Observation 2 late 2016; Observation 3 early 2018 **Estimated Cost of Data Collection:** Periodic CHC evaluations estimated at US$ 150,000 each covering 16 districts **Responsible Individual(s):** Research and M&E Officers			
c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)			
Data Analysis: Univariate and bivariate statistics. CHC evaluative survey data will be compared with trends in GOU/USG IP data drawn from HMIS. **Presentation of Data:** Frequency tables/ graphs/trend lines **Review of Data:** By survey periods **Reporting of Data:** CHC survey reports, presentations			
d. Data Quality Issues			
Initial Data Quality Assessment: None **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:**			
e. Other Notes			
Notes on Baselines/Targets: CHC Observation one covering 16 districts (one peri-urban and one rural per region) is scheduled for April-May 2015. CHC evaluative survey protocol attempts to measure CHC contribution to selected variables/indicators (see – Annex 2). Notably, the minimum detectable effect sizes measure feasible CHC contribution, based on a calculation of UDHS 2011 data, current national target projections as reflected in HSSP III, and total number of expected evaluation districts for a given indicator (all 16 for HIV behaviors since USG IP HIV prevention activities exist country-wide). CHC survey data will be supplemented with HMIS trend data six months back from the survey point. **Location of Data Storage:** CHC M&E and Research data bases, FHI360, Kampala.			
e. 1 Performance Data Table			
	Target	**Actual**	**Comments**
Reference Point: UAIS 2011 - Men 14.8%, Women 15.8%			
2014	N/A		
2015	75% general pop. 80% Key pop.		
2016	80% general pop. 85% Key pop.		
2017	N/A		
2018	85% general pop. 90% Key pop.		
THIS SHEET LAST UPDATED ON: February 2015			

Indicator Reference Sheet			
Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication			
SO OUTCOME Indicator 3: Percent of mothers of children 0-11 months who delivered their last baby in a health facility in response to CHC messages			
Date Established:	**Date Last Reviewed:**		
a. Description			
Precise Definition(s): The change in the percentage of mothers of children 0-11 months who delivered their last baby in a health facility. Health Facility includes: 1) Hospital, 2) Health Centre II, III, IV; 3) Clinic [accredited private or government clinic] **Unit of Measure:** Percent **Numerator:** Number of mothers of children 0-11 months who delivered their last baby in a health facility **Denominator:** Number of mothers of children 0-11 months in the survey **Disaggregation:** Region, Age, Residence (rural/urban) **Justification/Management Utility:** Proxy indicator for demand for provider assisted delivery services by women as a means to improve MCH outcomes. Disaggregation by patterns across USG IP clusters, age, and residence facilitates targeted HC intervention.			
b. Plan for Data Collection			
Data Collection Method: CHC evaluative survey questionnaire. **Method of Measurement:** Illustratively in a survey, mothers of children 0-11 months are asked where they delivered their baby from. Responses are marked on a pre-coded sheet of all delivery point options currently used in communities. **Data Source(s):** CHC evaluative survey reports: Observations 1, 2, 3. **Frequency of Data Collection:** CHC Observation 1 early 2015; Observation 2 late 2016; Observation 3 early 2018 **Estimated Cost of Data Collection:** Periodic CHC evaluations estimated at US$ 150,000 each covering 16 districts **Responsible Individual(s):** Research and M&E Officers			
c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)			
Data Analysis: Univariate and bivariate statistics. CHC evaluative survey data will be compared with trends in GOU/USG IP data drawn from HMIS. **Presentation of Data:** Frequency tables/ graphs/trend lines **Review of Data:** By survey periods **Reporting of Data:** CHC survey reports, presentations			
d. Data Quality Issues			
Initial Data Quality Assessment: CHC Data manager. Continuously as field data is received into the mobile data platform. **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:**			
e. Other Notes			
Notes on Baselines/Targets: CHC Observation one covering 16 districts (one peri-urban and one rural per region) is scheduled for April-May 2015. CHC evaluative survey protocol attempts to measure CHC contribution to selected variables/indicators (see – Annex 2). Notably, the minimum detectable effect sizes measure feasible CHC contribution, based on a calculation of UDHS 2011 data, current national target projections as reflected in HSSP III, and total number of expected evaluation districts for a given indicator (all 16 for MCH behaviors since USG IP MCH activities exist country-wide). CHC survey data will be supplemented with HMIS trend data six months back from the survey point.			
Location of Data Storage: CHC M&E and Research databases, FHI360, Kampala.			
Other notes:			
e. 1 Performance Data Table			
	Target	**Actual**	**Comments**
Reference Point: UDHS 2011 – 57.4%			
2014	N/A		
2015	65%		
2016	72%		
2017	N/A		
2018	80%		
THIS SHEET LAST UPDATED ON: February 2015			

Indicator Reference Sheet			
Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication			
SO OUTCOME Indicator 4: Proportion of pregnant women who slept under an ITN/LLIN last night			
Date Established:		**Date Last Reviewed:**	
a. Description			
Precise Definition(s): The rate of ITN/LLIN use among pregnant women on the night preceding CHC survey (either for the first time, or as a reinforcement of practice) **Unit of Measure:** Percent **Numerator:** Number of pregnant women in HH with ITN/LLIN who slept under an ITN/LLIN the night before the survey **Denominator:** Number of pregnant women surveyed in HH with ITN/LLIN **Disaggregation:** Region, Age, Residence (rural/urban), season (hot/dry; cold/rainy) **Justification/Management Utility:** Assessing likely trends in net use by pregnant women. Documented use last night is understood to suggest a pattern of adherence, i.e. either consistent or inconsistent use, with implications for MCH outcomes.			
b. Plan for Data Collection			
Data Collection Method: CHC evaluative survey questionnaire. **Method of Measurement:** A household net roster will be used to collect data on net count and use in the specific household. The household roster is applicable for all household members, pregnant women, and children under 5 years of age. Specific questions for net use include: 1) Did anyone sleep under this mosquito net last night? YES/NO/NOT SURE. Who slept under this mosquito net last night? RECORD THE PERSON'S NAME AND NUMBER FROM THE HOUSEHOLD DEMOGRAPHIC SCHEDULE. **Data Source(s):** CHC evaluative survey reports: Observations 1, 2, 3. **Frequency of Data Collection:** CHC Observation 1 early 2015; Observation 2 late 2016; Observation 3 early 2018 **Estimated Cost of Data Collection:** Periodic CHC evaluations estimated at US$ 150,000 each covering 16 districts **Responsible Individual(s):** Research and M&E Officers			
c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)			
Data Analysis: Univariate and bivariate statistics. CHC evaluative survey data will be compared with trends in UMIS 2014/2015. **Presentation of Data:** Frequency tables/ graphs/trend lines **Review of Data:** By survey periods **Reporting of Data:** CHC survey reports, presentations, technical briefs			
d. Data Quality Issues			
Initial Data Quality Assessment: None **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:**			
e. Other Notes			
Notes on Baselines/Targets: CHC Observation one covering 16 districts (one peri-urban and one rural per region) is scheduled for April-May 2015. CHC evaluative survey protocol attempts to measure CHC contribution to selected variables/indicators (see – Annex 2). Notably, the minimum detectable effect sizes measure feasible CHC contribution, based on a calculation of UDHS 2011 data, current national PMI target projections, and total number of expected evaluation districts for a given indicator (all 16 for MCH/Malaria behaviors since USG IP MCH/Malaria activities exist country-wide). CHC may revise these targets following results in the CHC Observation 1 survey.			
Location of Data Storage: CHC M&E and Research databases, FHI360, Kampala.			
Other notes:			
e. 1 Performance Data Table			
	Target	**Actual**	**Comments**
Reference: UDHS 2011: 47% all HH; 71% HH with ITNs			
2014	N/A for CHC		
2015	85%		
2016	85%		
2017	N/A		
2018	85%		
THIS SHEET LAST UPDATED ON: February 2015			

Indicator Reference Sheet			
Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication			
SO OUTCOME Indicator 5: Proportion of children <5y who slept under an ITN last night			
Date Established:	**Date Last Reviewed:**		
a. Description			
Precise Definition(s): The rate of ITN/LLIN use among children under five years of age in CHC survey **Unit of Measure:** Percent **Numerator:** Number of children below five years of age who slept under an ITN/LLIN the night before the survey **Denominator:** Number of children <5y surveyed in HH with ITN **Disaggregation:** Region, Age, Residence (rural/urban), season (hot/dry; cold/rainy) **Justification/Management Utility:** Assessing likely trends in net use by children 0-5y. Documented use last night is understood to suggest a pattern of adherence, i.e. either consistent or inconsistent use.			
b. Plan for Data Collection			
Data Collection Method: CHC evaluative survey questionnaire for household demographic profile and net coverage/use. **Method of Measurement:** A household net roster will be used to collect data on net count and use in the specific household. The household roster is applicable for all household members, pregnant women, and children under 5 years of age. Specific questions for net use include: 1) Did anyone sleep under this mosquito net last night? YES/NO/NOT SURE. Who slept under this mosquito net last night? RECORD THE PERSON'S NAME AND NUMBER FROM THE HOUSEHOLD DEMOGRAPHIC SCHEDULE. **Data Source(s):** CHC evaluative survey reports: Observations 1, 2, 3. **Frequency of Data Collection:** CHC Observation 1 early 2015; Observation 2 late 2016; Observation 3 early 2018 **Estimated Cost of Data Collection:** Periodic CHC evaluations estimated at US$ 150,000 each covering 16 districts **Responsible Individual(s):** Research and M&E Officers			
c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)			
Data Analysis: Univariate and bivariate statistics. CHC evaluative survey data will be compared with trends in UMIS 2014/2015. **Presentation of Data:** Frequency tables/ graphs/trend lines **Review of Data:** By survey periods **Reporting of Data:** CHC survey reports, presentations, technical briefs			
d. Data Quality Issues			
Initial Data Quality Assessment: CHC Data manager. Continuously as field data is received into the mobile data platform. **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:**			
e. Other Notes			
Notes on Baselines/Targets: CHC Observation 1 covering 16 districts (one peri-urban and one rural per region) is scheduled for April-May 2015. CHC evaluative survey protocol attempts to measure CHC contribution to selected variables/indicators (see – Annex 2). Notably, the minimum detectable effect sizes measure feasible CHC contribution, based on a calculation of UDHS 2011 data, current national PMI target projections, and total number of expected evaluation districts for a given indicator (all 16 for MCH/Malaria behaviors since USG IP MCH/Malaria activities exist country-wide). CHC may revise these targets following results in the CHC Observation 1 survey.			
Location of Data Storage: CHC M&E and Research databases, FHI360, Kampala.			
Other notes:			
e. 1 Performance Data Table			
	Target	**Actual**	**Comments**
Reference point: UDHS 2011: 43% all HH; 63% HH with ITNs			
2014	N/A		
2015	85%		
2016	85%		
2017	N/A		
2018	85%		
THIS SHEET LAST UPDATED ON: February 2015			

Indicator Reference Sheet			
Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication			
SO OUTCOME Indicator 6: Proportion of children under five years old with fever in the last two weeks for whom advice or treatment was sought in response to CHC messages			
Date Established:		**Date Last Reviewed:**	
a. Description			
Precise Definition(s): The change in proportion of children under five years old with fever in the last two weeks for whom advice or treatment was sought in response to CHC messages (either for the first time, or as a reinforcement of practice) **Unit of Measure:** Proportion **Numerator:** Number of children under five years old who had a fever in the previous two weeks for whom advice or treatment was sought **Denominator:** Total number of children under five years old who had a fever in the previous two weeks and for whom advice/treatment was sought **Disaggregation:** Region, Age, Residence (rural/urban), type of provider. **Justification/Management Utility:** Assessing likely trends in health care seeking behaviors for management and treatment of malaria for children below 5y. Assesses whether caregivers recognize symptoms of malaria and seek prompt diagnosis and appropriate care.			
b. Plan for Data Collection			
Data Collection Method: CHC evaluative survey questionnaire for caregivers of children 0-14y. **Method of measurement:** CHC survey: Have any of the children under 5 in your care been ill with fever in the last 2 weeks? Did you seek advice or treatment for this episode of fever from any source? How long after this fever began did you first seek advice or treatment? **Data Source(s):** CHC evaluative survey reports: Observations 1, 2, 3. **Frequency of Data Collection:** CHC Observation 1 early 2015; Observation 2 late 2016; Observation 3 early 2018 **Estimated Cost of Data Collection:** Periodic CHC evaluations estimated at US$ 150,000 each covering 16 districts **Responsible Individual(s):** Research and M&E Officers			
c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)			
Data Analysis: Univariate and bivariate statistics. CHC evaluative survey data will be compared with trends in UMIS 2014/2015. **Presentation of Data:** Frequency tables/ graphs/trend lines **Review of Data:** By survey periods **Reporting of Data:** CHC survey reports, presentations, technical briefs			
d. Data Quality Issues			
Initial Data Quality Assessment: CHC Data manager. Continuously as field data is received into the mobile data platform. **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:**			
e. Other Notes			
Notes on Baselines/Targets: CHC Observation 1 covering 16 districts (one peri-urban and one rural per region) is scheduled for April-May 2015. CHC evaluative survey protocol attempts to measure CHC contribution to selected variables/indicators (see – Annex 2). Notably, the minimum detectable effect sizes measure feasible CHC contribution, based on a calculation of UDHS 2011 data, current national PMI target projections, and total number of expected evaluation districts for a given indicator (all 16 for MCH/Malaria behaviors since USG IP MCH/Malaria activities exist country-wide). CHC may revise these targets following results in the CHC Observation 1 survey.			
Location of Data Storage: CHC M&E and Research databases, FHI360, Kampala.			
Other notes:			
e. 1 Performance Data Table			
	Target	**Actual**	**Comments**
Reference point: UDHS 2011-30%			
2014	N/A		
2015	80%		
2016	80%		
2017	N/A		
2018	80%		
THIS SHEET LAST UPDATED ON: September 2014			

Indicator Reference Sheet			
Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication			
SO OUTCOME Indicator 7: Percent of individuals with a persistent cough lasting two or more weeks who sought TB screening and testing services			
Date Established:	**Date Last Reviewed:**		
a. Description			
Precise Definition(s): The change in the number of individuals with a persistent cough lasting 2/more weeks who sought TB (or for whom caregiver sought) screening and testing services in the last 6 months as a result of exposure to CHC messages **Unit of Measure:** Percent **Numerator:** Number of individuals (adults and children) with a persistent cough lasting two or more weeks who sought (or for whom the caregiver sought) TB screening and testing services in the last 6 months **Denominator:** Total number of individuals for whom a cough lasting 2/more weeks (in the last6 months) is reported in surveyed households **Disaggregation:** Region, Age, Marital status, Residence (rural/urban) **Justification/Management Utility:** TB programs outside of the context of HIV have only just began to pick up, and the current focus is on increasing awareness and knowledge about the signs and symptoms of TB, importance of screening and testing, and treatment adherence. This indicator assesses individuals and caregivers recognition of signs and symptoms of TB, and response to TB screening campaign			
b. Plan for Data Collection			
Data Collection Method: CHC evaluative survey questionnaire for individuals aged 15-49y. TB care seeking for children 0-14 years by caregivers is also covered in the individual survey. **Method of Measurement:** Individuals are asked if anyone in the family had a cough lasting more than two weeks in the past 6 months. For the affirmative response, individuals are asked whether they sought TB screening and testing services for that cough episode. **Data Source(s):** CHC evaluative survey reports: Observations 1, 2, 3. **Frequency of Data Collection:** CHC Observation 1 early 2015; Observation 2 late 2016; Observation 3 early 2018 **Estimated Cost of Data Collection:** Periodic CHC evaluations estimated at US$ 150,000 each covering 16 districts **Responsible Individual(s):** Research and M&E Officers			
c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)			
Data Analysis: Univariate and bivariate statistics. CHC evaluative survey data will be compared with trends in TB Track data and others when available. **Presentation of Data:** Frequency tables/ graphs/trend lines **Review of Data:** By survey periods **Reporting of Data:** CHC survey reports, presentations, technical briefs			
d. Data Quality Issues			
Initial Data Quality Assessment: CHC Data manager. Continuously as field data is received into the mobile data platform. **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:**			
e. Other Notes			
Notes on Baselines/Targets: National data estimates current case detection rate at 65%. Because this is a new area, CHC targets are pegged at 5% increase. This increase is estimated using the hierarchy of communication effects (see figure 1) which suggests the common trickle effect with a health communication coverage of 80% of the target population. The targets may be reviewed after further insight is obtained.			
Location of Data Storage: CHC M&E and Research data bases, FHI360, Kampala.			
Other notes:			
e. 1 Performance Data Table			
Key to Table:			
Rationale for selection of baselines and targets			
	Target	**Actual**	**Comments**
CHC baseline TBD Dec.2014-Feb.2015			
2014	N/A		
2015	70%		
2016	80%		
2017	N/A		
2018	80%		
THIS SHEET LAST UPDATED ON: February 2015			

4.5.3 Reference Sheets: Capacity Strengthening/ Technical Assistance Indicators

Indicator Reference Sheet			
Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication			
Intermediate Result 1 CS/TA Indicator 1.1: Proportion of collaborative partners that received CHC Capacity Strengthening (CS) and/or Technical Assistance (TA) that increased their HC competencies			
Date Established:	**Date Last Reviewed:**		
a. Description			
Precise Definition(s): Proportion of collaborative partners that received CHC Capacity Strengthening (CS) and/or Technical Assistance (TA) that increased their HC competencies based on a set of criteria/tools **Numerator:** Proportion of collaborative partners that received CHC Capacity Strengthening (CS) and/or Technical Assistance (TA) that increased their HC competencies based on a set of criteria/tools **Denominator**: Total number of collaborative partners who received CHC CS/TA **Unit of Measure:** Proportion **Disaggregation:** Health/ BCC area, District/region **Justification/Management Utility:** Important for tracking transfer of skills and improved HC implementation.			
b. Plan for Data Collection			
Data Collection Method: Targeted data extraction from HC implementation rollout and tracking tools, Capacity strengthening documentation logs. **Method of Acquisition:** Implementation and M&E staff extract and collate data from relevant HC development, capacity strengthening, and implementation rollout documentation logs **Data Source(s):** HC implementation plan/documents, continuous audit of HC activities, Champions activity logs, Partner reports, Case studies, Documented success stories/ snapshots, Organizational *Capacity Assessment Tool,* CS documentation logs and reports, Post CS work and implementation plans, strategies, job aids, *Intervention Quality Rating logs* etc, **Timing / Frequency of Data Collection:** Data collated quarterly, semi-annually, and annually by CHC reporting periods **Estimated Cost of Data Collection:** **Responsible Individual(s):** Campaign Manager & Regional technical officers (complete HC development/rollout logs), M&ER staff (extract/ collate)			
c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)			
Data Analysis: Analytical (qualitative) review for progress **Presentation of Data:** Progress trends, mapping/spatial representation, narratives **Review of Data:** CHC internal CHC review (monthly updates and quarterly review), activity level reviews (region, thematic area) with IPs **Reporting of Data:** CHC quarterly/progress reports, BCC WG progress updates, annual work-plan review reports, CHC evaluation reports/ publications.			
d. Data Quality Issues			
Initial Data Quality Assessment: CHC M&E and Campaign Rollout officers. Continuously as implementation is rolled out. **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:**			
e. Other Notes			
Notes on Baselines/Targets:			
Location of Data Storage: CHC M&E and Research data bases, FHI360, Kampala.			
Other notes:			
e. 1 Performance Data Table			
	Target	**Actual**	**Comments**
2013	N/A		
2014	N/A		
2015	N/A		
2016	N/A		
2017	N/A		
THIS SHEET LAST UPDATED ON: February 2015			

Indicator Reference Sheet			
Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication			
Intermediate Result 1 CS/TA Indicator 1.2: Number of collaborating partners that adopt one or more components of the integrated HC strategy			
Date Established:		**Date Last Reviewed:**	
a. Description			
Precise Definition(s): Number of GOU/USG IPs - who received SBCC technical assistance from CHC - that deploy at least one of the four components of the integrated HC strategy. **Numerator**: Number of GOU/USG IPs - who received SBCC technical assistance from CHC - that deploy at least one of the four components of the integrated HC strategy. **Unit of Measure:** Number **Disaggregation:** Health/ BCC area/ Materials, USG IP, District/region **Justification/Management Utility:** Important for tracking progress towards harmonized HC content delivery			
b. Plan for Data Collection			
Data Collection Method: Targeted data extraction from HC implementation rollout and tracking tools, Capacity strengthening documentation logs. **Method of Acquisition:** Implementation and M&E staff extract and collate data from relevant HC development, capacity strengthening, and implementation rollout documentation logs **Data Source(s):** HC implementation plan/documents, continuous audit of HC activities, Champions activity logs, Partner reports, Case studies, Documented success stories/ snapshots, Organizational *Capacity Assessment Tool,* CS documentation logs and reports, Post CS work and implementation plans, strategies, job aids, *Intervention Quality Rating logs* etc, **Timing / Frequency of Data Collection:** Monthly data collated quarterly, semi-annually, and annually by CHC reporting periods **Estimated Cost of Data Collection:** **Responsible Individual(s):** Campaign Manager & Regional technical officers (complete HC development/rollout logs), M&ER staff (extract/ collate)			
c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)			
Data Analysis: Analytical (qualitative) review **Presentation of Data:** Progress trends, mapping/spatial representation, narratives **Review of Data:** CHC internal CHC review (monthly updates and quarterly review), activity level reviews (region, thematic area) with IPs **Reporting of Data:** CHC quarterly/progress reports, BCC WG progress updates, annual work-plan review reports, CHC evaluation reports/ publications.			
d. Data Quality Issues			
Initial Data Quality Assessment: CHC M&E and Campaign Rollout officers. Continuously as implementation is rolled out. **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:**			
e. Other Notes			
Notes on Baselines/Targets: Targets are set on estimated benchmarks for optimal performance established in C-Change.			
Location of Data Storage: CHC M&E and Research data bases, FHI360, Kampala.			
Other notes:			
e. 1 Performance Data Table			
	Target	**Actual**	**Comments**
2013	N/A		
2014	N/A		
2015	N/A		
2016	N/A		
2017	N/A		
THIS SHEET LAST UPDATED ON: September 2014			

Indicator Reference Sheet			
Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication			
Intermediate Result 2 CS/TA Indicator 2.1: Percent of HC materials disseminated that have gone through the national standardization process			
Date Established: **Date Last Reviewed:**			
a. Description			
Precise Definition(s): Percent of HC materials disseminated that have gone through the national standardization process **Numerator**: Number of materials standardized through the national process **Denominator**: Number of materials disseminated through CHC-led HC intervention rollout **Unit of measurement**: Percent **Disaggregation:** Type, Health Area, Audience **Justification/Management Utility:** Important for tracking progress on minimum required performance benchmarks to increase capacity for MOH's coordination role, or harmonization of HC implementation.			
b. Plan for Data Collection			
Data Collection Method: Targeted data extraction from HC implementation rollout and tracking tools, Capacity strengthening documentation logs. **Method of Acquisition:** Implementation and M&E staff extract and collate data from relevant documentation logs **Data Source(s):** WG/Task force activity logs, Review/Adaptation/Standardization logs **Timing / Frequency of Data Collection:** Monthly data collated quarterly, semi-annually, and annually **Estimated Cost of Data Collection:** **Responsible Individual(s):** Capacity Strengthening Coordinator & Regional technical officers (documentation logs), M&ER staff (extract/ collate data)			
c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)			
Data Analysis: Analytical (qualitative) review **Presentation of Data:** Progress trends, narratives **Review of Data:** CHC internal CHC review (monthly updates and quarterly review), activity level reviews (region, thematic area) with IPs **Reporting of Data:** CHC quarterly/progress reports, BCC WG progress updates, annual work-plan review reports, CHC evaluation reports/ publications.			
d. Data Quality Issues			
Initial Data Quality Assessment: CHC M&E and Capacity Strengthening Coordinator. Continuously as capacity strengthening is carried out. **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:**			
e. Other Notes			
Notes on Baselines/Targets:			
Location of Data Storage: CHC M&E and Research data bases, FHI360, Kampala.			
Other notes:			
e. 1 Performance Data Table			
	Target	**Actual**	**Comments**
2013	N/A		
2014	N/A		
2015	N/A		
2016	N/A		
2017	N/A		
THIS SHEET LAST UPDATED ON: September 2014			

Indicator Reference Sheet			
Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication			
Intermediate Result 2 CS/TA Indicator 2.2: Number of collaborating IPs that disseminate nationally harmonized and standardized resources through their own communication activities			
Date Established:		**Date Last Reviewed:**	
a. Description			
Precise Definition(s): Proportion of GOU and IPs programs receiving CHC TA that use nationally standardized HC resources. Number of GOU and IPs programs who received CHC CS/TA that use nationally standardized HC resources **Unit**: Number **Disaggregation:** Health/ BCC area/ Materials, Audience, District/region **Justification/Management Utility:** Important for tracking progress towards harmonized HC content delivery			
b. Plan for Data Collection			
Data Collection Method: Targeted data extraction from HC implementation rollout and tracking tools, Capacity strengthening documentation logs. **Method of Acquisition:** Implementation and M&E staff extract and collate data from relevant HC development, capacity strengthening, and implementation rollout documentation logs **Data Source(s):** On-line survey reports, Follow-up interview for social network analysis, Random site visit reports, Reports of Intervention Quality Rating tool **Timing / Frequency of Data Collection:** Monthly data collated quarterly, semi-annually, and annually by CHC reporting periods **Estimated Cost of Data Collection:** **Responsible Individual(s):** Campaign Manager & Regional technical officers (complete HC development/rollout logs), M&ER staff (extract/ collate)			
c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)			
Data Analysis: Analytical (qualitative) review **Presentation of Data:** Progress trends, mapping/spatial representation, narratives **Review of Data:** CHC internal CHC review (monthly updates and quarterly review), activity level reviews (region, thematic area) with IPs **Reporting of Data:** CHC quarterly/progress reports, BCC WG progress updates, annual work-plan review reports, CHC evaluation reports/ publications.			
d. Data Quality Issues			
Initial Data Quality Assessment: CHC M&E and Campaign Rollout officers. Continuously as implementation is rolled out. **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:**			
e. Other Notes			
Notes on Baselines/Targets: Targets are set on estimated benchmarks for optimal performance established in C-Change.			
Location of Data Storage: CHC M&E and Research data bases, FHI360, Kampala.			
Other notes:			
e. 1 Performance Data Table			
	Target	**Actual**	**Comments**
2013	N/A		
2014	N/A		
2015	N/A		
2016	N/A		
2017	N/A		
THIS SHEET LAST UPDATED ON: September 2014			

Indicator Reference Sheet			
Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication			
Intermediate Result 3 CS/TA Indicator 3.1: Number of knowledge products disseminated through CHC support/Oversight			
Date Established:	**Date Last Reviewed:**		
a. Description			
Precise Definition(s): Number of knowledge products generated by CHC and/or collaborating partners and disseminated through CHC support/oversight. *Knowledge products* will mainly include explicit (written) information/knowledge e.g. research reports, databases, manuals, evidence-based SBCC lessons learnt snapshots and/or success stories, Newsletters. Available tacit knowledge (staff/ partners with specific skills/ expertise) will be contained in skills inventories/ maps. ***NOTE**: To avoid double counting with CS/TA Indicator # IR2.1 above, SBCC materials and/or implementation guides are excluded from the knowledge products under 3.1.* **Unit of Measure:** Number **Disaggregation:** KM product type (research briefs, HC materials, lessons learned, success stories etc), Health focus **Justification/Management Utility:** Important for tracking minimum required performance benchmarks for collaborative learning and adaptation to enhance evidence-based program design and implementation.			
b. Plan for Data Collection			
Data Collection Method: Targeted data extraction from HC implementation rollout and tracking tools, Capacity strengthening documentation logs. **Method of Acquisition:** Implementation and M&E staff extract and collate data from relevant research and KM development, capacity strengthening, and dissemination/learning events logs **Data Source(s):** Research/Knowledge Management (KM) task force activity logs, Customized research output/KM plans and dissemination documents/ logs **Timing / Frequency of Data Collection:** Monthly data collated quarterly, semi-annually, and annually by CHC reporting periods **Estimated Cost of Data Collection:** **Responsible Individual(s):** M&ER staff (documentation/ extraction/ collation)			
c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)			
Data Analysis: Analytical (qualitative) review for fidelity to implementation plan and targets **Presentation of Data:** Progress trends, mapping/spatial representation, narratives **Review of Data:** CHC internal CHC review (monthly updates and quarterly review), activity level reviews (region, thematic area) with IPs **Reporting of Data:** CHC quarterly/progress reports, BCC WG progress updates, annual work-plan review reports, CHC evaluation reports/ publications.			
d. Data Quality Issues			
Initial Data Quality Assessment: **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:**			
e. Other Notes			
Notes on Baselines/Targets:			
Location of Data Storage: CHC M&E and Research data bases, FHI360, Kampala.			
Other notes:			
e. 1 Performance Data Table			
	Target	**Actual**	**Comments**
2013	N/A		
2014	N/A		
2015	N/A		
2016	N/A		
2017	N/A		
THIS SHEET LAST UPDATED ON: February 2015			

Indicator Reference Sheet			
Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication			
Intermediate Result 3 CS/TA Indicator 3.2: Use of CHC-moderated cloud based knowledge repository and/or dissemination platform			
Date Established:		**Date Last Reviewed:**	
a. Description			
Precise Definition(s): Use of CHC-moderated cloud database/ knowledge collation and visualization platform *Domains of use include* 1) number of external downloads of knowledge products, 2) number of external uploads of knowledge products, 3) number of other site visits beyond the landing page, but that do not necessarily result in materials uploads or downloads. **NOTE**: Platform moderators will review third party products for quality before availing them onto the public platform. **Unit of Measure:** See domains **Disaggregation:** KM product type, Health focus, Upload/Download/Click through **Justification/Management Utility:** Important for tracking use and relevance of a CHC moderated web-portal for HC materials collation/access/data visualization.			
b. Plan for Data Collection			
Data Collection Method: Targeted data extraction from HC implementation rollout and tracking tools, Capacity strengthening documentation logs. **Method of Acquisition:** Implementation and M&E staff monitor and extract/collate data website counters **Data Source(s):** Inbuilt external downloads counter on CHC-moderated site, Inbuilt external uploads counter on CHC-moderated site, Inbuilt site visitor counter of click-through beyond the landing page **Timing / Frequency of Data Collection:** Monthly data collated quarterly, semi-annually, and annually by CHC reporting periods **Estimated Cost of Data Collection:** Approximately US$ 300,000 for set up and maintenance of data visualization board through LOP **Responsible Individual(s):** M&ER staff (documentation/ extraction/ collation)			
c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)			
Data Analysis: Analytical (qualitative) review for fidelity to implementation plan and targets **Presentation of Data:** Progress trends, mapping/spatial representation, narratives **Review of Data:** CHC internal CHC review (monthly updates and quarterly review), activity level reviews (region, thematic area) with IPs **Reporting of Data:** CHC quarterly/progress reports, BCC WG progress updates, annual work-plan review reports, CHC evaluation reports/ publications.			
d. Data Quality Issues			
Initial Data Quality Assessment: **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:**			
e. Other Notes			
Notes on Baselines/Targets:			
Location of Data Storage: CHC M&E and Research data bases, FHI360, Kampala.			
Other notes:			
e. 1 Performance Data Table			
	Target	**Actual**	**Comments**
2013	N/A		
2014	N/A		
2015	N/A		
2016	N/A		
2017	N/A		
THIS SHEET LAST UPDATED ON: February 2015			

Indicator Reference Sheet

Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication

Intermediate Result 3 CS/TA Indicator 3.3: Number of collaborating institutions that contribute to at least one step of development of SBCC research through CHC TA.

Date Established: **Date Last Reviewed:**

a. Description

Precise Definition(s): Number of local collaborating institutions that –through CHC TA – contribute to learning in at least one of five steps of planning and executing SBCC.

Domains for this indicator are based on the Communication for Change (C-Change) Program's *Steps of a Planning Process for SBCC* (*C-Modules: A Learning Package for Social and Behavior Change Communication, May 2012*). The C-Planning Model contains five steps including

1. Understanding the situation (*Problem identification and priority setting*)
2. Focusing and designing (*Formulation of research questions, Concept development*)
3. Creating (*Protocol development*)
4. Implementing and monitoring (*Monitoring program rollout and generating information for review*)
5. Evaluative assessment and re-planning (*Assessment of outcome indicators and generating information for program review*)

Local institutions include universities or health programs/projects collaborating with CHC.

Eligible output include those undertaken by IPs program staff, University faculty staff, and/or through interns/fellows attached to collaborating IPs programs/CHC.

NOTE: To avoid double-counting, knowledge products are counted under Indicator # 3.1 above

Unit of Measure: Number
Disaggregation: Type of institution, Type of research i.e. based on the five steps of SBCC planning
Justification/Management Utility: Important for tracking use and relevance of a CHC moderated web-portal for HC materials collation/access/data visualization.

b. Plan for Data Collection

Data Collection Method: Targeted data extraction from tracking tools/ documentation logs.
Method of Acquisition: Data extraction from documentation logs
Data Source(s): Collaborative HC research and/or KM documentation logs, Communities of practice documentation logs, Interns/fellows dissertations documentation logs, Inventory of research questions/ concepts/ protocols, Case study reports (where appropriate)
Timing / Frequency of Data Collection: Monthly data collated quarterly, semi-annually, and annually by CHC reporting periods
Estimated Cost of Data Collection: Approximately US$ 300,000 for set up and maintenance of data visualization board through LOP
Responsible Individual(s): M&ER staff (documentation/ extraction/ collation)

c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)

Data Analysis: Analytical (qualitative) review
Presentation of Data: Progress trends, mapping/spatial representation, narratives
Review of Data: CHC internal CHC review (monthly updates and quarterly review), activity level reviews (MER Task Force)
Reporting of Data: CHC quarterly/progress reports, BCC WG progress updates, annual work-plan review reports, CHC evaluation reports/ publications.

d. Data Quality Issues

Initial Data Quality Assessment:
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:

e. Other Notes

Notes on Baselines/Targets:
Location of Data Storage: CHC M&E and Research data bases, FHI360, Kampala.
Other notes:

e. 1 Performance Data Table

	Target	Actual	Comments
2013	N/A		
2014	N/A		
2015	N/A		
2016	N/A		
2017	N/A		

THIS SHEET LAST UPDATED ON: February 2015

4.5.4 Reference Sheets: Intermediate Result 1: Intermediate Outcome Indicators

Knowledge, Self-efficacy, Intention, Self-initiative to seek information, Attitudes, and Recall/Exposure

Indicator Reference Sheet			
Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication			
Intermediate Result 1 Indicator 1.1: Percent of 15-49 year olds in project areas with comprehensive knowledge about HIV/AIDS			
Date Established:		**Date Last Reviewed:**	
a. Description			
Precise Definition: Percent who have heard of HIV/AIDS and can name the three recommended behavioral practices for prevention of HIV infection; and reject two misconceptions about HIV/AIDS transmission as stated in the UDHS 2011 survey and 206097 PEPFAR 206097 PEPFAR Next Generation Indicators Reference Guide, Feb. 2013. **Unit of Measure:** Percent **Numerator:** Number of men and women aged 15-49 who have heard of HIV/AIDS and can name the three recommended behavioral practices for prevention of HIV infection; and reject two misconceptions about HIV/AIDS transmission **Denominator:** All men and women aged 15-49 in the CHC evaluative survey **Disaggregated by:** Sex, Age group (15-19, 20-24, 25+), general population vs key population, Region, Residence, **Justification/Management Utility:** HIV epidemics are perpetuated through primarily sexual transmission of infection to successive generations. Sound knowledge about HIV and AIDS is an essential pre-requisite — albeit, often an insufficient condition — for adoption of behaviors that reduce the risk of HIV transmission. The purpose of this indicator is to assess progress towards universal knowledge of the essential facts about HIV transmission.			
b. Plan for Data Collection			
Data Collection Method: CHC evaluative survey, triangulated with UDHS, UAIS, whenever available. **Method of Measurement:** Below are illustrative questions to be used in CHC evaluative surveys (baseline, midline, endline). ***Respondents who report being aware of HIV are asked the following five questions:*** 1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission? 2. Can using condoms reduce the risk of HIV transmission? 3. Can a healthy-looking person have HIV? 4. Can a person get HIV from mosquito bites? 5. Can a person get HIV by sharing a meal with someone who is infected **Data Source(s):** CHC Timeline 1/baseline, midline, and endline survey. UDHS and UAIS when available. **Timing / Frequency of Data Collection:** Periodic CHC evaluations: Baseline late 2014-early 2015; Midline late 2016, Endline 2018. If applicable, HMIS data collated on a quarterly basis. UDHS and UAIS when available. **Estimated Cost of Data Collection:** **Responsible Individual(s):** M&ER staff and Regional technical officers			
c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)			
Data Analysis: Univariate and bivariate statistics for specialized outcome studies. Data will be weighted by exposure and dose intensity of BCC. **Presentation of Data:** Frequency tables, data visualization using software such as Awhere (graphs/trend lines, mapping/spatial representation etc) **Review of Data:** CHC internal CHC review (monthly and quarterly), activity level reviews (region, thematic area) with IPs **Reporting of Data:** CHC quarterly/progress reports, BCC WG progress updates, annual work-plan review reports, CHC evaluation reports/ publications.			
d. Data Quality Issues			
Initial Data Quality Assessment: CHC Data manager. Continuously as field data is received into the mobile data platform. **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:**			
e. Other Notes			
Notes on Baselines/Targets: Baselines are set on current national data from UAIS 2011. The hierarchy of communication effects (see figure 1) will serve as the guide for CHC targets for this indicator. Assuming CHC achieves 80% reach/exposure of target audience groups to BCC, it is expected that at least 60% of those reached with information will understand it (demonstrate comprehensive correct knowledge on the given subject). Targets may be revised after the CHC baseline set for late 2014/early 2015.			
Location of Data Storage: CHC M&E and Research data bases, FHI360, Kampala.			
Other notes:			
e. 1 Performance Data Table			
Baseline: Men 42.7%, Women 36.1% - UAIS 2011	**Target**	**Actual**	**Comments**
2014	N/A		
2015	N/A		
2016	N/A		
2017	N/A		
2018	85%		

Indicator Reference Sheet

Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication

Intermediate Result 1 Indicator 1.2: Percent of individuals who demonstrate comprehensive correct knowledge of condom use

Date Established: **Date Last Reviewed:**

a. Description

Precise Definition(s): Percent of men and women 15-49y who not only know that condoms can protect one from HIV, but also demonstrate understanding of the correct ways to use condoms

Unit of Measure: Percent

Numerator: Number of individuals who report that condoms can protect one from HIV, and also report correct ways to use a condom.

Denominator: Number of individuals in the survey

Disaggregation: Region, Sex, Age (15-19, 20-24, 25-49), Residence (rural/urban)

Justification/Management Utility: Since incorrect condom-use significantly reduces the effectiveness of condoms, protected sex includes not only the use of condoms but also their correct use. Studies have identified mistakes ranging from completely unrolling the condom before application to using an oil-based lubricant. Additionally, evidence suggests that persons with no or less knowledge, including that of correct condom-use, are less likely to use condoms than those who have accurate knowledge. Therefore, both to reduce failure in condom-use and to augment condom-use, knowledge of correct condom-use is an important component of protected sex.(Stanton B et al, 2009, Bakole et al., 2007)

b. Plan for Data Collection

Data Collection: Primary data may also be collected as part of specialized outcome studies under CHC.

Method of Measurement: Respondents who have heard of a male condom are asked a related set of questions for which responses are either *agree, disagree, and don't know*. Illustrative questions (to be determined before survey) include:

1. Condoms cannot be used more than once.
2. Condoms can a) protect someone from HIV.
3. A condom should be should be put on a condom before contact of the penis with the vagina (anus in anal sex)?
4. A condom should be worn on a fully erect penis.
5. A condom should not be unrolled before putting it on.
6. A man should withdraw his penis from the woman (with the condom on) immediately after ejaculating.

Data Source(s): CHC Timeline 1/baseline, midline, and endline survey. UDHS and UAIS to the extent applicable, when available.

Timing / Frequency of Data Collection: Periodic CHC evaluations: Baseline late 2014-early 2015; Midline late 2016, Endline 2018. If applicable, HMIS data collated on a quarterly basis. UDHS and UAIS when available.

Estimated Cost of Data Collection:

Responsible Individual(s): M&ER staff and Regional technical officers

c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)

Data Analysis: Univariate and bivariate statistics for specialized outcome studies. Data will be weighted by exposure and dose intensity of BCC.

Presentation of Data: Frequency tables, data visualization using software such as Awhere (graphs/trend lines, mapping/spatial representation etc)

Review of Data: CHC internal CHC review (monthly and quarterly), activity level reviews (region, thematic area) with IPs

Reporting of Data: CHC quarterly/progress reports, BCC WG progress updates, annual work-plan review reports, CHC evaluation reports/ publications.

d. Data Quality Issues

Initial Data Quality Assessment: CHC Data manager. Continuously as field data is received into the mobile data platform.

Known Data Limitations and Significance (if any):

Actions Taken or Planned to Address Data Limitations:

e. Other Notes

Notes on Baselines/Targets: Baselines are set on current national data from UAIS 2011. The hierarchy of communication effects (see figure 1) will serve as the guide for CHC targets for this indicator. Assuming CHC achieves 80% reach/exposure of target audience groups to BCC, it is expected that at least 60% of those reached with information will understand it (demonstrate comprehensive correct knowledge on the given subject). Targets may be revised after the CHC baseline set for late 2014/early 2015.

Location of Data Storage: CHC M&E and Research data bases, FHI360, Kampala.

Other notes:

e. 1 Performance Data Table

Rationale for selection of baselines and targets

	Target	**Actual**	**Comments**
2013 (Baseline) Men 14.8%, Women 15.8%			
2014	N/A		
2015	N/A		
2016	N/A		
2017	N/A		
2018	90%		

Indicator Reference Sheet

Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication

Intermediate Result 1 Indicator 1.3: Percent of men and women with comprehensive knowledge about mother to child transmission of HIV/AIDS

Date Established: **Date Last Reviewed:**

a. Description

Precise Definition: Percent of men and women 15-49y who have heard of HIV/AIDS and are aware that a mother can transmit HIV/AIDS to her foetus/child during pregnancy and delivery, and through breastfeeding.
Unit of Measure: Percent
Numerator: Number of men and women aged 15-49 who have heard of HIV/AIDS and that a mother can transmit HIV/AIDS to her foetus/child during pregnancy and delivery, and through breastfeeding.
Denominator: All men and women aged 15-49 in the CHC evaluative survey
Disaggregated by: Sex, Age group (15-24, 25-34, 35-49), ever been pregnant, relationship status, currently pregnant, Region, Residence, (*Adapted from http://www.cdc.gov/reproductivehealth/Global/PDFs/HIV_AIDS_FINAL_2011_Tag508.pdf: Download Date May 9, 2014*)
Justification/Management Utility: Improves ability of communities for active use and demand at household level for identification/ treatment of all HIV-infected pregnant women.

b. Plan for Data Collection

Data Collection Method: CHC evaluative survey, triangulated with UDHS, UAIS, whenever available.
Method of Measurement: Respondents who report being aware of HIV are asked the following questions:
1. Can a pregnant woman transmit HIV/AIDS to her child during pregnancy and delivery?
2. Can a pregnant woman transmit HIV/AIDS to her child through breastfeeding?
Data Source(s): CHC Timeline 1/baseline, midline, and endline survey. UDHS and UAIS when available.
Timing / Frequency of Data Collection: Periodic CHC evaluations: Baseline late 2014-early 2015; Midline late 2016, Endline 2018. If applicable, HMIS data collated on a quarterly basis. UDHS and UAIS when available.
Estimated Cost of Data Collection:
Responsible Individual(s): M&ER staff and Regional technical officers

c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)

Data Analysis: Univariate and bivariate statistics for specialized outcome studies. Data will be weighted by exposure and dose intensity of BCC.
Presentation of Data: Frequency tables, data visualization using software such as Awhere (graphs/trend lines, mapping/spatial representation etc)
Review of Data: CHC internal CHC review (monthly and quarterly), activity level reviews (region, thematic area) with IPs
Reporting of Data: CHC quarterly/progress reports, BCC WG progress updates, annual work-plan review reports, CHC evaluation reports/ publications.

d. Data Quality Issues

Initial Data Quality Assessment: CHC Data manager. Continuously as field data is received into the mobile data platform.
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:

e. Other Notes

Notes on Baselines/Targets: Baselines are set on current national data from UAIS 2011. The hierarchy of communication effects (see figure 1) will serve as the guide for CHC targets for this indicator. Assuming CHC achieves 80% reach/exposure of target audience groups to BCC, it is expected that at least 60% of those reached with information will understand it (demonstrate comprehensive correct knowledge on the given subject). Targets may be revised after the CHC baseline set for late 2014/early 2015.

Location of Data Storage: CHC M&E and Research data bases, FHI360, Kampala.

Other notes:

e. 1 Performance Data Table

	Target	**Actual**	**Comments**
Baseline: Men 54.8%; Women 67% UAIS 2011			
2014	N/A		
2015	N/A		
2016	N/A		
2017	N/A		
2018	90%		

THIS SHEET LAST UPDATED ON: September 2014

Indicator Reference Sheet			
Strategic Objective*:* Increase adoption of healthy behaviors through strengthened health communication			
Intermediate Result 1 Indicator 1.4: Percent of men aged 15-49 with comprehensive correct knowledge of SMC for HIV prevention			
Date Established: Adopted from: A guide to indicators for male circumcision programmes in the formal health care system, WHO/UNAIDS 2009 **Date Last Reviewed:**			
a. Description			
Precise Definition(s): Percentage of population aged 15–49 years with correct knowledge of male circumcision for HIV prevention **Unit of Measure:** Percent **Numerator:** Number of respondents with correct knowledge **Denominator:** Number of men and women aged 15-49 in the survey **Disaggregation:** Region, Age, Residence (rural/urban), sex **Justification/Management Utility:** Knowledge is a key part of behavior change and thus is an indicator of the likelihood of increased demand for male circumcision. An important aspect of male programs is the knowledge that 1) circumcision is not 100% protective for males, 2) that it is not proven to protect women from acquiring HIV from HIV positive men, and 3) that safer sex methods are still needed for circumcised men in order to prevent risk compensation. This knowledge is important for both males and females. By measuring knowledge, this indicator shows the result of communication strategies creating awareness of the partially protective effect of male circumcision and for the continued use of safer sex practices. Evidence of a lack of knowledge or prevailing misconceptions suggests a need for enhanced communication strategies. Disaggregation by age and sex may inform the allocation of resources to improve targeted communication.			
b. Plan for Data Collection			
Data Collection Method: CHC evaluative survey questionnaire for individuals aged 15-49y. Targeted data extraction from existing data collected as part of UDHS, or UMIS when available. **Method of Measurement:** Illustrative questions to be asked to all survey respondents in CHC evaluations at baseline, midline, endline include: Can a man who is circumcised also be HIV-positive? 1) Yes 2) No 3) Don't know Can a circumcised HIV-negative man who has sex without a condom get infected with HIV during sex? 1) Yes 2) No 3) Don't know Can a circumcised HIV-positive man who has sex without a condom infect his sex partner* with HIV? 1) Yes 2) No 3) Don't know Can an HIV-negative woman who has sex without a condom with a circumcised HIV-positive man become infected with HIV? 1) Yes 2) No 3) Don't know Can an HIV-positive woman who has sex without a condom with a circumcised HIV-negative man infect him with HIV? 1) Yes 2) No 3) Don't know **N/B** The term 'sex partner' is used in the questions for men because it is appropriate for both heterosexuals and men who have sex with men. **Data Source(s):** CHC Timeline 1/baseline, midline, and endline survey. UDHS and UAIS when available. **Timing / Frequency of Data Collection:** Periodic CHC evaluations: Baseline late 2014-early 2015; Midline late 2016, Endline 2018. HMIS data collated on a quarterly basis. UDHS and UAIS when available. **Estimated Cost of Data Collection:** **Responsible Individual(s):** M&ER staff and Regional technical officers			
c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)			
Data Analysis: Univariate and bivariate statistics for specialized outcome studies. Data will be weighted by exposure and dose intensity of BCC. **Presentation of Data:** Frequency tables, data visualization using software such as aWhere (graphs/trend lines, mapping/spatial representation) **Review of Data:** CHC internal CHC review (monthly and quarterly), activity level reviews (region, thematic area) with IPs **Reporting of Data:** CHC quarterly/progress reports, BCC WG progress updates, annual work-plan review reports, CHC evaluation reports/ publications.			
d. Data Quality Issues			
Initial Data Quality Assessment: CHC Data manager. Continuously as field data is received into the mobile data platform. **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:**			
e. Other Notes			
Notes on Baselines/Targets: National data does not seem to exist for this indicator. The hierarchy of communication effects (see figure 1) will serve as the guide for CHC targets for this indicator. Assuming CHC achieves 80% reach/exposure of target audience groups to BCC, it is expected that at least 60% of those reached with information will understand it (demonstrate comprehensive correct knowledge on the given subject). Targets may be revised after the CHC baseline set for late 2014/early 2015.			
Location of Data Storage: CHC M&E and Research data bases, FHI360, Kampala.			
e. 1 Performance Data Table			
CHC baseline TBD Dec.2014-Feb.2015	**Target**	**Actual**	**Comments**
2014	N/A		
2015	N/A		
2016	N/A		
2017	N/A		
2018	70%		
THIS SHEET LAST UPDATED ON: September 2014			

Indicator Reference Sheet

Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication

Intermediate Result 1 Indicator 1.5: Percent of men and women 15-49 years with comprehensive correct knowledge of modern contraception.

Date Established: **Date Last Reviewed:**

a. Description

Precise Definition: Among women 15-49 years old, those who can 1) name at least three or more modern contraceptive methods, 2) name a place to obtain a modern contraceptive method of their preference, and 3) mention that modern contraceptives facilitate healthy timing and spacing of pregnancy.
Unit of Measure: Percent
Numerator: Number of men and women aged 15-49 who have heard about at least three modern methods of FP, mention that FP is beneficial to healthy timing and spacing of pregnancy, and can name a place to obtain FP.
Denominator: All men and women aged 15-49 in the CHC evaluative survey
Disaggregated by: Sex, Age group (15-19, 20-24, 25+), general population vs key population, Region, Residence

Justification/Management Utility: This indicator measures diffusion of knowledge of modern FP methods. Increasing user knowledge about the benefits of modern contraception such as bearing children at healthy times (including timing and spacing) helps prevent high-risk pregnancies, and pregnancy-related adverse outcomes may encourage them to use contraception. Understanding the perceived benefits of modern contraception is important for assessing what aspects people focus on and whether they facilitate uptake or maintenance of contraceptive use. Lastly, increasing use of modern contraceptives requires user knowledge of where to obtain modern methods.

b. Plan for Data Collection

Data Collection Method: CHC evaluative survey, triangulated with UDHS or IP data e.g. UNFPA, whenever available.
Method of Measurement: Below are illustrative questions to be used to obtain the numerator in CHC evaluative surveys.

1. Have you heard of modern contraceptive methods?
2. Please name at least three contraceptive methods you have heard of.
3. Please name at least one benefit of modern contraception in general. *Respondent is included in the numerator if they agree with at least one of these statements*: FP can help you delay births until the right age or time; FP can help you to space your children; FP can help you to limit the number of children.
4. Where can you obtain a contraceptive method if you need them?

SCORING RESPONDENT KNOWLEDGE: Scores will be categorized by: 4 = correct knowledge in all areas, 3= knowledge in more than half of the areas, 2= knowledge in at least a half of the areas, 1= knowledge in below a half of the areas, 0=negligible or no knowledge
Data Source(s): CHC Timeline 1/baseline, midline, and endline survey. UDHS when available.
Timing / Frequency of Data Collection: Periodic CHC evaluations: Baseline late 2014-early 2015; Midline late 2016, Endline 2018. If applicable, HMIS data collated on a quarterly basis. UDHS when available.
Estimated Cost of Data Collection:
Responsible Individual(s): M&ER staff and Regional technical officers

c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)

Data Analysis: Univariate and bivariate statistics for specialized outcome studies. Data will be weighted by exposure and dose intensity of BCC.
Presentation of Data: Frequency tables, data visualization using software such as aWhere (graphs/trend lines, mapping/spatial representation)
Review of Data: CHC internal CHC review (monthly and quarterly), activity level reviews (region, thematic area) with IPs
Reporting of Data: CHC quarterly/progress reports, BCC WG progress updates, annual work-plan review reports, CHC evaluation reports/ publications.

d. Data Quality Issues

Initial Data Quality Assessment: CHC Data manager. Continuously as field data is received into the mobile data platform.
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:

e. Other Notes

Notes on Baselines/Targets: There seems to be no baseline available for this indicator in the context that CHC aims to measure it (see indicator definition). The hierarchy of communication effects (see figure 1) will serve as the guide for CHC targets for this indicator. Assuming CHC achieves 80% reach/exposure of target audience groups to BCC, it is expected that at least 60% of those reached with information will understand it (demonstrate comprehensive correct knowledge on the given subject). Targets may be revised after the CHC baseline set for late 2014/early 2015.

Location of Data Storage: CHC M&E and Research data bases, FHI360, Kampala.

e. 1 Performance Data Table

	Target	**Actual**	**Comments**
No baseline available			
2014	N/A		
2015	N/A		
2016	N/A		
2017	N/A		
2018	70%		

THIS SHEET LAST UPDATED ON: September 2014

Indicator Reference Sheet

Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication

Intermediate Result 1 Indicator 1.6: Percentage of individuals aged 15-49y with comprehensive correct knowledge of key actions for a healthy pregnancy and baby

Date Established: **Date Last Reviewed:**

a. Description

Precise Definition(s): The change in the percentage of individuals aged 15-49y with who can name a set of key actions for a healthy pregnancy and baby
Unit of Measure: Percent
Numerator: Number of mothers of individuals aged 15-49y with who correctly name a set of key actions for a healthy pregnancy and baby
Denominator: Number of mothers of individuals 15-49y in the survey
Disaggregation: Sex, Age group (15-19, 20-24, 25+), general population vs key population, Region, Residence
Justification/Management Utility: Assess coverage and recall of a package of messages for young adults in relationships and pregnant couples on key actions to assure a safe and healthy pregnancy and healthy baby. Disaggregation by regions, age, and residence facilitates targeted HC intervention.

b. Plan for Data Collection

Data Collection Method: CHC evaluative survey questionnaire for individuals aged 15-49 years. Targeted data extraction from service IPs including LQAS, HMIS/HIBRID, and national data including UDHS when available.
Method of Measurement: Data for the numerator will be reduced from data on a set of questions on MCH including nutrition (prior to/during/after pregnancy), ANC and related services (HCT/eMTCT, IPTp, HF delivery), LLIN use, EBF including EIB, newborn care, post-partum FP, full course of vaccinations for children, and hand-washing with soap at critical times.
SCORING RESPONDENT KNOWLEDGE: Scores will be categorized by a) composite score, b) actions for mother (pregnancy/post-partum), and c) by living baby actions. 4 = correct knowledge in all areas, 3= knowledge in more than half of the areas, 2= knowledge in at least a half of the areas, 1= knowledge in below a half of the areas, 0=negligible or no knowledge
Data Source(s): CHC Timeline 1, midline, and endline survey. HF data and USAID service IPs records collated in HMIS for further triangulation.
Timing / Frequency of Data Collection: Periodic CHC evaluations: Baseline late 2014-early 2015; Midline late 2016, Endline 2018. HMIS data collated on a quarterly basis. LQAS when available.
Estimated Cost of Data Collection:
Responsible Individual(s): M&ER staff and Regional technical officers

c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)

Data Analysis: Univariate and bivariate statistics for CHC evaluation/ outcome studies. To the extent possible, HMIS data will be incorporated for triangulation and interpretation. When available, DHS data will be used as a reference point for interpretation of CHC data on this indicator.
Presentation of Data: Frequency tables, data visualization using software such as aWhere (graphs/trend lines, mapping/spatial representation)
Review of Data: CHC internal CHC review (monthly and quarterly), activity level reviews (region, thematic area) with IPs
Reporting of Data: CHC quarterly/progress reports, BCC WG progress updates, annual work-plan review reports, CHC evaluation reports/ publications.

d. Data Quality Issues

Initial Data Quality Assessment: CHC Data manager. Continuously as field data is received into the mobile data platform.
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:

e. Other Notes

Notes on Baselines/Targets: There seems to be no baseline data for this indicator. The hierarchy of communication effects (see figure 1) will serve as the guide for CHC targets for this indicator. Assuming CHC achieves 80% reach/exposure of target audience groups to BCC, it is expected that at least 60% of those reached with information will understand it (demonstrate comprehensive correct knowledge on the given subject). Targets may be revised after the CHC baseline set for late 2014/early 2015.

Location of Data Storage: CHC M&E and Research data bases, FHI360, Kampala.

Other notes:

e. 1 Performance Data Table

	Target	**Actual**	**Comments**
Baseline TBD May2015			
2014	N/A		
2015	N/A		
2016	N/A		
2017	N/A		
2018	60%		

THIS SHEET LAST UPDATED ON: September 2014

Indicator Reference Sheet

Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication

Intermediate Result 1 Indicator 1.8: Percent of men and women aged 15-49 with comprehensive correct knowledge of malaria

Date Established: Adopted from: Malaria Behavior Change Communication Indicator Reference Guide February 2014 **Date Last Reviewed:**

a. Description

Precise Definition(s): Percentage of population aged 15–49 years with correct knowledge regarding the cause of malaria, the main symptom of malaria, the correct treatment for malaria, and preventive measures.
Unit of Measure: Percent
Numerator: Number of respondents who know the cause, main symptom, treatment and preventive measures for malaria
Denominator: Number of men and women aged 15-49 in the survey
Disaggregation: Region, Age, Residence (rural/urban)
Justification/Management Utility: Better knowledge of malaria (cause, symptoms, treatment, and preventive measures) is a foundational step toward changing behavior, such as increasing the use of insecticide-treated nets or care-seeking practices, especially for caregivers. Members of the target population who know how to prevent getting malaria by avoiding the primary causes, who can recognize the first signs of infection, and who know how to treat cases, are generally more likely to engage in the behaviors that will protect themselves. Prompt and effective treatment is a key element in successful malaria control because of the rapid onset of illness and severe health outcomes related to Plasmodium falciparum malaria, especially among children and non-immune populations.

b. Plan for Data Collection

Data Collection Method: CHC evaluative survey, triangulated with UDHS, UMIS, whenever available, and to the extent possible.
Method of Measurement: The numerator is obtained by asking respondents a series of questions about the causes, signs/symptoms, treatment, and preventive measures for malaria.

1) Cause of malaria: The options in the questionnaire will include mosquitoes or mosquito bites. The respondent is counted in the numerator if they mention mosquitoes or mosquito bites as the cause of malaria.

2) Symptoms of malaria: What are the main signs or symptoms of malaria? The respondent is counted in the numerator if fever is among their responses.

3) Treatment for malaria: Name the most effective medication used to treat malaria. Only one response is required. The respondent is counted in the numerator if s/he cites artemisinin combination therapy (ACTs) as the most effective treatment. A local name for ACT is acceptable.

4) Prevention of malaria: Name one or more preventive measures for malaria. The options in the questionnaire will include the relevant preventive measures implemented in the community i.e. LLINs, IPTp, IRS as may be appropriate. Other options should include false preventive measures for malaria including cutting grass, keeping the house surroundings clean, and avoiding drinking dirty water. The respondent is only counted in the numerator if they name at least one of the relevant preventive interventions and none of the incorrect ones.

5) SCORING RESPONDENT KNOWLEDGE: 4= correct knowledge in all four areas, 3= knowledge in three areas, 2= knowledge in two areas, 1= knowledge in 1 area, 0= no knowledge

Data Source(s): CHC Timeline 1/baseline, midline, and endline survey. UDHS and UMIS to the extent applicable, when available.
Timing / Frequency of Data Collection: Periodic CHC evaluations: Baseline late 2014-early 2015; Midline late 2016, Endline 2018. If applicable, HMIS data collated on a quarterly basis. UDHS and UMIS when available.
Estimated Cost of Data Collection:
Responsible Individual(s): M&ER staff and Regional technical officers

c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)

Data Analysis: Univariate and bivariate statistics for specialized outcome studies. Data will be weighted by exposure and BCC dose intensity.
Presentation of Data: Frequency tables, data visualization using software such as aWhere (graphs/trend lines, mapping/spatial representation)
Review of Data: CHC internal CHC review (monthly and quarterly), activity level reviews (region, thematic area) with IPs
Reporting of Data: CHC quarterly/progress reports, BCC WG progress updates, annual work-plan review reports, CHC evaluation reports/ publications.

d. Data Quality Issues

Initial Data Quality Assessment: CHC Data manager. Continuously as field data is received into the mobile data platform.
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:

e. Other Notes

Notes on Baselines/Targets: There seems to be no baseline data for this indicator within the context indicated in the Malaria Behavior Change Communication Indicator Reference Guide, February 2014. The USAID-PMI contact in Uganda has also indicated this is the preferred context. The hierarchy of communication effects (see figure 1) will serve as the guide for CHC targets for this indicator. Assuming CHC achieves 80% reach/exposure of target audience groups to BCC, it is expected that at least 60% of those reached with information will understand it (demonstrate comprehensive correct knowledge on the given subject). Targets may be revised after the CHC baseline set for late 2014/early 2015.

Location of Data Storage: CHC M&E and Research data bases, FHI360, Kampala.

	Target	Actual	Comments
CHC baseline TBD May2015			
2014	N/A		
2015	N/A		
2016	N/A		
2017	N/A		
2018	85%		

THIS SHEET LAST UPDATED ON: September 2014

Indicator Reference Sheet

Strategic Objective*:* Increase adoption of healthy behaviors through strengthened health communication

Intermediate Result 1 Indicator 1.9: Percent of men aged 15-49 with comprehensive correct knowledge of malaria in pregnancy

Date Established: Adopted from: Malaria Behavior Change Communication Indicator Reference Guide February 2014 **Date Last Reviewed:**

a. Description

Precise Definition(s): Percentage of population aged 15–49 years who have heard of malaria in pregnancy (MIP), know the negative effects of MIP, can identify both LLINs and timely complete course of IPTp (2 or more doses) as effective means to prevent (MIP), and are aware of actions for a pregnant woman with malaria (test and treat).
Unit of Measure: Percent
Numerator: Number of respondents who know about MIP, the negative effects of MIP, and effective preventive measures (LLINs, timely complete IPTp),
Denominator: Number of men and women aged 15-49 in the survey
Disaggregation: Region, Age, Residence (rural/urban)
Justification/Management Utility: Better knowledge of malaria in pregnancy (effects, and preventive measures) is a foundational step toward changing behavior, such as increasing the use of insecticide-treated nets, attendance of ANC for IPTp, and care seeking including prompt testing and treatment for sick pregnant women. Members of the target population who know the negative effects of malaria in pregnancy and ways to avoid it are generally more likely to engage in the behaviors that will protect themselves. Prompt and effective treatment is a key element in successful management of malaria.

b. Plan for Data Collection

Data Collection Method: CHC evaluative survey, triangulated with UDHS, UMIS, whenever available, and to the extent possible.
Method of Measurement: The numerator is obtained by asking respondents a series of questions about effects of malaria in pregnancy, means to prevent malaria in pregnancy, and treatment of a sick pregnant woman.
1) Effects of malaria in pregnancy: The respondent is counted in the numerator if they mention maternal anemia, and low child birth weight.
2) Prevention of malaria in pregnancy: Name two important preventive measures for malaria in pregnancy. Options = LLINs, IPTp, IRS as may be appropriate. Other options should include false preventive measures for malaria including cutting grass, keeping the house surroundings clean, and avoiding drinking dirty water. The respondent is only counted in the numerator if they name at least one of the relevant preventive interventions.
3) Treatment for malaria in pregnancy: Name the most effective action for a pregnant woman suspected to be suffering from malaria. Only one response is required. The respondent is counted in the numerator if s/he cites seek prompt diagnosis (testing) and treatment.
4) SCORING RESPONDENT KNOWLEDGE: 3= correct knowledge in all 3 areas, 2= knowledge in two areas, 1= knowledge in 1 area, 0= no knowledge
Data Source(s): CHC Timeline 1/baseline, midline, and endline survey. UDHS and UMIS to the extent applicable, when available.
Timing / Frequency of Data Collection: Periodic CHC evaluations: Baseline late 2014-early 2015; Midline late 2016, Endline 2018. If applicable, UDHS and UMIS when available.
Estimated Cost of Data Collection:
Responsible Individual(s): M&ER staff and Regional technical officers

c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)

Data Analysis: Univariate and bivariate statistics for specialized outcome studies. Data will be weighted by exposure and BCC dose intensity.
Presentation of Data: Frequency tables, data visualization using software such as aWhere (graphs/trend lines, mapping/spatial representation)
Review of Data: CHC internal CHC review (monthly and quarterly), activity level reviews (region, thematic area) with IPs
Reporting of Data: CHC quarterly/progress reports, BCC WG progress updates, annual work-plan review reports, CHC evaluation reports/ publications.

d. Data Quality Issues

Initial Data Quality Assessment: CHC Data manager. Continuously as field data is received into the mobile data platform.
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:

e. Other Notes

Notes on Baselines/Targets: There seems to be no baseline data for this indicator within the context indicated in the Malaria Behavior Change Communication Indicator Reference Guide, February 2014. The USAID-PMI contact in Uganda has also indicated this is the preferred context. The hierarchy of communication effects (see figure 1) will serve as the guide for CHC targets for this indicator. Assuming CHC achieves 80% reach/exposure of target audience groups to BCC, it is expected that at least 60% of those reached with information will understand it (demonstrate comprehensive correct knowledge on the given subject). Targets may be revised after the CHC baseline set for late 2014/early 2015.

Location of Data Storage: CHC M&E and Research data bases, FHI360, Kampala.

e. 1 Performance Data Table

	Target	Actual	Comments
CHC baseline TBD May2015			
2014	N/A		
2015	N/A		
2016	N/A		
2017	N/A		
2018	85%		

THIS SHEET LAST UPDATED ON: September 2014

Indicator Reference Sheet			
Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication			
Intermediate Result 1 Indicator 1.10: Percent of men aged 15-49 with comprehensive correct knowledge of IRS			
Date Established: Adopted from: Malaria Behavior Change Communication Indicator Reference Guide February 2014 **Date Last Reviewed:**			
a. Description			
Precise Definition(s): Percentage of population aged 15–49 years who have heard of malaria in pregnancy (MIP), know the negative effects of MIP, can identify both LLINs and timely complete course of IPTp (2 or more doses) as effective means to prevent (MIP), and are aware of actions for a pregnant woman with malaria (test and treat). **Unit of Measure:** Percent **Numerator:** Number of respondents who know about IRS as a means to prevent malaria, that IRS is safe, that re-plastering walls reduces effectiveness of IRS. **Denominator:** Number of men and women aged 15-49 in the survey **Disaggregation:** Region, Age, Residence (rural/urban) **Justification/Management Utility:** Better knowledge of IRS as an effective means of preventing malaria, and how it works, is the first step towards acceptance of house spraying, and adherence with instructions post-spraying (not washing, continue to use other malaria strategies – sleep under nets, seek IPTp for pregnant women, test and treat in case of fever)			
b. Plan for Data Collection			
Data Collection Method: CHC evaluative survey, triangulated with UDHS, UMIS, whenever available, and to the extent possible. **Method of Measurement:** The numerator is obtained by asking respondents a series of questions about IRS: 1) IRS is an effective means to prevent malaria, 2) IRS is safe for humans in a house that has been sprayed 3) Washing or re-plastering walls reduced the effectiveness of IRS 4) People in IRS households still need to use other preventive measures (LLINs, IPTp for pregnant women) and seek prompt diagnosis and treatment in case of fever. 4) SCORING RESPONDENT KNOWLEDGE: 4 = correct knowledge in all 4 areas, 3= correct knowledge in 3 areas, 2= knowledge in two areas, 1= knowledge in 1 area, 0= no knowledge **Data Source(s):** CHC Timeline 1/baseline, midline, and endline survey. UDHS and UMIS to the extent applicable, when available. **Timing / Frequency of Data Collection:** Periodic CHC evaluations: Baseline late 2014-early 2015; Midline late 2016, Endline 2018. If applicable, HMIS data collated on a quarterly basis. UDHS, UMIS when available. **Estimated Cost of Data Collection:** **Responsible Individual(s):** M&ER staff and Regional technical officers			
c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)			
Data Analysis: Univariate and bivariate statistics for specialized outcome studies. Data will be weighted by exposure and BCC dose intensity. **Presentation of Data:** Frequency tables, data visualization using software such as aWhere (graphs/trend lines, mapping/spatial representation) **Review of Data:** CHC internal CHC review (monthly and quarterly), activity level reviews (region, thematic area) with IPs **Reporting of Data:** CHC quarterly/progress reports, BCC WG progress updates, annual work-plan review reports, CHC evaluation reports/ publications.			
d. Data Quality Issues			
Initial Data Quality Assessment: CHC Data manager. Continuously as field data is received into the mobile data platform. **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:**			
e. Other Notes			
Notes on Baselines/Targets: There seems to be no baseline data for this indicator. The hierarchy of communication effects (see figure 1) will serve as the guide for CHC targets for this indicator. Assuming CHC achieves 80% reach/exposure of target audience groups to BCC, it is expected that at least 60% of those reached with information will understand it (demonstrate comprehensive correct knowledge on the given subject). Targets may be revised after the CHC baseline set for late 2014/early 2015.			
Location of Data Storage: CHC M&E and Research data bases, FHI360, Kampala.			
e. 1 Performance Data Table			
	Target	**Actual**	**Comments**
CHC baseline TBD Dec.2014-Feb.2015			
2014	N/A		
2015	N/A		
2016	N/A		
2017	N/A		
2018	85%		
THIS SHEET LAST UPDATED ON: September 2014			

Indicator Reference Sheet			
Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication			
Intermediate Result 1 Indicator 1.11: Percent of individuals with comprehensive correct knowledge of TB			
Date Established:	**Date Last Reviewed:**		
a. Description			
Precise Definition(s): Number of individuals 15-49 who demonstrate comprehensive of TB including heard of TB, knowledge of at least 2 warning signs of TB, how TB is transmitted, that TB is curable, and the risk of not completing TB treatment. **Unit of Measure:** Percent **Numerator:** Number of individuals 15-49 who demonstrate comprehensive of TB including heard of TB, knowledge of at least 2 warning signs of TB, how TB is transmitted, that TB is curable, and the risk of not completing TB treatment. **Denominator:** Number of individuals in the survey **Disaggregation:** Region, Age, Marital status, Residence (rural/urban) **Justification/Management Utility:** Increase in knowledge is the first step to addressing personal attitudes, intentions, and potential to take up a recommended health behavior and/or service. TB programs outside of the context of HIV have only just began to pick up, and the current focus is on increasing awareness and knowledge about the signs and symptoms of TB, importance of screening and testing, and treatment adherence.			
b. Plan for Data Collection			
Data Collection: Primary data collected as part of specialized outcome studies under CHC. **Method of Measurement:** Individuals are asked if they have heard of TB. Those who have heard of TB are asked a set of questions on TB knowledge. 1) Signs and symptoms: Name at least 2 signs and symptoms of TB. The respondent is counted in the numerator if they mention at least 2 signs, one of which is cough lasting 2 or more weeks. 2) Transmission of TB: How is TB transmitted from one individual to the next? Respondent is included in numerator if 3) TB is curable using modern drugs 4) The risk of not completing TB treatment. Respondent is included in the numerator if they list MDR TB or premature death 5) Name a place where TB screening can be obtained. 6) SCORING RESPONDENT KNOWLEDGE: 5= correct knowledge in all five areas, 4 = knowledge in four areas. 3= knowledge in three areas, 2= knowledge in two areas, 1= knowledge in one area, 0= no knowledge **Data Source(s):** Baseline from CHC data (2014) complemented by partner data e.g. Track TB. **Timing / Frequency of Data Collection:** Periodic CHC evaluations: Baseline late 2014-early 2015; Midline late 2016, Endline 2018. If applicable, UDHS (CHC will explore with UBOS the potential to incorporate set of knowledge questions in the next UDHS). **Estimated Cost of Data Collection:** **Responsible Individual(s):** M&E and Research officers **Location of Data Storage:** CHC M&E data base, FHI360, Kampala.			
c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)			
Data Analysis: Univariate and bivariate statistics for specialized outcome studies. Data will be weighted by exposure and BCC dose intensity. **Presentation of Data:** Frequency tables, data visualization using software such as aWhere (graphs/trend lines, mapping/spatial representation) **Review of Data:** CHC internal CHC review (monthly and quarterly), activity level reviews (region, thematic area) with IPs **Reporting of Data:** CHC quarterly/progress reports, BCC WG progress updates, annual work-plan review reports, CHC evaluation reports/ publications.			
d. Data Quality Issues			
Initial Data Quality Assessment: CHC Data manager. Continuously as field data is received into the mobile data platform. **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:**			
e. Other Notes			
Notes on Baselines/Targets: There seems to be no baseline data for this indicator. The hierarchy of communication effects (see figure 1) will serve as the guide for CHC targets for this indicator. Assuming CHC achieves 80% reach/exposure of target audience groups to BCC, it is expected that at least 60% of those reached with information will understand it (demonstrate comprehensive correct knowledge on the given subject). Targets may be revised after the CHC baseline set for late 2014/early 2015.			
Location of Data Storage: CHC M&E and Research data bases, FHI360, Kampala.			
e. 1 Performance Data Table			
	Target	**Actual**	**Comments**
CHC baseline TBD Dec.2014-Feb.2015			
2014	N/A		
2015	N/A		
2016	N/A		
2017	N/A		
2018	90%		
THIS SHEET LAST UPDATED ON: September 2014			

Indicator Reference Sheet

Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication

Intermediate Result 1 Indicator 1.15: Percent of individuals 15-49 who approve of at least one of specific recommended behaviors and/or services promoted in OBULAMU messages

Date Established: **Date Last Reviewed:**

a. Description

Precise Definition(s): Proportion of individuals age 15-49y who report a favorable assessment of at least one key health behavior or service in health areas covered under CHC program i.e. statements from the respondent relate the behavior with a positive value held by the respondent. This indicator measures interest among respondents on a given health behavior/service including self-initiative to improve their knowledge and subsequently make informed decisions for their health or the health of minors 0-14y in their care. The various components are outlined in the indicators summarizing Behavior Change Communication (BCC) objectives related to HIV (*MCP reduction, condoms, HCT, eMTCT, SMC*) Tuberculosis (*screening and case detection, treatment adherence*), Malaria (*ITN use, IPTp2 or more, test and treat, IRS*), Nutrition (*EBF including EIB, minimum dietary diversity for children 6-23 months and breastfeeding mothers*), Maternal and Child Health (*ANC 4th visit, HF delivery, Full course of vaccinations for children, Post-partum care*) and Family Planning (*take up modern contraception to either delay, space, or limit births*). Caregivers will respond on actions to assure the health of a child/minor 0-14y.

Unit of Measure: Percent

Numerator: Individuals who report favorable attitudes about specific recommended behaviors and/or services promoted in OBULAMU messages

Denominator: Individuals in the CHC evaluative survey who are reached with OBULAMU messages at least twice through any/ combination of channels used by the project

Disaggregation: Region, Age, Sex, Residence (rural/urban)

Justification/Management Utility: Attitudes influence social behavior. People act in ways consistent with beliefs about whether a behavior will lead to certain outcomes. Individuals who change or strengthen their attitude following exposure to BCC efforts are more likely to take up desired behaviors and/or services (Fishbein and Ajzen, 1975).

b. Plan for Data Collection

Data Collection Method: CHC evaluative survey.

Method of Measurement: Respondents will be asked their opinion on statements on a Likert scale. Respondents express their values in terms of e expected outcome of the behavior, expected benefit or harm, or positive and negative attributes of the behavior/product.

SAMPLE favorable attitudes towards contraception:

1. It is better for a woman and her husband/partner to wait until she is age 18 to have a child. *Strongly agree/ Agree/ Disagree/ Strongly disagree*
2. If you try one type of contraception and do not like it, there are many other types of contraceptives to try. *Strongly agree/ Agree/ Disagree/ Strongly disagree*
3. Would you say your spouse/ partner approves or disapproves of couples that use contraception methods to avoid getting pregnant? *Approves/ Disapproves/ Don't Know*

Data Source(s): Baseline from CHC data (2014) complemented by partner service data.

Timing / Frequency of Data Collection: Periodic CHC evaluations: Baseline late 2014-early 2015; Midline late 2016, Endline 2018.

Estimated Cost of Data Collection:

Responsible Individual(s): M&E and Research officers

Location of Data Storage: CHC M&E data base, FHI360, Kampala.

c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)

Data Analysis: Data Analysis: Univariate and bivariate statistics for specialized outcome studies. Data will be weighted by exposure and dose intensity of BCC. For the various components of the indicator, a mean score greater than zero represents highly favourable attitude while a mean score less than zero represents unfavourable attitude. Data will be interpreted alongside available IPs service data (HMIS) or UDHS/UAIS/UMIS.

Presentation of Data: Frequency tables, data visualization (graphs/trend lines, mapping/spatial representation)

Review of Data: CHC internal CHC review (monthly and quarterly), activity level reviews (region, thematic area) with IPs

Reporting of Data: CHC quarterly/progress reports, BCC WG progress updates, annual work-plan review reports, CHC evaluation reports/ publications.

d. Data Quality Issues

Initial Data Quality Assessment: CHC Data manager. Continuously as field data is received into the mobile data platform.

Known Data Limitations and Significance (if any):

Actions Taken or Planned to Address Data Limitations:

e. Other Notes

Notes on Baselines/Targets: There seems to be no baseline data for this indicator. The hierarchy of communication effects (see figure 1) will serve as the guide for CHC targets for this indicator. Assuming CHC achieves 80% reach/exposure of target audience groups to BCC, it is expected that at least 40% of those reached with information will approve of the health behavior/ service. CHC aims to achieve 50% (10% above the expected hierarchical effect) through innovative mass media and IPC efforts.

Location of Data Storage: CHC M&E and Research data bases, FHI360, Kampala.

e. 1 Performance Data Table

CHC baseline TBD Dec.2014-Feb.2015	**Target**	**Actual**	**Comments**
2015	50%		
2016	50%		
2017	N/A		
2018	50%		

THIS SHEET LAST UPDATED ON: February 2015

Indicator Reference Sheet

Strategic Objective: Increase adoption of healthy behaviors through strengthened health communication

Intermediate Result 1 Indicator 1.13: Percent of individuals 15-49 who intend to adopt healthy behaviors and/or take up health services promoted in OBULAMU messages in the next 6 months

Date Established: **Date Last Reviewed:**

a. Description

Precise Definition(s): Percent of individuals 15-49 who report intention to initiate OR adopt healthy behaviors and/or take up health services promoted in OBULAMU messages in the next 6 months. This indicator measures intention in the near future (within the next 6 months) to initiate and/or adopt a behavior required to produce a particular outcome i.e. to take up selected health behaviors and/or demand for services in health areas covered by CHC and USG implementing partners. This indicator measures intention to act (either to initiate behavior or adopt consistent practice). The various components are outlined in the indicators summarizing Behavior Change Communication (BCC) objectives related to HIV (*MCP reduction, condoms, HCT, eMTCT, SMC*) Tuberculosis (*screening and case detection, treatment adherence*), Malaria (*ITN use, ANC and IPTp2 or more, Test and treat, IRS*), Nutrition (*EBF including EIB, minimum dietary diversity for children 6-23 months and breastfeeding mothers, minimum meal frequency*), Maternal and Child Health (*ANC 4th visit, HF delivery, Full course of vaccinations for children, Post-partum care*) and Family Planning (*take up modern contraception to either delay, space, or limit births*). Caregivers will respond on actions on behalf of a child/minor 0-14y.
Unit of Measure: Percent
Numerator: Individuals who report intention to initiate/ adopt specific healthy behaviors and/or take up health services promoted in OBULAMU messages in the next 6 months
Denominator: Individuals in the CHC evaluative survey who are reached with OBULAMU messages at least twice through any/ combination of channels used by the project
Disaggregation: Region, Age, Sex, Residence (rural/urban)
Justification/Management Utility: Individuals may have the knowledge and skills, positive beliefs, and attitudes yet avoid the behavior and/or health service. Understanding intentions is key to exploring the underlying barriers and the best triggers to motivate action (Witte, 1992 and 1998).

b. Plan for Data Collection

Data Collection Method: CHC evaluative survey.
Method of Measurement: CHC will use selected sets of questions used in behavioral studies.
SAMPLE for condom use:

i. How likely or unlikely are you to use a condom during sex in the next 6 months? *Very likely/ Likely/ Unlikely/ Very unlikely*

SAMPLE for HCT

1. How likely or unlikely are you to get HIV counselling and testing in the next 6 months? *Very likely/ Likely/ Unlikely/ Very unlikely*
2. Do you intend to receive the results of the HIV test? *Yes/ No/ Don't Know*

SAMPLE for CAREGIVERS: Do you intend to obtain safe male circumcision for boys in your care?
Data Source(s): Baseline from CHC data (2014) complemented by partner service data whenever available
Timing / Frequency of Data Collection: Periodic CHC evaluations: Baseline late 2014-early 2015; Midline late 2016, Endline 2018.
Estimated Cost of Data Collection:
Responsible Individual(s): M&E and Research officers
Location of Data Storage: CHC M&E data base, FHI360, Kampala.

c. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)

Data Analysis: Data Analysis: Univariate and bivariate statistics for specialized outcome studies. Data will be weighted by exposure and dose intensity of BCC. For the various components of the indicator, a mean score greater than zero represents high intention while a mean score less than zero represents low intention. Data will be interpreted alongside available IPs service data (HMIS) or UDHS/UAIS/UMIS.
Presentation of Data: Frequency tables, data visualization (graphs/trend lines, mapping/spatial representation etc)
Review of Data: CHC internal CHC review (monthly and quarterly), activity level reviews (region, thematic area) with IPs
Reporting of Data: CHC quarterly/progress reports, BCC WG progress updates, annual work-plan review reports, CHC evaluation reports/ publications.

d. Data Quality Issues

Initial Data Quality Assessment: CHC Data manager. Continuously as field data is received into the mobile data platform.
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:

e. Other Notes

Notes on Baselines/Targets: There seems to be no baseline data for this indicator. The hierarchy of communication effects (see figure 1) will serve as the guide for CHC targets for this indicator. Assuming CHC achieves 80% reach/exposure of target audience groups to BCC, it is expected that at least 20% of those reached with information will form intentions to take up required behaviors and/or health services. CHC aims to achieve 30% (10% above the common hierarchy effect) through innovative mass media and IPC efforts.

Location of Data Storage: CHC M&E and Research data bases, FHI360, Kampala.

e. 1 Performance Data Table

CHC baseline TBD Dec.2014-Feb.2015	**Target**	**Actual**	**Comments**
2014	N/A		
2015	30%		
2016	30%		
2017	N/A		
2018	30%		

THIS SHEET LAST UPDATED ON: September 2014

5. CHC PROJECT M&E SYSTEM

Overview

It is critical to find out what works and is most effective with target audiences from the start of the project. CHC monitoring and evaluative process is guided on an on-going basis by the MEL Plan and a Monitoring and Implementation Plan (MIP) held internally by CHC. Data will be collated and utilized on quarterly, semi-annual, and annual basis to inform the appraisal and implementation of project activities.

CHC data will be systematically gathered by project staff with appropriate levels of short term technical assistance (STTA) from FHI 360, USA, and stored in CHC database server. CHC Research and M&E staff, working closely with CHC Regional Technical Officers, will engage with M&E staff of GoU and implementing partners for appropriate data collected through their M&E systems. In 2014, MEEPP facilitated CHC M&E staff access to the HMIS data which forms a core reference point for baseline measures and interpretation of data generated through CHC routine monitoring and periodic evaluative surveys.

5.1 Development of CHC M&E Plan

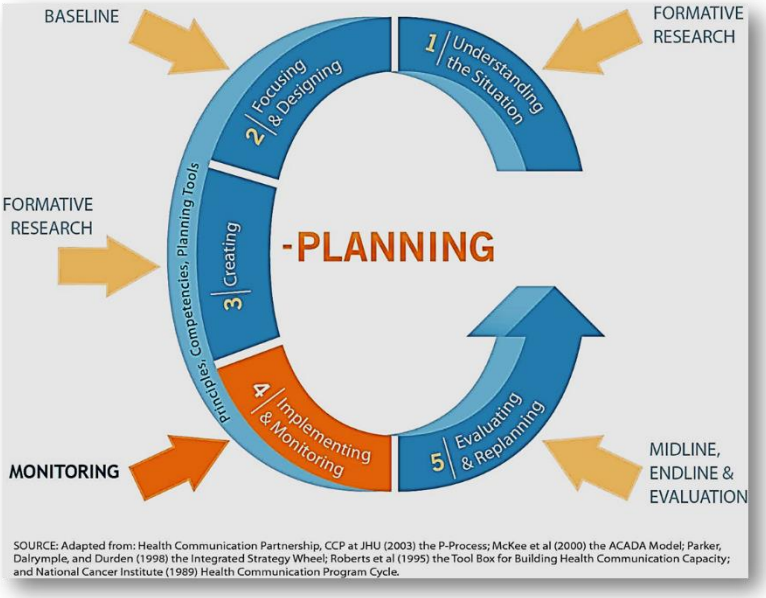
This M&E plan was initiated during program start-up in late 2013, and proposes activities for the life of project. During the preparation of the M&E plan, CHC and USAID SI maintained discussions leading to decisions about program performance outcome/results indicators (definitions, data sources, frequency of collection/reporting, and complementary data to aid interpretation). These are contained in the Monitoring, Evaluation, and Learning (MEL) Plan matrix. A separate Monitoring and Implementation Plan (MIP), to be held internally at CHC and from which data is availed to USAID upon request, contains intermediate outcome and process indicators which CHC uses to track progress and facilitate immediate learning and adaptation as needed during implementation. Insight into the MIP can be obtained from the following matrices in the annexes; 1) CHC M&E workplan matrix, 2) M&E timeline projections, and 3) CHC risks and unexpected negative outcomes assessment matrix.

The main reference documents used in preparing the M&E plan and assessing progress include:

i. Document W0834 - Uganda CHC - Cooperative Agreement
ii. CHC Annual work plans (YR1, YR2)
iii. OBULAMU Integrated Strategy
iv. OBULAMU Implementation Guides

5.2 Features of the CHC M&E system

CHC M&E system draws from the Communication for Change (C-Change) (see figure below: C-Planning process) and insight from resources available on USAID Learning Lab site[18] to ensure an iterative learning and adaptation process from situational analysis through to implementation, monitoring, and evaluation.



5.2.1 Monitoring versus evaluation: Application in CHC program

Although often mentioned together, monitoring and evaluation are two distinct activities that are related but not identical. The common connection is that they seek to capture information about what a program is doing and how it is being done.

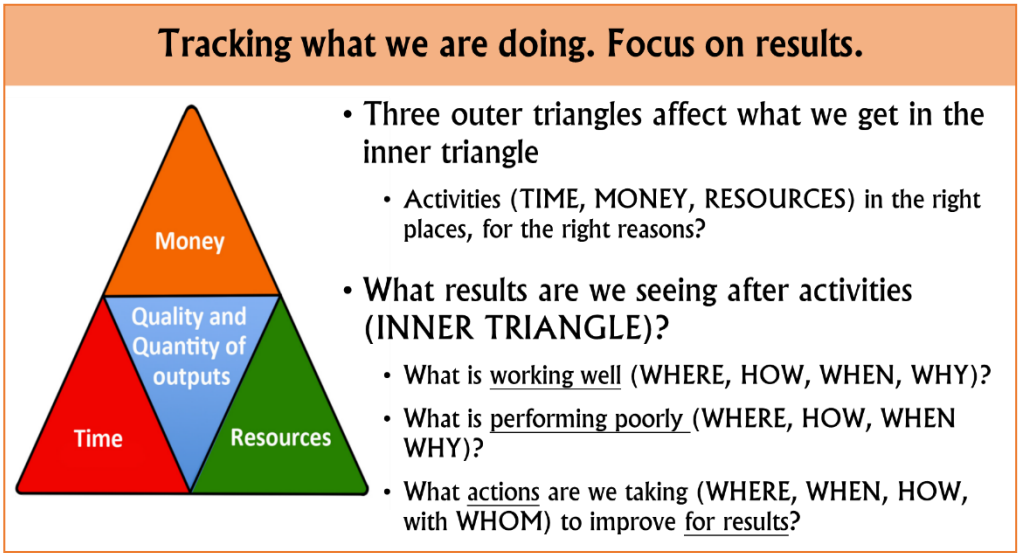
Monitoring involves tracking your CHC progress by systematically gathering and analyzing information about what the program is doing and whom the program is reaching. CHC will use monitoring data to troubleshoot if activities are being carried out as originally planned, and any needs for review. MER team will process the data and report emerging insights timely to the implementation team to facilitate strategy on measures to correct problems and adjust activities or the workplan where applicable for optimal results.

Evaluation involves a more in-depth assessment of performance and activities than monitoring. CHC evaluative studies aim to assess activity progress, quality and outcomes against program strategy, targets, and workplan.

CHC monitoring and evaluation data will complement each other to increase knowledge for both the program and stakeholders in the following areas;

[18] InProgress Monitoring Manual
http://usaidlearninglab.org/sites/default/files/resource/files/inProgress_Monitoring_Manual_v1.pdf

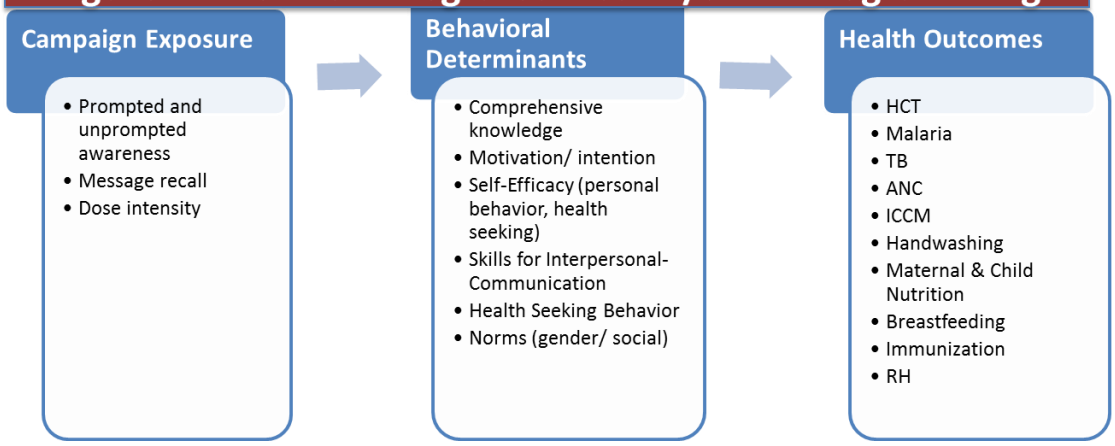
- Establish the extent activities were implemented as planned. If there were deviations, were these planned adaptations, or were they unplanned? What evidence and processes were used to inform adaptation, if any?
- Answer questions about accountability and inform management decisions i.e. did the program complete what was set in the cooperative agreement and approved workplans?
- Answer questions about accomplishments: what was accomplished, what is working, what may not be working, and what remedial actions are we taking (see illustration below: Tracking what we are doing with a focus on results)



5.2.2 CHC M&E planning for integrated Health/ SBCC program implementation

CHC M&E was incorporated into program design. Besides routine program monitoring, CHC will conduct household surveys to measure baseline and endline health outcomes and intermediate results for each of six health areas (See Data Collection). Additional monitoring and operations research comprises the use of qualitative studies (see Figure 2 below). While CHC evaluative baseline survey occurs in YR2, program M&E system incorporates reference to databases including HMIS, USAID HIBRID, and UMIS 2014 for assessment of outcomes such as shift in health indicators. Excerpt 1 below illustrates the translation of concepts in Figure 2 in development of the CHC evaluative household survey tool, a process that was undertaken in tandem with the development of the CHC OBULAMU SBCC campaign in order ensure alignment of the survey to program components.

Figure 2: M&E for Integrated Health/SBCC Programming



Excerpt 1: Household Survey to measure baseline and endline health outcomes and intermediate results for each of six health areas

Exposure	Knowledge	Motivation (Outcome expectations & Initiation)	Self-Efficacy (Behavior & Health Seeking)	Interpersonal communication (IPC) Skills	Health Seeking Behavior	Norms	Health Outcome
In the last 6 months, have you seen or heard any messages about ANC?	All pregnant women should take iron and folic acid supplementation as a part of routine pregnancy care. (Agree/Disagree)	If you/your partner get pregnant in the future, how likely or unlikely are you to attend antenatal care services at a health facility?	How confident are you that you can seek health facility antenatal care and delivery services when you/your partner are pregnant?	How comfortable are you discussing prevention of mother to child transmission of HIV with your spouse/partner?	Have you sought information about health facility antenatal care or delivery services in the past six months?	How many of your closest friends deliver their babies at health facilities?	How many antenatal care visits did you attend at the health facility during your last pregnancy/this pregnancy?

5.3 Data collection and utilization

5.3.1 Data collection

Data collection, quality, and processing for use is at the core of CHC M&E. CHC data collection and reporting instruments for routine monitoring have been adapted from standardized tools drawn from C-Change, FHI 360's vast research utilization experience, and USAID Snapshot/ Success stories guidelines (see Annex: Data collection and reporting tools). CHC evaluative survey questionnaire has been designed to match the indicators developed for the program, while the design of the CHC evaluative survey was matched to the context of CHC SBCC support to USG implementing partners.

5.3.2 Data quality verification

CHC M&E and Data Managers will work with key personnel to regularly conduct data quality assessments (DQAs) to check the quality of the data used to manage and report CHC program achievements. The focus will be on the accuracy and consistency of the data, and strengths and weaknesses, assessed using five data

quality standards outlined in the USAID DQA process. These include 1) validity, 2) reliability, 3) precision, 4) integrity, and timeliness (see Annexes: USAID Data Quality Standards).

The system for collecting and maintaining data are key to this process. CHC M&E and Research section will undertake data quality control measures from before data is collected through its collection, collation, entry, and storage. Important questions to guide this process may include:

- What is the data of interest and what is its intended use?
- Does it already exist or will new data be collected? What is the regularity with which this data is collected?
- Are the tools (current or new) adequate to collect this data? What is the scope (of partner or health facility data) and how does it compare with CHC data needs? What additional backstops are needed to secure all the required data?
    - Mechanisms to minimize bias in reporting, sampling etc
    - Written SOPs for data collection/collation
    - Training and support supervision to all staff with data capture responsibilities
    - Data accessibility management systems including ability to track last user, administrator rights for who may or may not edit data once it is entered, verified, and stored for analysis, etc
    - Continuous review and maintenance of source documents
- Are the tools for existing data standardized? What will be the data collation needs (especially if data tools across partners are not standardized)?
- How adequate is our database system to capture this data accurately? What revisions may be required? How does revision in one section affect other data capture within the system?
- How best should this data be disaggregated?

These questions aim to help troubleshoot the data systems and facilitate necessary feedback to data teams and partners for relevant action where there may be short comings. These feedback systems aim to identify whether there has been a data entry error, or whether it is a data source related error, e.g. in data capture etc. Data improvement measures will be taken with CHC staff and together with partners as may be appropriate.

5.3.3 Data management

Data will be organized and stored in the appropriate databases among the following:

i. **Key Indicators Database** – This core database stores the bulk of the indicators listed in this MEL Plan and is fed by the Intervention Tracking Tool, OBULAMU activity reporting template, and evaluative survey outputs. As activities and related monitoring and evaluation research are completed their results are reported using relevant indicator tracking tools to the central office in Kampala and entered into this database.

ii. **Partner Capacity Assessment and Strengthening [19]Database** - This data base will capture and store all HC program related training, Technical Assistance (TA), Mentoring and other forms of capacity strengthening activities which will be counted/analyzed by type of TA, topic of TA, IP/Cadre, Gender, etc...[20] The database will keep track of IP/organizational and individual scores on the 1) HC capacity assessment tools, 2) implementation quality assessment tools used to assess the integrity of implementation i.e. use of data for decision-making, among others. These will be stored from baseline through follow-up. This database will be fed mainly by the Organization Capacity Assessment Tool (O-CAT) and Capacity Strengthening Event Form.

iii. **Knowledge Generation and Sharing Database** - Tracks all research/knowledge products, downloads and click-through from the online data visualization dashboard or CHC webpage, etc., to keep track of stakeholder dissemination events, conference presentations, audiences, formats, and other article writing etc. Information captured from the initial and on-going HC Audit will also be compiled in this data base. This data base will also directly support activities under IR3 including progress towards a national research agenda: local investigators SBCC research capacity strengthening, development of research questions and execution of research, among others. It will have links with the output from data bases i-ii above to track progress towards outcomes especially as it appertains to use of evidence to inform programming, and incorporation of stakeholder insights into both programs and research.

iv. **HC products database** – Tracks all HC materials by category: designed through a national harmonization process, produced, disseminated.

5.3.4 Data processing

Data will be analyzed by structuring and organizing it on scheduled basis to get a sense of the trends and patterns emerging from project rollout. Formative, operations, and evaluative research data will be analyzed as soon as it is collected and shared with staff and stakeholders through a range of dissemination platforms outlined in "learning and adaptation", below. To facilitate timely use, preliminary results will be generated from all research data through mechanisms such as summary matrices of emerging themes (qualitative data) and frequency distribution tables and graphs (evaluative survey data). Routine monitoring/intervention tracking data will be organized and analyzed on a cumulative basis by CHC quarterly and annual reporting calendar. All analysis will be shared with staff and stakeholders both to improve decision-making and to engender support for M&E and program learning and adaptation.

5.3.5 Learning and adaptation

Progress towards achieving targets will be monitored by continuous assessment, a critical component of evidence based implementation continuation and/or adaptation to improve outcomes. Each database will have the capability of combining data points to calculate indicator results on a quarterly, annual, and life of project

[19] CHC will determine whether the tools need any adaptation i.e. the extent they should be used in whole, or selected sections to fit contexts of assessment

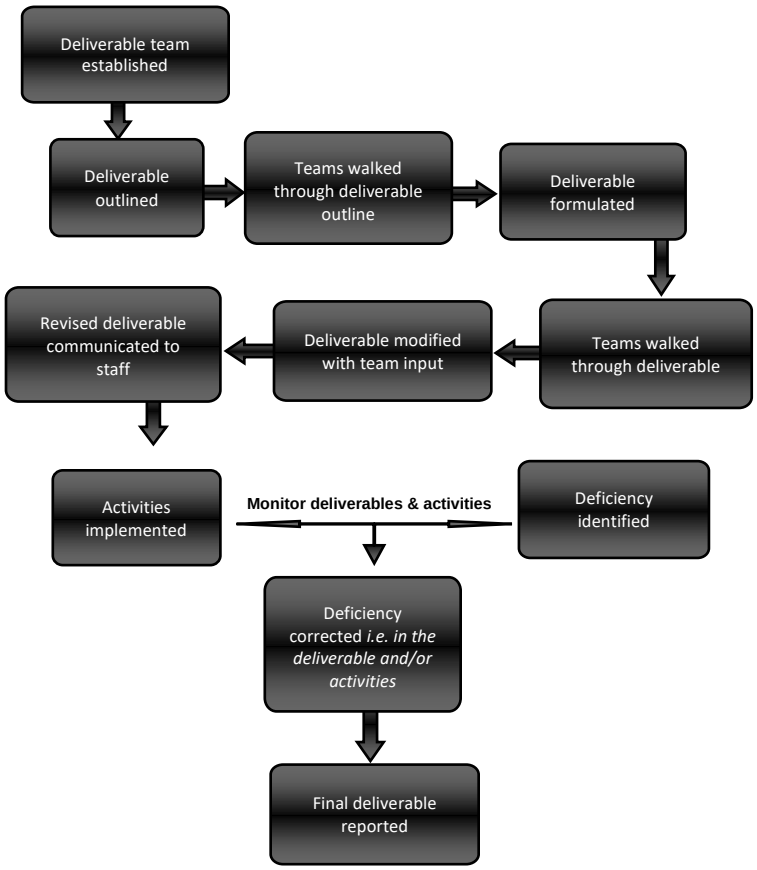
[20] Note that for the capacity strengthening database, CS data is collected for the trainings done by CHC and not by partners. Limited partner data will be captured using the results from the individual Capacity Assessment Tool (CAT).

basis. Most indicators and data collection tools will be designed to be analyzed by the six (6) broad themes of the CHC program as well as sex and age (where appropriate), thematic and geographic area, partner agency, and other relevant variables on the specific activity.

For each indicator, CHC will track progress through program level performance indicator monitoring reports that mirror the MELP indicators table columns i.e. indicator, target, actual, with a column to calculate variance in targets and what is actually attained. Activity implementation reports will be a combination derived from the MELP indicators table and the Performance Monitoring Tasks mirrored on the CHC annual work plans/ Gantt Charts.

CHC plan for collaborative learning and adaptation will engage both staff and stakeholders through platforms such as internal CHC staff work plan development, MoH-led technical working groups and task forces in which implementing partners participate, communities of practice, and data dissemination and interpretation workshops at the regional and national level. These platforms offer robust deliverable review processes for determining overall quality of CHC program interventions and results. The process is cyclic and conducted for each key deliverable, for example; design of the integrated health communication strategy and phased design and rollout of the integrated strategy based on the Life Stage approach. The deliverable process seeks to engender accountability across board and is a calculated move to both enforce and reinforce an iterative cycle of information sharing and feedback that involves 1) establishment of a deliverable team, 2) clarification of deliverable expectations, and 3) using deliverable walkthroughs to maintain a collaborative deliverable development, review, and adaptation process (see Figure 3).

Figure 3: Cyclic process of deliverables formulation and verification



5.4 Additional Data

CHC will undertake a series of qualitative assessments and case studies of several critical areas of contribution that have been made by the program. CHC plans to conduct a significant number of operational research activities towards measuring outcomes (with linkages to health service utilization) and impact. For instance, in Year 1 CHC collected data through participatory/action research methodologies include rapid case studies, action media methodology to document salient determinants for MCH (uptake of ANC, eMTCT, IPTp, health facility delivery, child vaccinations); Malaria (ANC for IPTp, LLIN use, Child fever case management); Family Planning; HIV prevention among key populations (HCT and condom use), and safe male circumcision, among others. Desk reviews were also completed for areas such as HIV (prevention as treatment, Hotspots, and child nutrition. The data collection questions were based on the Theory of Deviance, and focused on learning the characteristics of individuals who successfully adopt and adhere to recommended behaviors in the selected thematic areas. These data provided the evidence base for development of the CHC HC Strategy. CHC expects to streamline these customized studies through the platform of the BCC WG and ME/KM task force in line with intermediate result 3 which aims to increase local capacity for evidence-based research as a component of the collaborative learning and adaptation.

CHC M&E workplan matrix

General and Specific activity	Specific activity (what is assessed or being done)	When activity occurs? (schedule)	Who participates? (data collection, analysis)	Who leads? (Who is responsible for reporting?)	When reported? (schedule)	For whom? (Report to...)
Monitoring and Learning						
Formulate/Define activity deliverables/ Objectives	•Verify alignment to targets, make fundamental changes	By activity & Quarterly & Annual	Regional staff, M&E staff, key personnel	Activity leaders supported by CHC MER unit	Quarterly & Annual	Key personnel, USAID, TWGs
Routine intervention tracking and team reviews	•Progress and quality of activities •Progress on implementation rollout indicators •Project products achieved •Products distribution and delivery •Actual versus planned activities •Track resources; use vis-à-vis budgeted; use vis-à-vis achievements	Monthly (by activity) & Quarterly & Annual	Regional staff, M&E staff, key personnel	CHC MER unit supported by Key personnel (*see USAID-FHI 360 Co-AG*)	By activity and reporting schedule Also involves quarterly review retreat with all staff	All staff, USAID, MoH, USG IPs, FHI 360
Special studies	• Take a pulse of the intervention (immediate population response) • Generate lessons for further programming	Ad-hoc (at least 1-2 studies), informed by phased rollout of intervention	Regional staff, M&E staff, key personnel	CHC MER unit supported by Campaign manager	By activity schedule in workplans	All staff
After-Action-Reviews and dissemination	•Assess quality of implementation •Inform decisions for re-planning •Share knowledge and obtain feedback	Monthly (by activity) & Quarterly & Annual	Regional staff, M&E staff, key personnel	CHC Campaign manager supported by CHC MER unit	By activity schedule	All staff, USAID, MoH, USG IPs, FHI 360
Data Quality Assessments	•Assess quality of data systems to capture intended data •Assess quality of data used in reporting and analysis	Quarterly (*for general DQA*) & periodically by evaluative survey timing	M&E staff, Key personnel	CHC MER unit supported by Campaign manager	Quarterly & Annual	All staff, USAID, FHI 360
Context, risks & assumptions	•Verify and document social, political, economic, implementation environment •Monitor unexpected outcomes	Quarterly & Annual	Regional staff, M&E staff, key personnel	Key personnel supported by CHC MER unit	Quarterly & Annual	All staff, USAID, MoH, FHI 360
Reporting	•Periodic project progress/ accountability (activities, indicators, lessons learned, challenges, resources)	Quarterly & Annual	Regional staff, M&E staff, key personnel	CHC MER unit supported by Key personnel	Quarterly & Annual	All staff, USAID, FHI 360
Evaluation						
Baseline	•Establish baseline indicators for exposure to intervention, message recall, effects on comprehensive knowledge, attitudes, intentions, behaviors, gender and social norms	Pre- intervention rollout (April-May 2015)	CHC MER unit	Key Personnel supported by CHC MER unit	ASAP after study: avail preliminary results	Key personnel, USAID, TWGs

	• Context, assumptions					
Annual reviews	• Financial, physical, outputs, effects, context, assumptions	Annual	Regional staff, M&E staff, key personnel	Key Personnel supported by CHC MER unit	Annual	All staff, USAID, MOH
Mid-term evaluation	• Progress review – Achievements on indicators for exposure to intervention, message recall, effects on comprehensive knowledge, attitudes, intentions, behaviors, gender and social norms • Facilitate interpretation of progress – financial vs achievements • Context, risks, assumptions	18 months after intervention rollout (late 2016)	CHC MER unit	Key Personnel supported by CHC MER unit	ASAP after study: avail preliminary results	Key personnel, USAID, TWGs
Endline	• Overall achievements – Outputs, effects • Context, assumptions	Data collection to be completed **no later than** 3 months before project closeout (early 2018)	CHC MER unit	Key Personnel supported by CHC MER unit	Preliminary insights ready prior to phase out	Key personnel, USAID, TWGs
Final evaluation	• Achievements, sustainability • Cost-benefit	Within 6-9 months of end of project	Independent evaluation consultant appointed by USAID	USAID	USAID timeline	Stakeholders – FHI 360, MOH, USG IPs
Other						
Operations research/ desk review	• Generate evidence to inform intervention planning, re-planning, interpretation	Ad-hoc, informed by phased rollout of intervention	Regional staff, M&E staff, key personnel	CHC MER unit supported by Campaign manager	By activity schedule in workplans	All staff
• Adapt data collection and reporting tools • Orient staff and partners on M&E	• Improve documentation, emphasize results-based reporting, and data use for decision-making • Field support to troubleshoot reporting gaps	Aligned with intervention rollout and any introduction of data collection/ reporting tools	Regional staff, M&E staff, key personnel	CHC MER unit supported by Campaign manager	By activity schedule	All staff

CHC M&E Timeline projections

CHC M&E Timeline Projections																					
General/ Specific activity	**YR1**					**YR2**				**YR3**				**YR4**				**YR5**			
	Q1	**Q2**	**Q3**	**Q4**	**Q5**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Monitoring and Learning																					
Formulate/Define activity deliverables/ Objectives																					
Routine intervention tracking/ Quarterly reviews																					
Special studies																					
After-Action-Reviews and dissemination																					
Data Quality Assessments																					
Context, risks & assumptions																					
Reporting																					
Evaluation																					
HMIS for service data																					
Baseline (household behavioural survey)																					
Annual reviews																					
Mid-term evaluation																					
Endline and final reporting																					
Final evaluation (USAID to determine)																					
Other																					
• Desk reviews																					
• Adapt data collection and reporting tools (*align with integrated HC strategy and phased implementation guides*)																					
• Orient staff and partners on M&E																					

CHC risks and unexpected outcomes assessment matrix

Assessment of risks and unexpected negative outcomes matrix				
Levels of problems/concerns	**Problems encountered**	**Solutions recommended**	**Decisions made (what, when)**	**Actions taken (what, when)**
Community Level				
Project level (including partners)				
Policy and higher level (including donor, country office, headquarters, etc.				

Performance tracking/data to accompany USAID reporting (and team review meetings)

Date: _____

Reporting Period: _____

Intermediate Result 1	Performance Data Table												
Indicator name:	**Baseline/Previous reporting period**	**Target**				**Actual**				**Comments**			
Activity:		**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
	FY												
		Total targets in FY				**Total Actual in FY**				**Overall Comments for FY**			

6. CHC LEARNING AGENDA

Overview

The CHC learning agenda follows Mintzberg's principle[21]: i.e. that a program needs;

i. To create an enabling environment that encourages individuals and teams to reflect on and learn from their experience and from others (emergent learning), and
ii. To equally develop a more structured and planned approach to learning (planned learning).

The learning happens throughout the program from inception to completion, as indicated in C-Change's C-Planning model (see section 5.2 above: Features of the CHC M&E system).

In simple terms, a 'learning agenda' is a set of questions – broad in scope – directly related to the program's work that, when answered, will enable the program to work more effectively. These questions help to shape important decisions such as

i. What interventions (or intervention components) to strengthen or scale up,
ii. What interventions (or intervention components) to revise, and
iii. What additional formative/operations research questions are emerging from implementation rollout?

Questions in a learning agenda work best if they are open, broad in scale, and genuinely interesting (to stimulate the curiosity of staff and others). A good learning agenda facilitates focus on priorities and links together learning at the four main levels (individual, team, organization and inter-organization).

6.1 CHC learning agenda: Question domains

CHC's pursuit of strategic information in the learning agenda is envisaged at three distinct levels supplemented by the next national surveys (UMIS 2014, UDHS, and UAIS):

1. **Monitoring and evaluation** of selected indicators and results. There are two approaches to this;
    i. Periodic evaluative household surveys covering SRH and MNCH topics including sexual behaviors (number of partners and condom use) HTC uptake, ANC uptake (and eMTCT, IPTp uptake), exclusive breastfeeding, delivery at a health facility; and
    ii. Quarterly review of HMIS data on a quarterly basis for changes in uptake of HIV-related services as proxy for changes in behaviors.

2. **Evidence-building on effectiveness of CHC interventions**: This is at the core of CHC learning agenda and performance management. Data will come mainly from routine monitoring of CHC interventions and evaluative surveys (Survey II is projected for late 2016). Analyses will be guided by the following three key questions:

[21] https://thelearningngo.wordpress.com/tag/learning-agenda/

i. What effects are CHC interventions having on comprehensive knowledge, gender and social norms, health behaviors, and uptake of available health services?
ii. What components of the SBCC interventions are supportive of attitude change, shifting gender norms, and uptake of pro-health behaviors and services related to HIV prevention and care?
iii. The extent of enhancement of the technical capacities of implementing partners (MoH and GOU) through CHC-led capacity strengthening (CS) and/or Technical Assistance (TA) efforts, and the quality of the CHC-led integrated HC i.e. extent of coordinated/harmonized approaches
iv. What evidence, processes, and strategies are successful in shaping these interventions?

3. **Focused formative research** prioritizing the HIV corridor to understand normative (generalized) behaviors and how people interact with HIV/AIDS interventions (information services, preventive products, and health services) and make recommendations, especially for social and behavior change communication (SBCC). The tools here include desk review, social network analysis, key informant interviews, and participatory approaches such as action media research especially among potentially marginalized groups such as women, young people, and selected key populations who may not have easy access to mainstream information services/channels.

6.2 Matching questions to assessment methods and tools

As part of the overall program implementation plan, CHC has broken down the question domains and proposed specific data collection tools (Table 3 below) for tracking and managing results.

Table 3: Question domains in CHC Learning Agenda	Methods to Address Questions
Enhanced partner technical capacity: Are CHC activities on-course to enhance the technical capacity of MOH and USG IPs to deliver high quality, evidence-based HC? • What TA is being provided to enhance partners' technical capacity? • Are IPs HC competencies increased as a result of CHC CS/TA? • What components of the integrated HC are partners implementing? What data/research is informing these decisions/choices? What are the emerging challenges and coping strategies? What are the emerging lessons learned? • How is learning under this agenda documented and disseminated?	**As part of continuous process evaluation:** Monitor scope and quality of CS/TA **TOOLS**: • CS/TA beneficiary evaluation forms • Indicator tracking forms **Setting the stage for outcome evaluation:** Assess increase in **1)** capacity for HC and **2)** HC quality assurance standards of activities/interventions **TOOLS**: • Self-administered Organizational *Capacity Assessment Tool* prior to and after CS/TA, • Self-administered Individual staff *Capacity Assessment Tool* prior to and after CS/TA, • Interview/observation tools for site visits with a random sample of USG IPs (*special focus on CHC evaluation districts, and indicators emerging from HMIS and LQAS data*) • Intervention Quality Rating Tool based on HC quality assurance standards • Expert/Exit interviews and informal listening surveys
Enhanced coordination/leadership in HC: Are CHC activities on course to contribute to an enhanced coordination and leadership role by the MOH related to an HIV and HC response? • Are USG IPs, MOH and other entities providing favourable feedback on CHC-supported coordination structure and activities? How is stakeholder feedback used in program/TA implementation and review? • What are the identified facilitators and barriers to an enhanced coordination and MOH leadership role? How is CHC facilitating actions to address these barriers? • In what specific aspects is coordination shifting from before CHC interventions? • How is learning under this agenda documented and disseminated?	**As part of continuous process evaluation:** Monitor the scope and quality of CHC coordination **TOOLS**: • Interview/observation tools for site visits with a random sample of USG IPs (*special focus on CHC evaluation districts, and indicators emerging from HMIS and LQAS data*) • Intervention Quality Rating Tool based on HC quality assurance standards • Indicator tracking forms **Setting the stage for outcome evaluation:** • Map linkages between IPs, GOU entities and other entities involved in the response • Measure domains of collaboration and leadership **TOOLS**: • Social network analysis • Key informant interviews, focus group discussions

<u>Effect of integrated HC interventions</u>: What effects is CHC-led HC having on **1)** comprehensive knowledge of health issues **2)** gender and social norms and **3)** uptake of health behaviors and/or services? • Is CHC-led HC contributing to desired changes? What are the facilitators? What are the challenges? How is formative research and process evaluation data being used in implementation monitoring and review? • What components of the integrated HC seem to be achieving results, and in what context? What may not be working well, and in what context? How do the costs compare with the results? • How is learning under this agenda documented and disseminated?	**<u>Understanding the situation</u>** Understand the context of various health behaviors and uptake of related services **TOOLS** • Partner data review e.g. LQAS, HMIS • Desk review of available published literature • Participatory formative research (KII, FGDs, Action Media Research) • Continuous mapping of implementation partner activities and locations **<u>As part of continuous process evaluation:</u>** • Routinely monitor fidelity/exposure to HC interventions by channel (at least one special/ targeted survey) • Obtain feedback on message content harmonization and communication format effectiveness **TOOLS** • FHI 360 Intervention Tracking Tool • Periodic participatory research (KIIs, FGDs, Action Media Method • Exit interviews at community shows **<u>Setting the stage for outcome, impact and cost-effectiveness evaluations:</u>** • Conduct periodic evaluative studies (approx.18 months apart) covering different health areas/ life stages (including key populations) at baseline and periodically throughout intervention roll-out • Deploy evaluation design that responds to the field context of the CHC-led integrated HC • Routinely obtain intervention cost data • Track relevant health outcome indicators (MELP/PIRS document) **TOOLS** • One-group pre/post only evaluation design with multiple substantive post-tests (*Observation 1 in Q2 of YR2, Observation 2 in Q4 of YR3, Observation 3 in Q2-3 of YR5*) • Triangulation of methods (*in addition to the evaluative survey tool – participatory qualitative data obtained from KIIs and FGDs and/or community ethnographic methodology*) • Intervention Cost Template • Data from periodic evaluative studies, HMIS, LQAS

6.3 Communication and Dissemination Plan

Each activity will have a specific report and distribution process, either stand-alone through CHC mechanisms, or jointly with partners as may be appropriate, e.g. through partner affiliation with CHC by thematic or geographic area (regional or national). The final reports will be widely disseminated through the MoH meeting platforms, local partners' networks, journal articles, and conference presentations. In all cases the intention is to use this learning directly in thematic program areas and across the integrated approach to enhance knowledge, build skills, and improve upon health communication outcomes. ***See Annexes for more insight into the Communication Plan and Learning Matrix.***

Notably, the roll-out of the integrated health communication is coordinated through the National Behavior Change Communication Working Group (BCC WG) chaired by the Ministry of Health's (MOH) Health Promotion and Education Division, in which CHC is a regular participant and technical lead. Underlying the WG's activities is a collaborative learning and adaptation agenda spearheaded through thematic area Technical Working Groups (TWGs) that addresses 1) identification, collection and dissemination of evaluation findings, 2) research utilization for continuous quality improvement, and 3) continuous exchange of knowledge including data and lessons learned in health communication.

At the district level, CHC regional staff coordinate activities with District Health Teams, and work specifically with District Health Educators and champions/VHTs to support IPC. As an ongoing process of learning and adaptation, CHC works closely with regional staff to keep stakeholders updated on program progress and research findings during regular meetings with the District Health Teams. Also, community IPC support networks such as champions/VHTs activities delivered either door-to-door or through community dialogue sessions will provide opportunity for regular household feedback and exchange of information and updates on project findings.

At the end of the project after evaluative findings have been consolidated CHC will hold data dissemination and interpretation meetings with stakeholders at the national and regional/community levels. CHC will support development of multiple types of knowledge products for dissemination that will target different audiences for optimal learning and utility. Considerable attention will be paid to the implications of the project experience with regard to the effectiveness of its approaches and feasibility of replication.

7. DEMONSTRATING CHC ATTRIBUTION TO BEHAVIOR CHANGE

In addition to collecting data about progress in the strategic objective indicators (outcome level), CHC evaluation protocol has made statistical attempts to be more specific about CHC contribution overall by calculating the minimum detectable effect sizes (MDES) linked to individual strategic objective indicators (see Annexes, Table 4). The MDES are based on a calculation of the current values from existing national reference data (UDHS 2011, UAIS 2011, MIS 2009), national target projections reflected in the Health Sector Strategic Plan (HSSP) III 2010/11-2014/15 and USAID DO3 indicator targets, and total number of expected evaluation districts for a given indicator (informed by presence of USG implementing partner activities in a given thematic health area). To the extent available, CHC will use health service uptake data collected through the HMIS to triangulate and/or interpret findings of the evaluative survey. Whenever available, UDHS, UAIS, and UMIS findings will also be used to triangulate and/or interpret output from CHC evaluations.

8. OTHER REPORTING REQUIREMENTS (PEPFAR, FTF, DO3, PPR)

CHC monitoring and implementation plan (MIP) held internally by CHC to track implementation and process indicators among other intermediate outcome indicators such as exposure to HC intervention, recall of key HC messages, will collate routine data and avail them to USAID upon request. CHC will periodically review the requirements for such reporting indicators and make adjustments to the MELP and program monitoring plans as may be appropriate.

Annexes

- CHC Theory of Change
- Hierarchy of Communication Effects
- Minimum Detectable Effect Sizes (MDES) Table estimating expected CHC attributions
- Communication Plan and Learning Matrix
- CHC Data collection and reporting tools for routine monitoring

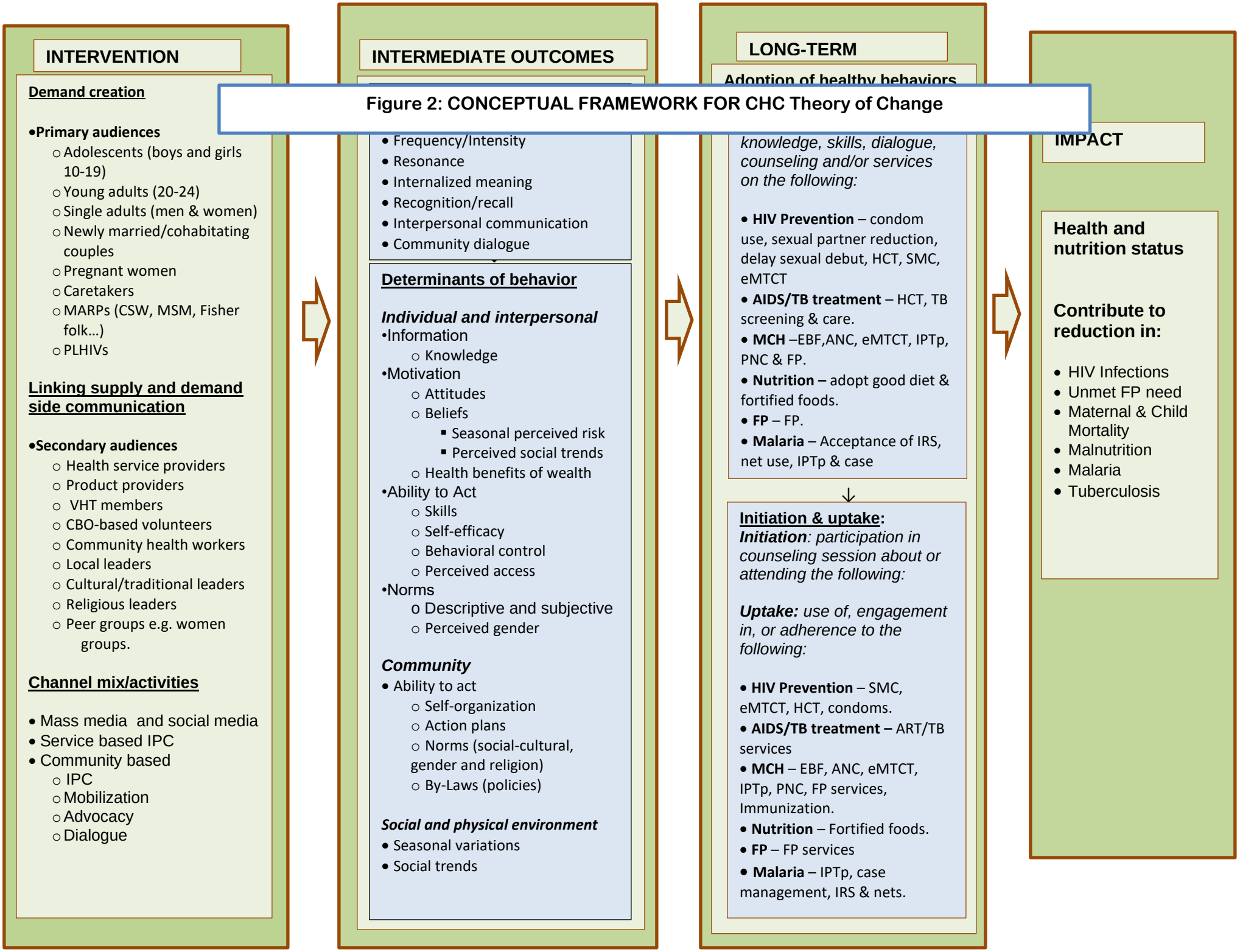
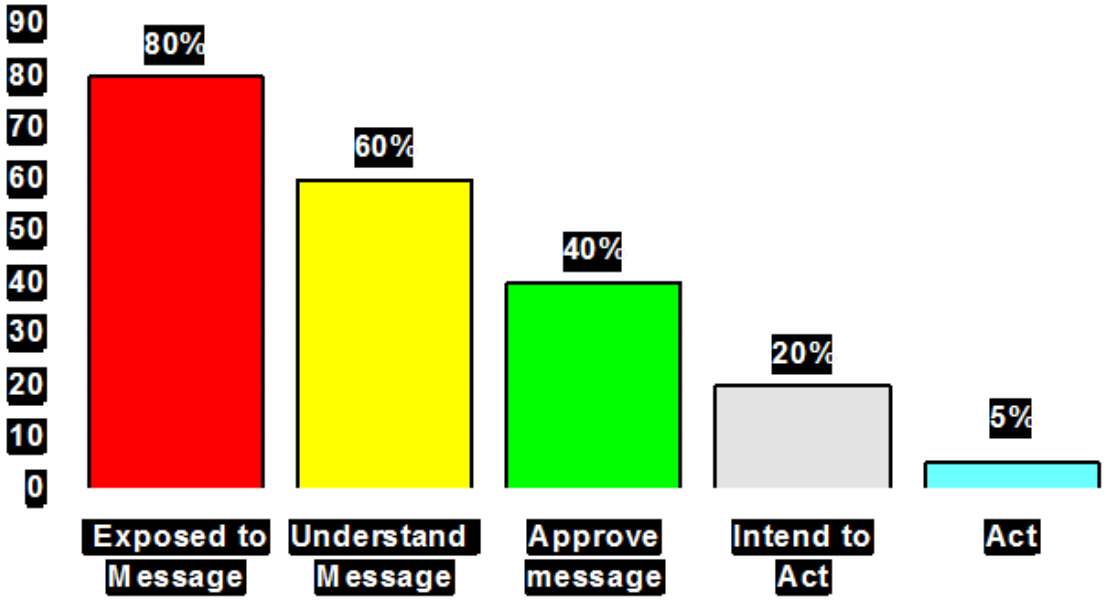


Figure 2: CONCEPTUAL FRAMEWORK FOR CHC Theory of Change

Figure 3: Hierarchy of Communication Effects



CHC evaluation of IR1 indicators including knowledge, skills, motivation, intention, and actively seeking information will be guided by the hierarchy of communication effects model above. The model is based on a combination of the stages of change model and wider communication effects research/debate by Prochaska & Diclemente et al (1984, 1998), and recent work by Thomas W. Valente (2002) *Evaluating Health Promotion Programs* Oxford University Press.

Exposure will be measured as Moderate 40%; High 60%; Very High 80%. The target is at least 80% exposure level for any given message delivered via IPC or mass media.

Table 4: Minimum Detectable Effect Sizes (MDES) calculations to estimate contribution of CHC SBCC to national indicators

Health Area	Indicator	# Evaluation survey Districts	# parishes (5/ district)	#3 Villages/ Parish #10 HH /village)	#(%) of households in denominator (target population)	Scale	Mean at reference data (UDHS 2011)	MDES (two-tail)
HIV	% individuals tested for HIV in the last 6 months and received test results	16	80	2400	2400 (100% or 30/cluster)	binary indicator	64 %	±5%
	% individuals who used a condom at last higher risk sex	16	80	2400	Men 640 (~25% or 8/cluster) Women 160 (~4% or 2/cluster)	binary indicator	Men 14.5% Women 15.8%	Men ±7% Women ± 13%
	% of males 15-49y circumcised in the last 6 months	16	80	2400	2400 (100% or 30/cluster)	binary indicator	26%	±5%
Maternal and Child Health	% of mothers of children 0 – 11 months who attended ANC at least 4 times in last pregnancy (4th visit)	16	80	2400	640 (~25% or 8/cluster)	binary indicator	Urban 57% Rural 46.7%	±9%
	% mothers of children 0-11 months who delivered their last baby in health facility	16	80	2400	640 (~25% or 8/cluster)	binary indicator	57%	±8%
	% mothers of children 0-11 months who exclusively breastfed for the first 6 months of life	16	80	2400	640 (~25% or 8/cluster)	binary indicator	62%	±7%
Malaria	% pregnant women_15-49y living in a household with at least one mosquito net who slept under an ITN/LLIN the previous night	16	80	2400	160 (~6% or 2/cluster)	binary indicator	71%	±13%
	% mothers of children 0-11 months who received 2 or more doses of IPTp in their last pregnancy	16	80	2400	640 (~25% 8 per cluster)	binary indicator	25%	±8%

	% children <5 years living in a household with at least one mosquito net who slept under an ITN last night	16	80	2400	960 (~ 42% 12 per cluster)	binary indicator	63%	±7%
	% children <5 years with a recent fever (in the last 2 weeks) for whom caregiver sought prompt diagnosis for malaria and correct treatment using recommended malaria medicines	16	80	2400	720 (~ 70% 9 per cluster)	binary indicator	43%	±8%
Family Planning	% sexually active women aged 15-49 years who are currently using any modern contraceptive method	16	80	2400	2400 (100% 30 per cluster)	binary indicator	26%	±5%
TB	% individuals with suspected TB (cough last >2 weeks) who are screened and tested for TB in the last 6 months	4	20	600	120 (20% 6per cluster)	binary indicator	57%	±18%

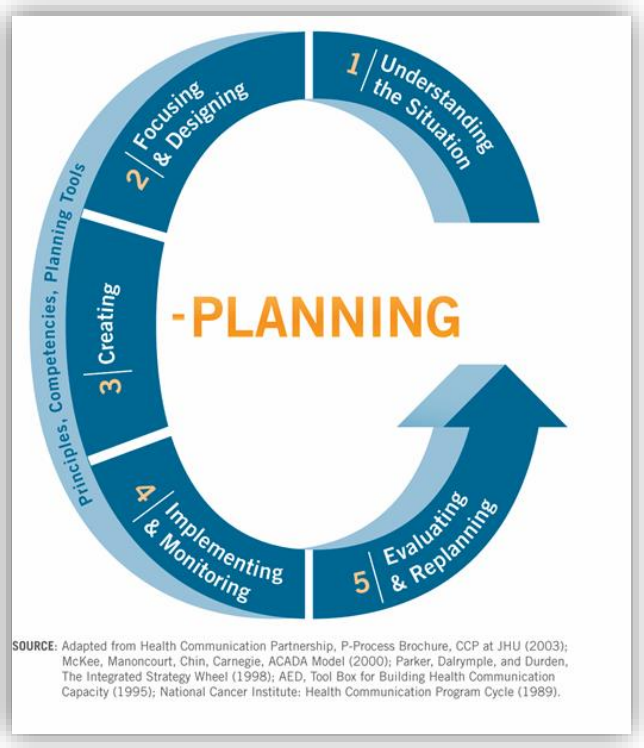
Annex: CHC Communication Plan

1. Purpose

The Communication Plan outlines the strategy and methodologies to be used for project communications, information distribution, feedback and stakeholder management, and how these will be managed during the life of project.

The Communication Plan is 1) shaped around Communication for Change (C-Change) C-Planning process for effective SBCC intervention design, implementation, and monitoring – summarized in the figure below – and 2) functions in tandem with the following project documents:

- The Implementation Plan for the Integrated OBULAMU Campaign
- Annual Project work plans
- The project monitoring, evaluation, and learning plan (MELP)



The Communication Plan aims to facilitate an interactive learning and adaptation structure that:

- Maximizes the opportunity for Communication for Healthy Communities to facilitate and support the attainment of the strategic objectives as outlined in the Cooperative Agreement with USAID (Co-AG) and position itself for supporting further plans.
- Collaborates effectively with the GOU and USG implementing partners in the core business of social and behavior change communication and assists collaborating partners in achieving performance objectives including linking demand and supply to improve uptake of health services;
- Is responsive to the challenges of supporting a diverse program delivery community and their geographical distribution;

- Ensures CHC technical skills base is known and recognized, with clear roles and a team resource that operates in a way that encourages direct interaction with collaborating partners and the project's field offices.

2. Communication plan objectives

The objectives of the CHC communication plan are:

- To share information and to create alignment within the program's three intermediate result areas
- To create alignment with collaborating stakeholders program goals
- To manage stakeholder information and expectations
- To maintain focus on learning and adaptation.

3. Scope

This plan covers:

- Stakeholder Management – mapping project stakeholders, and collaborative analysis of their requirements, and planning for their CS and TA needs
- Communication Planning - the communication and information needs of project stakeholders. Who needs what information, when, in what format, by what means and how to receive input and feedback and to create buy-in and ownership.
- Information Distribution - how information will be distributed to all stakeholders.

4. Assumptions

This communication plan is based on the following assumptions:

- Communication activity has already commenced with the early phases of the project
- Overall project outcomes and transition plans have been endorsed by Agreement Officer's Representative.
- This communication plan is available to all CHC staff.

5. Constraints

The anticipated constraints underlying this plan include:

- Time constraints for implementing partners to effectively collaborate in the communication process
- Managing donor and implementing partners' expectations of CHC, particularly with regard to facilitating increased utilization of health services.
- Current implementing partners' perceptions of the role of CHC as the partner with the budget for SBCC.

6. Communication Management

To support the Knowledge Management component to plan and manage communications the following staffing portfolios will be primarily responsible for implementation;

- Senior Advisor, Monitoring and Evaluation Research
- Deputy Chief of Party
- Senior Technical Advisor – Health Communication

- Knowledge Management Officer
- Monitoring and Evaluation Officer
- Regional Technical Officers

Informal communication is encouraged between CHC staff and implementing partners. Resources developed as part of the communication plan will be provided to all project staff in order to 1) maximize dissemination of consistent key messages and 2) develop a shared understanding of the way forward internally among CHC staff and externally with clients. If informal communication needs to be formalized it will be done in consultation with staff members above to ensure a consistent and planned approach for managing the communication. Consideration and reflection of the communication plan will be undertaken in quarterly review Liaison Team meetings and by the MER Unit.

7. Information Management

7.1. Meetings

- Implementation Committee meetings will be held every 4 weeks or as required to coincide with key milestones in the plan. Action notes will be kept of all meetings and distributed to meeting attendees and Regional Teams within three working days of the meeting completion.
- The MER unit will meet weekly.
- Ad hoc or special meetings may be held within the MER unit to flag key issues or activities that will impact success or progress. Decisions and actions from these meetings will be reported at the next Implementation committee meeting and included for monitoring
- Other meetings will align with the Communication Matrix.

7.2. Reports

A progress report enables the Implementation Committee and MER unit staff stay up-to-date on the progress of each component of the plan.

The Communication Matrix will be updated periodically for use during the Implementation Committee meetings. The aim is to provide activity progress updates. These updates may include progress against plans, future activities, new issues arising, changes required, and risk/issue identification.

7.3. Document Storage

Final versions will be located at: CHC server; cloud database and data visualization platform; and catalogued at the MoH Resource Centre with BCC WG Secretariat oversight.

7.4. Communication Mechanisms

Communication channels are the 'delivery mechanism' for sending messages to and receiving feedback from stakeholders. These may include, but are not limited to:

Face-to-face	Virtual	Others
Presentations (PPT or VIPP)	E-mail	Audio-visual materials
Workshops	Telephone/conference calls	FAQs
Business/Staff meetings	Intranet	Posters and flyers
Site intervention quality improvement visits	Extranet	Information packages
	Webpages/Dashboards	

7.5. Other mechanisms

Several other mechanisms may be utilized to assist with knowledge management. These include, but are not limited to:

- Posters in the Regional Offices, DHE, and BCC Secretariat
- What's New and News articles
- Community shows – to provide community feedback as well as deliver messages and services
- Brown bag meetings – internal to CHC
- Breakfast meetings - external with key stakeholders.
- Communication by the D-COP and OBULAMU Campaign manager with Activity Leaders, and Regional Offices.
- Technical assistance and/or capacity strengthening sessions scheduled for staff and IPs.

8. Stakeholder Management

8.1. Key Stakeholders

CHC communication plan recognizes a number of stakeholders:

Stakeholders	
• CHC senior management team	• Implementing partners – **national** – MOH HPED, UAC, IPs, BCC WG, Thematic Technical WGs
• Activity Leaders plus Finance office	• Implementing partners – **regional** – DHEs, IPs
• Central office staff and Regional offices	• Local Communities
• Media	• External reviewers/evaluators

8.2. Feedback Mechanisms

Feedback is the key to ensure and measure the ongoing effectiveness of communications. By monitoring and responding to feedback regularly, communications can continue to address the needs and concerns of key stakeholders.

Feedback monitoring mechanisms will include:

- Direct feedback – face to face communications will provide an opportunity for the audience to give feedback directly to the communicators identified in the communication matrix
- Formal feedback – formal communication may be managed directly by Senior Management or Activity Leaders.
- Informal feedback – informal feedback will be obtained via word of mouth through staff on field activities or during workshops.

8.3. Measures of Success

Success will be measured through these questions

- Is the communicated information relevant?
- Does the information support broader CHC and collaborators' objectives?
- Are we effectively managing stakeholder expectations? Are we encouraging and responding to feedback?
- Is the frequency of communication appropriate to the needs of the intended audience?

COMMUNICATION AND LEARNING MATRIX

Audience	Vehicle	Frequency	Source	Responsibility	When/Dates	Expect
Internal CHC Staff	Meetings Email/Phone Updates template	Weekly	• Quarterly Work Plan • OBULAMU implementation guides	Activity leaders	• Every Monday (meetings) • Every Friday (weekly reports)	Progress activities
AOR	Written Briefs	Weekly	Quarterly Work Plan	COP	Every Friday of the week	AOR equ about CH activities
Collaborators	BCC WG meetings TWG meetings	By meeting calendar and on ad-hoc basis determined by emerging TA needs	TORs/ Annual Activity Calendar Activity Concept papers	• BCC – CHC Capacity Strengthening Officer • TWGs – CHC National Technical Assistance Coordinators	• At least bi-monthly based on activity calendar • Within 2 weeks of completion of a collaborative exercise e.g. participatory research	• Partne consul engage planni review • Excha eviden partne CHC) activit
Activity leaders	Progress review meetings	Monthly	Annual Work Plan Co-Ag. contract	CHC Monitoring and Evaluation Research Unit (CHC MER)	Half day event every 4th week of the month	• Teams activit RAG • Teams lesson strateg findin activit • Also s Data Assess
CHC staff	Progress review workshops	Quarterly and Annual	Annual Work Plan Co-Ag. contract	CHC MER and Chief of Party (COP)	2-day event held every final week in the 2nd month of a given activity quarter	• Teams activit • Teams mecha expedi • Teams targets quarte
USAID	Progress reporting templates Presentations (upon USAID request)	Quarterly and Annual Semi-annual for PEPFAR reporting (on request)	Annual Work Plan Co-Ag. contract	CHC MER and COP	Every quarter	USAID u progress Any revi addresse
Collaborators	SAME AS FOR ROUTINE UPDATES	SAME AS FOR ROUTINE UPDATES	SAME AS FOR ROUTINE UPDATES	SAME AS FOR ROUTINE UPDATES	SAME AS FOR ROUTINE UPDATES	SAME A ROUTIN
All (CHC/ MOH/ IPs/ USAID)	• Dissemination workshops	• Semi-annual (regional) • Annual (National)	• Annual work plan	Activity Leaders and CHC MER	• *Semi-annual dissemination*: Every June/July and	• *Dissem* --Colla learnir

USAID | UGANDA
FROM THE AMERICAN PEOPLE

COMMUNICATION AND LEARNING MATRIX

n	Audience	Vehicle	Frequency	Source	Responsibility	When/Dates	Expect
		• CHC webpage/website • CHC newsletter • CHC data visualization dashboard with extranet functions to allow partner sharing of knowledge	• Websites/data dashboards available throughout and consistently updated with new knowledge products	• BCC WG/TWG Calendars		February/March per dates secured with DHEs • *Annual dissemination*: Every November/ December per date secured with BCC WG and USAID • *Virtual dissemination mechanisms*: Just a click away where there is internet	dissem interp perfor --Con forwa shared • *Virtua* Contir of up inform learne learnir adapta
	All (CHC/ MOH/ IPs/ USAID)	Closeout dissemination events (regional and national)	One by region and one national	Co-Ag contract	COP and FHI 360 Country Director	At closeout per dates secured with USAID and MOH	Review o against o way forw
BD based on emerging needs							

Annexes:

Routine Monitoring and data collection tools

Communication for Healthy Communities (CHC)

APRIL 2015

Introduction

Communication for Healthy Communities (CHC) is a 5-year, USAID funded project whose goal is to support Government of Uganda and partners to design and implement quality health communication interventions that contribute to reduction in HIV Infections, total fertility, maternal & child mortality, malnutrition, malaria & tuberculosis. To achieve this, the project uses innovative health communication (HC) approaches, capacity strengthening, increased collaboration among partners, and rigorous research and knowledge management for health communication.

CHC envisages having a robust learning agenda that includes: 1) rigorous outcome and impact evaluation to measure the effectiveness of interventions implemented at scale; 2) implementation science to identify and overcome key implementation errors and barriers to translating evidence-based findings into common practice; and 3) a knowledge management strategy to disseminate and maximize the learning and application of scientific evidence to benefit program implementers and effective HC design, as well as the health of Ugandans as a whole.

To ensure a robust learning agenda and evidence based approach, CHC will follow the Monitoring, Evaluation and Learning Plan (MELP), the OBULAMU? Roll-out Plan and the Annual Workplans with specific focus on the Indicators and areas of learning.
The data collection tools highlighted in this document reflect the data required for the indicators in the CHC documents that measure progress.

Reference Documents
To measure CHC Project progress against the set targets, the following reference documents are pertinent;

1) Annual Workplan
2) OBULAMU Implementation Guide
3) Award Proposal
4) Monitoring, Evaluation and Learning Plan (MELP)
5) PEPFAR SIMS Guide

Routine Data collection tools
Drawing from the reference documents above, this manual presents data collection tools that will be used for CHC routine data collection to measure project progress against set targets. The following tools are presented herein;

1. Intervention Tracking tool
2. Mapping tool
3. Support supervision tool (Quality improvement checklist)
4. Quarterly reporting template
5. Weekly and Monthly reporting template
6. Materials distribution tool
7. Pre-post test tools (By activity)
8. Pre-test guide
9. Success story template
10. Snapshot stories template and guide
11. Listening surveys template
12. OBULAMU Community shows template
13. Capacity Strengthening Activity Reporting form
14. OBULAMU Activity Report form
15. OBULAMU Community Show Request Form
16. Registration form

MAPPING TOOL

CHC Summary Template for Audit of HC: RTO/RCO version

Region e.g. Karamoja, West Nile etc., _____

Thematic/Health area	**Name of Implementing Partner** (N.B: not limited to USG IPs)	**Name of Campaign/ HC activity**	**Target audience(s)**	**Name of District(s) HC activity is implemented in <u>AND</u> partner organizations (**if any**)**	**Type of IEC/BCC material or job aide** e.g. poster, radio spot, flip chart, etc	**Key message(s)** i.e. What is the take home message)?	**Channels used** e.g. radio, TV, community dialogue etc.,	**What gender/ social norm issues does the HCactivity cover (**if any**)?**	**List source(s) of data that inform HC activity (**if any**)**
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									

Summary/Key highlights Report outline:

1. Based on meeting with DHTs and IPs, provide a brief description of region
    a. Districts/sub-districts visited
    b. Priority health issues (DHT, IPs)
    c. Priority messages (DHT, IPs)
    d. Implementing partners and collaborators
        i. Who is doing what (health area, target group), where (geographic coverage), and with whom?
        ii. Collaboration and coordination – what is the role of the DHT in reality? What capacity strengthening needs do you foresee?

2. Current status of SBCC/HC
    a. Materials – availability, relevance, source(s) etc
    b. Channels used
        i. Most common (why)
        ii. Less common (why)
    c. HC development and implementation skills
    d. Noted strengths, weaknesses, opportunities
    e. What are the areas CHC interventions could provide impact? E.g.
        i. Capacity strengthening (for whom and in what?)
        ii. Health area with little HC attention (what health area, why the current status of things?) etc
    f. Consideration of gender and social norms issues in HC campaigns/ activities?
        i. Who is doing it?
        ii. What gender/ social norms issue is it?
    g. Any monitoring and evaluation activities?

3. Overall reflection of the above in view of CHC workplan
    a. What may we want to reconsider in view of the overall workplan?
    b. What are the key issues to consider in terms of the integrated intervention design/roll-out?

Appendices: The completed tables above.

SUPPORT SUPERVISION TOOL (QUALITY IMPROVEMENT CHECKLIST)

Monitor intervention roll-out for fidelity, quality, and coverage to inform mid-course review of the intervention and rollout as may be appropriate. Process to include i) intervention cost tracking ii) FGDs, KIIs, and social network analysis with selected audiences, iii) IP site visits and TA to take a pulse of the quality[22] of implementation, and iv) routine M&E and research analysis.

QUALITY IMPROVEMENT CHECKLISTS	QUALITY ELEMENTS TO BE ASSESSED DURING SITE APPRAISAL VISITS
1. QI Checklist for Planning and Design	To what extent staff/IPs translate integrated HC to fit the local context: • Contextual data i.e Health demographic and health service data (UDHS, District population data, Partner service data, HMIS) collected and used to inform HC • Implementation based on clear targets for uptake of recommended health behaviors and health services (ITN use, use of FP, HTC and Circumcision)? • Target audiences identified and segmented based on data and District targets? • Key determinants of behavior stated i.e: barriers (gender and cultural norms, lack of partner/social support), motivations
2. QI Checklist for Implementation	**Mass media:** • Use of multiple channels; TV, radio, print media • Have they been used and what components have been used • HC implemented to influence different levels (individual, family/interpersonal, community/environmental)? **IPC (Champions):** • Champions oriented on the campaign, • Are champions conversant with health topics and they are able to talk about the issues • Are champions equipped with necessary tools • Do they have forums for feedback **Community shows:** • Champions involved in the planning, • Are they targeted by IP and health issues, • Are they owned by the community through village organizing committees (VOC) • Support supervision/monitoring • Reporting data to health facilities – health assistant – DHE • RO, IPs and VHTs to track and document service uptake at a health facility after the community shows (is there drop or increase) **General issues** • Use of multiple communication strategies and channels to reach the target audience? • HC implemented to influence different levels (individual, family/interpersonal, community/environmental)? • Periodic reviews of HC approaches and materials to ensure they are evolving and relevant to the context and realities? (DHT issues – do they present the CHC agenda, do they use the data for learning and decision making)

[22]Among other tested and proven tools, CHC is in the process of adapting C-Change SBCC Quality Assessment Tool to align with the recently completed CHC integrated HC strategy. Originally developed for HIV/AIDS programs, the Quality Assessment/Improvement tool adapted above is amenable to adaptation for a wide range of public health topics including HIV/AIDS, malaria, family planning, and sexual and reproductive health. The tool can be deployed for varied purposes including 1) Quality assessment to determine existing technical capacity and critical gaps and needs, and to determine new standards of quality in providing SBCC, 2) monitoring and evaluation to identify areas for improvement and make short and long-term corrections on SBCC programming, 3) Training resource for organizations to develop an internal systematic approach to improving their technical capacity in SBCC, and 4) advocacy to highlight the gaps and needs of organizations that implement SBCC work.

<table>
<tr><td></td><td>

Are IPC materials and tools (e.g. manuals, flip charts, counselling cards, scripts) available to staff/providers/champions to support HC?
Are strategic partnerships developed and joint strategies for linking them negotiated? (how are they using resources together- leveraging, joint planning, representation i.e DHE representing CHC in meetings)
Interventions addressing underlying structural factors such as social and gender norms, access to services, etc?

</td></tr>
<tr><td>3. QI Checklist for Monitoring and Evaluation</td><td>

Are there monitoring tools to track HC outputs?
Indicators defined to measure changes in targeted behaviors (e.g. numbers who use bed nets every night, numbers who have used condoms)?
Does the VHT have targets?
What is the community saying about the messages during VHT reviews?
Interventions addressing underlying structural factors such as social and gender norms, access to services, etc?
Is monitoring data analysed and fed back to HC team?
Is monitoring data used to improve HC and program implementation in general?
Are results communicated to key stakeholders?
Are lessons learned and best practices systematically documented and disseminated?

NB: Programme team to demonstrate that data has been used for learning and decision making
</td></tr>
<tr><td>4. QI Checklist for Support and Observational Visits</td><td>
Frequent supervisory visits to HC implementers is critical for quality.

Does structure of the program allow technical supervisors to visit HC implementers at least bi-monthly?
(To be guided by the data – HMIS, have key deliverables – visit health facility, interact with champions and VOC, visit opinion leaders like boda-boda chairman, talk to the community members to get what they feel, move along with DHE and HA). This will also address other issues below;
Is the supervisory visit inclusive of 1) office meetings with BCC staff, 2) site visits and observation to identify strengths and weaknesses, and needs for further support?
Is there a supervisory checklist to guide supervisory visits? Does it include indicators related to HC delivery?

</td></tr>
<tr><td>Form to document Agreed Actionable Recommendations</td><td>
<table>
<tr><th>Agreed doable actions/ recommendation</th><th>Responsible Organization/ Person</th><th>Action Period/ Deadlines</th></tr>
<tr><td>• …
• …</td><td>• …
• …</td><td>• …
• …</td></tr>
</table>
</td></tr>
</table>

QUARTERLY REPORTING TEMPLATE

INTRODUCTION

An introduction of CHC and the three intermediate results.

SUMMARY OF ACHIEVEMENTS THIS QUARTER

Highlights the outstanding achievements during the reporting period.

-

PROGRAM COMPONENTS AND ACTIVITIES

Intermediate Result 1: High quality health communication interventions designed and implemented

1.1 Support on-going health communication campaigns and provide technical assistance to USG IPs
Organizations Involved:
Activities Planned: •
Activities accomplished: •
***Comments/ Challenges*:** •
Lessons learnt •
Plans for the next quarter (state reporting period): •

EXAMPLE

1.2.1 Orient OBULAMU Campaign Champions at community level in the integrated platform, materials and toolkits to link supply- and demand side-communication
Organizations Involved: FHI 360, MOH and USG IPs
Activities Planned: • Prepare for Campaign Champions orientation by finalizing the adaptation, field testing, translation and production of a set of tools supporting community dialogue and elements of the C-Change Community Conversation Toolkit (CCT) • Collaborate with USG IPs and DHEs to brief/orient selected champions on IPC, as well as dissemination and orientation on the use of HC materials and job aides • Work with USG IPs to update the champion's database with additional champions who will include; peers and key influencers for each audience life stage, KPs influencers and peers, opinion leaders at water collection points, markets, stalls, farmers' groups

Activities accomplished:

- **Initiated preparations for champions orientation:** Preparatory content and/or materials for orienting OBULAMU campaign champions countrywide was pursued as follows:
    - Finalized the field testing and production of champion's tools which include; (i) the OBULAMU champion's checklist, (ii) champion's conversation guide, (iii) champion's values clarification sheet (iv) champion's dialogue feedback tool (v) champion's code of conduct and (vi) champion's referral form.
    - Introduced the various tools to national TWGs stipulated in activity 1.1 and to a total of 58 IP representatives and 69 DHEs during the OBULAMU orientation and campaign rollout workshops in December 2014 *(See activity 1.2.4 below)*.
- **Collaborated with MOH/IPs towards Champions orientation:** Initiated activities towards orientation of Champions by orienting a total of 58 IPs (plus USG IPs) and 69 DHEs through Training of Trainers (TOTs) countrywide on OBULAMU campaign *(see activity 1.2.4.)* for collaborative orientation of champions in Quarter Two.
- **Updated the champions database:** In preparation for champions orientation and campaign rollout, CHC worked with various USG IPs to update the champions database from the previous 5,400 to 7,825. Significantly, the champion's database was updated with an additional 1,400 KP champions (fisher folks, SWs, UPDF, MSM and truckers), and 1,025 peer leaders who will be instrumental in facilitating conversations and referral to services among target groups throughout the campaign rollout phase.

Region	No of champions
Central	1,504
Northern	1,413
Western	620
West Nile	783
South West	890
Eastern	1,299
Karamoja	1,316
TOTAL	**7,825**

***Comments/ Challenges*:**

- N/A

Lessons learnt

- N/A

Plans for the next quarter, January - March 2015:

- Collaborate with USG IPs and DHEs to brief/orient selected champions on IPC, as well as dissemination and orientation on the use of HC materials and job aides
- Continue to update the champion's database with additional champions to further deepen the reach of health communication
- Utilize existing champion's feedback mechanism that USG IPs currently use to ensure supervision and monitoring of the quality of OBULAMU Champion activities (including; quarterly meetings, support supervision visits, activity implementation visits, telephone calls and SMS)

- Work with USG IPs to establish criteria for identifying and rewarding the best performing campaign champions, and based on performance monitoring data, develop a mechanism for recognizing and celebrating outstanding champions

ANNEX A: FINANCIAL REPORT

ANNEX B: SNAPSHOTS

WEEKLY AND MONTHLY REPORTING (CHC Regional Activity Highlights/ Progress Reports)

Region:.....

Reporting Period:		**Overview of partners supported and specific TA areas:**	**Prepared by:**	
Report ID: Only one ID to be selected at any time	Weekly Report: ☐ Monthly Report: ☐		**Date prepared:**	
RAG Status* See bottom of page			**Date submitted to supervisor:**	

Key Activities Initially Planned for this reporting period	Delivery Date	**Key Deliverables Attained for this reporting period**	**Key Deliverables Outstanding/pending for this reporting period**	Delivery Date

Comments on the level of achievements i.e. what are the take home lessons? Include an assessment of the impact and any actions taken Actions to mitigate similar challenges

What facilitated success?	**What were the challenges?**	**Actions in place to manage similar challenges in the future**

Planned deliverables for the next reporting period

Specific Activities Planned (Plus deliverables outstanding: see previous period)	Delivery Date	**Expected Outputs/ Outcomes** (Link this with the work plan)	Delivery Date	**Support need from SMT** (specify SMT)

* RED	"Major concern" – State specifics: Deliverables overly delayed. Quality severely compromised. Corrective Action/intervention urgently needed.
AMBER	"Medium concern" – Situation being actively managed (by whom?) Remedial plan in place (from what source?).
GREEN	"Normal level of attention" - No additional attention needed. Maintenance of gains/ achievements. Lessons learned documented.
SUBMIT WITH ALL RELEVANT ANNEXES e.g. Activity reports from workshops, materials distribution, meetings etc	

BCC – IEC MATERIALS DISTRIBUTION AND DISSEMINATION TOOL

Intervention Area (Please tick appropriately)

[ ] HIV [ ] MALARIA [ ] MCH [ ] NUTRITION [ ] TB [ ] FAMILY PLANNING [ ] OTHER (Specify)……

Date of Issue	Name of Organization	Type of Material	Prompted/ Non Prompted	Quantity (Pcs)	Recipient NAME & Signature	Recipient Job Title	CHC staff issuing	Remarks

Batch #: …..e.g. 1 of 1…… **CHC Officer Compiling:** …… **Signature**:…… **Date** ……..

NB: Batch #: How many forms are you submitting in the Consolidated Batch of Date X? If only one form in the batch enter 1 of 1; If two; enter 1 of 2 in the first, and 2 of 2 in the second one etc.

Please also note: Entries to the cells in the Table may be done by different staff depending on who is issuing. However, the final compilation (see Batch # section) is by one person who is putting everything together

PRE-POST TEST
OBULAMU VHT Orientation for LIFE STAGE 1

1. **What do you know about OBULAMU campaign?**

☐ It is a greeting

☐ It's about examining/checking our lives

☐ It's a MOH led health communication program supporting other partners

☐ I have heard about the campaign but do not have clear information

☐ Not aware of the OBULAMU campaign

☐ None

☐ **OTHER**: please specify: _____

2. **What is your role in the OBULAMU Campaign?**

☐ Meet people in their homes and community to discuss health issues

☐ Refer people to health services

☐ Follow up clients referred to health facilities

☐ Provide health information that address negative practices and norms

☐ None

☐ **OTHER**: (specify) _____

3. **What tools do you have to do your work?**

☐ Planning Checklist

☐ Client Referral tool

☐ Reporting tool

☐ Code of conduct

☐ Handbook

☐ Conversation guide

☐ None

☐ **OTHER**: (specify) _____

4. What are some of the things I consider when interacting with my clients?

☐ Beliefs

☐ Gender/Sex

☐ Culture

☐ Religion

☐ Looks/Physical Appearance

☐ Social status

☐ HIV/Status

☐ None

☐ **OTHER**: (specify) _____

SOP for PRE-TEST GUIDE (Guides for Testing Materials and Concepts)

Put pre-test instruction/guide (let this be in the sop – annex)

From the C-Planning Cycle/ Process step 3 materials development and testing

Introduction Language

Good Morning/Afternoon. Thank you for your interest in participating in this discussion. My name is …… and my colleague is ……. We work with Heritage Communications and we are here on behalf of FHI 360 to have a short discussion with you.

We have come with some materials/messages that we want you to look at after which we will ask you a few questions to guide a discussion. We are therefore here to find out how you feel about the materials/messages so as to establish whether they communicate clearly, are easy to understand, acceptable in your community and also record your suggestions for improving on them. We anticipate that the discussion will take about one and a half hours. Remember there are no 'wrong' answers but we just want to get your opinion on the materials/messages. We will also audio record the discussion that you are going to participate in and we would also like to take a few photographs if it is okay with you. We assure you that your opinions and the photographs will not be shared with anyone other than people working on this project and your names will not be included in the activity report.

May I record the discussion/take photographs? ..... (Yes...../No.....)

Questions for Posters

Show One Poster at a time and lead the discussion using the following questions

1. What is happening in this poster? Probe; what do you think they are doing in the poster?
2. Does the poster grab your attention? What grabbed your attention about the poster? Would it grab the attention of other people like you?
3. What are the key messages in the material?
4. What do you think you are being asked to do in this poster?
5. Does the poster actually encourage you to go ahead and do what is being require of you? Probe: what in this poster encourages you?
6. Is the language used in the material clear to you? Are there any phrases or words that you do not understand? Probe: Which ones are those? How can they be corrected?
7. Who do you think is this material meant for? **Probe:** Please describe the person/people you think the material is meant for and why?
8. Are the messages in the poster believable or credible?
9. I there anything offensive/confusing in the material? What is it? How can it be corrected?
10. Is there any other suggestion you have on how the material can be improved?
11. What is the likelihood that you pay attention to this poster?
12. Where do you think this material should be distributed from for the people whom it is targeting? Probe; why these places suggested?

NB: **Remember to ask the above questions for each of the posters.**

Questions for Radio spots

Play one radio spot at a time and lead the discussion using the following questions

1. What is happening in the radio spot that you just heard? Probe: What are the messages in the radio spot?
2. How did the radio spot make you feel?
3. What do you think you are being asked to do in the radio spot?
4. Does the spot actually encourage you to go ahead and do what is being required of you? Probe: What in the radio spot encourages you?
5. Does it grab your attention? What grabbed your attention about the radio spot?
6. Is the language used in the radio spot clear to you? Are there any phrases or words that you do not understand? Probe: Which ones are those? How can they be corrected?
7. Who do you think the messages in the radio spot are meant for? Probe: Please describe the person you think the messages are meant for and why?
8. Are the messages in the radio spot believable or credible?
9. I there anything offensive/confusing in the radio spot? What is it? How can it be corrected?
10. Is there any other suggestion you have on how the radio spot can be improved?

TVC's

Play one TVC at a time for the participants before asking the following questions

Questions for the TVC's

1. What is happening in this Television spot?
2. What is/are the main messages of the spot?
3. Is there anything the spot is telling you to do? If yes, what?
4. Who is this Television spot for? Describe the person.
5. Is there anything unclear in the Television spot? If so, what?
6. Is there anything offensive in the Television spot? If so, what?
7. How did the Television spot make you feel? (E.g. Happy, sad, worried, angry, afraid) NOTE: Please note how the participants reacted___ did they laugh; shake their heads in disbelief etc?
8. How can we improve this Television spot?

NB: Remember to ask the above questions for each of the TVC

Brochures

Allow the participants enough time to read through the material and then lead a discussion using the following Questions

9. What is happening in this brochure? Probe; what do you think they are doing in the brochure?
10. Does the brochure grab your attention? What grabbed your attention about the
11. What are the key messages in the brochure?
12. What do you think you are being asked to do in this brochure?
13. Does the brochure actually encourage you to go ahead and do what is being required of you? Probe: what in this brochure encourages you?
14. Is the language used in the material clear to you? Are there any phrases or words that you do not understand? Probe: Which ones are those? How can they be corrected?
15. Who do you think is this material meant for? **Probe:** Please describe the person/people you think the material is meant for and why?
16. Are the messages in the brochure believable or credible?
17. I there anything offensive/confusing in the material? What is it? How can it be corrected?

10. What is the likelihood that you pay attention to this poster?
11. Is there any other suggestion you have on how the material can be improved?
12. Where do you think this material should be distributed from for the people whom it is targeting? **Probe;** why these places suggested?

Questions for the Midwives Calendar

Allow the Health Worker time to read through the material and then lead a discussion using the following Questions

Content

1. What is this calendar about? (General description)
2. What are the main messages being put across on the calendar?
    a. Are these messages accurate/ correct? (Yes/No & Why/Why Not respectively)
    b. Are these messages convincing enough for you to take action/ adopt the recommended actions?

Usability

3. As a midwife, how do you intend to utilize this calendar? (Probe; the various purposes that the calendar can serve)
    a. Where do you intend to display this calendar? (Probe; the various areas they will display it, where they think it will be effective if displayed, etc)

Attitude & Preferences

4. How does this calendar make you feel as a midwife?
    a. Do you like it? What exactly do you like and why?

b. Is there anything you dislike about it? What and why?

c. Why would you prefer this calendar to the normal/ usual calendars?

Target Audience

5. To whom do you think this kind of calendar is addressed to/ meant for? Why that kind/category of person?

Improvements

6. What do you think can me changed or added to make this calendar communicate the messages better, and appeal to its user more?

Questions for the Lover's Pass

Allow the participants enough time to read through the material and then lead a discussion using the following Questions

General Question: In your own way/words, how would you describe this "pass"?

Content

1. What is this pass about? (General description)
2. What are the main messages being put across in the pass?
    a. Are these messages accurate/ correct? (Yes/No & Why/Why Not respectively)
    b. Are these messages convincing enough for you to take action/ adopt the recommended actions?

Usability

3. How do you intend to utilize this purse? / Or, What will you use it for? (Probe; the various purposes that the pass may serve) (E.g. can it be given as a gift, can it be kept as a memoir, etc…)
    a. Where do you intend to keep this pass? (Probe; the most likely point of storage from where one can easily access it)
    b. What can one do to ensure that they have this pass most of the time?

Attitude & Preferences

4. How does this pass make you feel?
    a. Do you like it? What exactly do you like and why?
    b. Is there anything you dislike about it? What and why? (Could be something offensive, etc…)
    c. What do you find unique about this pass, if any? Why?

Target Audience

5. To whom do you think this pass is addressed to/ meant for? Why that kind/category of person?

Improvements

6. What do you think can me changed or added to make this pass communicate the messages better, and appeal to its user more?
7. What do you think needs to be done to make other people like you appreciate and use this pass

Success Story Template

Each section is followed by a self-check which outlines criteria relevant to that section

1. TITLE OF THE SUCCESS STORY (should be attention grabbing, yet meaningful**)**

SELF-CHECK – Has your suggested title:

- ☐ Captured the overall message of the story?
- ☐ Included an action verb?
- ☐ Captured the reader's attention?

2. OVERVIEW OF THE PROBLEM/ CHALLENGE:

SELF-CHECK – Has the overview:

- ☐ Described the problem being addressed and why it is important?
- ☐ Incorporated data to frame the problem, including e.g. health burden, economic costs?
- ☐ Specified the affected population(s) groups?

3. ACTIVITY DESCRIPTION

SELF-CHECK – Has the description of the activity:

- ☐ Identified WHO was involved, including relevant partners (MoH, IPs)?
- ☐ Illustrated WHAT was implemented, WHERE and WHEN, plus HOW the problem was addressed?
- ☐ Identified the target audience of the activity?
- ☐ Described HOW progress of the activity is evaluated (i.e. how was success determined)?

☐ Stated HOW (and WHAT) the involvement of CHC contributed to the program/activity?

4. ACTIVITY OUTCOMES:

SELF-CHECK – Has the outcomes section:

☐ Reflected short-term or intermediate outcomes that demonstrate HOW the activity addressed a problem (e.g., used to inform policy process, use of HC Strategy, change in household-level behaviors, communities demanding quality health services, etc.)?

☐ Provided a conclusion devoid of broad, sweeping statements such as "There was a noticeable increase in healthy eating habits"?

5. STORY CONCLUSION:

SELF-CHECK – Has the conclusion of the success story:

☐ Summarized the problem, activity, and outcomes?

---

6. CHECK ANY ITEM THAT YOU ARE SUBMITTING TO COMPLEMENT YOUR STORY:

☐ Testimonials
☐ Quote from Partner/Participant
☐ Sample of Materials Produced
☐ Photo(s) from the activity
☐ Press Release
☐ Promotional Materials
☐ Video/Audio Clip
☐ Other (Specify: _____)

7. CONTACT INFORMATION:

Name:
Title:
Organization:
Phone:
E-mail:

Name:
Title:
Organization:
Phone:
E-mail:

8. DOES CHC HAVE PERMISSION TO SHARE THIS SUCCESS STORY? ☐ Yes ☐ No

9. DOES CHC HAVE PERMISSION TO SHARE PHOTOS? ☐ Yes ☐ No

10. CHC STAFF SUBMITTING STORY: _____ REGION _____ DATE __/__/____/

11. Overall Style Reminders

- ☐ Keep paragraphs short – no more than 5-6 sentences.
- ☐ Avoid passive voice (e.g., "Trainings were provided."). Use active voice (e.g., "X partner provided Y trainings.").
- ☐ Include direct quotes IF THEY ADD VALUE.
- ☐ If you MUST use acronyms, spell them out on first mention.
- ☐ Avoid jargon. You don't want readers to skip over any content.
- ☐ Keep messages simple and concise.
- ☐ Avoid broad, sweeping statements (e.g., "There was a noticeable increase in healthy eating habits" or "A significant amount of money was saved").

Adapted from CDC/DASH success story template. http://www.cdc.gov/healthyyouth/stories/pdf/success_story_template.doc
DD 20Jan2014

LISTENING SURVEY GUIDE

The following will guide documentation of ideas from the listening survey on OBULAMU Campaign.

1. **What** is being said about OBULAMU Campaign?
2. **Where** is it being said?
3. **Who** is saying it?
4: **OPTIONAL**: Any idea about what may have triggered the conversation? This is optional because if you are just listening in, and not directly part of the conversation, you may not know how or why the conversation was started.

Listening survey Template

WHAT	WHO	WHERE	IDEAS ON WHAT TRIGGERED THE CONVERSATION (Optional)

Snapshot Stories Guide

Snapshots are photographs that capture a moment in time.

There are stories behind every scene, person and situation in a photograph – why the picture was taken, who took it, how someone ended up in a particular place, what they were thinking and feeling…

To write a good snapshot story one needs to consider the following:

- Who is in the picture?
- Where are they and why?
- How are they feeling or thinking?
- What will they talk to you about when you meet them?

Always use your imagination and look at this picture carefully. Consider, what story does it tell? Your challenge is to translate the photo-story into words.

Snapshot story: Example

Look at this picture carefully. What story does it tell? Your challenge is to translate the photo-story into words. Use the questions below to get started… and don't forget to use your imagination!

A photograph from the Samuel Butler Collection

What are these people doing and where are they?

How do they know each other? Are they having a good time?

Who is the girl at the front waving to?

What is the man at the back thinking about?

OBULAMU COMMUNITY SHOWS – DATA COLLECTION TOOLS

DATE: ……..

REGION | **SUB-COUNTY/PARISH** | **DISTRICT**

IMPLEMENTING PARTNER: ……

THEMATIC AREAS/ SERVICES OFFERED		NO REACHED PREVIOUS (QUARTER)			NO CURRENTLY REACHED			COMMENTS/OBSERVATIONS
		MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	
HIV/AIDS	*NEW POSITIVES (1ST TIME TESTERS)*							
	OLD POSITIVES (REPEAT TESTERS)							
	NEW NEGATIVES (1st Time)							
	OLD NEGATIVES (Repeat)							
TB	*NUMBER SCREENED*							
	SUSPECTED +VE							
FAMILY PLANNING	*IUD*							
	IMPLANT							
	PILLS							
	DEPO							
	CONDOM SALES							
	VASECTOMY							

THEMATIC AREAS/ SERVICES OFFERED			NO REACHED PREVIOUS (QUARTER)			NO CURRENTLY REACHED			COMMENTS/OBSERVATIONS
			MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	
	TUBALLIGATION								
MALARIA	*LLIN*								
	DIAGNOSIS & TREATMENT								
	IRS								
MCH	*EXCLUSIVE BREAD FEEDING*								
	IMMUNIZATION								
	ANC	*1st ANC Visit*							
		2nd ANC Visit							
		3rd ANC Visit							
		4th ANC Visit							
	DELIVERY AT HF								
	IPTp	*IPTp1*							
		IPTp2							
	NUTRITION								
	LLIN	*Pregnant Women*							

THEMATIC AREAS/ SERVICES OFFERED			NO REACHED PREVIOUS (QUARTER)			NO CURRENTLY REACHED			COMMENTS/OBSERVATIONS
			MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	
		Children <5							
NUMBER OF REFERRALS	*HTC*								
	SUSPECTED TB +VE *REFERRED FOR TESTING*								
	Emtct								
	SMC								
	ART								
	FP								

NB: ***Enter data for the respective health areas that the specific IPs focus on and indicate not applicable (N/A) to the ones which don't apply***

OTHERS (MENTION):

INTER-PERSONAL COMMUNICATION (IPC) BY OBULAMU CHAMPIONS DURING THE COMMUNITY SHOWS

REPORTING PERIOD: ……..

IPC AGENT/CHAMPION	THEMATIC AREA/SERVICE	NO OF PEOPLE REACHED			KEY ISSUES DISCUSSED	MATERIALS DISTRIBUTED BY AGENT	COMMENTS/OBSERVATIONS
		MALE	FEMALE	TOTAL			

CHC CAPACITY STRENGTHENING ACTIVITY REPORTING FORM

# CS Activity Days __/__/	# Participants:	# Female
		# Male
Activity dates: __/__/_____ TO _/__/_____	Date documented: __/__/_____	
Geographical location CS took place in _____	Staff documenting:_____	

1. Type of Capacity Strengthening Activity

☐ Training	☐ Orientation
☐ TA	☐ Meeting
☐ Mentoring	☐ Other

☐ Participatory Facilitation Skills **Briefly Specify**:	☐ Website management **Briefly Specify**:
☐ Master Trainer Training **Briefly Specify**:	☐ Use of online HC map webpage platform **Briefly Specify**:
☐ Participatory needs assessment methodologies **Briefly Specify**: Action media to explore poor ART adherence	☐ Community of Practice Facilitation **Briefly Specify**:
☐ Research and evaluation methodologies **Briefly Specify**:	☐ Knowledge Management **Briefly Specify**:
☐ SBCC design and implementation **Briefly specify**:	☐ Community mobilization/facilitation **Briefly Specify**:

☐ Use of implementation guides **Briefly Specify**:	☐ SBCC event planning **Briefly Specify**:
☐ Other **Briefly Specify**:	

2. Was this CS any of the following?

3. Type of Partners involved: (can be more than one type per event)

☐ National Government **List**:	☐ Local Faith Based **List**:
☐ Sub-National Government **List**:	☐ Clinic/Health Center **List**:
☐ USAID **List**:	☐ Media/Journalists **List**:
☐ International NGO **List**:	☐ Local University: **List**:
☐ Local NGO/CBO **List**:	☐ Other: **List**:

4. Pre/post tests used? (check): ☐ YES/ ☐ NO

# Participants taking pre-test	# Female
	# Male
# Participants with improved post test	# Female
	# Male

5. Assignments e.g. to Develop a Strategic Plan, Action Plan, M&E Plan etc? (check) ☐ YES/ ☐ NO.

Specify assignment: _____

# Participants undertaking assignment	# Female
	# Male
# Participants with improved post test review of assignment	# Female
	# Male

OBULAMU ACTIVITY REPORT FORM

Name of Activity: _____ **Date:** _____

Region: _____ **District:** _____ **Venue:** _____

Name of CHC Staff Involved:

(1) _____

(2) _____

(2) _____

Objectives of the Activity

(1) _____

(2) _____

(3) _____

Brief Description of the Activity:

Names of IPs Involved including Districts & Champions

Name of Implementing Partner	No. of Staff/ Personnel Involved	Specific Roles

Resources used in the Activity e.g. IEC Materials, Financial Resources etc.

Resources	Contributing Partner	No/ Amount of Resources

Key Accomplishments from the Activity

(1) _____

(2) _____

(3) _____

Number of People Reached by the Activity

Audience Category	No of Males	No of Females	Total No. Reached
Total			

Challenges Encountered in Implementation

Challenges Encountered	Proposed Solutions during Future Activities

Key Learnings

(1) _____

(2) _____

(3) _____

Action Points from the Activity (if applicable)

Action Point	Responsible Party	Deadline

Other Observations:

N.B Please attach captioned photos and quotations, attendance sheets, OBULAMU community show data collection form

OBULAMU COMMUNITY SHOW REQUEST FORM

Region: _____ Implementing Partner: _____

Proposed Thematic/ Focus Area: _____

District: _____Proposed Sub County/ Parish: _____

Target Audience:

(1) _____

(2) _____

Proposed Venue: _____ Proposed Date: _____

Justification based on Health Service Data & Demographic Data:

Services to be provided:

(1) _____

(2) _____

(3) _____

(4) _____

Service Check List:

Services to be Provided	Expected No. of Target Audience/ Expected Turn-up	Available Resources (Personnel) in relation to expected turn-up/demand?

Communication for Healthy Communities

REGISTRATION FORM

Obulamu?

Activity: ……

Date……..

No.	Name	Title /Organisation	Telephone Number	Email Address	Signature

Plot 15, Kitante Close P.O BOX 5768 Kampala – Uganda Tel: +256 312 266 406 Fax: +256 312 266 407 website: www.fhi360.org