Improving Healthy Behaviors Program (IHBP) Final Performance Evaluation Report

December 2014

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Iain McLellan, Lalita Shankar, Kumkum Srivastava, and Michele Wehle of Social Impact.

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IMPROVING HEALTHY BEHAVIORS PROGRAM (IHBP) EVALUATION REPORT

The objective of this exercise is to conduct a final performance evaluation of the Improving Healthy Behaviors Program (IHBP), the flagship project of USAID/India under the bilateral agreement with the Government of India (GoI) to support Social and Behavioral Change Communication (SBCC) activities.

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ACRONYMS

AAP	Annual Action Plan
ACC	Associated Cement Companies
ACSM	Advocacy, communication, and social mobilization
AED	Academy for Educational Development
AIDS	Acquired Immunodeficiency Syndrome
AH	Adolescent health
AHS	Annual Health Survey
AMC	Annual Maintenance Contract
AMP	Award Monitoring Plan
ASHA	Accredited social health activist
AWP	Annual Work Plan
BCC	Behavior Change Communication
BEE	Block Extension Educator
CDCS	Country Development Cooperation Strategy
CH	Child Health
CO	Contracting Officer
COP	Chief of Party
COR	Contracting Officer's Representative
COTR	Contracting Officer's Technical Representative
CTD	Central Tuberculosis Division
DAC	Department of AIDS Control
DAVP	Directorate of Advertising and Visual Publicity
DC	Deputy Commissioner
DDG	Deputy Director General
DEC	Development Experience Clearinghouse
DLHS	District-Level Household and Facility Survey
DHS	District Health Society
DHS staff (HP)	Directorate Health Services

DO	Development Objective
DOTS	Directly Observed Treatment, Short-Course
DOWCD	Department of Women and Child Development
DCOP	Deputy Chief of Party
EAG	Empowered Action Group
FGD	Focus Group Discussions
FHI 360	FHI Development 360 LLC
FP	Family planning
GoI	Government of India
HE	Health Educator
HIV	Human immunodeficiency virus
HMIS	Health Management Information System
HP	Himachal Pradesh
HPP	Health Partnership Program
ICDS	Integrated Child Development Services
ICT	Information communication technologies
IEC	Information, Education, and Communication
IHBP	Improving Healthy Behaviors Program
IMRB	Indian Market Research Bureau
IPC	Interpersonal communication
IQC	Indefinite Quantity Contract
IR	Intermediate Result
IT	Information Technology
ITBP	India TB Program
IUCD	Intrauterine Contraceptive Device
IVR	Interactive Voice Response
JHU	Johns Hopkins University
JHUCCP	Johns Hopkins University Center for Communication Programs
JS	Joint Secretary
KII	Key Informant Interview
LOE	Level of Effort contracts
LOP	Length of the Program

M&E	Monitoring and Evaluation
MCH	Maternal and child health
MCHIP	Maternal and Child Integrated Program
MD	Mission Director
MEIO (HP)	Mass Education & Information Officer
MH	Maternal health
MIS	Management Information System
MOHFW	Ministry of Health and Family Welfare
MOU	Memorandum of Understanding
MoWCD	Ministry of Women and Child Development
MPH	Master of Public Health
NACO	National AIDS Control Organization
NACP	National AIDS Control Program
NFHS	National Family Health Survey
NGO	Nongovernmental Organization
NHCRSC	National HIV/AIDS Communication Resource and Support Center
NIHFW	National Institute of Health and Family Welfare
NIPCCD	National Institute of Public Cooperation and Child Development
NPCC	National Program Coordination Committee
NRC	National Resource Center
NHM	National Health Mission
NRHM	National Rural Health Mission
NRP	Nutrition Resource Platform
NRU	National Resource Unit
ONA	Organizational Needs Assessment
OR	Operations Research
PA	Program Assistant
PE	Performance Evaluation
PEPFAR	President's Emergency Plan For AIDS Relief
PIP	Project Implementation Plan
PLHIV	People Living with HIV
PM	Program Manager

POA	Plan of Action
PopCouncil	Population Council
PPIUCD	Programming and Learning for Postpartum Intrauterine Contraceptive Device
PPTCT	Prevention of Parent to Child Transmission
PRACHAR	Promoting Change in Reproductive Behavior Project
PSI	Population Services International
PSU	Public Sector Undertaking
RCH	Reproductive and Child Health
RCH-II	Reproductive and Child Health II program
RFP	Request for Proposals
RH	Reproductive Health
RMNCH+A	Reproductive, Maternal, Newborn, Child and Adolescent Health
RNTCP	Revised National TB Control Programme
RoP	Record of Proceedings
SACS	State AIDS Control Society
SBCC	Social and Behavior Change Communication
SGD	Simulated group discussion
SI	Social Impact
SIHFW	State Institute of Health and Family Welfare
SOW	Scope of Work
SRI	Social and Rural Research Institute of IMRB
SRU	State Resource Unit
STA	Senior Technical Advisor
TA	Technical Assistance
TAG	Technical Advisory Group
TWG	Technical Working Group
TB	Tuberculosis
TL	Team Leader
TO	Task Order
TOR	Terms of Reference
ToT	Training of Trainers

TPM	Team Planning Meeting
TVC	Television Commercial
UNICEF	United Nations Children's Fund
UP	Uttar Pradesh
UPSACS	Uttar Pradesh State AIDS Control Society
USAID	United States Agency for International Development
VBD	Vector-Borne Diseases

EXECUTIVE SUMMARY

EVALUATION PURPOSE AND EVALUATION QUESTIONS

This is the final performance evaluation of the Improving Healthy Behaviors Program (IHBP), the flagship project of USAID/India under the bilateral agreement with the Government of India (GoI) to support Social and Behavioral Change Communication (SBCC) activities. The project is primarily implemented by FHI 360, with Population Council and Population Services International as sub-partners. The specific purpose of the evaluation is to gain an independent appraisal of the IHBP project's performance and effectiveness in order to provide lessons learned and help guide future national SBCC investments. The evaluation sought to answer questions regarding the effectiveness of advocacy for strategic SBCC interventions and activities, to strengthen capacities in SBCC as well as evaluate the technical assistance, and identify best practices and promising new approaches, including innovative means to reach people.

PROJECT BACKGROUND

The goal of the IHBP is to improve the adoption of healthy behaviors in three areas: reproductive, maternal, neonatal, child and adolescent health (RMNCH+A)[1], HIV/AIDS, and tuberculosis (TB). At the national level, key stakeholders include the Ministry of Health and Family Welfare (MoHFW) and the Ministry of Women and Child Development (MoWCD). The National Institute of Health and Family Welfare (NIHFW) is a key partner and nodal institution of IHBP, focused on training health care workers. IHBP continues to work in eight states, and provides technical assistance (TA) to Empowered Action Group (EAG) states by working with institutions such as the State Institutes of Health and Family Welfare (SIHFW) and National Health Missions (NHM). These states are Chhattisgarh, Jharkhand, Haryana, Himachal Pradesh, Punjab, Rajasthan, Uttarakhand, and Delhi.

EVALUATION QUESTIONS, DESIGN, METHODS, AND LIMITATIONS

The evaluation incorporated a mixed-methods approach to provide credible evidence to best answer the evaluation's four questions. The methodology included a desk review, Key Informant Interviews (KII), and Focus Group Discussions (FGD), which are elaborated upon further below. Given the highly qualitative nature of the evaluation, the team distributed Likert-type questions to key informants to help quantify data that provided another method to triangulate findings. The team worked in close consultation with USAID/India and IHBP staff to finalize the evaluation design and schedule.

The evaluation team reviewed more than 450 documents supplied by FHI 360, including project design documents, project proposals, baseline reports, annual work plans, M&E data, and reports. Three weeks were devoted to in-country data collection and included fieldwork in Jharkhand and Haryana. KIIs were conducted with GoI representatives from MoHFW and NIHFW, as well as with project staff and project partners, including PopCouncil, PSI and the United Nations Children's Fund (UNICEF). FGDs were held

[1] Please note that family planning is included in the RMNCH+A framework.

with IEC/SBCC communicators and Likert-scale questionnaires were administered to more than 50 stakeholders.

The USAID/India evaluation questions are:

1. What is the perceived effectiveness of IHBP in advocating for strategic SBCC for key health programs at the national and state level?

2a. What is the perceived effectiveness of the project's activities in strengthening capacities in SBCC of MOHFW and nodal institutions?

2b. What were the key challenges that the project faced in institutional strengthening for SBCC?

3a. According to the perceptions of key informants, to what extent was the technical expertise provided on SBCC to MOHFW and state health departments effective?

3b. What key lessons can be drawn from its implementation?

4a. What are the key learnings from the IHBP project that can inform investments in SBCC in the future?

4b. What do key informants identify as best practices, promising new approaches, innovative ways to reach people, and leveraging strategies that can inform future programs?

FINDINGS AND CONCLUSIONS

Broad-based understanding of the need for incorporating evidence-based strategic planning in GoI and state SBCC strategies. There is evidence that the GoI at both the national and state levels embraced the transition for traditional Information Education and Communication approaches to a SBCC approach.

Substantial leveraged funds by GoI is a sign of effective advocacy. The GoI did not simply pay lip service to adopting the SBCC approach but invested its own resources on a large scale. As of September 2014, more than $12.5 million has been leveraged through the GoI at a ratio of one to one with USAID/India funding. The GoI was open to the need for SBCC activities and the approach was both inclusive and collaborative.

Better balance between mass and mid-media and interpersonal communication. As a result of IHBP inputs there is a better balance between communication channels that increases the chances of reaching into mass media dark areas, which represent surprisingly large areas in some states. A cost-effectiveness study of different SBCC approaches and channels that can be used in SBCC strategic planning, would help guide and inform the media mix and selection however.

Training was successful in creating broad support for SBCC approach and increased skills for evidence-based planning. The combination of training and embedded project staff has ensured that SBCC is the predominant approach used for promoting positive public health practices.

Additional training in interpersonal communication is needed. Training in SBCC and interpersonal communication of front line workers has been successful but a more systematic series of trainings and better supervision is needed.

Understanding of the need for effective M&E and closing the skills gap. Progress has been made in creating an awareness of the role of M&E at the national and state levels. What is missing is the establishment of effective systems that not only collect data but also use it to guide future SBCC

planning. Moreover, due to the shortened project period, IHBP indicators have only focused at the process level rather than at the outcome or impact level, which makes measuring social and behavioral change among target audiences challenging.

Institutional strengthening at the national level: IHBP has used a multi-sector approach to work across the three sectors of RMNCH+A, Tuberculosis and HIV/AIDS with the RCH division, CTD, and NACO, besides working with MoWCD. Extensive TA has been provided across national-level institutions in the form of training, with mentoring and assistance provided by IHBP consultants, and there has been ongoing communication and support of IHBP by the GoI.

Institutional strengthening at the state level: IHBP focused on building capacity at the state level by strengthening, wherever possible, the unit responsible for planning and implementing communication/IEC activities, since there was no specific division focusing on SBCC. IHBP succeeded in providing appropriate and relevant TA to address the variable capacities across the eight states with respect to planning and implementation of SBCC activities.

If focused TA does not continue, IHBP successes will be difficult to sustain. There is evidence of increased skill levels for planning SBCC at the national and state levels. Fears were expressed that if there is no continuity the progress will be limited, however.

Progress made with the resource centers, but there is scope for expanding their use. The resource centers have contributed to the collection and electronic housing of materials and documents, but more support is needed to ensure that they are easily accessible and that strategies are developed to promote their use.

Large amount of technical assistance needed to identify and build up center(s) of excellence. In order to maintain the momentum well into the future, a center or centers of excellence in SBCC are needed. It could be found in either the government or NGO sectors and would likely require immediate organizational development and technical capacity building. It should be expected that there would be a certain transition period before IHBP could hand over responsibilities to the center(s) of excellence.

Progress made with new communication technologies but on a small scale. There needs to be more in-depth accounting with specific audience segments of the impact of mobile phone use and other mobile devices and the Internet, including social media, before bringing to scale.

IHBP consultants expected to work outside of their mandate. Embedded IHBP consultants are greatly appreciated at both the national and state government levels. Implementing SBCC strategies is a challenge at all levels, however, and there is a tendency to over-rely on the consultants to help more with implementation rather than with facilitating and supporting.

Private-sector leveraging not as extensive as envisioned but involvement has potential. The extent of the involvement of the private sector has been generally below expectations due to a number of obstacles, but the potential remains for more leveraging in the future.

RECOMMENDATIONS

Continuation of Momentum

- USAID/India should find existing mechanisms to keep the core functions of IHBP operating and enable SBCC TA to continue and build on successes in the transition to the post-project period.
- A USAID/India follow-up procurement for more long-term support would ensure the full transition to sustainable SBCC planning and implementation.
- Further discussions between USAID/India, IHBP, and GoI are needed for USAID/India to fully understand its priorities, leveraging opportunities and objectives for the future.
- Need for better collaboration between bilaterals and multilaterals for improved coordination, reduced duplication, and the best use of resources.

Strengthening the Model

- IHBP should conduct a study based on existing data, secondary and original research that considers the cost-effectiveness of different media used in the 360-degree package in order to guide future strategic planning when selecting a variety of mutually reinforcing channels.
- IHBP should provide TA to the GoI to develop a comprehensive and robust M&E system as a pilot in one state as a model.
- New indicators are needed that measure more precise changes in behavior at the GoI level and that are focused on measurable changes in target population behavior.
- USAID should continue to support the innovative use and expansion of new communication technologies, including the Internet, mobile phones, tablets, and social media as other channels in the SBCC mix and find evidence of cost-effectiveness for specific audiences.
- IHBP should reinforce the SBCC training and increase time of practical exercises and supervised fieldwork.

Prioritization Moving Forward

- USAID/India might consider scaling down IHBP by focusing its resources in a smaller number of states, which would permit the development of a comprehensive and integrated SBCC model for replication.
- IHBP should rationalize its staff and consultants at all levels to maximize opportunities for mentoring.
- USAID/India should focus its SBCC resources on RMNCH+A primarily under IHBP and curtail other health intervention areas.
- IHBP should look at ways to reduce the production complexity of the 360 degree multi-media campaigns, particularly the television spot ad production, to lower the cost of each with the goal of GoI eventually take over the total management of campaigns in the future.

Transition to Sustainability

- Accelerate the finalization of a body of evidence by IHBP that accounts for the transition from IEC to SBCC, including guides, sample materials, training modules and other documents that can lead to exportation of the model and eventual expansion to additional states.
- Ensure that IHBP TA continues for a limited duration, which will enable a seamless transition to the GoI and its partners so that they continue to develop effective and sustainable SBCC.
- USAID/India should consider the identification of local expertise in SBCC to continue the TA and institutional strengthening after the project end. Such a center or centers of excellence could be located within an existing government, parastatal, or civil society institution or a combination of the three.

- To increase the participation of the private sector, the focus of its involvement should be changed by fully leveraging its core competencies and networks to increase corporate ownership and sustainability.

EVALUATION PURPOSE & EVALUATION QUESTIONS

EVALUATION PURPOSE

The objective of this exercise is to conduct a final performance evaluation of the Improving Healthy Behaviors Program (IHBP), the flagship project of USAID/India under the bilateral agreement with the Government of India (GoI) to support Social and Behavioral Change Communication (SBCC) activities. The project is primarily implemented by FHI 360, with Population Council and Population Services International (PSI) as sub-partners. The specific purpose of the evaluation is to gain an independent appraisal of the IHBP project's performance and effectiveness in order to provide lessons learned and help guide future national SBCC investments. The results of this evaluation will assist the Mission in learning about what did and did not work and why these activities were effective or ineffective in supporting the GoI on SBCC. The effectiveness of ongoing technical assistance will also be a major focus of the evaluation, as it supported the eight intervention states in staff capacity building at the national and state levels and aided institutional strengthening. USAID/India will use this evaluation to assess the potential for project scale-up and glean relevant lessons learned to inform the design of future SBCC-focused programming in India.

The primary intended users of this evaluation are USAID/India and the GoI. In particular the Health Office, Program Support Office, and Mission management are interested in the evaluation's lessons learned. The secondary audience of the evaluation is local institutions, other donors, USAID/Washington, and other USAID missions worldwide.

EVALUATION QUESTIONS

The evaluation approach is designed to answer the four questions below that address aspects of IHBP performance and processes. The questions are slightly modified from those in the original SOW and were finalized in consultation with USAID. Data collection instruments, found in Annex III, were structured to inform each question:

1. What is the perceived effectiveness of IHBP in advocating for strategic SBCC for key health programs at the national and state levels?

2a. What is the perceived effectiveness of the project's activities in strengthening capacities in SBCC of MOHFW and nodal institutions?

2b. What were the key challenges that the project faced in institutional strengthening for SBCC?

3a. According to the perceptions of key informants, to what extent was the technical expertise provided on SBCC to MOHFW and state health departments effective?

3b. What key lessons can be drawn from its implementation?

4a. What are the key learnings from the IHBP project that can inform investments in SBCC in the future?

4b. What do key informants identify as best practices, promising new approaches, innovative ways to reach people, and leveraging strategies that can inform future programs?

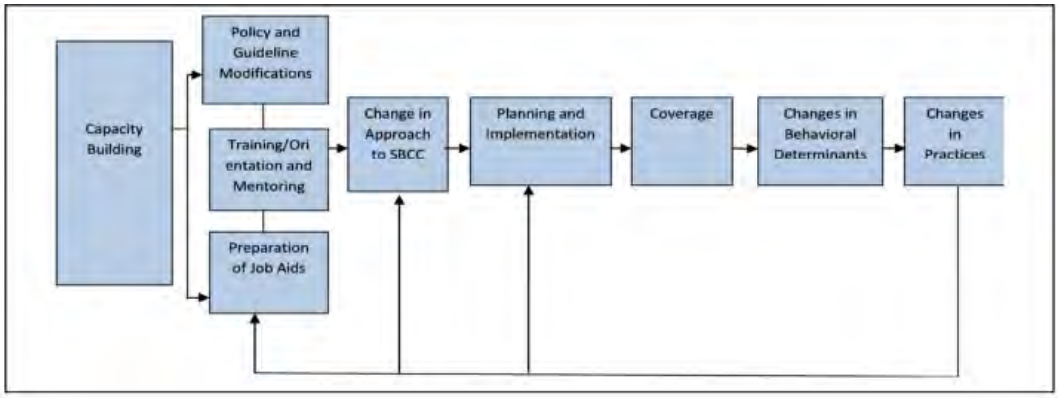
PROJECT BACKGROUND

In October 2010, USAID/India awarded a task order (TO) to the Academy for Educational Development (AED) to implement behavior change communication activities (BCC) under the Improving Healthy Behaviors Program (IHBP). The TO was initially awarded for a base period of three years with two one-year options but was eventually taken over by FHI 360 in 2011. This management change, in addition to changes in geographic focus and other project delays, resulted in the extension of the TO until December 12, 2014. The project's two subcontractors are Population Council (PopCouncil) and Population Services International (PSI). PopCouncil is responsible for operations research (OR) and monitoring and evaluation (M&E), while PSI focuses on BCC, mid-media, and interpersonal communication (IPC) activities. In addition to working closely with project partners, IHBP is unique in that it also requires one-to-one leveraging to bolster the sustainability of SBCC activities. To accomplish this, IHBP works with the GoI, in addition to 12 private sector organizations, to disseminate communication materials and SBCC messaging.

Project Logic and Results Chain. The goal of IHBP is to improve the adoption of healthy behaviors in three areas: reproductive, maternal, neonatal, and child health plus adolescents (RMNCH+A), HIV/AIDS, and tuberculosis (TB). At the national level, key stakeholders include the Ministry of Health and Family Welfare (MoHFW) and the Ministry of Women and Child Development (MoWCD), while the National Institute of Health and Family Welfare (NIHFW) is considered a key partner and nodal institution. IHBP continues to work in eight states, and provides technical assistance (TA) to Empowered Action Group (EAG) states by working with institutions such as the State Institutes of Health and Family Welfare (SIHFW) and National Health Missions (NHM). These states are Jharkhand, Haryana, Himachal Pradesh, Punjab, Rajasthan, Chhattisgarh, Uttarakhand, and Delhi.

Figure 1 provides an overview of the IHBP logic model. The model illustrates how SBCC capacity building activities are at the crux of the program design and how capacity building will result in changes in health practices through ongoing TA at both the national and state levels of government. Through focused TA in the form of trainings, mentoring, and the development of job aids, IHBP staff and consultants work with national- and state-level government counterparts to implement SBCC activities. Figure 1 presents the IHBP strategic framework model:

Figure 1: IHBP Strategic Framework Model



Source: IHBP Award Monitoring Plan: Year 4, September 15, 2013 (revised November 22, 2013), 3.

EVALUATION METHODS & LIMITATIONS

EVALUATION METHODOLOGY

The evaluation incorporated a mixed-methods approach to provide credible evidence to best answer the evaluation's four questions. The methodology included a desk review, key informant interviews (KIIs), and focus group discussions (FGDs), which are elaborated upon further below. Given the highly qualitative nature of the evaluation, the team distributed Likert scales to key informants to help quantify data that provided another method to triangulate findings. The team worked in close consultation with USAID/India and IHBP staff to finalize the evaluation design and schedule. An evaluation design matrix was submitted as part of the evaluation team's Work Plan and can be found in Annex II.

The evaluation team was led by Team Leader Iain McLellan, a specialist in Social and Behavior Change Communication (SBCC). The team was comprised of two local specialists, Lalita Shankar, a Health Systems Strengthening Specialist, and Dr. Kumkum Srivastava, a Health Evaluation Specialist. While in country, Program Manager Michele Wehle supported the team's data collection efforts. Dr. Ash Pachauri, Social Impact's In-Country Representative, provided logistical support to the team.

Desk Review and Work Plan Preparation Phase. Before arriving in country, the evaluation team conducted a thorough desk review of more than 450 documents supplied by FHI 360. The review included, but was not limited to, project design documents, project proposals, baseline reports, annual work plans, M&E data, and other project-related documents and reports. The review informed the drafting of data collection protocols and provided an overview of the IHBP program.

Data Collection Phase. The evaluation team spent three weeks in country to undertake data collection work. Fieldwork began in New Delhi with a Mission in-brief, followed by KIIs with the MOHFW. During the second week of the evaluation, the team conducted fieldwork in Jharkhand and Haryana for a total of four days and met with IHBP consultants and state government and project partners.

Key Informant Interviews. The team conducted KIIs to triangulate the data collected in the desk review and gain further insights into perceptions of the program's effectiveness. More than 90 KIIs were conducted with individuals from the institutions listed below. The selection of KIIs was finalized with ongoing consultation from USAID/India and IHBP staff. A wide breadth of KIIs was conducted, which provided a rich understanding of IHBP operations at national and state levels of government.

- Staff from MOHFW, including appropriate representatives from:
  - NRHM, IEC, and RCH Division
  - Department of AIDS Control (DAC)
  - Central Tuberculosis Division (CTD)
  - National Institute of Health and Family Welfare (NIHFW)
- Staff from MoWCD, including NIPCCD
- Beneficiary staff in the Empowered Action Group (EAG) states
- Project partners (PopCouncil, PSI, and UNICEF) including private-sector organizations in IHBP

- IHBP staff and consultants at headquarters and the field

Focus Group Discussions. Five FGDs were held with 28 participants, including SBCC trainees and Block Extension Educators. Key themes of FGDs included discussions around SBCC curriculum, methodology, training tools, material, follow-up and monitoring, application, and challenges experienced in the field. An FGD guide can be found in Annex III.

Likert Scales. In order to complement the KIIs, the team administered three mini-studies with a small sample from the principal target populations using the Likert scale, which had also been translated in Hindi. (See the protocol in Annex III.) The team distributed data collection instruments that featured Likert scales to four categories of respondents, including the GoI, IEC/BCC educators, project partners in the program (PopCouncil, PSI, UNICEF), and private-sector organizations. The tool consisted of seven statements, and respondents were asked to indicate the degree to which they agreed or disagreed with each statement. Participants ranked their responses on a 1–5 scale, with 1 indicating that they strongly disagreed with the statement and 5 indicating that they strongly agreed. While these results cannot be considered statistically representative, they help triangulate data obtained from other data collection methods.

Table 1: Likert Scale Summary

Category	Government personnel (national- and state-level)	SBCC practitioners (district- and block-level IEC government personnel)	Partners	Private sector	Total
Number of persons	19 (34.5%)	17 (30.9%)	12 (21.8%)	7 (12.7%)	**55 (100.0%)**
Overall average score	4.3	4.4	4.2	3.9	

The Likert scale also included three open-ended questions (see below) to provide additional context:

Question 8: To what extent was the expertise in SBCC of the IHBP project efficient and useful to you and your organization? Give some examples.

Question 9: What have been the two most significant contributions or results from the IHBP project for you and your organization?

Question 10: What would be the most significant contribution or result that a future health communication project could make in the future?

Data Analysis Phase. During the last week of fieldwork, the team began analyzing data obtained from KIIs, FGDs, and the Likert scales. As part of this analysis, the team discussed the overall trends and any discrepancies in data obtained during fieldwork and began identifying common themes to answer the four evaluation questions. These themes were then used to draw conclusions and make recommendations regarding future programming.

EVALUATION LIMITATIONS

Due to time constraints, the geographical spread of the project activities, and the numerous participating institutions and partners, the evaluation's sample size within the allotted timeframe was limited. While the team did conduct visits to two states, Haryana and Jharkhand, these states have more extensive activities and may portray an unbalanced perspective of IHBP. To account for this limitation, the two local team members conducted additional KIIs in Rajasthan and Uttarakhand after fieldwork. These additional interviews provide a more nuanced picture of both the successes and challenges of the program, as both states are less advanced in implementation. It should be noted that only a handful of interviews were conducted in these two states, which only captured data from a small number of key informants at senior levels of state government.[2] While the team strove to include diversity as a key factor in sample selection with regards to state selection and the variety of key informants, the resulting sample and evaluation design were not intended to be statistically representative.

Qualitative data that presents a mixture of factual reporting and perceptual interpretation can be accompanied by presentational and recall biases. The evaluation team countered this challenge by using systematic protocols with probing questions in interviews, assigning team members who are closely familiar with IHBP and partner organizations to conduct interviews, and triangulated interview data with documentary sources and across various interview sources to build reliability into findings. The use of Likert scales also aided triangulation. The nature of this summative evaluation limits observations and interviews to one point-in-time, as any follow-up will probably not be possible given project completion in December 2014.

Second start to evaluation. It should be noted that the evaluation originally began in June of 2014 and was undertaken by a different evaluation team. Due to complications experienced during the beginning of the fieldwork, USAID/India and Social Impact jointly agreed to halt the evaluation and reconstitute the team. The transition to the second start of the evaluation went smoothly and the new team accessed the prior team's interview notes and data to inform their work. Several interviews were conducted again to account for any gaps in or questions with the original team's data.

[2] See Annex VIII for a detailed listed of interviewed key informants by state.

FINDINGS

1. What is the perceived effectiveness of IHBP in advocating for strategic SBCC for key health programs at the national and state levels?

Meets USAID goals of health systems strengthening and reaching vulnerable populations. USAID/India made a strategic shift from a disease-centric approach towards an integrated approach that is centered on building a strong public- and private-sector health system. This also includes moving from direct implementation and grants management to a more sustainable role as a provider of technical assistance to bolster sustainability, which is in line with the country's health program goals and objectives. For example, USAID/India established the goal of improving the health of vulnerable populations as articulated in IR3 in the IHBP TO, which calls for increasing healthy behaviors, to help "ensure the supply or service delivery side, at both national, state, district, community and household levels by creating and supporting positive health behaviors which may be practiced at home, in the community or generate increased demand for health services and has gender as is an explicit focus."[3]

IHBP objectives also support the first Development Objective (DO) outlined in the Mission's Country Development Cooperation Strategy (CDCS): to increase the capacity of India's health system to improve the health of vulnerable populations in India.[4] In order to effectively reach and work with vulnerable populations, IHBP's work at the state level and across a variety of communication channels and innovations, such as mHealth, is crucial to ensure the sustainability and effectiveness of health programming. Moreover, sensitizing frontline workers to communication best practices will help sustain interventions targeting vulnerable populations.

As confirmed in interviews with USAID and IHBP staff, IHBP's focus on quality TA, cooperation, and partnership was closely linked to the goals and objectives of GoI programs, and it worked towards strengthening related platforms and institutions, as well as those that exist within the growing private sector. In a meeting with the evaluation team and USAID/India, it was communicated that the IHBP's legacy will be in mainstreaming SBCC and strengthening GoI staff at state and national levels. IHBP corresponded well to attaining the objectives of the third IR within USAID's overall health results framework and resulted in strong government buy-in and endorsement, which was reflected in KIIs with senior-level officials at national and state levels.

Well-conceived, based on evidence, confirmed by organizational needs assessments. The concept of the project was based on national level reviews[5] that highlighted persistent problems within the existing government SBCC platforms, including a lack of capacity to design and deliver evidence-based BCC campaigns at the national and state levels, lack of strategic planning, overdependence on

[3] Final Task Order – Behavior Change Communication – Improving Healthy Behaviors Program Project in India (IHBP) Task Order #: AID-386-TO-11-00001 BCC-IHBP.
[4] USAID/India Country Development Cooperation Strategy (CDCS) 2012–2016.
[5] See. for example, "Capacity Assessment: States," India, May 2014, New Delhi: FHI360.

mass media, low utilization of funds, and substantial vacancies of IEC/BCC staff. The most significant review was conducted by UNICEF in 2010.

Resulted in a strategic shift from traditional IEC to evidence-based SBCC. Awareness of the need for an evidence-based approach to SBCC within the GoI public-sector health programs, which includes the systematic development of guidelines, strategies, plans, and communication campaigns and materials, is now very high. The IEC approach used in the past was not cost-effective and had a poor return on investment. There was no strategic planning and the previous approach was not based on inputs. There is now emphasis on creative approaches based on the assessment. In a KII with the Deputy Director of the Jharkhand Rural Health Mission, it was communicated that "IHBP is well placed to bring SBCC into the system. We never used to do these activities before. We were doing IEC with hoardings and were ignorant of SBCC. Since the project started we are focused on SBCC." The BCC Director in Haryana expressed a similar endorsement of the SBCC approach with the following: "For decades we used mass media and did not move beyond a health education focus that was not scientific and based on a strategy." This view was also endorsed in the Likert scale studies when all respondent groups strongly agreed with the first statement: *IHBP has been effective in advocating strategic SBCC for health programs that I am involved with*; GoI (4.4), SBCC practitioners (4.3), NGO (4.5) and the private sector (4.3). See Table 2 for a summary of Likert scores.

Paradigm shift from a vertical approach to integrated multi-sector approach. IHBP corresponded well with integrated and systems-oriented programming that is replacing more vertical approaches. In a KII with the Assistant Professor of Communication at NIHFW, it was communicated that the previous approaches were flawed because of the isolation of the different people doing them. Now, however, the approach is more integrated and holistic. A transition has occurred without people realizing they were contributing to it. This wider approach was the case within RMNCH+A as well, according to its technical team leader at the Maternal and Child Integrated Program (MCHIP), who stated that they are now doing something new in reaching across vertical programs and focusing on life stages. It was mentioned further that SBCC works well with this holistic approach for meeting many different needs.

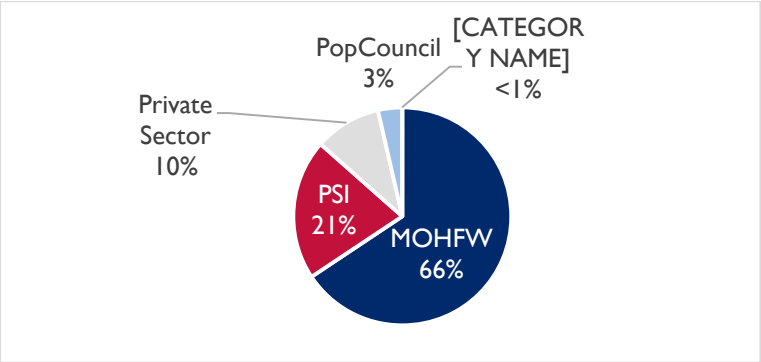
Project strategies developed collaboratively with key stakeholders at national and state levels. As part of the extensive desk review, the team learned more about IHBP formative research studies, which were conducted to inform the development of SBCC strategies and campaigns and training and IPC materials. The formative research studies were conducted in response to requests from GoI with close collaboration at every state and level. Examples of that concurrent work included the "Technical Consultation on the Need for Appropriate BCC Indicators to Monitor and Evaluate Health Programs in India Report of Proceedings" and "A Status Report on the Advocacy, Communication, and Social Mobilization (ACSM) in Revised National Tuberculosis Control Program."

Another study on TB looked at awareness, barriers, and issues related to treatment from the patient and the provider's perspective, as well as potential strategies. The Director of BCC in Haryana welcomed collaboration with IHBP: "Everything was developed in joint collaboration with IHBP. All of the training modules were developed to meet our needs. IHBP created the need for SBCC and were able to deliver it. They found consultants that mixed in with the government side." This view was also

reflected in the Likert scale, where the GoI respondents gave its highest rating (4.5) to the statement *IHBP was effective in strengthening capacities in SBCC in the organization where I work*.

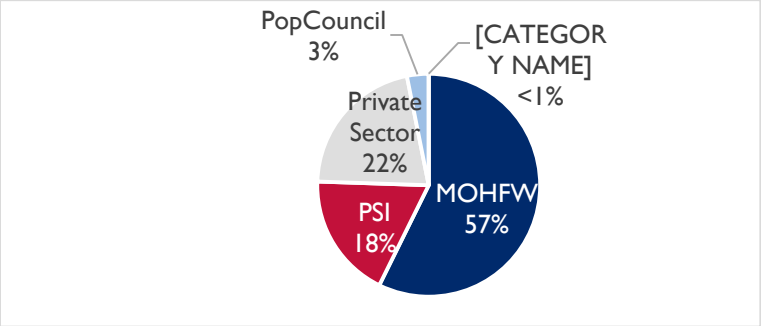
Strong GoI national and state commitment through leveraged funds. The GoI's response to IHBP's advocacy for the SBCC approach was evident in the large amount of funds that were leveraged at the national and state levels. As of September 2014, more than $12.5 million[6] has been leveraged through the GoI at a ratio of one to one with USAID/India funding. The GoI was open to the need for SBCC activities and the approach was both inclusive and collaborative. Graphs 1 and 2 illustrate IHBP leveraged funds by source through September 2014 and by the end of the program, respectively. Most notably, private-sector leveraging is expected to increase by the end of IHBP by more than 10%, or nearly $3 million.

Graph 1: IHBP-Leveraged Funds by Type (Oct 2010–Sept 2014)—Total $19.5 Million



Source: FHI 360 technical staff.

Graph 2: Expected IHBP-Leveraged Funds by Type by End of Project—Estimate $22.3 Million[7]



Source: FHI 360 technical staff.

[6] See Graph 1.
[7] Estimates for total leveraging through the end of the project are rough estimates. Percentages may vary, as only estimates for anticipated additional private-sector leveraging were added.

One of IHBP's indicators was the number of organizations provided with technical assistance for institutional capacity building. Under the last modification of IHBP's SOW, it was decided that IHBP would provide TA to MoHFW, MoWCD, NACO and eight state level IEC/BCC units. An Organizational Needs Assessment (ONA) conducted for the MoHFW was used to guide IHBP's technical assistance. Some of the ONA's recommendations were successfully implemented by IHBP, such as the establishment of the NHCRSC, which IHBP staff point to as an example of successful TA to NACO. As discussed later in the report, a baseline and midline assessment were conducted at the state level to study the effect of TA and it has been noted that there were some improvements at the state level.

A broad range of organizations was engaged at the national and state levels in both the public and private sectors. These included large GoI programs, such as RMNCH+A and National AIDS Control, and smaller organizations such as NIHFW and business groups. The involvement of the different organizations also varied and reflected the varying number of activities conducted in the eight states, and the relative ease that IHBP had in making progress with the different organizations. The main variant according to KIIs with both the GoI and organizations interviewed was among top leadership and to what degree it was engaged. The following comment by an IHBP staff member illustrates the divergent responses: "With the MOHFW there were no difficulties getting approvals. There were discussions but no delays. When they were shown research findings they incorporated them into strategies. At NACO there were so many people involved in decision making it was not clear."

Progress made engaging private sector but opportunities exist for stronger collaboration. It is evident that IHBP has made substantial progress engaging the private sector since the fourth quarter of 2012.[8] For example, MOUs with 12 private-sector companies have been signed and another eight are being finalized**.** Partnerships have also been facilitated between the private sector and state NRHMs. Two communication workshops were held with the private sector in Mumbai and Delhi, and a comprehensive desk review was undertaken to map the current environment for PPPs in the project's four health focal areas (HIV/AIDS, FP/RH, MCH, and TB).

Considering all of these advancements, KII with IHBP staff and the private sector illustrate that more work can be done to increase the influence and reach of the partnerships. Part of the challenge discovered in the desk review—and confirmed in a leveraging presentation with the Private Sector Senior Advisor at IHBP—is that corporations do not give high priority to health, in particular family planning and menstrual hygiene, which tend to be more controversial areas of health in India. Furthermore, it was revealed that the GoI is often hesitant to lend its brand to private corporations due to a lack of familiarity in working with the private sector. A relatively high average (4.4) was given by the 12 private sector companies to the seven issues raised in the Likert survey. The highest rating (4.8) was given to the statement *Strategies used by IHBP technical assistance were effective and should be used again in the future*. The lowest (3.5) was given to the statement *Challenges faced by IHBP in strengthening our capacity in SBCC were effectively overcome*. It was also communicated that the private sector would benefit from ongoing mentoring from IHBP staff on how to best utilize SBCC materials. FHI 360 technical staff

[8]IHBP Staff PowerPoint Presentation titled "Leveraging Partnerships to Enhance Reach & Impact of BCC," September 6, 2014.

also noted that another challenge that IHBP encountered in generating leveraging opportunities was that the program did not include an implementation arm and was solely focused on capacity building and institutional strengthening.

2a. What is the perceived effectiveness of the project's activities in strengthening capacities in SBCC of MOHFW and nodal institutions?

IHBP training developed collaboratively and adapted to local settings. According to KIIs with government officials at the MoHFW, training modules were developed collaboratively with GoI at the national and state levels and met a variety of needs, including basic training in SBCC, orientation workshops for officials and planners, capacity building of frontline workers and their supervisors, including IPC training for Accredited Social Health Activists (ASHAs) and the use of traditional folk theatre. There were also trainings on PIP development and campaign planning and rollout. All of the trainings were participatory and well adapted to local contexts and included local case studies, as confirmed by the Deputy Director of the Jharkhand Rural Health Mission. This key informant conveyed that the training modules were user-friendly and were well adapted to the local context and that participants were enthusiastic about all the training content. This was a typical comment made in the KIIs.

Training widely appreciated and enhanced SBCC skills. One example of an IHBP indicator was the number of participants trained on SBCC at national and state levels. This came to 1,087 trainees in all eight project states and a total of 19 trainings. The demand for SBCC training has been received from 15 other states. As per the Likert scale survey open-ended questions, 12 out of 19 GoI respondents, or 64%, said that the IHBP project helped build capacity for SBCC in the state. Eight out of 17 respondents (47%) from GoI SBCC practitioners, mentioned that *Training has helped improve the understanding and conceptual clarity of SBCC/IPC, and the change from IEC to SBCC, and also in understanding community*.

Three FGDs were held with 18 participants from three states, Jharkhand, Haryana and Himachal Pradesh, all who underwent the five-day SBCC or the two-day IPC trainings offered by IHBP. The participants, which included state and district IEC/SBCC officers and BEEs, all appreciated the training and felt that it enhanced their skills. Overall, participants were very impressed with the trainings and referred to them as "innovative" and expressed that they were "very useful at our level." The participants also said the training allowed them to develop a better sense of research-based strategic planning and provided them with different tools to understand the social environment.

IPC training reached field level. At the state level, the IPC training resulted in improved practices among frontline workers. For example, the BCC Director in Haryana was able to conduct a statewide training of Block Extension Educators (BEEs) who trained ASHAS with IHBP's help. This was crucial since the BEEs were working in the field for a long time but never received any health education. IHBP helped put a strategy in place, which has facilitated the worker's understanding of SBCC throughout the state and has helped BEEs improve their targeting and create effective messaging.

This was also reflected in the FGDs with the trainees, in which trainees communicated that there was more "conceptual clarity for implementation at grass roots level," and that they have "learned how to be more interactive with illiterate people." As per the district- and block-level IEC government personnel in the Likert scale survey, 15 out of 17 respondents (88%) said that training in SBCC and IPC

helped motivate workers, aided problem-solving, and resulted in better outputs, especially among ASHAs. It has also changed our own behavior and helped in sorting issues among the ASHAs.

SBCC too dense and insufficient for practical work. Though there was general satisfaction with the level of the trainings, there was some criticism that too much content was packed into too short a timeframe and that there was no time for fieldwork. According to an Assistant Professor at the NIHFW, the SBCC training was too loaded, and a simpler, briefer version is needed. There was also a need for more practical creative activities. This was also reflected in the FGD with trainees, who communicated that the training needs to be longer and went by too fast. More extensive training would help participants better absorb the training materials, which was another difficulty raised from FGD. FHI 360 technical staff noted that the training was reduced per GoI need and that it would be recommended to increase the training length or conduct two or three separate trainings to enhance the training experience.

The evaluation team found that trainings would also benefit from more practical exercises. Participants communicated that while the SBCC concept was clear, there was not enough time for actual activity design, and that implementing messages at the grass roots level needs more work. It was suggested that follow-up trainings that include fieldwork practicums would be advantageous for practicing situation analysis and pretesting. FHI 360 technical staff noted that each content area in the training contained an exercise geared towards practical application and was provided with a toolkit to serve as a handbook for skill application. It was suggested by this staff member that trainers may not have completed the exercises due to time constraints, although this has not been confirmed.

Need for more SBCC and IPC trainings. MOUs were signed with NIHFW, which piloted and managed many of the trainings, and with UNICEF, which collaborated with IHBP staff and consultants at the state level. According to stakeholders interviewed, there remains work to be done in offering follow-up training. In fact, all of the groups responding to the Likert scale survey (see Table 2) rated the following statement poorly: *Challenges faced by IHBP in strengthening our capacity in SBCC were effectively overcome*; GoI (3.9), SBCC practitioners (4.2), partners (3.8), private sector (3.5). These were the lowest ratings for all groups to any question.

The desire for additional training was also reflected in the FGDs with trainees. Trainees communicated that although they can better implement activities, they would benefit from refresher training. Refresher trainings could also hone in on specific skillsets or challenges encountered at the state level. In the open-ended questions as part of the Likert scale survey, in response to the question *What is the most significant contribution that a future communication project could make?*, 10 out of 17 district- and block-level IEC government personnel (59%) said that follow-up and refresher trainings should be conducted. Table 2 lists the average scores by respondent group.

Table 2: Summary of Likert Scale Scores

Statement Number	Statement	Government personnel (national- and state-level)	SBCC Practitioners (district- and block-level IEC government personnel)	Partners	Private providers
1	*Effective in advocating strategic SBCC for health programs that I am involved with.*	4.3	4.3	4.5	4

2	*IHBP was effective in strengthening capacities in SBCC in the organization where I work.*	4.3	NA	NA	4.3
3	*Challenges faced by IHBP in strengthening our capacity in SBCC were effectively overcome.*	3.9	4.2	3.8	3
4	*Technical expertise provided by IHBP was effective and improved our effectiveness.*	4.5	4.5	4.3	3.9
5	*Implementation of the technical expertise went smoothly and without hitch.*	4.2	4.2	3.8	4.2
6	*Strategies used by IHBP technical assistance were effective and should be used again in the future.*	4.4	4.6	4.5	4.3
7	*IHBP needs to employ new and innovative strategies in the future to meet the SBCC needs of my organization for technical assistance.*	4.4	4.5	4	3.4
	Overall Average	**4.3**	**4.4**	**4.2**	**3.9**

It should be noted that the respondents of the Likert surveys in all four groups gave relatively high ratings to the last two questions regarding project TA. While respondents found the TA to be effective and that it should be used in the future, they also believed that new and innovative strategies could benefit their organizations. Reviewing the Likert open-ended responses and data from FGD offers nuance to these statements, which when viewed in isolation can appear to be contradictory.

In FGDs with communication officers, there was a high degree of satisfaction with IHBP TA at the central and state levels but new and innovative approaches and TA are needed for SBCC to be successfully employed at the grassroots level. For example, more than half of communicators who completed the Likert open-ended questions suggested that more training was needed at the grassroots level to maximize implementation success. However, it should be pointed out that IHBP's scope was at the state and national levels, so it follows that training at the district level would have fallen outside the scope of the program. A typical comment included that training that adapts to the local context was especially needed for frontline workers in mid-media and IPC. This was corroborated in the FGD with communicators where the need for more SBCC and IPC trainings was recommended, and it was noted that there would be constraints in applying SBCC at the front lines if training is not conducted at this level.

Two thirds of GoI respondents noted in the open-ended questions that help was needed rolling out SBCC and providing TA at the district level. It is clear by their average Likert score of 4.4 to question 6 that TA was considered useful during this phase of the program and that slightly refocusing TA in the future could better meet district needs. Slightly less than half of the private-sector respondents in the open-ended question on future needs mentioned developing capacities of personnel. One respondent suggested that health communication strategies and materials would be an asset to community workers for inspiring significant behavior change.

Communication campaigns inspired a 360-degree approach. The greatest proportion of project funds spent on technical activities has been on the development and adaptation of communication campaigns (see Graph 3). In fact, one of the project indicators is the number of evidence-based campaigns developed by government agencies with TA from IHBP project; nine campaigns were created.

The topics included maternal health, family planning, PPIUCD, menstrual hygiene, teenage pregnancy, prevention of parent to child transmission (PPTCT), stigma and discrimination, youth, and TB/HIV.

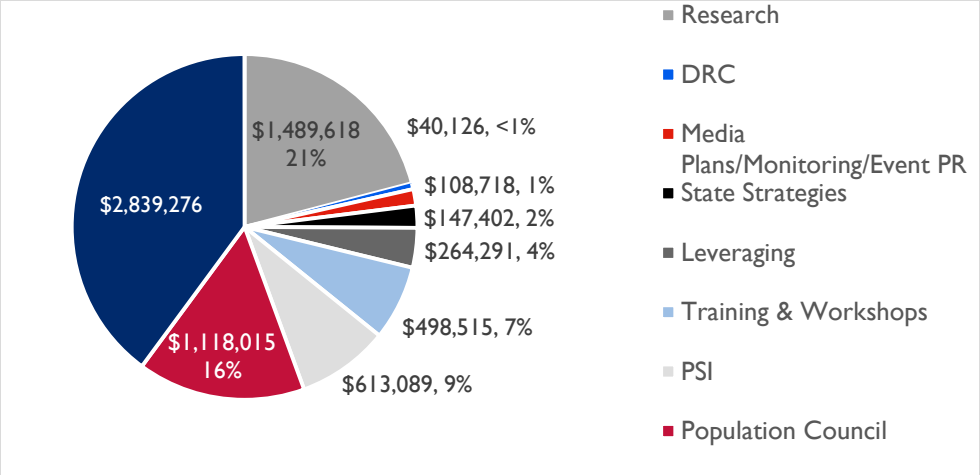
All of the campaigns were meticulously based on continuous research, including situation analysis, concept testing, pretesting of communication materials, and recall studies. This conclusion was reached following the review of the recall studies completed after two campaigns and from KIIs with stakeholders including GoI managers. Each campaign used a 360-degree approach that involved a mix of channels including mass media (mostly TV, some radio and videos) and mid-media (street theatre and hoardings) as well as IPC, with the help of flip charts, games, and leaflets. This approach represented a strategic shift for the GoI from the predominant use of mass media. Most notably, all of the campaigns went beyond just presenting facts and telling people what they should do to persuading them with a more compelling emotional tone. Interviews at the state level revealed a weak link in the strategy, however, since materials were provided to the states but support was not provided to adapt materials, which hampered their use.

Although the idea was to find a better balance between mass and other media, television still received the lion's share of resources (see Graph 3). Ideally, in a 360-degree campaign the portions spent on different channels is more balanced. Although mass media costs cents per person reached in most settings, it is less effective in inspiring behavior change than IPC, which costs much more per person reached when the training and support materials are factored in. Global experience shows that a combination of mass media, mid-media, and IPC works best. The evaluation team recognizes this is due in part to the higher costs needed to develop a television campaign and that IHBP's inputs have resulted in a better balance between communication channels.

A cost-effectiveness study would contribute to evidence-based SBCC, which in theory should begin in the planning and budgeting phases in order to be effective. The Chief Technical Advisor with IHBP noted, however, that a better balance between mass media and IPC/mid-media can be sought only through the allocation of resources during their implementation and not in design and development. Although television campaign costs will always be more costly to produce than leaflets and flyers, it is still possible to curtail costs in the implementation phase through careful planning and budgeting. This would aid the selection of mutually reinforcing media channels that are cost-effective and serve diverse target audiences, which have evolving media habits and preferences.

Graph 3: Technical Activities as a Percentage of Contractual Commitments Over $5,000 USD (as of November 2014)[9,10]

[9] Data represents contract amounts; actual amounts may vary. It should also be noted that many of these categories are not exclusive. For instance, while Population Council is split out separately, their core activities are research-related. Graph does not include consultant contracts, travel, and staff time.
[10] Please see Annex V for data on contractual commitments for RMNCH+A, HIV, and TB.



Source: FHI 360 technical staff.

Recognition as a trusted, capable, and reliable partner for GoI on communication support. Through continuous consultation throughout the process of developing campaigns with GoI counterparts, such as RMNCH+A, NACO and RNTCP, KIIs with IHBP and GoI staff confirmed that there was excellent participation and ownership. According to GoI staff interviewed, they had the impression that IHBP was working with them as well as for them. This high level of participation may have slowed the process but it permitted learning by doing. The SBCC Chief Technical Advisor in IHBP communicated that "the government decision-makers were kept involved at each stage. Everything is shared and approved including the concept, audience consultation, problem tree, technical points, and media selection. Everyone is in agreement."

The GoI was hesitant about adopting more nontraditional or innovative concepts, such as using humor in promoting birth spacing, but after conducting analysis and extensive discussions about what was appropriate, it was decided that this new approach should be embraced. The Deputy Commissioner of MCH/MOHFW characterized the collaboration with the IHBP experts as productive, allowing for increased success in reaching target audiences, due in large part to the ability of IHBP technical experts to respond directly to needs articulated by the GoI. For example, IHBP formulated concepts and accompanying storyboards for strategies to better reach rural areas.

Evidence-based approach firmly entrenched. One of the most significant achievements of IHBP was getting GoI planners to embrace the value of continuous formative evaluation when developing campaign strategies and content. This included conducting situation analyses to gain insights on target audiences, pretesting, process evaluations, and reach-and-recall studies, all of which are part and parcel of evidence-guided decision-making. Stakeholders at different levels pointed out in KIIs that senior managers made decisions on messages and content arbitrarily in the past with little or no research to back them up. As the Senior Manager of Communications at PSI pointed out, "The Ministry now has set up teams and has frameworks for research. Before, the cart was before the horse. Changes have taken place and there is a better understanding of target audiences." One staff member from IMRB, the primary project research contractor, agreed, stating that "the bar was raised with the use of evidence-based planning. The decision-makers learned from the project and they have gone full circle with their capacity for data analysis, conceptualization, and pretesting."

2b. What were the key challenges that the project faced in institutional strengthening for SBCC?

Delay in startup phase due to AED suspension. Through the desk review and KIIs with USAID Program and Technical Office staff and IHBP staff, it became evident that IHBP implementation was adversely affected at the start-up phase due to the suspension of the Academy for Educational Development (AED), the primary grantee of the IHBP project. Consequently, key personnel in critical positions such as the Procurement Officer, Finance Officer, and M&E specialist could not be hired in time. Those who were offered contracts eventually declined to join. Subcontracts with partners identified in the AED proposal also could not be executed in the revised plans of the project. The end result delayed IHBP by a year before the program could be mobilized.

Change in geographical focus and delay in finalization of states. The project documents, such as the IHBP Annual Reports identified changes and delays in selecting program states as a critical bottleneck early in the project timeline, with changing geographical priorities as per variable indications from GoI. The project award commenced with a plan to cover 10 districts in Uttar Pradesh, which was later changed radically to include other states known as "empowered action group" (EAG) states; EAG states are the GoI's priority focus states for expanded health coverage. The GoI confirmed the geographical scope of the project in mid-2013 and issued a contractual modification in September 2013 to focus work in eight states. Of the eight states, Rajasthan, Jharkhand, Chhattisgarh, and Himachal Pradesh are EAG states, while the other four are "cusp" states that may not be economically weak but have poor health-development indices. As a result of this uncertainty, the project lost critical time and personnel during the first year of the project, which was confirmed through KIIs with both USAID and IHBP staff. The current and former evaluation teams interviewed current and former IHBP staff, such as the second Chief of Party (COP), who echoed these findings.

Delay in major actions from USAID. A chronological documentation of the project milestones shows that beginning in December 2010, when AED's suspension by USAID/Washington prevented AED from receiving new awards, the USAID/India CO instructed IHBP to delay major actions, such as signing leases, staff recruitment, major procurements, and work plan activity implementation, as well as introductory meetings with government, USAID partners, and other donor projects. During this period, USAID/India waited for clarifications from USAID/Washington on the status of AED's existing in-country projects. This instruction delay was rescinded only in late March 2011. Since the acquisition of AED by FHI was not announced until July 2011, IHBP experienced difficulties recruiting new staff, as applicants were concerned about employment stability. The novation led to a modification (the first of a total of six more to come in the project period) in the name of the grantee in the IHBP task order from AED to FHI Development 360 LLC (FHI 360) in mid-September 2011. A subsequent novation occurred in January 2013 to Family Health International (FHI 360). Other fallouts of the delay that impacted the rollout of activities included procurement processes for equipment and signing subcontracts with proposed partners.

In addition to the finalization of the states, the project also faced a delay in major action instructions from USAID with respect to changes in scopes of work and subsequent revisions in the task orders. Due to AED's suspension, USAID delayed approval of IHBP's Year 1 Annual Work Plan (AWP) for the period October 2010–September 2011, which was submitted in November 2010. After a series of revisions to incorporate USAID comments, USAID/India formally approved Year 1 AWP and IHBP's Award Monitoring Plan (AMP) and the Branding and Marking Plan around the same time IHBP submitted its Year 2 AWP and updated AMP to USAID in September 2011. (For the year 2010–2011, IHBP operated without a formally approved AWP).

Stakeholder issues in institutional strengthening. The evaluation team found from the desk review that IHBP experienced delays in launching institutional strengthening assessments, which was a key component of the project's objective of building human capacity in SBCC due initially to a lack of

interest or ownership from the GoI. However, when the project responded to a GoI request for assistance in filling key vacancies in the IEC Division, the technical support offered by the project was seen as a reliable input to capacity development that led to increased government ownership in subsequent technical inputs provided by the project. This was corroborated by the FGDs with the IEC/SBCC communicators as well as key informants from MOHFW in KIIs. SBCC staff seconded by the project also confirmed this.

Delay in confirming the nodal organization of choice for institutional strengthening. While the MOFHW favored the NIHFW, through which it administers the institutionalized "in-service" training for various cadres of health care workers, the MoWCD wanted to use its counterpart institution, the NIPPCCD, for introducing an IPC curriculum. However, the evaluation team's interactions with several officials at NIHFW as well as with NIPCCD revealed that while these institutions do offer large-scale training programs using a training-of-trainers or cascade approach, neither institution has the technical capacity for curriculum development or the bandwidth to house the spectrum of knowledge or skill-based activities associated specifically with SBCC. A senior USAID specialist expressed that the project strategy could have worked better if an institution with the right platform for capacity development for SBCC, was in place, even if it is housed outside the government structure. IHBP staff consultants also agreed during a presentation on institutional strengthening provided for the evaluation team that the specific technical depth required for providing training on SBCC was inadequate in existing government institutions.

Delays in approvals of PIPs.[11] The MOHFW endorses budgets for all activities under its flagship health programs through a process of approving a Project Implementation Plan (PIP) submitted by the state. However, IHBP staff shared that in the absence of specific guidelines, states often found their requests for communication budgets reduced in the final disbursements, leaving little scope for evidence-based research and other SBCC activities outlined under the project. An IHBP-supported consultant in the RCH Division in the Ministry who was tasked to review state-level PIPs of 36 states told the evaluation team that there was a lack of clarity backed by strong evidence of data for decision-making at the state level to delineate communication activities in the PIPs. Specifically, it was revealed that states would assign a lump sum amount under the relevant section for communication activities, in particular under "IEC," which only included print and mass media. This showed that at least in some instances, the full 360-degree approach was not properly planned and budgeted for, although it is clear that this process is slowly improving.

A key outcome of IHBP was to develop guidelines for outlining specific SBCC activities based on formative research or media studies and habits under the existing IEC line item of the PIP states, which was shared with the evaluation team. It became apparent in KII with IHBP consultants and staff that there is a need for improvement in the PIP approval process at the national level in order to better implement critical SBCC activities. For example, to ensure budgets were allocated for SBCC activities including mid-media, IHBP consultants stated that they undertook an intensive exercise to determine the unspent communication budgets of previous years that could be requested to be utilized in the concurrent 2014–15 year. The approval for accepting this request came in May 2014, however, which

[11] See Annex VII for additional information.

was one month after the start of the financial year, which prompted a revision of PIPs and subsequent resubmissions to the MOHFW. The evaluation team understood from senior health officials during the field visits that the ROPs of the PIPs submitted by the states had just been received in September 2014, which is six months into the financial year. Despite these challenges, it is expected that the approval process will improve over time given lessons learned in previous iterations and with the creation of PIP guidelines.

The frequent changes in leadership at the National Health Mission at the state level also required further discussions and negotiations with the new key decision makers. During the field visit to Jharkhand, a KII with a consultant detailed the repercussions of such changes when it was stated that they have had three Mission Directors (MDs) in the past two years, and that every time a new MD begins it requires a fresh reorientation. The project and objectives have to be reintroduced and sometimes priorities change. Suggestions, such as systematically identifying obstacles, were made by state-level stakeholders to speed up the approval process. However, there was consensus that it was already an achievement to increase the budgets for SBCC and the process of expediting them is expected to improve in the future.

Human resources: selection, retention, and attrition. The evaluation team observed that IHBP also grappled with frequent changes in leadership over a span of three years. These included three changes at the decision-making level at COP and also three changes at the deputy chief of party (DCOP) position. During the evaluation, KIIs with USAID and the project staff corroborated instances related to inadequate leadership at the earliest stages of the program, including poor intercultural adaptability that not only increased communication gaps between the IHBP and GoI but also resulted in lowering moral of project staff. Throughout the project, there was a high rate of attrition among key personnel at the national and state levels, which challenged implementation further since carrying over knowledge and sustaining lessons learned were difficult due to the frequently changing staff structure.

Unfilled vacancies in key positions. The key findings summarized in the ONA prepared by IHBP highlight the need for strengthening the IEC Division in the MOHFW, which is responsible for supporting the technical divisions on BCC planning and implementation. The IEC Division continues to be headed by a Joint Secretary who is charged with additional functions other than IEC, implying that IEC/BCC is not a high priority in MOHFW. KIIs with BCC consultants revealed that there were only four staff members with media/communications qualifications and the shortage of professional staff drove technical divisions to outsource BCC activities. The majority of IEC initiatives continue to be planned and implemented as one-off activities with weak situation analyses and M&E. On the other hand, the MOWCD, a key ministry overseeing child health and nutrition has no dedicated IEC division to carry out the BCC activities within MOWCD. The ONA report states that the "Media Unit is neither technically nor technologically equipped to create and manage BCC-oriented materials and campaigns. There is no system to provide necessary support and guidance to the states on BCC." The desk review and KII further confirmed that the unfilled positions in the IEC Divisions in the GoI, at the national and state levels, contributed to the delay in implementation. The evaluation team found that some states do not have a dedicated IEC unit, such as Delhi and Himachal Pradesh, and some states had IEC staff who had weak or no SBCC strategic planning skills. This inadequate staffing model has tended to hamper planning and implementation of specific SBCC activities and has added additional pressures to IHBP consultant's workloads.

Progress made in last 18 months despite initial delays. The project overcame many of the above challenges through a subsequent change of persuasive and dynamic leadership at the COP and senior management level. The evaluation team noted in KIIs with IHBP, GoI, and USAID staff that the current COP commands a strong technical team at the Delhi and state levels. After a particularly stagnant pipeline over three years, the project demonstrated an accelerated project funding in the last 18 months

primarily due to efficient procurement mechanisms and flexibility from USAID, such as faster approvals for key personnel and revised scopes of work for TA in MOHFW, DAC, and MOWCD. In KIIs with senior IHBP staff they said that they greatly appreciated the accelerated pace of approvals for disbursements by USAID/India over the last 18 months. At the time of evaluation, the IHBP project had a pipeline of roughly USD $2 million.

Lack of strategic M&E system in place to assess SBCC implementation. The evaluation team was supplied with more than 25 reports and assessments that can be included as evidence-based reports or formative research that feeds into the overall IHBP M&E activities of the annual work plan. These reports were provided to the team by IHBP staff and consultants in Haryana and Jharkhand. The project has taken the initiative to formalize M&E guidelines for SBCC activities along with the development of a facilitator's guide for M&E of SBCC activities. At present, however, there is not a comprehensive M&E system that tracks and monitors the various SBCC activities across states and at the national level. It should be noted, however, that IHBP only began providing M&E TA last year to several states and will continue to do so in 2015.

Additionally, the M&E for monitoring SBCC activities is not part of a comprehensive strategy and is yet to be linked to the Health Management Information System (HMIS) used nationwide. M&E data that is generated into the national HMIS is facility-based and does not have any SBCC indicators for mid-media or IPC activities. IHBP staff has noted that behavior change data is not currently captured through the HMIS but is obtained from household surveys, such as the National Family Health Survey (NFHS), District-Level Household and Facility Survey (DLHS), and Annual Health Survey (AHS). IHBP has advocated for the inclusion of several BCC indicators in the HMIS and for the standardization of some of the existing questions, however.

In the Likert scale survey, almost every government respondent identified the need for a future TA requirement in order to have a robust and effective M&E system that could serve as an analytical tool for planning and implementing SBCC activities. Some state-level consultants in Jharkhand and Haryana had also identified vital SBCC indicators in the HMIS that would be useful for making timely management decisions. In Jharkhand, a system for monitoring and HMIS have been developed for every SBCC activity. Haryana wants to adapt this system and will hold a workshop with participation of the Jharkhand IHBP M&E consultant. In Haryana, a set of SBCC indicators, including media habits, has been included in the concurrent evaluation system of the state and also for regular monitoring as part of state Management Information Systems (MIS).

Limited understanding of data for decision-making at the state level. The field visits to Haryana and Jharkhand showed that there was inconsistency in the skills among state-level staff in the use of M&E indicators for planning, implementation, and monitoring of SBCC activities such that it promotes accuracy and reliability. State-level staff also had limited understanding of how they could better use data generated to improve performance. For instance, during a KII, a senior member of a state IEC Division was unable to outline to the evaluation team which data sets were used for decision-making for the effective use of channels or media for messages related to menstrual hygiene.

Inadequate outcome-level indicators of SBCC. The annual award monitoring plan shared with the evaluation team lists process indicators rather than outcome indicators, which makes it challenging to see how long-term progress is unfolding by state. Of the 14 total indicators, there were only three outcome-level indicators. Except for one indicator that noted the number of states with at least a 15% increase in the budget of IPC/mid-media activities, there are limited indicators related to institutional strengthening, apart from those focusing on capacity building. According to the Chief Technical Advisor

for Monitoring and Evaluation at IHBP, all capacity building–related process indicators were crafted to observe the change in one institutional strengthening outcome indicator. The evaluation team also recognizes the difficulty in designing and tracking longer-term indicators due to IHBP's evolving SOW and anticipates that outcome indicators will be included in the next phase of the program.

The inclusion of the private sector as an outlier. While the IHBP has shown progress in its efforts to develop a strengthened government capacity for a comprehensive SBCC response at the national and state levels, the evaluation team observed that the project could have focused additional resources in increasing private-sector engagement in SBCC. The expected outcomes warranted an independent project that could use a multidisciplinary approach to build institutional capacity by leveraging resources for SBCC activities from the private sector.

The team learned during several KIIs that the emphasis on a 1:1 leveraging requirement impacted the strategic selection of private-sector organizations that were eager to leverage other resources such as networks, skills, and training opportunities rather than print materials or canvassing kiosks. The desk review showed that maximum leverage came through NRHM and other state government–sponsored media spots of some of the IHBP campaigns. KIIs with IHBP staff revealed that there was a long negotiation process for pursuing a potential private-sector organization that may or may not culminate into a formal partnership due to various issues. These issues ranged from geographical considerations, such as selecting companies that had interests in states that aligned with USAID and GoI priority states, which was the case with Jubilant Bhartia, to a reluctance to sign legal memoranda of understanding, which was the case for Associated Cement Companies (ACC).

The project experienced mixed results for partnerships with government-owned public companies known as PSUs (public sector units). For example MECON Limited, which is a Public Sector Undertaking (PSU) in Jharkhand, expressed interest in a partnership on the basis of government-supported communication through its parent government department, the Ministry of Steel. The National Thermal Power Corporation (NTPC), one of India's largest PSUs also had initial reservations for signing an MOU with a non-Indian entity such as FHI 360. The evaluation team noted that given the project's thin resources (there was only one full time staff in the Senior Advisor position for partnerships), pursuing these potential partnerships and overcoming these challenges warranted resources and specific strategies that were beyond the scope of the project. For example, the nature and purpose of IHBP was on capacity building rather than implementation, which made it difficult to effectively leverage private-sector opportunities. This made this component of the project more of an outlier to the far more intensive operational support accrued under the institutional strengthening component.

Mismatch of GoI priorities and corporate interests. The IHBP project has succeeded in drawing the attention of private players to large-scale health issues such as birth spacing, blood donation, and child survival. The team met with key stakeholders from the private sector who acknowledged the opportunities and resources leveraged through the project. The project has signed MOUs with more than 12 private-sector organizations and will have leveraged almost USD $5 million by the end of

IHBP.[12] However, the Likert scale responses from the private sector revealed that there was a mismatch of GoI priorities with company values and priorities on some areas, such as family planning and menstrual hygiene. A few stakeholders also shared concerns about the GoI reluctance for co-branding the NRHM logo until a clear policy on public private partnerships enabled them to do so.

3a. According to the perceptions of key informants, to what extent was the technical expertise provided on SBCC to MOHFW and state health departments effective?

TA was greatly appreciated. The TA provided by IHBP was universally appreciated by the government both at the national and state levels. This is supported by the Likert scale analysis, which provided an average score of 4.5 for the statement *The technical expertise provided by IHBP was effective and improved our effectiveness*. District- and block-level government SBCC practitioners provided an average score of 4.5 for this statement. According to the Deputy Commissioner of Family Planning (DC FP) at MoHFW, the TA was very good, collaborative, and professional. The Joint Secretary of the RCH division found IHBP to be very proactive, and said that IHBP staff was able to organize a partner's meeting on SBCC for adolescents in a span of three days. In Jharkhand, the MD of the NRHM praised IHBP consultants further and communicated that they are always there to help, describing staff as "omnipresent."

TA resulted in SBCC being accepted and embraced at all levels. IHBP has been given the lead by the MoHFW for providing capacity building on RMNCH+A communication at the national and state levels. The importance of the SBCC concept and of IHBP was confirmed with other donors as well. A KII with the Chief Communication for Development at UNICEF revealed the following: "IHBP is working in an area forgotten by development partners; flagship programs focus mainly on the supply side." Furthermore, IHBP is a member of the National Governing Board for tuberculosis, and has been asked to review PIPs for BCC. They are also invited to all of the NPCC meetings to review PIPs.

In addition to clear successes in several states, the GoI has directed the states to adopt the standardized communication strategies, approaches, and messages, which has reached beyond the eight mandated states, for example in Odisha, West Bengal, and Gujarat. IHBP is expected to provide TA for all events related to communication by the IEC and the technical divisions. IHBP provided inputs for communication issues in the national surveys, DLHS 4 (2012–13), NFHS 4 (2014–15), and for the 7th Common Review Mission. As per the Likert scale survey analysis of the open-ended questions, 14 out of 17 district- and block-level IEC government personnel (82%) said that the trainings on SBCC, IPC, and folk media instruction were effective, and have improved understanding of SBCC/IPC and change from IEC to SBCC.

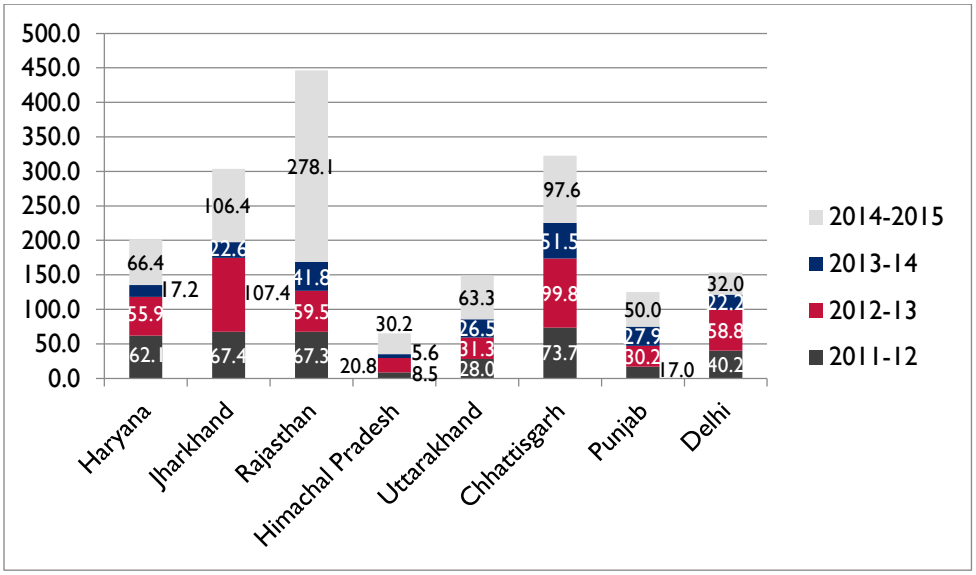
SBCC component of PIPs strengthened with inclusion of evidence-based 360-degree approach with justifications.[13] According to multiple KIIs with high-level GoI staff, IHBP consultants and staff are considered highly competent, responsive to national and state needs, and were key to PIP preparation. Due to the revised guidelines and training provided by IHBP consultants, the quality of PIPs

[12] See Graph 2.
[13] See Annex VII for supporting evidence on PIP budgetary information and trends. Data provided by IHBP staff.

greatly improved with proper justifications, monitoring plans, and detailed budget with a focus on mid-media and IPC instead of mass media activities. Haryana, Jharkhand, and Punjab made three-year PIPs, with budgets for one year, as was advised to all states.

The IHBP consultant stationed at the MoHFW reviewed the PIPs of all the 28 states and union territories for BCC, and participated in the NPCC meeting after which the ROPs[14] were prepared. Graph 4 shows the state budgets for IEC/SBCC for the last three years and the approved budget for 2014–15. The budget for SBCC in the PIPs is substantially high for all the IHBP focused states as compared to the budget for 2013–14. The maximum increase can be seen in Rajasthan, where the budget has increased from almost 42 million rupees in 2013–14 to 278 million rupees in 2014–15.

Graph 4: State PIP Budget for SBCC (2011–2014) and Approved Budget for 2014–15 in millions of Rupees



Source: State PIPs and IHBP. All figures are in million INR.

As illustrated in Graph 4, the percentage change in state IEC/BCC–approved budgets pre- and post-IHBP state-level TA is significant across the eight states. Rajasthan has seen its budget increase by more than 500% (from 41.8 to 278.1 million INR), while Haryana, Jharkhand, and Himachal Pradesh have all seen increases in the range of 200–400%. Please see Annex VII for an overview of the percentage increase in approved state IEC/BCC budgets between the 2013–2014 and 2014–2015 periods.

Improved SBCC at the state level (IHBP supported). IHBP developed the job descriptions, specific TORs, and deliverables for the state- and district-block IEC/BCC officials and staff. In Haryana,

[14] ROP: Record of Proceeding is the document sanctioning the approved workplan and budget for the state NHM PIP.

with support from IHBP, three consultants were appointed to the state IEC bureau. In Jharkhand, the existing IEC personnel from the districts have been brought to the state IEC bureau. According to the Deputy Director of IEC at the Jharkhand Rural Health Mission, "The Health Educators (HEs) at the district level and BEEs were never used for IEC properly." Induction training and orientation has been undertaken on SBCC for newly appointed personnel in all the state IEC/BCC units/bureaus along with handholding, which has enhanced the staff's skills in planning and implementation. The communication materials have been adapted by all states and Media Plans have been developed for Jharkhand, Uttarakhand, Haryana, and Rajasthan.

The effect of TA at the state level is seen further in the Understanding Communication Activities Management[15] study in which the baseline (mid-2013) data has been compared with the midline study data (May 2014). For Haryana, it was found that progress was made from baseline, where systematic situation analysis was not conducted and where programs were not found to collect or rely on existing or original research, as the design was perceived to be predetermined. At midline, however, a systematic process was initiated to some extent. In Rajasthan, the same study observations include that the IEC department made remarkable progress from the baseline phase, which had not held trainings over the past 8 to10 years, to now having capacity enhancement training plans that were proposed in the PIP last year and to having trainings in progress this year. Per the same study in Jharkhand, in the baseline it was found that the planning document only included details of responsibilities and time frames as to when to implement each activity. During midline, however, the document included details related to resources allocated, particularly budgetary resources.

Effect of IHBP TA in non-IHBP states. IHBP has been mandated to provide TA at the national level and in eight states, but from KIIs with IHBP consultants and staff it is apparent that consultants and staff are expected to provide support on all communication-related activities. One cause of this is the recognized need for health-related communication activities at the highest levels of government. For example, the GoI organized a workshop in 2012 on SBCC to which all states were invited, including non-IHBP states. Word also spread to non-IHBP states about SBCC activities in core IHBP states, which sparked interest among various state governments and created a demand for additional SBCC activities.

The communication materials were adapted by Odisha, Assam, Gujarat, Bihar, Uttar Pradesh, and West Bengal and translated into their local languages. In Assam and Odisha, SBCC training was organized at the request of the state government. In Assam, IHBP provided support in PIP development. The NIHFW has been approached by Meghalaya and Karnataka to conduct SBCC training.

Effects of IHBP on the various departments and programs. IHBP has used a multi-sector approach of working across the three sectors of RMNCH+A, Tuberculosis, and HIV/AIDS with the RCH division, CTD, and NACO, besides working with MoWCD. Per the midline study conducted on Communication Activities Management, progress was made in Jharkhand from the baseline where the programs only had plans for capacity training but were not able to implement them whereas at midline, it was observed that the IEC team was able to implement their training plans. Furthermore, training was already taken care of for most of the district personnel and is now ongoing for the block staff. In this regard, the senior IEC official interviewed acknowledged the inputs of the IHBP team in training the IEC staff.

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[15] "Understanding Communication Activities Management, India," May 2014, New Delhi: FHI360 "Understanding Communication Activities Management: Midline," FHI 360, 2014.

Examples of this work and collaboration include:

RMNCH+A focus of campaigns. IHBP placed a full-time consultant in the RCH division (MH, CH, FP, AH), which facilitated a smooth coordination between RMNCH+A and the various technical divisions of Maternal Health, Family Planning, and Adolescent Health for SBCC. For effective coordination among the various RMNCH+A counterparts, coordination meetings are regularly organized with IHBP facilitating the process. Campaign materials developed in collaboration with the technical divisions using the 360 approach have been appreciated immensely and are being used along with media selection for effective delivery of messages.

NIHFW highly involved in SBCC training logistics. IHBP has provided TA to NIHFW in strengthening their capacities for SBCC for training personnel and in helping to set up the NRC for SBCC. A budgetary provision has been made under the budget head of the Public Health Museum, which will be used for NRC in the 12th Plan, which has ensured its sustainability. An analytical review of state-level IEC strategies and materials and a gap assessment of the Resource Center has been conducted by IHBP. IHBP has facilitated the process for setting up the NRC with the involvement of a number of organizations who have worked in health communication. According to the Chief Communication of Development at UNICEF, the organization has agreed to support the development of the NRC since they already have a national repository of 1,400 communication materials in different stages of the life cycle, consisting of mass media, mid-media, IPC, and ICT.

Strengthening RNTCP with the Central Tuberculosis Division (CTD). At the national level, ACSM has been strengthened through regular National ACSM advisory group meetings and the development of a strategy document and guidelines. Media analysis was completed, a media kit was prepared, and capacities of the personnel were developed for media engagement through training and handholding. A campaign was developed by IHBP for TB and HIV co-infection. This is one step for integration of CTD and NACO. PSI and IHBP jointly organized a social media campaign for World TB day with an objective to generate awareness about TB notification and also garner support from private medical doctors in the fight against Tuberculosis. This initiative was developed to support the current TB notification drive and Nikshay program of the Revised National Tuberculosis Control Program (RNTCP). A PIP for ACSM was developed and revised after training of the IEC officials in SBCC by IHBP.

Strengthening National AIDS Control Program of NACO (DAC) through establishing National HIV Communication Resource & Support Center (NHCRSC). Seventeen consultants were placed at NACO in the last 18 months for establishing the NHCRSC as a technical support unit within NACO for planning and implementing an SBCC approach. Initially there were eight consultants, and this number gradually increased per requirements from NACO. The consultants undertook field visits to SACS to gain in-depth understanding of the IEC/mainstreaming efforts at the state level. Over the course of Year 3, the team travelled to Orissa, Maharashtra, Karnataka, Tamil Nadu, Mizoram, Madhya Pradesh, UP, Rajasthan, Jharkhand, Gujarat, Chhattisgarh, and Haryana to review the progress being made compared to the SACS-approved Annual Action Plans (AAPs).

IHBP provided SBCC training to 14 master trainers from DAC and SACS, and 98 state IEC and program officers from 37 SACS were trained. According to the Deputy Director General of NACO, it was a good experience to work with IHBP: whatever was wanted or expected was addressed. NHCRSC has drafted an M&E strategy for the IEC Division to streamline and strengthen the current reporting of IEC activities. NHCRSC gave support to the recall study for vector-borne diseases (VBD) campaign. IHBP developed the 360-degree campaigns in Stigma and Discrimination, PPTCT, and a campaign for youth. IHBP consultants on the NHCRSC team reviewed the AAPs of 33 states and provided input to help in finalization. Despite initial progress, the state units have not been strengthened to our satisfaction, according to the Deputy Director General of NACO. A member of the IHBP staff noted that TA was only provided to NACO at the national level, apart from several SBCC trainings conducted at the state

level. NACO decided that it would strengthen states through the NHCRSC so the lack of progress cannot be entirely attributed to IHBP. Moreover, the Digital Resource Center is the first national repository of HIV in India and 200 materials have been uploaded and 2,000 materials sourced. A physical library and digital library have been established, over 3,000 resources have been collected, and over 600 documents classified and cataloged. In addition, 250 digital resources and 250 books are part of this library.

Strengthening the MoWCD. The Nutrition Resource Platform (NRP) was set up with the support of IHBP to NIPCCD and received an e-governance award from the GoI in 2013–14. The GoI has allocated funds of INR 10 million yearly and has been mentioned as a budget line in the national MOWCD regular budget. The NRP can be accessed in eight languages and is a very popular site, having received more than 6 million hits and more than 129,000 unique visitors to date. The NRP has hosted the four phases of the IEC campaign (TV, radio, and newspaper) on the use of Mother and Child Protection cards and on malnutrition. A nationwide campaign on malnutrition coordinated by MOWCD was hosted on NRP, with pro bono support from the famous Bollywood actor Amir Khan. IHBP developed the framework for using ICT to strengthen the training component of ICDS. The adaptation of BBC Media Action's Mobile Kunji and Mobile Academy, for hosting on NRP platform, has been completed and the pilot tested in Bihar. NRP has also developed an Interactive Voice Response (IVR) and SMS-based monitoring system in coordination with NIC, Bharat Sanchar Nigam Limited, and the GoI Department of IT. IHBP provided initial training design support for this, developed modules, and identified with the MoWCD 44 messages relevant for ensuring good nutrition.

Institutional strengthening at the state level. IHBP focused on building capacity at the state level by strengthening, wherever possible, the responsible unit for planning and implementation of communication/IEC activities, since there was no specific division focusing on SBCC. At the national level, the IEC Division was the designated department under which IEC or communication planning activities were traditionally undertaken. From the KIIs and project documents such as annual reports, it was evident that IHBP made significant progress in raising the awareness of the spectrum of SBCC activities in these IEC divisions/units at the national and state levels. Additionally, the project succeeded in providing appropriate and relevant TA to address the variable capacities across the eight states with respect to planning and implementation of SBCC activities.

In Haryana, IHBP successfully advocated for revising the job descriptions and expanding the role of the one-person IEC unit into a full-fledged BCC Division with qualified professionals for various skills related to communication and media planning. IHBP also helped Haryana garner interest from the private sector for leveraging SBCC activities, which can be expected to fructify after additional discussions and negotiations, which will occur beyond the project period. In Jharkhand, IHBP advocacy led to restructuring and expanding the existing BCC cell to include IHBP-trained BEEs. Additionally, the state government requested IHBP project support for developing new job descriptions to reflect the revised scope of work related to SBCC in key personnel in the communications division.

The KIIs with senior state officials in Haryana, Jharkhand, Rajasthan, and Uttarakhand confirmed that IHBP staff provided handholding and mentoring support to all state BCC staff at a very critical juncture, when state PIPs were due to the federal Ministry. The IHBP staff based in the states built the capacity of the state teams in providing evidence-based documentation for the appropriate SBCC activities under the various budget lines proposed in the PIP. The evaluation team accessed project documents that highlighted the workshops that were conducted by the project to train government staff on the spectrum of communication activities, capacity building plans, and development of M&E for BCC. Part of the TA that IHBP provided also included building capacity of staff to conduct a training needs assessment in order to plan the annual training calendar, which the evaluation team confirmed during the field visit to Haryana. In Rajasthan, IHBP's intensive advocacy efforts with the Director of the IEC Unit led to an

official directive from his office to appoint existing bloc- and district-level ASHA coordinators as point persons for block and district levels, respectively, to support SBCC planning and monitoring.

3b. What key lessons can be drawn from its implementation?

Technical assistance strategies employed by IHBP were well received. The IHBP TA response was deemed timely, appropriate, participatory, and responsive in KIIs with GoI staff. It met the needs of the GoI and was successful at introducing innovation and creating a sense of ownership of the new approaches at the same time. This was done by adapting well to the government's bureaucratic style and relatively slower pace of doing things.

The responses in the Likert scale regarding TA had the most positive rating of the seven questions asked of all groups surveyed; GoI (4.5), SBCC personnel (4.6), project partners (4.5), and private sector (4.8). This was in response to the statement *Strategies used by IHBP technical assistance were effective and should be used again in the future*. This was confirmed in the study "Understanding Communication Activities Management," which was conducted in the eight project states. The study measured changes in technical abilities in five aspects of communications following IHBP work in the states. There were positive changes in each category in each of the states reviewed for the evaluation: Haryana, Jharkhand, Uttarakhand, Chhattisgarh, and Rajasthan. These changes were seen in a very short period of time, less than one year from baseline to midline. The study examined different parts of planning and implementing SBCC, from analyzing data to planning and evaluation. It is important to see progress in each aspect as evidence of progress with SBCC strategic planning.

Table 3. Communication Activities in 5 States

	Haryana			Jharkhand			Rajasthan			Chhattisgarh			Uttarakhand		
Parameter	**B**	**M**	**% Diff.**	**B**	**M**	**% Diff.**	**B**	**M**	**% Diff.**	**B**	**M**	**% Diff.**	**B**	**M**	**% Diff.**
Situation analysis	7	11	**57%**	10	12	**20%**	12	12	**0%**	8	8	**0%**	8	9	**13%**
Communication strategy	10	11	**10%**	16	20	**25%**	16	18	**11%**	9	12	**33%**	9	12	**33%**
Intervention materials for change	5	7	**40%**	10	12	**20%**	7	8	**13%**	6	7	**17%**	6	10	**67%**
Implementation	17	15	**-12%**	16	21	**31%**	20	21	**5%**	7	13	**86%**	14	21	**50%**
Evaluation and replanning	13	18	**38%**	8	13	**63%**	14	17	**18%**	8	12	**50%**	11	15	**36%**
Overall	**52**	**62**	**19%**	**60**	**78**	**30%**	**69**	**76**	**9%**	**38**	**52**	**37%**	**48**	**68**	**42%**

B=Baseline; M= Mid-line
Source: Understanding Communication Activities Management, India, May 2014, New Delhi: FHI360

As can be seen in Table 3, improvements were seen across the five states from baseline to midline. While implementation and intervention materials for change saw the strongest improvement in Chhattisgarh and Uttarakhand, situation analysis and evaluation and replanning saw the most improvement, in Haryana for situation analysis and in Jharkhand and Rajasthan for evaluation and replanning.

In addition, the study states that in Haryana, the IEC department strongly believes that with further dialogue with IHBP, more areas for intervention apart from communication strategy, M&E, and capacity building, such as material designing, could be explored.[16] In Rajasthan, the same study has noted that the state shows progress in this regard from baseline where programs did not ensure that staff were trained in communication. In addition, though plans were prepared for the same, actual implementation failed to take place due to development of training plans for district-level functionaries and actual implantation of the same two times in a year. The state perceives a huge scope for partners such as IHBP in this regard. In addition to this, conducting skill-based and refresher trainings at the block level have been recognized as another need area, the training plans of which are presently in progress.

Training is a continuous process. The SBCC training implemented by IHBP was well received and greatly appreciated, and it resulted in significant changes in terms of stakeholders' accepting evidence-based strategic planning. It was clear from both the KIIs and the FGDs with IEC/SBCC communicators that there is a need for refresher SBCC training and follow-up to facilitate implementation. This is particularly true with training in SBCC interpersonal communication for frontline workers, according to those interviewed. There were also complaints about insufficient practical exercises and field practicums to increase opportunities for application as well as materials and training at the state level to better use the nine campaigns developed by IHBP.

4a. What are the key learnings from the IHBP project that can inform investments in SBCC in the future?

Consensus that project strategies and model bring about change and are well worth continuing. There is universal consensus among key informants at both national and state levels of the GoI and among partners that the project strategies, approach, and the model brought about the required change. SBCC has now been accepted as an important strategy instead of IEC. The Senior Manager of Communications at PSI stated, "For decades mass media did not move beyond a health education focus, and was not scientific and based on a strategy." Fifteen out of 17 IEC personnel (88%) in the Likert scale survey open-ended questions said that training in SBCC and IPC helped in motivating workers and in problem-solving and has also resulted in producing better outputs, especially for ASHAs. Strengthening of the IEC units at all levels, development of SBCC-focused PIPs, evidence-based campaigns, development of resource centers for communication, and innovative use of ICT have been successful strategies.

Widespread concern that progress made will be lost without continued TA at national and state levels. Most KII with IHBP consultants, staff, and GoI counterparts expressed concern that progress will be lost if the TA does not continue at both the national and state levels. Most of the interventions in this project have been implemented in the last 12 to 18 months, especially at the state level. According to KIIs, most states, including those with more extensive activities such as Haryana and Jharkhand, require additional support and handholding. The Mission Director (NHM) and IEC Director in Rajasthan said, "If the TA does not continue, the efforts made for SBCC will go into oblivion." Clarity about SBCC has happened to some

[16] "Understanding Communication Activities Management," India, May 2014, New Delhi: FHI360, 28.

extent, but capacity building to the level of execution has not happened, and sustained inputs are necessary for SBCC to become institutionalized and a routine process. As stated in the midline study titled "Understanding Communication Activities Management" regarding Chhattisgarh, "The IEC department perceives the need for stable presence of a development partner so that activities can then accordingly be planned in PIP and implemented, with continued support. The areas of intervention presently seem to be in all areas of communication, capacity building and M&E".

Further TA support needed to implement PIPs. The PIPs have received approvals and the budget has increased substantially as compared to last year's budget in most states. As expressed by senior state officials the operational plans will need to be developed for the PIPs for their successful implementation. For this to happen, TA will be absolutely necessary, as the states do not have adequate capacity for implementation. This TA is expected to come eventually through local mechanisms such as a SBCC Center of Excellence.

Working in close collaboration with GoI at all levels and stages proved successful. Working in close collaboration with IHBP has been welcomed by the GoI. The approach of facilitation, building institutional capacity, mentoring, and handholding through placing consultants in the system and providing targeted BCC TA to government partners has resulted in the successful acceptance and implementation of the program. The state-level IEC personnel have developed a greater sense of usefulness after several decades of service as expressed in the FGD participants from Himachal Pradesh. As per the Likert scale survey of the district- and block-level IEC government personnel, the strategies used by IHBP TA were effective and should be used again in the future had a value of 4.6. A value of 4.5 was given to technical expertise provided by IHBP which was considered "effective and improved our effectiveness."

Sustainability built in from beginning through mentoring, leveraging, and working with existing GoI institutions. Sustainability has been built in from the beginning through mentoring and handholding of the IEC personnel and working with the existing government institutions. According to the Chief, Communication for Development from UNICEF, IHBP is doing a great job of not creating a dependency. It wants the government to see the added value of investing its own resources in SBCC, and develop a clear road map for the future, and the GoI is taking it seriously. Examples include the NIHFW which has developed skills for capacity building on communication with the support of the IHBP team. The NHCRSC has been developed as a technical support unit in NACO, and the GoI has appointed consultants in Haryana to sustain efforts. In Jharkhand, the existing IEC personnel from the districts have been incorporated in the state IEC bureau. Some non-IHBP states like Assam and Odisha have also asked for consultants to assist in PIP development. In the 12th Plan there is budgetary provision for a Resource Center. NRP has been successfully hosted in NIPCCD with appointment of government consultants and a budget line have been added to the regular NIPCCD budget. IHBP has developed a number of documents, training material, and excellent campaign material for use by the MoHFW. M&E and capacity building plans for BCC have been included in state PIPs and have been approved.

For a more comprehensive and effective response, improve coordination and strategic alliances with donors and partners (partnership with UNICEF). Improved coordination and building strategic alliances with a variety of donors and a number of partners is essential for a more comprehensive and effective response, especially among private-sector networks and resources. KIIs with Jhpiego, MCHIP, PSI, and PopCouncil provided high Likert scores to IHBP TA, but donor coordination mechanisms could be strengthened to avoid duplication and to streamline expectations and roles among parties. The Chief, Communication for Development at UNICEF recognized that there are overlaps and that there have been some issues related to partnerships in some states, such as Chhattisgarh and Rajasthan. This point was not shared by all key informants, however, and IHBP

consultants in Jharkhand and Haryana and project partners such as Jhpiego saw no such issues with the collaboration.

4b. What do key informants identify as best practices, promising new approaches, innovative ways to reach people, and leveraging strategies that can inform future programs?

Evidence-based, well-targeted 360-degree campaigns with appropriate emotional tone and use of multiple channels. The evaluation team found through its desk review that IHBP used formative research and audience consultations to demonstrate a number of well-designed SBCC campaigns. Additionally, the FGDs and the open-ended questions in the Likert scale survey on the contribution of the IHBP project established that across respondents at the national and state levels there was an increased statewide capacity and greater understanding of designing and implementing a 360-degree SBCC campaign.

Recall studies for obtaining feedback for replanning. A senior Director at the MOHFW told the evaluation team that the intense interaction between his department and IHBP during conceptualizing and rolling out of the FP campaign have increased the capacities of government health personnel to design, roll out, and evaluate a media campaign. The recall studies also led to a concerted coordination between the national- and state-level decision makers. For instance, in the state of Chhattisgarh, the media plan and mix, which were critical for increasing the reach of the family planning campaign, were decided in joint consultations with the Directorate of Advertising and Visual Publicity (DAVP) at the national level and the state's local media partner. The feedback that was provided from the qualitative research supported a concerted 360 campaign that also used print material from the campaign to complement local family planning communication activities. The use of such evidence to match the media mix with the appropriate message and target audience is clearly a new direction for planning SBCC activities.

Establishment of easily accessible electronic resource centers. The IHBP project successfully supported the development of the Nutrition Resource Platform (NRP), an initiative of the Ministry of Women and Child Development (MWCD), GoI, to collate and make available resources and materials on nutrition and child development. The web-enabled platform serves as an easily accessible, low-cost repository on nutrition- and child care–related topics and improves adoption of good practices to influence behavior change around nutrition and child care. The evaluation noted that this platform is now housed under the GoI server (www.nic.in) and its operations are budgeted in the annual financial provisions by the Ministry, making it sustainable. The project also helped to establish a digital resource center and an interactive digital library that houses more than 2000 resources in multiple languages for the Department of AIDS Control (DAC). The FGD with stakeholders at NACO as well as the open-ended questions in the Likert scale survey acknowledged that these electronic resource platforms are one of the project's significant contributions toward SBCC strengthening.

Use of mHealth to increase vulnerable population's access to services. The IHBP project was instrumental in the innovative use of mobile technology to increase uptake of health information and services. In partnership with PSI, IHBP supported an interactive, mobile-based training module to improve private providers' (health care providers from the AYUSH systems and pharmacists) knowledge about TB diagnosis and treatment. PSI shared initial assessment reports with the evaluation team that show a significant increase in referrals from one group of providers (pharmacists), which augurs well as a potential outcome of the expanded use of mHealth.

Social media and new media experimentation in nascent stage. The IHBP project has succeeded in kindling the interest of senior decision makers and planners in the MOHFW in the use of social media as a tool for strategic communication. The IHBP consultant responsible for social media at the MoHFW shared with the evaluation team that while the process is in a nascent stage, the social

media platform has evinced wide interest from a variety of stakeholders, including the Prime Minister's Office. The use and effectiveness of social media was shared during interviews at the states as well, but insufficient resources have prevented its broader adoption. It was raised in a KII with PSI that PSI has benefited from using social media for public health and that the new mHealth social media strategy has great potential for scale-up.

Strategic use of field workers for effective and participatory IPC. The engagement of field workers such as BEEs and ASHAs to conduct SBCC-focused IPC and mid-media is a good example of how the project engendered new communication skills among existing cadres. The FGDs with these newly trained workers revealed a renewed confidence and discovery of innate interpersonal communication techniques relating to soft skills, attitude, body language, and use of other nonverbal skills that brought improved results, such as increased demand for health services. "I learned not to get angry when that member of the community refused to visit our (health) services. But this new technique made me change my attitude. Instead I focus on their points of view and today instead of 3 to 4 institutional deliveries in a month, we are seeing 35 to 40 from that same community!" enthused a BEE in Haryana.

CONCLUSIONS

Broad-based understanding of the need for incorporating evidence-based strategic planning in GoI and state SBCC strategies. There is evidence that the GoI, at both the national and state levels, was already open to the transition from traditional IEC approaches to an SBCC approach but it was the project inputs that succeeded in making the transition a reality.

Substantial leveraged funds by GoI is a sign of effective advocacy. The GoI did not simply pay lip service to adopting the SBCC approach but invested its own resources on a large scale at the national and state level towards staffing, planning, researching and implementing the approach.

Better balance between mass and mid-media and interpersonal communication. The GoI has placed emphasis in the past on mass media campaigns[17], with television getting the bulk of resources. As a result of IHBP inputs there is a better balance between communication channels, which increases the chances of reaching into mass media "dark areas," which represent surprisingly large areas in some states, A cost-effectiveness study of different SBCC approaches and channels that can be used in SBCC strategic planning, would help guide and inform the media mix and selection however.

[17] Mass media expenses also include the cost to dub/adapt all of the HIV materials in ten languages, the cost of video production for several campaigns, and a music video.

Training successful in creating broad support for SBCC approach and increased skills for evidence-based planning. The combination of training and embedded project staff has ensured that SBCC is the predominant approach used for promoting positive public health practices.

Additional training in interpersonal communication is needed. Some states have conducted training in SBCC and interpersonal communication of their frontline workers but there needs to be a more systematic series of trainings, including guidance in using support materials interactively. Supervision is also required to ensure the effective use of SBCC on a broad scale.

Acceptance of the need for effective M&E but skills are needed. Progress has been made in creating an awareness of the M&E role at the national and state levels. What is missing is the establishment of effective systems that not only collect data but use it to guide future SBCC planning; at present there is no comprehensive M&E system that tracks and monitors the various SBCC activities across states and at the national level. A comprehensive M&E system would still be capable of tracking progress of activities at the state level against targets despite a wide variety of activities across states. Such a system would also be incredibly useful in assessing progress at the state level and planning for future activities.

Institutional strengthening at the national level: IHBP has used a multi-sector approach to work across the three sectors of RMNCH+A, Tuberculosis, and HIV/AIDS with the RCH division, CTD, and NACO, besides working with MoWCD. Extensive TA has been provided across national-level institutions in the form of training, with mentoring and assistance provided by IHBP consultants, and there has been ongoing communication and support of IHBP by the GoI.

Institutional strengthening at the state level: IHBP focused on building capacity at the state level by strengthening, wherever possible, the unit responsible for planning and implementing communication/IEC activities, since there was no specific division focusing on SBCC. IHBP succeeded in providing appropriate and relevant TA to address the variable capacities across the eight states with respect to planning and implementation of SBCC activities.

If focused TA does not continue, IHBP successes will be difficult to sustain. IHBP has had remarkable success in a very short time frame in facilitating the transition from IEC to SBCC and increased GoI commitment to it. There is also evidence of increased skill levels for planning SBCC at the national and state levels. But strong fears were expressed by many interviewed in government and among partners and SBCC staff that if there is no continuity in the technical assistance and institutional support, the progress will be limited.

Progress made with the resource centers, but there is scope for expanding use. The resource centers that have been created or planned with assistance from IHBP have contributed to the collection and electronic housing of materials and documents. More support is needed to ensure that they are easily accessible and that strategies are developed to promote their use.

Large amount of technical assistance needed to identify and build up center(s) of excellence. There is general consensus that TA in SBCC will be needed to continue building the capacity at the national and state levels when IHBP winds down. In order to maintain the momentum well into the future, a center or centers of excellence in SBCC are needed. They could be found in either the government or NGO sectors and would likely require immediate organizational development and technical capacity building. It should be expected that there would be a certain transition period before IHBP could hand over responsibilities to the center(s) of excellence.

Progress made with new communication technologies but on a small scale. The use of mobile phones and other mobile devices, the Internet, and social media has been experimented with by IHBP, and early indications show good potential under certain circumstances. Most importantly, there needs to be an in-depth accounting with specific audience segments of its impact before bringing their use to scale.

IHBP consultants expected to work outside of their mandate, which can limit their mentoring role. Embedded IHBP consultants are greatly appreciated at both the national and state government levels. Implementing SBCC strategies is a challenge at all levels and there is a tendency to rely on the consultants to do the implementation rather than facilitating and supporting. It is essential to find a balance between doing and helping that allows GoI newly built capacity in SBCC to be sustained.

Private-sector leveraging not as extensive as envisioned but involvement has potential. The extent of the involvement of the private sector has been generally below expectations due to a number of obstacles but should not be abandoned. Some successes have provided both a blueprint and model for future collaborations. There is a better understanding now of what can and cannot be accomplished and the potential remains for more leveraging in the future.

RECOMMENDATIONS

CONTINUATION OF MOMENTUM

There is a clear consensus among all stakeholders that IHBP has had a substantial impact in creating an environment supportive of evidence-based SBCC approaches. There is also consensus among GoI and its partners that further support is needed to build on the initial success.

- USAID/India is currently considering existing funding mechanisms that will keep the core components of IHBP functioning. Considering the proven value of IHBP outputs and utility to GoI, USAID/India should extend this funding as long as necessary to ensure a smooth and seamless transition to post-IHBP strategies that will enable SBCC TA to continue and build on successes.
- USAID/India might consider preparing a follow-up procurement for more long-term support to capitalize on momentum and ensure the full transition to sustainable SBCC planning and implementation.
- USAID/India and IHBP should continue discussions with the GoI, for USAID/India to fully understand its priorities, leveraging opportunities and objectives for the future.
- IHBP, in collaboration with USAID/India and UNICEF, should take the lead to establish or reactivate stakeholder committees, and create MOUs and undertake resource-sharing where appropriate. This spirit of enhanced collaboration should be extended to bilaterals and multilaterals for improved coordination, reduced duplication, and the best use of resources.

STRENGTHENING THE MODEL

The SBCC model used by IHBP has been well understood, greatly appreciated, and widely adopted by GoI and its partners. However, there are some gaps that need immediate attention and consideration for the post-IHBP phase.

- IHBP should immediately design a study based on existing data, secondary and original research that considers the cost-effectiveness of different media used in the 360-degree package in order to guide future strategic planning when selecting a variety of mutually reinforcing channels. There is an urgent need for IHBP to provide GoI and its partners with greater insights on the relative cost-effectiveness of different SBCC approaches and channels that can be used in SBCC strategic planning, especially channel selection at both the national and state levels For example, planners could benefit from more insights on the programming options for reaching target audiences in media dark areas and the cost-effectiveness of different mid-media strategies such as street theater, hoardings, and transport ads. The cost-effectiveness of regional radio compared to national television is also a useful insight.
- IHBP should provide TA to the GoI to develop a comprehensive and robust M&E system in a pilot phase in one state that incorporates SBCC monitoring indicators into the national HMIS system.
- USAID/India should consider the development of new indicators for future programming that measure more precise changes in behavior at the GoI level, such as increases in filled or new SBCC staff positions, use of interactive IPC SBCC by frontline workers or increased budgets dedicated to SBCC. Ultimately, indicators need to be established that are focused on measurable changes in target population behavior resulting from SBCC interventions.
- USAID/India should continue its support for the innovative use and expansion of new communication technologies, including mHealth and other Internet links as well as mobile phones and messaging, tablets to convey support materials and as job aids, and social media. Bringing to scale these media is contingent on the current piloting of them, providing concrete proof of cost-effectiveness and access by a critical mass of target audiences.
- IHBP should take concrete steps to reinforce the SBCC training that has been done through refresher trainings that increase the amount of time conducting practical exercises and supervised fieldwork. Increasing the training length or conducting two or three separate trainings to enhance the training experience are viable options. Supervision and the systematic development of IPC skills among frontline workers will also increase the success of implementation.

PRIORITIZATION MOVING FORWARD

USAID/India has indicated that it intends to provide assistance to keep a scaled-down version of IHBP vitally functional for at least a year, with the hope that other means of sustaining the SBCC technical assistance and the provision of institution building will develop and provide continuity.

- USAID/India might consider scaling-down IHBP by focusing its resources in a smaller number of states. This would permit the development of a comprehensive and integrated SBCC model that includes effective M&E systems that could be replicated in other states. Part and parcel of focusing in fewer states would be the accounting of the process and production of tools and how-to guides to facilitate replication.
- IHBP should rationalize IHBP staff and consultants at all levels to maximize opportunities for mentoring. The support that IHBP SBCC staff seconded to GoI has proved to be useful especially at the state level, with the improvement of the PIP process. The challenge remains to find a balance between facilitating others to do the work and doing it themselves.

- In light of GoI priorities and the high level of collaboration, USAID/India should focus its SBCC resources on RMNCH+A primarily under IHBP and curtail other health intervention areas or encourage others like NACO to seek other mechanisms for support in SBCC.
- The 360-degree multi-media campaigns have received the largest single portion of IHBP programing resources. IHBP should look for ways to reduce production complexity to lower the cost of each but continue IHBP collaboration with advertising and research agencies. The ultimate goal would be for the GoI to eventually take over the total management of developing and implementing future campaigns.

TRANSITION TO SUSTAINABILITY

IHBP was developed with the goal of improving the capacity of GoI and its partners to do evidence-based strategic planning of SBCC. The intention now is to gradually phase out the program but ensure that there are supports in place to ensure that the progress made is sustained and built upon.

- IHBP should accelerate the finalization of a body of evidence that accounts for the transition from IEC to SBCC including how-to guides, sample materials, training modules, and other documents that can lead to exportation of the model and eventual expansion to additional states.
- USAID/India should ensure that IHBP TA continues for a limited duration, which will enable a seamless transition to the GoI and its partners to continue to develop effective and sustainable SBCC.
- IHBP in collaboration with GoI should conduct a study evaluating potential institutions that could host the center(s) of SBCC excellence and their institutional strengthening and TA needs. It would be expected that this center(s) would provide TA and institutional strengthening in place of IHBP. Such a center or centers of excellence could be located within an existing government, parastatal, or civil society institution or a combination of the three. The selection of center(s) would be based on having a proven track record in SBCC as well as management stability to increase the chances for sustainability.
- To increase the participation of the private sector, the focus of its involvement should be changed by fully leveraging its core competencies and networks to increase corporate ownership and sustainability.

ANNEXES

ANNEX I: EVALUATION STATEMENT OF WORK

PROJECT INFORMATION

a) Project Title: Evaluation of Improving Healthy Behaviors Program (IHBP)

b) Start-End Dates: October 25, 2010- December 12, 2014

c) Project Budget: $21,881,000

Program/Project Description:

USAID has signed a bilateral Health Partnership Program Agreement (HPP) with the Government of India (GoI), focusing on strengthening the health system to address core health needs of vulnerable populations. Increasing demand for health services is one of the five key results under the HPP. The Improving Healthy Behaviors Program (IHBP) is the flagship project of USAID under this bilateral agreement to support Social and Behavior Change Communication (SBCC) activities. The project is implemented by FHI 360 as the prime partner, with Population Council and Population Services International as sub-partners.

The IHBP project aims to strengthen institutional and human resource capacity of national and state-level government and nodal institutions to design, deliver and evaluate programs to improve adoption of healthy behaviors. Through strengthened institutions at all levels, the project provides technical support in planning and implementing community-level SBCC activities at the national level and in priority states in India. The SBCC activities cover four program areas- HIV/AIDS, family planning/reproductive health, tuberculosis and maternal and child health. The IHBP has four objectives:

1. Strengthen capacity of government and nodal institutions to design, deliver and evaluate strategic communication programs;
2. Increase accurate and appropriate knowledge/attitudes among individuals, families, communities and providers;
3. Enhance community platforms, organizations, and key individuals' support to improved health behaviors; and,
4. Empower vulnerable communities to seek health services and products.

The project was initially awarded for a base period of three years, starting October 2010. In

March 2013, USAID issued a change order, revising IHBP's scope of work (SOW) and deliverables, and extending the Task Order (TO) for the option period-from October 1, 2013 to December 12, 2014-based on the end date of the parent indefinite quantity contract (IQC), the Technical Assistance and Support Contract (TASC) 3.

USAID's Development Objective related to health in India is to increase the capacity of its health system to improve the health of vulnerable populations. IHBP contributes to achievement of this Development Objective, specifically to intermediate result (IR) 1.1, "Increase access to priority health services." During the project period, IHBP has contributed through four key results:

- Result 1: Institutions and capacity strengthened to design, deliver, and evaluate strategic communication at national, state, and district levels
- Result 2: Accurate and appropriate knowledge/attitudes increased among individuals, families, communities, and providers at district, state, and national levels
- Result 3: Community platforms, organizations, and key individuals (influencers) support improved health behaviors
- Result 4: Vulnerable communities empowered to seek health services and products

With the change order in March 2013 and subsequent modification of the TO, the expected results were reduced to IR 1 and IR 2.

The project start-up and implementation was slow, losing crucial time when it started, due to following reasons: The initial awardee of the IHBP, AED was suspended by USAID/Washington from receiving new awards in December 2010. Due to AED's suspension by USAID/Washington, the USAID/India Contracts Officer (CO) instructed IHBP to delay major actions. This adversely affected the project start-up and full implementation in several ways, including slowdown in staff recruitment in Year 1, establishing a permanent office space, postponement of subcontract signing and launch of activities, delay in the approval of annual work plan for Year 1 and the award monitoring and branding and marking plans, delay in introductory meetings with government and other stakeholders at national and state levels, and delay in procuring office equipment, including computers for existing staff. This instruction to delay was rescinded in late March 2011. In April 2011, IHBP set out to accelerate activities and the project management was novated to FHI360. IHBP was originally designed to provide technical assistance (TA) at the national level, and in 10 districts of Uttar Pradesh (UP). USAID/India gave instruction to IHBP in mid-August 2011 to delay activities in UP, the key geographic area for implementation, based on the discussions between USAID and the Ministry of Health and Family Welfare (MOHFW) on the possibility of USAID considering another state for bilateral health assistance. IHBP was asked, in January 2013, to close its UP office and instead provide TA to Empowered Action Group (EAG) states. By August 2013 , USAID asked IHBP to focus on eight states[18], six of which were states where USAID was the lead development partner for the MOHFW's new reproductive, maternal, neonatal, and child health plus adolescents (RMNCH+A) strategy and two other EAG states.

The project's momentum dramatically increased in 2012, as IHBP staffed up and established strong working relationships with the national level government. In 2013, the project's institutional strengthening activities at the national level and in the EAG and other USAID priority states started, and several key SBCC campaigns were designed and launched.

[18] Eight states include six where USAID is the lead development partner namely Haryana, Himachal Pradesh, Delhi, Jharkhand, Punjab, and Uttarakhand and two additional EAG states Rajasthan and Chhattisgarh

Major Achievements of the Project

The overall approach of IHBP is to improve the adoption of positive healthy behaviors by building institutional and human resource capacity of national and state institutions and developing strong, evidence-based SBCC programs for government counterparts. The project focuses on four program areas: HIV/AIDS, family pla1ming/reproductive health (FP/RH), TB, and maternal and child health (MCH). The project provides TA on SBCC to the MOHFW, including the Department of AIDS Control (DAC, formerly the National AIDS Control Organization [NACO]), the Central TB Division (CTD), and the National Institute of Health and Family Welfare (NIHFW). IHBP also supported limited efforts to strengthen SBCC capacity in the Ministry of Women and Child Development (MoWCD) to improve information and communication activities for child nutrition programs. Major project achievements include:

Institutional strengthening at the national Level: IHBP's main focus has been institutional strengthening. IHBP completed rapid organizational needs assessments of institutional and human resource capacities for SBCC planning, implementation, and monitoring and evaluation (M&E) activities for the MOHFW and the MoWCD. IHBP placed consultants to strengthen the Information, Education and Communication (IEC) and program divisions to address human resource gaps.

IHBP assisted the MOHFW in finalizing and implementing four national-level campaigns: on repositioning FP/RH, a Maternal Health campaign, a campaign for promoting the postpartum intrauterine contraceptive device (PPTUCD) and promoting menstrual hygiene. Materials developed were highly appreciated by the MOHFW. The project also conducted national-level orientation for implementing these campaigns, and distributed the prototype open-source materials to all the states. IHBP then provided TA for the rollout of campaign materials in a number of EAG states, including training of folk troupes, media planning, implementation of mid-media materials, and monitoring and evaluation of the campaign.

The project has provided support to DAC for establishment and operationalization of a National HN/AIDS Communication Resource Support Center (NHCRSC). The NHCRSC is serving as a digital and physical media resource center and as the SBCC program support center for the IEC division of DAC and select State AIDS Control Societies. IHBP placed consultants within CTD to assist with the planning and implementation of advocacy, communication, and social mobilization (ACSM) activities. To improve the level of advocacy for TB, IHBP conducted news media content analysis and training in media management for state TB officers. A desk review of barriers and facilitators for TB diagnosis and treatment compliance was conducted, and an innovative mHealth game pilot activity was launched to train private providers in diagnosis and referral of potential TB patients.

IHBP assisted MoWCD in operationalizing its Nutrition Resource Platform as a resource center for all aspects of nutrition, including nutrition education and communication. The website received an award for e-governance in January 2014.

Institutional strengthening and TA at the state level: In Year 3, IHBP was a strong partner in supporting SBCC in the revised MOHFW's Call to Action strategy for RMNCH+A. Since its redirection by USAID in mid- 2013 to focus on eight states, IHBP hired state-based technical experts to assist in capacity building, improved planning and budgeting, and rollout of campaigns at the field level. IHBP began providing TA in the focus states of Rajasthan, Chhattisgarh, Haryana, Himachal Pradesh, Jharkhand, Punjab, Delhi and Uttarakhand. IHBP has placed technical experts in health communication, capacity building, and M&E in the states, and helped to strengthen the IEC units in each state. The project has worked with these state governments to strengthen their capacity to do comprehensive

communication campaigns, including providing TA for development and roll out of mid-media and inter-personal communication (IPC) tools. They have conducted capacity assessment of human resources, SBCC skills, implementation, and monitoring, and are now working with some of the state governments to establish operational SBCC units, and training and mentoring their staff.

Capacity building activities on strategic communication: The project partnered with the NIHFW to build capacity of various health personnel on SBCC. They worked to develop a comprehensive training package including training modules and toolkits on SBCC for state and district IEC officers and IPC skills for frontline workers. The project conducted trainings on M&E of strategic communication for state and district level officials. Training of State TB Officers on media management and advocacy was also conducted.

Developing SBCC strategies and campaigns: The project provided TA to the MOHFW in developing four SBCC campaigns: 1) Promoting care for pregnant mothers and institutional delivery, 2) Repositioning of family planning to promote spacing methods, 3) Promotion of Programming and Learning for Postpartum Intrauterine Contraceptive Device (PPIUCD) and 4) a campaign targeted at adolescent girls and promoting menstrual hygiene. The project has also done a campaign recall study for the repositioning of the family planning campaign in Chhattisgarh.

The project has developed a draft ACSM strategy for addressing TB in urban areas, especially in urban slums. They have also conducted an ACSM assessment in five states as a basis for developing an ACSM operational handbook for field-level officers.

The project conducted audience consultations, developed strategic frameworks, and drafted creative concepts for two national-level campaigns in collaboration with DAC. These were on stigma and discrimination (S&D) against people living with HIV among health providers, and HIV prevention among migrants. DAC decided to cancel the development of the migrant campaign, but approved and implemented the S&D campaign in Year 4. IHBP worked with DAC to develop pretest and finalize a campaign to promote Prevention of Mother to Child Transmission services.

Leveraging through private sector partnerships: The project has established nine new private sector partnerships to leverage the private sector for communications programs. These are with private sector associations and Corporate Social Responsibility arms of commercial sector organizations, for widespread use of communication materials that have been produced under this project. By the end of Year 3, an estimated $7.4 million has been leveraged from government and private sector by the project.

Evaluation Purpose

The purpose of this final evaluation is to:

1. Review and analyze the outputs, outcomes, and potential impact of the project;
2. Assess the overall program strategies and technical approaches adopted by the project;
3. Review and assess the effectiveness of the project's support to Government of India (GoI) on SBCC and to the eight states (for campaigns, capacity building of staff at national and state levels and institutional strengthening); and
4. Provide recommendations on lessons learned to guide future SBCC investments in India.

Intended Uses or other Audiences for the Evaluation

The primary intended users of this evaluation are USAID/India and the GoI. In particular the Health Office, Program Support Office, and Mission management are interested in lessons learned.

The secondary audience of the evaluation is local institutions, other donors, USAID/Washington, and other USAID missions worldwide.

Evaluation Questions

1. What is the perceived effectiveness of IHBP in advocating for strategic SBCC for key health programs at the national and state level?
2. What is the perceived effectiveness of the project's activities in strengthening capacities in SBCC of MOHFW and nodal institutions? What were the key challenges that the project faced in institutional strengthening for SBCC?
3. According to the perceptions of key informants, to what extent was the technical expertise provided on SBCC, to MOHFW and state health departments, effective? What key lessons can be drawn from its implementation?
4. What are the key learnings from the IHBP project that can inf01m investments in SBCC in the future? What do key informants identify as best practices, promising new approaches, innovative ways to reach people, leveraging strategies that can inform future programs?

TECHNICAL REQUIREMENTS

Data Collection and Analysis Methods

Desk review of documents: USAID/India will provide the team with all relevant country and project specific documents including proposals, evaluation rep01ts and other relevant documents for conducting this desk review. The evaluation team is expected to collect and collate relevant international documents, reports, and data, and all team members are expected to review these documents in preparation for the team planning meeting. This desk review will help to organize the materials for review of progress to date, and facilitate the field work, analysis and report writing stages. Extensive project documentation will be provided by FHI 360.

Data sources: Data sources that the team will be expected to utilize, review and analyze include project design documents, project proposals, annual work plans, and M&E data including any baseline information on project sub-components, state annual action plan, assessment/evaluation reports, and other project-related documents and reports. Additional relevant documents related to public health in India may be utilized as supporting documents.

Composition, Technical Qualifications and Experience Requirements of the Evaluation Team

USAID seeks a three-member evaluation team (one international and two local) comprised of a Team Leader (Public Health Institutional Strengthening and Capacity Building Expert), a Health Social Behavior Change Communications Expert (including expertise in private sector engagement), and a Health Evaluation Specialist. Relevant prior experience in India and familiarity with USAID's approaches and operations among the team members is desirable. The team members must have prior evaluation/assessment experience. The responsibilities and technical qualifications and required experience of individual team members identified are given below:

1. Team Leader/Public Health Institutional Strengthening Expert (International)

The Team Leader should have extensive experience in managing public health programs. Specifically, s/he must have a thorough knowledge of successful approaches to institutional strengthening, experience working with governments, and various management issues related to such assistance. S/he should have a good understanding of project administration, financing, and management skills. S/he should have excellent English language writing, editing, and communication skills. In addition to proven ability to leading evaluations, s/he should have substantial and demonstrated expertise in evaluation techniques involving assistance, training, advocacy, and partnership components. The person must have the ability to lead a diverse team of technical and management experts and to interface with various stakeholders ranging from government to non-government organizations, donors and the private sector. A minimum of 10-12 years of experience in the design, management and evaluation of public health programs is required. The expert cannot be directly affiliated with FHI360 or its sub-partners (LOE up to 41 days).

2. Health SBCC Expert (Local)

The SBCC expert will be responsible for assessing the key SBCC strategies promoted by the project and assess the innovative concepts piloted by the project. S/he should have 7-10 years of experience, in assessing the lessons learned from SBCC activities, demand generation, marketing and generic promotion activities such as campaign development and will provide recommendations for strengthening these interventions, as well as provide suggestions for new directions. The expert should have extensive and proven experience in the areas of SBCC, and some exposure to catalyzing innovation and technologies for SBCC and in implementing SBCC strategies in the private sector. S/he should assess and analyze the processes used by IHBP to identify opportunities for private sector partnerships for SBCC, specifically reviewing the mechanisms leveraged as well as constraints faced in greater involvement. S/he should have a good understanding of generic promotion, advertising and market research in the area of health. The expert cannot be directly affiliated with FHI360 or its sub-partners (LOE up to 34 days).

3. Health Evaluation Specialist

The Evaluation Specialist will have deep knowledge of evaluation methodologies and their practical applications in public health settings and complex technical assistance for SBCC programs. 7-10 years of experience in strategic planning, operations research, and/or monitoring and evaluation of global and national health programs particularly in evaluating SBCC programs is required. S/he should also have strong experience in understanding of secondary literature reviews and developing and implementing evaluation methodologies, experience in incorporating research information and/or complex qualitative and quantitative information will be an added advantage. The expert cannot be directly affiliated with FHI360 or its sub-partners (LOE up to 34 days).

EVALUATION MANAGEMENT

Roles and Responsibilities: The Evaluation COR and the CO will provide overall direction to the evaluation team.

- The Contractor will be responsible for obtaining visas and country clearances for travel for consultants.

- The Contractor will be responsible for setting up, coordinating, facilitating and implementing assessment-related team planning meetings, field trips, interviews, and meetings in conjunction with USAID and the IHBP Project.
- The Contractor will be responsible for proposing and agreeing on a budget for all costs incurred in carrying out this review. The cost may include, but not be limited to: (1) international and in-country travel; (2) lodging; (3) M&IE; (4) in-country transportation; and (5) other office supplies and logistical support services (i.e., communication costs, etc.) as needed.
- The Contractor will be responsible for in-country logistics including transp01tation, accommodations, communications, office support, etc.

Schedule: The evaluation team is expected to provide a schedule (in a tabular form) defining when specific steps in the evaluation process will occur and when deliverables are due. The evaluation is expected to take place during July-August 2014.

Team Planning Meeting (TPM): A two-day team planning meeting will be held by the evaluation team at an offsite location before the evaluation begins. This will be facilitated by the evaluation team leader, and will provide the Mission with an opportunity to present the scope of work for the assignment. The evaluators shall come prepared with a draft set of tools and guidelines and a preliminary itinerary for the proposed evaluations. In addition, the TPM will also:

- Clarify team members' roles and responsibilities
- Establish the timeline, share experiences and firm up the evaluation methodology
- Finalize the methodology guidelines including tools and questionnaires to be used by the team
- Discuss and finalize evaluation questions based on the SOW

Site Visits and Interviews: The evaluation team will conduct a relevant site visits and interviews. Interviewees will include key members from all stakeholder groups, including MOHFW at the national and state levels, implementing partners, other donors and partners working on SBCC in India, USAID/India and beneficiaries. An interview questionnaire will be prepared in advance and finalized during the TPM, in addition to other evaluation tools that may be required. Site visits will be planned taking into consideration factors like geographical diversity, representation of various beneficiary groups, and scale of interventions. Site visits may also include pilot activities and areas of operations research.

Draft Work Plan and Briefings: The evaluation team will develop a draft work plan prior to departure from Washington D.C. The team will meet with USAID/India and other relevant implementing partner staff for at least three working days prior to departure for the field. The evaluation team will provide a mid-point briefing to the USAID/India team, including evaluation and technical members, to clarify any outstanding queries that may have emerged since the initiation of the evaluation process.

If this is not feasible based on scheduled field work, the Team Leader will submit weekly progress reports to the COR via email by Opening of Business Monday (beginning of the next week).

REPORTS AND DELIVERABLES

I. Work Plan: The work plan will be submitted to the Evaluation COR at USAID for approval after the team is confirmed prior to departure for the field.

II. Interim briefings, including status reports: The team leader will provide weekly status reports to USAID on work plan implementation via email by OOB Monday (beginning of the next week).

III. Debriefing with USAID: During the debrief, the evaluation team will present the major findings of the evaluations to USAID; and the detailed final findings and recommendation will follow in the subsequent draft evaluation report.

IV. Debriefings with other stakeholders/implementing partner: The team will independently present the major findings of the evaluation to the USAID partner (as appropriate and as defined by USAID) and /or GoI and state government officials. The debriefing will include a discussion of findings, conclusions and recommendations. The evaluation team will consider partner comments and revise the draft reports accordingly, as appropriate.

V. Draft Evaluation Report: The evaluation team will present a draft report not to exceed 30 pages of its findings and recommendations to the USAID/India's Health

VI. Evaluation Specialist/Evaluation COR, after the oral de-brief.

VII. Final Evaluation Report: The final report, with executive summary and in electronic form, must be received by the Evaluation COR/Health Evaluation Specialist within seven working days after receiving the final comments on the draft evaluation report from USAID/India team. The final report should also be submitted to Development Experience Clearinghouse (DEC). The final report should include an executive summary of no more than three pages, a main report with conclusions and recommendations not to exceed 20 to 30 pages, a copy of this scope of work, evaluation questionnaires used to collect information on each of the program components, and lists of persons and organizations contacted.

EVALUATION LEVEL OF EFFORT

Labor Category	Level	Maximum LOE
Team Leader / Social Behavior Change Communications Expert	1	37 days
Health Systems Strengthening Specialist	1	30 days
Health Evaluation Specialist	1	30 days

ANNEX II: EVALUATION WORK PLAN

EVALUATION PURPOSE

The objective of this exercise is to conduct a final performance evaluation of the Improving Healthy Behaviors Program (IHBP), the flagship project of USAID/India under the bilateral agreement with the Government of India (GoI) to support Social and Behavioral Change Communication (SBCC) activities. The project is primarily implemented by FHI 360, with Population Council and Population Services International as sub-partners. The specific purpose of the evaluation is to gain an independent appraisal of the IHBP project's performance in order to provide lessons learned and help guide future national SBCC investments. The results of this evaluation will assist the Mission in learning about what worked, what did not work, and why these activities were effective or ineffective in terms of supporting GoI on SBCC and supporting the eight intervention states in staff capacity building at the national and state levels and institutional strengthening. USAID/India will use this evaluation to assess the potential for project scale-up and glean relevant lessons learned to inform the design of future SBCC-focused programming in India.

Social Impact (SI) is pleased to present the United States Agency for International Development (USAID) Mission to India with this work plan for the final performance evaluation of the Improving Healthy Behaviors Program (IHBP). SI will conduct a qualitative performance evaluation to assist the Mission in learning about what worked, what did not work, and why these activities were effective or ineffective. Our team will be led by Team Leader (TL), Iain McLellan, who will be a key point of contact in the field during the implementation of the evaluation. Health Systems Strengthening Specialist, Lalita Shankar, and Health Evaluation Specialist, Dr. Kumkum Srivastava will serve as locally based technical experts on the performance evaluation. Also joining the team is Ms. Michele Wehle who will serve as the Program Manager (PM) based at SI headquarters in the United States and will accompany the team during fieldwork. Additional dedicated SI-based program staff, Dr. Ash Pachauri (in-country representative), James Fremming (Senior Technical Advisor), and Mr. Philip Rihm (Program Assistant) will support the team with logistics and quality assurance.

The evaluation approach is designed to answer USAID/India questions that address aspects of project performance and processes:

1. What is the perceived effectiveness of IHBP in advocating for strategic SBCC for key health programs at the national and state level?
2. What is the perceived effectiveness of the project's activities in strengthening capacities in SBCC of MOHFW and nodal institutions? What were the key challenges that the project faced in institutional strengthening for SBCC?
3. According to the perceptions of key informants, to what extent was the technical expertise provided on SBCC, to MOHFW and state health departments, effective? What key lessons can be drawn from its implementation?
4. What are the key lessons learned from the IHBP project that can inform investments in SBCC in the future? What do key informants identify as best practices, promising new approaches, innovative ways to reach people and leveraging strategies that can inform future programs?

In Attachment 1 – the Evaluation Matrix, the team provides a table that outlines the primary research questions, the outcomes of interest, potential data collection activity, as well as potential respondent

category. This table summarizes SI's overall design and methodological approach, and is intended to accompany the presentation below.

PROPOSED METHODOLOGY

Phase One: Project Planning and Desk Review

Upon issuance of the contract modification releasing the funds for the IHBP performance evaluation, the evaluation team conducted a thorough desk review. For the desk review, the team spent one week reviewing available documents supplied by FHI 360. The review included, but was not limited to the documents below:

- IHBP concept note and other available project design documents, primarily those post-2013 change order;
- Project quarterly reports, annual reports, workplans, and monitoring data;
- Organizational needs assessments conducted for the MOHFW and MoWCD;
- IHBP Performance Monitoring Plan and annual workplans;
- State annual actions plans;
- Various campaign materials produced by IHBP;
- Training modules and toolkits produced by IHBP; and
- Secondary data on other public health programs in India (collected from available
- Quarterly report (April 2014 to June 2014) and if possible July 2014 to August 2014. Planned activities for September to End of project
- National and State BCC PIPs of MoHFW and MoWCD
- NHCRSC documents on BCC/Community processes
- TA needs assessments for each state
- Studies conducted – Rapid Organizational Needs Assessment of MoHFW and MoWCD, Recall study of mass media campaign in Chhattisgarh, Capacity Assessment of the states. Monitoring documents including workshops conducted, including M&E in SBCC training manual and facilitator's guide and PEPFAR COP, the templates and indicators shared by USAID

The evaluation will rely heavily on the IHBP project data to corroborate findings from interviews and other data sources. The team will also review and analyze other relevant data as it is made available. Project design documents and results from any documented operations research are particularly useful for the evaluation team, as this information allows for the analysis of the project's development hypothesis alongside its performance.

Another evaluation team conducted an initial round of interviews. The current evaluation team reviewed the prior team's interview notes with key informants. In addition to meetings with IHBP/FHI 360 staff, the original team conducted KIIs with individuals in the MOHFW, NIHFW, CTD, DAC, UNICEF, and private sector partners. After reviewing the interview transcripts, the evaluation team requested re-conducting an interview with Dr. Mario Mosquera of UNICEF, but understands he is currently out of the country. IHBP staff will check his availability for a potential interview. The evaluation

team has also inquired about the possibility of re-conducting interviews with Dr. Rakesh Kumar and Shri Jitendra Arora of MOHFW, and with Dr. Neera Dhar of NIHFW.

Mission In-brief

Upon arrival in-country, the team held an internal Team Planning Meeting (TPM) on September 1. The team will conduct their inbrief with USAID/India on September 3, which will be attended by members of the Program Office and Health Office. During the inbrief, the team will clarify expectations and discuss future utilization of the evaluation to ensure that the work plan is feasible and achievable within the time frame of the evaluation and is responsive to the Mission's needs.

Following the inbrief with USAID/India and the resolution of issues and agreement on the Work Plan, the evaluation team will conduct key informant interviews (KIIs) in Delhi, before traveling to project sites in Haryana and Jharkhand. Additional KIIs with key project personnel and private sector partners will be conducted in Delhi and in the state site visits as time and logistical circumstances allow. The team would also like to conduct focus group discussions (FGD) with two categories of individuals: the first with SBCC partners who received training and the second with SBCC consultants and those who conducted the SBCC training (the project technical counterparts). Potential key themes of FGDs include discussions around SBCC curriculum, methodology, training tools, material, follow-up and monitoring, application and challenges experienced in the field.

The Evaluation Matrix on the following page, details the primary and secondary data sources and key respondent categories that will inform the answers to each of the evaluation's questions. The Matrix references Attachment 5, Sample Indicators, which includes a compilation of indicators listed in the latest quarterly reports provided to the evaluation team.

Table 1: Evaluation Matrix

Research Question	Outcome of interest/Indicator*	Potential Primary Data Source	Potential Secondary Data Source	Respondents
What is the perceived effectiveness of IHBP in advocating for strategic SBCC for key health programs at the national and state level?	Institutions and capacity strengthened to design, deliver, and evaluate strategic communication at national, state, and district level See sample indicators list in annex.	• Desk review • KIIs • Likert Scale	• Project M&E documents • Materials produced by IHBP • Secondary data, e.g Annual Health Surveys; HMIS	**Program participants** (GoI **Program implementers** (IHBP staff and partners) **Private sector partners**
What is the perceived effectiveness of the project's activities in strengthening capacities in SBCC of MOHFW and nodal institutions? What were the key challenges that the project faced in institutional strengthening for SBCC?	Institutions and capacity strengthened to design, deliver, and evaluate strategic communication at national, state, and district levels See sample indicators list in annex.	• Desk review • KIIs • Likert Scale • FGDs	• Project M&E documents • Materials produced by IHBP • Surveys (if available)	**Program participants** (GoI; SBCC partners who received training – FGDs;) **Program implementers** (IHBP staff and partners; SBCC consultants who led training – FGDs;) **Private sector partners**
According to the perceptions of key informants, to what extent was the technical expertise provided on SBCC, to MOHFW and state health departments, effective? What key lessons can be drawn from its implementation?	Institutions and capacity strengthened to design, deliver, and evaluate strategic communication at national, state, and district levels See sample indicators list in annex.	• Desk review • KIIs • Likert Scale • FGDs	• Project M&E documents • Materials produced by IHBP • Secondary data	**Program participants** (GoI; SBCC partners who received training – FGDs; **Program implementers** (IHBP staff and partners;)
What are the key learnings from the IHBP project that can inform investments in SBCC in the future? What do key informants identify as best practices, promising new approaches, innovative ways to reach people, leveraging strategies that can inform future programs?		• Desk review • KIIs • Likert Scale • FGDs	• Project M&E documents • Secondary data	**Program participants** (GoI; SBCC partners who received training – FGDs; **Program implementers** (IHBP staff and partners; SBCC consultants who led training – FGDs;) **Private sector partners**

** To be revised upon review of the project monitoring plan.*

DATA COLLECTION

Phase Two: Key Informant Interviews, Focus Group Discussions and Likert Scales

In consultation with USAID, the original evaluation team considered evaluation priorities such as geographical and cultural diversity in selection of the location for site visits decided to visit two states; Haryana and Jharkhand. Given the extensive activities conducted in both states, and the consensus to visit both Haryana and Jharkhand during the first phase of the evaluation, the team will commence with data collection in these locations.

Key Informant Interviews

The team will conduct KIIs to triangulate the data collected in the desk review and gain further insights into perceptions of the program's effectiveness. Data sources that the Evaluation Team will utilize, review and analyze include: project design documents, project proposals, baseline reports, annual work plans, M&E data, and other project-related documents and reports. The Evaluation Team may utilize additional documents related to SBCC as supporting materials, provided after the desk review, as well as other relevant reference documents related to IHBP project activities.

The evaluation team will conduct key informant interviews (KII) with the following categories of individuals:

i. Staff from the Ministry of Health and Family Welfare (MOHFW), including appropriate representatives from:
   - NRHM, IEC and RCH Division
   - Department of AIDS Control (DAC)
   - Central Tuberculosis Division (CTD)
   - National Institute of Health and Family Welfare (NIHFW);

ii. Staff from the Ministry of Women and Child Development (MoWCD);

iii. NIPCCD

iv. Beneficiary staff in the Empowered Action Group (EAG) states;

v. UNICEF

vi. Project partners including private sector partners in IHBP

vii. IHBP staff and consultants at headquarters and the field.

Focus Group Discussions for SBCC/IEC specialist and SBCC communication consultants

At each level partner (government, other partner and private sector) there are SBCC/IEC specialists who have received specific training and developed and implemented strategies. Some of them might be identified as key informants and undergo in-depth individual interviews though they will generally be focused on the more senior level officials.

To ensure that insights are gained specifically on the technical assistance IHBP provided and how it was put to use, the evaluation team recommends four focus group discussions. Three FGDs should be held with SBCC/IEC staff who underwent training (two at the states to be visited and one in Delhi) and one

FGD with the communication consultants who were seconded to the partners and those who conducted the training to be held in Delhi.

The evaluation team will seek to conduct separate FGDs with the following types of individuals:

i. SBCC partners who received training
ii. SBCC consultants
iii. Those who lead the training (the project technical counterparts).

Potential key themes of FGDs with the training recipients will center on the effectiveness of the trainings in building capacity for SBCC

Likert Qualitative Mini Studies

In order to complement the key informant interviews, the evaluation recommends the administration of three mini studies with a small sample from the three principle target populations using the Likert scale. (Please see the draft in Attachment 2). The tool consists of seven statements that respondents are asked to indicate to what degree they agree or disagree with the statement.

The statements are related directly to the questions included in the evaluation SOW by USAID/India. There are two open ended questions included in the tool that seek an indication of the most significant contributions or results from the IHBP project and contributions a future health SBCC project could make in the future.

Tools have been prepared for the three specific groups including: government officials key informants with connections to the project; partners key informants; and key private partner key informants. It can be expected that the number of respondents will vary from 25 to 50 depending on the group of respondents. It is expected that there will be more from the government considering that there are several ministries involved.

The team will administer Likert scales at each KII to help quantify data and facilitate data analysis of the qualitative information and ensure that the four evaluation questions are addressed. For example, the Likert scales will measure key informants responses, on a scale of 1-5, to statements such as "IHBP has been effective in advocating strategic SBCC for health programs that I am involved with." Participants who strongly agree with the above statement will circle number 5 on the scale, whereas those who do not agree or strongly disagree will select lower numbers, 1 representing participants who "disagree very much" with the statement. The Likert scales can also be disseminated via email to key informants the team is unable to meet with due to scheduling conflicts.

Phase Three: Data Analysis

Upon completion of the data collection, the team will analyze the existing data, as well as newly gathered data for relevance to the evaluation questions and the SOW of the project. In addition, the team will conduct debriefs at least every two or three days with each other as part of a rolling analysis in order to discuss evidence collected, patterns, and discrepancies that will help answer the evaluation questions and any adjustments that may be needed in the evaluation schedule. These themes will then be used to draw conclusions and make recommendations regarding future programming. The team leader will send updates to USAID at least weekly and conduct a midterm review with USAID during the second week of fieldwork.

DELIVERABLES AND TIMELINE

For the final performance evaluation of the IHBP project, SI will submit the following deliverables:

i. **Work Plan:** The work plan will be submitted to the Evaluation COR at USAID for approval before fieldwork begins.

ii. **Interim briefings, including status reports:** The team leader will provide weekly status reports to USAID on work plan implementation via email by OOB Monday (beginning Tuesday, September 2 to account for the U.S. Federal holiday on September 1).

iii. **Debriefing with USAID (Tentative date – September 18, 2014):** During the debrief, the evaluation team will present the major findings of the evaluations to USAID; and the detailed final findings and recommendation will follow in the subsequent draft evaluation report.

iv. **Debriefings with other stakeholders/implementing partner (Tentative date – September 19, 2014):** During The team will independently present the major findings of the evaluation to the USAID partner (as appropriate and as defined by USAID) and /or GoI and state government officials. The debriefing will include a discussion of findings, conclusions and recommendations. The evaluation team will consider partner comments and revise the draft reports accordingly, as appropriate.

v. **Draft Evaluation Report (Tentative submission date – October 20, 2014):** The evaluation team will present a draft report not to exceed 30 pages of its findings and recommendations to the USAID/India's Health Evaluation Specialist/Evaluation COR. Two weeks after submitting the first draft report, USAID and the GoI will submit feedback to Social Impact. Social Impact will then submit the second draft report to the Mission on October 13, and will incorporate feedback from USAID, and possibly the GoI, if comments are received in time.

vi. **Final Evaluation Report (Tentative submission date – December 12, 2014):** The final report, with executive summary and in electronic form, must be received by the Evaluation COR/Health Evaluation Specialist within seven working days after receiving the final comments on the draft evaluation report from USAID/India team. Upon final approval by USAID/India, SI will submit the report and associated data to USAID's Development Experience Clearinghouse (DEC). The final report will include an executive summary of no more than three pages, a main report with conclusions and recommendations not to exceed 20 to 30 pages, a copy of this scope of work, evaluation questionnaires used to collect information on each of the program components, and lists of persons and organizations contacted.

LIMITATIONS AND RESPONSES

The team has identified several preliminary limitations which are listed below. Additional limitations may arise which the team will bring to the Mission's attention in a timely manner.

1. The evaluation time frame is somewhat limited for the collection of qualitative data and information from participating institutions and beneficiaries and may be impacted by the availability of key informants for interview. The Social Impact team will counter this challenge by identifying and informing interviewees as far in advance as possible and structuring interview sessions for efficient use of interviewees' time.

2. The geographical spread of the project activities and the numerous participating institutions and partners also limits the sample size within the timeframe for the evaluation. We expect to include diversity as a key factor in sample selection, but do not expect the resulting sample to be statistically representative.
3. There could be limitations on the availability of staff from MOHFW, MoWCD, EAG, state TB officers, and IHBP staff at headquarters and the field.
4. Qualitative data that presents a mixture of factual reporting and perceptual interpretation can be accompanied by presentational and recall biases. The Social Impact Team intends to counter this challenge by (a) utilizing systematic protocols with probing questions in interviews; (b) assigning team members who are closely familiar with IHBP and partner organizations to conduct interviews; and (c) triangulating interview data with documentary sources and across various interview sources to build reliability into findings.
5. The nature of this summative evaluation limits observations and interviews to one point-in-time, as any follow-up will probably not be possible.
6. While the evaluation team will carefully rank the various participants in the project to prioritize them for interviews to ensure that the major evaluation questions are answered, some key areas may not be covered if circumstances or activities have been changed or delayed. SI will counter this limitation by using our protocols and periodically monitoring adequacy of substantive coverage of data collection vis-à-vis the evaluation questions.

DATA COLLECTION INSTRUMENTS

Questionnaires will be developed for each type of participating institution and group of beneficiaries so as to address their specific role in the project (Attachment 2: Sample Questionnaire Format). The institutional and private sector partners involved in the project, which will form the basis for the sample to be interviewed, include staff from the MOHFW, staff from the MoWCD, NIHFW, NIPCCD, beneficiary staff in the EAG states, UNICEF, project partners in IHBP including private sector partners, and IHBP staff at headquarters and the field. Questionnaires have been prepared in advance for each group and adapted to individual key informants and groups.

SAMPLING

The sampling strategy will be purposive in nature, such that the most relevant stakeholders will be identified and prioritized during the planning phase, to help meet the objectives of the evaluation. Therefore, the team will create interview protocols at the desk review phase and make any revisions if necessary after the first round of interviews. Questions will focus on IHBP activities included in their SOW along with modifications that were made during the life of the program (LOP), including the adequacy of the support given to targeted stakeholders and changes to their operational and technical capacity to plan, design, and implement quality SBCC programs as described in project documents and agreements.

Since the IHBP focus shifted during implementation, the evaluation will focus on results of implementation at the institutional and state levels. Beneficiaries will not be primary targets of the evaluation.

PROJECT STAKEHOLDERS

The evaluation team will engage with a variety of project stakeholders. The limiting factor will be the timeframe of the project process and the geographical spread of the project activities. Priorities may

have to be set when choosing the sample of stakeholders for interviews. Other stakeholders will include state and national government officials, and beneficiaries of IHBP programming. These stakeholder lists will be discussed with USAID during the TPM (see the lists presented in the Data Collection section above).

THE EVALUATION TEAM

Team Leader – Iain McLellan. Mr. Iain McLellan has over 30 years of experience in design and evaluation of social and behavior change communication (SBCC), interpersonal communication strategies, community mobilization, and social marketing programs in HIV/AIDS, population, nutrition and hygiene, child survival, and agriculture. In the last decades, Mr. McLellan has conducted numerous evaluations primarily for USAID but also for DfID, and other organizations like CARE and Red Cross. His most recent evaluations were conducted in Kenya, Mali, Sénégal, India, Bangladesh, Malawi, and Benin. Mr. McLellan has also undertaken a number of long-term assignments, providing SBCC expertise to UNICEF, the World Bank, and the World Health Organization.

Health Systems Strengthening Specialist – Lalita Shankar. Ms. Lalita Shankar has over twenty years of experience in a wide range of health programming, including reproductive and sexual health, integrated health programs, health systems strengthening, institutional capacity development, program design, monitoring and evaluation, and public-private partnerships. Ms. Shankar has a strong record of project management and administration across many areas within the health sector. She has proven expertise working with diverse stakeholders, including displaced and marginalized populations, multi-government settings, civil society, bilateral and multilateral donors, corporate and private sector, academicians and scientific organizations, and research and development firms.

Health Evaluation Specialist – Dr. Kumkum Srivastava Dr. Kumkum Srivastava is a Senior Public Health Expert, Pediatrician and Medical Doctor with over 35 years of experience in the areas of maternal, neonatal and child health, child development, family planning, gender, and nutrition. Dr. Srivastava also has extensive experience working on health systems for primary and secondary healthcare, strategic planning, health sector reforms and has managed large scale community development programs from inception. Dr. Srivastava has provided expertise on monitoring and evaluation for health sector reform programs, and most recently has developed e-learning systems and an e-learning course module for program managers in NRHM at the NIHFW.

Senior Technical Advisor – James Fremming. Mr. Fremming is Social Impact's Manager for USAID's Evaluation Services Indefinite Quantity Contract, and supports long-term monitoring and evaluation projects in Bangladesh, Lebanon and India as headquarters-based Senior Technical Advisor. His experience includes developing strategic frameworks and performance management systems with numerous USAID clients, implementing partners and local counterpart organizations. In 2009, for example, he led four teams of strategic planning and sector specialists in guiding all four major ministries of Georgia's Autonomous Republic of Adjara to develop their first strategic plans. He has served on several monitoring and evaluation assignments in Afghanistan since 2009.

Previous to joining SI in 2010, Jim was an independent consultant in international development, a Senior Associate with Management Systems International, a Senior Evaluation Methodologist at the U.S. Government Accountability Office, and an Instructor of political science and international affairs at Northwestern University and Georgetown University. He holds Master's degrees in political science (Northwestern) and international studies (American University).

Program Manager – Michele Wehle. Ms. Wehle has more than two years of experience in program management and evaluation. As a fulltime Program Associate at Social Impact's headquarters office working primarily in the performance evaluation practice, Ms. Wehle will be responsible for managing the evaluation. At SI, she has provided managerial support and technical assistance to a variety of Social Impact's short and long-term contracts around the world and in various sectors. Ms. Wehle holds a BS in Business Administration, with a concentration in finance from Indiana University-Bloomington, and a Master's degree from Tufts University's Fletcher School of Law and Diplomacy, with a focus on Human Security and International Political Economy.

Program Assistant – Philip Rihm. Mr. Rihm is a Program Assistant with Social Impact, providing administrative, logistical, and technical backstopping on projects for USAID and MCC. Mr. Rihm supports projects across several of SI's service areas, with a focus on capacity building and performance management. Recent projects include the development of a Mission-wide PMP for USAID/Nepal and ongoing backstopping and support for SI's Lebanon field office, which provides monitoring and evaluation services to USAID/Lebanon. Mr. Rihm holds a bachelor's degree in political science from the University of Rochester.

EVALUATION MANAGEMENT PLAN

Managing the Activities: Social Impact proposes a streamlined approach to managing this contract based on lessons learned from our experience conducting various evaluations for the USAID/India Mission under the same Evaluation Services Task Order, all of which demand intricate and highly nuanced management approaches in light of the complex operating environments. We will operate under the supervision of our Contracting Officer's Representative (COR).

Iain will be accountable for day-to-day management of the evaluation, while the Program Manager (PM), Ms. Michele Wehle, will be accountable for overall contract activities and management and will review all deliverables to provide quality assurance. She will be supported by a Program Assistant (PA), Mr. Philip Rihm. Dr. Ash Pachauri, SI's in-country representative, will be available to the SI team during field work to ensure that the Missions technical and managerial requirements are being met.

Each team member will be responsible for several cross cutting themes:

- Iain: SBCC, SCSM, Evidence-based planning, Methodology, Training, Government and Partners
- Lalita: Institutional Strengthening, Financial Management, Management, Pipeline budget
- Kumkum: Monitoring and Evaluation, Operations Research, Project Implementation Plans, Formative assessments
- Michele: Private Sector, Leveraging, Monitoring and Evaluation

Working Relationship with USAID: The Team Leader will be USAID's primary point of contact for day-to-day and urgent technical matters while in-country. Ms. Wehle will serve as the primary point of contact with USAID for non-technical matters including scheduling and will be responsible for timely submission of quality deliverables. In collaboration with the Senior Technical Advisor, the Program Manager will review all plans, reports, and presentations. Through a collaborative approach, the management team will identify any potential problems via bi-weekly team meetings and will be prepared to develop and share with USAID flexible, workable solutions for any challenges that may arise. Please see attachment 3. IHBP Evaluation Calendar, for details on the proposed evaluation schedule.

ANNEX III: DATA COLLECTION INSTRUMENTS

I. Interview Protocol for Key Informant Interviews

Evaluation of Improving Healthy Behaviors Program (IHBP)

Name: _____**Designation:**_____

Department/Institution: _____

Introduction: We have been asked to evaluate the IHBP health communication project with an eye to understand its effectiveness and best practices. We are independent evaluators working for the firm Social Impact. Do you understand the purpose of this interview and are you willing to participate?

Experience with IHBP

E1. What is or was your involvement with IHBP?

Effectiveness of Advocacy of Strategic SBCC

A2. How has IHBP influenced your changes in approaches to plan, implement and monitor SBCC?

A3. What concrete changes have been made to the way SBCC is done now as compared to what was done earlier?

Effectiveness of Institutional Strengthening

IS4. Could you share an example of any systemic change at the planning and implementation and monitoring level that the IHBP affected? E.g. Any technical approach or tool or contribution by the IHBP that will now be an integral part of the system while planning or implementing or monitoring any SBCC activity?

IS5. How did IHBP increase institutional capacity?

IS6. How effective was the capacity building component under the IHBP?

IS7. What were the strengths and weaknesses of the capacity building approaches used?

IS8. What institutional strengthening needs still remain?

Technical Assistance

TA9. How effective were the technical experts who were placed within the institutions?

TA10. How effective were the technical approaches used by the project (training, tools, manuals, guidelines)?

TA11. What were some of the signs that their approach brought about changes in the way SBCC was planned or implemented?

TA12. To what extent was the technical expertise or guidance shared?

TA13. To what degree has your institution applied evidence based planning for SBCC including for monitoring and evaluation of campaigns or communications?

Innovations and best practices

BP14. What are some innovative approaches that IBHP used that you think is promising enough to be a best practice or effective way of reaching people?

BP15. Which specific strategies would you recommend for replication or leveraging for future programming**?**

Future needs

F16. Do you have any other specific observations or recommendations of the IHBP that can be useful for future programming?

II. Likert Scale Mini Survey[19]

Introduction: We are doing an assessment of the IHBP health communication project. We would appreciate if you can help us with the assessment.

PART A: We will read you several statements. We would like you to tell us how much you agree or disagree with the statements on a scale of one to five. Five meaning that you agree very much and one meaning that you don't agree at all.

(5) agree very much (4) agree (3) neither agree nor disagree (2) disagree (1) disagree very much

1) IHBP has been effective in advocating strategic SBCC for health programs that I am involved with.

1 2 3 4 5

2) IHBP was effective in strengthening capacities in SBCC in the organization where I work.

1 2 3 4 5

[19] Please note. Participants who did not find a particular question(s) relevant were instructed to skip the question(s) or write "NA."

3) The challenges faced by IHBP in strengthening our capacity in SBCC were effectively overcome.

1 2 3 4 5

4) The technical expertise provided by IHBP was effective and improved our effectiveness.

1 2 3 4 5

5) The implementation of the technical expertise went smoothly.

1 2 3 4 5

6) The strategies used by IHBP technical assistance were effective and should be used again in the future.

1 2 3 4 5

7) IHBP needs to employ new and innovative strategies in the future to meet the SBCC needs of my organization for technical assistance.

1 2 3 4 5

PART B: Please answer in your own words the following questions:

8) To what extent was the expertise in SBCC of the IHBP project efficient and useful to you and your organization? Give some examples.

_____
_____
_____
_____

9) What has been the two most significant contributions or results from the IHBP project?

_____
_____
_____

_____

10) What would be the most significant contribution or result that a future health communication project could make in the future?

_____
_____
_____
_____

III. Focus Group Discussion Guide for SBCC Consultants and IEC Specialists

1. Describe the activities you were involved with under IHBP.
2. How would describe the training curriculum used by IHBP that you used?
3. To what degree did the content of the curriculum meet the needs of the trainees?
4. How did you find the trainers who conducted the meeting?
5. How appropriate was the training in meeting the needs of the trainees?
6. How would you rate the complexity of the training in terms of being easy or hard to follow and understand?
7. What was the most significant thing that you learned from your involvement in training that you have applied to your work?
8. Overall, how was the quality of the technical assistance provided by IHBP?
9. Overall, how efficient and useful was the expertise provided by IHBP?
10. What were the most significant contributions IHBP has made to improve the ways SBCC is done in India?
11. What would be the most significant contribution a future health communication project could make in the future?

ANNEX IV: SOURCES OF INFORMATION

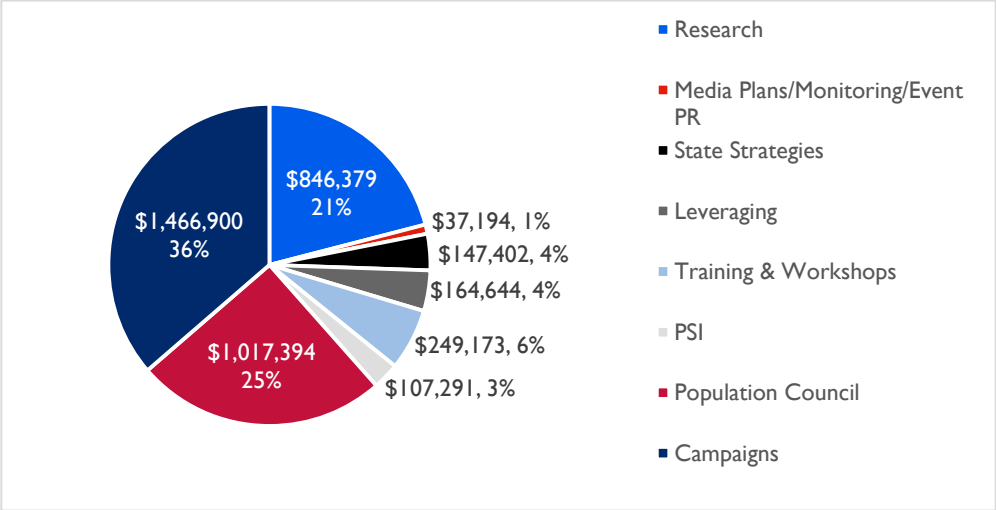
Desk Review Documents

1. IHBP concept note, AED, October 2010
2. IHBP Task Order, FHI 360, 2011
3. IHBP Task Order Modification1, FHI 360,
4. IHBP Task Order Modification 2, FHI 360, January 2011
5. IHBP Task Order Modification 3 FHI 360, January 2013
6. IHBP Task Order Modification 4, FHI 360, February 2013
7. IHBP Task Order Modification 5, FHI 360, September 2013
8. IHBP Task Order Modification 6, FHI 360, November 2013
9. Bilateral Health Partnership Program (HPP) Agreement, USAID, September 2011
10. IHBP Performance Monitoring Plan and annual work plans for Year 1, September 2010
11. IHBP Performance Monitoring Plan and annual work plans for Year 4, February 2013
12. IHBP Cost Summary Reports 2010,
13. IHBP Cost Summary Reports 2014
14. IHBP Annual Report, FHI 360, 2010-2011
15. IHBP Annual Report, FHI 360, 2012-2013
16. IHBP, Quarterly Report, April 2014 - June 2014
17. IHBP Quarterly Report, July- August 2014.
18. IHBP Newsletters for Years 2014,
19. Organizational Needs Assessments, MOHFW, FHI 360, July2012
20. Organizational needs assessments, MOWCD, FHI 360, July2012
21. Annual Actions Plans, Haryana, 2013-2014
22. Annual Action Plan, Jharkhand, 2012-2013
23. SBCC Training modules and toolkits , IHBP, FHI 360, 2012
24. SBCC facilitators Training Module, IHBP, FHI 360, 2012
25. National Program Implementation Plan RCH Phase II–Program Document II (NPIP RCH II)
26. Template – Preliminary Appraisal IEC/BCC Component of state NHM PIPs
27. Monographs for good practices – Family Planning, IHBP, FHI 360,
28. Monographs for good practices-HIV/AIDS,IHBP, FHI 360
29. PIP- State of Haryana, 2014-15
30. PIP, State of Jharkhand, 2014-15
31. Operations Research Protocol on mobile health pilot in selected districts of Madhya Pradesh, 2011
32. Capacity Assessment of the states, baselines, IHBP, FHI 360, 2012
33. Media Habits Assessment Report, government of Haryana, 2013
34. Concurrent Evaluation Report, government of Haryana, 2013
35. Report on Training of ASHAs on IPC, Government of Haryana, 2013
36. Jharkhand State Communication Strategy, Government of Jharkhand, 2008
37. IVR-Based Training for Frontline Workers on Post-partum insertion of IUCD, MOHFW
38. A status report of ACSM in RNTCP, Central TB Division, MOHFW, FHI 360, 2013
39. Barriers and facilitation for urban TB control in India, Central TB Division, MOHFW

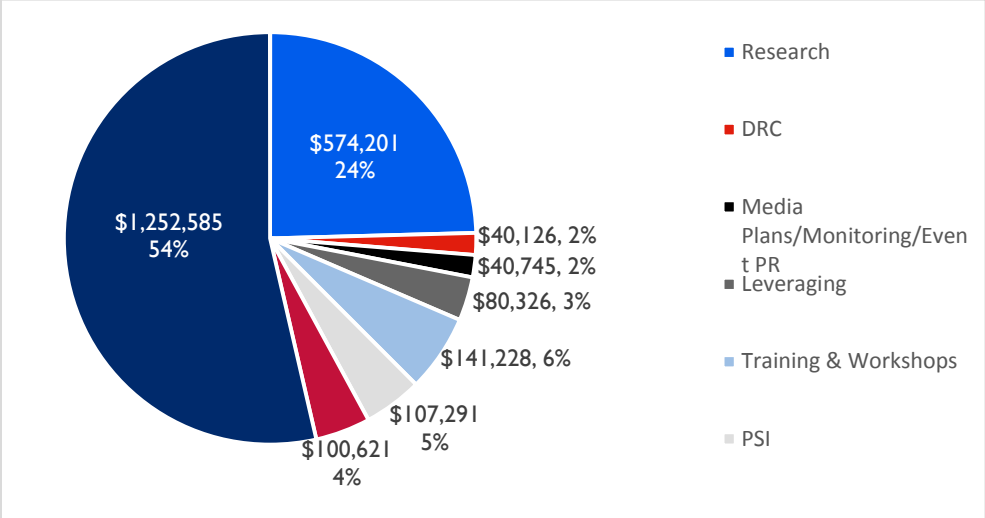
40. Operations Research document on pilot for improving the knowledge of TB through use of mobile technology, PSI,
41. Report on Social Media Campaign for World TB Day 2013
42. Barriers and Facilitators to Early detection and treatment of TB in Urban India, MOHFW
43. Urban ACSM Strategy for TB, Central TB Division, MOHFW
44. MOU with Bharti Foundation
45. MOU with Dimagi,
46. MOU with Jubilant,
47. MOU with ZMQ
48. IHBP Workshop Report - Communication Workshop with Private Sector - New Delhi and Mumbai
49. Concept Note: The Taj Must Smile - Activation Platform for Private Sector
50. MOU with NIHFW
51. MOU with Department of AIDs Control
52. MOU with UNICEF
53. Framework for Nutrition Resource Platform, 2012
54. Framework Document for establishment of NHCRSC, 2012
55. PPIUCD situational analysis, radiospots, flyers and IVR content/pretest documents
56. Research brief-1 for recall study on family planning
57. Research brief-2 for recall study on voluntary blood donation
58. www.ihbp.org (IHBP project website)
59. www.poshan.nic.in (Nutrition Resource Platform)
60. http://connect2mfi.org/zmq/node/9 (India HIV/AIDS Resource Center)

ANNEX V: TECHNICAL ACTIVITIES AS A PERCENTAGE OF OVER $5,000 USD CONTRACTUAL COMMITMENTS (AS OF NOVEMBER 2014)[20]

RMNCH+A Technical Activities as a % of Over $5,000 USD Contractual Commitments (Total $4.0m)

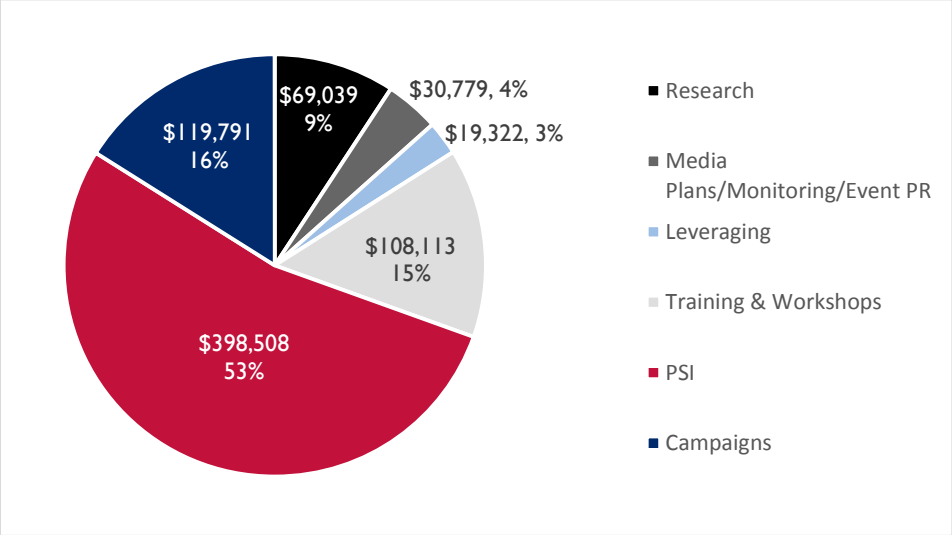


HIV Technical Activities as a Percent of Over $5,000 USD Contractual Commitments ($2.3m)



[20] Data provided by FHI 360 technical staff. Allocations by area are approximations and may change.

TB Technical Activities as a Percent of Over $5,000 USD Contractual Commitments ($746k)



ANNEX VI: IHBP TRAININGS CONDUCTED (INFORMATION PROVIDED BY IHBP)

IHBP Trainings Conducted in 2012-2013 and 2013-2014

Trainings conducted in 2012-13										
	Themes									
	FH/RH			TB			HIV/AIDS			
Training Name	Male	Female	Total	Male	Female	Total	Male	Female	Total	Quarter
Maternal health & repositioning family planning campaign , orientation & planning workshop	49	17	66							Q1
Workshop on media launch for maternal health and family planning	50	17	67							Q1
Master training on capacity building of IEC officers in SBCC	12	6	18							Q2
Training of district level IEC officers on SBCC & M&E in Rajasthan	22	6	28							Q2
State level orientation on family planning and maternal health in Uttar Pradesh for 23 districts	37	40	77							Q2
Orientation of district & state IEC officers on SBCC	21	6	27							Q3
Media management workshop for STOs on TB				5	3	8				Q3
Training of ANM Tutors and supervisors from Chhattisgarh on SBCC	7	12	19							Q4
Training of ANM Tutors and supervisors from Rajasthan on SBCC	21	1	22							Q4
Training of state IEC officials from Haryana, Punjab, Uttarakhand & Jharkhand, IEC consultants, MOHFW, NACO on SBCC	12	3	15							Q4
Regional workshop for capacity building on IEC officers, managers and consultants of SBCC from Rajasthan	21	3	24							Q4
Training of DACs and BEEs on SBCC from 10 districts of Haryana	20	8	28							Q4
Regional workshop for capacity building of IEC officers, managers and consultants on SBCC from Jharkhand and Chhattisgarh	14	5	19							Q4
Total (2012-13)	**286**	**124**	**410**	**5**	**3**	**8**	**0**	**0**	**0**	**418**

Trainings conducted in 2013-14										
	Themes									
	FH/RH			TB			HIV/AIDS			
Training Name	Male	Female	Total	Male	Female	Total	Male	Female	Total	Quarter
Training of DACs & BEEs on SBCC communications	13	7	20							Q1
Training of health educators on SBCC/IPC (1st batch)	11	14	25							Q1
Training of health educators on SBCC/IPC (2ns batch)	33	7	40							Q1
Training workshop on media engagement and ACSM in TB care and control				20	13	33				Q1
ToT of ASHA trainers on communication and IPC in Haryana	19	13	32							Q2
National level professional training on capacity building of IEC officers in SBCC	18	7	25							Q2
Training of BCC consultant, NRHM on communication and planning in Punjab	19	7	26							Q2
National level professional training on capacity building of district level media officers on SBCC skills in Assam	12	11	23							Q2
Professional training on capacity building of IEC officers of Uttarakhand in SBCC skills	18	7	25							Q2
Follow up workshop on SBCC for IEC officers of Chhattisgarh state NRHM in Chhattisgarh	8	3	11							Q2
Follow up workshop on SBCC for IEC officers of Rajasthan state NRHM in Rajasthan	15	5	20							Q2
Follow up workshop on SBCC for IEC officers of Jharkhand state NRHM in Jharkhand	16	4	20							Q2
Training workshop on M&E of SBCC in health program, Raipur	25	5	30							Q2

Master Training on communication (HIV)							9	5	14	Q3
National level training on communication (HIV)							66	32	98	Q3
Training workshop on M&E of SBCC in health program, Jaipur, Rajasthan	33	2	35							Q3
Training workshop on M&E of SBCC in health program, Ranchi, Jharkhand	27	5	32							Q3
Five days training of state/district and block level officials on SBCC, NHM, Haryana	34	8	42							Q3
ANM Supervisor training, Haryana	39	23	62							Q3
SBCC training for Delhi state IEC officials under NHM	4	14	18							Q4
SBCC training for state IEC officials under RNTCP				12	10	22				Q4
National level M&E training	10	2	12							Q4
Total (2013-14)	**354**	**144**	**498**	**32**	**23**	**55**	**75**	**37**	**112**	**665**

Trainings conducted in 2014-15										
	Themes									
	FH/RH			TB			HIV/AIDS			
Training Name	Male	Female	Total	Male	Female	Total	Male	Female	Total	**Quarter**
Training of Master trainers on SBCC, NIHFW, Delhi	10	6	16							Q1
Training workshop on M&E of SBCC in health program, Shimla	21	12	33							Q1
Total (2014-15)	**31**	**18**	**49**	**0**	**0**	**0**	**0**	**0**	**0**	**49**

State-Wide Trainings Conducted

No	State	Name of the Workshop
1	Jharkhand	• 2013 Dec 9 State Level Review and Visioning Workshop PIP development • 2014 Apr 22-25 Script development workshop • 2014 Mar 27-28 Follow Up Training • 2014 May 30-31 IPC Training
2	Haryana	• 2013 Oct 23-26 FLW Supervisor 2nd batch Training • 2013 Sept 17-19 FLW Supervisor Training • 2014 Apr 16-20 SBCC Communication Workshop NHM • 2014 Feb 17 IPC training • 2014 Jan 2-3- Training of ASHA workers on Communication & SBCC –Training • 2014 IPC Training for ASHA workers
3	Rajasthan	• 2014 March 26-27 Communication launch workshop 26-27
4	Chhattisgarh	• 2012 July 23-25 Orientation Workshop for State & District IEC Officials • 2013 Nov 22-23 State Level Orientation Workshop on SBCC
5	Himachal Pradesh	• 2013 Nov 13-14 & 22-23 Training Workshop on Communication Planning, IEC and RMNCHA • 2014 Sept 1-5 SBCC Training for State, district and block IEC officials
6	Uttarakhand	• 2014 Apr 25-26 Workshop on Campaign Orientation and Roll Out Planning • 2104 Feb 17-21 SBCC Training for IEC Officials under NHM
7	Punjab	• 2014 Apr 21-23 SBCC Communication Workshop NHM • 2014 Jan 17 Communication Orientation & PIP Planning Workshop
8	Delhi	• 2012 July 17-19 Cap Building for Frontline Workers • 2012 July 23-25 Cap Building for Frontline Workers • 2013 Sept 26-27 State Staff Orientation Workshop
9	Assam	• 2014 Feb 4-8 SBCC Communication Workshop

ANNEX VII: IHBP PIP BUDGETARY DATA[21]

State-Wide Budget in PIPs for SBCC for 2011–2014

No.	State	Approved amount (Rs. In Lakhs)			
		2011-12	2012-13	2013-14	Total for last 3 years
1	Haryana	621.08	559.25	172.02	**1352.35**
2	Jharkhand	674.08	1073.98	226.07	**1974.13**
3	Rajasthan	673.2	594.61	418.4	**1686.21**
4	Himachal Pradesh	84.69	208.5	56	**349.19**
5	Uttarakhand	280	313	265	**858**
6	Chhattisgarh	737.52	998	514.61	**2250.13**
7	Punjab	170.24	301.87	278.6	**750.71**
8	Delhi	401.59	587.73	221.46	**1210.78**

State-Wide Approved Budget in PIPs for SBCC for 2014–15

No	State	Amount approved (Rs. In Millions) (2013-14)	Amount proposed this year 2014 (Rs. In Millions)	Amount approved (Rs. In Millions) (2014-2015)	Percentage Increase
1	Haryana	17.2	108.908	66.423	**286%**
2	Jharkhand	22.6	111.86	106.4	**371%**
3	Rajasthan	41.8	805.197	278.078	**565%**
4	Himachal Pradesh	5.6	41.58	30.237	**440%**
5	Uttarakhand	26.5	89.291	63.3	**139%**
6	Chhattisgarh	51.5	162.824	97.6	**90%**
7	Punjab	27.9	60.95 + 71.757 (supplementary)	50.034	**79%**
8	Delhi	22.2	319.53	31.953	**44%**

[21] Data provided by IHBP HQ staff members.

ANNEX VIII: KEY INFORMANT INTERVIEW AND FOCUS GROUP DISCUSSION PARTICIPANTS

No.	Name	Designation	Institutional Affiliation	Location
National and International				
1	Dr. Rakesh Kumar	Joint Secretary RCH	MOHFW	New Delhi
2	Mr. SK Rao	Joint Secretary Co-ordination, IEC	MOHFW	New Delhi
3	Dr. Himanshu Bhushan	Dy Commissioner MCH	MOHFW	New Delhi
4	Dr. Niraj Kulshrestha	ADDG TB	CTD, MOHFW	New Delhi
5	Dr Naresh Goel	Dy. Director General	NACO (DAC), MOHFW	New Delhi
6	Dr. S.K.Sikdar	DC (FP)	RCH Division, MOHFW	New Delhi
7	Mr. J.K. Arora	Director IEC	IEC Division MOHFW	New Delhi
8	Dr. Sushma Dureja	DC(AH)	MOHFW	New Delhi
9	Dr. R.S. Gupta	Dy Director General	Central TB Division	New Delhi
10	Dr. Ajay Khera	Deputy Commissioner Child Health	MOHFW	New Delhi
11	Shreeni	ICT Manager, Digital Resource Center , DAC	MOHFW	New Delhi
12	Dr. Dinesh Paul	Director	NIPCCD	New Delhi
13	Dr. Rita Patnaik	Dy. Director, Nutrition	NIPCCD	New Delhi
14	Dr. JK Das	Director	NIHFW	New Delhi
15	Dr. Neera Dhar	Prof and Head, Communication	NIHFW	New Delhi
16	Dr. Ankur Yadav	Assistant Professor, Communication	NIHFW	New Delhi
17	Mr. Ganesh Prasad Devrani	Research Officer, Communication	NIHFW	New Delhi
18	Rajesh Rana	Director Media, DAC	IHBP (previously with Clinton Foundation and with Samarth)	New Delhi
19	Mr. Mario Mosquera	Head Communication for Development	UNICEF	New Delhi
20	Dr. M.E. Khan	Senior Program Associate	Population Council	New Delhi

No.	Name	Designation	Institutional Affiliation	Location
21	Dr. Avishek Hazra	Senior Program Officer	Population Council	New Delhi
22	Dr. Arupendra Mozumdar	Program Officer	Population Council	New Delhi
23	Mr. Atul Kapoor	Chief Operating Officer	PSI	New Delhi
24	Mr. Kali Prosad Roy	National Research Specialist	PSI	New Delhi
25	Mr. Gaurav Khurana	Senior Manager Communications	PSI	New Delhi
26	Mr. Pritpal Marjara	Managing Director	PSI	New Delhi
27	Mr. A.V.Surya	Vice President	Social and Rural Research Institute (SRI), IMRB	New Delhi
28	Ms. Charu Sheela	Group Business Director	SRI, IMRB	New Delhi
29	Mr. Raj Sekhar Satyavada	Insights Director (Qualitative research)	SRI, IMRB	New Delhi
30	Mr. Trilok Singh Sisodiya	Group Business Director (Quantitative research)	SRI, IMRB	New Delhi
31	Mr. Pushpraj Dalal	Senior Technical Advisor SBCC	PSI	New Delhi
32	Deepti Mathur	Senior Manager – Knowledge Management	PSI	New Delhi
33	Abhilash Philip	Gen. Manager – New Business Development	PSI	New Delhi
34	Rohit Singh	Principal Director Programs	Gram Vaani	**???**
35	Mr. Hilmi Quraishi	Co-Founder	ZMQ	New Delhi
36	Mr. Vivek Prakash	Chief CSR General Manager	Jubilant Bhartia	New Delhi
37	Antony Nellissery	General Manager Program (Primary Schools)		
38	Prashant Das	Manager- CSR	Jubilant Bhartia	New Delhi
39	Arun Varma	Group Head, Health Initiatives	IL&FS Education & Technology Services Limited	New Delhi
40	Ashish Alex	Manager Program Partnerships	Bharti Foundation	New Delhi
41	Ms. Sheena Chhabra	Team Leader Health Systems Strengthening	USAID	New Delhi

No.	Name	Designation	Institutional Affiliation	Location
42	Ms. Charushila Lal	Program Development Specialist, M&E	USAID	New Delhi
43	Ms. Moni Sagar	Program Management Specialist	USAID	New Delhi
44	Mr. Amit Shah	Project Management Specialist	USAID	New Delhi
45	Ms. Rita Leavell	Former COP	IHBP	Telcom to Oregon, USA
46	Ms. Kara Tureski	Technical Officer	FHI 360	USA
Rajasthan				
47	Mr. Niraj Kumar Pawan	Additional Mission Director (NHM) and Director IEC	DoHFW, Rajasthan	Jaipur
48	Dr. M.L. Jain	Director	SIHFW, Rajasthan	Jaipur
Jharkhand				
49	Mr. Ashish Singhmar	Mission Director	NHM, Jharkhand	Ranchi
50	Dr. T. Hemrom	Nodal Officer cum Deputy Director	IEC Bureau, NHM, Jharkhand	Ranchi
51	Ms. Akay Minz	State Project Coordinator	Sahhiya Resource Center	Ranchi
52	Mr. Ajay Kr. Sharma	State Media Consultant	NHM, Jharkhand	Ranchi
53	Ms. Purnalata Kundu	Health Educator	NHM, Jharkhand	Ranchi
54	Mr. Shailendra Shrivastava	Director	Institute of Public Health	Ranchi
55	Mr. Avanindra Kumar	State System Analyst	NHM, Jharkhand	Ranchi
56	Ms. Rafat Farzana	State ARSH Consultant	NHM, Jharkhand	Ranchi
57	Dr. Suranjeen Prasad	State Programme Manager	JHPEIGO	Ranchi
58	Dr. Gunjan Taneja	Technical Team Leader, RMNCH+A	MCHIP	Ranchi
59	Dr. D.P. Taneja	State Improvement Coordinator	URC, ASSIST project	Ranchi
Haryana				

No.	Name	Designation	Institutional Affiliation	Location
60	Dr. Rakesh Gupta	Mission Director	NHM, Haryana	Chandigarh
61	Dr. Ravikant Gupta	Director, BCC	NHM, Haryana	Chandigarh
62	Dr. Amit Phogat	Deputy Director- RT,IT and HMIS	NHM, Haryana	Chandigarh
63	Mr. Harish	Project Officer IT and HMIS	NHM, Haryana	Chandigarh
64	Mr. Anil Saddi	Consultant BCC	NHM, Haryana	Chandigarh
65	Ms. Jyotika	Jr Consultant, Mass Media and Publicity, BCC Division	NHM, Haryana	Chandigarh
66	Dr. Anshu Jain	Jr Consultant, Capacity Building, BCC Division	NHM, Haryana	Chandigarh
67	Dr. Arpita	Faculty Child Health and Admin in Charge	SIHFW	Chandigarh
68	Dr. Anil Sharma	Consultant Research Officer	SIHFW	Chandigarh
69	Dr. Puneet Gupta	Consultant Training	SIHFW	Chandigarh
70	Dr. Shailendra Tomar	Technical Officer, RMNCH+A,	MCHIP	Chandigarh

LIST OF KEY INFORMANT INTERVIEWS WITH IHBP STAFF

No.	Name	Designation	Placement	Location
National and International				
1	Bitra George	Country Representative	FHI 360	New Delhi
2	Orlando Hernandez	Monitoring and Evaluation Specialist	FHI360	Washington, DC
3	Ms. Tara Appachus Sharma	Chief of Party	IHBP Headquarters	New Delhi
4	Mr. Dharmendra Singh	Chief Technical Advisor SBCC	IHBP Headquarters	New Delhi
5	Mr Sanjeev Vyas	Senior Advisor- Private Sector	IHBP Headquarters	New Delhi
6	Ms. Maithili Ganjoo	Senior Advisor - Knowledge Management	IHBP Headquarters	New Delhi
7	Dr. Subroto Mondal	Chief Technical Advisor - Monitoring and Evaluation	IHBP Headquarters	New Delhi
8	Dr. Vasanthi Krishnan	Co-ordinator NHCRSC	NACO	New Delhi
9	Mr. Satish Kumar	National BCC Consultant , Planning and Coordination	MOHFW	New Delhi
10	Ms. Jhimly Baruah	Institutional Strengthening Specialist	IHBP Headquarters	New Delhi
11	Mr. Daya Shanker	Institutional Strengthening State Specialist	IHBP Headquarters	New Delhi
12	Ms. Pooja Passi	National BCC Consultant , HIV/RCH, PIP appraisals	MOHFW	New Delhi
13	Ms. Geetanjali	National BCC Consultant , Social Media	MOHFW	New Delhi
14	Mr. Manoj Varghese	National BCC Consultant , Consultant for NIHFW	NIHFW	New Delhi
15	Mr. Mukesh Kumar	Chief Coordinator Nutrition Resource Platform (NRP), Consultant	NIPCCD	New Delhi
Jharkhand				
16	Mr. Pankaj K. Gupta	Technical Expert, Monitoring and Evaluation, IHBP Jharkhand	NHM, Jharkhand	Ranchi
17	Ms. Soumi Guha Haldar	Technical Expert, Health Communication	NHM, Jharkhand	Ranchi
18	Nasreen Jamal	Technical Expert, Capacity Building	NHM, Jharkhand	Ranchi

Haryana				
19	Ms. Reshma Azmi	Technical Expert, Capacity Building	NHM, Haryana	Chandigarh
Himachal Pradesh				
20	Mr. Deep Pathak	Technical Expert, Health Communication,	IEC Division, HP	Shimla, HP

LIST OF FOCUS GROUP DISCUSSION (FGD) PARTICIPANTS

No.	Name	Designation	Institutional Affiliation	Location
FGD with district and block level officials - District Family Welfare Education Officers/Block Extension Educators in Directorate Health Services, Himachal Pradesh				
1	Ms. Anjali	Health Educator	District IEC Bureau, Kangra	Dharamshala
2	Ms. Promila Mahajan	Mass Education Officer	CMO Office, District Sirmour	Nahan
3	Mr. Chhamga Ram Thakur	Health Educator	BMO Office, District Kangra	Gangath
4	Mr. L.R.Sharma	State IEC Officer	Directorate of Health Services	Shimla
5	Mr. Devendra Gaud	Health Educator	CMO Office, District Chamba	Chamba
FGD with district and block level officials, Jharkhand				
6	Mr. Lalit Kumar	Health Educator	State IEC Cell, NHM	Ranchi
7	Mr. Ramesh Kumar	Block Extension Educator	State IEC Cell, NHM	Ranchi
8	Mr. Rajiv Kumar	District Data Manager	DPMU	Gumla
9	Mr. Xavier Ekka	District Program Coordinator	DPMU	Gumla
10	Ms. Jacinta Aind	State Trainer Team	DPMU	Ranchi
11	Mr. Doman Chardra Mahto	DPC	DPMU	Sarikela
12	Ms. Sweta Singh	DDM	DPMU	Khunti
FGD with district and block level officials, BEEs, NHM, Haryana				
13	Mr. Rajesh Kumar	BEE, NHM	CHC Bopali	District Panipat
14	Mr. Devender Kumar	BEE, NHM	CHC Jhirly	District Mewat
15	Mr. Kapil Dev	BEE, NHM	CHC Avengabad	District Palwal
16	Mr. Jeetendra Singh	BEE, NHM	CHC Ballah	District Karnal
17	Mr. Satyavan	BEE, NHM	CHC Chiri	District Rohtak
18	Mr. Satya Prakash	BEE, NHM	CHC Ateli	District Mahendergarh

No.	Name	Designation	Institutional Affiliation	Location
FGD with Trainers of Folk Media Troupes, Institute of Professional Studies Society, Mumbai				
19	Mr. Sudhir Rana		IPSS	Mumbai
20	Mr. Naveen Diwaker		IPSS	Mumbai
21	Mr. Himanshu Mehta		IPSS	Mumbai
22	Ms. Manisha Malhotra		IPSS	Mumbai
23	Ms. Ashima Pandey		IPSS	Mumbai
24	Mr. Sankalp Srivastava		IPSS	Mumbai
FGD with IHBP Consultants placed at the MOHFW				
25	Anukampa	ACSM	CTD	New Delhi
26	Emily	SBCC Capacity Building		New Delhi
27	Satish	BCC, Planning and Coordination		New Delhi
28	Pooja	HIV/RCH, PIP appraisals		New Delhi

ANNEX IX: DISCLOSURE OF ANY CONFLICTS OF INTEREST

Name	Iain McLellan
Title	Team Leader
Organization	Social Impact
Evaluation Position?	**X** Team Leader ☐ Team member
Evaluation Award Number *(contract or other instrument)*	AID-386-TO-10-00003
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	IHBP
I have real or potential conflicts of interest to disclose.	☐ Yes X No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	
Date	23 August 2014

Name	Lalita Shankar
Title	Health Systems Strengthening Specialist
Organization	Social Impact
Evaluation Position?	☐ Team Leader X Team member
Evaluation Award Number *(contract or other instrument)*	AID-386-TO-10-00003
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	IHBP
I have real or potential conflicts of interest to disclose.	☐ Yes X No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	

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Signature	
Date	25 August 2014

Name	Kumkum Srivastava
Title	Health Evaluation Specialist
Organization	Social Impact
Evaluation Position?	☐ Team Leader **X** Team member
Evaluation Award Number *(contract or other instrument)*	AID-386-TO-10-00003
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	IHBP
I have real or potential conflicts of interest to disclose.	☐ Yes X No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	

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Signature	Kumkum Srivastava
Date	25 August 2014

Name	Michele Wehle
Title	Program Manager
Organization	Social Impact
Evaluation Position?	☐ Team Leader **X** Team member
Evaluation Award Number *(contract or other instrument)*	AID-386-TO-10-00003
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	IHBP
I have real or potential conflicts of interest to disclose.	☐ Yes **X** No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	

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Signature	Michele Wehle
Date	8/27/2014

U.S. Agency for International Development

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Washington, DC 20523