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HEALTH COMMUNICATION COMPONENT

FINAL EVALUATION

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HEALTH COMMUNICATION COMPONENT

FINAL EVALUATION

Contracted under Order No. AID-391-C-15-00004

Performance Management Support Contract

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
AOR	Agreement Officer's Representative
BCC	Behavior Change Communication
CCP	Center for Communication Programs
CCPP	Center for Communication Programs Pakistan
CHW	Community Health Worker
CIP	Costed Implementation Plan
CPR	Contraceptive Prevalence Rate
CSG	Community Support Group
DFID	Department for International Development (United Kingdom)
DG	Director General
DHS	Demographic and Health Survey
DoH	Department of Health
FP	Family Planning
FPRH	Family Planning and Reproductive Health
HCC	Health Communication Component
HCP	Health Communication Project
HIV	Human Immunodeficiency Virus
IP	Implementing Partner
IPC	Interpersonal Communication
IUCD	Intrauterine Contraceptive Device
JHU/CCP	Johns Hopkins Center for Communication Programs
LHW	Lady Health Worker
MCH	Maternal and Child Health
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn, and Child Health
MSI	Management Systems International
M&E	Monitoring and Evaluation
NGO	Non-Governmental Organization
PDHS	Pakistan Demographic and Health Survey
PWD	Population Welfare Department
RSPN	Rural Support Program Network

SBA	Skilled Birth Attendant
SBCC	Social and Behavior Change Communication
UC	Union Council
UNICEF	United Nations International Children's Emergency Fund
U.N.	United Nations
USAID	United States Agency for International Development
USG	United States Government
VHC	Village Health Committee

PROJECT SUMMARY

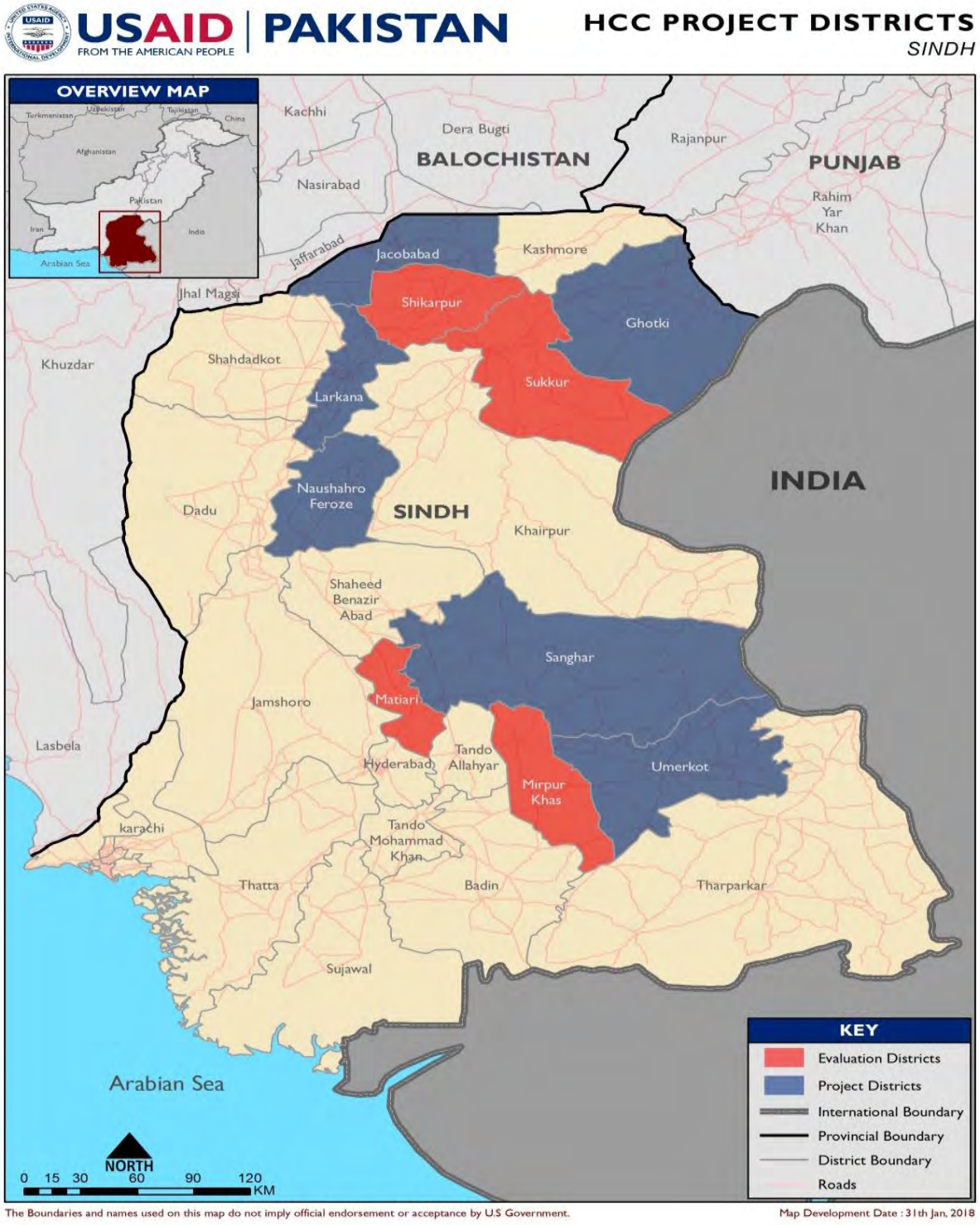
Table 1 summarizes basic information about the Health Communication Component (HCC) of the USAID-funded Maternal and Child Health (MCH) program.

TABLE 1: PROJECT SUMMARY

Title/Field	Project/Activity Information
Contract/agreement numbers	AID-391-A-14-00002
Agreement officer's representative (AOR)	--
Start date	April 25, 2014
Completion date	March 31, 2018
Location	10 districts in Sindh province, i.e., Umerkot, Sanghar, Matiari, Mirpur Khas, Naushahro Feroze, Sukkur, Larkana, Jacobabad, Shikarpur, and Ghotki.
Implementing partner(s)	Johns Hopkins Center for Communication Programs (CCP) with local partners Mercy Corps, Rural Support Program Network (RSPN), and the Center for Communication Programs Pakistan (CCPP).
USAID/Pakistan Mission Strategic Framework objectives addressed	IR 5.2.1: improved demand for high impact health services
Budget	$--

Figure 1 illustrates the districts in which the project worked and those in which the evaluation team conducted its fieldwork.

FIGURE 1: PROJECT AREA MAP



EXECUTIVE SUMMARY

Evaluation Purpose and Questions

This evaluation highlights lessons learned, best practices, and innovative methods of social and behavior change communication (SBCC) distilled from the implementation of the Health Communication Component (HCC) of the United States Agency for International Development in Pakistan's (USAID/Pakistan's) Maternal and Child Health (MCH) program. USAID/Pakistan expects to use the evaluation results to inform the design and implementation of a follow-on health communication project. The evaluation addresses five questions:

1. What is the reach of the project's SBCC activities and to what extent have they been effective in changing norms related to family planning, family planning behaviors, and demand for family planning services? What unanticipated results, if any, have been achieved?
2. How effective have the project's capacity-building strategy and individual approaches been in building sustainable capacities at the individual and institutional levels to design, implement, and evaluate high-quality SBCC?
3. To what extent have the project's pretesting and formative research results contributed to designing and implementing the SBCC campaigns and how are stakeholders using the information?
4. To what extent did HCC project activities address gender issues and what effects did this have on increased uptake of family planning (FP) services?
5. What best practices, innovations, and lessons learned can be applied to other existing or future programming in health communication?

Key Findings and Conclusions

Reach and effectiveness of FP messaging – The project reported reaching almost 39 million people, 99.7 percent through its mass media campaign, which consisted of television commercials, the "Sammi" drama,[1] the Bright Star campaign, radio spots, an anthem, and mid-level media including billboards, posters, vehicle advertisements, carnivals (melas), and theater performances. However, few of the individuals the evaluation team interviewed in the four districts that the team visited reported watching the channel (HUM TV) on which the project aired its commercials and the "Sammi" drama, either because the channel was not accessible in their area or they preferred Indian and Sindhi-language channels (HUM TV broadcasts in Urdu). The evaluation suggests that fewer people than the project estimated heard or saw a project-supported FP message through the mass media campaign. However, evidence from a small, purposively selected sample of individuals who had seen the "Sammi" drama suggests that it is effective in changing attitudes and practices about FP.

Community-based approaches that relied on personal interaction were very effective in communicating FP messages. Most married women and their husbands the evaluation team interviewed reported hearing FP messages in community support groups (CSGs) for women, village health committee (VHC) meetings for men, and home visits from lady health workers (LHWs) and community health workers (CHWs) for both men and women. The interpersonal communication (IPC) toolkit and the training on how to use it that the project developed were innovative and extraordinarily effective, for both the LHWs and CHWs who used it as a counseling aid and for the men and women who were exposed to the material. While the toolkit was an effective communication tool, it could be improved by

[1] "Sammi" is a TV drama that addresses social issues. CCP co-produces the show.

incorporating more FP messages (especially about a broader range of side effects associated with FP methods) and larger, more realistic, and more regionally appropriate illustrations.

Messages about the economic benefits of a small family (i.e., being able to better care for family needs such as food, clothing, and education) were persuasive for both men and women, as were messages about the positive health benefits for women and children. The campaign changed attitudes about FP among 93 percent of respondents, largely by improving their knowledge of FP methods, including how methods worked and potential side effects, and their understanding of the religious acceptability of FP. Most of those who changed their views also changed, or intended to change, their FP practices—40 percent to use contraceptives and 36 percent to practice birth spacing. Increasing women's knowledge of FP practices, along with increasing acceptance of FP by men and other influential household members, also gave many women the confidence to initiate discussions about FP with their husbands.

Sustainability – One of the project's important achievements was establishing a close working relationship with the Population Welfare Department (PWD) and Department of Health (DoH) and convincing them of the importance of SBCC to change FP attitudes and behaviors. As a result, these government departments demonstrated a commitment to SBCC by developing communication strategies and including SBCC activities in their annual plans with allocated funding. This government ownership, instilled by HCC's collaborative approach, eased implementation of communication activities at the district and community levels and enhanced prospects for sustainable results. The IPC toolkit, and the cadre of LHWs and CHWs trained to use the toolkit, and train others to do so, also represents an important sustainable outcome that should continue to contribute to improved communication about FP.

The evaluation team questioned the sustainability of some aspects of the project, however. The mass media component of the campaign may not be sustainable without outside financial support. And, although PWD has developed a costed implementation plan that includes health communication, it may not have allocated sufficient funding to accommodate the anticipated increase in demand for FP services. The evaluation also concluded that institutional barriers may thwart plans to transition the health education cell at the DoH in Hyderabad to an SBCC cell that could support district health education units and officers.

Pretesting and formative research – The project's formative research seems to have been vested largely with the implementing partner (IP) and consisted primarily of a survey on enhancing communication for improved FP and the 360 Degree Media Report that informed the design of the overall communication strategy. The media report generally contributed to developing appropriate interventions but somehow missed the fact that few households in the target areas watched HUM TV, the channel the project used for most of its mass media communication. Pretesting the communication tools engaged a larger number of stakeholders who reported finding the exercise useful and informative. Pretesting contributed to improving most elements of the campaign.

Gender – The communication strategy effectively reached women and men, but had some difficulty reaching men with the community activities as easily as it reached women, e.g., some female LHWs and CHWs found speaking with men in VHC meetings to be uncomfortable. However, the evaluation suggests that a subject as sensitive as FP can be discussed in communities, including Muslim communities, and that with the development of appropriate empowerment skills and knowledge, women, including illiterate and economically disadvantaged women, should be able to initiate discussions about FP with their spouses.

Best practices, innovations, and lessons learned – The IPC toolkit and the methods LHWs/CHWs employed when using the toolkit emerged as best practices because they were effective and appropriate to the rural Sindh context. The project's close working relationship with government

counterparts also eased implementation, built capacity, and enhanced prospects for sustainability. This relationship also contributed to being able to deploy consistent FP and maternal, newborn, and child health (MNCH) messages using proven communication strategies. Much of the project's success also rested on its practice of strategically coordinating its use of mass media, mid-level media, and community activities to reinforce messages.

EVALUATION PURPOSE AND QUESTIONS

This evaluation assesses the effectiveness of the HCC project, which is one component of USAID/Pakistan's MCH program. It highlights lessons learned, best practices, and innovative methods of SBCC related to FP and MNCH from the project that will inform the design and implementation of a follow-on project.

Evaluation Questions

The evaluation addresses five questions specified in the statement of work and elaborated in the assignment work plan.

1. What is the reach of the project's SBCC activities and to what extent have they been effective in changing norms related to family planning, family planning behaviors, and demand for family planning services? What unanticipated results, if any, have been achieved?
2. How effective have the project's capacity-building strategy and individual approaches been in building sustainable capacities at the individual and institutional levels to design, implement, and evaluate high-quality SBCC?
3. To what extent have the project's pretesting and formative research results contributed to designing and implementing the SBCC campaigns and how are stakeholders using the information?
4. To what extent did HCC project activities address gender issues and what effects did this have on increased uptake of FP services?
5. What best practices, innovations, and lessons learned can be applied to other existing or future programming in health communication?

PROJECT BACKGROUND

According to preliminary 2017 census results, Pakistan's population has grown faster than projected[2] over the last 19 years, reaching 207.8 million, a 57 percent increase since 1998, when the last census

[2] The Ministry of Planning, Development, and Reforms estimated a 2016 population of 199.1 million, which implies an average annual average growth rate of 2.3 percent, while the actual rate was 2.4 percent. Finance Division, *Pakistan Economic Survey 2016-17* (Government of Pakistan, 2017), 197-207, http://www.finance.gov.pk/survey/chapters_17/12-Population.pdf.

was conducted.[3] The census also reported that between mid-2016 (estimated) and mid-2017, the population grew by 2.4 percent rather than the anticipated 1.9 percent.[4] The population is still predominantly rural (36 percent urban 64 percent rural), and roughly two-thirds resides in Sindh and Punjab provinces. The preliminary 2017 census results also indicate that the population is expected to surpass 400 million by 2050.

Pakistan's overall maternal mortality ratio (MMR), which was last measured in 2006–2007, was 276 per 100,000 live births, with a much higher ratio in rural (319) than in urban (175) areas, reflecting disparities in the availability of and access to skilled birth attendants (SBAs).[5] World Bank data indicates that MMR dropped in 2015 to 178, but the rural or urban breakdown of this statistic was unavailable.[6] The 2012–2013 Pakistan Demographic and Health Survey (PDHS) notes that the national contraceptive prevalence rate (CPR) is 35 percent, with 26 percent of the population using modern methods. In Sindh, the provincial CPR is 30 percent, with 25 percent using modern methods. These rates have not changed significantly since the 2007 PDHS.

About 24 percent of Pakistan's population lives in Sindh province, on which the HCC project focuses. Sindh includes Karachi and 22 predominantly rural districts, which lack adequate health infrastructure. The 2012–2013 PDHS found that the neonatal mortality rate in Sindh was 44 per 1,000 live births, the infant mortality rate was 81 per 1,000 live births, and the under-5 mortality rate was 106 per 1,000 live births (unchanged since 2006–2007). Sindh had a total fertility rate[7] of 3.9, the second-highest in the country after Balochistan (4.2). The PDHS also found that 37 percent of Pakistani children are born less than 24 months after a previous birth, a birth interval considered "too short,"[8] and this was only 3 percentage points better than the proportions measured in 2006–2007. Although knowledge of birth control methods was nearly universal, only 25 percent of currently married women—and only 17 percent of rural women—in Sindh used modern contraceptive methods in 2012–2013.[9] The 2012–2013 PDHS found that 24 percent of married women in rural areas of Sindh had an unmet need for FP (12 percent for spacing and 12 percent for limiting).

Although Pakistan has the highest fertility rate in South Asia, it has had one of the longest-running FP programs in Asia. According to previous PDHS reports and multiple indicator cluster surveys, knowledge of FP increased from 90 percent in 1994–1995 to 94 percent in 1996–1997 and 98 percent in 2012–2013. In the past, Pakistan's FP programming focused on limiting childbearing through voluntary surgical contraception. In recent years, the programming focus has shifted toward spacing births using reversible contraceptive methods. The 2012–2013 PDHS reported that quality of care has been an impediment to the use of contraception, with 37 percent of women discontinuing contraceptive use within a year, often because of side effects or other health issues. It also showed no change in the use of

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[3] Shahbaz Rana, "6th Census findings: 207 million and counting," *Express Tribune*, August 25, 2017, https://tribune.com.pk/story/1490674/57-increase-pakistans-population-19-years-shows-new-census/.

[4] Ibid.

[5] National Institute of Population Studies, MEASURE DHS, and ICF International, *Pakistan Demographic and Health Survey 2012-13* (National Institute for Population Studies, 2013).

[6] World Bank Country MMR data, https://data.worldbank.org.

[7] The number of children who would be born per woman (or per 1,000 women) if she (or they) were to pass through the childbearing years bearing children according to a current schedule of age-specific fertility rates. See "Total fertility rate," MEASURE Evaluation, https://www.measureevaluation.org/prh/rh_indicators/family-planning/fertility/total-fertility-rate.

[8] National Institute of Population Studies and Macro International, *Pakistan Demographic and Health Survey 2006-07* (National Institute of Population Studies, 2008).

[9] Ibid.

the three main reversible methods over six years. Both the 2012–2013 and 2006–2007 PDHS reports found that 6.7 percent of married women used intrauterine contraceptive devices (IUCDs) or oral or injectable contraceptives. Condom use, which has continued to be the main method of contraception, was 8.8 percent in 2012–2013, followed by female sterilization (8.7 percent). Use of traditional methods was at 8.5 percent, a higher rate than IUCDs and oral and injectable contraceptives combined. The preference for less effective methods, such as condoms and withdrawal, is believed to be an indicator of the poor quality of FP counseling and follow-up services available in Pakistan. Also, traditional attitudes related to culture and religion have contributed to limited acceptance of contraception in Pakistan.[10]

Despite a long-standing commitment from public sector and other stakeholders, health communication efforts in Pakistan have been poorly coordinated and fragmented. The 18th Amendment to the Constitution, enacted in 2010, exacerbated the fragmentation of the health sector by devolving responsibility for managing health services to the provincial level. As an example, the LHW program has stagnated due to the unresolved ownership of the program, with neither federal nor provincial health authorities taking ownership. To address the governance issues, the governments of Sindh and Punjab recently approved health strategies that include health communication plans. While this is encouraging, there is still a lack of harmonization (i.e., unified guidelines and policies) among the different health sectors and programs (e.g., FP, MNCH, HIV/AIDS, and malaria).[11]

The main health communication concerns revolve around the fact that, although Pakistanis in general have a high level of knowledge about FP, this has not translated into significant behavior change and FP adoption, a situation that experts blame on a lack of comprehensive knowledge and on poor-quality counseling and services. In addition, previous health communication and health education programs have not focused on increasing demand for health products and services. Instead, they have focused on lifestyle change or healthy behaviors at home. Another issue is that much of the health communication programming has favored mass media, which has not consistently reached priority, underserved audiences. The 2006–2007 PDHS reported that 56 percent of married women had no access to TV or radio messages. Those who were exposed to TV tended to be wealthy, educated, urban women—not their poor, educationally challenged, rural counterparts. The mass media approaches have also raised other concerns, such as coordination between media and community-based strategies. Also, previous efforts have not consistently selected the most appropriate channels to maximize reach and the impact of messages for this underserved audience.[12]

As background, Table 2 summarizes district-level trends in FP indicators collected during Management Systems International's (MSI's) monitoring of the MCH program.

TABLE 2: FP INDICATOR VALUES BY DISTRICT

Region	District	Indicator 5.1.2.1 (Birth Spacing)			Indicator 5.1.2.2 (Messages)			Indicator 5.1.2.3 (Discussing FP)
		2013	2014	2016	2013	2014	2016	2016
Northern	Sukkur	15%	19%	39%	10%	29%	59%	35%
	Naushahro Feroze	34%	21%	28%	5%	33%	24%	45%

[10] Jhpiego Corporation, *Maternal and Child Health (MCH) Program Indicator Survey 2013 Sindh Province* (USAID, 2013).

[11] Cooperative Agreement No: AID-391-A-14-00002, Health Communication Project (HCP), Attachment B: "Program Description."

[12] Terms of reference for consultancy for designing tutorials on health reporting, Center for Communication Programs Pakistan, end date December 25, 2015, http://www1.brightspyre.com/jobs/18744/Center-for-Communication-Programs-Pakistan/Consultancy-for-Designing-Tutorials-on-Health-Reporting/.

Region	District	Indicator 5.1.2.1 (Birth Spacing)			Indicator 5.1.2.2 (Messages)			Indicator 5.1.2.3 (Discussing FP)
		2013	2014	2016	2013	2014	2016	2016
	Larkana	19%	29%	20%	9%	34%	39%	46%
Northern – tribal	Ghotki	26%	25%	23%	8%	16%	21%	54%
	Shikarpur	34%	22%	22%	8%	28%	17%	62%
	Jacobabad	19%	28%	11%	2%	21%	38%	61%
Southern	Umerkot	34%	24%	39%	14%	23%	4%	57%
	Matiari	20%	17%	6%	13%	37%	80%	28%
	Mirpur Khas	37%	39%	20%	26%	39%	31%	50%
	Sanghar	25%	20%	32%	20%	25%	40%	49%

Source: 2013 and 2014 data are from the CCP indicator survey. 2016 data are from the MSI indicator survey.
Note: JHU collected and analyzed the 2013 and 2014 data reported in this table while MSI collected the 2016 data. The apparent trends in the indicator data may thus reflect differences in the way data were collected, sampling error, or errors in preparing the data may.
Indicator 5.1.2.1: Percent of married women of reproductive age who intend to wait at least two years between their last birth and their next birth.
Indicator 5.1.2.2: Percent of audience who recall hearing or seeing a specific United States Government (USG)-supported family planning and reproductive health (FP/RH) or MNCH message.
Indicator 5.1.2.3: Percent of married women/men who discussed FP with their spouses/partners.

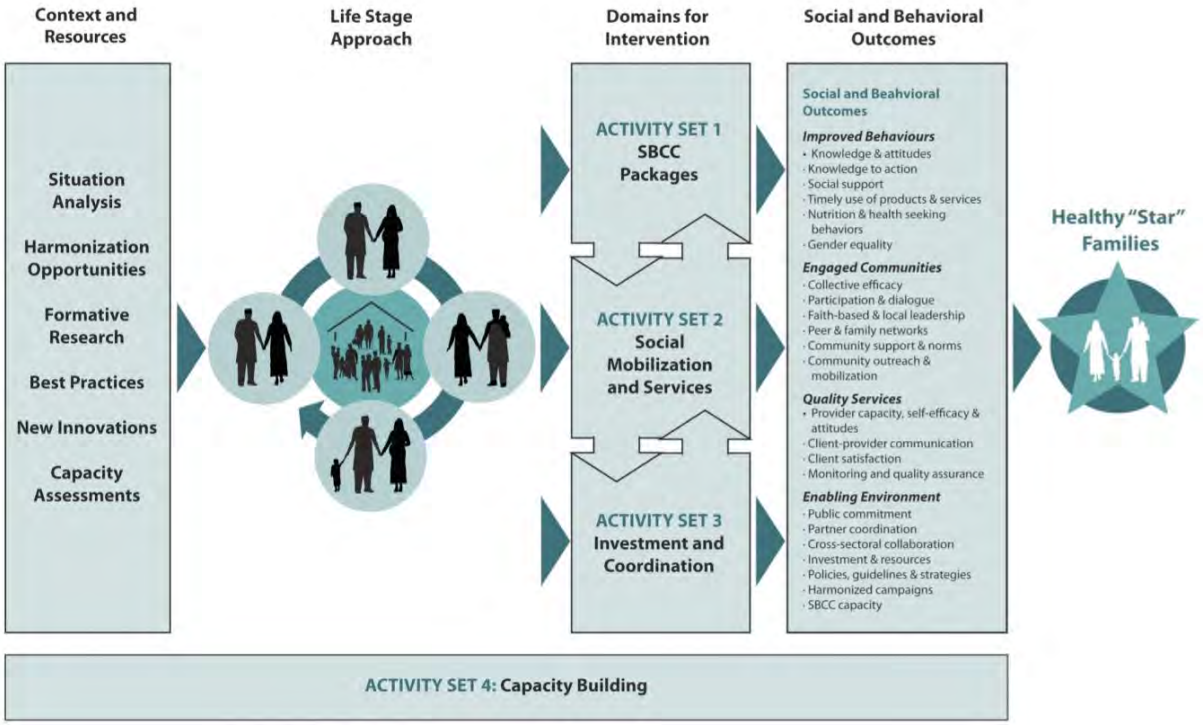
The indicators show mixed results for changes in FP knowledge and practices between 2013 and 2016. Only 4 of 10 districts showed an increase in the percentage of married women who intend to practice birth spacing, but 9 of 10 districts showed an increase in the percentage of people recalling a USG-supported FP message.

Theory of Change

The Johns Hopkins Center for Communication Programs (CCP) developed a project-specific conceptual framework (the HCC Integrated Change Model) based on its Pathways model. The Pathways model provides a generic framework for designing health communication programs and presents a strategy to address both immediate drivers of change and the contextual factors that determine outcomes.[13] The **Integrated Change Model** (Figure 2) depicts the layers of this framework as applied to the HCC project. The project's intent was to implement an array of evidence-based SBCC interventions tailored to each level of this framework and to the life stages of the target population, to achieve outcomes embodied in the project's central logo or theme: "Healthy 'Star' Families," or Bright Stars, when translated literally from Urdu (روشن ستارے).

[13] Urie Bronfenbrenner, *The Ecology of Human Development: Experiments by Design and Nature* (Cambridge, MA: Harvard University Press, 1979).

FIGURE 2: HCC INTEGRATED CHANGE MODEL



Source: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs, *Working Together for a Brighter Future: Quarterly Report* July 1 to September 30, 2014 (Karachi: USAID/Pakistan MCH Program, 2014).

The framework relies on three tenets of contemporary behavior change theory for implementation:

- Create an **enabling environment for change**. Information alone is not enough. Despite adequate knowledge, people may perceive barriers and lack of normative support to adopt new behaviors.
- Work through and bolster **social networks** to create a sense of social support. Expand the use of community and support groups to increase social capital.
- Ensure that the target audience perceives MNCH challenges as personal **threats**, and at the same time empower them with a sense of **self-efficacy** to confront those challenges.

Based on this model, the HCC project designed the following activities.

- Activity Set 1: Design and deliver an effective package of SBCC interventions at the individual, household, and community levels.
- Activity Set 2: Support an enabling environment at the community and health facility levels to foster beneficial health-seeking behaviors.
- Activity Set 3: Advocate for improved investment in coordination of behavioral programming.
- Activity Set 4: Build capacity to improve design, implementation, and evaluation of high-quality SBCC activities.

- Crosscutting: Support MCH program SBCC efforts through pretesting, monitoring, and formative research.

EVALUATION METHODS AND LIMITATIONS

The evaluation draws on primary and secondary data collected from a variety of sources. The approach allowed the evaluation team to triangulate findings across multiple sources and methods to strengthen findings and conclusions.

Data Collection

The evaluation team reviewed documents (e.g., project research and performance reports, agreement documents, work plans, survey reports, and government strategies) to collect secondary data. Annex 3: Bibliographycontains a bibliography of all the documents the team reviewed. Primary data collection consisted chiefly of key informant, individual, and group interviews with project beneficiaries and participants, residents (men and women) in communities where the project was implemented, IPs, personnel from relevant government departments, and journalists.

The evaluation team conducted **individual interviews** with the primary target groups of married men and women because the evaluation team's experience suggested these individuals may have been reluctant to discuss sensitive issues in the presence of their peers. It conducted **group interviews** with influential men, mothers-in-law (influential women), journalists, LHWs, and CHWs—groups that the evaluation team's experience suggested were less susceptible to biases introduced through group settings. It conducted **key informant interviews** with senior IP staff and government officials selected for their unique perspectives or expertise. Table 3 summarizes the primary data collection.

TABLE 3: INTERVIEWS BY RESPONDENT TYPE AND METHOD

Type of Respondent	Method	Number of Interviews	Number of Respondents
LHWs and CHWs	Group interviews	8	31
Influential men	Group interviews	8	39
Influential women	Group interviews	9	36
Journalists	Group interviews	4	20
Married women	Individual interviews	32	32
Married men	Individual interviews	32	32
IPs: CCP, CCPP, RSPN, and Mercy Corps	Key informant interviews	15	15
Government officials: DoH, PWD, and the LHW program	Key informant interviews	14	14

Sampling

The evaluators selected four districts in which to conduct the fieldwork. These included Shikarpur district as representative of tribal districts in northern Sindh; Sukkur, representing non-tribal northern Sindh districts; and Matiari and Mirpur Khas in the southern part of the province. From each of the four

selected districts, the team randomly selected one rural and one urban or peri-urban union council to achieve a mix of socio-economic classes and to ensure representation from these populations. The team also conducted interviews in Islamabad and Karachi with the IPs. Annex 2: Details of Sample Selection provides greater detail on the sampling approach.

Data Analysis

The data the team collected were primarily qualitative. The team used MAXQDA (a qualitative data analysis software package) to manage and analyze the data. The qualitative analysis approach identified themes relevant to answering the evaluation questions, recorded the frequency with which the themes occurred in the interview notes, and examined the content of the illustrative text to better understand the meaning and context of the statements. The analysis also assessed and highlighted evidence that deviated from the common themes.

Limitations and Mitigation

The evaluation faced a number of limitations that potentially affected the quality and interpretation of the data. The primary limitations and the measures the team took to mitigate their effects were:

- The evaluation relied almost entirely on qualitative data collected from non-random samples of project participants, stakeholders, and members of groups the project targeted for FP messaging. The design did not permit rigorous causal attribution of results to project activities. However, triangulation of results across data sources and methods at times provides a level of plausible attribution.

- Conducting the evaluation after the project had closed affected the team's access to the individuals it planned to interview. Mercy Corps had closed its district offices, although RSPN representatives were still accessible. This limited the team's access to partners' data and local contacts and made it more difficult for the team to identify and approach beneficiaries, particularly for selecting pseudo-random samples.

- The team's greater-than-planned reliance on partners to identify potential respondents, its use of LHWs and CHWs to identify their "clients" for interviews, and using snowball sampling techniques to reduce its reliance on partners and health care workers for selection all resulted in non-random samples which introduced the potential for selection and other types of bias. This means that results cannot be generalized to any identifiable population. Nevertheless, they do provide evidence of the effectiveness of project activities and approaches.

- Several senior staff members of government counterparts had been posted elsewhere. The team attempted to reach transferred individuals at their new posts and, in all cases, interviewed their replacements, even though they were often less informed about the project.

FINDINGS

This section discusses the evaluation findings organized around the evaluation questions in the USAID statement of work. However, many of the findings under Question 1 (which addresses the reach of project SBCC activities) also relate to Question 4 (which addresses gender). Therefore, the Question 4 subsection refers the reader back to Question 1 for more extensive discussion of some findings.

Question 1: Reach and Effectiveness

What is the extent of the reach[14] of the project's SBCC activities and to what extent have they been effective in changing social norms related to family planning, family planning behaviors, and demand for family planning services?

Reach of Campaign Media

The project's IPs reported reaching 38,838,839 people through their mass media campaign (television commercials, the "Sammi" drama, and Bright Star campaign),[15] 96,712 through mid-level media (local public events drawing large numbers of residents, such as festivals and melas), and 33,437 through community education activities (CSGs, VHCs, and home visits by LHWs and CHWs).[16] These numbers represent about 81 percent of the almost 48 million people of Sindh province.[17] They probably, to an unknown extent, overstate the number of people exposed to the project's FP messaging, since they do not account for double-counting of beneficiaries potentially exposed through multiple sources. Furthermore, the number of people the project estimates having reached through television and radio appear to be based on estimates of the number of individuals who reported viewing or listening to these sources—and the highest among four independent estimates—rather than on actual viewing or listening behavior.[18] While this may produce relatively accurate estimates of the number of people exposed to commercials and similar types of messaging, it will not provide good estimates of the reach of messages associated with more discretionary viewing (e.g., the "Sammi" drama or commercials aired on HUM TV).

It is important, however, that a communication campaign disseminate consistent messages multiple times through different sources to prompt changes in attitudes and behaviors. Integration and coordinated timing are necessary to reinforce messages, which is why the FP campaign activities were arranged to occur simultaneously through different sources. The campaign lasted seven weeks during May and June 2017.

To assess the effectiveness of various information sources in disseminating messages, the team examined beneficiary respondents' recall of FP and MNCH messages as well as the sources—i.e., where the respondents heard the messages. Identifying the sources was important so that the evaluation could link beneficiaries' exposure to messages with specific project activities. Additionally, since other development organizations have been implementing health activities in the area, in some cases the interviewers asked respondents to identify the time frame when they had heard or viewed the messages to loosely assess attribution to HCC activities. Although this evaluation question asks only about recall

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[14] For the purposes of this question, "reach" refers to the number of people exposed to the project's messages. Because the evaluation did not include a large-scale survey, it cannot independently validate the numbers reported by the IPs. Instead it focuses largely on developing an understanding of which sources were most effective in exposing people to the project's messages and their effect on FP attitudes and behaviors.

[15] The mass media numbers are based on tallies from TV and radio broadcasting agencies estimated through standard rating mechanisms, and though these tend to be inflated, CCP staff said that since the numbers were calculated by a third party, they thought they might be relatively accurate.

[16] HCC program data, quarterly beneficiaries' data sheet, December 2017.

[17] Government of Pakistan, *Province Wise Provisional Results of Census - 2017* (Government of Pakistan, 2017), http://www.pbs.gov.pk/sites/default/files//PAKISTAN%20TEHSIL%20WISE%20FOR%20WEB%20CENSUS_2017.pdf.

[18] Johns Hopkins Center for Communication Programs, RSPN, and Mercy Corps, *360 Degree Media Report: Analysis of Available Media, Channels and Communication Tools in Focus Districts of Sindh* (Islamabad: USAID, 2015).

of FP messages, the USAID AOR asked that, where possible, the evaluation team also ask respondents about MNCH messages since some of the materials and activities focused on both areas.

Since the key identifiers of any communication program or campaign are the logo and theme, the team first asked whether people recognized the logo. The team's review of project documents prior to the fieldwork raised a concern that the logo had been developed by CCP in Baltimore, which sent several versions to CCP/Pakistan to be presented to government officials, MCH partners, and non-governmental organizations (NGOs) working in Sindh. This group of stakeholders then selected what it considered the most appropriate logo with some recommended changes. Since CCP did not thoroughly pretest the logo with communities in Sindh, the evaluation team questioned whether it effectively communicated the project message (small families are happy families) to the target audience. Contrary to this concern, 92 percent of respondents recognized the Bright Star logo. Most of them had seen it on an IPC toolkit during home visits from LHWs or CHWs (74 percent) or at women's CSG or men's VHC meetings (55 percent). Only 5 percent associated the logo with television activities.[19] Additionally, when asked, 58 percent of respondents who recognized the logo said it was widely recognized in their communities as promoting FP. Most people interpreted the primary message of the logo to be "a small family is a happy family."

> *"This logo makes me feel that a small family means an easy and happy life (chota khandan zindagi asan). Fewer children means a bright future. Our future will be tension-free if we have fewer children. Monthly expenses will be manageable for a small family with two children."*
> *– Married woman, Matiari*

Despite the wide recognition of the logo and its small family message, respondents offered several suggestions to make the logo more appealing and effective. Many thought the logo should have more color, i.e., the man's cap and the woman's headpiece (nobody wears a white cap or headscarf in Sindh), the hair (they said it should be black instead of gray), and the star (it should have more "star" colors like silver and gold). They noted that the family members looked unhealthy because they appeared sad, their eyes were closed, and their cheeks were not pink.

To assess the effectiveness of various media and compare the team's findings with the findings in the 360 Degree Media Report,[20] the evaluation team asked respondents where (from which sources) they had heard or seen FP or MNCH messages. Figure 3 illustrates the percentage of individual and group interviews where respondents recalled hearing FP and MNCH messages from each source. What stands out is that more respondents seemed to recall messages disseminated through personal interaction with LHWs and CHWs[21] than those disseminated through mass media, and a large percentage of men and women obtained information from CHWs. Another interesting finding is that men obtained information from a variety of sources, including some outside the home (74 percent from VHCs), while women

[19] It is important to note that these numbers do not in any way represent the number of people exposed to a message through a specific source—both because of the vast differences in the number of people exposed to different sources and due to the purposive samples of respondents. For example, 5 percent of the estimated 39 million people who watch television in the project area is almost 2 million people, far more than the project could reach through more intensive sources such as LHW and CHW home visits.

[20] CCP, RSPN, and Mercy Corps, *360 Degree Media Report*.

[21] LHWs and CHWs conduct VHC meetings.

acquired information almost exclusively from sources that come to them in their homes (100 percent from home visits by LHWs or CHWs).[22]

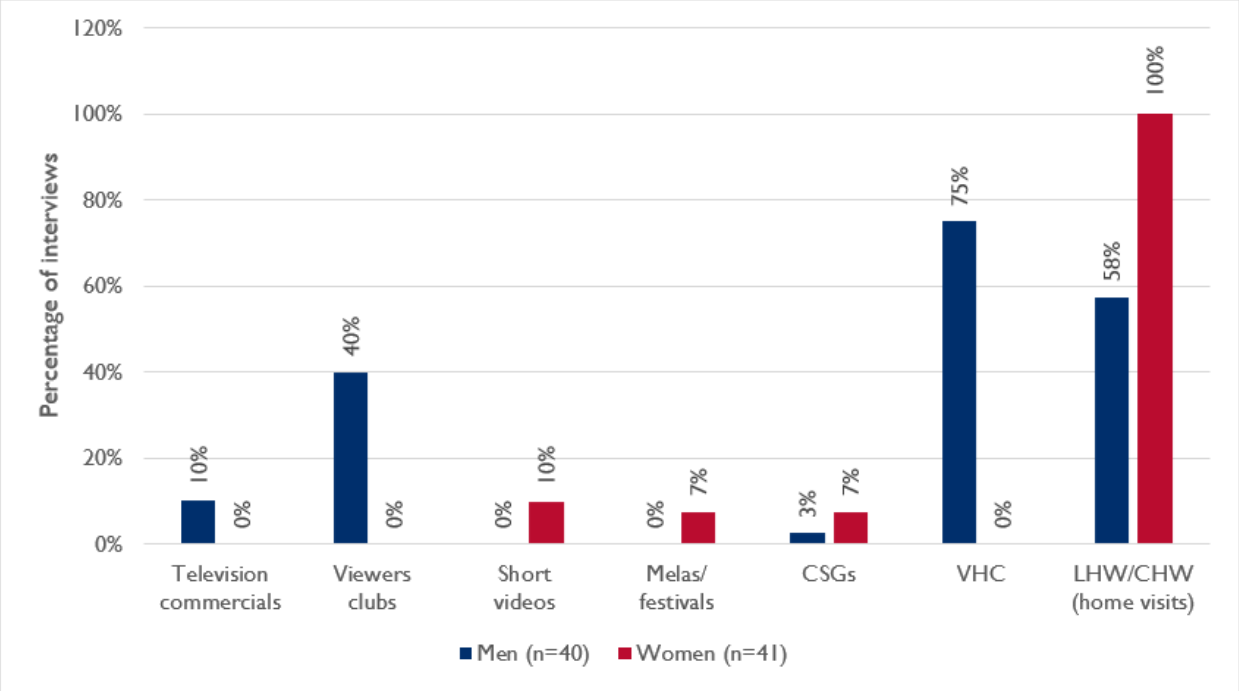
None of the respondents reported watching the TV drama "Sammi" at home, i.e., outside of the viewers clubs.[23] Although 82 percent of them have access to TV, and 73 percent said they watch TV, only 18 percent (of the 82 percent that had access to TV) reported watching HUM TV, which carries "Sammi" in Urdu. Respondents preferred watching Indian channels (49 percent of women and 71 percent men who watch TV) or Sindhi-language, instead of Urdu-language, channels (18 percent of women and 87 percent of men). Also, the cable providers in Sindh usually provide only a few channels and opt for the Sindhi-language channels. During the evaluation team's presentation of evaluation results to the Mission, the USAID AOR indicated that the project was translating "Sammi" into Sindhi, which may help the show to reach a larger audience in Sindh. These findings are consistent with the 360 Degree Media Report,[24] which noted that the Indian channel Star Plus was the most popular channel among married women and mothers-in-law in Sindh, followed by Sindhi language channels such as KTN, which was also the most popular local channel among married men. The media report also noted that married women watched HUM TV, although none of the respondents the evaluation team interviewed had watched it. Consistent with the HCC evaluation findings, the media report found that 80 percent of people interviewed in the project districts had access to TV and watched it every day.

[22] Because much of the sampling was purposive, the findings on sources cannot be generalized to the population. For example, since the evaluation team purposively selected men who had attended viewers clubs (meetings where a group of people watch the TV drama "Sammi" together), the finding that 40 percent of respondents recalled messages from "Sammi" almost certainly dramatically overestimates the percentage of the population that heard messages from this source. Nevertheless, the conclusions presented in this paragraph with respect to the general types of sources (i.e., public versus in the home) that reached people and differences in sources reported by men and women probably generally reflect the relative importance of sources to reaching individuals. However, as noted previously, the results do not reflect in any way the total number of individuals reached.

[23] Viewers clubs are meetings where a group of people watch "Sammi" together.

[24] CCP, RSPN, and Mercy Corps, *360 Degree Media Report*.

FIGURE 3: SOURCES OF RECALLED FP AND MNCH MESSAGES

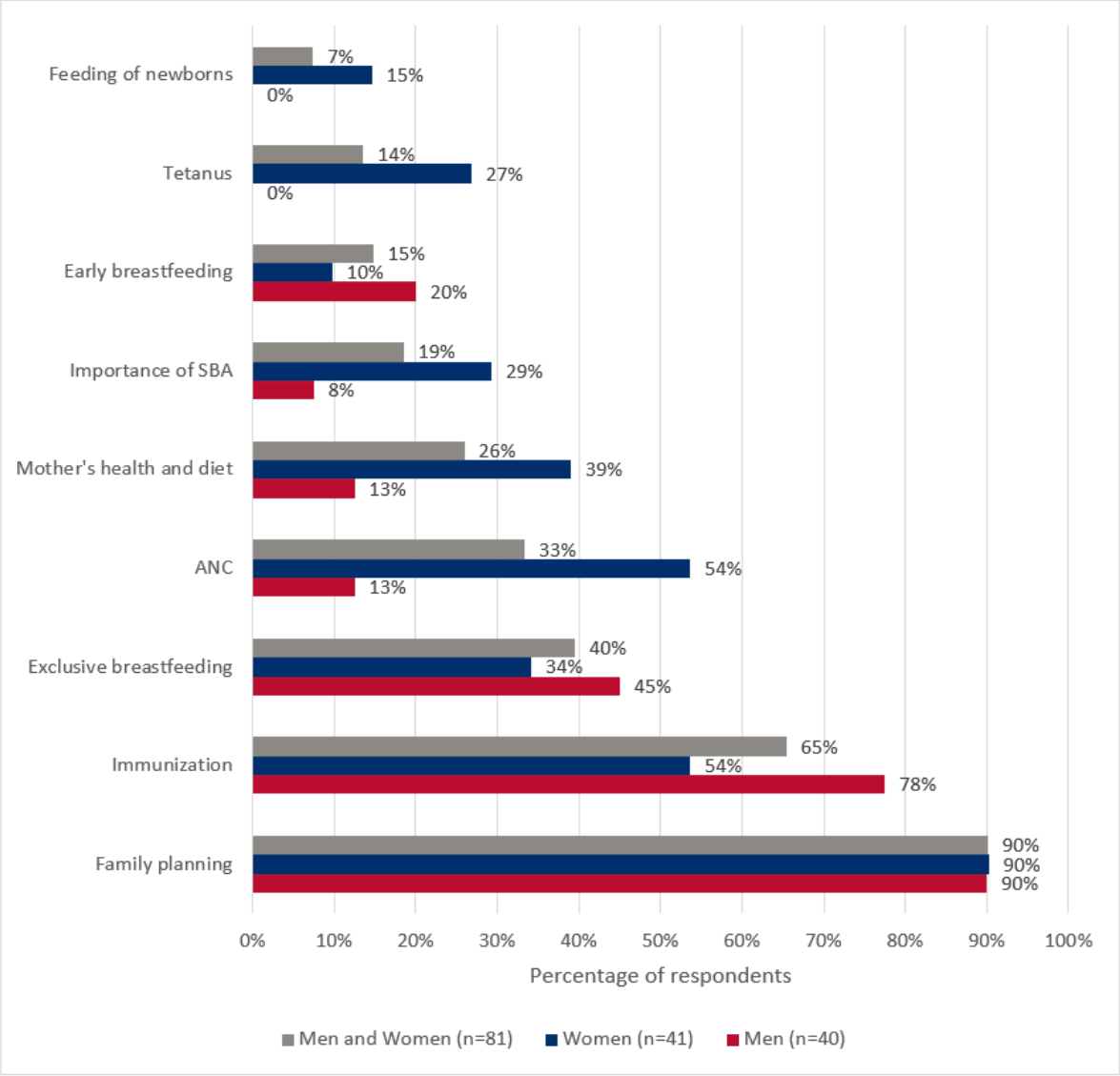


Source: MSI group and individual interviews. This figure represents the percentage of individual and group interview transcripts that contained at least one reference to a source. Because group interviews included multiple respondents, the figure does not represent the percentage of respondents. Nevertheless, it is indicative of the relative importance of sources in reaching individuals.

Reach of FP and MNCH Messages

The evaluation distinguished between the reach of sources (i.e., the percentage of respondents exposed to various sources) and the reach of messages (i.e., the percentage of respondents that recalled a message independently of a source). To assess the effectiveness of the communication strategy, the evaluators also asked respondents which messages they recalled hearing. In 90 percent of group and individual interviews, respondents recalled FP messages. In 65 percent, they recalled immunization messages; in 40 percent, they remembered messages about exclusive breastfeeding; and in 33 percent, they recalled messages about antenatal care (Figure 4). The evaluators noted that the LHWs and CHWs focused on these messages particularly during home visits and that the DoH recently organized a large immunization campaign in the project area.

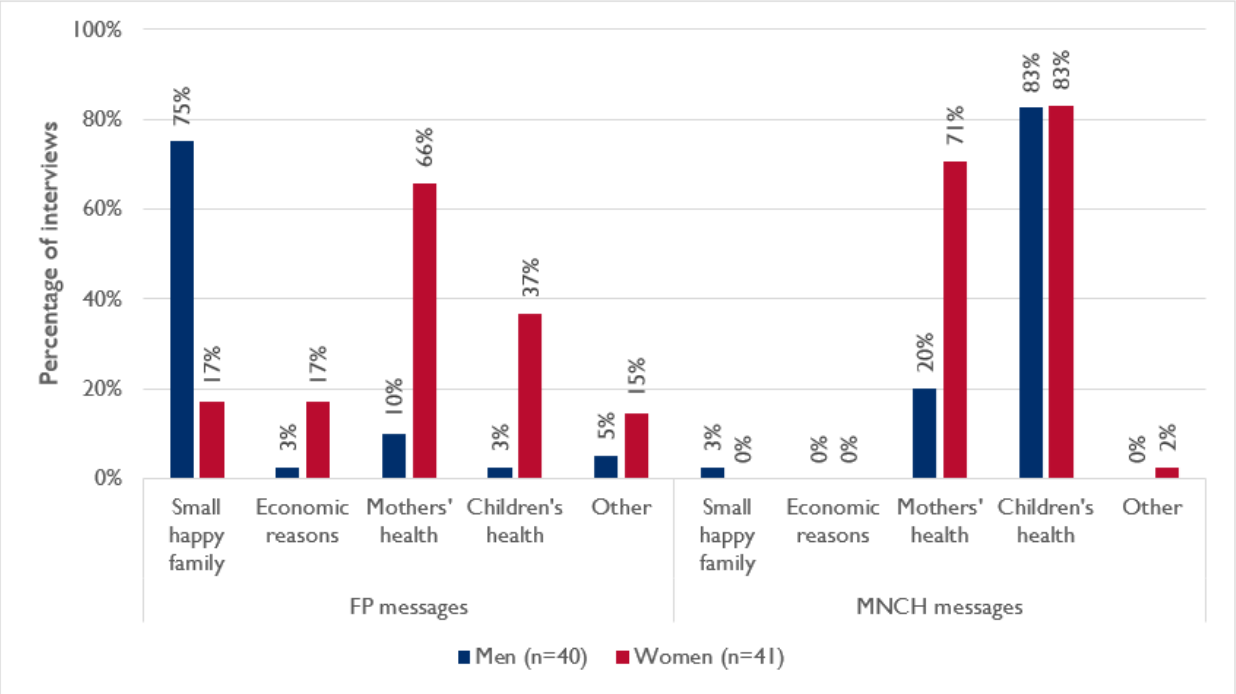
FIGURE 4: FP AND MNCH MESSAGES RECALLED



Source: MSI group and individual interviews. Less than 10 percent of interviews mentioned other messages included in the IPC toolkit, i.e., nutrition, importance of SBA, early breastfeeding, tetanus vaccination, malnutrition, newborn care, diarrhea management, acute respiratory infection prevention and treatment, diarrhea prevention, interspousal communication, danger signs after birth, and postnatal care. No interviews mentioned cord care, hypothermia, danger signs during birth, three delays, or danger signs during pregnancy.

When evaluators asked interview respondents which of the recalled FP messages they liked, women most liked the messages that discussed the importance of mothers' health (this came up in 66 percent of individual and group interviews) and children's health (37 percent), whereas men indicated that they liked the "small happy family" message (75 percent of interviews). Similarly, for the MNCH messages, 83 percent of women liked the messages related to children's health, and 71 percent said they liked messages related to mothers' health. Most men (83 percent of interviews) reported liking messages about children's health (Figure 5).

FIGURE 5: MESSAGES RESPONDENTS LIKED



Source: MSI interviews.

When the evaluators asked respondents for their perceptions of which HCC activities were most effective in reaching men and women about FP, women reported that LHW and CHW home visits were most effective, while men cited public events and VHC meetings (Figure 6). These findings highlight personal interaction as the most effective approach for reaching women and men. They are also consistent with the sources respondents identified as providing the most frequent exposure to FP messages. Although no one outside the viewers clubs had seen the TV drama "Sammi," 14 percent of respondents (20 percent of men and 7 percent of women) said that the drama was an effective means of disseminating FP messages.

It is important to note that these findings do not imply that any single source is more effective than another. Effective communication campaigns disseminate consistent messages multiple times through different sources to prompt changes in attitudes and behaviors.

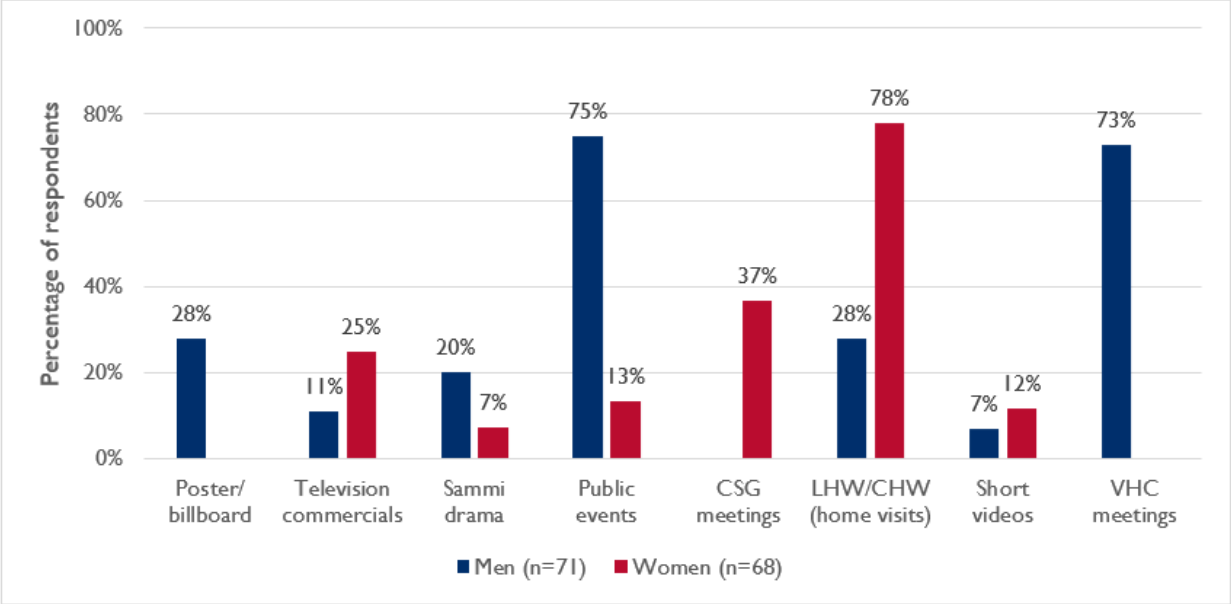
Changes in Attitudes and Behaviors

Once the evaluation team established that target community members had heard FP and MNCH messages and identified where they had heard them, it was important to determine whether the messages had influenced the respondents' attitudes and behaviors. To assess the messages' effects, the evaluators asked respondents if they had changed their views about FP as a result of what they heard.

Most respondents (93 percent) stated that they had changed their views about FP as a result of project activities. Eighty-eight percent of respondents who reported changing their views on FP stated that, before the project, they knew little about FP or how FP methods worked; 17 percent reported having misperceptions about FP methods; and 10 percent said that they feared side effects. Ninety-six percent of respondents who changed their views said they had done so primarily because of improved knowledge about FP, including awareness of health implications for mothers and children (40 percent of respondents) and economic reasons (16 percent). As one women explained:

"Yes, there is a change. I have learned in the meetings how important it is to have fewer children; before we didn't think about it. We didn't know about FP methods in detail. Now I have thought about it and realize that I can do birth spacing without being sick from the side effects. I was really afraid of FP methods before because I had heard about them from here and there and did not have solid information. Now I am clear and I want to space my next."
– Woman from Mirpur Khas

FIGURE 6: ACTIVITIES INFLUENTIAL IN CHANGING ATTITUDES AND BEHAVIORS



Source: MSI group and individual interviews.

As a result of their improved knowledge, 40 percent of the respondents who changed their views on FP said they had started, or intended to start, using contraceptive methods; 33 percent said they intended to start spacing the births of their children; 46 percent said they would begin vaccinating their children; and 38 percent said they had used, or intended to use, breastfeeding practices promoted by HCC. As a point of comparison, CCP conducted a population-based endline survey in the 10 HCC project districts in 2017. Preliminary findings suggested that 85 percent of study participants who had been exposed to HCC FP messages had changed their views about FP, and at the time of the endline survey they approved of birth spacing and limiting the number of children in a family (79 percent) and were using modern contraception (33 percent).[25]

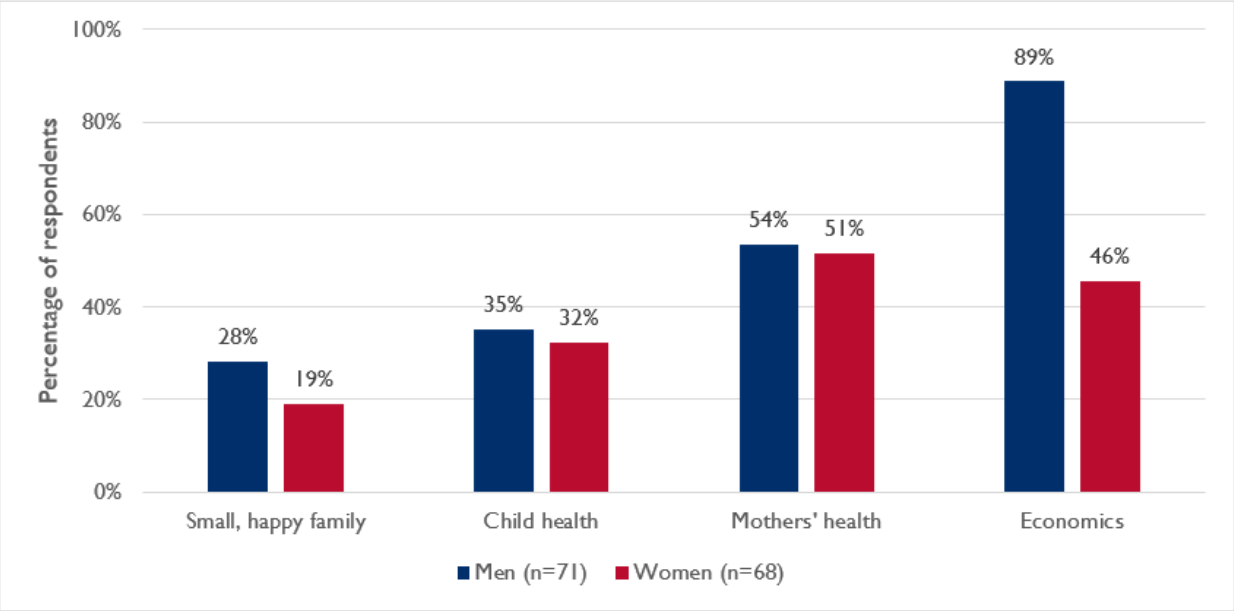
Influential Messages and Arguments

The evaluators asked about the arguments (i.e., the rationale, reasons, or motivations that messages presented for changing attitudes and behavior) that were most persuasive in changing respondents' attitudes and behaviors regarding FP. Men were most persuaded by economic arguments, while the effects of FP on the health of the mother were most persuasive for women (Figure 7). The only

[25] It is important to note that the evaluation results come from interviews with a small non-random sample of "clients" with whom CCP engaged directly while the HCC survey collected data from a random sample of the population of the project districts. Therefore, the results are not directly comparable.

significant difference between men and women was that economic arguments were more important for men than for women. Respondents explained that high and rising prices coupled with low wages made it difficult to manage monthly expenses. Men in particular saw it as their responsibility to care for the family's needs, i.e., food, clothing, education, and health care, and thought they would be better able to meet these obligations with fewer children. This finding is consistent with the results of formative research on spousal communication that highlighted happiness and prosperity, associated with smaller families, as one of the key perceived benefits of family planning.[26]

FIGURE 7: MOST PERSUASIVE ARGUMENTS FOR FP



Source: MSI individual and group interviews.

A married woman from Mirpur Khas explained how personal interaction with a CHW influenced her views on FP and the benefits of a smaller family:

> *"I now believe that with fewer children, household expenses are manageable and the children will remain happy and healthy. Also, I will be healthy. I did not think much about it before the CHW discussed it with the community. But now I firmly believe in a family of three or four children. Before, I did not know that I could control the number of children. I learned about FP methods from the CHW when I was pregnant with my baby girl. The CHW is my husband's relative and she lives nearby. She comes to our house often and I can ask her all sorts of questions. I had learned about injections from her and started using them. I also have knowledge of pills and IUCD."*

Another key theme on which the project focused was promoting interspousal communication about FP. Ninety-three percent of men and 93 percent of women the team interviewed had discussed FP with their spouses. Of these, 53 percent of men said they had started discussing FP with their wives within the past year, which coincides with the timeline of the HCC campaign, and 40 percent of women said they had started within the past two years, which coincides with the timeline of HCC community

[26] Arjumand and Associates. *Understanding the Factors Influencing Spousal Communication for Family Planning, Reproductive and Maternal Health in Sindh, Pakistan: A Qualitative Study*. August 2016.

activities. When asked what motivated the interspousal communication, 53 percent of women who said they discussed FP with their husbands said that they initiated FP discussions after participating in HCC activities, 45 percent said they began the discussions because their husbands were more receptive to FP, and 43 percent said that conversations with LHWs/CHWs gave them the confidence to speak with their husbands. Among men, 70 percent said that they had initiated the FP discussion with their wives, 71 percent reported that discussions at the VHCs encouraged them to speak with their wives about FP, 53 percent attributed their decision to speak with their wives to conversations with LHWs/CHWs, and 44 percent mentioned the "Sammi" viewers club as a motivating influence. These findings are consistent with the preliminary CCP assessment results, which found that husbands were more than twice as likely (49 percent) as their wives (22 percent) to initiate FP discussions with their spouses.

When the evaluators probed about this change in FP communication patterns, considering that the subject had always been taboo and not discussed between the sexes, respondents explained that the FP educational activities had created an atmosphere of acceptability and that their increased knowledge of FP issues and practices increased their confidence to discuss the subject with their spouses, families, and other groups. A married woman from Sukkur commented:

> *"Her [LHW's] counseling has built my confidence to discuss FP issues with family members. I discuss it with other family members like my sisters-in-law. I can talk to my husband and my mother-in-law as well if there is a need to do so. The LHW has explained all the methods and I am informed on family planning."*

When asked to evaluate the SBCC activities and materials, almost all respondents said they thought the materials were suitable and appropriate, and particularly praised the IPC toolkit. Ninety-two percent of respondents said the toolkit was useful; 52 percent thought the pictures and graphics in the toolkit communicated effectively; and 89 percent of respondents, including 92 percent of men in VHCs, said the LHWs and CHWs explained the material well. Regarding the teaching method, LHW and CHW respondents explained that the participative interactions and role plays, as well as the three-step process used to analyze health problems and arrive at remedial actions, were particularly effective. The three-step process is a problem-oriented approach of (1) defining the health problem, (2) discussing the problem and its causes, and (3) deciding on solutions, which usually entails accessing FP or MNCH services. LHWs and CHWs also liked the "positive deviance" method they were taught to employ, a method in which someone in the community who is practicing the desired health/FP behavior is used as an example for other community members. When evaluators asked LHWs and CHWs about the IPC toolkit, 84 percent said it was well-designed and made their job of conveying health messages easier. Previously, they had just booklets with writing, which they showed beneficiaries, but they did not use an educational strategy to prompt beneficiaries to take health actions.

The project also developed a community dialogue toolkit to accompany a series of 10 short videos being developed. The videos were mainly viewed at VHC meetings, in part to make it easier for LHWs/CHWs to communicate about FP with men. The purpose of the community dialogue toolkit was to provide a discussion guide with standardized information for group facilitators. The guide was finalized in March 2017, and then CCPP trained a select group of social organizers and lady health supervisors on its use in May and June. HCC introduced the community dialogue toolkit just before the end of the project, so the evaluation team did not get much feedback from respondents on its effectiveness.

Effect of Campaign on Demand for FP Services

The evaluation also examined whether there was a perceived change in demand for FP. All the LHWs and CHWs interviewed said that demand for FP had increased and that this was documented in their monthly reports; 48 percent of LHWs/CHWs reported an increase in the use of IUCDs, and 42 percent

reported increased use of injections. Unfortunately, the evaluation team has not been able to obtain independent data to validate these figures.

Referral data collected by the project partner, RSPN, in the 10 districts where the project worked provide another indicator of change in demand for FP.[27] These data were collected before and after the HCC campaign in 2017 and show a 42 percent increase in referrals (Table 4). Because other programs were implementing health-related interventions in the district concurrently with HCC, it is not possible for the evaluation to rigorously attribute the large increase in referrals to HCC. Unfortunately, even though the project placed referral boxes in health facilities in an attempt to assess actions taken on referrals, and patients who received referrals used the boxes, neither the government nor MCH partners followed up at the facilities.

TABLE 4: AVERAGE MONTHLY REFERRALS BEFORE AND AFTER HCC

District	Referrals Before HCC	Referrals After HCC	Percent Change
Naushahro Feroze	871	1,324	52%
Ghotki	1,412	1,686	19%
Shikarpur	1,841	2,500	36%
Jacobabad	453	1,177	160%
Larkana	795	1,407	77%
Umerkot	398	411	3%
Matiari	460	578	26%
Mirpur Khas	1,281	1,536	20%
Sukkur	424	712	68%
Sanghar	295	355	20%
Total	8,230	11,686	42%

Source: Presentation by CCP.

Potential Issues

The interviews and the evaluation team's observations raised several potential issues.

- It is interesting that demand for FP increased even though the IPC toolkit, which is the basis for the LHW/CHW counseling, has only two cards that discuss FP. The team deduced that the multiple media and activities used for the campaign (mass media, mid-level media, and community activities), which also addressed FP, may have reached people through multiple channels. Also, based on their understanding of the local health care context, the evaluation team thought the LHWs may have emphasized FP since it is one of their primary responsibilities. CCP confirmed that the LHWs emphasized FP during the FP campaign.

- The team thought the flyer (not an HCC flyer) that LHWs and CHWs used to illustrate FP methods to clients needed to be updated so the pictures showing FP methods were consistent with methods distributed by health facilities. Team members also suggested that LHWs and CHWs should show women actual samples of FP methods and products (e.g., IUCDs, implants, pills, and condoms) rather than pictures so women could see the size and material composition when choosing a method.

[27] RSPN collected these data in conjunction with another project it is implementing with Population Services International.

- The IPC toolkit does not specifically address interspousal communication, and given that this is a major theme of the FP campaign, the team thought this should be included.

- When the evaluation team spoke with mothers-in-law, it found that many of the older women could not see the pictures due to poor eyesight and because the pictures were small. Also, they did not relate well to the drawings and would have preferred photos.

In summary, the beneficiaries of the HCC project that the evaluation team interviewed received most of their FP and MNCH information from community-based activities—women largely through home visits from CHWs and LHWs, and men through VHC meetings and CHW and LHW home visits. Personal interaction was the most effective approach for convincing interview respondents to change their views about FP. Economic arguments and those about the mother's health tended to be most persuasive for men and women. A larger percentage of men than women initiated FP discussions with their spouses. The IPC toolkit and educational methods used by LHWs and CHWs were effective in reaching respondents and influencing their behaviors and opinions about FP and MNCH. LHWs and CHWs interviewed said that FP demand had increased significantly because of the HCC campaign.

Question 2: Sustainability

How effective have the project's capacity-building strategy and individual approaches been in building sustainable capacities at the individual and institutional levels to design, implement, and evaluate high-quality SBCC?

The bulk of training focused on teaching LHWs how to use the IPC toolkit to counsel clients on FP. CCP trained 700 LHWs as trainers of interpersonal communication and counseling skills using the IPC toolkit. This cadre of trainers then trained 6,260 LHWs and 1,571 CHWs in the HCC project districts. The LHWs and CHWs were trained to use the three-step approach when using the toolkit to council beneficiaries: identify the problem, analyze the problem, and then guide the beneficiaries to come up with FP and MNCH solutions. The training of trainers was five days, and the district-level training was three days. The project also revitalized 1,335 VHCs, and project-supported CHWs established 5,340 CSGs.

In addressing this question, the evaluation team examined design and implementation aspects of HCC capacity-building activities. It did not explore the evaluation aspect because CCP reported that the HCC statement of work did not specifically include building evaluation capacity and that the project did not support this aspect of the design. The project's annual work plans mention building evaluation capacity in general but do not mention specific activities related to evaluation capacity. Furthermore, IPs and government partners stated that the project had not been functioning long enough to have fully developed the evaluation skills of PWD and DoH partners.

Design

Most of the project's efforts in strengthening capacities to design SBCC campaigns focused on the institutional level. The project worked with both the DoH and the PWD to develop their provincial-level communication strategies. Key staff from these departments participated in a two-week leadership in strategy communication workshop to start the process. Training participants whom the evaluation team interviewed stated that the strategy development process helped them improve their communication skills to develop messages and design campaigns. The government officials the team interviewed said that HCC worked with DoH and PWD senior communication staff to develop strategies using evidence from data sources such as the PDHS to identify obstacles to successful adoption of FP and MNCH practices. The data convinced government partners and United Nations

(U.N.) agencies that communicating about these obstacles was important and that all programs needed to transmit consistent FP and MNCH messages. Based on this discussion, department staff decided: (1) to prioritize behaviors that needed to be changed, (2) to achieve consensus between government and project partners on technical content, and (3) to design the Bright Star campaign.

The project also supported the design of the IPC toolkit. With an agreed-upon need for consistent messages, HCC proceeded to work with government and project partners to develop the toolkit using 22 agreed-upon health and FP messages in a colorful booklet with a pictorial format and few words. The project was concerned about LHWs and CHWs communicating inconsistent messages. To address this, as well as lapses in education activities that might occur with staff turnover, the project developed a mobile health phone application (mHealth) that included short videos and standardized messages aligned with the content of the IPC toolkit to enhance the consistency of messages LHWs disseminated. The evaluation team identified two issues related to prospects for sustainability of design capacity.

- IPs noted that although there is a health education cell at the provincial DoH in Hyderabad, it is not active, and there is no link between the provincial level and the district health education officers. HCC proposed to the director general (DG) for health that not only should the health education cell be transformed into an SBCC cell that promotes the new DoH communication strategy, but that this SBCC cell should then be linked to health education officers at the district level. HCC developed a concept paper with a plan for how to do this, which the DG for health approved and submitted to the secretary of health. HCC offered to provide support to develop this health education/communication center. The DG for health sent a requisition to recruit more health education personnel for the five or six districts that had not created these positions. He also added the positions to the proposed plan for 2018. Despite this, when the evaluators were in the field, they did not encounter any district health education personnel involved in communication activities. The concern is that, now that HCC has ended, there is no one to follow up or help with the transformation and activation of SBCC units at the provincial and district levels. If district-level health/FP communication activities are to continue, it is important for the DoH to establish SBCC units in the districts.

- Another issue is that although the IPC toolkit has become a key instrument used for educating community members about FP, only 2 of the 20 cards in the toolkit address FP.[28] These cards discuss reasons for adopting FP but do not discuss or dispel misperceptions about the side effects of FP methods, one of the areas the PDHS identified as a major obstacle to acceptance of FP methods.[29] To understand the lack of extensive FP information in the toolkit, it is important to recognize that the IPC toolkit is based on the 22 health messages developed by the DoH, and covers multiple health topics. However, the PWD has developed its own toolkit of 16 FP-specific messages in Urdu. The evaluation team found no evidence of plans to disseminate these FP messages, and since the DoH and PWD are separate departments, it may prove difficult to combine the two message systems.

Implementation

As noted above, in addition to training 7,700 LHWs and CHWs to conduct home visits and community meetings, the project also trained 700 LHW trainers. This large cadre of training staff can continue to

[28] CCP explained that when the project developed the IPC toolkit, the emphasis was on MCH, and the role of LHWs and CHWs focused on MCH. That emphasis has now changed to FP.

[29] National Institute of Population Studies, MEASURE DHS, and ICF International, PDHS 2012–13.

train new staff and thus enhance prospects for sustainable results. In fact, both DoH and CCP respondents said that they planned to expand the IPC training to the entire province.

When asked, 81 percent of the LHWs and CHWs the evaluation team interviewed said they found the training very informative, and 61 percent thought the courses were well-designed. They particularly liked the participatory nature of the training, which included role plays and fieldwork that allowed them to practice their new skills and receive feedback. An LHW from Matiari noted:

> *"Before this project, we only conveyed our message verbally, but now we demonstrate and show pictures to the women. Women see them with interest and remember the messages and pictures. In the IPC toolkit we gained knowledge of how to communicate with families during home visits and with the communities through CSG meetings. The training gave us systematic skills, and the toolkit was also designed accordingly. We really appreciated the IPC skills taught during the training. We also learned how to talk with mothers-in-law and with husbands. Before that we were using our own traditional style of building rapport and teaching people."*

Other evidence of the project's effect on SBCC implementation is the fact that the PWD included an SBCC budget in its costed implementation plan (CIP). PWD officials reported that because of the HCC experience, the CIP now focuses on mid-level media public events (e.g., melas, flotillas, and special days) and IPC-related community home visits and support groups. They noted that for rural areas, the CIP has budgeted selective mass media, mainly Sindhi local TV, but has not planned for other mass media.

The project also trained 199 journalists to improve their FP and health reporting skills. All 20 journalists the evaluation team interviewed said that the training improved their health reporting skills, and 90 percent said they now collect and analyze health data for their reporting. Furthermore, 75 percent said they had increased their FP reporting and 65 percent had increased their MNCH reporting as a result of the HCC training. The evaluation team questioned why HCC had focused on journalists given that the 360 Degree Media Report[30] funded by HCC noted that only 4–5 percent of the Sindh population reads newspapers. HCC staff explained that the newspaper layer of the campaign targeted decision-makers such as government officials and other influential individuals. The project expected increased health and FP reporting to indirectly influence decision-makers, and potentially policy, by increasing the visibility of FP and MNCH issues.[31]

The evaluation team identified two issues related to sustainability of implementation.

- Although the PWD has developed a CIP with a budget for all planned health communication activities in line with the PWD communication strategy, the DoH situation is different; instead of having one overall program, the DoH has multiple vertical programs, each with specific communication requirements. Four programs are MCH-related: LHW, nutrition, MNCH, and the Expanded Program in Immunization. Each of these has developed its own planning initiative for release of funds at the district level. HCC has been working with these programs to prepare their individual SBCC implementation plans, but now that HCC is ending, it is unclear whether this will be completed.

[30] CCP, RSPN, and Mercy Corps, *360 Degree Media Report*.

[31] USAID explained that it transferred journalist training to the USAID-funded Health Policy Plus activity in 2016.

- Some IPs questioned whether the PWD's CIP allocated sufficient funds to implement a set of planned communication activities designed to meet the FP2020[32] targets for increasing the CPR. Furthermore, some partners doubted that the CIP included sufficient funding for services to meet the increased demand that the communication activities were expected to generate. LHWs and CHWs also raised this concern; 55 percent thought that distance to health facilities was a major obstacle for FP access, 48 percent said that the quality and availability of service delivery was an issue, and 68 percent thought that health care providers in FP and MNCH needed better training in counseling and service provision. Partners raised this latter issue, citing examples of women who did not receive proper counseling when accessing FP services and who then stopped using their chosen method of contraception. This suggests that the health system and its providers are not sufficiently trained and equipped to meet increased demand for FP services.

Sustainability

Most of the IPs, government officials, and LHWs/CHWs interviewed thought that the LHW home visits using IPC skills would continue, as this is one of the LHWs' and CHWs' normal responsibilities. The program also now has a large network of trained trainers to continue IPC capacity building. According to HCC and government respondents, the DoH also may expand LHW IPC training to all of Sindh province.

The HCC materials are likely to be sustained. These include the IPC toolkit, videos, and mHealth app which the DoH has adopted. Also, other provinces and DoH programs (e.g., nutrition) have asked to adapt and use these materials. The advantage of these materials is that they present standardized messages that will not be lost when trained staff move on or when staff who remain do not remember all the messages. Project staff and some government stakeholders saw the mHealth app as an efficient way of updating LHWs in the field.

Another example of sustainability is the development of DoH and PWD communication strategies, which lay out plans for SBCC activities to be completed by each department. The PWD has included SBCC district action plans in its CIP, and the DoH has included LHW district training in its budget for IPC.

Despite these promising signs of sustainability, the team also found evidence that some aspects of the project may not be sustainable.

- Most of the government officials and IPs the evaluation team interviewed did not think the mass media programming would continue without outside support. Government plans and budgets include only small amounts of funding for mass media, primarily for marginal areas. Respondents also thought that the mid-level media and community education activities were more effective. A few respondents also questioned whether the planned funding would be released for the SBCC activities.

- IPs and government staff also thought that LHW mid-level and CSG activities may require outside support to continue. This is mainly because these are not part of the normal LHW

[32] FP2020 is a global partnership hosted by the U.N. Foundation. More than 20 governments, including Pakistan, committed to addressing the policy, financing, delivery, and socio-cultural barriers to women's accessing contraceptive information, services, and supplies. Pakistan has developed country-specific targets for improving access to and use of FP. For more information on FP2020, see http://www.familyplanning2020.org/.

responsibilities, and the LHWs already are expected to contribute to other activities, such as polio campaigns.

- A key question is what will happen to the CHWs, a cadre of community workers trained by HCC to provide program activities in hard-to-reach areas that are not covered by LHWs. At the time of the final evaluation, the CHWs thought they were going to be integrated into the LHW program after the close of the HCC project, but this apparently will not happen. IPs and government staff told the evaluation team that the positions in the uncovered areas would be subject to a competitive process and that there was no assurance that they would be given to the CHWs. They said, however, that they thought the CHWs had made a major contribution to the project and in some respects were more effective than the LHWs.

Question 3: Formative Research and Pretesting

To what extent have the project's pretesting and formative research activities contributed to the designing and implementing of SBCC campaigns and how are stakeholders using this information?

Formative Research

To contribute to designing effective BCC interventions (media and messages), CCP commissioned formative research to understand the factors influencing family planning choices and spousal communication about family planning.[33] Study respondents described the main benefits of family planning as promoting happiness and prosperity—by limiting family size to the number of children a family could afford to raise. On the other hand, concerns about side effects and whether Islam allowed family planning dominated the issues that constrained uptake of family planning. Respondents in the study named LHWs and doctors as their preferred and trusted sources of health information, including information about family planning. Inter-spousal communication was common among respondents but the husband—often in consultation with his mother, other female relatives, friends, healthcare providers, and other influential individuals—ultimately made the decision about whether to practice family planning and, if so, how.

The study recommended that BCC programming should focus not only on women but also on husbands and their older family members, especially their mothers. Because LHWs are the most trusted and accessible source of family planning information, especially for women, the study also recommended that CCP actively engage these individuals. However, because of its ubiquity and appeal, television can also be an effective source of BCC messages around family planning. Finally, because factors such as poverty, education, and gender dynamics also influence family planning behavior, the study recommended programming to identify and address some of these root causes of behavior. While none of the stakeholders the evaluation team interviewed cited this study, the project's implementation approaches reflect many of the studies key recommendations.

Stakeholders also cited the 360 Degree Media Report[34] as another example of formative research design to learn about media use and other communication preferences of the target audience. The report provided CCP with information about local media sources and who or what influenced the target

[33] Arjumand and Associates. *Understanding the Factors Influencing Spousal Communication for Family Planning, Reproductive and Maternal Health in Sindh, Pakistan: A Qualitative Study*. August 2016.

[34] CCP, RSPN, and Mercy Corps, *360 Degree Media Report*.

audience. CCP based the project communication strategy on the study findings. CCP representatives noted that they also decided to target men as a secondary audience based on the study's findings.

The media report noted that 80 percent of Sindh households had access to television (dish and cable). Indian channels (Star TV) and local Sindhi channels were the most popular, and the best-liked formats were dramas and talk shows. The report recommended that the project develop a TV strategy since TV was so accessible in the target districts. The study also noted that, although radio was not as popular as TV (4–5 percent listened), with the advent of mobile phones that can access radio, it might be worth considering a radio strategy. The report also recommended IPC through group meetings, community festivals, billboards, and other pictorial messages. Additionally, it recommended targeting men and developing strategies that encourage wives to talk to husbands about FP.

Based on the media report, HCC decided to target men and mothers-in-law as secondary audiences; develop or work through existing men's and women's community groups; use public events (melas, festivals, and special days) as mid-level media events; use television for mass media campaigns, focusing on dramas and TV commercials; and develop a few radio commercials. Later the project developed short videos (also recommended in the media report) on various health and FP topics to stimulate discussion in CSG/VHC meetings. The project used all these communication channels at appropriate times during the FP campaign to reinforce messages.

The main issue that arose from the evaluation team's fieldwork was that even though the project strategy accounted for the fact that 80 percent of households had access to television, it failed to consider that households in the target areas mostly viewed either Indian (Star TV) or local Sindhi channels (KTN). HCC chose HUM TV as the channel for its "Sammi" drama series. HUM is a national cable network that is not widely available in rural Sindh, as most of its programming is in Urdu. When the evaluation team questioned this choice, the USAID AOR noted that the original project design anticipated that the project would work in partnership with the DFID-funded Empowerment, Voice, and Accountability for Better Health and Nutrition program and cover Punjab as well as Sindh, and for that reason it selected HUM TV as a channel potentially accessible in both provinces. She also stated that the project was currently translating the drama into Sindhi, which would probably make it more appealing in the target districts.

Only five percent of interview respondents reported having a radio, which is consistent with the media report findings, and the 6 percent reported by the 2014–2015 Pakistan Social and Living Standards Measurement (PSLM) survey for the districts the evaluation team visited. The 2012–2013 PDHS reported that 11 percent of households nationwide owned radios—down substantially from 32 percent in 2006–2007—but only 3 percent of women and 6 percent of men in Sindh reported listening to a radio at least once per week. However, the media report found that 90 percent of men and 50 percent of married women have mobile phones and CCP made an educated guess that with the increased access to the internet on smartphones, many people may be listening to the radio on their phones. HCC made use of this information, developing the mHealth app to accompany the IPC toolkit and be a resource for LHWs and CHWs.

Pretesting

The IPs organized the pretesting of communication materials. Most of the partners the evaluation team interviewed said that they found pretesting useful for refining the materials and making them more culturally appropriate. CCP asked Ishtehari, its local media firm, to pretest the family planning materials, which it arranged through a subcontract to a market research firm. Ishtehari tested the IPC toolkit with 20 LHWs and monitored them while they used it. Through the pretest, the firm found that LHWs preferred the Sindhi language (rather than Urdu), and it found the same result when it tested the mHealth app. Pretesting also contributed to refining the three-step teaching method used for the

toolkit. Pretesting led to changing the dress worn by the figures in toolkit illustrations to make it more appropriate to Sindhi culture and modifying pictures that audiences did not understand. The pretesting process also made HCC personnel aware that the LHWs had varying capacities to teach the messages, so they decided that it would be useful to standardize the stories and messages, and they converted them into video formats. This realization also brought about the development of the mHealth app to help LHWs and CHWs with IPC counseling, especially among men, so that both LHWs/CHWs and the men could feel comfortable discussing FP issues in a mixed-sex setting.

The evaluation team learned of several issues related to pretesting. One concern, noted in the discussion of Question 1, is that the logo was not tested with the target audience, and although more than 90 percent of respondents recognized it, they made a number of suggestions for improvement (see "Reach of Campaign Media" in the Question 1 discussion).

Although the majority of respondents liked the IPC toolkit and the way LHWs and CHWs used it, they also had a number of suggestions to improve it:

- The evaluation team found that respondents in the communities were visually starved, and most were illiterate. They were, therefore, very receptive to any visual image, no matter what the quality. When asked, respondents said they would have liked the images in the IPC toolkit to be larger, in different colors, and with different faces in each illustration. They wanted them to be pretty and would have preferred photos. The target population included Muslims, Hindus, and Christians, but the toolkit only shows pictures of a Muslim man. They thought the image could be more neutral.

- In the toolkit were pictures of a woman who had recently given birth lying on a bed, and her child was lying on the floor a few feet away from her. The team did not understand why the child was not shown with the mother. Also, respondents noted that the woman in many of the illustrations looks like she is in pain, e.g., in the pictures showing initiation of breastfeeding and after delivery.

Another point mentioned previously is that the IPC toolkit contains only two cards on FP. The sector experts on the evaluation team thought the cards could cover a wider range of potential side effects so as to dispel a greater number of misperceptions. They also thought that the toolkit should include a card on interspousal communication, given that this issue is so important and a campaign theme. Because it is hard for women to initiate FP discussions with their husbands, it would be useful to include tips on how to convince a husband to discuss or practice FP.

Also, as mentioned previously, the older women and mothers-in-law had a hard time seeing the pictures, partly because of poor vision and the small size of the pictures, but also because they did not relate to the pictures. They would have preferred photographs or drawings that looked more realistic. In the future, those who are designing materials may need to consider the different audiences they are targeting and whether the images and messages are reaching all target audiences.

Question 4: Gender

To what extent did HCC project activities address gender issues and what effects did this have in increased uptake of FP services?

The Question 1 discussion presents many of the gender-related findings. The 360 Degree Media Report[35] identified husbands and mothers-in-law as the people who have the most influence on women's health and FP decision-making. For this reason, HCC decided to target men and older women with health messages, in addition to married women, who were the primary target audience. Fifty-eight percent of LHWs and CHWs (61 percent of LHWs and 54 percent of CHWs) the team interviewed reported counseling men, either through home visits or in VHC meetings. The large percentage of male interviewees that reported hearing FP messages through the VHCs (75 percent) and through home visits with LHWs and CHWs (58 percent) attests to the efficacy of this approach (Figure 3).

In response to categorical questions, 93 percent of interview respondents (93 percent of men and 93 percent of women) stated that they now discuss FP with their spouses, and 61 percent said that they had started communicating about FP during the HCC project period (during the past year). Seventy percent of men and 53 percent of women reported that they had initiated the discussions. Similarly, the preliminary CCP assessment[36] found that husbands were more than twice as likely (49 percent) as their wives (22 percent) to initiate FP discussions with their spouses. The study suggested that a subject as sensitive as FP could be discussed in communities, including Muslim communities, and that with the development of appropriate empowerment skills, women, including illiterate and economically disadvantaged women, would be able to initiate discussions about this topic with their spouses.

When the evaluation team asked community respondents what had motivated them to speak with their spouses about FP, 86 percent of men and 53 percent of women who reported speaking with their spouses about FP said that increased knowledge about FP gave them the confidence to discuss the issue. When asked about activities that motivated them to discuss FP, 71 percent of men identified the discussions at VHC meetings, 43 percent of women identified discussions with LHWs/CHWs during home visits, and 45 percent of women identified their husbands' increased receptiveness to discussing FP. So again, the activities that motivated men to discuss FP were group meetings, and for women, they were home visits.

Individual and group interview respondents reported that communities were more open to discussing FP than before the project. This may be the result of the group discussions (i.e., CSGs and VHCs) in the communities, particularly with men. Before the project, FP was a taboo subject, so respondents thought this change was evidence of a new openness.

The evaluation also identified some challenges related to gender and communication that illustrate ways in which the project adapted its implementation approach to the operating environment. Although the IPC training covered effective approaches that LHWs and CHWs could use in communicating with men, several confided to the evaluation team that they had difficulty discussing FP in the VHC meetings. They explained that they felt it was culturally inappropriate for a woman to discuss FP with a group of men. Some LHWs got around this obstacle by training male members of the VHCs to lead FP discussions. CCP also developed the mHealth app in part to address this difficulty. The app allowed LHWs and

[35] CCP, RSPN, and Mercy Corps, *360 Degree Media Report*.

[36] Kumoji E. K., Sohail S., Siddiqui, A., Wolff, L., Leslie, L., Shuaib, S. & Haq, Z., *Enhancing Communication for Improved Family Planning and Maternal and Child Health in Sindh Province, Pakistan: A Cross-sectional Study* (USAID, 2018).

CHWs to introduce FP to men through a digital "speaker" which served to break the ice and increase comfort for both the LHWs/CHWs and male clients.

Question 5: Best Practices, Innovations, and Lessons Learned

What best practices, innovations, and lessons learned can be applied to other existing or future programming in health communication?

Best Practices and Innovations

When asked about best practices, most respondents talked about the IPC toolkit. The government and IPs consider it a best practice because it consists of 22 health messages that everyone (government partners, IPs, and other stakeholders) agreed on. This agreement among the various stakeholders providing community health education had not occurred before the project, so this was considered a major achievement. Moreover, the LHWs and CHWs had never worked with this kind of participative teaching method, so they considered it quite innovative.

Respondents representing RSPN (29 percent), DoH (33 percent), and LHWs/CHWs (29 percent) thought the project's approach of integrating health and FP activities and messages with access to services during public festivals, where large numbers of community members turned out, was innovative. They considered these events successful because they transmitted health and FP messages to the target audience at a venue where people could immediately follow up with service providers. Everyone the evaluation team asked about the events attributed their success to the HCC project's effective coordination with the district governments that were responsible for organizing the events.

LHWs and CHWs believed that the way they were taught to use IPC skills during home visits (49 percent of respondents) and in CSG/VHC meetings (48 percent) was also innovative. They explained that, although they had been making home visits, they had not been taught the kinds of communication and problem-solving skills that they learned with IPC.

The strong working relationship that HCC developed with the DoH and PWD was a successful practice that enhances the prospects for sustainability of key results, such as the departmental communication strategies and the communication materials (i.e., the IPC toolkit), because the government participated in their development and is now convinced of their importance. HCC staff also thought that convincing the government departments to make decisions about health priorities based on data (e.g., PDHS data) will be key to sustaining the SBCC activities budgeted in the CIP.

IP and LHW respondents considered the mHealth app and the community dialogue kit to be innovative because they standardized the FP and MNCH messages. The app was designed to accompany video profiles of positive deviance in community settings that modeled desired behaviors as part of the project's teaching methodology.

Lessons Learned

One of the crucial lessons learned in this project was the importance of developing a good working partnership with the government when implementing SBCC activities. As the project director noted: "(1) If your project is to provide support to government departments, then you need to work with the department from the beginning of each step so you will have the buy-in and support for your project implementation. (2) You need to build the SBCC institutional capacity of the department so it will continue the program after you leave." It was clear that HCC's coordination and collaboration with the PWD and DoH enhanced government participation in and ownership of project activities. Although IPs noted that working with government departments sometimes caused delays in project registration and

approval for activities and products, they saw their role as helping government meet its objectives and believed that the communication strategies and partnerships in local activities that they developed with the government will contribute to sustainability for future SBCC activities. HCC was one of the USAID MCH projects that was able to develop a good working relationship with government departments.

Another lesson learning was the importance of involving all partners, relevant government agencies, and communities for effective public events (melas, mohalla meetings, flotillas, and international days). The NGO partners reported that, before involving the government departments, they tried to organize activities around public events, but these were not successful because they did not have local political support. In discussing how the relationship evolved between the project and the government departments, the project director noted that when designing the campaign, the DoH secretary and his team wrote to all the districts—not only to the district health teams, but to the police commissions—and copied the chair of FP2020. The chair is the elder sister of the chair of the Pakistan People's Party, which is the ruling party in Sindh, and when she heard about the planned event, she told the government to stop the activities. The PWD secretary arranged a meeting with her and the DoH secretary. He explained the process to her, and she was convinced and agreed to help with the events. She called all district management officials so that when project staff went to the districts to conduct events, all the administrators and the police were there to support the events. In addition to transmitting FP and MNCH messages to festival attendees, the government departments seized the opportunity—with so many people motivated to seek health services—to provide services and referrals at the sites of the events.

The IPs noted that another lesson learned was deciding the right time to use the right media. Some HCC staff had worked on another USAID project that had not integrated the three levels—mass media, mid-level media, and community activities. The HCC project achieved better results by timing all three levels to reinforce each other at close to the same time. The IPs learned how to strategically use media to influence various behaviors. For example, with regard to exclusive breastfeeding, research showed that mass media campaigns improved awareness but did not seem to affect behavior. CCP examined the literature and found that mass media campaigns were effective in changing some behaviors (e.g., those associated with dealing with epidemics or emergencies) but had less effect on chronic or ongoing behaviors. The lesson is to spend communication money wisely. Mass media is costly, so it needs to be used strategically when and where it is most effective, keeping in mind that it reaches more households than most other media. Strategies often overlook mid-level media (local pamphlets, billboards, mohalla meetings, melas, street theaters, flotillas, and international day celebrations), but HCC found them to be powerful. The PWD officials interviewed stated that they would concentrate on mid-level media with community IPC to reinforce the messages. They thought mid-level media were more effective than mass media, and that even though mass media messages were widely viewed, they were not focused and did not stick in people's minds. Furthermore, they believed that unless the messages were disseminated through popular local channels, they did not reach rural areas.

Another lesson learned was the efficacy of the strategy the project employed through its CCPP partner, which was to leverage the USAID resources the project had for TV as seed money to get media companies to buy into the project. HUM TV agreed to work with CCPP on the "Sammi" drama series, gave the project free air time, covered production costs, and encouraged artists and writers from elite companies to volunteer much of their time. CCP staff reported that HUM TV was so pleased with the series' success and high level of viewership in large urban areas that it is opening an office in Islamabad to pursue more work with the development sector. Although few members of the HCC project's target audience viewed the series, as noted in the discussion of Questions 1 and 3, 40 percent of the group interviews with men who had attended viewers clubs said watching the "Sammi" drama influenced their decisions to pursue FP. Similarly, 27 percent of the 93 percent of men who reported discussing FP with their spouses attributed the discussion to participation in the "Sammi" viewers club. Now that the

drama is being translated into Sindhi, there is a good possibility of increased viewership in Sindh if it is aired on local channels.

Another interesting lesson concerning the drama series was how it is affecting the TV entertainment industry. The media culture in Pakistan is competitive, so it focuses largely on commercial TV and film content with violence, such as action movies and thrillers, but offers little social programming. The "Sammi" series has revitalized interest in the drama genre, and CCPP respondents think that there is a big opportunity in Pakistan for corporate social responsibility endeavors, such as HUM TV's work with the project.

CONCLUSIONS

One of the important achievements of the HCC project was that it established a close working relationship with the PWD and DoH in Sindh and convinced them of the importance of SBCC to change FP attitudes and behaviors. As a result, these government departments demonstrated a commitment to SBCC by developing communication strategies and including SBCC activities in their annual plans with allocated funding. This government ownership instilled by HCC's collaborative approach eased implementation of communication activities at the district and community levels and enhanced prospects for sustainable results. HCC and government partners made use of multiple layers of communication inputs to reinforce educational messages and encourage the desired FP and MNCH behaviors.

The project built a large cadre of trained LHWs and CHWs, including some trained as trainers, along with a system of accompanying educational tools (IPC toolkit, mHealth application, videos, and community dialogue kit) providing standardized messages that are likely to be sustained.

Project beneficiaries received most of the FP and MNCH information from community-based activities, reaching women predominantly through LHW/CHW home visits and men through VHC meetings and LHW/CHW home visits. Personal interaction was the best method for convincing people to change their views about accepting FP, and economic reasons tended to be the most persuasive arguments for changing attitudes and behaviors, followed by concerns about mothers' and children's health. Almost all community members said that they had increased communication with their spouses and family members about FP since participating in project activities. A larger percentage of men than women initiated FP discussions with their spouses. The IPC toolkit and three-step educational method LHWs and CHWs used to convey the 22 standardized messages were very effective in reaching people and influencing their behaviors and opinions about FP and MNCH. LHWs and CHWs said that FP demand had increased significantly as a result of the HCC campaign and documented this in their reports.

Some aspects of the project may not be institutionally sustainable. In collaboration with the DG for health, the project outlined a plan to revitalize the health education cell at the DoH in Hyderabad, transforming it into an SBCC cell and strengthening its linkages with district health education units and officers. Now that HCC has ended, it is not clear whether this plan, or the hiring of district health education staff to run the cell, will be implemented. Another question concerns the future of the CHWs, a cadre of community workers HCC trained with the understanding that they would be integrated into the LHW program after HCC ended. Due to government hiring practices, the integration seems unlikely.

Another consideration regarding the project's effectiveness is the strategy used to integrate different layers of communication activities (mass media, mid-level media, and community home visits and groups) to reinforce FP and MNCH messages. Mid-level media and community activities were very effective in convincing community members to adopt FP practices. The effect of the mass media activities is less

clear. While the "Sammi" drama reached large numbers of people, it did not reach the HCC project's target audience, as Urdu-language TV channels were either unavailable or not preferred in the HCC districts. However, many of the men who saw videos of the "Sammi" drama in VHC meetings said that it influenced their decisions to accept FP practices. Thus, the message presentation was effective, but it was not transmitted through the right channels. This suggests that a mass media serial drama has the potential to affect not only FP awareness but also attitudes and behaviors among impoverished audiences with low levels of literacy in rural Sindh.

RECOMMENDATIONS

- When designing and implementing future health communication projects, **USAID/Pakistan** should consider the following.

- Specify conducting baseline and endline surveys of FP knowledge, attitudes, and practices. Use identical sampling approaches and data collection instruments to ensure consistency of the data. Without before- and after-project data, it is difficult to determine whether knowledge, attitudes, and practices changed. If it is important to rigorously attribute changes in FP knowledge, attitudes, and practices to project activities, design an experimental, or strong quasi-experimental, impact evaluation. Plan for, and design, the impact evaluation in advance of the project start since, otherwise, the design and implementation of the project will limit the range of impact evaluation approaches available.

- Carefully evaluate the different levels of media in terms of project objectives and target audience media requirements in order to ascertain the most effective messages and channels for reaching the audience to effect changes in attitudes and behaviors.

- Conduct research on the segment of the population that remains opposed to FP (as opposed to those who are practicing FP or have an unmet need for FP) to find out why they are opposed and what specific communication messages, methods, and channels are needed to reach them. Use future programming to test innovative approaches for reaching this segment of the population. For example, some previous projects have found directly engaging religious leaders to be an effective approach;[37] in the evaluation's research, objections to FP based on religious beliefs emerged as an important barrier to practicing FP.

- Continue producing tools with standardized messages that LHWs and other community health workers, perhaps across multiple vertical programs, can use to educate communities. These tools, such as videos and phone apps to accompany teaching tools, help to maintain message integrity.

- Produce health communication tools and media in the language most appropriate for the target audience, i.e., Sindhi in rural Sindh. One of the reasons the "Sammi" drama series was not viewed by a larger portion of the target population was because it was in Urdu.

- Continue working with the DoH vertical programs to encourage funding for communication activities in their plans.

[37] The project did engage religious leaders on MNCH issues.

- Incorporate IPC counseling training for a broader range of health providers, particularly about methods, effectiveness, side effects, and availability.

- The evaluation identified a number of potential improvements to the IPC toolkit that may make it more effective. The **DoH or PWD** might consider revising the toolkit to incorporate the following.

- Add a card on counseling and tips on how to talk to one's spouse about FP.

- Consider a toolkit version or flipchart with larger pictures that can be used for group meetings.

- Consider using larger, realistic-looking pictures (or photos) when talking to older women with poor vision.

- Provide actual FP methods as samples to be used by LHWs when counseling women about FP methods.

- Depict the mother with a happier face throughout the toolkit and move the baby to be with the mother during the newborn period. Consider making the father more religion-neutral (as Sindh has three major religions).

The **DoH or PWD** may also consider the following to ensure the sustainability of health communication programs and FP services.

- Ensure that the PWD CIP includes sufficient resources and services to meet the projected demand for services envisioned in the PWD communication strategy and plans.

- Incorporate the CHWs—who work in areas not covered by the LHWs—into the LHW program. The CHWs are a trained resource who have proven their effectiveness, and it would be Sindh province's loss not to keep them involved.

ANNEX 1: INTERVIEWS CONDUCTED

To protect the anonymity of respondents, the list of individuals interviewed includes designations but not names.

Title	Organization	Location
Deputy Director Communications	PWD	Karachi
Senior Technical Advisor	PWD	Karachi
District Population Welfare Officer	PWD	Shikarpur
District Population Welfare Officer	PWD	Mirpur Khas
District Population Welfare Officer	PWD	Mitiari
District Population Welfare Officer	PWD	Sukkur
District Health Officer	DoH	Karachi
District Health Officer	DoH	Karachi
District Health Officer	DoH	Shikarpur
District Coordinator	LHW Program	Mitiari
District Coordinator	LHW Program	Mirpur Khas
District Coordinator	LHW Program	Mirpur Khas
District Coordinator	LHW Program	Sukkur
District Coordinator	LHW Program	Shikarpur
National IPC Coordinator	Mercy Corps	Islamabad
Director Health Programs	Mercy Corps	Karachi
Program Manager (Health)	Mercy Corps	Karachi
Chief of Party	JHU-CCP	Karachi
Deputy Chief of Party	JHU-CCP	Karachi
SBCC Specialist	JHU-CCP	Karachi
Senior SBCC Specialist	JHU-CCP	Karachi
M&E Specialist	CCPP	Karachi
Specialist Social Sectors	RSPN	Karachi
Provincial Coordinator	RSPN	Karachi
Senior M&E Specialist	RSPN	Karachi
District Program Officer	RSPN	Mitiari
District Program Officer	RSPN	Mirpur Khas
District Program Officer	RSPN	Sukkur
District Program Officer	RSPN	Shikarpur

ANNEX 2: DETAILS OF SAMPLE SELECTION

Selection of Districts and Communities

The 10 districts of Sindh where JHU/CCP implemented the health communication component (HCC) can be broadly divided into three strata/geographic clusters with different cultural characteristics which could affect the outcomes of the project, i.e., 1) southern Sindh (Umerkot, Sanghar, Matiari, and Mirpur Khas districts), 2) northern Sindh – non-tribal (Naushahro Feroz, Sukkur, and Larkana districts), and 3) northern Sindh – tribal (Jacobabad, Shikarpur, and Ghotki districts). To manage the time and financial costs of the evaluation, the team selected a sample of districts from each cluster in consultation with the Mission.

PERFORM's analysis of the MCH monitoring data for 2013, 2014, and 2016 showed little significant difference in key FP indicators within the two northern Sindh clusters (Table 5 Indicator values by district). In the southern Sindh cluster, Umerkot, Mirpur Khas, and Sanghar are similar but Matiari stood out from the other three with significantly lower values for the birth spacing indicator and higher values for the other two indicators. PERFORM included Mitiari in the sample, in addition to one district each from the three regions. PERFORM selected three other districts to ensure it captured the variation in trends and values in the three indicators. Based on these criteria, the evaluation team selected Sukkur and Shikarpur from the two northern Sindh clusters, Mirpur Khas from the three similar districts in the southern Sindh cluster, and the Matiari district.

TABLE 5 INDICATOR VALUES BY DISTRICT

Region	District	Indicator 5.1.2.1 (Birth Spacing)			Indicator 5.1.2.2 (Messages)			Indicator 5.1.2.3 (Discussing FP)
		2013	2014	2016	2013	2014	2016	2016
Northern	Sukkur	15%	19%	39%	10%	29%	59%	35%
	Naushahro Feroze	34%	21%	28%	5%	33%	24%	45%
	Larkana	19%	29%	20%	9%	34%	39%	46%
Northern – tribal	Ghotki	26%	25%	23%	8%	16%	21%	54%
	Shikarpur	34%	22%	22%	8%	28%	17%	62%
	Jacobabad	19%	28%	11%	2%	21%	38%	61%
Southern	Umerkot	34%	24%	39%	14%	23%	4%	57%
	Matiari	20%	17%	6%	13%	37%	80%	28%
	Mirpur Khas	37%	39%	20%	26%	39%	31%	50%
	Sanghar	25%	20%	32%	20%	25%	40%	49%

* The MCH survey collected data on this indicator for 2016 only.

From each of the four selected districts, the team randomly selected one rural and one urban/semi-urban union council (UC) to achieve a mix of different socio-economic classes and to ensure that results were as representative as possible.

Fieldwork

PERFORM devised the evaluation methodology with an eye on the sensitive nature of family planning and maternal, newborn, and child health. In addition to a document review and secondary data analysis, the study relied on a mixture of individual interviews, group interviews, and key informant interviews, as outlined below.

1) **Individual interviews**—the PERFORM evaluation team conducted individual interviews with the primary target groups, such as married men and married women, who are

susceptible to both groupthink and avoiding honest feedback when in the presence of their peers.

2) **Group interviews**—the PERFORM evaluation team conducted these with groups that are less susceptible to biases introduced through group settings, such as influential men, mothers-in-law, and journalists.

3) **Key informant interviews**—the PERFORM evaluation team conducted these with senior implementing partner (IP) staff, USAID staff, and government officials.

Apart from certain target groups that operated at the provincial or national levels, the evaluation team divided the remaining groups—primarily at the client level—between urban and rural union councils to facilitate comparison of results from both types of areas.

Key Informant Interviews

PERFORM conducted key informant interviews with a purposively selected sample of:

1) Senior IP staff; and

2) Key government stakeholders, such as the Lady Health Worker (LHW) program, and the Department of Health (DoH) staff.

Table 6 shows the distribution of key informant interviews conducted. The evaluation team adjusted the distribution of key informants due to the closure of IP offices at the district and provincial levels, and the absence of government stakeholders for various reasons. The evaluation team conducted as many key informant interviews as possible to ensure the initial sample was covered.

TABLE 6: DISTRIBUTION OF KEY INFORMANT INTERVIEWS

Districts/areas	DHO and IPC Officer	DoH	PWD	LHW Program	USAID	JHU-CCP	CCPP	RSPN	Mercy Corps
Matiari	2	1	1	1	–	–	–	–	–
Mirpur Khas	2	1	1	1	–	–	–	–	–
Sukkur	2	1	1	1	–	–	–	–	–
Shikarpur	2	1	1	1	–	–	–	–	–
Provincial/ program level	–	-	2	2	1	1	1	1	1
Total number of interviews	8	4	6	6	1	1	1	1	1
Interviews completed	0	3	6	5	0	4	1	7	3

Group Interviews

Group interviews were a primary method of data collection, used for target groups that were not prone to biased responses due to peer pressure. The PERFORM evaluation team conducted group interviews with the individuals below.

1) **Journalists**—PERFORM purposively sampled groups of four to five journalists to gauge the project's impact on their reporting. In addition, as key civil society actors, the evaluation team also asked for their perspectives on other aspects of the project. As per the plan, the evaluation team interviewed 20 journalists across the four districts.

2) **LHWs/CHWs**—LHWs and Community Health Workers (CHWs) operate in mutually exclusive areas. Three to six LHWs/CHWs participated in each group interview; a total of 31 participated in the eight group interviews.

3) **Influential men**—these were individuals identified as having an impact on the social behaviors of residents of their respective UCs. The evaluation team randomly selected these men in each UC. Several of these men were members of the village health committees as well. Between four and five participated in each group interview. In all, the evaluation team interviewed 39 influential men.

4) **Influential women**—The evaluation team selected these women largely through a snowball method (i.e., asking identified women to suggest other potential respondents) at the UC level; some of them belonged to women's support groups. Pretesting suggested that most influential women were mothers-in-law, a key target group when promoting social and behavior change communication activities; the evaluation team thus treated the groups inter-changeably. The team interviewed 36 influential women/mothers-in-law.

TABLE 7: DISTRIBUTION OF GROUP INTERVIEWS

District	LHWs/ CHWs	Influential Men	Influential Women	Journalists
Matiari	2	2	2	1
Mirpur Khas	2	2	2	1
Sukkur	2	2	2	1
Shikarpur	2	2	3	1
Total number of interviews planned	8	8	8	4
Total number of interviews conducted	8	8	9	4
Maximum number of participants	40	40	40	20
Total number of participants	31	39	36	20

Individual Interviews

Since family planning is a sensitive and personal subject, the evaluation team decided to interview the key target groups—married women of reproductive age and their husbands—individually rather than in groups. The aim was to mitigate potential reluctance to responding honestly to personal questions in a group setting. The evaluation team ask LHWs and CHWs to help with selection, but "snowballed" the sample by asking those selected to identify other respondents. Half of the participants were selected from semi-urban areas and half from rural areas.

Table 8 shows the planned distribution of individual interviews in each district.

TABLE 8: DISTRIBUTION OF INDIVIDUAL INTERVIEWS

District	Married Women	Husbands	Total
Matiari	8	8	16
Mirpur Khas	8	8	16
Sukkur	8	8	16
Shikarpur	8	8	16

District	Married Women	Husbands	Total
Number of individual interviews	32	32	64

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ANNEX 4: STATEMENT OF WORK

Statement of Work (SOW) for:
Final Performance Evaluation of the Health Communication Component of the Maternal and Child Health Program
OFFICE OF HEALTH, POPULATION AND NUTRITION

Assignment Title:	Final Performance Evaluation of the Health Communication Component of the Maternal and Child Health Program
Assignment Type:	Evaluation
DO Team Assignment POC:	
PMU Assignment Manager:	
Assignment Start Date of the Assignment:	o/a 01 July 2017
Assignment End Date of the Assignment:	o/a 30 September 2017
Estimated Total Time to Complete the Assignment (months)*	Three months

Period of Performance

To begin o/a July 2017and end o/a September 2017

Timeline

The final report and supporting documentation should be completed within 3 months from the commencement of evaluation activities.

ASSIGNMENT OVERVIEW

BACKGROUND INFORMATION

Background

Problem Statement:

With the highest population growth and birth rates in South Asia, Pakistan is the 6th most populous country in the world. Adding over 4 million people annually, Pakistan's population will surpass 300 million by 2050. Such rapid population growth is overwhelming Pakistan's ability to provide power, food, jobs, education, and healthcare to its citizens. Less than one-third of Pakistani women are currently using modern contraceptives despite the desire of 70 percent of married women to delay their next

pregnancy or to not have any additional children. These family planning challenges are a major contributor to Pakistan lagging behind on a range of health indicators and having some of the world's highest maternal, child, and infant mortality rates.
USAID's flagship MCH Program supports innovative approaches to strengthen the capacity of Pakistan's public and private sectors to deliver high-impact, evidence-based health interventions. The MCH Program is comprised of five interconnected and mutually reinforcing components led by national and internationally renowned public health organizations:

1. Family Planning and Reproductive Health (FPRH)*
2. maternal, newborn, child health services;
3. 2) health communication;
4. 3) health commodities and supply chain; and
5. 4) health systems strengthening.

*The Family Planning/Reproductive Health activity led by Marie Stopes Society was terminated in September 2016 due to reduced FP funding to the mission.

Through the MCH Program, USAID assists Pakistan to meet the primary health needs of its most marginalized and vulnerable populations—women and children. The MCH program also seeks to improve government performance, oversight, and accountability by strengthening the health system and engaging civil society.

Within USAID/Pakistan's Strategy for Pakistan, the Health Office is responsible for Development Objective #5: *Improved Maternal and Child Health Outcomes in Target Areas*. In support of this Development Objective, the Health Office's Maternal and Child Health Program supports six components as outlined below.

Component	Leading Implementing Partner
1. Family Planning – Service Delivery[1]	Marie Stopes Society (MSS) (ended in September 2016)
2. Maternal, Newborn, and Child Health (MNCH) – Service Delivery	Jhpiego
3. Health Communication	Johns Hopkins University, Center for Communication Programs JHU.CCP
4. Health Commodities (Procurement and Supply Management)	Chemonics
5. Health Systems Strengthening (HSS) 5.a Health Policy Plus	John Snow Incorporation (JSI) Palladium
6. Nutrition/Water, Sanitation, and Hygiene (Nutr./WASH)	UNICEF and WFP

Issues and Challenges in Health Communication

[1] Ended in on September 30, 2016

Successive health education surveys have shown that investments in health education over the last decade have yielded positive results in many areas. Some of the identified issues affecting effective health communication programming in Pakistan includes:

- Social and Behavior Change Communication (SBCC) is poorly coordinated at the national and sub-national levels (as evidenced by lack of useable SBCC strategies or harmonized messages):
- High general knowledge has not translated into behavior change:
- Demand creation for products and services has not been adequately emphasized, due to a historical emphasis on "stand-alone" behaviors or lifestyle change:
- Programming has favored mass media, which has not consistently reached priority and underserved audience sub-groups.

TABLE 1: ACTIVITY/PROJECT SUMMARY—IF APPLICABLE

Contract/Agreement Number:	AID-391-A-14-00002
Contract/Agreement Officer's Representative:	
Activity/Project Start Date:	April 25, 2014
Activity/Project End Date:	March 2018
Location of Activities (Provinces/Districts):	Sindh Province
Implementing Partner:	John Hopkins University center for Communications program (JHU-CCP)
USAID/Pakistan Mission Strategic Framework Linkages:	I.R 5.2.1: improved demand for high impact health services
Activity/Project Budget:	$24.5

Activity/Project Description

USAID/Pakistan Health Communication Component was led by PSI/Greenstar during Year 1 and Year 2. The Project transitioned to JHU.CCP in May 2014, and in June 2014, JHU.CCP (with sub-partners) began implementation under a new multi-year bilateral Cooperative Agreement. To support this initiative JHU·CCP has been working in partnership with Mercy Corps, Rural Support Program Network (RSPN) and the Center for Communication Programs Pakistan (CCPP). Over the life of the project, the project is expected to intervene in 10 districts in Sindh Province. The effective dates of the subject award are April 25, 2014 to January 24, 2019. Due to declining budget and for strategic reprogramming of funds, the Office of Health, Population and Nutrition made the decision to end HCC on March 31, 2018 as a new activity encompassing service delivery and health communication is planned to start in October 2017.

The project supports Component 3 of the USAID/Pakistan Maternal and Child Health Program and was designed to provide leadership and strategic cohesion to the various communication activities under the MCH Program. JHU·CCP and its partners are implementing activities in five key areas:

1) Design and deliver an effective package of SBCC interventions at the individual and household level;
2) Support an enabling environment at the community and health facility level to foster beneficial health seeking behaviors;

3) Advocate for improved investment in and coordination of behavioral programming;
4) Build capacity to improve design, implementation and evaluation of high-quality SBCC activities; and,
5) Support MCH Program SBCC efforts through pre-testing and formative research.

Anticipated Results and Associated Performance Indicators

The project is expected to report on the following three indicators:

- Percent of married women of reproductive age who intend to wait at least two years between their last birth and their next birth (from 23.7% to 28%)
- % of audience who recall hearing or seeing a specific USG supported FP/RH and MNCH messages (from 27.5% to 38%)
- Percent of married women of reproductive age who discussed FP with their spouse (no baseline available but the end of project projection is 60%)

List of Existing Project Documents and Information

- USAID Pakistan OHPN Project Appraisal Document (PAD)
- Health Communications Project (HCP) Cooperative Agreement and Modifications
- HCP Pakistan Performance Monitoring Plan
- HCP Pakistan Baseline report
- Workplans: FY14-FY17
- Annual Reports: FY14-FY16
- Quarterly Reports:
  - FY14: Q3, Q4
  - FY15: Q1, Q2, Q3, Q4
  - FY16: Q1, Q2, Q3
  - FY17: Q1, Q2,
- USAID Pakistan, Gender and Social Inclusion Strategy
- USAID Pakistan, Assessment of Gender and Social Inclusion
- USAID Pakistan MCH, Communication Strategy
- Sindh Department of Health, Communication Strategy
- Sindh Population Welfare Department, Population Communication Strategy
- Bright Star Community Mobilization Toolkit
- HCP Final Program Description
- HCP program presentation for the evaluation team
- 2012/2013 Pakistan DHS report
- 2015 Pakistan Multiple indicator Cluster Survey (MICS) report
- 2016 MCH Performance Indicator Survey report
- Other materials identified by PERFORM

PURPOSE, AUDIENCE AND LEARNING OBJECTIVE

TABLE 2: SUMMARY OF PURPOSE, AUDIENCE AND LEARNING OBJECTIVE

Assignment Purpose	Intended Audience	Learning Objective	Information Source	Timeline
To inform the follow-on project design	USAID/Pakistan, HCC Project partners, implementing partners leading other USAID/Pakistan MNCH projects, Government of Pakistan and Provincial Government of Sindh and other external stakeholders	To understand the extent to which the project has been successful in meeting its objectives, cost and coverage of mass media and other interventions , , and to highlight best practices, innovations, and lessons learned that can be applied to future programs	Direct observation of the implementation of health communication activities; review of key program documents, secondary analysis of data, interviews and focus-group discussions with key informants (community members, health care personnel (e.g. LHWs and LH Supervisors, HCC project staff.)	To begin o/a July 2017 and end o/a September 2017

KEY EVALUATION/STUDY/ASSESSMENT QUESTIONS

1. To what extent has the project been successful in meeting its objectives in the five key areas?
2. To what extent did HCP project activities address gender issues and what effects did this have in increased uptake of FP services?
3. What best practices, innovations, and lessons learned can be applied to other existing or future programming in health communication?
4. To what extent are results likely to be sustained after the project ends?

Additional Guiding Questions:

a- **Reach and Impact of the SBCC Campaigns and Approaches:** How haves the campaigns and activities for specific populations and groups led to behavior change and demand generation for family planning?

- What progress has been made in implementing benchmarked activities outlined in M&E and annual workplans? What unanticipated results, if any, have been achieved?

- What is the reach of Social and Behavior Change Communication (SBCC) campaigns and programs among priority audiences?
- What evidence is there that SBCC campaigns and programs have contributed to changes in demand for family planning products and services among those exposed?
  What evidence is there that SBCC campaigns and programs have contributed to changes in social norms related to desired fertility and family planning among those exposed?

b- **Capacity Strengthening Activities:** How the project measure the qualitative aspect of the capacity strengthening activities (beyond achievement of target counts) to ensure the most robust results are recorded

- To what extent, and in what manner, have HCC capacity strengthening interventions improved the ability of individuals and institutions to design, implement, and evaluate high-quality SBCC?
- What capacity strengthening approaches appear to most directly influence the quality of in- country SBCC design, production, and implementation?
- To what extent are HCC's capacities strengthening interventions replicable or sustainable? What differences, if any, are seen between individual-level interventions and those designed to enact change at the district levels? What technical, operational, or financial support would be required in the next three-five years in order to ensure continued capacity strengthening, with an eye to transition of technical and programmatic leadership to the government and/or other local institutions?

Evidence Based Approach: What evidence has the project generated that has contributed to design and implementation of the SBCC campaigns and improving FP? How is this evidence being used by the relevant stakeholders?

- How has local data and/or formative research informed design of SBCC campaigns?
- What monitoring and quality assurance mechanisms are in place for SBCC interventions at all levels? How have these contributed to refinements in activities?
- To what extent have other partners, including the PWD and USAID implementers, been engaged in the design, implementation, dissemination, or utilization of research, monitoring, and evaluation?
- What evidence (from monitoring and quality assurance systems) exists that project-supported interventions have achieved intended behavior change? Are they reaching the intended target audiences? If yes, how is the audience reached (eg; media, IPC through skilled agents, etc)
- What evidence exists that the ministry or other stakeholders will fund these programs in future?

METHODOLOGY

The team will conduct a non-experimental mixed method performance evaluation of project activities. This may include direct observation of awareness raising activities, a desk review of project documents, secondary analysis of data, as well as key informants and focus groups interviews.

TABLE 3: DATA COLLECTION METHODS

Data Collection Methods (click here for additional guidance on selecting data collection method)
a) Extraction: Cull data from document review/secondary source data sets
b) Extraction: Cull data from project performance monitoring data
c) Structured observation
d) Unstructured observations
e) Key Informant interviews (KIIs)—not less than twenty (20) interviews of key informants relevant to the project
f) Focus group discussions (FGDs) not less than four (4) FGDs, made up of between 4-8 participants in each group, with separate male and female focus groups for adequate gender representation of project beneficiaries.

Data Analysis

The Evaluation Team will develop an analysis plan and review with USAID/Pakistan for inputs. It is expected that the analysis plan will include analysis of qualitative data derived from Key Informant Interviews, Focus Group Discussions and Client/Participant Satisfaction or Exit Interviews. For quantitative data, basic descriptive statistics and minimal level inferential statistics are expected.

All analyses will be geared to answer the evaluation questions. Additionally, the evaluation will review both qualitative and quantitative data related to the project/program's achievements against its objectives and/or targets. Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age, and location, whenever feasible. Other statistical test of association (i.e., odds ratio) and correlations will be run if appropriate.

Thematic review of qualitative data will be performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances and homogeneity and outliers to better explain what is happening and the perception of those involved. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data do not exist.

Use of multiple methods that are quantitative and qualitative, as well as existing data (e.g., project/program performance indicator data, DHS, HMIS data, etc.) will allow the Team to triangulate findings to produce more robust evaluation results. The Evaluation Report will describe analytic methods and statistical tests employed in this evaluation

Text data from all locations would be transcribed and organized in Microsoft Excel qualitative analysis template for content and thematic analysis. Quantitative analysis of secondary data will be conducted using mainly descriptive statistics and presented in tables, graphs and trends using the Statistical Package for Social Sciences (SPSS) version 20.

The evaluation methodology and report will be compliant with the ADS 201

The Evaluation Report should exclude any potentially procurement-sensitive information. As needed, any procurement sensitive information or other sensitive but unclassified (SBU) information will be submitted in a memo to USAID separate from the Evaluation Report.

All data instruments, data sets (if appropriate), presentations, meeting notes and report for this evaluation/analysis will be provided to PERFORM and presented electronically to the USAID POC. All data will be in an unlocked, editable format.

The datasets must not include any identifying or confidential information. The datasets must also be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. Qualitative data included in this submission should not contain identifying or confidential information. Category of respondent is acceptable, but names, addresses and other confidential information that can easily lead to identifying the respondent should not be included in any quantitative or qualitative data submitted.

Across all areas of inquiry, it is expected that the evaluation will consider and document internal and external factors that may have influenced the achievement of results. To the greatest extent possible, analysis will disaggregate findings by audience and/or programmatic approach. Evaluation presentations and reports will clearly describe lessons learned in program design and implementation, and make specific and actionable recommendations for future investment

TABLE 4: DATA ANALYSIS METHODS

Data Analysis Methods (Click here for additional information)	
a)	Descriptive statistics (frequency, percent, ratio, cross-tabulations)
i.	Frequency; percentages are preferable to ratios.
ii.	Cross-Tabulations
iii.	Multi-variable descriptive
b)	Content, thematic or pattern analysis (describes patterns in qualitative responses)
c)	Gender/Sex differential effects

Gender Considerations

The second evaluation question is to discuss how project activities addressed gender issues and what effects this had on increased uptake of FP services.

TEAM COMPOSITION

The Evaluation team will consist of:

(a) A team leader with at least five (5) years of experience evaluating international health programs and relevant regional experience, and

(b) Four other technical and support staff listed below.

The team members will represent a balance of technical expertise related to program evaluation, qualitative and quantitative analysis, health communication, as well as Family Planning/Reproductive Health. All team members must have excellent oral and written proficiency in English.

The team composition is as follows:

- Team Leader/Evaluation Specialist with a Health Communication background,
- Health Communication Expert,
- Research Specialist,
- Data Analyst, and
- Local survey specialist

DELIVERABLES

- In-briefing with Mission and Project to review expectations, timeline, and approach (Assignment workplan)
- Evaluation plan detailing methodology, data collection tools and guides
- Draft Report (see format below) for review by Mission
- Presentation of key findings and recommendations to Mission and Project
- Final Evaluation Report (see format below)
- One Pager covering purpose, finding, conclusion and recommendation

The format for the evaluation report is as follows:

1. Executive Summary (2 pg)
2. Table of Contents (1 pg)
3. Introduction (1 pg)
4. Background (2 pg)
5. Methodology (1 pg)
6. Limitations
7. Findings/Conclusions/Recommendations (10-12 pg)
8. Issues (1-2 pg)
9. Future Directions (2 pg)
10. References
11. Annexes

Please note that per ADS 579 - USAID Development Data –all primary data (both quantitative and qualitative) collected for this assignment will be submitted to USAID in electronic format within 30 days of completion.

LEVEL-OF-EFFORT

To be proposed by PERFORM and approved by USAID/Pakistan through PERFORM COR.

TimeLine

TABLE 5: ILLUSTRATIVE TIMELINE

Task/Deliverable	Wk1-2	Wk3-4	Wk5-6	Wk 7-8	Wk 9-10	Wk 11-12	Wk 13-14	Wk 15-16	Wk 17-18	Wk 19-20
AWP developed										
Team Planning Mtg										
Revision to AWP										
Field Work										
Data Analysis										
Initial Findings Review/Data Utilization Session										
Analysis & Report Writing										
Presentation of Draft Report										
Draft Report										
Final Report										

*Detailed timeline will be proposed by PERFORM and approved by USAID/Pakistan through PERFORM COR.

ANNEX 5: ASSIGNMENT WORK PLAN

Final Evaluation of the Health Communication Component of the Maternal and Child Health Program

Assignment Work Plan (EVL.017)

Revised: August 18, 2017

TABLE OF CONTENTS

LIST OF TABLES

ACRONYMS

CCPP	Centre for Communication Programs Pakistan
CHW	Community Health Worker
CSG	Community Support Group
DoH	Department of Health
FGD	Focus Group Discussion
FP/RH	Family Planning and Reproductive Health
GI	Group Interview
HCC	Health Communication Component
IP	Implementing Partner
IPC	Interpersonal Communication
JHU- CCP	Johns Hopkins Center for Communication Programs
KII	Key Informant Interview
LHW	Lady Health Worker
M&E	Monitoring and Evaluation
MNCH	Maternal, Newborn, and Child Health
PWD	Population Welfare Department
SBCC	Social and Behavior Change Communications
SOW	Statement of Work
TPW	Team Planning Workshop
VHC	Village Health Committee

SUMMARY

Assignment Work Plan (AWP) Number	EVL017
AWP Title	Final Evaluation of the Health Communication Component of the Maternal and Child Health Program
USAID/Pakistan Requesting Office	Office of Health, Population and Nutrition
Requesting Office Point of Contact	--
PERFORM Assignment Manager	--
Start Date	July 15, 2017
End Date	December 31, 2017
Total AWP Cost Estimate	$--

ASSIGNMENT PURPOSE

The evaluation will assess the effectiveness of the health communication component (HCC) of the United States Agency for International Development in Pakistan's (USAID/Pakistan) maternal and child health (MCH) program. The evaluation will highlight lessons learnt, best practices, and innovative methods of social behavior change communication (SBCC) related to family planning and reproductive health (FP/RH) and maternal, newborn, and child health (MNCH) to inform the implementation phase of a follow-on health project.[1] The evaluation will determine the effectiveness of mass media interventions with other project interventions based on the cost and coverage analysis. The recommendations and findings of the evaluation will be useful for USAID/Pakistan, HCC project partners, implementing partners leading other USAID MNCH projects, and the Governments of Pakistan and Sindh as they will guide the design and implementation of similar future programs.

BACKGROUND

The project aims to promote sustainable change in FP/RH and MNCH behavior in 10 marginalized and under-served districts of Sindh. Increased knowledge of health-promoting FP and MNCH behaviors will increase demand for associated services provided by the service delivery components of the MCH program—the FP/RH and MNCH components. The project intends to achieve these objectives by designing and implementing a mass media campaign and building indigenous capacity to design and implement SBCC strategies at the institutional and community levels. The evaluation will focus on changes in three key outcome indicators:

1. Percentage of married women of reproductive age who intend to wait at least two years between their last birth and their next birth,

[1] The follow-on project has already been designed so the evaluation will focus on providing guidance on the choice of implementation details and approaches.

2. Percentage of audience who recall hearing or seeing a specific United States Government (USG)-supported FP/RH or MNCH message, and

3. Percentage of married women of reproductive age who discussed FP with their spouse.

The program was initially implemented by Population Services International working through Greenstar Social Marketing but after the second year of the project, USAID transferred implementation to the Johns Hopkins Center for Communication Programs (JHU-CCP) in partnership Mercy Corps, the Rural Support Program Network (RSPN), and the Centre for Communication Programs Pakistan (CCPP).

METHODS

Evaluation Questions

The evaluation will focus on five questions.

Question 1: What is the reach of the project's SBCC activities and to what extent have they been effective in changing social norms related to family planning, family planning behaviors, and demand for family planning services? What unanticipated results, if any have been achieved?

Explanation: The question will assess the effectiveness of the project overall and of its main communication components, i.e., the mass media SBCC campaigns and the community and facility level communication activities implemented through lady health workers (LHWs) and community health workers (CHWs). The question will examine the reach (i.e., the number of people and geographic areas exposed) and effectiveness (i.e., awareness of the messages and their effect on social norms related to family planning, and related attitudes and practices) of the SBCC strategy overall and of its individual components (i.e., television commercials, serial drama, LHWs, CHWs, journalism, and religious actors).

The question will examine the relevance and importance of brand identity (i.e., Bright Star), assess the target communities' awareness and perceptions of the Bright Star brand, and develop conclusions and recommendations for if and how USAID, or others, can advance or improve the Bright Star campaign.

To the extent possible, the question will also collect qualitative data to help explain how the project has influenced the three quantitative indicators on which it reports. While it does not validate partner-reported numbers, the qualitative data will provide evidence of whether project activities have influenced specific knowledge, attitudes, and practices.

Question 2: How effective have the project's capacity building strategy and individual approaches been in building sustainable capacities at the individual and institutional levels to design, implement, and evaluate high-quality SBCC?

Explanation: The question will assess project results in building sustainable capacity among individuals and institutions to design, implement, and evaluate high-quality SBCC campaigns. It will examine the effectiveness of the overall capacity building strategy and of the individual capacity building approaches (e.g., support to Department of Health [DoH] and the Population Welfare Department [PWD] to develop communication strategies, internship program, etc.). It will also examine the likely replicability and sustainability of capacities built at both the individual and institutional levels and provide recommendations for the technical, operational, and financial support that may be required in the next 3-5 years to enhance prospects for sustainability with an eye to transitioning the technical and programmatic leadership to government and/or other local institutions.

Question 3: To what extent have the project's pre-testing and formative research activities contributed to designing and implementing SBCC campaigns and how are stakeholders using this information?

Explanation: The question will explore the extent to which partners, including PWD and other MCH component partners, have been engaged in designing, implementing, disseminating, or utilizing research, monitoring, and evaluation related to SBCC. It will specifically determine whether appropriate monitoring and quality assurance mechanisms are in place for SBCC interventions at all levels, the extent to which implementers are learning from these mechanisms to refine approaches, and the likelihood that government or other stakeholders will sustain these mechanisms in the future.

Question 4: To what extent did HCC project activities address gender issues and what effects did this have on increased uptake of FP services?

Explanation: The question will examine whether the project integrated gender considerations in the design and implementation of project activities including communication strategies and capacity building and the extent to which gender-specific strategies affected changes in social norms and behaviors among men and women. It will explore the nuanced ways in which the HCC content has been received by both men and women to identify the communication tools and methods which are most effective in increasing the uptake of FP services.

Question 5: What best practices, innovations, and lessons learned can be applied to other existing or future programming in health communication?

Explanation: The question draws on findings from the other questions to identify the SBCC practices that have been successful in positively changing individuals' knowledge, attitudes, and behaviors with respect to FP/RH and MNCH and increasing the uptake of FP services. It will also elaborate the lessons learnt from the program to inform future programs on health communication and SBCC.

Methods of Data Collection and Analysis

The evaluation team will collect quantitative and qualitative data from both primary and secondary sources. Primary data and sources include qualitative data collected through key informant and group interviews, including:

- Qualitative data from community level group interviews with married women of reproductive age and their husbands, mothers-in-law, and extended family members; influential men of the area (including but not limited to members of the village health committees [VHCs] created under the project); influential women of the area (including but not limited to members of community support groups [CSGs] facilitated by project-supported LHWs and CHWs), and the LHWs, CHWs, community midwives (CMWs), and social mobilizers trained in using the interpersonal communication (IPC) toolkit developed by the project.
- Qualitative data from group interviews at the district level with journalists trained under the project.
- Qualitative data from the key informant interviews at the district level with district health officers and IPC officers (representatives of the implementing partners), PWD and DoH staff, and staff of the LHW program.

- Qualitative data from key informant interviews at the provincial level with the directors general of PWD and DoH, the provincial coordinator of the LHW program, senior officials from the implementing partners, and USAID.
- Review of the mass media and IPC content developed by the project to determine what messages are incorporated in the various components of the overall communication strategy and how they are communicated or presented. The findings from the review constitute evaluation findings and will also guide the design of data collection instruments.

Secondary data sources include project documents and databases as well as other relevant publicly available datasets, e.g., the Demographic and Health Surveys (DHS) or the Multiple Indicator Cluster Surveys (MICS). The evaluation team will use information from project documents to develop a thorough understanding of the project's activities and their reach. It will use quantitative data from the project's databases to document the beneficiaries and geographic distribution of project activities. It will also use the quantitative data from the MCH survey,[2] and other datasets, to investigate trends and differences across districts in the three key indicators on which the project reports.

Selection of Districts and Communities

The 10 districts of Sindh where HCC was implemented can be broadly divided into three strata/geographic clusters with different cultural characteristics which may affect project outcomes, i.e., 1) Southern Sindh (Umerkot, Sanghar, Matiari, and Mirpur Khas districts), 2) Northern Sindh – non-tribal (Nowshehro Feroz, Sukkur, and Larkana districts), and 3) Northern Sindh – tribal (Jacobabad, Shikarpur, and Ghotki districts). To manage the time and financial costs of the evaluation, the team will select a sample of districts from each cluster in consultation with the Mission.

PERFORM's analysis of the MCH data for 2013, 2014, and 2016 shows little significant difference in key indicators of FP within the two Northern Sindh clusters (Table 1). In the Southern Sind cluster, Umerkote, Mirpu Khas, and Sanghar are similar but Matiari stands out from the other three with significantly lower values for the birth spacing indicator and higher values for the other two indicators. PERFORM therefore proposes to select one district from each of the two Northern Sindh clusters, one district from the three similar districts in the Southern Sindh cluster and the Matiari district for fieldwork. This sample represents a practical approach to covering what appear to be different experiences with implantation.

TABLE 1: INDICATOR VALUES BY DISTRICT

Region	District	Indicator 5.1.2.1 (Birth Spacing)			Indicator 5.1.2.2 (Messages)			Indicator 5.1.2.3 (Discussing FP)[a]
		2013	2014	2016	2013	2014	2016	2016
Northern	Sukkur	15%	19%	32%	10%	29%	18%	61%
	Nausharhro Feroz	32%	20%	28%	4%	32%	22%	56%
	Larkana	19%	31%	16%	8%	33%	26%	57%
Northern - Tribal	Ghotki	27%	26%	22%	10%	15%	25%	49%
	Shikarpur	34%	21%	22%	8%	25%	18%	42%
	Jacobabad	20%	29%	16%	1%	18%	34%	34%
Southern	Umerkote	35%	21%	37%	13%	18%	4%	49%
	Matiari	18%	15%	5%	6%	28%	74%	72%
	Mirpur Khas	37%	39%	20%	26%	37%	27%	47%
	Sanghar	25%	18%	32%	14%	19%	40%	49%

[2] The MCH survey is an annual survey conducted by PERFORM to monitor key MCH program indicators.

a. The MCH survey collected data on this indicator only for 2016.

From each of the four selected districts, the team will randomly select one rural and one urban/semi-urban union council (UC) to achieve a mix of different socio-economic classes and to ensure that results are as representative as possible.

Group Interviews

The evaluation team will conduct 52 group interviews, 13 in each sampled district, to collect qualitative data on if and how SBCC activities were effective in 1) changing social norms related to family planning, family planning behaviors, and demand for family planning services among married couples and 2) in building sustainable capacities for SBCC at the individual and institutional levels (Table 2).

In each selected UC within a sampled district, the team will identify groups of individuals for interviews. The team will randomly select LHWs, CHWs, CMWs, and social mobilizers trained on the IPC toolkit from lists of these individuals provided by the project. Because it will be difficult to recruit married women of reproductive age and their husbands, mothers-in-law, and extended family while protecting their anonymity, the team will most likely ask LHWs and CHWs to arrange these group discussions. In these instances, it will not be possible to randomly select interview subjects. The evaluation team will obtain lists of the members of influential men's and women's groups from LHWs, CHWs, CMWs, or social mobilizers and randomly select members of these groups for group interviews. To achieve a varied mix of participants, the group interview participants will belong to a cluster of UCs and not be limited to the selected LHW/CHW/CMW/Social Mobilizer's own area of assignment. The team will select the journalists purposively to capture sectoral knowledge and geographic coverage within the district. Each group interview will consist of four to five participants for a maximum of 260 individuals (Table 2).

TABLE 2: DISTRIBUTION OF GROUP INTERVIEWS

	LHWs/ CHWs/ CMWs/ Social Mobilizers	Married Women	Husbands	Mothers-in-Law and Extended Family	Influential Men's Groups	Influential Women's Groups	Journalists
District 1	2	2	2	2	2	2	1
District 2	2	2	2	2	2	2	1
District 3	2	2	2	2	2	2	1
District 4	2	2	2	2	2	2	1
Total number of interviews	**8**	**8**	**8**	**8**	**8**	**8**	**4**
Maximum number of participants	**40**	**40**	**40**	**40**	**40**	**40**	**20**

Stakeholder and Expert Interviews

In each sampled district, the evaluation team will conduct about five semi-structured key informant interviews with stakeholders and experts associated with the project who can provide feedback on the

project's design, implementation, outcomes, and lessons learned. The evaluation team will purposively select key informants to capture specific experience or perspectives. Potential informants include district representatives from implementing partners, DoH, PWD, and the LHW program.

Additionally, the team will conduct 11 semi-structured key informant interviews at the province and program levels with representatives of USAID, JHU-CCP, CCPP, Mercy Corps, RSPN, DoH, PWD, and LHW program (Table 3).

TABLE 3: DISTRIBUTION OF KEY INFORMANT INTERVIEWS

	DHO /IPC Officer	DoH	PWD	LHW Program	USAID	JHU-CCP	CCPP	RSPN	Mercy Corps
District 1	2	1	1	1	-	-	-	-	-
District 2	2	1	1	1	-	-	-	-	-
District 3	2	1	1	1	-	-	-	-	-
District 4	2	1	1	1	-	-	-	-	-
Provincial/ program level	-	2	2	2	1	1	1	1	1
Total number of Interviews	**8**	**6**	**6**	**6**	**1**	**1**	**1**	**1**	**1**

Data Analysis

Quantitative data from project documents, mass-media and training content, and quantitative datasets will provide evidence of 'what' happened while qualitative data collected through key informant and group interviews will provide rich evidence of 'how' and 'why' project activities were effective or ineffective in changing communities' knowledge, attitudes, and behavior regarding FP/RH and MNCH; and subsequently changing the uptake of FP services.

Descriptive Statistics: For quantitative data from project documents, the MCH survey, and structured portions of key informant and group interviews, descriptive statistics will provide trends and simple summaries by geographic cluster and type of respondent. Appropriate statistical tests will be used where necessary to test the significance of differences by geography or respondent type and the correlation between variables. Data visualization techniques will be used as appropriate to illustrate the results.

Content Analysis: For all responses from key informant and group interviews, content analysis will be used to examine and illustrate patterns. Content analysis identifies themes relevant to answering the evaluation questions, records the frequency with which the themes occur, and examines the content of the illustrative text to better understand the meaning of and context in which statements were employed. The analysis will also assess, and when warranted highlight, evidence that deviates from the common themes.

Data Management

The evaluation team will document data from semi-structured key informant and group interviews in interview notes and, where appropriate, audio recordings, from which team members will prepare transcripts or summaries in English.

All interview notes, recordings, and transcripts will be stored in a secure folder to which only the assignment team and PERFORM staff working on the evaluation will have access. The storage and transfer of data collected as part of this evaluation will adhere to ADS 579 requirements.

All interim data (e.g., field notes) generated during the evaluation will be deposited in a unified, cloud-based digital repository such as Dropbox or Google Drive to which only the evaluation team and necessary PERFORM staff will have access. The data collection team should finish and upload notes within three days of completing an interview. The assignment manager will review notes within two days of their upload.

Implementation

Document Review and Preparation

Prior to convening for the team planning workshop (TPW), all team members will review relevant project documents, tools, and reports. This will ensure that the team is well acquainted with project activities, scope, and progress.

Team Planning Workshop

The evaluation team will participate in a two-week TPW to design data collection instruments, develop data collection and data analysis plans, and plan the fieldwork. During the TPW, the team will meet with USAID and implementing partner staff to develop a thorough understanding of project objectives, implementation mechanisms, and the evaluation purpose and context. Prior to the conclusion of the TPW, the team will conduct a data rehearsal to familiarize mission staff with the evaluation plan including the instruments and data analysis plan.

Fieldwork

For fieldwork, the evaluation team will be split into three field teams, each field team will comprise a sector specialist and a Sindhi-speaking field researcher. The sector specialists will lead the field teams and conduct key informant and group interviews. The field researchers will assist the sector specialists by taking notes during the group interviews, translating the notes from Sindhi to English and preparing interview transcripts or summaries, as decided by the team during the TPW. The researcher, in consultation with the sector specialist, will be responsible for finalizing the interview transcripts/summaries and sharing them with the evaluation team. During the interview, the field researcher will also act as a translator when necessary.

We anticipate that the three field teams will travel together and be able to complete all interviews in a district within a week.

Limitations and Mitigations

Some of the key limitations of the proposed approach and methods the team will use to mitigate the influence of the limitations include:

- **Data validity and reliability**: Key informant and group interviews constitute the primary methods of data collection. If respondents to not consistently interpret questions as researchers intend, the resulting data may not be valid or reliable. To mitigate this limitation, the evaluation

team will design and pretest instruments carefully and systematically triangulate evidence from a variety of methods and sources to minimize potential bias and ensure the validity and reliability of findings.

- **Recall error:** Respondents may not be able to accurately recall whether past project activities influenced their knowledge, attitudes, or behavior. Poor recall will affect the reliability of data. To mitigate this source of error, the team will design the survey and interview instruments to help respondents recall their participation in project activities and the effect of their participation on knowledge, attitudes, and behavior.
- **Selection bias in key informant and group interviews:** Due to the sensitive nature of the topic, the team will have to rely on non-random methods to select some types of respondents. This will make it nearly impossible to determine the sampling error or make inferences about populations based on the data. To the extent that non-random selection methods result in a non-representative group of respondents, they create the potential for biased results. Since this limitation applies largely to qualitative data, it is not a serious limitation but the potential for bias remains. Potential sources of selection bias include:

  (i) Selection bias: The respondents for the community level interviews will be recruited by LHWs and CHWs who may select respondents with whom they have close ties or those who have been more receptive to their messages and visits.

  (ii) Self-selection bias: Individuals who agree to participate in group interviews may differ systematically from those who refuse to participate. If these differences are correlated with responses to questions, they will bias the interview results.

  (iii) Convenience sampling biases: When assembling group interview respondents from a cluster of UCs, the LHW and CHWs may select only more conveniently accessible individuals. A nominal transport stipend to offset travel costs may partially mitigate this effect.

- **Language/translation:** Some respondents may be more comfortable communicating in Sindhi which will necessitate translating for team members who do not speak Sindhi. Translation will introduce some loss of fidelity in the data. To minimize this, the evaluation team will thoroughly train the field researchers (who are responsible for note-taking, transcription, and translation of the data) and verify the translations, transcripts, and analysis carefully with the Sindh speaking field researchers to ensure that responses have been documented and interpreted as accurately as possible.

TABLE 4: SUMMARY OF PROPOSED DATA COLLECTION AND ANALYSIS METHODS

Evaluation Question	Data Source	Data Collection Method	Sampling	Method of Data Analysis	Limitations/Risks
Question 1: What is the reach of the project's SBCC activities and to what extent have they been effective in changing social norms related to family planning, family planning behaviors, and demand for family planning services?	Community members in the target districts	Group interviews	Randomized sampling at the LHW level but non-random sampling at the respondent level	• The interviews will explore individuals' perceptions of whether their knowledge, attitudes, and behavior regarding FP/RH and MNCH have changed over time. The interviews will focus on 'how' and 'why' change occurred and attempt to link changes to HCC activities, including the mass media campaign and the community level efforts. When change did not occur, the interviews will explore the factors that prevented change. • The interviews will help identify the impact of the components of the 'Bright Star' campaign, especially of the celebrities' role in the media campaign, on individuals' FP/RH and MNCH knowledge, attitudes, and practices. They will also examine individuals' ability to identify with the campaign and its messages. • Qualitative analysis of the individuals' response to corroborate the quantitative data on the three key indicators reported by the program.	• Recall error • Response bias due to group setting • Selection, self-selection, and convenience sampling biases
	UC-level influential male and female groups	Group interviews	Randomized sampling at the LHW level but purposive sampling at the respondent level	• The interviews will explore participants' perception and willingness to encourage a change in their communities' knowledge, attitudes, and behavior regarding FP/RH and MNCH. They will also examine perceptions of whether the uptake of FP services has increased in the community and 'how' and 'why' this change has happened. In cases where there has been no change, the interviews will explore the factors which could have potentially facilitated change and those which potentially prevented change.	• Recall error • Response bias due to group setting • Selection, self-selection, and convenience sampling biases
	Program documents and surveys	Secondary review of materials	N/A	• Culling data based on intended target population to illustrate trends and patterns • Descriptive statistics to depict differences in relevant indicators by district • Cross tabulations of statistical data on project outputs	N/A

Evaluation Question	Data Source	Data Collection Method	Sampling	Method of Data Analysis	Limitations/Risks
				• Triangulation of the secondary data with the response of community members to verify the 'extent' of the program's reach.	
	Implementing partner and other partner organizations (Mercy Corps, RSPN, and CCPP)	Key informant interviews	Purposive sampling	• Interviews will explore perceptions of the reach of the program and its effectiveness in changing the target audiences' knowledge, attitudes, and behavior with respect to FP/RH and MNCH.	• Information and knowledge gaps across partners due to their unique roles in the project
	LHWs, CHWs, CMWs, and social mobilizers	Group interviews	Randomized sampling	• Interviews will examine perception of whether there has been a change in individuals' behavior and understanding of FP/RH and MNCH practices and the factors that have potentially contributed to or limited this change. • Triangulation with the responses of community members.	• Recall error • Response bias
Question 2: How effective have the project's capacity building strategy and individual approaches been in building sustainable capacities at the individual and institutional levels to design, implement, and evaluate high-quality SBCC?	Implementing partner and other partner organizations (Mercy Corps, RSPN, and CCPP)	Key informant interviews	Purposive sampling	• Interviews will explore perceptions on the effectiveness and the limitations of the project's capacity building activities. It will also discuss the government's capacity and willingness to take ownership and further the efforts of HCC. • Triangulation with the response of the government stakeholders.	• Information and knowledge gaps across partners due to their unique roles in the project
	Government stakeholders	Key informant interviews	Purposive sampling	• Interviews will explore perceptions about the capacity building activities and resources provided under the project, and the extent to which capacity building will be beneficial in generating knowledge and capacity in the DoH and PWD. • The interviews will provide information on the government's institutional capacity and strength with respect to its technical knowledge, finances, and man-power, to further the work of HCC and may highlight	• Response bias • Recall error

Evaluation Question	Data Source	Data Collection Method	Sampling	Method of Data Analysis	Limitations/Risks
				institutional weaknesses or limitations. • The interviews will also provide information on government stakeholders' plans and capabilities to replicate the HCC capacity building activities in the future. • Qualitative analysis of government stakeholders' will to utilize the capacities and resources developed through the program and facilitate change in knowledge, attitude, and behavior with regards to FP/RH and MNCH. • Triangulation with implementing partners' responses.	
	Communication materials (television commercials, videos, serial drama, etc.), strategies, content, and capacity building tools (IPC toolkits)	Secondary review of materials	N/A	• Review and analysis of communication content, community toolkit, and IPC toolkits to understand messages and communication approach. • Review of mass media content to gauge its usefulness in effectively delivering messages to target audiences. • Qualitative analysis of the communication strategies to assess their effectiveness and usefulness. • Triangulation with responses' of LHW/CHW and other trainees.	N/A
	LHWs, CHWs, CMWs, and social mobilizers	Group interviews	Randomized sampling	• Interviews will explore perceptions of the effectiveness and usefulness of the IPC toolkits for LHWs and CHWs; and measures to improve them. • Triangulation with responses of the implementing partner and other partner organizations	• Response bias • Recall error
	Journalists	Group interviews	Purposive sampling	• The interviews will examine journalists' perceptions of 'how' and 'why' the trainings were effective or ineffective in changing their knowledge, attitudes, and behavior with regards to FP/RH and MNCH. • It will further explore the usefulness of the trainings and 'how' the journalists' have utilized or intend to utilize	• Response bias • Recall error

Evaluation Question	Data Source	Data Collection Method	Sampling	Method of Data Analysis	Limitations/Risks
				the information and capacity built through the trainings. • Triangulation with the response of the implementing partner and other partner organization.	
Question 3: To what extent have the project's pre-testing and formative research activities contributed to designing and implementing SBCC campaigns and how are stakeholders using this information?	Program documents and surveys	Secondary review of materials	N/A	• Qualitative analysis of the program's design, implementation and quality assurance mechanisms. • Triangulation with the implementing partners' response.	N/A
	Government stakeholders	Key informant interviews	Purposive sampling	• The interviews will explore government stakeholders' perceptions on the significance of their role in the collaborative activities between them and the implementing partners; and their satisfaction with the collaborative process. • Interviews will examine governments' perceptions of the various ways in which the government is using the information and resources generated through the project; and the prospective usefulness of these resources for the government and other stakeholders. • Qualitative analysis of government's perception with respect to the importance of sustaining the research, implementation, and quality assurance mechanisms developed by the program. • Triangulation with response of the implementing partners.	• Response bias • Recall error
	Implementing partner and other MCH partner organizations	Key informant interviews	Purposive sampling	• The interviews will explore 'why' and 'how' various government stakeholders and MCH partner organizations were engaged in the design, implementation, and dissemination of monitoring and evaluating the program; and their capacities to further monitoring and evaluation. • Qualitative analysis of the program's quality assurance mechanisms to explore their effectiveness. • The interviews will explore implementing partner and other partner organizations' perceptions on the usefulness of the research and resources generated	• Information and knowledge gaps across partners due to their unique roles in the project

Evaluation Question	Data Source	Data Collection Method	Sampling	Method of Data Analysis	Limitations/Risks
				through the project; and their prospective relevance and utilization. • Qualitative analysis of the other MCH partner organizations' perceptions with respect to the importance of sustaining the research, implementation, and quality assurance mechanisms developed by the project.	
Question 4: To what extent did HCC project activities address gender issues and what effects did this have in increased uptake of FP services?	Community members in the target districts	Group interviews	Randomized sampling at the LHW level but non-random sampling at the respondent level	• The interviews will examine communities' perceptions of the project's community level and mass media activities in informing men and women about FP/RH and MNCH, and inducing a change in their knowledge, attitudes, and behavior. • The interviews will also elicit community members' recommendations for improving the activities under the program; and their opinion regarding its limitations in reaching and influencing men and women. • The interviews will help identify the inter gender differences in the impact of the 'Bright Star' campaign, especially of the specific celebrities' role in the media campaign, and in changing men's and women's knowledge, attitudes, and behavior regarding FP/RH. • Triangulation of the responses with the program progress reports.	• Recall error • Response bias due to group setting • Selection, self-selection, and convenience sampling biases
	UC-level influential male and female groups	Group interviews	Randomized sampling at the LHW level but purposive sampling at the respondent level	• The interviews will explore influential community members' perceptions on the differences in men's and women's knowledge, attitudes, and behavior regarding the importance of FP/RH and MNCH. It will also explore the differences in men's and women's access to mass media.	• Recall error • Response bias due to group setting • Selection, self-selection, and convenience sampling biases
	Program documents	Secondary review of materials	N/A	• Qualitative analysis of the MCH gender and social inclusion strategy. • Qualitative analysis of program activities, design, implementation, workplan, and reports to assess	N/A

Evaluation Question	Data Source	Data Collection Method	Sampling	Method of Data Analysis	Limitations/Risks
				whether gender considerations have been effectively incorporated in each stage of the program. • Culling data based on intended target population to illustrate trends and patterns. • Descriptive statistics and cross tabulations of statistical data on project outcomes and outputs. • Triangulation of the quantitative data with the qualitative data.	
	Communication materials, content, and tools	Secondary review of materials	N/A	• Review of mass media activities (content and medium) to gauge their usefulness and effectiveness in targeting and delivering messages to men and women. • Triangulation of the analysis of the mass media content, medium, and tools with the communities' response.	N/A
	Implementing partner and other partner organizations (Mercy Corps, RSPN, and CCPP)	KIIs	Purposive sampling	• The interviews will provide the perceptions of the implementing partners on 'how' they have integrated gender considerations in the design and implementation phase of the program. • Triangulation with program document, workplans, and reports.	• Information and knowledge gaps across partners due to their unique roles in the project.
Question 5: What best practices, innovations, and lessons learned can be applied to other existing or future programming in health communication?	Program documents and relevant literature	Secondary review of materials	N/A	• Qualitative analysis of progress reports to explore 'how' and 'why' certain practices are more effective than others to highlight the best practices and lesson learnt from the project. • Review of international and national literature on health communication to deduce the most effective and sustainable health communication and SBCC strategies. • Triangulation with communities' response about the effectiveness of project activities in affecting their knowledge, attitudes, and behavior with regards to FP/RH and MNCH.	N/A
	Implementing partner and	Key informant	Purposive sampling	• The interviews will examine the implementing partners' perceptions of the most effective activities and the	• Information and knowledge gaps

Evaluation Question	Data Source	Data Collection Method	Sampling	Method of Data Analysis	Limitations/Risks
	other partnered organizations	interviews		factors that contributed to their effectiveness. It will also explore the challenges that were faced while implementing the various activities. • Triangulation with project progress reports.	across partners due to their unique roles in the project
	Government stakeholders	Key informant interviews	Purposive sampling	• The interviews will explore government stakeholders' perceptions of the most effective activities and the factors that contributed to their effectiveness. It will also discuss the ease of replicability and scale-up of the various activities under the project.	• Response bias. • Recall error

DELIVERABLES

Deliverables under this assignment include:

- **Detailed Methodology, Data Analysis Plan, Data Collection Tools and Data Collection Plan:** During the team planning workshop (TPW), the assignment team will prepare a detailed methodology, data analysis plan, data collection tools and a data collection plan for the assignment. The methodology in the AWP will be updated and the AWP revised as needed at the end of the TPW and submitted for PERFORM COR approval. The data analysis plan, data collection tools and data collection plan will be submitted to the PERFORM COR for approval at the end of the TPW and before the start of fieldwork.
- **Data Collection Completion Report:** After data collection, PERFORM will submit to the PERFORM COR a final data collection schedule indicating dates and location of data collection activities and persons or groups interviewed if relevant.
- **Debriefing with USAID/Pakistan of Findings, Conclusions, and Recommendations:** At or near the conclusion of data analysis the assignment team will present the major findings, conclusions, and recommendations to USAID/Pakistan. As appropriate, the team will consider USAID comments during the debriefing when writing the draft report.
- **Draft Report:** The draft report will answer the assignment questions and will include findings, conclusions, and recommendations across the components/sub-components. The draft report (not to exceed 30 pages) will be submitted by PERFORM to the PERFORM COR for USAID/Pakistan review and comments. The PERFORM COR will submit all comments to the draft report to PERFORM within two to three weeks of receipt of the draft report.
- **Final Report:** The final report will address all USAID/Pakistan comments. PERFORM will finalize the report and submit it to the PERFORM COR for approval within two to three weeks.
- **One-page Brief:** A brief of the key (qualitative and quantitative) findings, conclusions and recommendations related to the assignment questions will be developed by PERFORM for use by USAID/Pakistan decision makers and other relevant stakeholders. This document will be written in English and may be translated and disseminated as desired by USAID/Pakistan. PERFORM will submit the document to the PERFORM COR after the final report is approved.
- **Presentation(s) to USAID/Pakistan:** Presentation(s) of the final report will be made to USAID/Pakistan, implementing partners and other relevant stakeholders if desired by USAID/Pakistan.
- **Raw Data:** Per ADS 579 - USAID Development Data – all quantitative data collected for this assignment will be submitted to USAID/Pakistan in electronic format within 30 days of completion. Qualitative data will be delivered as 1) the coded segments used in analysis extracted from MAXQDA in an excel format or 2) tally sheets, as applicable to the analysis.
- **Development Experience Clearinghouse (DEC) Review:** Once the report is finalized, USAID/Pakistan may conduct a DEC review of the report. The PERFORM COR will share the DEC version of the report with PERFORM for final editing, formatting and uploading to the DEC.

ANTICIPATED SCHEDULE OF ACTIVITIES AND LEVEL OF EFFORT

Table 5 describes the roles and responsibilities of each proposed assignment team member, and Table 6 gives details of the anticipated assignment schedule and level of effort.

TABLE 5: ASSIGNMENT STAFFING WITH ROLES AND RESPONSIBILTIES

Position	Status	Roles and Responsibilities
Team leader	Expat STTA	The team leader will be an experienced evaluator with superior social science research skills and experience in health communications. The team leader will be responsible for leading the team, managing assignments among team members to complete the fieldwork, and completing deliverables on time and to required quality standards.
Behavior change communication specialists (x3)	Local STTA	The three behavior change communication specialists will have expertise in communication strategies and tools. They will participate fully in all aspects of the evaluation including the TPW, developing data collection instruments, collecting and analyzing data, and contributing to the report.
Field researchers (x3)	Local STTA	The team will include three Sindhi-speaking field researchers. They will translate for field team members when necessary and facilitate qualitative data collection activities which include, but are not limited to, conducting interviews, taking interview notes, and preparing transcripts and interview summaries.
Data analysts (x2)	Local STTA	The two data analysts will help the team code and analyze the qualitative and quantitative data. The analysts contribute to the analysis phase of the evaluation.
Assignment manager	PERFORM LTTA	The assignment manager will oversee the evaluation and facilitate the work of the team as required. This will include preparing a draft evaluation design; coordinating all travel and logistics; facilitating meetings with USAID/Pakistan; participating in the TPW, data rehearsal, data analysis, and initial debrief; reviewing draft reports; and ensuring that the team adheres to the strict deadlines for deliverables contained in the AWP.
PERFORM advisor	PERFORM LTTA	The evaluation and assessments advisor will provide evaluation expertise. He will otherwise be responsible for reviewing and approving all aspects of the assignment and is ultimately responsible for ensuring that the team completes the assignment on time and to the required quality standards.

TABLE 6: ANTICIPATED ASSIGNMENT SCHEDULE AND LEVEL OF EFFORT

Assignment Phase	Location of activity	Anticipated schedule	Deliverable(s)	Team Leader	Behavior Change Communication Specialist #1	Behavior Change Communication Specialist #2	Behavior Change Communication Specialist #3	Field Researcher #1	Field Researcher #2	Field Researcher #3	Data Analyst #1	Data Analyst #2
Travel	Local / international	-		8	4	4	4	4	4	4	2	2
Preparation	Home base	Aug 23 – Sep 10	• Document review	10	5	5	5	1	1	1	1	1
TPW and approval of instruments	Islamabad/Sindh	Sep 11- Sep 23	• Draft data collection and analysis plans • Draft and final instruments • Data rehearsal presentation	12	12	12	12	2	2	2		
Fieldwork	Sindh	Sep 25 - Oct 21	• Data collection completion report	12	24	24	24	24	24	24	15	15
Analysis	Islamabad	Oct 23 - Nov 11		18	18	18	18				10	10
Reporting	Islamabad	Nov 13 - Dec 11	• Debriefing with USAID/Pakistan • Presentation to USAID/Pakistan and stakeholders • Draft report to USAID/Pakistan • Draft one-page summary to USAID/Pakistan • Comments on one-page summary returned by USAID/Pakistan • Final report to USAID/Pakistan • Final one-page summary to USAID/Pakistan	15	10	10	10					
			Total LOE	75	73	73	73	31	31	31	28	28

PERFORM ASSIGNMENT WORK PLAN 18

LOE Summary by Position			
Status	**Position**	**LOE (days)**	
STTA	Team leader	75	
STTA	Behavior change communication specialists (x3)	219	
STTA	Field researchers (x3)	93	
STTA	Data analysts (x2)	56	
Total LOE		**443**	

COST ESTIMATE

A break-down of costs by the four line items is below:

Direct Labor	$--
Travel	$--
Other Direct Costs	$--
Subcontractors	$--
Grand Total*	$--

**Total cost estimates do not include cross-cutting costs, indirect costs, or the MSI fee.*

PERFORM COR APPROVAL

[COR will indicate approval by signing below or indicating "approval" by return email].

Contracting Officer's Representative (COR) **Date**

PERFORM ASSIGNMENT WORK PLAN 20

ANNEX 6: DATA COLLECTION INSTRUMENTS

Health Communications Component Evaluation
Group Interviews with VHCs, CSGs, and Viewing Clubs
Individual Interviews with Community Members

1. Date **(D/M/Y)**: _____
2. Interviewer name **(PERSON INTERVIEWING)**:

   _____
3. Note taker name **(PERSON TAKING NOTES)**:

   _____
4. Interview location **(UNION COUNCIL):** _____
5. UC type **(CIRCLE ONE)**:

   1 Rural
   2 Urban

6. Interview location

   (DISTRICT): _____
7. Interview type **(CIRCLE ONE NUMBER)**

   1 Group interview
   2 Individual interview

8. Interviewee type **(CIRCLE ONE NUMBER)**

   1 Married women
   2 Husbands
   3 Mothers-in-law
   4 Influential men (VHC members)
   5 Viewing club
   6 Influential women _____ **(SPECIFY CATEGORY)**

9. Interviewee name 1: _____
10. Interviewee name 2: _____
11. Interviewee name 3: _____
12. Interviewee name 4: _____
13. Interviewee name 5: _____

My name is _____, my partner is named _____. I work for a research organization that is assessing the impact of recent health communication interventions in Sindh. We would like to ask you a few questions. This interview will take approximately 30-45 minutes to conduct.

Do I have your permission to record interview? **(CIRCLE ONE)**

1 Yes
2 No

Evaluation question: What is the reach of the project's SBCC activities and to what extent have they been effective in changing social norms related to family planning, family planning behaviors and demand for family planning services?

1. Do you recognize this logo? **(SHOW BRIGHTSTAR LOGO AND SLOGAN)**

   1 Yes
   2 No .....**GO TO Q 3**
   3 Maybe/don't know .....**GO TO Q 3**

2. **IF YES**, What do you think of when you see this logo and slogan? **(***probe: feelings invoked, please describe what you see in this picture***)**

3. Where you have seen this logo? **(DON'T PROMPT AND CIRCLE ALL MENTIONED)**

   1 Sammi
   2 Television commercials
   3 Videos _____
   4 Newspapers
   5 Poster, billboards, etc.
   6 Home visits from LHW/CHW (IPC toolkit)
   7 CSG or VHC meetings (IPC toolkit)
   8 Public events
   9 Others (**SPECIFY**) _____

4. In your opinion, to what extent is this logo recognized amongst people you know? **(CIRCLE ONE NUMBER)**

   1 It is widely recognized as promoting family planning
   2 Some people I know would recognize it as promoting family planning
   3 Very few people I know would recognize it as promoting family planning
   4 No one I know would recognize it
   5 Don't know

5. Do you have a television in your household? **(CIRCLE ONE NUMBER)**

   1 Yes
   2 No

6. Do you watch it? **(CIRCLE ONE NUMBER)**

   1 Yes.....**GO TO Q 8**
   2 No

7. Why not? ***(Probe for load shedding, time, etc.)***

8. Which channels do you have access to? ***(Probe to get a yes or no answer to HUM TV)***

9. Which channels do you watch and why? ***(Probe to get a yes or no answer to HUM TV and reasons)***

10. Do you have a radio in your household?

11. Do you listen to it? If not, why not?

12. What, at any, messages have you heard or seen about family planning and maternal, child, and newborn health in the past 12 months? **(DO NOT PROMPT AND CIRCLE NUMBER OF ALL RESPONSES MENTIONED)**		13. Where did you hear or see these messages?	14. What messages did you like and why? **(Probe for why they thought the message was effective)**
1	Family planning		
2	Antenatal care		
3	Nutrition for pregnancy		
4	Danger signs during pregnancy		
5	Importance of SBA		
6	Three delays		
7	Danger signs during birth		
8	Post-natal care		
9	Danger signs during post-natal period		
10	Newborn care		
11	Danger signs for newborn		
12	Prevention of hypothermia		
13	Early initiation of breastfeeding		
14	Cord care		
15	Exclusive breastfeeding		
16	Tetanus		
17	Routine immunization		
18	Diarrhea prevention		
19	Diarrhea management		
20	Acute respiratory infection		
21	Malnutrition		
22	Interspousal communication		

15. You've told me about a number of messages you've heard related to **family planning**. Did you, or do you intend to, take action on any of these? Explain.

16. You've told me about a number of messages you've heard related to **maternal, newborn, and child health**. Did you, or do you intend to, take action on any of these? Explain

Now I'd like to discuss whether the messages you heard or saw about family planning affected your views on family planning.

17. Did the messages about family planning that you saw or heard affect your views about family planning?
    1 Yes
    2 No .....**GO TO Q 19**
    3 Don't know .....**GO TO Q 19**

18. Can you describe how it changed your views? What were your views before you heard the messages and what are your views now. ***(Probe for before and after)***

19. Did the messages about family planning affect the views of other members of your household about family planning?
    1 Yes
    2 No .....**GO TO Q 21**
    3 Don't know .....**GO TO Q 21**

20. Can you describe how it changed their views? What were their views before they heard the messages and what are their views now. ***(Probe spouse, mother-in-law, mother, others and ask about before and after)***

21. Do you discuss family planning issues with your spouse? **(CIRCLE ONE NUMBER)**
    1 Yes.....**GO TO Q 22**
    2 No .....**GO TO Q 24**

22. When did you start discussing family planning issues with your spouse? **(READ RESPONSES AND CIRCLE ONE NUMBER)**
    1 More than 2 years ago
    2 About two years ago
    3 About 1 year ago
    4 About 6 months ago

23. Why did you begin discussing family planning issues with your spouse? **(*Probe for when the change took place and what influenced the change, especially anything related to behavior change campaigns or Sammi. Probe for change in spouse's acceptance, support of other family members, reached desired family size, etc.*)**

    GO TO Q 25

24. Why do you not discuss family planning issues with your spouse? **(*Probe for not acceptable in the household, family members not supportive, s/he is not receptive, no interest in family planning, etc.***

25. Has your comfort with discussing family planning with your spouse or family members changed in the past 12 months?
    1 Yes
    2 No .....G**O TO Q 27**

26. Please describe how and why your comfort with discussing family planning with members of your family has changed. **(*Probe for increased/decreased comfort. Probe for why: family members more accepting/supportive of family planning, your role in decisions has changed, which family members, etc. Listen for mention of HCC interventions*)**

27. **ASK ONLY FROM RESPONDENTS WHO MENTIONED HEARING ABOUT FAMILY PLANNING OR MATERNAL, NEWBORN, AND CHILD HEALTH FROM AN LHW OR CHW.** Were the method and materials the lady health worker or community health worker used during the home visit or the community support group or village health committee meeting suitable to helping you learn?

    1 Yes

    2 No .....**GO TO Q 29**

28. Why were they suitable to helping you learn? **(*Probe for language, graphics, quality of teaching, etc.*)**

29. How, if at all, could the methods or materials have been improved to be more suitable to helping you learn? **(*Probe for language, graphics, quality of teaching, etc.*)**

Now I'll ask you about the sources of information that worked best for reaching men and women.

	30. Which sources do you think were best for reaching <u>women</u> about family planning? **(DO NOT PROMPT. CIRCLE NUMBER IN APPROPRIATE ROWS)** **ASK ONLY IF MENTIONED**, Why did they work well? ***(Probe for available time, literacy, exposure, barriers to access, appeal, etc.)***		31. Which sources do you think were best for reaching <u>men</u> about family planning? **(DO NOT PROMPT. CIRCLE NUMBER IN APPROPRIATE ROWS)** **ASK ONLY IF MENTIONED**, Why did they work well? ***(Probe for available time, literacy, exposure, barriers to access, appeal, etc.)***	
		Why did they work?		Why did they work?
Sammi	1		1	
Television	2		2	
Short videos	3		3	
Radio	4		4	
Newspapers	5		5	
Poster, billboards, flyers, etc.	6		6	
Home visits from LHW/CHW (IPC toolkit)	7		7	
CSG or VHC meetings (IPC toolkit)	8		8	
Public events	9		9	
Other **(SPECIFY)**	10		10	

Now I'd like to ask about the sources of information that did not work well for reaching men and women.

	32. Which sources do you think did not work for reaching <u>women</u> about family planning? **(DO NOT PROMPT. CIRCLE NUMBER IN APPROPRIATE ROWS)** **ASK ONLY IF MENTIONED**, Why did they work well? ***(Probe for available time, literacy, exposure, barriers to access, appeal, etc.)***		33. Which sources do you think did not work for reaching <u>men</u> about family planning? **(DO NOT PROMPT. CIRCLE NUMBER IN APPROPRIATE ROWS)** **ASK ONLY IF MENTIONED**, Why did they work well? ***(Probe for available time, literacy, exposure, barriers to access, appeal, etc.)***	
		Why did they not work?		Why did they not work?
Sammi	1		1	
Television	2		2	
Short videos	3		3	
Radio	4		4	
Newspapers	5		5	
Poster, billboards, flyers, etc.	6		6	
Home visits from LHW/CHW (IPC toolkit)	7		7	
CSG or VHC meetings (IPC toolkit)	8		8	
Public events	9		9	
Other **(SPECIFY)**	10		10	

34. Why is family planning important to you? **(*Probe to understand the respondent's rationale for family planning. Examples may include economic, social, health, religious, etc.*)**

35. In your opinion, why is family planning important your spouse? **(*Probe to understand the respondent's rationale for family planning. Examples may include economic, social, health, religious, etc.*)**

36. In your opinion, why is family planning important other members of your family? **(*Probe to understand the respondent's rationale for family planning. Examples may include economic, social, health, religious, etc.*)**

Health Communications Component Evaluation
Individual Interview Instrument for LHW/CHW/LHS

1. Date **(D/M/Y)**:
2. Interviewer name **(PERSON INTERVIEWING)**: _____
3. Note taker name **(PERSON TAKING NOTES)**: _____
4. Interview location **(UNION COUNCIL):** _____
5. UC type **(CIRCLE ONE)**:
    a. Rural
    b. Urban
6. Interview location **(DISTRICT):** _____
7. Interviewee type **(CIRCLE ONE NUMBER)**
    a. LHWs
    b. CHWs
    c. LHS
8. **IF OTHER PEOPLE ATTEND THE INTERVIEW, RECORD THEIR NAMES AND TITLES HERE**
9. Interviewee name 1: _____
10. Interviewee name 2: _____
11. Interviewee name 3: _____
12. Interviewee name 4: _____

My name is _____, my partner is named _____. I work for a research organization that is assessing the impact of recent health communication interventions in Sindh. We would like to ask you a few questions. This interview will take approximately 30-45 minutes to conduct.

Do I have your permission to record interview? **(CIRCLE ONE)**

1. Yes
2. No

1. For how long have you been working as a [**ASK AS APPROPRIATE,** lady health worker, community health worker, lady health supervisor] _____ years,_____months

2. What do you do as a [**ASK AS APPROPRIATE,** lady health worker, community health worker, lady health supervisor]?

3. For how long have you been involved with HCC: _____ years, _____ months

4. What, if any, capacity building training have you received from the HCC project? ***(Probe to capture all – type, duration, number of trainings)***

Type of training	Duration/intensity	Number of trainings on this topic

5. What did you like about the training? ***(Probe for duration, methods, trainers, etc.)***

6. What did you not like about the training? ***(Probe for duration, methods, trainers, etc.)***

7. Have you used the HCC interpersonal communication toolkit? **(CIRCLE ONE NUMBER)**

   1 Yes
   2 No .....**GO TO Q 9**

8. How, if at all, did the toolkit help you perform your job? Please give examples. ***(Probe for more effective communication, appeal to clients, etc.)***

9. Have you received any gender training from HCC? **(CIRCLE ONE NUMBER)**

   1 Yes
   2 No .....**GO TO Q 13**
   3 Don't know.....**GO TO Q 13**

10. What do you recall learning from the gender training?

11. Has the HCC gender training helped you promote family planning? **(CIRCLE ONE NUMBER)**

   1 Yes
   2 No .....**GO TO Q 13**

12. Please explain how. Give examples.

13. Were you trained on how to counsel men by HCC? **(CIRCLE ONE NUMBER)**

   1 Yes

2 No .....**GO TO Q 15**

14. Did the training help you learn how to communicate better with men? **(CIRCLE ONE NUMBER)**

1 Yes
2 No

15. Do the HCC materials have any specific messages for men? **(CIRCLE ONE NUMBER)**

1 Yes
2 No .....**GO TO Q 17**

16. During your home visits, who do you counsel on family planning? **(CIRCLE ALL NUMBERS THAT APPLY)**

1 Wives
2 Husbands
3 Mothers-in-law
4 Others **(SPECIFY)**_____

17. In your opinion what HCC activities **were most useful** for building your capacity to communicate about family planning with your clients? ***(Prompt for an explanation with specific examples)***

18. Do you believe your behavior change communication work has caused any increase in the number of family planning clients in the community? **(CIRCLE ONE NUMBER)**

1 Yes .....**GO TO Q 19**
2 No .....**GO TO Q 20**
3 Don't know .....**GO TO Q 21**

19. How do you think your behavior change communication work has contributed to increasing the number of family planning clients? Please explain, using examples. **THEN GO TO Q 21**

20. Why do you think your behavior change communication work has not increased the number of family planning clients in the community? *(Probe for limited access, affordability, ineffective, etc.)*

I'd like to ask you now about whether you intend to continue some of the activities that HCC supported after HCC ends.

21. Which HCC activities, if any, did you like most? **(CIRCLE ONE NUMBER)**
    1 Training
    2 IPC toolkit
    3 Community support group meetings
    4 Melas and other public events
    5 Videos shown on phones or tables (pilot on phones or
    6 Videos shown in groups as a campaign activity (Mohalla meeting)
    7 Village health committees
    8 Other **(SPECIFY)**_____
22. Why did you like this activity the most?
23. Which one did you like the least and why?

24. Which activities, if any, do you expect to continue after HCC ends?	25. What challenges, if any, do you expect to face continuing these activities and what would you need to overcome them?

26. Which activities, if any, do you **not** expect to continue after HCC ends?	27. Why do you not expect to continue these activities? *(Probe for support, cost, time, etc.)*

The next questions ask about accessing family planning services in your area and how, if at all, the behavior change communication activities helped address obstacles to accessing services.

28. In your opinion, what have been the greatest obstacles women and men in your area face accessing family planning services?
29. In your opinion, did the HCC-supported behavior change communication activities help to overcome these obstacles? **(CIRCLE ONE NUMBER)**

    1 Yes
    2 Partially
    3 No GO TO Q 31

30. Which obstacles did HCC-supported behavior change communication activities help you overcome and how? ***(Probe for examples)***

31. In your opinion, what best practices and/or innovations did the HCC program create that could be used to improve existing or future health communication programs? (Probe for examples)

Best practices and/or innovation identified?	Why is it important? How would it improve existing or future health communication program?

32. Which information sources do you think were most effective for reaching men and women and why do you think they were effective?
33. How do you think family planning-related behavior change communication programming could be improved in the future?

I'd like now to ask you some questions about your experience with how to communicate about family planning and maternal, newborn, and child health with different audiences. The first questions ask about the sources or mediums that are effective in reaching men and women.

34. What challenges, if any, have you experienced accessing or communicating with men to provide information about family planning and maternal, newborn, and child health?
35. Which sources of information are best for reaching men with information about family planning and maternal, newborn, and child health and why are these the best way to communicate with men?
36. What challenges, if any, have you experienced accessing or communicating with women to provide information about family planning and maternal, newborn, and child health?
37. Which sources of information are best for reaching women with information about family planning and maternal, newborn, and child health and why are these the best way to communicate with women?

These following questions ask about the messages that are effective in communicating with men and women, not the source of the message.

38. Do you think that the mass media campaign used different **<u>messages</u>** to reach men and women? **(CIRCLE ONE NUMBER)**

    1 Yes
    2 No GO TO Q 40
    3 Don't know **GO TO Q 40**

39. Please explain. What messages did it use for men and which did it use for women?
40. Which family planning messages do men and women like best, and why? (Probe for messages that work best with men and those that work best with women)
41. In your opinion or experience, have the family planning behavior change communication **<u>messages</u>** changed knowledge, attitudes, or practices about family planning in the broader community? **(CIRCLE ONE NUMBER IN EACH ROW)**

		Yes	No	Don't know
a	Knowledge	1	2	3
b	Attitudes	1	2	3
c	Practices	1	2	3

42. **IF YES TO KNOWLEDGE, ATTITUDES, OR PRACTICES**, How have knowledge/attitudes/practices changed for men and for women? What factors prevented change?

	Changes for men	Changes for women
Knowledge		
Attitudes		
Practices		

43. As a result of the messaging described above, do you believe there has been any change in demand for family planning services and methods in the communities? **(CIRCLE ONE NUMBER)**

1 Yes
2 No GO TO Q 45

44. For which services or products has demand changed? Has it increased or decreased? ***(Probe for changes in services and products)***
45. What, if any, factors other than family planning messages, do you think contribute to changing peoples' attitudes about family planning?
46. In your opinion, what do you feel are the most important family planning communication needs in the/your area, and why? ***(Focus on communication/ education needs not services/ supply side etc.)***

Most important family planning communication needs?	Why is it important?

Health Communications Component Evaluation
Implementing Partners and Sub Awardees Questionnaire

1. Date **(D/M/Y)**:_
2. Interviewer name **(PERSON INTERVIEWING)**: _____
3. Note taker name **(PERSON TAKING NOTES)**: _____
4. Interview location **(UNION COUNCIL):** _____
5. UC type (CIRCLE ONE):
    a. Rural
    b. Urban

6. Interview location **(DISTRICT):**_____
7. Interview type (CIRCLE ONE NUMBER)
    a. Group interview
    b. Individual interview

8. Interviewee type (CIRCLE ONE NUMBER)
    a. JHU-CCP Staff
    b. CCPP
    c. Mercy Corps.
    d. RSPN
    e. Other sub-awardee (Specify): _____

9. IF OTHER PEOPLE ATTEND THE INTERVIEW, RECORD THEIR NAMES AND TITLES HERE
10. Interviewee name 1: _____
11. Interviewee name 2: _____
12. Interviewee name 3: _____
13. Interviewee name 4: _____

My name is _____, my partner is named _. I work for a research organization that is assessing the impact of recent health communication interventions in Sindh. We would like to ask you a few questions. This interview will take approximately 30-45 minutes to conduct.

Do I have your permission to record interview? **(CIRCLE ONE)**

1. Yes
2. No

1. What is your designation and role in this organization?

2. For how long have you been involved with HCC? _____years, _____months

3. Please describe your organization's HCC capacity building activities with DOH, PWD, and the LHW program?

4. In your opinion did HCC improve DOH, PWD, and the LHW program capacity to **design** behavior change communication programming? **(CIRCLE ONE NUMBER IN EACH ROW)**

		Yes	No	Don't know
a	DoH	1	2	3
b	PWD	1	2	3
c	LHW Program	1	2	3

5. **IF YES**, How did it improve **design** capacity? Explain and give examples.

6. **IF NO**, Explain why not?

7. In your opinion did HCC improve DOH, the LHW program, and PWD capacity to **implement** behavior change communication programming? **(CIRCLE ONE NUMBER IN EACH ROW)**

		Yes	No	Don't know
a	DoH	1	2	3
b	PWD	1	2	3
c	LHW Program	1	2	3

8. **IF YES**, How did it improve **implementation** capacity? Explain and give examples.

9. **IF NO**, Explain why not?

10. In your opinion did HCC improve DOH, the LHW program, and PWD capacity to **evaluate** behavior change communication programming? **(CIRCLE ONE NUMBER IN EACH ROW)**

		Yes	No	Don't know
a	DoH	1	2	3
b	PWD	1	2	3
c	LHW Program	1	2	3

11. **IF YES**, How did it improve **evaluation** capacity? Explain and give examples.

12. **IF NO**, Explain why not?

13. In your opinion what were the most effective capacity building activities undertaken by the project? Please explain your answer? *(Probe for specific examples)*

14. In your opinion, can DoH and PWD design, implement, and evaluate their own behavior change communication programming without external support? **(CIRCLE ONE NUMBER IN EACH ROW)**

		Yes	No	Don't know
a	DoH	1	2	3
b	PWD	1	2	3
c	LHW Program	1	2	3

15. In your opinion, to what extent are HCC-supported behavior change communication capacity building activities with DOH and PWD likely to continue after HCC ends? **(CIRCLE ONE NUMBER)**

1	Fully	GO TO Q 17
2	Partially	**GO TO Q 16**
3	Not at all	**GO TO Q 16**
4	Don't know	**GO TO Q 18**

16. Please explain which activities are not likely to continue and why not. *(Probe for evidence or examples)*

17. What capacity-building activities are likely to continue? Please explain how these activities will continue without HCC support. *(Probe for organizational commitments to continue activities)*

18. Are there specific measures that have been put in place to sustain DOH and PWD behavior change communication activities after the HCC project ends? **(CIRCLE ONE NUMBER IN EACH ROW)**

		Yes	**No**	**Don't know**
a	DoH	1	2	3
b	PWD	1	2	3
c	LHW program	1	2	3

19. What specific measures have been put in place? **(ASK ONLY IF RELEVANT FROM Q 18. CIRCLE NUMBER OF ALL THAT APPLY IN EACH COLUMN)**

	DoH (a)	**PWD (b)**	**LHW program (c)**
Policies	1	1	1
Guidelines, SOPs	2	2	2
Coordination mechanisms with other organizations	3	3	3
Dedicated behavior change communication personnel	4	4	4
Dedicated behavior change communication funding	5	5	5
Other (**SPECIFY**)	6	6	6

20. What, if any, challenges did your organization face in implementing the HCC project with the PWD or DOH? How did you address these challenges?

21. Did your working relationship with PWD and DOH change over time because of the capacity building activities you conducted with them? **IF YES**, Please explain how the relationship changed.

22. What, if any, suggestions do you have to improve family planning behavior change communication-related programming with the government in the future?

Then next set of questions asks about HCC-supported formative research activities.

23. What, if any, formative research on spousal communication activities have you conducted under the HCC program? (**IF NONE, GO TO Q 29)**

24. Did you work with other organizations to conduct the formative research? **(CIRCLE ONE NUMBER)**

1	Yes	
2	No	GO TO Q 26
3	Don't know	**GO TO Q 26**

25. Who were these organizations and how were they engaged?

Organization	Mode and type of engagement

26. Did the formative research influence the design and implementation of the HCC-supported behavior change communication campaign? **(CIRLCE ONE NUMBER)**

1 Yes
2 No GO TO Q 29
3 Don't know **GO TO Q 29**

27. Please explain how formative research influenced design and implementation. Give examples.

GO TO Q 30

28. Please explain why the formative research did not influence design and implementation.

Now I'd like to ask about pre-testing activities.

29. What, if any, pre-testing activities took place under HCC to test family planning messages or communication materials? **(IF RESPONDENT DOES NOT KNOW OR WAS NOT INVOLVED GO TO Q 35)**

(Probe: what was pre-tested, who participated in the pre-testing, how was the pretesting conducted, how did you learn about the HCC pre-testing?)

Pretesting activity	What was pre-tested?	Who participated?

30. Who were these organizations and how were they engaged?

Organization	How organization was engaged

31. Did the pre-testing influence the design and implementation of the HCC family planning behavior change communication campaign? **(CIRCLE ONE NUMBER)**

1 Yes
2 No
3 Don't know

32. Please explain your answer, with examples.

33. Were the pre-testing results used by any other stakeholder/organization? **(CIRCLE ONE NUMBER)**

1 Yes
2 No
3 Don't know

34. Please explain your answer *(Probe: who used it, how was it used, any examples or evidence of its use?)*

35. Do you know how the Brightstar logo was developed? **(CIRCLE ONE NUMBER)**

1 Yes
2 No GO TO Q 37

36. Please describe the logo development process? (*Probe: Was the process collaborative, did it engage the public through focus groups or other pretesting?*)

37. In your opinion, what lessons emerged from the HCC program that could improve existing or future communication programming? *(Probe for examples)*

Lessons learned?	Why is it important? How will it improve future communication activities?

38. In your opinion, what best practices and/or innovations have been created by the HCC program that could improve existing or future communication programming? *(Probe for examples)*

Best practices and/or innovation created?	Why is it important? How will it improve future communication programming?

Now I'd like to talk about your perceptions of the reach and effectiveness of the behavior change communication campaign in the broader community. I'll ask first about the sources of information you believe worked best for reaching men and women.

	39. Which sources do you think were best for reaching women about family planning? **(DO NOT PROMPT. CIRCLE NUMBER IN APPROPRIATE ROWS)** **ASK ONLY IF MENTIONED**, Why did they work well? (Probe for available time, literacy, exposure, barriers to access, appeal, etc.)		40. Which sources do you think were best for reaching men about family planning? **(DO NOT PROMPT. CIRCLE NUMBER IN APPROPRIATE ROWS)** **ASK ONLY IF MENTIONED**, Why did they work well? (Probe for available time, literacy, exposure, barriers to access, appeal, etc.)	
		Why did they work?		Why did they work?
Sammi	1		1	
Television commercials	2		2	
Short videos	3		3	
Radio	4		4	
Newspapers	5		5	
Poster, billboards, flyers, calendar, etc.	6		6	
Home visits from LHW/CHW	7		7	
CSG or VHC meetings	8		8	
Public events	9		9	
Other **(SPECIFY)**	10		10	

Now I'd like to ask about the sources of information that did not work well for reaching men and women.

	41. Which sources do you think did not work for reaching <u>women</u> about family planning? **(DO NOT PROMPT. CIRCLE NUMBER IN APPROPRIATE ROWS)** **ASK ONLY IF MENTIONED**, Why did they work well? (Probe for available time, literacy, exposure, barriers to access, appeal, etc.)		42. Which sources do you think did not work for reaching <u>men</u> about family planning? **(DO NOT PROMPT. CIRCLE NUMBER IN APPROPRIATE ROWS)** **ASK ONLY IF MENTIONED**, Why did they work well? (Probe for available time, literacy, exposure, barriers to access, appeal, etc.)	
		Why did they not work?		Why did they not work?
Sammi	1		1	
Television commercials	2		2	
Short videos	3		3	
Radio	4		4	
Newspapers	5		5	
Poster, billboards, flyers, calendar, etc.	6		6	
Home visits from LHW/CHW	7		7	
CSG or VHC meetings	8		8	
Public events	9		9	
Other **(SPECIFY)**	10		10	

43. Do you think that the mass media campaign used different **<u>messages</u>** to reach men and women?

4 Yes
5 No GO TO Q 45
6 Don't know **GO TO Q 45**

44. Please explain, what messages did the campaign use to reach men and which did it use to reach women? *(Probe: which messages reached men better? Which reached women better and why?)*

45. How, if at all, did you attempt to measure changes in knowledge, attitudes, and practices. ***(Probe to make sure they answer about measuring outcomes. Ask for tools or other evidence)***

46. As a result of the messaging described above, do you believe there has been any change in demand for family planning services and products in the communities? **(CIRCLE ONE NUMBER)**

1 Yes
2 No GO TO Q 48

47. How do you believe demand has changed? What caused the change? *(Probe for evidence of changes in services and products)*

48. What, if any, factors other than family planning messages, do you think contribute to changing peoples' views about family planning?

49. In your opinion, what do you think are the most important family planning communication needs in the/your area, and why? ***(PROBE FOR MEDIUM AND MESSAGES) (FOCUS ON COMMUNICATION/ EDUCATION NEEDS NOT SERVICES/ SUPPLY SIDE ETC.)***

Most important FP communication needs?	Why is it important? (Probe for media source and messages)

Health Communications Component Evaluation
Individual Interviews with DoH, PWD, and LHW Program

1. Date **(D/M/Y)**: _____
2. Interviewer name **(PERSON INTERVIEWING)**:

   _____
3. Note taker name **(PERSON TAKING NOTES)**:

   _____
4. Interview location **(UNION COUNCIL):** _____
5. UC type **(CIRCLE ONE)**:
   a. Rural
   b. Urban
   c. Not Applicable
6. Interview location **(DISTRICT):** _____
7. Interview type **(CIRCLE ONE NUMBER)**
   a. Group interview
   b. Individual interview
8. Interviewee type **(CIRCLE ONE NUMBER)**
   a. DoH officials
   b. PWD officials
   c. LHW program staff
   d. Others **(ORGANIZATION/INDIVIDUAL):** _____
9. **IF OTHER PEOPLE ATTEND THE INTERVIEW, RECORD THEIR NAMES AND TITLES HERE**
10. Interviewee name 1: _____
11. Interviewee name 2: _____
12. Interviewee name 3: _____
13. Interviewee name 4: _____

My name is _____, my partner is named _____. I work for a research organization that is assessing the impact of recent health communication interventions in Sindh. We would like to ask you a few questions. This interview will take approximately 30-45 minutes to conduct.

Do I have your permission to record interview? **(CIRCLE ONE)**

3 Yes

4 No

1. What is your designation and role in the DoH, PWD, or LHW program?

2. How long have you been involved with HCC: _____years,_____months

3. Please describe your department's/program's interaction with HCC? *(Probe: When did it start? Who did you deal with? How did you communicate?)*

4. Does your department/program have a role or responsibility in designing, implementing, or evaluating family planning behavior change communication strategies or programs? **(CIRCLE ONE NUMBER)**

   1 Yes
   2 No .....**GO TO Q 6**
   3 Don't know .....**GO TO Q 6**

5. Please describe these roles and responsibilities? *(Probe: Is there a formal mandate? Is it for all three: design, implementation, and evaluation? Is it shared?)*

Activity	Role	Responsibility
a. Design		
b. Implementation		
c. Evaluation		

6. Did HCC play any role in building your department's/program's capacity? **(CIRCLE ONE NUMBER)**

   1 Yes
   2 No .....**GO TO Q 17**
   3 Don't know .....**GO TO Q 17**

7. Please describe the types of activities HCC used to build your department's/program's capacity. *(Probe capacity-building activities; the intensity of activities, e.g., a one-day training versus a more intensive training)*

8. In your opinion, what were the most effective capacity building activities undertaken by the HCC project to build capacity in your department/program? Please explain your answer? *(Probe for specific examples)*

9. In your opinion, did HCC change your department's/program's capacity to design, implement, and evaluate family planning- and maternal, newborn, and child health-related behavior change communication programming? **(CIRCLE ONE NUMBER IN EACH ROW)**

		Yes	No	Don't know	Not applicable
a	Design	1	2	3	4
b	Implement	1	2	3	4
c	Evaluate	1	2	3	4

10. **ASK AS APPROPRIATE TO THE RESPONSE TO QUESTION 9.** How did HCC change your department's/program's capacity to design, implement, and evaluate behavior change communication strategies and materials? *(Probe for before/after differences in capacity. What do they do differently now?)*

I'd like to talk now about whether you think your department or program is likely to continue behavior change activities after HCC ends.

11. Do you believe your department/program will continue designing, implementing, and evaluating behavior change communication activities after HCC ends? **(CIRCLE ONE NUMBER FOR DESIGNING, IMPLEMENTING, AND EVALUATING)**

		Yes	No	Don't know	Not applicable
a	Designing	1	2	3	4
b	Implementing	1	2	3	4
c	Evaluating	1	2	3	4

12. Please explain, why do you think your department /program **<u>will or will not</u>** continue designing, implementing, or evaluating behavior change communication activities after HCC ends. *(Probe for political will, cost, capacity, transfers, etc.)*

13. Has your department/program put any specific measures in place to sustain behavior change communication activities in the future?

1 Yes
2 No .....**GO TO Q 15**
3 Don't know .....**GO TO Q 15**

14. What measures specific measures have you put in place? **(CIRCLE NUMBERS OF ALL THAT APPLY)**

1 Policies
2 Guidelines, SOPs
3 Coordination mechanisms with other organizations
4 Dedicated SBCC personal
5 Dedicated SBCC funding
6 Other, specify _____
7 Other, specify _____
8 Other, specify _____
9 Other, specify _____

15. What if any, was the most useful support your department/program received from the HCC project and why was it useful?

16. What, if any, challenges did your department face in working with HCC? How, if at all, did you address these challenges?

17. What recommendations do you have to improve future family planning-related behavior change communication programming?

18. Are you aware of any research activities conducted under the HCC program?

    1 Yes
    2 No .....**GO TO Q 20**
    3 Don't know.....**GO TO Q 20**

19. Please describe these activities? *(Probe: look for answers in line with: pre-testing, formative research on spousal communication, 360 degree media report)*

20. Are you aware of the findings of the formative research on spousal communication conducted by JHU/CCP?

    1 Yes
    2 No .....**GO TO Q 25**
    3 Don't know .....**GO TO Q 25**

21. How did you learn about the findings of the formative research on spousal communication for family planning?

22. Did the formative research study on spousal communication or the 360 degree media report findings influence the design and implementation of the family planning-related behavior change communication campaign?

    1 Yes
    2 No .....**GO TO Q 24**
    3 Don't know .....**GO TO Q 24**

23. How did it influence design and implementation of the SBCC campaign? Give examples.

24. Did you participate in the formative research on spousal communication?

    1 Yes
    2 No

25. Are you aware of any pre-testing of communication materials or messages that took place through HCC?

    1 Yes
    2 No .....**GO TO Q 29**

26. Please describe the pre-test. What was pre-tested, who participated in the pre-testing, how was the pretesting conducted, how did you learn about this HCC pre-testing?

27. Did the pre-testing influence the design or implementation of the HCC-supported behavior change communication campaign? **(CIRCLE ONE NUMBER FOR DESIGN, IMPLEMENTATION, AND EVALUATION)**

		Yes	No	Don't know
a	Design	1	2	3
b	Implementation	1	2	3
c	Evaluation	1	2	3

28. **IF YES TO EITHER DESIGN, IMPLEMENTATION, OR EVALUATION**, How did it influence design, implementation, or evaluation. Explain and give examples**.** *(Probe: don't forget to ask about changes in messaging, target audience, media and audience interpretation, ask for examples of design and implementation).*

29. In your opinion, what, if any, lessons have been learned from HCC that could be used to improve existing or future health communication programs? *(Probe for examples)*

Lesson learned?	Why is it important? How will it improve existing or future communication programs?

30. In your opinion, what best practices and/or innovations have been developed by the HCC program that could be used to improve existing or future health communication programs? *(Probe for examples)*

Best practices and/or innovation identified?	Why is it important? How will it improve future communication programs?

31. Are you aware of the Brightstar campaign? If yes, which elements of the campaign do you recall? **(DO NOT PROMPT. TRY TO GET RESPONDENTS TO DIFFERENTIATE BETWEEN COMPONENTS.)**

1 Music video
2 Sammi drama series
3 TV commercials

4 Radio commercials
5 Animated public service announcement
6 Slogan
7 News supplements (separate section of newspaper)
8 Billboards

32. Which sources of information do you think were most effective for reaching [**men/women**]?	**33.** Why do you think they were effective?
Men	
Women	

34. Which sources of information do you think were least effective for reaching [**men/women**]?	**35.** Why do you think they were effective?
Men	
Women	

36. Please tell us what you thought about the quality and suitability of the educational materials and messages. **(PROBE FOR UNDERSTANDING OF MESSAGES, LANGUAGE, PICTURES).**

37. In your opinion or experience, have the family planning behavior change communication **messages** changed knowledge, attitudes, or practices about family planning in the broader community? **(CIRCLE ONE NUMBER IN EACH ROW)**

		Yes	**No**	**Don't know**
a	Knowledge	1	2	3
b	Attitudes	1	2	3
c	Practices	1	2	3

38. **IF YES TO KNOWLEDGE, ATTITUDES, OR PRACTICES**, How have knowledge/attitudes/practices changed for men and for women? What factors prevented change?

	Changes for men	**Changes for women**
Knowledge		
Attitudes		
Practices		

39. **IF YES TO KNOWLEDGE, ATTITUDES, <u>OR</u> PRACTICES**, When did you notice these changes? When did they begin? **(CIRCLE ONE NUMBER)**

1 3 months ago or less

2 Between 3 and 6 months ago

3 6 months to 1 year ago

4 More than 1 year ago

5 More than 2 years ago

40. As a result of the messaging described above, do you believe there has been any change in demand for family planning services and products in the communities?

3 Yes

4 No.....**GO TO Q 42**

41. How do you believe demand has changed? What caused the change? *(Probe for changes in services and products)*

42. What, if any, factors other than family planning messages, do you think contribute to changing peoples' attitudes about FP?

43. In your opinion, what do you feel are the most important family planning communication needs in the/your area, and why? *(Probe for medium and messages. Focus on communication/ education needs not services/ supply side etc.)*

Most important FP communication needs?	Why is it important? **(PROBE FOR MEDIA SOURCE AND MESSAGES)**

Health Communications Component Evaluation
Group Interviews with Journalists

1. Date **(D/M/Y)**: _____
2. Interviewer name **(PERSON INTERVIEWING)**: _____
3. Note taker name **(PERSON TAKING NOTES)**:_____
4. Interview location **(UNION COUNCIL):** _____
5. UC type **(CIRCLE ONE)**:
    a. Rural
    b. Urban
6. Interview location **(DISTRICT):** _____
7. Interview type **(CIRCLE ONE NUMBER)**
    a. Group interview
    b. Individual interview
8. Interviewee name 1: _____
9. Interviewee name 2: _____
10. Interviewee name 3: _____
11. Interviewee name 4: _____
12. Interviewee name 5: _____

My name is _____, my partner is named _____. I work for a research organization that is assessing the impact of recent health communication interventions in Sindh. We would like to ask you a few questions. This interview will take approximately 30-45 minutes to conduct.

Do I have your permission to record interview? **(CIRCLE ONE)**

5 Yes
6 No

13. When did you attend HCC training on family planning? **(ENTER NAME OF TRAINING COURSE AND YEAR AND MONTH PARTICIPANT TOOK THE COURSE)**

		When attended	
Journalist number	Name of training course	Year	Month

14. What was the training about?

15. Did you learn anything new? **(CIRCLE ONE NUMBER)**

1 Yes
2 No.....**GO TO Q 16**

16. Did you learn anything new? What did you learn?

17. Did you expand your reporting on family planning and maternal, newborn, and child health after attending this training? **(CIRCLE ONE NUMBER)**

1 Yes
2 No.....**GO TO Q 16**

18. If yes, How did your reporting expand? ***(Probe: frequency of filing, depth of stories, use of different media)***

19. If no, why hasn't your reporting on family planning expanded?

20. If your reporting hasn't expanded, what would cause you to expand your reporting of family planning and maternal, newborn, and child health?

21. Did the training improve your health reporting skills? **(CIRCLE ONE NUMBER)**

1 Yes
2 No.....**END INTERVIEW**

22. If yes, in what ways did it improve your health reporting? ***(Possible probes for change in understanding of issues, use of research and facts)***

ANNEX 7: CONFLICT OF INTEREST DECLARATIONS

Conflict of interest declarations have been removed to protect the personal information of team members. They are available for review by qualified parties at the MSI/PERFORM offices.

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