RBM Partnership
To End Malaria

Developing Monitoring and Evaluation Plans for Malaria Social and Behavior Change Programs: A Step-by-Step Guide

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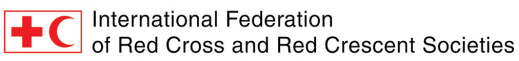
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Contents

Acronyms

ACT	Artemisinin-based combination therapy
HMIS	Health management information system
IRB	Institutional Review Board
ITN	Insecticide-treated nets
JHCCP	Johns Hopkins Center for Communication Programs
LMIS	Logistics management information systems
M&E	Monitoring and evaluation
RBM	Roll Back Malaria
SBC	Social and behavior change
SBCC	Social and behavior change communicat**ion**
SMS	Short message service
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

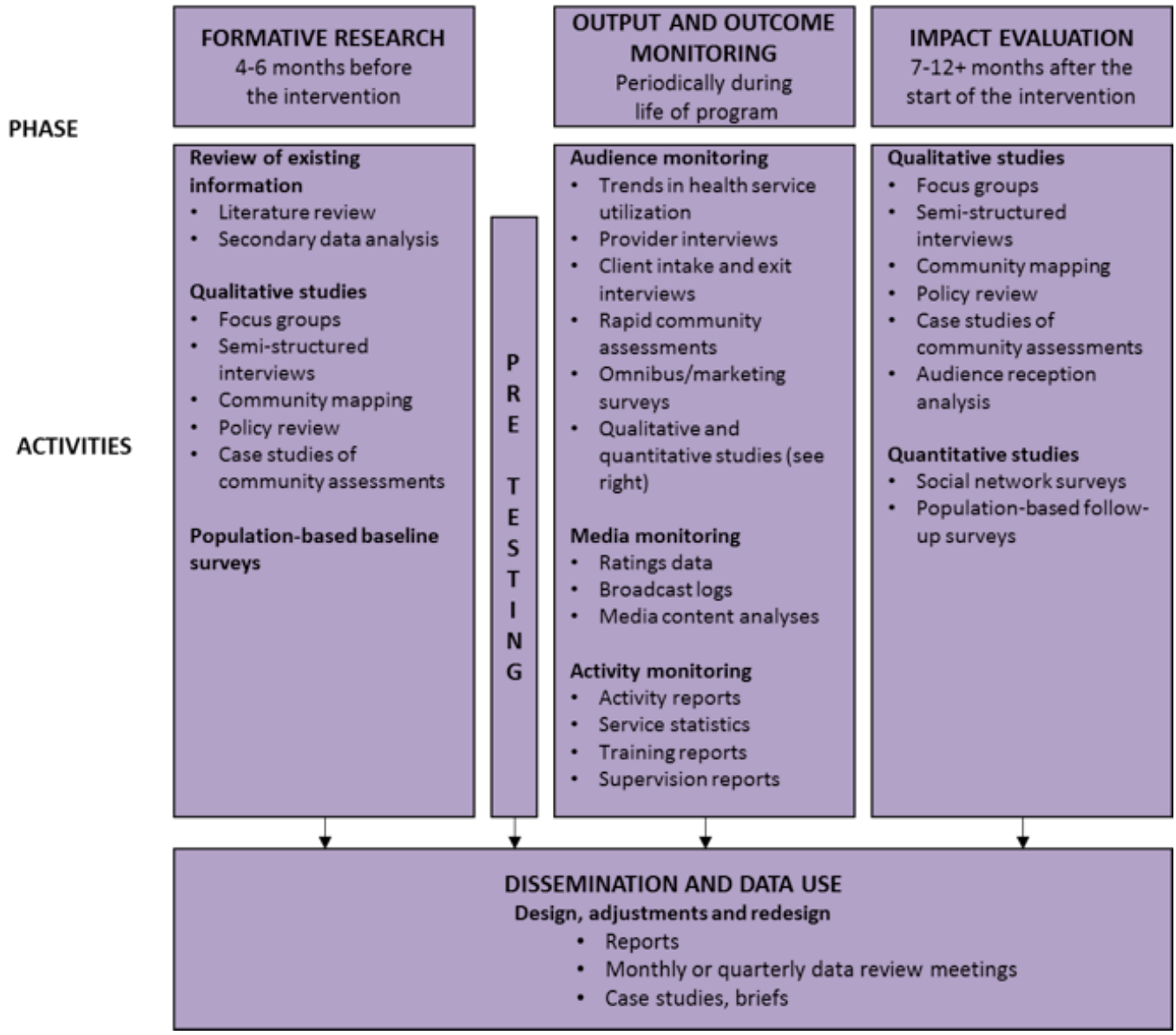
Introduction

Social and behavior change (SBC) is a vital part of malaria control programs; it helps ensure that communities seek prevention, diagnostic, and treatment services; and use drugs and long-lasting insecticide-treated nets (ITNs) properly.[1] To be successful, SBC programs need to encompass more than just the design and printing of materials. As Figure 1 shows, a comprehensive monitoring and evaluation (M&E) system must be the foundation of an SBC program.[2] Formative research and pretesting identify the context-specific barriers to behavioral and social change and ensures the target audiences accept the SBC materials and approaches. The SBC programs should be monitored to ensure they are implemented well and to track whether the desired changes are beginning to take effect. To maximize effectiveness, SBC programs need to be evaluated, so countries can learn from previous experiences and adapt proven strategies.

An M&E plan incorporates all the elements in Figure 1. It is a management tool that shows staff, donors, and stakeholders how the program will answer programmatic questions, demonstrate results, and be accountable for project resources. An M&E plan describes how the M&E system of the project should be run.[3] It communicates the process of monitoring, evaluating, analyzing, and using data; and it summarizes M&E-related deliverables, activities, timelines, and markers of progress. It should enable data to be collected and transformed into information that allows for evidence-based decision making at all stages of the program, ensuring that the SBC goals and objectives are systematically identified, addressed, and assessed.[4]

This document introduces the elements of an M&E plan for malaria SBC programs. It seeks to help countries and implementers draft strong M&E plans for SBC proposals and work plans, and to help staff manage SBC activities.

Figure 1. Monitoring and evaluation needs and data sources during the life of a malaria SBC program



Steps to Developing an M&E Plan

1. Assemble the team. During the planning process, identify a core team comprising M&E staff and SBC team members. The main purpose of the team is to consult stakeholders during the development of the plan. Following a consultative approach increases the chances of obtaining participation in M&E processes and securing resources for M&E.
2. Assess the information needs of SBC program managers, donors, the national malaria control program, and other stakeholders. The M&E plan should serve the practical information needs of its intended users.[5] The M&E team should participate in work planning and communication strategy discussions to ensure they understand the objectives of the campaign and its activities, and to identify what information stakeholders need to make decisions during the life of the program.
3. Identify, prioritize, and define indicators and data sources. Try to avoid duplication of data collection. Do not collect information that will not be used and build on existing systems instead of establishing a parallel system.[3]
4. Define what data products need to be developed, how often, and how they will be discussed and used.
5. Develop and cost a work plan for collecting data and disseminating data products. Ensure that data will be collected and used legally and ethically.[5]
6. Present the M&E plan to stakeholders, to ensure they are aware of the indicators being tracked, the targets, the data sources, how the data will be used, and their roles in implementing the plan. The M&E plan may affect where and how activities will be conducted (for example, the choice of implementation and comparison areas), so their buy-in will be key to its effective implementation.

Elements of an M&E Plan

The M&E plans are usually an annex or a companion document to the communication strategy. For this reason, the M&E plan will refer to and be based on the strategy.

Background

Situational analysis

The communication strategy document should include a full situational analysis; the M&E plan only summarizes this section. State the epidemiological problem—the burden of malaria (deaths, economic costs, prevalence), intensity of transmission, geography—and the country's policies and goals, in relation to the problem. Describe the key malaria behaviors involved and the related barriers. These barriers can include a lack of knowledge; social/cultural/religious norms; myths about malaria or the products and services in question; poor access to commodities or services; outdated, unclear, or incompletely implemented policies; and provider and caregiver attitudes. The situational analysis should cite findings from qualitative and quantitative assessments.

In many settings, more data will be needed to fully understand the context and determinants of the key malaria behaviors. The SBC programs often conduct formative research to provide this information. This activity can be described in the research and evaluation section of the M&E plan.

SBC program description

Describe the goals and objectives of the SBC campaign. If available, display the SBC programs' conceptual model. Describe the activities that will need monitoring and evaluation. In addition, make it a point to mention that SBC materials and activities will be pretested prior to rollout. Pretesting lets program managers know whether they are relevant, appropriate, understandable, and liked by the target audiences. Pretesting will also help maximize cost effectiveness; with a few audience tests, programs will be able to focus on materials and activities with the greatest potential effectiveness. Many SBC programs use M&E officers to facilitate pretesting sessions because of their skills in facilitating qualitative discussions, tabulating results, and preparing reports. They are also thought to be less biased toward specific materials, because they are not involved in actual materials development, unlike the design team.

Purpose of the M&E plan

This section states the purpose of the M&E plan:

- Contributes to the overall evaluation of the program by illustrating the connection between the program's objectives, activities, and results.
- Informs program managers of the need for refinement through timely assessments of activities compared to targets, and their contribution to the program's objectives.
- Describes how the M&E system of the project should be managed. It communicates the process of monitoring, evaluating, analyzing, and using data; and summarizes M&E-related deliverables, activities, timelines, and markers of progress.

Finally, for the core M&E team: A senior researcher or data analyst may be needed for research design and analysis, while M&E officers at different levels—for example, national and provincial—may be responsible for monitoring and data collection.

Conceptual Model or Framework

A conceptual model or framework can be used to illustrate the logical progression between activities and the expected results. This will provide a useful overview of the program and inform the M&E plan. For example, the model below suggests that the planned SBC program would be well served by a health facility assessment looking at provider and client behaviors, as well as changes in provider and client attitudes, client knowledge, and provider skills.[6]

Funding sources and institutions vary in their preferred style of models or frameworks. For those that prefer indicator frameworks, a generic one from the Malaria SBCC Indicator Reference Guide is provided below for adaptation.[7]

Figure 2. Conceptual model for an SBC program designed to increase malaria testing and adherence

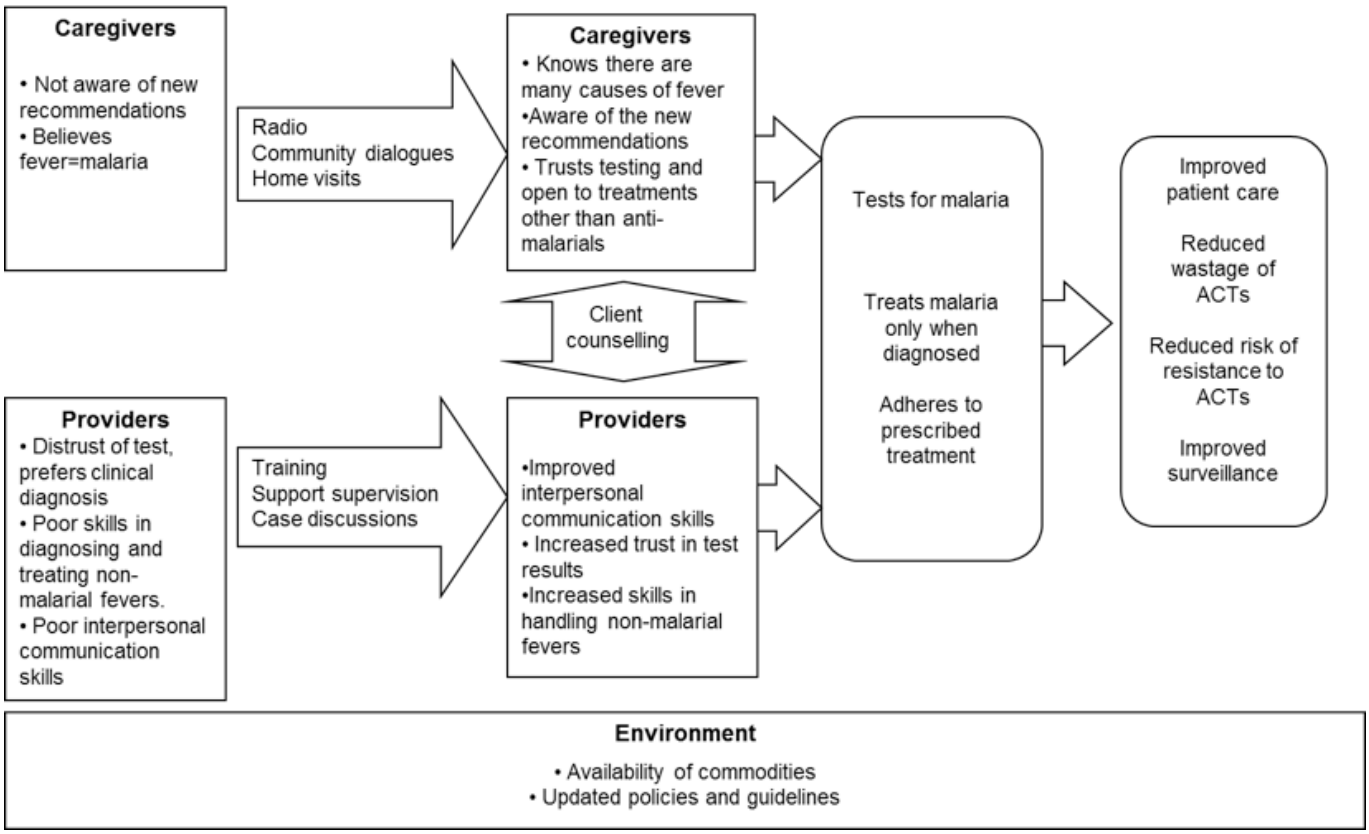
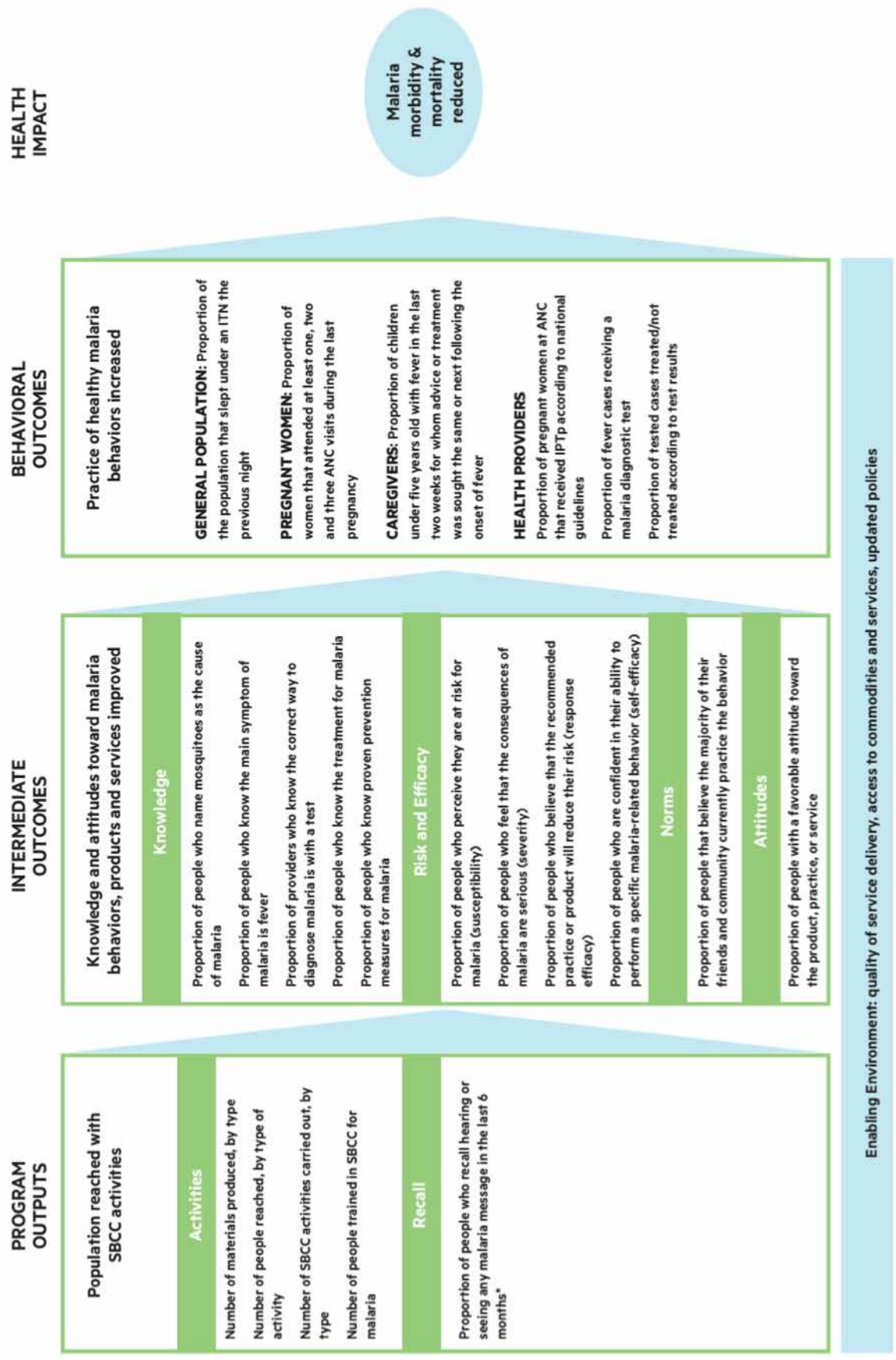


Figure 3. Generic indicator framework from the Malaria SBCC Indicator Reference Guide, showing the relationship between SBC program outputs to intermediate communication and behavioral outcomes



Indicators and Targets

Indicators show how programs measure progress toward a specific objective. Changes in behavior may take time and the methods required to quantitatively isolate the effects of SBC on behavior often require a high level of statistical capacity, as well as financial resources. This should not discourage programs. Instead, M&E plans for malaria SBC should include recall and intermediate outcomes—changes in knowledge, perceived risk and severity, self-efficacy, response efficacy, norms, and attitudes. These outcomes can all be measured, both as intervention monitoring to gauge how SBCC activities are received and to adjust programs, as needed; as well as to evaluate whether programs had the desired impact on the target population. Indicators can be found in *RBM's Malaria Social and Behavior Change Communication Indicator Reference Guide: Second Edition* (some are listed in the sample table below), and the National M&E plan.[7]

Targets provide a concrete measure by which to judge whether the SBC program is progressing as it should. One should select targets based on baseline results, past trends, expert opinion, research results, and the team's understanding of the capacity of the system to change in the given time period. [5] Programs should set targets that are on the aspirational end of achievable. Expecting to reach 80 percent rates of a behavior when it is 30 percent at baseline is rarely realistic.

Table 1. Illustrative indicators for an SBC campaign designed to increase net use in the dry season

Sample Indicators	Data Source	Frequency	Target
Behavioral Outcomes			
Proportion of people who practice the recommended behavior (specifically the ITN use-to-access ratio, defined as, "the proportion of the population using nets, among those people who have access to one within their household")			
Intermediate outcomes			
Proportion of people who name only mosquitoes as the cause of malaria			
Proportion of people with misconceptions about effective malaria prevention practices			
Proportion of people who perceive they are at risk from malaria			
Proportion of people who feel consequences of malaria are serious			
Proportion of people who believe that the recommended practice or product will reduce their risk (such as net use in the dry season)			
Proportion of people who are confident in their ability to perform a specific malaria-related behavior (a such as net use in the dry season)			
Proportion of people who believe the majority of their friends and community members currently practice the behavior			
Proportion of people with a favorable attitude toward the product, service, or behavior (such as net use in the dry season)			
Reach			
Proportion of people who recall hearing or seeing any malaria messages within the last six months			
Proportion of people who recall hearing or seeing specific malaria messages (about net use), in the past 6 months			
Proportion of people who recall hearing or seeing a message through communication channel "X" (reported by each specific communication channel)			
Program Outputs			
Number of SBCC activities carried out, by type			
Number of people reached, by type of activity and type of individual			
Number of materials produced, by type and target audience			
Number of people trained, by type and topic			

Monitoring Plan

Monitoring gives stakeholders a general idea of the program's progress toward its targets, enabling them to make mid-course corrections to SBC activities. Monitoring is also helpful for sustaining program activities, particularly when fiscal planning takes places one or more years in advance. Monitoring data allows donors and program teams to secure funds to ensure the program can be replicated or continued with minimum interruption. Finally, SBC monitoring can help inform future programs, because it can help document the elements that are key to success. [7]

Within this section, describe the sources of monitoring data and how often these data will be collected. Make sure to monitor both activities and audiences, and state how the data quality will be assured. Finally, describe how data flows up the system, where it is stored, and who is responsible for it. A database that can store project data and generate summaries may be needed.

Table 2. Sample monitoring and data source table

Data Source	Frequency of Collection	Persons Responsible
Activity reports and quotes from audiences	Continuous	Community health workers submit to field supervisors for verification and logging into project database.
Media monitoring reports	Monthly	Monitoring agency submits to SBC manager. SBC manager sends data to M&E assistant to add to project database.
Omnibus surveys	Quarterly	Agency sends preliminary report to SBC manager. Agency also submits data to M&E manager for analysis.
Health facility exit interviews and observations	Bi-annually	Research advisor supervises design, data collection, and analysis.

Activity monitoring: To what extent were activities completed as planned?

- **Real-time monitoring** typically uses mobile phones and tablets to collect and analyze data quickly. Interactive short message service (SMS) reminders to health workers or community health workers can be sent and their responses can be automatically analyzed and visualized to track indicators, such as number of referrals, completion of fever or malaria in pregnancy referrals, stockouts, number of community dialogues or home visits conducted, among others. Problems, such as failure to meet quotas, stockouts, or non-responsiveness can be flagged for supervisors to follow up. Free and low-cost platforms are available and data quality checks are automated.[8]
- **Activity report forms** provide information on trainings and community mobilization activities to track how many activities were conducted and how many people participated. The SBC program needs to create a system for collecting these forms regularly from implementers and checking to ensure they are filled out correctly. Mobile reporting, supervision visits, and data review meetings can bolster these channels.
- **Media monitoring reports** are created by third-party agencies who track which radio or TV materials are being aired, at what time, and how often. This allows the program to negotiate "make goods" or airings to make up for under-broadcasting. When media monitoring services are not available, **broadcast logs** can be requested from stations. Station logs can be verified by having community-based listeners also listen to and log the dates and times of broadcasts.

Audience monitoring: Are we reaching our target audiences? Are there early indications of changes?

- **Mobile phone surveys** can be used to collect data from respondents in areas with high mobile penetration. They can be used for both evaluations, as well as for monitoring. Numbers can be randomly dialed from a national list of phone numbers; respondents can be screened for age, gender, and geographic locale with opening questions. However, the number of questions that can be asked via this method is limited (about 16 and at most 50). Past experience in Ghana found that while this method succeeded at reaching its sample size targets for urban, educated, and male populations, it was unable to do so for pregnant women and caregivers of children under 5; this can be a major drawback for malaria programs, which have historically targeted those two groups.[9]
- **Dipstick surveys** use qualitative or mixed method approaches to assess reach, perceptions of adopters versus non-adopters, and perceptions of the campaign. In Uganda, where they have been more commonly used for malaria SBC, dipstick surveys are conducted twice a year and include focus groups with urban, rural, males, and females; key informant interviews with providers, district health teams, and adopters and non-adopters; and quantitative surveys with adopters and non-adopters. The survey sample sizes are not powered to provide district-level estimates, but the overall methodology is useful for gauging audience response and gleaning additional insights for strengthening the campaign. [10]
- **Omnibus surveys** are regularly occurring large surveys conducted by marketing firms. Firms charge for each question added to the survey. Omnibus surveys can be used to track exposure to key messages and attitudes over time. They occur frequently, questions are inexpensive, and a national- or regional-level sample can be obtained. Unfortunately, they are often biased toward urban areas and their sampling methods are not as robust as household surveys.[8]
- **Health management information system (HMIS)/logistics management information systems (LMIS)** can be helpful for tracking service use, like intermittent preventive treatment in pregnancy (IPTp), testing, treatment, and providing ITNs at the facility or community level. Some countries have indicators for number or percentage of patients provided with family planning or HIV counseling; or number of health education sessions on a given topic; similar indicators can be adopted for malaria.
- **Health facility exit surveys and client-provider observations** can be an excellent tool for SBC programs that include improving quality of care and interpersonal communication training for health providers. However, it's expensive to conduct them in a large number of facilities or more frequently than annually; it is not possible to generalize the results to all health facilities [8]. In Nigeria, confidential SMS surveys have also been

used to obtain client feedback on health services.[8]

- **Media content analyses** are used to track the level of discussion around a topic. For example, a malaria advocacy project might use this to determine how often politicians are shown as engaged in malaria-related activities or making supportive statements about malaria funding.[8] Similarly, social media channels, such as Facebook and Twitter, can be monitored to identify trending complaints, misconceptions, or influencers. Third-party services can set up real-time alerts for key words or combinations of words.[8]

- **Complexity-aware methods** can be used, such as Outcome Harvesting and Most Significant Change. The M&E plans focused only on tracking the direct relationship between outputs, outcomes, and impact may fail to identify unintended outcomes (positive or negative), alternative explanations (such as other actors or events), or indirect outcomes. Complexity aware methods can assist with navigating these blind spots and they are helpful for situations when cause-and-effect relationships are uncertain; stakeholders bring diverse perspectives to the issue, making consensus impractical; or when contextual factors are likely to influence the type of and outcome of programming. Examples of recent applications include advocacy and capacity building. The Most Significant Change method involves collecting and analyzing stories from stakeholders about the most significant project outcomes, while Outcome Harvesting uses desk reviews and interviews to first identify what outcomes emerged and then working backward to determine whether and how an intervention contributed.[11, 12]

Of the audience monitoring methods described above, media content analyses and secondary analysis of HMIS or LMIS data are probably the least costly/effort because they mainly involve desk work with existing data sets. On the other hand, complexity aware methods will cost slightly more because skilled facilitators and stakeholder meetings are required; while mobile surveys, dipstick surveys, and exit interviews will cost significantly more because they require data collection and analysis. The last two will likely cost more than mobile phone surveys because of the fieldwork, but they also have greater potential for data quality control.

Research and Evaluation Plan

This section describes the studies planned and the research questions they are intended to address, including any needs assessments/ formative research activities; baseline, midline, and final evaluations; Operations Research studies; and secondary data sources, such as Malaria Indicator Surveys and Demographic Health Surveys. See the Research and Evaluation Toolkit for Malaria SBCC[13] for sample questions and operational guidance for qualitative and quantitative malaria SBC research.

Formative research

When not enough information is available to inform the design of the program, formative research may be needed. For SBC, the five goals for formative research are—

1. Identify the target population: Who is responsible for practicing the intended behavior? Who has influence over these people?
2. Identify the behaviors, perceptions, and information to promote: For example, what do net users in a targeted area know, think, and feel about caring for and repairing their nets?
3. Identify the factors that hinder or motivate them to practice the behavior.
4. Identify previous SBC programs that showed positive impact on similar audiences for similar issues.
5. Understand the media habits of the audience and identify what channels they can access, use, and trust.

Conducting formative research includes reviewing the existing information using literature reviews or secondary data analysis, determining your goals and objectives for the intervention, then collecting and analyzing qualitative and/or quantitative data to better understand the audience and proper framing of the SBC messaging.

For detailed information on how to conduct formative research, see Module 2, Formative Research for SBC: Do You Know Your Audience? from Evidence-based Malaria SBC: From Theory to Program Evaluation.[14]

Evaluations

Evaluations for SBC need to answer two questions: (1) Was the program effective? and (2) How did it work? The SBC program messages influence behaviors indirectly through knowledge, attitudes, and beliefs that drive behavioral decisions. Understanding the specific attitudes through which messages affected behavior is important because this helps take the lessons from a successful program and applies them elsewhere.

Evaluators of SBC programs generally agree that there is no one perfect design for evaluating SBC programs. However, it is acknowledged that although randomization of individuals, facilities, or communities to control—or intervention groups—provides compelling evidence of effectiveness, it is often not practical for SBC programs. Many campaigns are designed for maximum reach and it is often difficult to prevent contamination in control areas. [15, 16] Even if the program does not fully cover an area or use mass media, messages may be diffused when individuals exposed to the messages communicate this health information to their family and friends, or to travelers who enter the study area. In fact, this diffusion is desired, and even encouraged, as SBC interventions encourage audiences to share the messages with friends and family. Furthermore, it may not be financially feasible to randomly assign communities to interventions or control groups. The number of communities that would need to be included in a randomized control trial—to ensure that randomization results in equivalent exposed and controlled groups—would need to be very large. [17]

Another design commonly used in public health involves comparing changes in the desired outcome between the baseline and endline surveys. This design assumes that everyone in the endline survey is exposed to the intervention. This is not realistic when communities today listen to many radio stations and access many types of media. Moreover, it is difficult to separate the effects of the SBC activities from other influences on behavior. For example, an influx of commodities like artemisinin-based combination therapy (ACTs) and tests may have led to a significant increase in cases being tested and treated for malaria. Finally, it is directed mainly to learn whether a program worked and has limited ability to assess how it worked or why it did not work.

One powerful way to establish a strong link between exposure

and behavior is to use self-reported exposure to SBC messages in household surveys to construct the groups of exposed and unexposed individuals. In this approach, a series of questions in a household survey are constructed to ask each respondent about their exposure to SBC messages and to specific program elements, such as logos and slogans. For example, the Malaria Indicator Survey now asks two questions:

a. In the past six months, have you seen or heard any messages about malaria?

b. Have you seen or heard these messages
   - On the radio?
   - On the television?
   - On a poster or billboard?
   - From a community health worker?
   - At a community event?

In the analysis, the responses to these survey questions are then used to categorize individuals as either exposed or unexposed to the program messages. This approach more precisely matches the randomization approach of defining the groups based on their exposure to an intervention. Although in this approach, membership in the exposed and unexposed groups are defined by the individuals, based on their recall of prior exposure to the messages, instead of randomly allocating individuals to groups prior to the intervention, as in an randomized control trial. Propensity score matching can then be used to create statistically matched control groups, based on known confounders—such as age, education, sex, and rural or urban residence. A sensitivity analysis can be applied to test the effect of unmeasured confounders, helping ensure that all key confounders are controlled. Finally, mediation analysis enables researchers to test the extent to which specific changes in knowledge and attitudes can be mapped and linked to behavior change. Altogether, this combined analytical approach, called multivariate causal attribution, makes it possible to draw a valid causal inference about how much behavior change can be attributed to the communication campaign and how the program worked.[18–20]

For detailed information on how to conduct evaluations for malaria SBC programs, see Module 5, Evaluating Social and Behavior Change Communication from Evidence-based Malaria SBC: From Theory to Program Evaluation.[14]

Research considerations

Evaluations take a long time to implement. They should be planned from the beginning of the program, and the evaluation questions and methods should be set before activities begin. Sometimes, project activities are designed based on evaluation questions. For example, specific catchment areas or facilities may receive certain activities while others do not. Establishing this linkage between evaluation questions and program design at the outset allows the project to make a judicious use of resources.

In addition, the Institutional Review Board (IRB) and donors may need to vet the research activities. IRBs review the research plan and data collection tools to ensure that human subjects are not harmed, and their approval is especially recommended if the study addresses sensitive issues, covers a large scale, or if the results will be broadly published or disseminated. The IRB process can take up to a year or more from the start of developing the study protocol to the final approval, so allow adequate time—start early.

Data Use and Knowledge Management

Collecting data is important, but using data to communicate results and to manage the program is the most important part of M&E. Each SBC program should plan to create appropriate data products and timely feedback loops for each key audience. Involving stakeholders in the development of the M&E plan helps the team identify the key deliverables that the M&E team will need to help generate and when. Data use products should also feed into the program's knowledge management processes, creating content for toolkits, discussion forums, trainings, websites, and others.

Table 3. Sample table of research activities

Study	Purpose/Research Question	Design	Timing	Geographic Scope	Lead
Formative research on net care and repair behaviors	To understand audience's views around net care and repair and identify motivators and barriers to practicing net care and repair behaviors.	Qualitative study using key informant interviews and direct observation	Year 1	Intervention district only	Partner A
Health facility survey	To assess access to malaria services and commodities and perceived quality of care among caregivers of children under 5 with febrile illness.	Repeated cross- sectional survey design, with facility audit, exit interviews, and direct observations	Years 1, 3, and 5	In 12 project districts, two per region, approximately 235 facilities	Partner C
Malaria Indicator Survey	To monitor population-level trends in net use, care-seeking, malaria testing, and treatment, and malaria prevalence.	Population-based household survey	Years 1 and 4	National	NMCP

Table 4. Data use for SBC programs

Program Stage and Audience	Decisions Involved	Data Products Needed
Design		
Implementing partners, creative/ad agency, government representatives	What audiences, messages, and materials should be used in the SBC strategy	Presentation during the strategy design workshop featuring formative research and literature review results
BCC design team (ad agency, SBC manager)		Pretest report
Implementation		
Program management team; donor	Adjustments needed to contracts and budgets, number and type of planned activities for the next reporting period; how to make up for airings, areas or audiences skipped	Monthly and/or quarterly reports showing, against targets: activities conducted or airings completed, trends in service utilization or sales; results from omnibus or rapid assessments Quarterly and annual review meetings
Evaluation and re-design		
Program management team, donors, technical partners, government representatives	Whether to scale up the program; what variations of the program to fund or test in the future; whether similar programs should be discontinued	Case studies Presentations to technical working groups Technical guidance notes Toolkits (SBC and training materials, supervision and M&E tools, etc.) Funding proposals
Policymakers		Policy briefs Publications

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Annex A: Budget

The budget for the SBC program should include money and personnel for M&E activities. The program may require access to at least one senior M&E person or consultant with experience in designing research on SBC. It will also need one or more junior M&E staffers who can assist with collecting and managing data. The budget should also allow for printing the M&E forms; software for tracking program activities; software for data analysis; data review and dissemination meetings; fieldwork for data collection and supervision; and layout and dissemination for data use products like case studies, policy briefs, research reports and publications, guides, and project reports. Because of the wide range of contextual factors and data collection activities that affect costs, Table 5 does not suggest specific amounts for each activity, but, instead, provides a complete list of budget items to be factored into the budgeting process. The research and evaluation toolkit has sample budget amounts for specific line items.[13]

Table 5. Sample budget items for M&E of SBC activities

M&E Area	Illustrative Activities	Budget Items
Development of M&E plan	Meetings between M&E and SBC staff	Staff time
Situational analysis	Literature review Formative research	Staff time Researcher or data analyst fees Per diem, lodging and transport for data collectors Data entry assistants or hardware Data management and analysis software
Pretesting	Concept testing Pretesting or posttesting	Staff time Per diem, lodging and transport for traveling to audience sites Venue and refreshments for participants Mockups of SBC materials to be tested
Monitoring	Media monitoring Activity reports Data quality meetings Omnibus or mobile surveys Exit interviews HMIS data review	Staff time Media monitoring agency fees Per diem, lodging and transport for supervisors Database software and/or development
Evaluation	Household survey	Staff time Researcher or data analyst fees Per diem, lodging and transport for data collectors Data entry assistants or hardware Data management and analysis software
Data use	Data review meetings Case studies Reports Policy briefs Presentations	Staff time Writer or editor fees Meeting venue, refreshments, travel expenses Layout, translation, and printing Journal publication fees