A conversation with the Johns Hopkins Center for Communication Programs, June 20, 2017

Participants

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Note: These notes were compiled by GiveWell and give an overview of the major points made by CCP.

Summary

GiveWell spoke with CCP (https://ccp.jhu.edu) as part of its investigation into potential family planning giving opportunities. Conversation topics included CCP's family planning activities, funding, potential for scaling up, and monitoring and evaluation, with a focus on its work in Nigeria.

CCP

Background

CCP was founded in 1988 and has at various times worked in over 30 countries, including the Philippines, the Democratic Republic of the Congo (DRC), Indonesia, Egypt, and Nigeria. Initially, most of its activities focused on family planning, but they subsequently evolved to include HIV/AIDS, malaria, water and hygiene, emerging infectious and neglected diseases, child and maternal health and nutrition.

CCP describes its work as follows:

"CCP designs communication solutions that solve public health problems. It was established over 30 years ago in recognition of the pivotal role communication plays in the way people think and behave about health and development issues. CCP is a Center within the Department of Health, Behavior and Society at the Johns Hopkins Bloomberg School of Public Health. It has active programs and staff in more than 35 countries and in the U.S. Its core strengths include:

- Social and behavior change communication – to influence social norms and individual health behaviors
- Knowledge Management – to put correct, concise and timely information into the hands of health providers
- Capacity Strengthening – of communication professionals at all levels, in all types of organizations

- Research and Evaluation – to build the evidence base for our work and our field."

Budget and room for growth

CCP's annual expenditure is approximately $100 million, of which family planning and HIV/AIDS receive about $20-25 million each. CCP's capacity to absorb more funds is fairly large, especially if spread over a number of countries.

While investment in family planning is generally increasing, investment in communication for family planning (and other health areas) tends to be less well funded than other health interventions. One possible use of additional money is therefore expanding behavior change communication into francophone African countries, such as the Ouagadougou Partnership countries and the DRC, which tend to receive relatively little attention.

Nigeria

Funding and scale

CCP's family planning programs in Nigeria have expanded to new locations as additional funding becomes available. The Nigerian Urban Reproductive Health Initiative (NURHI) began in 2009 with a grant from the Bill & Melinda Gates Foundation of $39 million over five years in six cities. The Foundation gave some additional funds after that, and an investor provided a further $10 million over three years for programs in two states. $600,000 over three years was also given to support just the radio portion of work in one of the states, to great effect.

The Gates Foundation then provided an additional $18 million for NURHI over five years, but reduced the number of locations. The very populous Lagos State was added, but funding for two other states was discontinued, as part of the Foundation's overall strategy in Nigeria.

Contraception promotion activities

CCP's contraception work in the initial six NURHI cities comprised three integrated components:

- Service delivery
- Advocacy
- Communication and demand generation

Service delivery

CCP's main service delivery interventions were:

- Clinical training for service providers, especially in the use of long-acting reversible contraceptives (LARCs). Many clinicians' training is out of date and they are not confident in recommending and providing some methods.
- Introduction of interpersonal and counseling skills training and support, including tools such as client brochures, flipcharts, videos of counseling

vignettes, and a smart phone application for downloading standard practice guidelines. The program works to reduce existing bias in the provision of certain methods for certain types of client.

CCP's work focused on public sector clinical sites with a large number of clients. However, the program also worked with some private facilities, such as patent medicine vendors and pharmacies. Those did not receive the same level of clinical skills training, but a Family Planning Provider Network was set up in each city to improve the referral system.

Other service-related activities included:

- Improving the supply of commodities and basic consumables, as well as some other factors related to service quality, to ensure that people could access the full range of contraceptive methods.
- Using mobile services to deliver services to poorly-served areas, and mobilizing community groups prior to arrival to ensure high uptake. This was part of CCP's effort to take a client and consumer perspective, and proved to be very successful.

Advocacy

CCP-supported advocacy groups advocated for state and local budgets to include family planning, and persuaded religious, traditional, and political leaders to speak publicly about the topic. Advocacy coalitions were organized in and around the cities in which CCP worked to establish their own objectives and strategies.

Communication

Demand for contraception had been low prior to CCP's work, largely because most people were unaware of it, concerned about side effects, or used ineffective methods. The demand generation campaign, called "Get It Together," aimed to communicate about family planning in an accessible way and get people in all parts of society talking about the subject.

CCP investigated where people got their information, such as what shows they watched on television and heard on the radio and what kind of information was available through those channels. Based on that, each state or city formulated a communication plan comprising activities with enhanced family planning content, including:

- Print, radio, and television advertisements.
- A radio serial drama, adapted to each of the cities, with a call-in component, and listening groups based on the program.
- A very popular song with two of the biggest artists in Nigeria, which received well over two million views on YouTube.
- Training community mobilizers to reach people directly, such as in hair salons and barber shops.

Partners

In every country in which it works, CCP aims to ground its work in local cultures and networks, and create a critical mass of expertise. Local partners are given a wide variety of technical assistance but ultimately take responsibility for implementation. This helps ensure that programs are driven by the needs and sensitivities of the local population.

For the NURHI project, CCP provided technical leadership for all of the activities, including financial management and overall campaign strategy. There were local teams of CCP employees in each state in which it worked. The main partner was CCP Nigeria (CCPN), a local organization that CCP helped establish around 10 years ago. CCPN is a locally registered independent non-governmental organization (NGO). It has grown rapidly over the last few years.

Other partners included:

- The Association for Reproductive and Family Health (ARFH), which works out of a university and supported a lot of the clinical training.
- Marie Stopes International, which assisted with some service delivery.
- The Development Communications Network (DevCom) and the African Radio Drama Association (ARDA), which supported the radio programs.

Monitoring and evaluation

CCP's work with NURHI has produced the best and most recent evidence of program effectiveness, including data from cost-effectiveness and impact evaluations by the Measurement, Learning & Evaluation (MLE) project, an independent initiative funded by the Bill & Melinda Gates Foundation. CCP also conducts substantial research, monitoring, and evaluation of its family planning work in other places, including the DRC, Indonesia, and Egypt.

Study designs

It is challenging to use randomized controlled trials (RCTs) to measure program impact, given the nature of CCP-supported initiatives. CCP aims to have a population-level impact by reaching the broadest audience possible; RCT designs are not feasible for such programs because there can be no randomly assigned control group. In addition, local community conditions are typically so variable that identifying valid comparison groups is difficult, reducing the validity of quasi-experimental field designs. Nevertheless, CCP has occasionally used some treatment-control designs where appropriate, usually on a localized scale to test specific aspects of a program. For example, under NURHI, CCP received a supplemental grant to conduct operations research on the concept of "gateway factors." The Gates Foundation wanted to know whether there were any behaviors that, if changed at an early stage, would have a catalytic effect on multiple subsequent behaviors, since many of these programs address multiple reproductive, maternal, newborn, and child health (RMNCH) outcomes. A field experiment in Ilorin, the state capital of Kwara in western Nigeria, built on a series of other studies

indicating that two early stage behaviors encourage good birth practices: spousal communication and proactive communication with antenatal care providers to help mothers prepare for safe delivery and encourage high quality postnatal care (breastfeeding, immunizations, and hygiene). Treatment and comparison communities were assigned to receive or not receive a community-based spousal communication and antenatal care (ANC) intervention. Post-intervention measurement found significant differences in the number of RMNCH behaviors in treatment communities among women who were exposed to the combination of communication and ANC activities.

However, CCP more commonly uses post-hoc statistical techniques, such as propensity score matching and tests for endogeneity to approximate the counterfactual conditions that RCT designs are known for but which are inappropriate for evaluating full-coverage programs. These studies examine "dose response" within intervention regions. That is, despite efforts to reach everyone, there is always variation in the degree to which the program reaches different populations; some people have no exposure at all to the program, for a variety of reasons. The difference in outcomes among these groups can be analyzed, controlling for the factors that predict exposure, such as access to media, distance from facilities, literacy level, and wealth quintile.

In addition to these types of evidence, other compelling data about the NURHI program also come from the national Demographic and Health Surveys (DHSs), which are not project-specific evaluations but can reveal intervention effects. The difference in changes in contraceptive prevalence between places where the NURHI program did and did not have a presence is quite striking; in many states, contraceptive use was stable or declining, whereas it rose substantially in the NURHI intervention areas.

Metrics

CCP collects a wide range of data, including:

- Self-reported behaviors regarding family planning adoption and continuation (similar to those in the DHS).
- Service utilization rates, such as service traffic at health facilities and uptake of various kinds of family planning methods, both clinical and over-the-counter.
- Commodity supply and expenditures.

CCP is particularly interested in the mechanisms for these changes, even though donors do not always ask for such information. In order to inform the design of communication interventions and understand why people do or do not respond to social and behavior change programs, CCP also collects data on psychosocial determinants of behavior that are locally relevant in order to help explain behavioral decision making processes (time to adopt, choice of contraceptive method, continuation dynamics, etc.). While the main tool for these kinds of investigations is surveys, qualitative research is also conducted into these factors.

Where service delivery is part of the strategy, service quality is also examined. Indicators may include counseling techniques and materials, bias in counseling (one study compared bias between trained and untrained counselors), client-provider communication, supply levels, commodity availability, and infection control. For example, CCP's quality recognition initiatives beginning in the 1990s in Egypt and West Africa rated clinics and rewarded high performers with a special promotion effort that made their services more attractive to clients and increased service utilization.

All GiveWell conversations are available at http://www.givewell.org/conversations