

EVALUATING CAPACITY STRENGTHENING FOR SOCIAL AND BEHAVIOUR CHANGE COMMUNICATION THROUGH OUTCOME HARVESTING: INSIGHTS FROM ETHIOPIA, BANGLADESH, AND LIBERIA

Tilly A. Gurman
Grace Awantang
Lindsey Tyler Leslie
Ruchita V Pillai
Anna Helland
Rebecca Arnold
Betemarian A Tiruneh

Abstract

Global health projects, especially those that focus on social and behaviour change communication (SBCC) and/or capacity strengthening, have become increasingly more complex. Selecting appropriate ways to measure the success of these projects is especially challenging. Conventional evaluation approaches, which tend to focus solely on change among individuals, often fall short in capturing a complete picture in complex SBCC projects, especially those involving capacity strengthening of organisations and systems. Outcome Harvesting is an innovative and participatory evaluation approach which embraces, rather than ignores, complexity. The Health Communication Capacity Collaborative project (HC3) implemented Outcome Harvesting in three countries (Ethiopia, Bangladesh, Liberia) to evaluate capacity strengthening activities for improved SBCC. This article presents challenges regarding evaluating complex international SBCC projects, introduces Outcome Harvesting, summarises HC3's OH evaluations, and outlines useful insights for future SBCC-related OH evaluations.

Introduction

For years, global health programmes have sought to strengthen the capacity of individuals, organisations, and systems (LaFond et al., 2002). Capacity strengthening

can come in a variety of forms, including training individuals to enhance professional knowledge/skills, establishing processes that ensure the development of materials that adhere to certain quality standards, as well as building internal processes, systems, and structures to achieve optimal performance within and across organisations, institutions, and agencies. (See Table 1 for specific examples of capacity strengthening activities.) Capacity strengthening represents an investment in the long-term effectiveness and future sustainability of its beneficiaries' endeavors. Selecting ways to measure the success of capacity strengthening is especially challenging due to its inherent complexity—often occurring in evolving political/sociocultural contexts and incorporating multi-faceted components in order to affect change within individuals and across organisations/systems (James, 2001; Ebbesen et al., 2004).

Using conventional monitoring and evaluation (M&E) approaches to evaluate capacity strengthening pose three distinct challenges. First, conventional M&E approaches, especially those using survey methods, rely on sufficiently large sample sizes in order to reach statistical significance. While survey methods work when assessing change across large groups of individuals, in capacity strengthening interventions change may transpire at the organisation or system level. In these instances, the maximum sample size tends to be small. In these instances, employing survey methods would yield less meaningful and valid results (Ebbesen et al., 2004). Similarly, the likelihood of staff turnover within organisations also poses a significant challenge to accurate and valid data collection for survey methods with repeat measures.

Second, the use of indicators for measuring change in capacity is problematic (Ebbesen et al., 2004). Although establishing quantitative indicators can often be helpful in measuring change over time, when assessing change within a single system or organisation, achieving a certain indicator target may be less meaningful. For example, consider an indicator of the number of policies approved. An increase from zero to one is only somewhat meaningful since the multiple victories that needed to happen along the way to achieve that policy are not captured by that single indicator. And in the case where the policy change does not occur but important steps towards a policy change do occur, the result for the above indicator would still be zero—not fully capturing that there were, in fact, multiple substantive programmatic successes achieved towards policy change. In other words, the total number of policies approved may be less important and instructive than the process whereby change occurred.

Third, complex interventions are dynamic and must often change and adapt over time due to the dynamic and evolving nature of the organisations and systems where they are implemented. As a result, initial M&E plans may not be relevant once the intervention has shifted and evolved to meet the specific local context (Ebbesen et al., 2004, Labonte and Laverack, 2001, Woodhill, 2010, Berwick, 2008). Moreover, the dynamic and evolving nature of capacity strengthening interventions is coupled with

the fact that achieving long-lasting change may require a long time (James, 2001; Ebbesen et al., 2004). Conventional evaluation study designs, such as experimental or quasi-experimental designs using baseline and endline surveys, assume a linear pathway to achieving change and are not flexible in terms of capturing change in light of program evolution over time (Berwick, 2008). Moreover, for many of the reasons highlighted above, these types of designs are often cost-prohibitive and logistically challenging to administer (LaFond et al., 2002; James, 2001).

The Health Communication Capacity Collaborative (HC3), a five-year project (2012–2017) implemented by the Johns Hopkins Center for Communication Programs (CCP) and funded by the United States Agency for International Development (USAID), investigated potential methods to evaluate its capacity strengthening efforts for improved social and behaviour change communication (SBCC). Of particular interest were complexity-aware evaluation methods (USAID, 2013; UNDP, 2013). HC3 ultimately selected Outcome Harvesting to evaluate its SBCC capacity strengthening efforts in three countries: Ethiopia, Bangladesh, and Liberia. Outcome Harvesting is a participatory qualitative monitoring and evaluation method which uses existing programme-related documentation to identify changes (referred to as outcomes) in the behaviour of a system, organisation or key individual(s). Some examples of outcomes include modifications in organisational policies/procedures, demonstration of the application of learned skills by individuals, as well as changes in regular coordination between actors within a particular system or organisation.

This paper introduces Outcome Harvesting and provides an overview of the HC3 experience in four segments. First, an overview of HC3 sets the contextual stage on which HC3 implemented and modified Outcome Harvesting. Second, an introduction to Outcome Harvesting describes HC3's rationale for choosing Outcome Harvesting. Third, a description of the general six-step implementation process for Outcome Harvesting highlights several modifications that HC3 incorporated. Finally, cross-cutting results and practical lessons learned from the HC3 experience provide helpful insights about applying Outcome Harvesting for international development projects implementing SBCC and/or capacity strengthening.

Overview of HC3 and Its Work in Ethiopia, Bangladesh, and Liberia

The HC3 project worked in over 30 low- and middle-income countries — including Ethiopia, Bangladesh, and Liberia — to strengthen country capacity to implement state-of-the-art SBCC. (See Table 1 for more details about HC3's efforts in these three countries.) HC3 focused on increasing the capacity of individuals, organisations, and systems to design, implement, manage, and evaluate SBCC. HC3's health areas of primary interest included HIV/AIDS, malaria, and Ebola, as well as reproductive, maternal, neonatal and child health.

Prior to HC3, CCP had operated in Ethiopia for over a decade in various multi-year HIV-related projects. HC3 Ethiopia's immediate predecessor, the ISHARE project (2010-2013), aimed to increase access to HIV/AIDS information among health professionals and the general public through the implementation of activities such as the national HIV/AIDS 952 Health Hotline as well as national and regional HIV/AIDS

resource centres (ARCs). Throughout the country, HIV/AIDS had been declining due to extensive SBCC efforts made by government and partner agencies. HC3 Ethiopia—which ran from March 2014 to September 2016—built upon the work of ISHARE and initiated the development of a health communication strategy designed to strengthen capacity to design and implement comprehensive SBCC. In addition, HC3 activities enhanced professionals' SBCC capacity and transferred existing HC3 mechanisms (e.g. 952 Health Hotline) to the public health sector. Fostering sustained SBCC capacity within the public health system and local implementing partners was critical in order to ensure lasting achievements across Ethiopia.

The Bangladesh Knowledge Management Initiative II (BKMI) which ran from October 2013 to October 2016 — built upon previous capacity strengthening work in Bangladesh conducted under USAID's flagship knowledge management project, Knowledge for Health (also known as K4Health). BKMI focused its capacity strengthening work on a variety of actors and activities within the Ministry of Health and Family Welfare (MoHFW). BKMI's overall capacity strengthening strategy for the MoHFW was to second SBCC staff to work closely with the three MoHFW units responsible for SBCC, as well as to introduce information, communication and technology tools, as appropriate, to facilitate knowledge management and promote harmonisation of SBCC messaging for all SBCC stakeholders. Creating and routinising processes and tools in the three MoHFW units was important due to the high level of turnover among government workers. Routinising processes and tools across MoHFW units could improve institutional memory and foster greater sustainability of programmatic efforts to ensure quality SBCC, regardless of current staffing at the MoHFW.

Unlike HC3 Ethiopia and BKMI, HC3 Liberia—which ran from October 2014 to February 2017—began as an emergency response project to support USAID's strategy to rapidly implement SBCC activities during the Ebola outbreak. A training and mentoring programme for Liberian journalists was a response to the fact that, throughout the country, Ebola had become a top newspaper headline and the central topic on the radio. The fellowship provided a unique opportunity to train and empower Liberian journalists to accurately report about the Ebola crisis as well as to investigate and mitigate rumors. As the number of Ebola cases decreased in early 2015, the national focus shifted toward health system rebuilding and strengthening. From 2015 to 2017, HC3 worked with three divisions within the Liberian Ministry of Health (MOH), and general community health volunteers (gCHVs) to support this shift. Providing technical input and mentoring to MOH divisions—including processes for better coordination/collaboration—and training gCHVs fostered the potential of quality health promotion in the future.

Overview of Outcome Harvesting

When it came time to evaluate its capacity strengthening endeavours, HC3 faced a challenge. HC3 initially piloted a conventional evaluation approach using

Table 1: Overview of Countries Where HC3 Implemented Outcome Harvesting

	Ethiopia	Bangladesh	Liberia
Project dates	March 2014–September-2016	October 2013–October 2016	October 2014–February 2017
Total funds	\$3.1 million	\$3 million	\$6.5 million
Primary audiences for capacity strengthening efforts	<ul style="list-style-type: none"> Federal and regional HIV/AIDS Programmes Control Office (HAPCO) HAPCO leaders and professionals US Government NGO partners 	<ul style="list-style-type: none"> Ministry of Health and Family Welfare (MoHFW) Behaviour Change Communication (BCC) Working Group 	<ul style="list-style-type: none"> Divisions within Ministry of Health (MoH) Journalists reporting on health-related topics General community health volunteers (gCHVs)
Key capacity strengthening activities	<ul style="list-style-type: none"> Trained HIV/AIDS leaders and professionals at federal and regional levels Assisted Federal Ministry of Health (FMoH) to assume ownership and management of National AIDS Resource Center (NARC) Advocated to government about importance of social and behaviour change communication (SBCC) Implemented SBCC mentoring programme for university students 	<ul style="list-style-type: none"> Seconded SBCC specialists to advise three MoHFW units that apply SBCC (Information, Education and Motivation [IEM], Bureau of Health Education [BHE], Institute of Public Health Nutrition [IPHN]) Worked with MoHFW units and others to build knowledge management platforms (e.g. digital archives of materials) and improve coordination and integration (e.g. development of cross-unit criteria for quality SBCC messages and materials) Developed digital SBCC tools and training activities for field workers and programme managers 	<ul style="list-style-type: none"> Revised Ebola hotline call center manual and trained call agents Implemented training and mentoring programme for journalists Conducted radio distance learning programme for gCHVs Strengthened MoH vetting and approval process for message/material development Engaged in technical assistance to National Health Promotion Division, Community Health Services Division, and Health Monitoring, Evaluation and Research Division within MoH

a baseline survey of organisational representatives and had plans to implement a similar end-of-project survey. HC3 realised, however, that this approach had three major pitfalls. First, the high possibility of staff turnover precluded that the same representative from an organisation would necessarily complete the survey at both time points—raising data validity concerns. Second, there was no determination as to whether or not the organisational representative that completed the survey had the most accurate and up-to-date knowledge about an organisation’s SBCC capacity. Third, survey methods would have likely underestimated effects and oversimplified

complexity, given that they would have failed to capture unexpected change that might have occurred. As a result, HC3 recognised the need to modify its evaluation approach for its capacity strengthening efforts. HC3 investigated a number of options, obtaining input from key HC3 staff in the three countries— Ethiopia, Bangladesh, and Liberia—where HC3 would conduct the evaluations. Ultimately, HC3 selected Outcome Harvesting.

Table 2: Sample Outcomes Harvested for HC3 Ethiopia, Bangladesh, and Liberia

Ethiopia (Total # outcomes: 37)	Bangladesh (Total # outcomes: 51)	Liberia (Total # outcomes: 39)
<p>Outcome Description: During 2015, the Federal Ministry of Health (FMOH) transferred the management, staff, and equipment of all National AIDS Resource Center (NARC) units from HC3 to the FMOH including the 952 Hotline and the previous radio programme unit.</p> <p>Importance: Demonstrated the potential for decreased dependence on external funding. Incorporation into the civil service/ government infrastructure allows for increased sustainability.</p>	<p>Outcome Description: In August 2016, the Bureau of Health Education (BHE), Information, Education and Motivation (IEM), and Institute of Public Health Nutrition (IPHN) units of the Ministry of Health and Family Welfare began allocating resources in their respective operational plans for SBCC capacity strengthening, advocacy, coordination, and digital resources (e.g. for eLearning Courses, Toolkits and Digital Archives).</p> <p>Importance: IEM had budgeted for SBCC capacity strengthening before, but they did not consistently use the funds for this purpose. Putting this in the budget reflects recognition that capacity strengthening for SBCC is important.</p>	<p>Outcome Description: Since October 2014, the Messages and Materials Development (MMD) and SBCC actors/partners adopted a more systematic approach for review and approval for vetting SBCC materials during MMD meetings.</p> <p>Importance: MMD working group partners bought into the MMD’s process of vetting SBCC materials, resulting in a more coordinated approach to creating SBCC messages and materials.</p>
	<p>Outcome Description: Since June 2014, a subgroup of the BCC Working Group, which includes the IEM, BHE, IPHN units, has been leading the process of collecting, compiling, tagging, vetting (with experts and with field workers), and uploading materials to the eToolkit for field workers.</p> <p>Importance: BKMI had previously been leading these processes. The capacity of the staff in three units has since been built, making it possible for each unit to update the eToolkits themselves.</p>	<p>Outcome Description: In July 2015, journalists who participated in the HC3 fellowship program for Ebola health reporting established a network of journalists, called Local Voices, and created a website as a platform for communicating on community issues on health and other topics and publishing their content.</p> <p>Importance: Local Voices gave journalists in Liberia access to a professional network and website to share their work. No such platform previously existed for journalists.</p>

Outcome Harvesting has gained recent attention as an innovative complexity-aware monitoring and evaluation method (USAID, 2013). Instead of a comparison

against pre-determined goals, Outcome Harvesting identifies positive or negative changes that occurred since the beginning of a project and works backward to assess the project's contribution to these outcomes (UNDP, 2013). An outcome details the who changed what, as well as where and when that change occurred. (See Table 2 for several examples of outcomes, and their importance, from each of the three HC3 countries.) Furthermore, Outcome Harvesting can capture intended and unintended outcomes and can be used alone or can complement other evaluation approaches (Wilson-Grau, 2012).

When choosing whether or not to apply Outcome Harvesting, four considerations arise. First, Outcome Harvesting works well to understand the process of change, not just a collection of results (Wilson-Grau, 2012). Second, Outcome Harvesting is well-suited when uncertainty exists regarding solutions to specific problems (Wilson-Grau, 2012; World Bank, 2014). Under these circumstances of uncertainty, there may be multiple, non-linear, or under-determined pathways to achieving expected change. Moreover, reliable quantitative indicators of programme effects may not exist (Ebbesen et al., 2004). Third, given Outcome Harvesting's participatory nature, it requires involvement from those most knowledgeable about potential outcomes (Wilson-Grau, 2012). Participation, either virtual or in-person, of such individuals throughout the process of identifying and vetting outcomes is essential to the success of Outcome Harvesting. Finally, implementing Outcome Harvesting is accessible to anyone with critical thinking skills and who is knowledgeable about the programme (or can gain that knowledge from reviewing programme documentation). In other words, although there are distinct steps to applying Outcome Harvesting, the ability to successfully implement it, is not reserved solely for individuals with expertise in research.

Six Steps to Implementing Outcome Harvesting

Implementing Outcome Harvesting includes six general steps that can be tailored to the unique needs of each project and context (Wilson-Grau, 2012). The HC3 evaluation team comprised five CCP headquarter staff who worked together to refine the evaluation process as well as analyse the data. Two to three members of the HC3 evaluation team conducted each country visit and worked with the local team to harvest outcomes. In adapting Outcome Harvesting, HC3 standardised data collection across countries and applied a rigorous process that captured change given the particular context. These adaptations helped ensure both internal utility and buy-in as well as external validity. Below are the six steps of Outcome Harvesting, as implemented by HC3.

Step 1: Design the outcome harvesting evaluation

During this initial step, the evaluation team and programme staff agreed on the overarching questions and overall focus of the evaluation. As mentioned above,

HC3's evaluation focused solely on its efforts in capacity strengthening for improved SBCC. Although this step could be conducted virtually via email, HC3 determined that real-time engagement, whether by phone or video, was valuable in order to expedite the process of answering questions and addressing any concerns. A key output from this step was the data collection instrument that the team later used when extracting data from existing programme documentation. Before moving to Step 2, the evaluation team solicited feedback on the evaluation design from key internal and external stakeholders.

Step 2: Review documentation and draft outcome descriptions

The evaluation team reviewed existing programme documentation from each country and drafted potential outcomes. Each outcome description detailed the specific change observed—who did what, when and where—and its importance, along with a brief explanation of HC3's contribution to the outcome. Throughout this and the next step, the evaluation team sought to clarify and refine the wording used to describe the outcomes. One modification made during this step was that HC3 inquired about the “importance” of each outcome as opposed to the “significance”—the term typically used in Outcome Harvesting. HC3 made this subtle adaptation to avoid internal critique of the qualitative method due to the potential connotation of the term “significance” which suggests application of quantitative statistical tests.

Step 3: Engage knowledgeable individuals to finalise outcome descriptions and begin internal verification of outcomes

Two to three HC3 evaluation team members worked with relevant programme staff and other individuals for each country to review, revise, and finalise outcomes. HC3 facilitated week-long in-country workshops to train HC3 field staff about Outcome Harvesting and to harvest outcomes. During this iterative step, the evaluation team also identified the need for additional documentation from the field staff in order to obtain sufficient detail to support each outcome.

The evaluation team made some modifications to the Outcome Harvesting process while finalizing outcome descriptions. First, although the evaluation team arrived with a list of potential outcomes identified from existing programme documentation, during the country visits they invited individuals (both internal and external to HC3) to contribute to this list. HC3 based this adaptation on the determination that the final list of outcomes would be more comprehensive with input from local partners knowledgeable about, yet external to, HC3. Moreover, since an outcome could be positive or negative, HC3 concluded that this modification would also increase external validity of the findings. Second, in addition to exploring HC3's contribution to each outcome, HC3 inquired about contributions from other actors and factors. This addition contextualised HC3's contributions in a more transparent manner.

Furthermore, it expanded the opportunity for internal reflection and learning.

A third modification to the Outcome Harvesting process occurred when verifying outcomes. For every finalised outcome, the HC3 evaluation team required internal and external verification that the description of the outcome as well as of HC3's contribution seemed plausible. Outcome Harvesting outlines that each project determines what percentage of outcomes should be verified ("substantiated" in Outcome Harvesting terms) according to specific programmatic needs and thresholds (Wilson-Grau 2012). HC3 determined, however, that in order to assure internal and external validity of the results, it would not be acceptable to verify only a subset of outcomes. Instead, HC3 concluded that its Outcome Harvesting evaluations would undergo a more exhaustive level of verification, requiring verification for all outcomes. In Step 3, the verification process focused on internal sources. HC3 project documentation (e.g. emails, meeting minutes, project reports, photos, videos) as well as individual HC3 staff willing to go on-record, served as internal sources of verification. For example, an outcome might state that the target of capacity strengthening activities adopted a recommended practice (e.g. chairing coordination meetings) since a certain month and year. During Step 3, team members would further discuss the outcome with in-country staff, confirming the project's contribution towards that outcome, defining the importance of the outcome, and locating internal programme documentation to validate the outcome. If the local team could not locate programme documentation in support of the outcome, then the outcome would not make the final list of outcomes,

Step 4: Verify outcomes externally

As introduced above, the evaluation team required an internal and external source of verification for every outcome. In Step 4, the focus was on external verification of outcomes. In Ethiopia, the evaluation team finalised all outcomes before verifying them externally with knowledgeable key informants who were familiar with the work of HC3 although not directly involved in the implementation process. In Bangladesh and Liberia, however, the internal and external verification of sources became more of an iterative process. For example, at times, an external source would propose slight modifications to an outcome or identify an additional outcome. In these instances, the evaluation team would revert back to the local HC3 staff to locate a source of internal verification of the revised outcome description/HC3 contribution. In all three countries, and in accordance to the Outcome Harvesting approach, a person could serve as an external source of verification if they were someone familiar with HC3's work but not directly involved in the implementation of the project. In addition, HC3 also allowed other sources of external verification (e.g. meeting minutes kept by external partners, written letters requesting training). Only outcomes that achieved both levels of verification were included in the list of final outcomes.

In all three countries, a consultant assisted with the external verification of outcomes. In Ethiopia, the consultant was a thought-leader in Outcome Harvesting, whereas in Bangladesh and Liberia, the evaluation team hired a local consultant. In all three countries, the consultant compiled internal verification documentation from the HC3 team and interviewed external key informants when another external source of documentation was not available. Whereas external verification with individuals in Ethiopia occurred over email for several outcomes, external verification in Bangladesh and Liberia occurred only in-person. Although Outcome Harvesting allows for engaging with informants using virtual communication, HC3 found that it was most time efficient to engage with informants face-to-face, hence the modification after Ethiopia. In-person interactions also allowed for deeper conversations about the programmatic context and importance of outcomes.

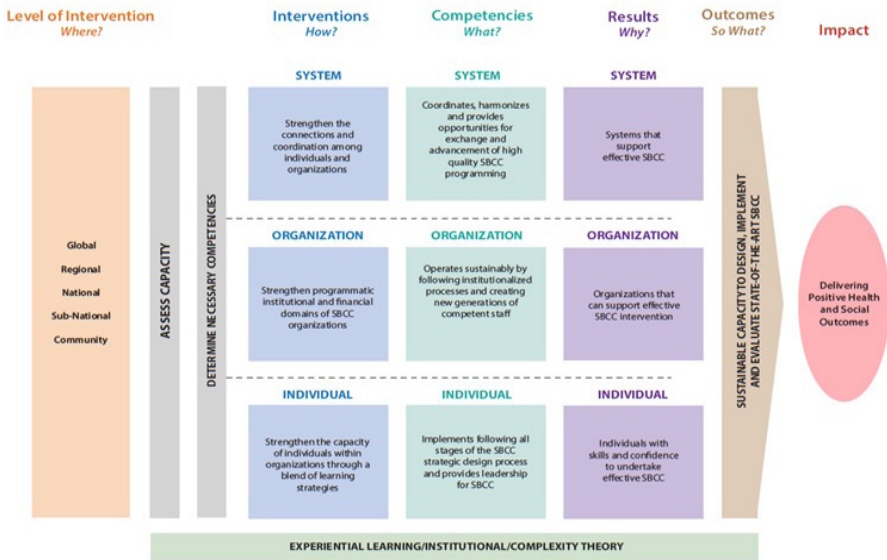


Figure 1: Social and Behaviour Change Communication (SBCC) Capacity Ecosystem Framework (HC3, 2016)

Step 5: Analyse and interpret

The evaluation team organised outcomes into categories of programmatic interest, getting feedback from the field staff along the way. One area of categorising the outcomes was by the official programme objectives. The evaluation team later classified outcome descriptions according to whether the change took place at the individual, organisation, or system level. The definition of these levels came from the SBCC Capacity Ecosystem Framework (see Figure 1), which HC3 developed in order to inform the design, implementation, and evaluation of capacity strengthening

Table 3: Sample Outcomes Harvested by the HC3 Project, by Country and by Level of the Social and Behavior Change Ecosystem Framework*

Ecosystem Level	Ethiopia	Bangladesh	Liberia
Individual	<ul style="list-style-type: none"> From April 1, 2014 to March 31, 2015, up to 173,000 callers failed to connect with the 952 Health Hotline (hang-up calls). 	<ul style="list-style-type: none"> Between June 2016 and August 24, 2016, 110 field workers completed the eLearning course and received a certificate. 	<ul style="list-style-type: none"> Between August and December 2016, community members and health-facility staff held joint meetings in at least six counties— Bong, Grand Bassa, Lofa, Margibi, Monsterrado and Nimba— and reported progress on action points for improving the relationship between the two groups.
Organisation	<ul style="list-style-type: none"> During the course of 2015, the Ethiopian National Archives and Library Agency (ENALA) incorporated the HC3 resource center into its operations. 	<ul style="list-style-type: none"> Since November 2014, the Information, Education and Motivation (IEM) unit of the Ministry of Health and Family Welfare (MOHFW) implemented two campaigns that were more systematic, more strategic and better coordinated than before. 	<ul style="list-style-type: none"> In September 2016, the National Health Promotion Division (NHPD) conducted a six-day design, development and pretesting workshop for its staff members to develop and pretest messages and materials for 14 different priority diseases. They revised and updated existing materials and identified gaps and developed new materials.
System	<ul style="list-style-type: none"> In May 2016, the Ministry of Civil Service granted approval to the Federal Ministry of Health to absorb the 952 Health Hotline and expand it from 41 to 69 counselors. 	<ul style="list-style-type: none"> Since July 2014, line directors from the three MOHFW units sign official letters—such as invitations and calls for materials—together. 	<ul style="list-style-type: none"> On September 30, 2016, the Ministry of Health (MOH) determined that the digital library for NHPD, which serves as a repository and a knowledge management platform for both MOH information and materials as well as partners' materials, will become a part of the MOH website, and MOH also allocated resources to update and maintain the website.

*Health Communication Capacity Collaborative (HC3). (2016). The Social Behaviour Change Communication Capacity Ecosystem™: A Model for Social and Behaviour Change Communication Capacity Strengthening. Johns Hopkins Center for Communication Programmes, Baltimore,

programmes for improved SBCC (HC3, 2016). This framework emphasises the inherently complex and often-unpredictable nature of capacity strengthening which can, and must, occur across multiple levels in order to achieve sustainable changes in country capacity for SBCC. In particular, the framework suggests that capacity

strengthening efforts for SBCC go beyond the individual level and influence change in the policies, procedures, and resources within organisations and systems (Health Communication Capacity Collaborative, 2016). Table 3 provides example outcomes from each country by level of the SBCC Capacity Ecosystem Framework.

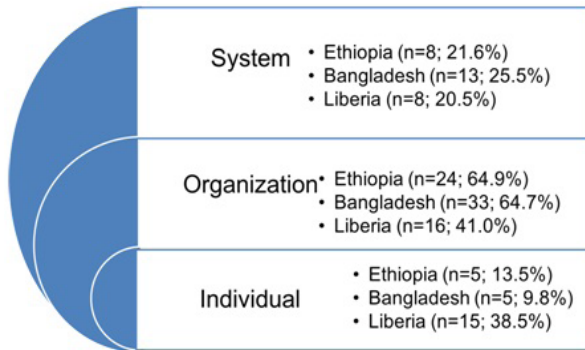
By analysing capacity strengthening outcomes according to these different levels, HC3 implicitly highlighted sustainability of efforts. HC3 decided to go one step further and assess sustainability more explicitly. In particular, the larger HC3 evaluation team assessed an outcome's potential for long-term sustainability by identifying changes in policy or practice. A policy change could describe a change in SBCC planning procedures or policy. Examples of policy changes include when ministries/agencies officially made funding allocations for SBCC and SBCC capacity strengthening activities. Another example is when ministries approved national SBCC strategies which described national priorities for future SBCC endeavors. A sustained shift in practice needed to have occurred repeatedly over the course of the project for at least six months prior to the evaluation. Examples of changes in practice include when new or newly revitalised SBCC working groups continued to meet on a regular basis without the coordination support of HC3.

Step 6: Support use of findings

In the final step, the evaluation team presented evaluation results to the country programme staff and other stakeholders. This presentation facilitated internal reflection about the implications and application of the findings. HC3 later shared insights from the process with USAID and presented results and lessons learned at global conferences, as well as incorporated findings into end-of-project reports and future work. For example, in Ethiopia, findings from the Outcome Harvesting evaluation guided the new project, Communication for Health, in making programmatic adjustments early-on to enhance capacity strengthening activities and bolster knowledge management practices.

Cross-cutting Insights from the Outcome Harvesting Evaluations

Overall, HC3's results demonstrated the value of investing in capacity strengthening. In addition, the use of Outcome Harvesting — an evaluation method that embraces the complexity inherent in SBCC and capacity strengthening — yielded four types of useful insights that would have, otherwise, likely been overlooked. First, HC3 demonstrated various types of change across individuals, organisations, and systems. Outcome Harvesting served especially valuable for demonstrating changes beyond individuals. Of the total 127 outcomes measured in the three countries, almost 58% (n=73) represented change within organisations (see Figure 2). In Bangladesh, in particular, the vast majority of its outcomes occurred within organisations (n=33;



*Health Communication Capacity Collaborative (HC3). (2016). The Social Behaviour Change Communication Capacity Ecosystem™: A Model for Social and Behaviour Change Communication Capacity Strengthening. Johns Hopkins Center for Communication Programs, Baltimore, MD.

Figure 2: Outcome Harvesting Results (n=127) According to the Social and Behaviour Change Capacity Strengthening Ecosystem*

64.7%) or systems (n=13; 25.5%). Had HC3 used more conventional evaluation approaches, which best measure change among individuals, it would have missed these important changes and underestimated the programmatic effect.

Second, through the Outcome Harvesting process, HC3 uncovered interesting outcomes that were not envisioned in the original objectives of the projects. For example, in Liberia, HC3 developed programme booklets to complement the information presented in its radio distance-learning programme for community health volunteers. The community health volunteers, however, viewed HC3’s booklets as a valuable health communication resource that could help them further their careers in health promotion, beyond that of being community health volunteers. Through Outcome Harvesting, HC3 discovered that some community health volunteers used their radio distance-learning programme booklets as a study guide for Community Health Assistant exams while other volunteers touted their completion of the distance-learning programme when applying for a position in a private health organization. In Ethiopia, Outcome Harvesting also documented a few unexpected negative outcomes where there was a greater demand for the national HIV hotline than there were telephone operators. The dearth of telephone operators led to an extended period where the national HIV hotline could not support the quantity of calls received on a daily basis. As a result, a considerable number of HIV hotline calls were left unanswered. These outcomes provided important internal learning about the process of transitioning the hotline from CCP to federal government ownership.

Third, through the assessment of sustainability, as defined above, HC3 captured a large subset of outcomes that indicated potential for long-lasting change. This reflective exercise prompted recognition of the key actions, important decisions, and critical steps taken during the project implementation cycle. For example, HC3 Ethiopia’s continued advocacy efforts facilitated the successful transition of HIV

hotline services to the national government. Although HC3 Ethiopia ended, the exercise of reflecting on sustainability provided valuable insight as to the future impact of HC3's programmatic efforts in SBCC capacity.

Finally, Outcome Harvesting allowed HC3 to map the evolution of change over time. Through Outcome Harvesting, HC3 identified a series of outcomes that occurred earlier in a project which culminated in additional and in some cases, more substantive outcomes. Outcomes that occurred earlier in a project were influential and often necessary steps that led to subsequent outcomes by project-end. By looking at outcomes over time, HC3 was able to paint a more compelling story of the pathways and processes to success.

Lessons Learned

Upon completing the Outcome Harvesting evaluation in three countries, HC3 evaluation team members worked with the leadership from the three HC3 field teams to identify lessons learned. A total of five lessons learned surfaced which can be applied in other global health settings when considering using Outcome Harvesting to evaluate SBCC, capacity strengthening, or otherwise complex programmes.

First, plan for Outcome Harvesting from the beginning of the project. In all three countries, Outcome Harvesting was implemented as an end-of-project evaluation, which made it difficult to incorporate the learning into future work within the same project. Field teams agreed that planning for Outcome Harvesting earlier in the project would allow the teams time to capture outcomes in a more systematic way. An important element of more systematic documentation earlier on would be to identify routine types of data collection (e.g. meeting minutes, meeting/training agendas, meeting attendance logs) and knowledge management processes that could support Outcome Harvesting. Establishing such a process would enable future harvests to quickly locate relevant information.

Earlier, and possibly more routine, implementation of Outcome Harvesting could also serve as a valuable addition to other monitoring activities and ultimately enhance more comprehensive documentation of project accomplishments. By conducting earlier and more frequent harvests, teams could check progress along the way and incorporate findings to continuously improve the programme. Teams could also build lessons learned from such harvests into ongoing discussions about progress, achievements, and challenges.

Second, consider the timing of the Outcome Harvesting in light of other planned activities. If the Outcome Harvesting coincides with competing activities, a project will want to account for additional time and resources in workplans and budgets. Implementing Outcome Harvesting at the end-of-project was challenging in all three HC3 evaluations because project close-out priorities competed for the staff time allocated to the evaluation. For example, in addition to HC3 closing in Ethiopia, the new Communication for Health project was simultaneously starting the

implementation of baseline research and other activities. Ultimately, other planned activities in each country shifted some level of staff availability and office resources away from the Outcome Harvesting evaluation. Earlier planning, as outlined in the lesson learned above, would also give teams an opportunity to coordinate Outcome Harvesting in light of other planned competing activities.

Third, use Outcome Harvesting to complement, not replace, other evaluation methods. Outcome Harvesting proved valuable for evaluating complex project activities and capturing capacity strengthening outcomes that other evaluation methods would overlook, especially outcomes occurring within organisations and systems. But Outcome Harvesting should not be seen as the end-all-be-all evaluation method. Outcome harvests should focus on outcomes that are not captured well by other evaluation methods (e.g. surveys). An evaluation strategy that includes Outcome Harvesting to assess complex aspects of a project and appropriately selects more conventional methods to evaluate other project aspects will result in a more comprehensive picture of success.

Fourth, train the local project team early on about the basic elements of Outcome Harvesting. When a project decides to implement Outcome Harvesting, it would be helpful to train the field team as early as possible about basic concepts of Outcome Harvesting. The basics include the definition and purpose of Outcome Harvesting, the difference between a programmatic outcome and output, the necessary level and detail of program documentation, and the six-step process to implementing the method. This initial training should be face-to-face but could be opportunistic, in terms of incorporating it with a planned trip to visit the field team. Training the project team earlier would be useful regardless whether the team will conduct Outcome Harvesting once or multiple times. Even if a project only plans to harvest outcomes at endline, understanding the method early on will enable the team to ensure better tracking of more appropriate programme documentation for harvesting. In the HC3 experience, the evaluation team trained field teams just prior to the beginning of the harvest, which, due to multiple circumstances, occurred at end-of-project. Projects that train the field team earlier on the process will need to develop and facilitate a shorter refresher training when it is time to harvest outcomes.

Fifth, plan sufficient time for both the in-person workshop and harvesting activities. As previously stated above, active participation by local partners throughout the process of identifying and evaluating outcomes is key to the success of Outcome Harvesting. Across all three HC3 Outcome Harvesting evaluations, engagement was most effective and efficient during face-to-face engagement. The HC3 approach of combining a single in-person training with the harvesting of outcomes required a minimum of ten working days per country (through Step 4 of the process outlined above). Although this amount of time may be somewhat of a challenge when dealing with competing demands on time, the dedicated time passes quickly when brainstorming and refining outcomes that have occurred, identifying and locating existing programme documentation (e.g. reports, meeting minutes/rosters) that verifies those changes, and determining the most appropriate external

sources of verification. In order to maximise the limited timeline, an evaluation team should start with a prepared matrix of preliminary outcomes extracted from available project documentation.

Conclusion

In debriefing with each country team about the insights gained when applying Outcome Harvesting, HC3 received similar concluding feedback across the three country projects. Outcome Harvesting represented a novel and valuable approach to evaluate complex global health situations and projects. In particular, Outcome Harvesting was helpful in identifying changes in capacity within complex organisations and systems — changes that are more difficult to capture using conventional M&E methods. The participatory nature of Outcome Harvesting was especially valuable as it imparted a sense of local ownership over the evaluation and provoked rich introspective discussion and learning. Moreover, HC3's application and adaptation of the Outcome Harvesting process, which included both internal and external verification of every outcome, ensured rigour and improved both the internal and external validity of the results.

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Tilly A. Gurman, DrPH, MPH, is a Senior Research and Evaluation Officer at the Johns Hopkins Center for Communication Programs (CCP). She is dedicated to using a mix of qualitative and quantitative methods to support rigorous, yet practical, research and has supported projects in various countries (e.g., Swaziland, Guatemala, Guinea, Dominican Republic). Email: tgurman@jhu.edu



Grace Awangtang, MPH, serves as Breakthrough ACTION's Monitoring and Evaluation Advisor at CCP. Her research at CCP has focused on using survey methods to identify priorities for SBCC programmes combatting malaria among children under five and pregnant women. Lindsey Tyler Leslie, MSPH, is a Programme Officer II at the CCP. She has worked in Central America, South Asia, and East Africa on multiple health areas, including Maternal and Child Health, Nutrition, Sexual and Reproductive Health, Water, Sanitation and Hygiene, and Zoonotic Diseases.



Lindsey Tyler Leslie, MSPH, is a Programme Officer II at the CCP. She has worked in Central America, South Asia, and East Africa on multiple health areas, including Maternal and Child Health, Nutrition, Sexual and Reproductive Health, Water, Sanitation and Hygiene, and Zoonotic Diseases. Under the HC3 project, she served as a member of the HC3 evaluation team that conducted Outcome Harvesting.

Collaborating Authors: Ruchita V Pillai, *Anna Helland*, Rebecca Arnold & Betemarian A Tiruneh