Malaria Partners Social and Behavior Change Self-Assessments

WABA 2 PMI Togo

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Breakthrough ACTION FOR SOCIAL & BEHAVIOR CHANGE

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Acronyms

BE	Behavioral Economics
CCP	Johns Hopkins Center for Communication Programs
HCD	Human Centered-Design
IEC	Information Education and Communication
IR	Intermediate Result
IRB	Institutional Review Board
M&E	Monitoring and Evaluation
NGO	Non-Government Organizations
NMP	National Malaria Program
SBC	Social and Behavior Change
SBCC	Social and Behavior Change Communication
USAID	United States Agency for International Development

Background

Breakthrough ACTION is an eight-year cooperative agreement from the United States Agency for International Development (USAID), mandated to lead the Agency's global social and behavior change (SBC) programming. Johns Hopkins Center for Communication Programs (CCP) implements the project in partnership with Save the Children, ideas42, Think Place USA, Camber Collective, Viamo, and the International Center for Research on Women.

With funding from USAID, Breakthrough ACTION will strengthen the capacity of the National Malaria Program (NMP) and implementing partners to coordinate, design, implement, monitor, and evaluate SBC programs and interventions. The project's mandate is articulated in two Intermediate Sub Results (IRs):

1. Sub-IR 2.1 Effective systems developed for ensuring the quality of SBC products and activities
2. Sub-IR 2.2: Evidence of SBC and applied learning shared

In support of Sub-IR 2.1, WABA 2 Togo, in cooperation with the NMP, facilitated malaria SBC capacity self-assessments with the 10 Togolese organizations.

Overview of malaria SBC capacity self-assessments

To understand the NMP and PMI implementing partners' current organizational experience and capacity to design, implement, monitor, and coordinate SBC programs related to malaria, WABA 2 facilitated malaria SBC capacity self-assessments with the NMP and nine implementing partners (most of whom are members of the newly formed malaria SBC technical working group). While this is a comprehensive measure of each organization's SBC capacity, the goal is not merely understanding where each organization stands. These sessions are inherently capacity-strengthening, as each organization is introduced to each element of SBC and given detailed descriptions of each level of capacity for each element assessed. The resulting understanding helps each organization determine areas for growth, and the workshop with the technical working group that directly followed the assessments provided a forum to showcase SBC resources that respond to identified needs.

The current iteration of Breakthrough ACTION's SBC capacity assessment tool builds on previous experiences in Nigeria, Nepal, Rwanda, South Sudan, Mozambique, Niger, and most recently Burundi. The tool has been streamlined to contain fewer questions that focus more on SBC than previous iterations (a narrower focus that did not take new approaches such as human-centered design, behavioral economics, or structural factors into account). Most notably, this latest methodology did not include self-assessments in groups, in a large workshop. Instead, to build rapport and ensure a more neutral, trusting atmosphere, WABA 2 met with each organization individually.

The desired result of these malaria SBC capacity self-assessments is to understand each organization's understanding of four SBC themes: Overarching SBC, defining the problem, designing and testing, and application.

SBC Mapping tool

The SBC capacity mapping tool is a structured, participatory process that allows organizations to assess their performance and select priorities based on their own goals and experiences.

Previous iterations of this tool used the Program for Organizational Growth, Resilience, and Sustainability for Social and Behavior Change Communication organizations (PROGRES-SBCC) tool, originally developed by Management Sciences for Health and adapted by the Health Communication Capacity Collaborative project. This tool has been further developed during the Breakthrough ACTION project and has been used to measure institutional SBC capacity in other countries in the Breakthrough ACTION portfolio.

Previous iterations of the tool included the following elements:

- Program Management
- Social and Behavior Change
- Advocacy
- Networking and Alliance Building
- Knowledge Management, Collaboration and Coordination
- External Communications
- Research, Monitoring and Evaluation

In consultation with Breakthrough ACTION colleagues who have implemented various previous iterations of SBC capacity assessments, and taking into account PMI feedback from the most recent SBC capacity assessment in Burundi, the WABA 2 team significantly streamlined and revised this tool.

In general, there remains some, but less emphasis on program management, and more focus on SBC.[1]There are no longer questions about advocacy. There is a question that articulates whether or not a program separates the role of an SBC officer and someone who might perform external communications functions (as this is often the case, and can be confusing and problematic), but otherwise, all other questions about external communications have been eliminated. (Communications, here, refers to public relations, and promotion of the organization.) Questions related to new approaches have been added, and there are now questions that delve into empathy, co-creation, prototyping, and involvement of intended audiences early and throughout various stages of problem identification and co-creation. The new malaria SBC capacity self-assessment tools include the following themes and sub-themes:

1. **Overarching SBC**
    a. Use of a systematic approach to program design
    b. Documentation of SBC strategy
    c. Costed work plans
    d. Strategic engagement to support stakeholders
    e. Networking and alliance-building
    f. Forming and participation in alliance-building platforms
    g. Staff capacity

[1] While advocacy is an important aspect of the SBC domain, it was not included in this assessment; previous teams that have deployed this tool found there is a great deal of confusion about differences between advocacy for resources at higher institutional and political levels, and social and behavior change approaches deployed to change community-level behaviors.

    h. Staff development
    i. Implementing and monitoring SBC solutions
    j. Using knowledge management
2. **Defining the problem**
    a. Use of information and knowledge to generate ideas
    b. Multidisciplinary co-creation and engagement
    c. Strategic engagement to define intent
    d. Audience segmentation
    e. Audience prioritization
    f. Deepening understanding and building empathy
    g. Application of behavioral theory
3. **Designing and testing**
    a. Co-creation of SBC interventions (ideation and scaling for impact)
    b. Design process with stakeholders
    c. Implementation planning
    d. Budgeting interventions
    e. Communication channel selection
4. **Application**
    a. Implementing and monitoring SBC solutions
    b. Mobilization and coordination
    c. Training
    d. Data utilization
    e. Evaluation and refinement of SBC solutions
    f. Adapting and scaling SBC solutions

Self-assessment process

Participant selection: In consultation with PMI and the NMP, Breakthrough ACTION identified a total of 10 organizations (including the NMP) that met the following criteria:

- An organization that implements malaria interventions,
- An organization that implements SBC activities in support of malaria interventions,
- A mix of partners representing all levels of coordination and implementation, from central coordination partners (NMP, Red Cross Togo, Catholic Relief Services (Global Fund Principal Recipient), to an international non-profit organization (Malaria Consortium), a foreign governmental organization (United States Peace Corps) and local non-governmental organizations (SAR, APEB, GRASE, RADAR, 3ASC),
- Local non-governmental organizations were chosen because of their implication in malaria SBC activities, identified by the NMP.

Preparation: The new capacity self-assessment tool was shared with PMI and the NMP. A week before the workshop, on September 18, Breakthrough ACTION and the NMP sent the terms of reference to participants that included the tool (a Microsoft Excel sheet with themes, questions, ideal responses, levels of capacity, and a column for scores and justification) and an outline of how the assessments would be conducted. Organizations were asked for a minimum of three to four participants, ideally

someone in a coordination role, someone in an M&E role, a financial officer, and an individual responsible for SBC.

Facilitation: Between October 1–9, two members of the WABA 2 team, Senior Program Officers Jeanne Madinde and Michael Toso, paid visits to the offices of six of the ten participating Organizations (NMP, Malaria Consortium, Peace Corps, Catholic Relief Services, Red Cross, RADAR), and facilitated virtual interviews with the four local NGOs located outside of Lomé (SAR, 3ASC, APEB, GRASE).[2] Each session took between three and three and a half hours.

Organizations were asked to have one of their staff share their screen and read questions while another individual took notes (this was observed in all but one instance, the only instance where there was a single individual present who performed both tasks). After each question, the WABA 2 team would provide clarifying context and answer participant questions. At the end of each session, participating partners were asked to review their scores and justifications internally, and submit a final version the following day. All organizations were then provided with a list of resources, organized according to the tool's themes, and a template for providing their lessons learned and identified SBC needs during the upcoming workshop. The workshop provided an opportunity to review and discuss aggregated results as well as to walk through resources in detail. During the workshop, two WhatsApp groups were created for the NMP and for implementing partners to continue sharing resources and foster the sharing of experiences and questions.

Mitigating response bias: While the WABA 2 team practiced and discussed how to facilitate the self-assessments uniformly, it was systematically necessary to intervene in several ways to ensure participants were providing accurate responses. The WABA 2 team mitigated participant response bias (desire to present themselves in a favorable light) in the following ways:

- At the outset, even having been assured that individual organization's scores would not be shared, most organizations began by scoring themselves with a perfect score. The WABA 2 team asked for examples of various criteria for each question and prodded for understanding of terms. After several such instances partners began scoring more modestly (anticipating being asked to provide examples and justification).
- Partners would often agree on their level of capacity, but in cases where this was level 1 (lowest level), they preferred to score themselves "at least a two". In these cases, the Breakthrough ACTION team would re-emphasize the anonymity of the scores, and assure participants the goal of the exercise is to help the organization identify their strengths and weaknesses. However, in the end, Breakthrough ACTION would not insist on a score: all organizations made final decisions. It is noteworthy that all organization scores improved (but not greatly) between the assessment session and the final email submission.
- Where it was clear, with explanations given, that the organization's score on a particular question was 1 or 2, Breakthrough ACTION facilitators would simply remind participants to record their justifications in the area provided. The team systematically probed for full understanding and specific examples in instances of a score of 3 or 4 (still reminding teams to

[2] While it would be ideal to visit all organizations face-to-face, a combination of reasons necessitated some virtual sessions. Distance from Lomé, budgetary constraints, conflicting schedules, and ongoing partner activities were taken in to account.

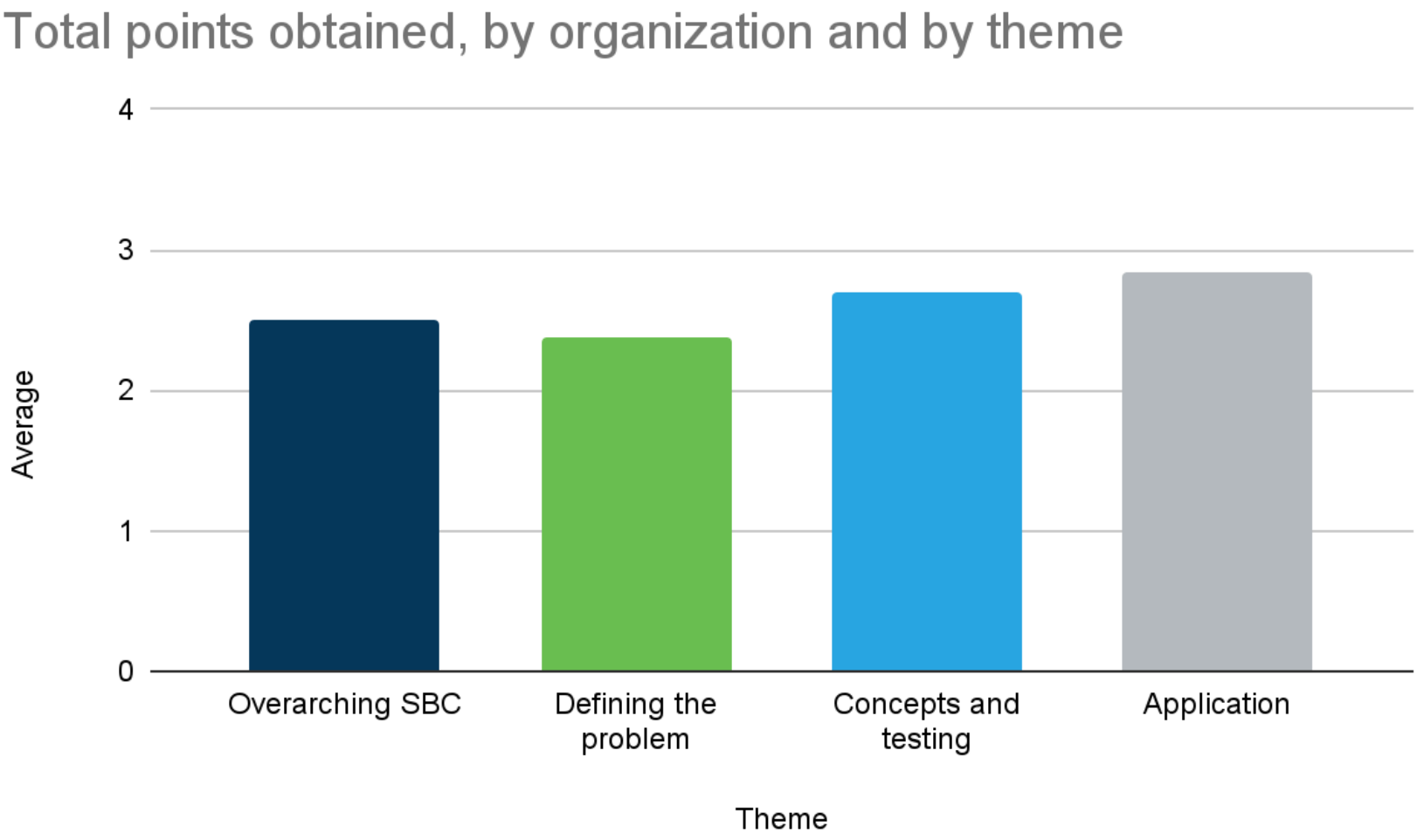
provide their justification in the notes). Often the nuances of the difference between the third and fourth level of capacity require detailed explanation.

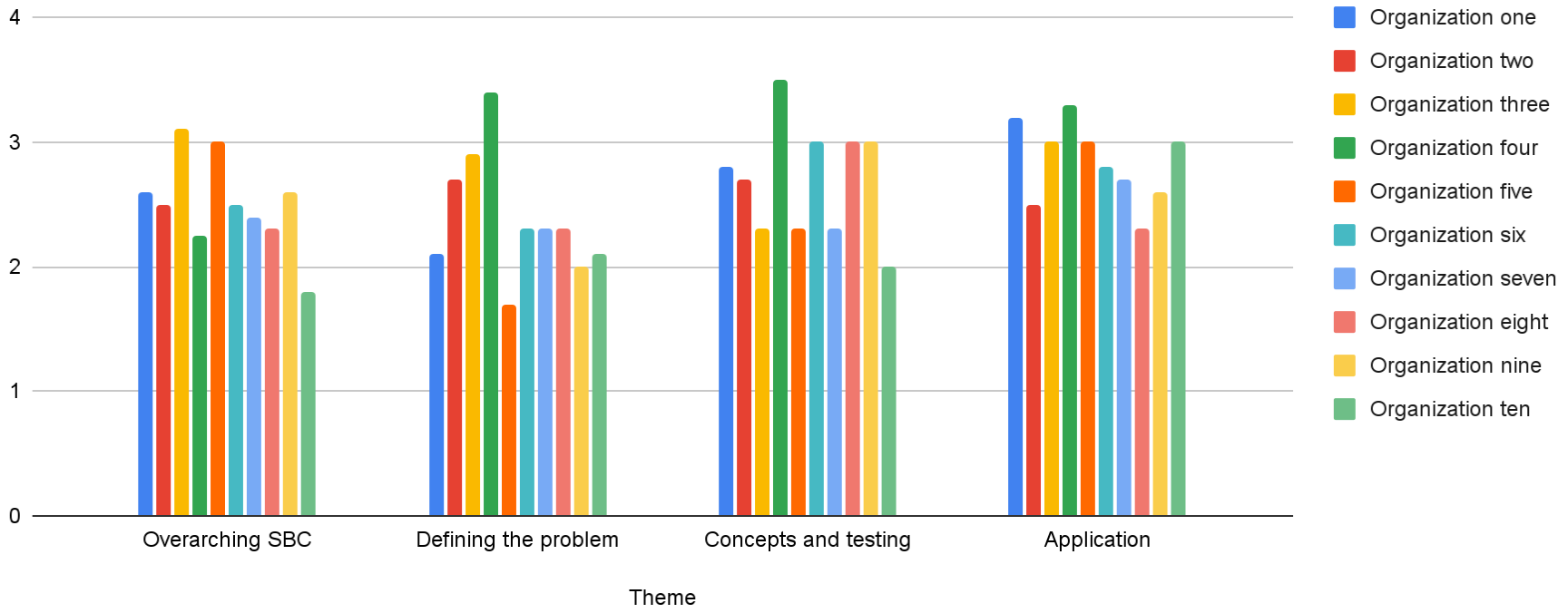
Mitigating reflexivity bias: It was impossible to eliminate bias on the part of the facilitator or the respondents. To address this bias, the assessment facilitators switched back and forth during the assessments to reduce response or reflexivity bias, which may have been introduced as part of the interviews or the scoring.

Stakeholder workshop: Following the self-assessment sessions with each of the ten partners (all of whom participated in the entire process), WABA 2 convened a formal stakeholder workshop with the recently established malaria SBC technical working group, to share lessons learned, identify needs, and discuss the aggregated results of the assessments. Of the ten organizations invited, all but one attended (the Malaria Consortium representative was on vacation)**.** Each organization received the same PowerPoint template beforehand, which included slides (for each of the four SBC themes) to share lessons learned and identified needs. The stakeholder meeting started with 10-minute presentations given by each organization, followed by a presentation of the aggregated results (see below).

Combined results

As described previously, each organization scored themselves from 1 to 4 based on specific definitions of what each capacity level means for each question. In the following chart, the total points all organizations scored on each theme (proportionate to the total possible in that theme) is shown. As we can see, defining the problem is an area with the most room for growth. On the second chart, which displays the scores each organization awarded themself for each theme, we see both a wide variance in SBC capacity but also universally low scores (none scoring three or four).


Total points obtained, by organization and by theme
4
3
2
1
0
Average
Overarching SBC
Defining the problem
Concepts and testing
Application
Theme


4
3
2
1
0
Overarching SBC
Defining the problem
Concepts and testing
Application
Theme
Organization one
Organization two
Organization three
Organization four
Organization five
Organization six
Organization seven
Organization eight
Organization nine
Organization ten

As the first graph above shows, defining the problem is a weakness among Togo malaria SBC partners. Specifically, of the seven elements this theme is composed of, three scored particularly low: audience segmentation (and prioritization), deepening understanding and building empathy, and understanding of behavioral theory. With a few exceptions, partners limit audience segmentation to sociodemographic factors. The few that do segment groups by psychographic factors do not design programs using that data. None of the partners delved deeper than basic audience segmentation or prioritized and addressed sub-groups in terms of access, motivation, or capacity. Only one partner was familiar with (and has applied) a specific behavioral theory. This poses a challenge, as accurate identification of behavioral determinants and the use of what is known about those determinants to deliberately design measurable interventions are essential first steps to improving malaria behaviors.

Overarching SBC also scored low among the themes assessed. The lowest-scoring sub-themes included understanding new trends in SBC and the existence of SBC-dedicated personnel. While a few organizations had an overarching project or organization strategy, very few had an SBC strategy. This was most often justified by noting that the NMP's role is to provide strategic guidance and implementing partners' role to implement it.

The practice of co-creation, in particular with community-level stakeholders, is not yet taking place among malaria SBC stakeholders in Togo: neither is the practice of prototyping in any form. While several organizations mentioned examples of working in an interdisciplinary fashion, with other health domains, for example, this is not happening in terms of SBC programming or activity implementation.

Malaria SBC stakeholders in Togo excel at planning, costing, and implementing SBC activities. Scores for developing monitoring and evaluation systems, for activity planning, developing costed budgets, and using data to evaluate programs were all high (with the caveat that data is used to evaluate programs overall, not necessarily SBC components of an overall program). It should be noted that organizations spoke about SBC as a cross-cutting activity, rather than a discrete activity or program. As such, when scoring themselves in these categories, organizations did so with the understanding that SBC is part of a larger whole. So while none of these processes was SBC-specific (SBC-specific implementation plans or SBC-specific monitoring and evaluation plans, for example), SBC was being scored as a part of overall processes. As such, these higher scores are more indicative of organizations' general programmatic/managerial capacity than SBC-specific planning, costing, and implementation.

Findings by theme

Overarching SBC

The overarching SBC section contains questions designed to determine at what level organizations use a systematic process during the design phase, whether or not they have developed an SBC strategy (organizational or program-specific), whether or not stakeholders are engaged in program or activity design, whether not an organization has established or participates in a network of SBC stakeholders, whether or not they have heard of or understand what human-centered design, behavioral economics, or SBC interventions that address structural behavioral determinants, whether or not they have

dedicated SBC personal and whether or not the organization has mechanisms in place to build SBC capacity of their personal, whether or not work plans with SBC elements are costed, whether or monitoring SBC is conceived during the design phase, and whether or not an organization understands of has put in place any kind of knowledge management system.

Strengths: When all organizations' scores for this theme are combined, the use of a systematic approach during program development, engaging stakeholders during program development, and having costed plans in place scored three or higher (out of four), indicating these are areas of strength.

Weaknesses: Average partner scores related to new approaches, SBC personnel capacity, and SBC personal training, were below 2. Most partners had not heard of these new approaches, and those that scored themselves a 2 did so because their overarching or global program includes them, but they do not have experience themselves. Only one partner could define a new approach, that partner did not have experience with any of the new approaches. Human-centered design, behavioral economics, and SBC interventions that address structural behavioral determinants are not yet a part of the lexicon among malaria SBC partners in Togo. Only one organization has a dedicated SBC role (and does not have an individual whose role it is to oversee monitoring and evaluation specific to SBC), most others assign SBC tasks to an individual with another primary role. Some personnel who perform SBC tasks also perform external communication tasks. Whether or not personnel tasked with SBC responsibilities demonstrate capacity to perform that function is mixed. Most organizations have some way to train their personnel in SBC but few do this systematically or frequently.

Most groups do not have a strategy specifically designed for SBC but have an overall logic framework or work plans that include SBC as a cross-cutting element. The most often cited reason was that the NMP provides strategic guidance (organizations work to fulfill the objectives in the NMP SBC strategy), and that implementing partners follow that guidance. Finally, most organizations have some knowledge management system in place, even if it is not labeled as such. Most stakeholders use digital and analog (paper) means of capturing, packaging, and sharing information and knowledge, but these systems tend to be fragmented. Several organizations have identified improved knowledge management as a priority and have plans in place (not yet realized) to do so.

Recommendations:

- As the NMP is recognized as the leader and coordinator of malaria SBC programming, the NMP may leverage the newly formed malaria SBC technical working group as a platform to establish a systematic process for designing SBC activities and programming. This process should include elements articulated in the RBM Partnership to End Malaria's SBC Strategic Framework. An SBC strategy and SBC design concepts development are two upcoming activities where this process can be applied.
- The technical working group will benefit from in-depth introductions to behavioral economics, human-centered design, and a thorough explanation of how SBC is used to address structural determinants of health. Some partners are not yet implicated in this group that participated in this assessment, and could be included.
- While resource constraints might not allow for dedicated SBC personnel in all organizations, at all levels, malaria SBC implementing partners in Togo would benefit from a clearer distinction of the roles an SBC officer plays (distinct from the roles of an individual who performs external communications, for example). All organizations will benefit from more frequent SBC training

opportunities that are available to all levels of staff. (i.e, the SBC Learning Central Platform on the Breakthrough ACTION website.)

- The NMP and malaria SBC implementing partners will benefit from a systematic way of capturing, organizing, and making programmatic data and reports available. A first step might be regularly incorporating data sharing (partner activities and behavioral data) into technical working group agendas.

Questions	Scores (average)
Use of a systematic approach to program design	3
Documentation of SBC strategy	2.1
Strategic engagement and support to stakeholders	3.5
Networking and alliance building	2.7
Forming and participating in coordination platforms	2.6
Understanding SBC trends	1.9
Staff assigned to SBC	1.6
Staff capacity in SBC	1.9
Staff development	2.2
Costed work plans	3.4
Implementing and monitoring the best SBC solutions	2.6
Using Knowledge Management	2.5

The average of all overarching SBC scores was 2.505, indicating a “progressing” capacity score according to the tool scoring rubric (below). The median score was 2.5.

Defining the problem

The defining the problem section measures foundational understanding of behavioral problems from two perspectives: the existing knowledge and published literature, and the new shared knowledge of the lived experiences of the households, community, health system, and political environment. It also assesses stakeholders’ alignment around shared intent for activity, project, or national objectives. The sub-domain consists of questions that explore examining data and knowledge to understand behavior, engagement with stakeholders, building consensus among stakeholders, identifying key audience segments and prioritizing audience segments, developing a deep understanding of structural, social, institutional, behavioral, cognitive, and emotional drivers of behavior, and using behavioral theory when designing SBC interventions.

Defining the problem strengths: None of the participating stakeholders scored an average of three or higher in the defining the problem section. There is room for improvement across all aspects of this theme, with only one organization averaging higher than a three. This single outlier masks the scores of other organizations. Without the outlier, the average scores for this theme and sub-domains would be even lower.

Defining the problem weaknesses: Most organizations do some kind of situation analysis but most do not have a structured, standard process that is systematically followed. While some larger organizations review literature, smaller local organizations do not (this is understandable, given the likelihood of finding a pertinent study in smaller geographic areas). Most organizations do not segment audiences any further than demographic characteristics and the few that do have access to psychosocial data do not use it to further segment their audiences. Several organizations explained that this is because the current national malaria SBC plan does not include objectives or indicators related to intermediate indicators such as attitudes, perceptions, and perceived social norms. None of the participating organizations had experience prioritizing audience segments by ranking segments based on opportunity to engage, motivation to engage, or ability to engage. None of the organizations systematically address structural, social, institutional, behavioral, cognitive, and emotional determinants of malaria behavior. The concept of addressing structural determinants of behavior was new to all organizations and required some time to explain during the assessment sessions. Only a few organizations could name a behavioral theory and only one had used a specific theory to guide and evaluate their SBC programming (one named a theory and had used it for SBC program development, but not to guide evaluation).

Except for the NMP and one implementing partner, organizations in Togo that play a role in implementing malaria SBC do not systematically rely on or use data to define behavioral challenges. It is commonly understood that the NMP takes the lead in prioritizing behaviors and challenges and that partners' role is to implement. While several organizations mentioned having been included in national-level workshops where the last SBC strategy was developed, it is not generally the case that organizations have been exposed to or have experience examining and using behavioral data to establish a foundational understanding of behavioral determinants and there is no current process whereby all stakeholders examine data together to establish collective intent to address identified behavioral determinants.

Recommendations:

- During the development of a new NMP malaria SBC strategy, ensure that not only is data reviewed but that it is reviewed with partners, and in-person so that all stakeholders are allowed to engage in a process of forming a common understanding and collective intent for activities and approaches to address identified objectives. All stakeholders, whether international organizations or local organizations, should feel as though they are not merely implementers, but co-creators.
- During the annual work plan development process, all stakeholders meet with the NMP and discuss how their respective activities align with national malaria SBC objectives. This process should not be limited to choice of activities, but should also ensure that partners are developing activity materials (or involved in the development of materials) using available data on the determinants of behavior (as opposed to centrally developed tools, such as flipcharts, being developed centrally and then sent to partners for use).

- Psychosocial determinants of behavior should be identified and all stakeholders should be introduced to examples of different theories of change that address specific factors. All partners should be part of a process where new materials and tools are co-developed, prototyped, and pre-tested, using theory to guide message framing and appropriate channels.

Questions	Scores (average)
Use of information and knowledge to generate ideas	2.5
Multidisciplinary co-creation and engagement	2.7
Strategic engagement to define intent	2.8
Audience segmentation	2.3
Audience prioritization	2.5
Deepening understanding and building empathy	2.2
Application of behavioral theory	1.7

The average of all overarching SBC scores was 2.38, indicating a "progressing" capacity score according to the tool scoring rubric (below). The median score was 2.3.

Designing and testing

The designing and testing sub-domain consists of questions that explore workflow processes that include interdisciplinary design with health experts, development specialists, stakeholders, and representatives from target audiences. The extent to which these groups are included in generating a broad array of ideas for possible solutions using insights and opportunities identified during the problem definition phase is measured.

Designing and testing strengths: Stakeholders scored particularly high in SBC implementation planning and costing SBC interventions. As mentioned previously, most organizations do not have SBC-specific strategies, but all organizations incorporate SBC activities into their overall strategy (if they did not, they would not have been selected for participation in this assessment). All participating organizations have well-defined work planning processes and adhere to their overall strategy goals when implementing, and all organizations set budgets according to actual costs and track costs.

Designing and testing weaknesses: Malaria SBC stakeholders in Togo are not currently working with other disciplines (other health areas) to co-create or plan SBC activities. The process of prototyping has not yet been introduced and partners are not engaging with representatives from priority audiences to

co-create SBC materials, activities, or approaches. While partners scored themselves low in SBC design processes, they scored themselves much higher in terms of implementation planning and budgeting.

While all partners scored themselves high in terms of budgeting SBC activities, most did not budget activities during the design phase, as most were not involved in SBC formative research or materials design. As there is limited behavioral data to generate ideas to address specific determinants of priority behaviors, most organizations are not using data to develop SBC approaches and activities. The process of prototyping in terms of rapid, iterative, and open generation of ideas or in terms of rapidly and interactively developing low-fidelity materials has not yet been introduced to SBC partners in Togo. SBC strategy, approaches, activities, and materials are not designed or co-created with prioritized audiences. While several organizations described having developed a novel SBC approach and having scaled it up, to varying extents, none did this systematically during the design phase or had a deliberate process in place for scaling successful approaches. Most organizations used more than one channel of communication but the idea of coordinating channels to achieve scale and saturation was new to all partners. None of the participating partners had experience planning a deliberate dissemination plan to maximize the timing and synergy of message dissemination (either in terms of a single organization's channels or across multiple partners' channels).

Recommendations:

- All malaria SBC partners in Togo will benefit from being introduced to and will benefit from practicing empathetic idea generation and co-creation with priority audiences (representatives from target audiences). This should be done before and during the strategy development and materials design activities planned for the coming year.
- All malaria SBC partners will benefit from a thorough review of available data, particularly after quantitative and qualitative data become available this year. It will be particularly important to establish an understanding of not only what key determinants of priority malaria behaviors are, but also how different behavioral theories can inform the design of new approaches and activities.
- The existing malaria SBC technical working group might benefit from a discussion about how to regularly share innovations in Togo SBC, with the intention of setting in motion a standard process for testing and scaling new approaches and activities.

Questions	Scores (average)
Co-creation of SBC interventions (ideation)	2.7
Co -creation of SBC interventions (scaling for impact)	2.4
Design process with stakeholders	1.5
Implementation planning	3.1
Budgeting interventions	3.6
Communication channel selection	2.9

The average scores for designing and testing was 2.75, indicating a "progressing" capacity score according to the tool scoring rubric (below). The median score was 2.75.

2.69

Application

The application phase is assessed by exploring workflow processes that enable interdisciplinary groups to decide on how to use prototypes and new SBC approaches at scale, and how they will be monitored and evaluated for impact.

Application strengths: Almost all participating malaria SBC stakeholders scored high on mobilization and coordination with other partners. Partners also have strong training systems in place, although not all training systems include SBC. SBC training opportunities that do exist aren't necessarily available to all employees and aren't necessarily offered frequently. Almost all partners' training systems include adult learning techniques, SMART training objectives, participatory processes, and some form of training evaluation. While SBC data is scarce, all partners reported using available data to decide on key indicators. Partners look to the NMP to decide if changes, or lack of changes, will inform changes in work plan indicators. While several organizations have begun the process of planning to improve knowledge management, capturing, packaging, and sharing of knowledge is not yet an intentional, systematic process among participating partners.

Application weaknesses: Malaria SBC stakeholders in Togo who participated in the assessment do not yet have systems in place to monitor SBC activities in such a way that would allow for course corrections or necessary adjustments. For example, while partners monitor SBC activity implementation, data on shifts in behavior or shifts in determinants of behaviors are not collected with a frequency that would allow for adaptation in terms of message framing. None of the participating partners set SBC benchmarks or targets that would trigger a pivot or programmatic change in focus. Monitoring and evaluation is a component of all partners' programming, but this is done broadly, and is not specific to SBC. For example, many partners measure SBC activity frequency, and some even measure exposure or reach of activities, but these indicators are not used to adapt programming after annual work plans are approved and finalized. None of the partners had experience evaluating SBC activities, other than as part of an overall program evaluation.

Recommendations:

- All malaria SBC partners in Togo will benefit from more frequent SBC training, and training that is available to all levels of staff.
- All malaria SBC partners in Togo will also benefit from the development and use of monitoring and evaluation plans that capture a broader set of SBC indicators (not only output indicators like number of activities completed or numbers of people reached, but intermediate indicators like shifts in priority determinants of behavior). This should take place starting with the development of a new malaria SBC strategy in the coming year. Specifically, the monitoring and evaluation section of that strategy should be developed with implementing partners' input and should

specify which indicators each organization is responsible for, and should also specify the frequency of data collection.

- SBC monitoring plans should be developed that include benchmarks and targets that, if met, signal a predefined shift in SBC programming.
- The NMP would benefit from the development of an SBC learning agenda that identifies gaps in behavioral understanding and prioritizes specific research topics. This agenda should then be used to funnel implementing partner research activities into a deliberate learning plan that is used during annual planning.

Questions	Scores (average)
Implementing and monitoring SBC solutions	2.7
Mobilization and coordination	3.3
Training	3.6
Data utilization	3.9
Evaluation and refinement of SBC solutions	2.2
Adapting and scaling SBC solutions	1.4

The average application score was 2.84, indicating an almost “early maturity” capacity score according to the tool scoring rubric (below). The median score was 2.9.

2.84

Next Steps

It should be noted that Breakthrough ACTION’s work plan was deliberately structured such that a malaria technical working group would be established, that working group would then be assessed for SBC capacity, and after qualitative and quantitative data were gathered, Breakthrough ACTION would then build stakeholders’ capacity by using new data to co-develop a new strategy and co-design new SBC materials. As such, these SBC self-assessments took place before planned capacity-building efforts, and could be considered as a baseline. While the new broader definition of SBC was introduced during the establishment of the new technical working group, and the group did then convene and practice developing a series of theme-specific SBC theories of change, these preliminary activities did not address the broad spectrum of SBC capacity assessed with this tool during these sessions.

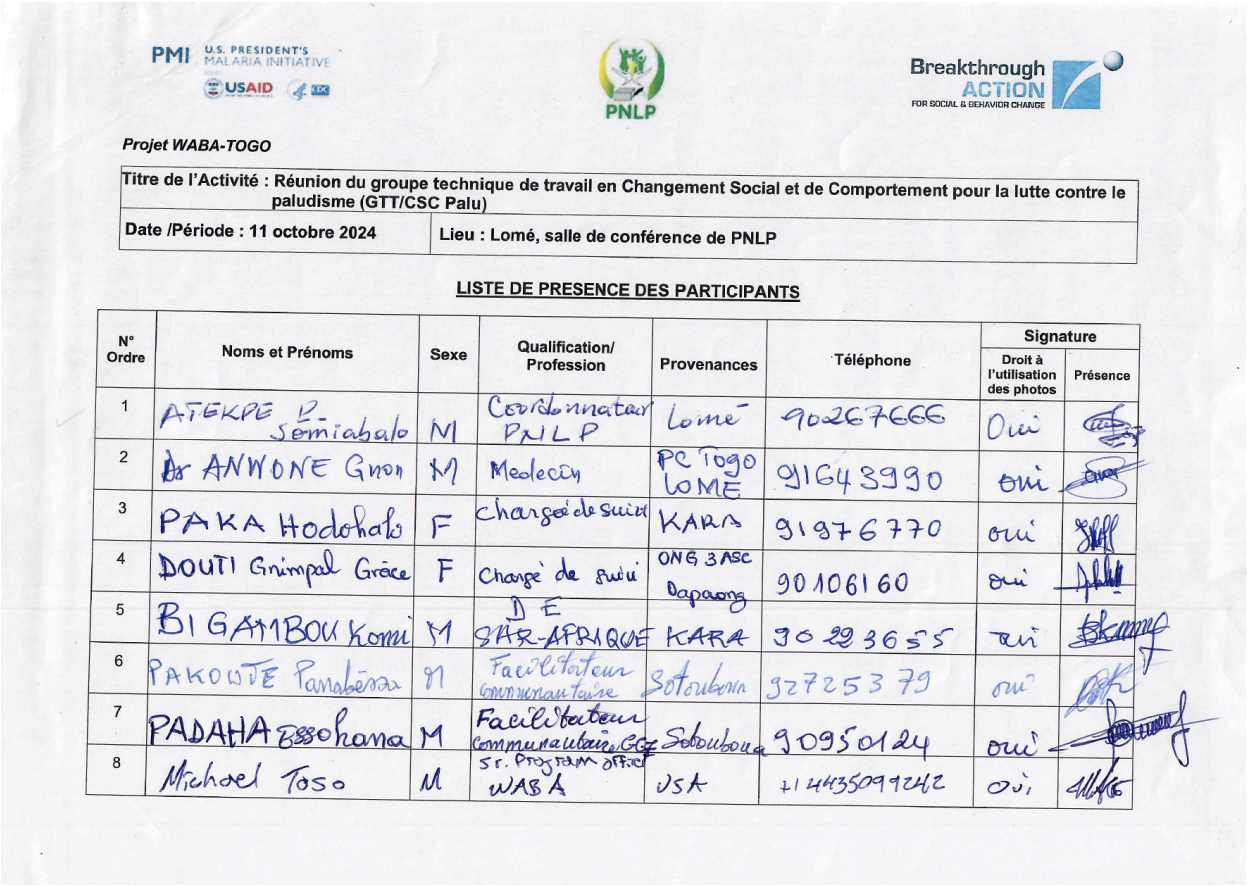
With a comprehensive understanding of where malaria SBC partners in Togo stand, Breakthrough ACTION will now set out to use the strategy and materials development processes in a way that introduces and then applies newly formed SBC capacities. After several years' time, and experience implementing the new national malaria SBC strategy using new approaches and materials, malaria SBC partners may find it beneficial to conduct a second self-assessment to measure progress.

Annex 1: Assessment timeline

Date	Organization	Intervention zone	Contact
1/10/2024	Programme National de Lutte contre le Paludisme	National	Dr ATEKPE Payakissim Somiabalo Tél: +228 90 26 76 66 Email: abrahamatekpe@gmail.com
1/10/2024	Croix rouge togolaise	Nationale	Dr Koffi NSOUKPOE Tél : +228 90 32 67 20 Email : nsoukpoe_koffi@yahoo.fr
2/10/2024	SAR-Afrique (Santé Rurale en Afrique)	Région de la Kara	BIGAMBOU Komi Tél : 90223655 Email : sarafrique_togo@yahoo.fr
3/10/2024	CRS (Catholic Relief Services)/PMI	Nationale	Anicet NEMEYIMANA Tél: 96860064 Email: anicet.nemeyimana@crs.org Antoine.AZIALEY@crs.org
3/10/2024	3ASC (Association d'Appui aux Activités de Santé Communautaire)	Région des Savanes	YANGNENAM Jean de La Croix Tél : 90046945 Email: yjendelacroix@yahoo.fr
4/10/2024	RADAR (Regroupement des Associations pour le développement Appliqué des Ruraux)	Sotouboua, Blitta, Mô	PANA Tetoutokina Tél : 90223348 E-mail : societeradar@yahoo.fr/ Responsable Programme : POTCHONESSA ESSONIWA Tél : 90138855 E-mailgeorgepotch@gmail.com

7/10/2024	APEB (Association pour la Promotion de l'Education de Base)	Bas-Mono, Lacs et Yoto	GBODJO Kodjo Edouard Tél : 90392474 E-mail : vkgbodjo@gmail.com
7/10/2024	GRASE-Population (Groupe de Recherche et d'Appui pour la Santé et l'Education de la Population)	Danyi, agou, Amou, Kpélé	Responsable suivi évaluation : TSOGBE Kossi Tél: 92526941/99580929 E-mail: tsogbe.kossi@yahoo.fr
8/10/2024	Corps de la Paix (Peace Corps) /USAID	Nationale	Dr. Gnon ANWONE Tél : 91343990 E-mail : ganwone@peacecorps.gov
8/10 /2024	Malaria Consortium	Zone CPS (Savanes, Kara, Centrale, Plateaux)	Dr AWOKOU Tel : 90094563 Email : f.awokou@malariaconsortium.org

Annex 2: Stakeholder's workshop attendance



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Breakthrough ACTION FOR SOCIAL & BEHAVIOR CHANGE

Projet WABA-TOGO

Titre de l'Activité : Réunion du groupe technique de travail en Changement Social et de Comportement pour la lutte contre le paludisme (GTT/CSC Palu)	
Date /Période : 11 octobre 2024	Lieu : Lomé, salle de conférence de PNLP

LISTE DE PRESENCE DES PARTICIPANTS

N° Ordre	Noms et Prénoms	Sexe	Qualification/ Profession	Provenances	Téléphone	Signature	
						Droit à l'utilisation des photos	Présence
1	ATEKPE P. Semiabalo	M	Coordonnateur PNLP	Lomé	90267666	Oui	
2	Dr ANWONE Gnon	M	Medecin	PC Togo LOME	91643990	oui	
3	PAKA Hodoha ko	F	Chargée de suivi	KARA	91976770	oui	
4	DOUTI Grimpal Grace	F	Chargé de suivi	ONG 3ASC Dapaong	90106160	oui	
5	BIGAMBOU Komi	M	D E SAR-AFRIQUE	KARA	90 22 36 55	oui	
6	PAKOUTE Panabessa	M	Facilitateur communautaire	Sotouboua	92725379	oui	
7	PADAHA Essohana	M	Facilitateur communautaire CSC	Sotouboua	90950124	oui	
8	Michael Toso	M	Sr. Program officer WABA	USA	+14435099242	oui	

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N° Ordre	Noms et Prénoms	Sexe	Qualification/ Profession	Provenances	Téléphone	Signature: Droit à l'utilisation des photos	Signature: Présence
9	KADZAHLO Komla	M	Médecin SP	Lomé	90216528	—	
10	TETOU Samiratou	F	A S E à la CRT	Lomé	93373733	oui	
11	TOKPLO Hilaire	M	Coordo WABA	Lomé	91764558	oui	
12	ATABA Essoham	M	Resp. Surveil.	Lomé	90781075	Oui	
13	KOMBATE Dambé	M	Médecin conseil 3ASC	Dapaong	92263918	Oui	
14	OBODJO Kodjo Edouard	M	Directeur ONG-APEB	Aného	90392474	Oui	
15	AHAYO Aku Precious	F	Chargée de Suivi ONG APEB	Aného	91818171	Oui	
16	ANAGONOU Rodrigue	M	Co P-PMI EVOLVE	Lomé	56341111	oui	
17	ATSU Aku	F	Secretaire GRASE-Population	Adéta	91445632	oui	
18	GAMADO Atchon Komi Joseph	M	Responsable suivi-Evaluation	Adéta	93153724	Oui	
19	AKOKOU Afi	F	Assistante Prog Santé/CRT	Lomé	91746879	oui	
20	JAKPA Kossi	M	Resp. de Labo	Lomé	90096378	oui	

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N° Ordre	Noms et Prénoms	Sexe	Qualification/ Profession	Provenances	Téléphone	Signature	
						Droit à l'utilisation des photos	Présence
21	Mwindahabi Tonique	F	PMI Resident Advisor	USAID_PMI	91931802	oui	
22	AGNANDOM Padawassa	M	Logisticien	PNLP/Lomé	90012324	Oui	
23	KOLANI Yaya	M	SGA	ACRT/SD	92720429	oui	
24	MADINDB Jeanne A.	F	Senior Program Officer/WABA	Lomé	98079494		
25	KPADJA Mawuli	M	Comptable	WABA Lomé	90858436	oui	
26							
27							
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