STOCKHOLM EVALUATION UNIT

MÉDECINS SANS FRONTIÈRES LÄKARE UTAN GRÄNSER

EVALUATION OF

COVID-19 DIGITAL HEALTH PROMOTION

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This publication was produced at the request of MSF-OCB under the management of the Stockholm Evaluation Unit.

It was prepared independently by Allison Cantor.

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ACRONYMS

BLS	The Brand Lift Studies
Covid-19	Coronavirus disease 2019
DHP	Digital Health Promotion
DHPU	Digital Health Promotion Unit
DRC	Democratic Republic of Congo
EQ	Evaluation Question
FB	Facebook
HP	Health Promotion
KI	Key Informant
KII	Key Informant Interviews
ME	Monitoring and Evaluation
MSF	*Médecins Sans Frontières* (ENG. Doctors Without Borders)
OC	Operational Centre
OCB	Operational Centre Brussels
SEU	Stockholm Evaluation Unit
SQ	(Evaluation) Sub-Question

EXECUTIVE SUMMARY

BACKGROUND

Coronavirus disease (Covid-19) is responsible for more than 4.5 million deaths worldwide.[1] The Covid-19 pandemic created a variety of challenges for implementing health promotion (HP) activities for humanitarian organizations, especially regarding limitations to person-to-person contact. *Médecins Sans Frontières*' (MSF) Operational Centre Brussels (OCB) adapted to this context by scaling up the implementation of Digital Health Promotion (DHP) activities in a variety of contexts, including some where MSF had limited or no previous experience. The pilot campaign was launched in Belgium in April 2020 and, to date, 27 Covid-19 DHP campaigns have been completed across 19 countries.

The purpose of this evaluation is to provide an independent assessment of a sample (n=10) of MSF's Covid-19 DHP campaigns, which include Belgium, Brazil (Bahia), Democratic Republic of Congo (DRC), Greece (Moria), Guinea, Haiti, Palestine (Gaza), Indonesia, South Africa, and Zimbabwe. The evaluation was conducted between July and September 2021. The evaluation questions (EQ) are based on five criteria defined by the RE-AIM[2] approach (reach, effectiveness, adoption, implementation, and maintenance).

METHODOLOGY

This evaluation used a mixed methods approach to answer the evaluation questions, drawing on the following sources of data:

1. Primary data
   a. Semi-structured interviews (n=12)
2. Secondary data
   a. Facebook (FB) quantitative campaign metrics
   b. FB Brand Lift Studies (BLS)
   c. Digital Health Promotion Units' (DHPU) Microsoft Forms analysis
   d. Sherlog documents (n=49)
   e. Desk review documents (65)
   f. Peer-reviewed and grey literature (n=26).

Qualitative and quantitative analysis was conducted using MAXQDA[3] and Excel.

[1] https://covid19.who.int/
[2] https://www.re-aim.org/
[3] https://www.maxqda.com/

KEY FINDINGS

The absolute number of individuals reached during each of the campaigns was high. However, due to lack of baseline data within the program documents I had access to, there is no way to measure the adequacy or success of the overall **reach.** There were mixed results regarding the **effectiveness** of the campaigns. Beneficiary comments analysed by the DHPU indicate that there were more negative attitudes than positive attitudes towards the campaigns. However, the ambiguity surrounding the categories used in analysis, as well as the gaps in the dataset, are problematic for drawing conclusions. The FB BLS reveal that the campaigns in Brazil, Indonesia, and South Africa had some impact on beneficiaries, but there was no impact reported for Zimbabwe. HP focal points reported positive experiences with DHP, contributing to their willingness to **adopt** DHP in the future. The field teams were able to successfully **implement** the DHP campaigns in accordance with the process outlined by the DHPU. Most HP focal points attributed this success to the support they received from the DHPU. Regarding **maintenance**, DHP has impacted MSF as an organization by creating visibility, enhancing the capability of MSF to adapt to contemporary trends, and by providing a framework that will allow MSF to incorporate DHP into regular operations. While it is not possible to determine the impacts on beneficiaries with the available program data, likely impacts include developing trust in MSF and access to emotional support and referrals.

Recommendations

To address the second objective of the evaluation, the evaluator led a participatory workshop to co-create practical recommendations based on the evaluation results. Participants included the evaluator, members of the SEU, and the commissioners of the evaluation. The following recommendations were identified:

1. Develop transversal collaborations within MSF to create a more robust monitoring and evaluation (ME) system for digital health promotion (DHP)
    a. Draw on existing resources to develop and implement ME tools
    b. Strengthen relationships between the DHPU, SEU, MSF-OCB, and MSF to develop an ME framework
    c. Formalize the roles of the DHP field teams within MSF as an organization
2. Enhance the existing strengths of the DHPU by expanding HR
    a. Offer more technical training and support to field teams, which could include a training of trainer's program
    b. Add an additional member of DHPU to manage ME framework
3. Increasing continuity between health promotion (HP) and DHP
    a. Increase accessibility to DHP resources within the HP context
    b. Create more internal awareness about HP and DHP frameworks, guidance documents, and resources

Overall, the recommendations identified during the participatory workshop provide practical examples of how to strengthen MSF's DHP initiatives. While the evaluation identified many gaps that need to be filled in order to determine the success of the programs, it is clear from the desk review (see Annex 13) and semi-structured interviews, that DHP is part of a broader global trend towards digitization of health services and HP. As such, efforts to strengthen DHP activities should be integrated into MSFs HP strategy.

INTRODUCTION

BACKGROUND AND CONTEXT

Médecins Sans Frontières (MSF) has responded to the Covid-19 pandemic in more than 70 countries across Asia & Pacific, the Middle East & Northern Africa, Africa, Europe & Central Asia, and the Americas.[4] In the context of Covid-19, MSF provides expertise in emergency response to countries with robust health systems and direct care in low-resource settings with fragile health systems. During the Covid-19 pandemic, MSF has focused on supporting authorities to provide care for Covid-19 patients, protecting people who are vulnerable and at risk, and keeping essential medical services running.[5] Across these projects, MSF teams work to improve Covid-19 infection and prevention control measures as well as support critical medical activities that need to be maintained or adapted during the global health crisis, such as malaria prevention and cholera outbreaks.[6]

MSF has also maintained an active role in HP, despite the challenges that the Covid-19 pandemic has created, especially regarding limitations to person-to-person contact.[7] One of the ways that MSF-OCB has confronted these challenges is by increasing Digital Health Promotion (DHP) implementation in a variety of contexts.[8] In 2020, MSF-OCB created a Digital Health Promotion Unit (DHPU) to work with field teams to develop and implement Covid-19 DHP campaigns, launching the pilot in Belgium in April, 2020. To date, 24 Covid-19 campaigns have been completed in 18 countries, and some are ongoing. This evaluation assesses the completed 2-way campaigns[9], including Belgium, Greece (Moria), Democratic Republic of Congo (DRC), Haiti, and Palestine (Gaza), as well as 1-way campaigns with a Brand Lift Studies (BLS) component, which includes Brazil (Bahia), Indonesia, South Africa, and Zimbabwe.

THE DIGITAL HEALTH PROMOTION UNIT

MSF has long-recognized the importance of digitally supported global health and began implementing Telemedicine in 2010.[7] MSF-OCB first piloted DHP campaigns in South Africa in 2018 to complement existing HP strategies. Once the pandemic started, DHPU was formalized under the Covid-19 task force. The team spent most of 2020 focusing their efforts on Covid-19. While the DHPU continues to work on Covid-19 projects, the unit also collaborates with HP managers in the field to address other relevant health concerns, such as Tuberculosis, sexual and reproductive health, and HIV.[10]

Housed in the Medical Department, the DHPU facilitates the process of DHP campaign implementation among operations through capacity-building with HP field managers and their teams, as well as providing the structure for each specific digital campaign. The process starts when an HP manager or field team focal

[4] https://www.doctorswithoutborders.org/covid19
[5] https://www.msf.org/covid-19
[6] "RESPONDING TO Covid-19: Global Accountability Report 1, March 2020-May2020." *Médecins Sans Frontières*, 2020.
[7] https://www.msf.org/covid-19-depth
[8] https://msf-siu.org/blog/digitalhealth
[9] 2-way campaigns allow beneficiaries to converse with first responders directly through messaging
[10] Discussion with MSF Personnel

point contacts the DHPU for support in developing a DHP campaign. First, an assessment is conducted to explore the resources available (e.g., budget, human resources (HR), etc.), technical capacities of the field teams, and technological feasibility within the target population (e.g., social media and WhatsApp accessibility). Subsequently, the DHPU creates a strategy with the field teams, which includes technical training and gathering messaging. The DHPU uses assessment data and messaging to create a structure for the campaign (1-way[11]/2-way, digital platform, etc.) and visual content. After content is pretested, the campaign is implemented. The DHPU also monitors campaign messaging, provides support to the field teams, manages and analyses DHP campaign data, and recently started to implement BLS. BLS[12] is a Facebook (FB) tool which analyses the performance of advertisements and is used by the DHPU to assess campaign impacts on beneficiaries.

It is important to note that other MSF Operational Centres (OC) have implemented DHP campaigns (e.g., Operational Centre Barcelona-Athens), but MSF-OCB was the first to do so, and has elaborated a DHP Toolbox,[13] which is shared with MSF stakeholders. MSF-OCB DHPU is also collaborating with some OCs (e.g., Operational Centre Amsterdam and Operational Centre Geneva) to incorporate DHP into future missions to complement existing HP progamming.[8]

DHP COVID-19 CAMPAIGNS

To date, the DHPU has supported the operations of 27 Covid-19 DHP campaigns (see Annex 1 for a complete list of Covid-19 DHP campaigns) across 19 countries in 2020 and 2021. Due to the predetermined timeline for this evaluation (see Annex 2 for Terms of Reference) a sample of Covid-19 campaigns (n=10) was identified and assessed (see Annex 3 for sample characteristics). The sample includes the 2-way campaigns (n=6) completed to date and 1-way campaigns with a BLS component (n=4). Two-way campaigns provide beneficiaries with opportunities to engage with the HP field teams in some way (e.g., via FB or WhatsApp conversations). Campaigns with a BSL component have the potential to measure changes in health behaviour associated with HP.[14] This is valuable for exploring dimensions of the evaluation related to beneficiary outcomes. One-way campaigns provide visual content to the target population with more limited engagement than 2-way campaigns (e.g., via comments, video views, etc.) (see Table 1 for definitions of terms commonly used in DHP and Annex 4 for a more complete list).

Each Covid-19 DHP campaign had its own objectives related to various HP topics, including Covid-19 awareness and prevention, addressing concerns about co-morbidities (e.g., Covid-19 and HIV), and dispelling rumours (see Annex 5 for a complete list of campaign objectives). Target populations also vary and include entire populations (16+ or 18+), migrants, asylum seekers, and homeless individuals, and specific communities (Camp Moria, community in Gaza City, Arabic, Amharic, and Tigrinya speakers) (see Table 9 below for a complete list of target populations).

[11] 1-way campaigns provide content to beneficiaries without direct interaction with first responders
[12] https://www.facebook.com/business/help/1693381447650068?id=546437386202686
[13] Hein, Jakub. n.d. "Digital Health Promotion Toolbox: THE ESSENTIAL GUIDE TO MISSIONS CONSIDERING OR STARTING DIGITAL HEALTH PROMOTION INTERVENTIONS." v0.3-Covid-19 working Version. *Médecins Sans Frontieres*.
[14] Gumucios, et al., 2019. "The Kap Survey Model - Knowledge Attitude and Practices." Data Collection: Quantitative Methods. Médecins du monde. Accessed July 13, 2021. https://www.medecinsdumonde.org/en/actualites/publications/2012/02/20/kap-survey-model-knowledge-attitude-and-practices.

Table 1. Common Terms Used in Digital Health Promotion[15]

METRIC	DEFINITION
REACH	The number of people who saw your ads at least once. Reach is different from impressions, which may include multiple views of your ads by the same people.
FREQUENCY	The average number of times each person saw your ad.
IMPRESSIONS	The number of times your posts were on screen.
POST ENGAGEMENT	The total number of actions that people take involving your ads.

EVALUATION OBJECTIVES

The objectives of the evaluation are twofold:

1. Determine how successful the DHP campaigns in the sample (n=10) have been by:
   a. Identifying good practices
   b. Identifying areas of improvement
2. Co-create recommendations with key stakeholders from/for the Digital Health Promotion Unit, Health Promotion referent, and Medical Directors.

EVALUATION QUESTIONS

The evaluation questions (EQs) and sub-questions (SQs) were developed collaboratively with the commissioners of the evaluation (see Table 2 for evaluation questions). The RE-AIM Approach[16] was used as a guiding framework due to its widespread application in planning, monitoring, and evaluation of HP programming, and increasingly of DHP activities (see Annex 6 for key definitions associated with this framework). Additionally, the emphasis this approach places on evaluating aspects of the setting level (i.e., the institutions and individuals engaging in implementation) is appropriate for this evaluation, since there is limited data on how the DHP campaigns impacted beneficiary behaviour. The RE-AIM approach explores 5 dimensions: reach, effectiveness, adoption, implementation, and maintenance.

[15] https://www.facebook.com/business/help?ref=mobile_logo
[16] https://www.re-aim.org/

Table 2. Evaluation questions

RE-AIM DIMENSION	EQ	SQ
REACH	**EQ1:** Was the reach of the Covid-19 DHP campaigns adequate according to each campaign's stated objective and target population?	**SQ1:** What was the level of beneficiary engagement within and across the campaigns, including conversations, comments, etc.?
EFFECTIVENESS	**EQ2:** What was the impact of the campaigns on beneficiaries as evidenced by their comments and conversations (and KAP surveys when available)?	**SQ2:** Were there any unintended impacts (positive or negative)?
ADOPTION	**EQ3:** Which factors influenced program adoption for the field teams?	**SQ3:** Would field teams adopt DHP programs in the future? Why or why not?
IMPLEMENTATION	**EQ4:** Were operations staff able to successfully implement each campaign in accordance with the process outlined by the digital health promotion unit and HP best practices as outlined by MSF-OCB?	**SQ4.1:** What factors facilitated successful implementation? **SQ4.2:** What factors were barriers or challenges to implementation? **SQ4.3:** Were campaigns appropriately adapted to the specific contexts?
	EQ5: Which parts or aspects of the campaigns generated the most valuable outcome for the time, money and effort invested?	-
MAINTENANCE	**EQ6:** What are the long-term impacts of digital health promotion campaigns within MSF as an organization?	-
	EQ7: What are the long-term effects of the DHP outcomes on beneficiaries?	-

APPROACH AND METHODOLOGY

The evaluator has met as far as possible with the available data the objectives of the external evaluation by systematically collecting and analysing data which answers the proposed EQs and associated SQs (see Table 3 for the evaluation matrix). This evaluation is rooted in approaches from influential evaluation, a type of formative evaluation,[17] which emphasize the ways that the lessons learned from the evaluation can be used to improve ongoing and future programs. This is achieved by including stakeholders in a collaborative and active process of reflecting on the evaluation process and results.

The evaluator relied on both primary and secondary data sources. Primary data was collected using semi-structured interviews with key informants (KII) (n=12). Secondary data included the following:

- FB quantitative campaign metrics
- BLS
- DHPU Microsoft Forms
- Sherlog documents (n=49)
- Desk review documents (65)
- Peer reviewed and grey literature (n=26)

Qualitative data were analysed using MAXQDA, a mixed methods analysis software and quantitative data was analysed using Excel.

Table 3. Evaluation Matrix

PROPOSED EQS AND SQS	METHODS	ANALYSIS
Reach	Document Review	Deductive and Inductive Coding
EQ1: Was the reach of the Covid-19 DHP campaigns adequate according to each campaign's stated objective and target population? **SQ1:** What was the level of beneficiary engagement within and across the campaigns?	▪ Campaign documents ▪ Peer-reviewed and grey literature ▪ KII ▪ HP field manager or focal	Quantitative

[17] Herbert, James Leslie. 2014. "Researching Evaluation Influence: A Review of the Literature." *Evaluation Review* 38 (5): 388–419. https://doi.org/10.1177/0193841X14547230.

Effectiveness	Document Review	Deductive and Inductive Coding
EQ2: What was the impact of the campaigns on beneficiaries as evidenced by their comments and conversations (and BLS surveys when available)? **SQ2:** Were there any unintended impacts (positive or negative)?	▪ Campaign documents ▪ BLS ▪ KII ▪ HP field manager or focal point ▪ DHPU	Quantitative analysis
Adoption	**Document Review**	**Deductive and Inductive Coding**
EQ3: Which factors influenced program adoption for the field teams? **SQ3:** Would field teams adopt DHP programs in the future? **SQ3.a:** Why or why not?	▪ HP field manager or focal point	Coding
Implementation	**Document Review**	**Deductive and Inductive Coding**
EQ4: Were operations staff able to successfully implement each campaign in accordance with the process outlined by the digital health promotion unit and HP best practices as outlined by MSF-OCB? **SQ4.1:** What factors facilitated successful implementation? **SQ4.2:** What factors were barriers or challenges to implementation? **SQ4.3:** Were campaigns appropriately adapted to the specific contexts? **EQ5:** Which parts or aspects of the campaigns generated the most valuable outcome for the time, money and effort invested?	▪ Campaign documents ▪ DHP Toolbox (and associated documents) ▪ MSF-OCB HP guidance documents ▪ KII ▪ HP field manager or focal point ▪ DHPU ▪ Other MSF Personnel	Coding

Maintenance	Document Review	Deductive and Inductive Coding
EQ6: What are the long-term impacts of digital health promotion campaigns within MSF as an organization? **EQ7:** What are the long-term effects of the DHP outcomes on beneficiaries?	▪ Campaign documents ▪ BLS surveys ▪ KII ▪ HP field manager or focal point ▪ DHPU	Quantitative

SAMPLING

This evaluation analysed a sample of 10 Covid-19 DHP campaigns. The sampling strategy was based on 1) the accessible data for the DHP campaigns and 2) the timeline for the evaluation. The DHP campaign sample consisted of the 2-way Covid-19 campaigns (n=6) completed to date as well as the campaigns that had a BLS component (n=4).

The sample strategy for KIs was similar. The sample consisted of individuals who could provide in-depth perspectives across and within the campaigns to identify good practices and areas for improvement. The timeframe for the evaluation also informed the sample size. Originally, 17 KIs were identified. This included, HP field managers or focal points (n=10), the DHPU team (n=4), and key MSF personnel (n=2) (see Table 4). However, of the ten campaigns included in the sample, two had the same focal point and two focal points were not available for an interview. Additionally, due to the summer holiday, it was not possible to interview more than one individual from MSF-OCB headquarters (MSF key personnel). Overall, 16 individuals were contacted for interviews and 12 agreed to participate, resulting in a 75% response rate. This included HP field managers or focal points (n=7), the DHPU team (n=4), and key MSF personnel (n=1) (see Table 4).

SEMI-STRUCTURED INTERVIEWS

Semi-structured interviews were conducted via Zoom, Teams, or WhatsApp. Each interview guide was tailored to the specific context of the role of the participant (for an example interview guide, see Annex 7). With permission of participants, all interviews were audio-recorded. Interviews were transcribed for qualitative analysis (see Annex 8 for a list of KIs consulted).

Table 4. Key Informant Inclusions Criteria for Semi-structured Interviews

KEY INFORMANT INCLUSION CRITERIA	ROLE	N
HP field managers or focal points	Responsible for campaign implementation	7
Digital Health Promotion Unit	Provide the structure and training for each of the campaigns	4
MSF Key Personnel	Involved in the creation and continued operations of the DHPU	1
Total		12

DESK REVIEW

The evaluator conducted an in-depth review of DHP campaign documents and MSF-OCB HP documents. DHP campaign documents included overarching documents, BLS reports, and final reports (n=65). HP documents (n=49) included strategies, guidelines, manuals, and other relevant documentation (e.g., documents, presentations, and webinars) from Sherlog (MSF-OCB's internal system for collaboration and information sharing. Additionally, peer-reviewed and grey literature (n=26) was consulted to frame the results of the evaluation in the context of other validated works.

The evaluator was given access to Sherlog, the internal information-sharing site used by MSF-OCB. The evaluator used the following search terms to find documents relevant to this evaluation: "Health promotion" and "digital health promotion." In addition, the evaluation commissioners identified specific content (documents, presentations, and webinars) to be included in this review. These MSF documents provide the official context and framework for answering some of the evaluation questions, since MSF-OCB provides the official guidance documents and HP frameworks for application in the field.

Documents from Sherlog were included in the desk review if they met the following criteria:

1. They were focused on HP frameworks used by MSF
2. They were official HP guidance documents (used within MSF or MSF-OCB)
3. They were digital HP guidance materials used by MSF or MSF-OCB
4. General Digital HP materials used by MSF or MSF-OCB
5. Material on Covid-19 and HP or Covid-19 and DHP

BRAND LIFT STUDIES

BLS is a FB mechanism which measures how well advertising performs using a lift test.[18] A lift test is an experiment using two groups of people; a group that saw the advertisements and a group that did not (i.e. a control group).[19] Each group is asked to respond to a series of questions. The results include a confidence percentage (i.e., likelihood of a causal result) and a lift percentage (i.e. the percentage higher that your brand survey performed in the group that saw the advertisements in comparison with the control group). For DHP, the BLS questions are based on those commonly used in Knowledge, Attitudes, and Practices surveys. This mechanism allows MSF to determine impacts on beneficiaries who are exposed to the DHP campaigns. For the DHPU, this is a new assessment tool, therefore data were only available for Brazil, Indonesia, South Africa, and Zimbabwe.

RAW AND EXISTING DATA

During the inception phase, raw and existing data sources were identified by key stakeholders. Quantitative data are generated for each campaign in the sample. This includes reach, impressions, frequencies, link clicks, post comments, post engagement, post reactions, and thruplays. These sources of raw data were incorporated into an Excel spreadsheet and analysed using descriptive statistics. Qualitative data are also managed for each campaign, which included comments that have already been synthesized by the DHPU and field teams via Microsoft Forms. The evaluator used the Excel spreadsheets generated by Forms for analysis in Excel. Data included topics of conversation related to the campaign, tone, and attitude of comments.

ANALYSIS

Qualitative data from semi-structured interviews and desk review documents were analysed using a layered analysis approach,[20] beginning with a round of deductive coding based on the evaluation questions and RE-AIM criteria (reach, effectiveness, adoption, implementation, and maintenance). The codebook includes the RE-AIM criteria and specific constructs associated with each sub-question (e.g. facilitators and barriers) (see Annex 9 for the MAXQDA codebook). This was followed by a round of inductive coding. This technique is used to identify other themes in the data relevant to this evaluation, such as the impacts that capacity-building and technical training have on field teams.

[18] https://www.facebook.com/business/help/1693381447650068?id=546437386202686
[19] https://www.facebook.com/business/help/552097218528551?id=546437386202686

[20] Bernard, H. Russell. Research Methods in Anthropology: Qualitative and Quantitative Approaches. Rowman & Littlefield, 2017.

LIMITATIONS AND MITIGATING FACTORS

There are a number of limitations and mitigating factors that impacted this evaluation. First, due to the limited time frame for which the evaluation is scheduled, it was not possible to analyse primary data from all of the Covid-19 DHP campaigns. The evaluator created a specific sampling strategy to address this limitation (i.e., to focus on the 2-way campaigns and 1-way campaigns with BSL surveys), but it is still important to note. The timing of the evaluation was also a factor, as there was lagged response (or no response) from some KIs due to the summer holidays in Europe. This may have impacted the KI response rate.

The evaluator also recognized certain limitations due to the Covid-19 pandemic. Namely, the evaluator could not travel due to Covid-19-related restrictions and safety concerns, making the evaluation completely remote in nature. This comes with its own challenges. Primarily, technology was a concern, regarding internet quality in some locations as well as access to both internet and communication applications, such as Zoom or Teams. This disrupted interview times more than once, but rescheduling was possible. There were also limited opportunities to build rapport with KIs, which could impact how much they disclosed to the evaluator during data collection. There were some concerns about anonymity in reporting of the data. To address this, the evaluator has not used the specific campaign names when quoting individuals or citing specific information. The sample size is small and the privacy of KIs is an important concern.

The evaluator was transparent in the inception report about the limitations of assessing the projects' impacts due to a lack of baseline in the available data, closing data on beneficiaries' behaviours and the level of access the evaluator had to reporting functions on FB. While the original methodology entailed focusing on the qualitative aspects of beneficiary experiences (i.e. positive or negative) as indicated in participants' comments and conversations via social media platforms, it was not possible to access raw data.

Finally, MSF uses FB advertising for DHP campaigns. Data related to measuring the campaigns is produced by FB and accessible by the DHPU. While this includes a variety of measurements, use of these data for analysis is limited due to the way the data are collected and reported (see Annex 10 for more information on this). For example, data from various campaigns within each country cannot be simply added to accurately describe the reach (number of people who saw your ads at least once) for that country due to the way that FB calculates metrics based on sampling. Data was cross-checked using project documents. In cases where there was a discrepancy, the data from FB was used.

ETHICAL CONSIDERATIONS

MSF's humanitarian action across the sites where the DHP campaigns were implemented involves work with at-risk and marginalized populations. This requires an appropriate level of sensitivity that draws on evidence-based work among these groups. The evaluator considered each project setting and context when developing data collection instruments. While the evaluator did not work directly with any of these populations for this evaluation, it is a consideration worth noting.

As the DHP campaigns were implemented in a digital space over social media, privacy and confidentiality are important concerns. Members of the DHPU have indicated that measures are already in place to protect the privacy and confidentiality of beneficiary data (e.g., screening comments and conversations for private and sensitive data). To ensure that these policies are upheld throughout the evaluation, the evaluator clarified the specifics of the DHPU's policies and protocols regarding privacy and confidentiality of information collected and shared during the DHP campaigns.

The evaluator developed a standard verbal informed consent process for all KIs to ensure their participation was voluntary, they understood why their information was being collected, and were aware of how it would be used. Regarding data management, all data was confidential and stored in a secure location. It was only accessible to the evaluator. During reporting, all data is anonymous. Data will only be used for the purposes of this external evaluation. Once the evaluation is completed, the Head of Evaluation Unit will be responsible for the disposal of data in accordance with MSF policy on the disposal of records. The evaluator has also read the Stockholm Evaluation Unit (SEU) ethical guidelines for evaluation and agrees to adhere to the practices outlined in the document.[21]

[21] SEU ETHICAL GUIDELINES FOR EVALUATION, MSF-SEU, March 2020

RESULTS

REACH

REACH OF DHP CAMPAIGNS

EQ1: WAS THE REACH OF THE COVID-19 DHP CAMPAIGNS ADEQUATE ACCORDING TO EACH CAMPAIGN'S STATED OBJECTIVE AND TARGET POPULATION?

It was not possible to independently assess how adequate the reach (i.e., absolute number, proportion, and representativeness of beneficiaries) [22] was based on campaign objectives and the available data (for campaign objectives see Annex 5). This finding is attributed to two factors. First, potential reach was *not* adequately defined in project documents, objectives, or when describing the target population. Campaign documents often identify the target population as everyone in the population over the age of 18. Second, the lack of readily available baseline data on population characteristics (e.g., gender, language, ethnicity, etc.) makes it impossible to determine how successful the reach was for each campaign, or for the campaigns overall. For example, the pilot campaign aimed to target migrants, asylum seekers, and homeless individuals who speak specific languages, although no baseline data that I had access to was available in project documents or elsewhere. Overall, it is unclear if the individuals who saw and/or engaged with the campaigns (e.g., through conversations, comments, link clicks, etc.) are representative of the target populations since the target populations are broadly defined or lack population characteristics in project documents. Table 5 outlines the estimated calculations of proportion and representativeness of beneficiaries. [23] The evaluator used baseline data from the campaign reports. When no data was available, the evaluator identified data points from other credible sources. The source of each data point is indicated in the footnotes.

Despite these limitations, quantitative indicators of the campaigns appear high. Key informants (KI) ((n=12) agreed that the reach across the campaigns in the sample was adequate based on the target populations identified. This was facilitated by FB's geo-targeting capabilities. As one KI noted, "the thing is that, in pools like FB you can segment who will see your advertising, not like billboard or newspaper where you cannot control who sees it." A couple of KIs (n=2) were surprised that they were able to reach older adults, as they were perceived to have low participation on social media. Others (n=2) see the potential in using geo-targeting in the future, to target specific age ranges or other hard-to reach populations that they work with.

- KIs also identified various challenges involving reach of target populations. This included, not having culturally or context appropriate campaign content (n=4) (e.g., in local languages), access issues regarding the technology (n=4) (i.e., government restrictions on social media and the lack of internet connection among target population), Limited HR to respond to beneficiaries (n=1), and local context (n=1).[24]

[22] https://www.re-aim.org/about/what-is-re-aim/reach/
[23] The evaluator identified baseline data points for reference when they were too limited in the project documents to make any assessment.

[24] One KI noted that events in the local environment could be disruptive to running the DHP campaigns, which was identified as a challenge.

A couple of KIs (n=2) were also concerned that the good quantitative results (reach, impressions, etc.) would not be possible if they had to use their own budget. The DHPU paid for many of the Covid-19 campaigns, although FB data shows that MSF paid for three campaigns and FB paid for the rest as part of their dedication to the Covid-19 response.

Table 5. Estimated calculations of proportion and representativeness of beneficiaries

REACH BY CAMPAIGN				
Campaign	Target Population	Statistics	Campaign Reach	Reach proportion
Belgium[25]	▪ Migrants and asylum seekers who speak Arabic, Amharic, and Tigrinya ▪ Homeless in Belgium who speak English and French	29,305 asylum seekers[26] 5,313 homeless[27]	27, 472	No way to calculate based on available data
Brazil (Bahia)[28]	Everyone aged 18 and above in the State of Bahia	14,016,906[29] (total population)	3,838,691	27.38%[30]
DRC[31]	Everyone in Limeté, Kinshasa (18-65+)	15,000,000 (total population) 300,000 estimated audience[32]	507,927	3.62%[33] 169.31%[34]
Gaza[35]	Everyone aged 13 + living in Gaza City and surrounding 5 governates	1.2 million FB users	1,179,701[36]	98.30%
Greece (Moria)[37]	Everyone 1km around Camp Moria	18,966 (total population)		
V1-Messenger	-	-	12,276	64.73%
V2-Messenger	-	-	10,106	53.28%
V3-Messenger	-	-	7,946	41.90%
V1-Phone calls	-	-	6,642	35.02%

[25] COVID19 - Belgium Digital HP campaign proposal v4
[26] https://www.unhcr.org/refugee-statistics/download/?url=U6pKkh
[27] There is no official data regarding the homeless population in Belgium. https://www.brusselstimes.com/news/belgium-all-news/160430/vanbiervliet-brusshelp-brussels-homeless-population-hits-new-record-frank-vanbiervliet-brusshelp-squatting-shelter-unoccupied-housing-coronavirus-pandemic/
[28] Bahia report JH v2
[29] https://academic-eb-com.proxy.libraries.smu.edu/levels/collegiate/article/Bahia/11777
[30] This is a conservative estimate, as there is no data on Bahia population by age. This is calculated using the total population.
[31] Final_Report_DHP_DRC-Limete_updated en
[32] It's unclear from the project documents how this number was determined and if this refers to the number of social media users or not.
[33] This is a conservative estimate, as there is no data on Kinshasa population by age. This is calculated using the total population.
[34] This statistic shows that the estimated audience was too conservative.
[35] Gaza C19 DHP campaign report 2021 07_v2
[36] Due to data reporting on FB, it is possible that this number is inflated.
[37] Final_Report_DHP_Moria

V2-Phone calls	-	-	5,900	31.11 %
Guinea	Everyone aged 16 + living in Guinea	13,132,792[38] (total population)	1,310,779	50.00%[39]
Haiti	Everyone in Haiti (18 -65+)	1,5 - 2 million people possible audience	1,441,857	72.09%
Indonesia	Facebook and Instagram users in Indonesia 18 +	170 million potential active social media users	55,347,645	32.56%
South Africa	Everyone aged 18 and above living in South Africa	21 million social media users	4,096,185	19.50%
Zimbabwe	Everyone above the age of 16 living in Zimbabwe	14,862,927 [40] (total population)	639,005	4.29%
TOTAL			67,182,089[41]	

SQ1: What was the level of beneficiary engagement within and across the campaigns, including conversations, comments, etc.?

FB metrics include data points related to engagement, such as link clicks, post comments, and post reactions. However here are important limitations with the way that data are collected and reported. For example, post engagement reflects the total actions taken, not the unique actions. Therefore, this doesn't account for multiple actions taken by one individual. This is similar for 3-second video plays.

Data from FB indicates, that across the campaigns (n=10), quantitative measures of beneficiary engagement include (for complete quantitative data for each campaign, see Annex 11):

- Impressions: 406449863
- Link clicks: 541640
- Post engagements: 118808
- Post comments: 11425
- Post reactions: 235440
- 3-second video plays: 797789

However, data shared by DHPU from their own monitoring system, involving the use of Microsoft Forms, indicates that there were 16771 comments across 8 campaigns.[42] This discrepancy highlights the need for more accurate and transparent monitoring and reporting mechanisms.

[38] https://data.worldbank.org/indicator/SP.POP.TOTL?locations=GN
[39] This data point comes directly from the Guinea final report
[40] https://data.worldbank.org/indicator/SP.POP.TOTL?locations=ZW
[41] Excludes data from Greece. Due to FB data limitations, there is no way to calculate total reach accurately.
[42] There is no monitoring data from Belgium and Greece, as these were pilot programs and the current DHPU monitoring system was not yet in place

EFFECTIVENESS

IMPACT OF CAMPAIGNS ON BENEFICIARIES

EQ2: WHAT WAS THE IMPACT OF THE CAMPAIGNS ON BENEFICIARIES AS EVIDENCED BY THEIR COMMENTS AND LEX DEC (AND KAP SURVEYS WHEN AVAILABLE)?

Unfortunately, the raw FB data regarding comments, conversations, and BLS was not available due to data protection concerns. Therefore, it was not possible to determine the impact of the campaigns on beneficiaries using primary data. However, comments from the campaigns were recorded by each HP field manager or focal point and input to Microsoft Forms for internal DHPU monitoring. Data on the tone of the comment as well as the attitude of the comment were available for Brazil, Indonesia, South Africa, and Zimbabwe (3744 comments). However, these concepts were not defined, making their interpretation subjective. Additionally, there were no data on the conversations after the comments were responded to. Therefore, it is not possible to determine how the interactions with first responders impacted beneficiaries.

Based on a monitoring system set up by the DHPU in Microsoft forms there were mixed results when attempting to measure the beneficiary impacts. Across the campaigns, the tone was overall rational (n=1616, 55%), but some beneficiaries were emotional (n=680, 23%) and aggressive (n=432, 15%) (see Figure 1). Regarding the attitude of the comments, there were more negative comments (1429, 39%) than positive comments (1048, 29%), indicating that the campaigns were perceived more negatively by the population (see Figure 2). However, it is not possible to determine if the negative attitudes were towards the campaigns themselves or the campaign topics (e.g., Covid-19). Further, it's unclear how the impacts on beneficiaries after the comments were addressed by the MSF field teams. Despite this, some KIs (n=4) noted that they received appreciative messages from beneficiaries, indicating that the campaigns had a positive impact.

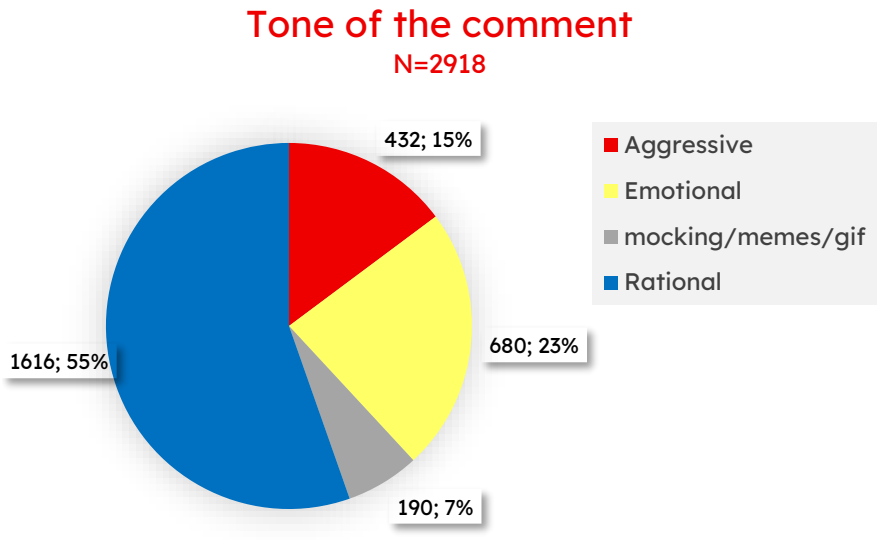

Figure 1. Tone of comments

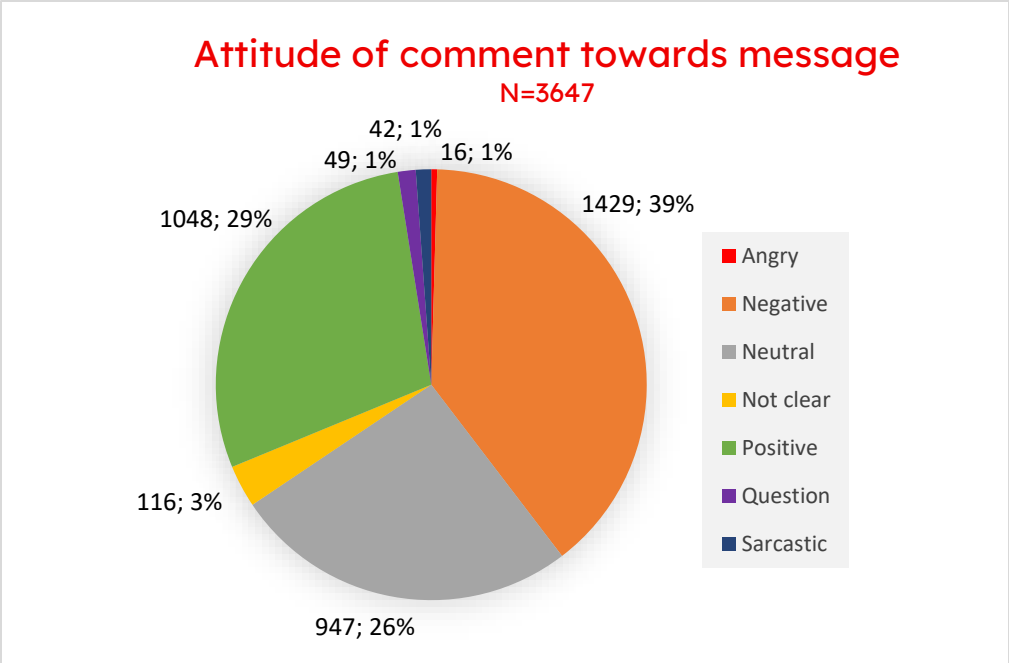

Figure 2. Attitude of comment towards message

Brand Lift Studies[43]

The BLS results from FB also show mixed results. BLS include questions that assess areas commonly found on Knowledge, Attitudes, and Practices surveys, to determine impacts on beneficiaries who were exposed to MSF's campaigns. There is some evidence to suggest beneficiaries who saw or engaged with some campaigns were impacted, as is the case for Brazil. Findings were mixed for Indonesia and South Africa and there does not appear to be an impact on beneficiaries for Zimbabwe. As noted in the methodology, FB compares two groups of users; one group who has seen the advertisements and one who has not (i.e., the control group). The overall "lift" is the difference in score between the two groups, in their response to specific questions.

Brazil

The Covid-19 campaigns in Brazil had FB objectives involving brand awareness (i.e., advertisement recall), traffic (i.e., directing individuals to a specific destination via link clicks, for example), and reach, and the BLS assessed the following:

- Organizational trust
  - Do you agree or disagree that MSF is a reliable source of facts and information on the Covid-19 vaccine?
- Attitude
  - How important is wearing a mask in public and washing your hands with soap to help stop the spread of Coronavirus (Covid-19)?

[43] While the FB results provide data for a more nuanced understanding of how beneficiaries were impacted by the MSF campaigns (e.g., by gender, age, and question response), exploring these details was not appropriate for this evaluation, as the target groups were broadly defined.

- Safety
  - How safe do you think a vaccine against Covid-19 is?

While FB reported good scores for ad recall, reach, and traffic, the results regarding organizational trust, attitude and safety were mixed. For organizational trust there was some lift on traffic (+2.5 pts), but not reach. For attitude, there was slight lift on reach (+1.4 pts), but none for traffic, and for safety, there was lift on traffic (+3.8 pts) but none for reach. These findings indicate that there may be an impact on beneficiaries regarding trust in MSF and attitudes and knowledge surrounding Covid-19 after seeing MSF's campaigns, compared to the control group.

Indonesia

Of the campaigns in Indonesia with the objectives of video views, brand awareness, and reach, the following topics were assessed through the BLS:

- Actions to stop the spread of C19
- How important to keep physical distance
- How important to wear a mask
- Maintained hand hygiene in the past 2 days
- Worn a mask in the past 2 days

FB reported a correlation between frequency, ad recall, and lift in responses to questions on physical distancing (+3.0 pts), and how important it was to wear a mask (+1.5 pts) and if they wore a mask in the past 2 days (+1.8 pts). This lift in percentage points in comparison with the control indicates that there may have been an impact on beneficiaries' knowledge and practices due to seeing MSF's FB campaigns. FB did not find any correlation between frequency and engagement metrics or the lift in responses. Similarly, FB did not identify any correlation between video engagement, ad recall, and the lift in responses, indicating that there was not an impact on beneficiaries' knowledge and attitudes after watching the videos associated with MSF's FB campaigns.

South Africa

For the Covid-19 campaign in South Africa, the BLS assessed the following:

- Perceived knowledge (+1.5 pts)
  - How confident are you that you could explain how Covid-19 vaccines work to a close friend or family member?
- Safety (+.9 pts)
  - How safe do you think a Covid-19 vaccine is?
- Organization trust (+2.6 pts)
  - Do you agree or disagree that Doctors Without Borders (MSF) is a trustworthy source of Covid-19 vaccine facts and information?

The data summary provided by FB indicates that for ad recall, lift was good (+3.4 pts). There was lift regarding perceived knowledge and organizational trust, indicating that there was an impact for beneficiaries who saw the MSF campaign in these two areas. However, there was not much lift regarding safety, indicating that there may not be an impact for beneficiaries regarding knowledge about vaccine safety.

Zimbabwe

The BLS for Zimbabwe focused on assessing the following:

- Perceived knowledge (+1.7 Pts)
  - How confident are you that you could explain how Covid-19 vaccines work to a close friend or family member?
- Organizational trust (+.5 pts)
  - Do you agree or disagree that Doctors Without Borders (MSF) is a trustworthy source of Covid-19 vaccine facts and information?
- Safety (+.6 pts)
  - How safe do you think a Covid-19 vaccine is?

While the FB summary indicates that the standard ad recall was high (+5.2 pts), there was no lift for organizational trust, slight lift for perceived knowledge, and no lift for safety**.** This indicates that this campaign did not have an impact on beneficiaries' knowledge or attitudes after being exposed to MSF's campaign.

SQ2: Were there any unintended impacts (positive or negative)?

There were numerous unintended impacts from the Covid-19 campaigns (see Annex 12). The most frequently mentioned were: having to address other beneficiary concerns (n=7) and capacity-building among field teams (n=6). When beneficiaries spoke with the responders, they sometimes asked for legal advice, where they can find food, where they can get medical attention for non-Covid-19 health concerns and had questions about other current health issues (i.e., Ebola outbreak and the bombing in Gaza). This also resulted in providing mental health support to the beneficiaries, and the recognition that there is a mental health burden for the MSF field team. Capacity-building was also recognized as an unintended outcome of the campaigns (n=6). Through training on how to do DHP, field teams learned technical skills. Some also commented that they felt independent enough to run their own DHP campaigns in the future without the DHPU.

ADOPTION

INFLUENCE FACTORS ON PROGRAM ADOPTION

EQ3: WHICH FACTORS INFLUENCED PROGRAM ADOPTION FOR THE FIELD TEAMS?

SQ3: Would field teams adopt DHP programs in the future? Why or why not?

All the field KIs (n=7) agreed that they would adopt DHP program in the future. MSF field teams in the sample learned about DHP internally through DHPU awareness-raising efforts (n=2) or via word of mouth (n=2) and agreed to adopt Covid-19 DHP as part of their HP strategy based on their previous positive experiences with DHP (n=3) and their understanding that they can reach many beneficiaries (n=3). This may also be related to the positive experiences that many KIs had with the DHPU (n=5) (discussed in detail below).

IMPLEMENTATION

IMPLEMENTATION OF CAMPAIGNS

EQ4: WERE OPERATIONS STAFF ABLE TO SUCCESSFULLY IMPLEMENT EACH CAMPAIGN IN ACCORDANCE WITH THE PROCESS OUTLINED BY THE DIGITAL HEALTH PROMOTION UNIT AND HP BEST PRACTICES AS OUTLINED BY MSF-OCB?

Overall, the staff were able to implement the DHP campaigns in accordance with the process outlined by the DHPU. This process was facilitated by the support they received from the DHPU. And the guidance materials, which were utilized by more than half of field KIs (n=4) consulted. This includes the DHP Toolbox[44] and the Question-and-Answer documents.

However, when field KIs (n=7) were asked about applying MSF-OCB's current HP framework to DHP, only one indicated that they actively used the materials, which used to be provided via flash drive, but are now accessible on Sherlog. Another KI noted that they have used HP principles for many years but do not actively apply the MSF-OCB HP framework.

SQ4.1: What factors facilitated successful implementation?

Of the field personnel interviewed for this evaluation (n=7), the majority (n=5) attributed the success of their campaigns to their collaboration with the DHPU. This included training (n=6), technical support (n=5), providing guidance documents (n=4), maintaining regular communication (n=4), accessibility and availability of the team when needed (n=4), monitoring and evaluation (n=3), content design (n=3), and feedback (n=2).

SQ4.2: What factors were barriers or challenges to implementation?

KIs identified various challenges to implementation, including operations (n=10), relationships with stakeholders (8), technical difficulties (n=5), and the local context (n=5), among others.

Operations

A central challenge identified by KIs was defining the new operations for the DHP in the field (n=10). This included the role of DHP in the field (n=6), monitoring and reporting (n=4), and the lack of HR (n=3), and turnover of field staff (n=2).

Overall, it was unclear to field teams what resources they would need to setup the DHP and how it would operate. For example, one KI noted:

"But how do they do it? Do they need to be in an office, ya know with chairs? With tables? With good internet? And then at one point some of them [the responders], they had like one or two messages a day, especially at the beginning. It is also super boring for the team when you know there is other work to be done, and to be inside in an office…when you don't have so much to do. So, in terms of being able to keep

[44] Hein, Jakub. n.d. "Digital Health Promotion Toolbox:THE ESSENTIAL GUIDE TO MISSIONS CONSIDERING OR STARTING DIGITAL HEALTH PROMOTION INTERVENTIONS." v0.3-Covid-19 working Version. Médecins Sans Frontieres.

them motivated at the beginning it was a bit hard and then at one point we found another way to be more flexible and for them to answer with their phone. But this took a bit of time at the beginning. I was just like, 'but can we do it with a phone?' It was a bit like, being able to frame that better in terms of HR and everything was a bit complicated especially at the beginning."

Additionally, monitoring and reporting (n=4) was a challenge for two reasons. First, it was difficult to continually monitor the campaigns and interactions with beneficiaries. As one project document indicated, "we were constantly assessing challenges and questions until we constantly improve the work of the campaign through meetings with DHP team, monitoring of the quality of answers and regular feedback from line managers." Second, some KIs pointed out that they did not see the campaign data until the end of the campaign. This was problematic for them, as they were responsible for reporting to others in the field and writing reports that required the campaign data.

It was also difficult to transition the HP field teams to do the DHP, as personnel had to transfer their communication skills to a digital space. In one instance, the field team perceived the DHP personnel as not working, since they were sitting in an office all day. It was also unclear to some field teams where HP started and Communications stopped as there are overlapping elements to both roles operating in a digital space. Similarly, the relationship between the Medco and the DHP was not well defined, and at least one KI would have liked more support from the Medco when responding to beneficiaries. A couple of KIs also mentioned that turnover in the field was an issue because the transition in personnel could change the field team's attitude about DHP.

Relationships with Stakeholders

Another challenge to implementation that KIs identified was the relationship between various stakeholders (n=8). This includes the relationship between the DHPU and the field teams (n=6), the relationship between MSF and local entities (e.g., ministry of health) (n=2), and the relationship between the emergency team and the field team (n=1).

As previously noted, KIs agreed that the DHPU offered a lot of support during implementation. They also identified numerous challenges to working with the DHPU, which included agreement between the field team and the DHPU regarding campaign content (n=3), working from a distance (n=2), miscommunication between the teams (n=1), and the power imbalance (n=1). In some cases, there was disagreement between the field teams and DHPU regarding content for campaigns. This was attributed to lack of cultural context and indecisiveness among specific personnel. While miscommunication and power imbalances were only described by one individual, it is still important to note. The KI pointed out that the underlying power imbalance between field teams and HQ posed a challenge for their working relationship, as there may be hesitancy on the part of the field teams to be forthcoming about their own technical skills and overall preparedness for the campaigns.

Technical Difficulties

Technical challenges were also part of the KI experience (n=5). KIs reported that the technical requirement (having the correct equipment and internet connect) could be a challenge for some (n=2). Also, learning how to use the FB platform to communicate with beneficiaries was difficult for others (n=2), and in one case there was a pause in the campaign (n=1) due to technical issues.

Local Context

The local context was challenging for implementation (n=5) due to the lack of local health care, which made referrals very difficult (n=3). Also, in some cases, target populations had other priorities besides Covid-19 (e.g., food and healthcare) (n=3). Finally, people's perception within the local context as well as keeping up with the changing context of Covid-19 (n=1) (e.g., latest guidance) made implementation difficult.

Other

KIs noted other challenges, such as knowing how to respond to beneficiaries (n=4), campaign delays (n=4), the lack of pre-testing or pre-assessment (n=2), budget (n=2), reliance on the DHPU (n=2), field teams' resources (n=1), and English as the dominant working language of the DHPU (n=1).

SQ4.3: Were campaigns appropriately adapted to the specific contexts?

While most KIs agreed (n=9) that the Covid-19 campaigns were well adapted to the context, some (n=4) also noted that there were ways that they could have been better adapted to the local context.

Well adapted

While the local context of Covid-19 was continuing to change on the ground, some KIs attributed the success of the campaigns to their alignment with these changes. For example, introducing vaccine messages when vaccines were arriving. In one setting, the topic of vaccines was already trending when the MSF Covid-19 campaign started. Another KI indicated that the team (field team and DHPU) were able to work together to adapt messages and tailor interactions with beneficiaries to the context as it evolved on the ground.

Better adapted

The KIs that felt the campaigns could have been better adapted (n=4) cited various reasons that were context and campaign specific. This included running the campaigns in more local languages (n=1) and using designs produced locally (n=1). One KI noted that the messaging was not updated from one campaign to the next in their context. Since the context on the ground was changing, this could have been improved.

THE MOST VALUABLE OUTCOME

EQ5: WHICH PARTS OR ASPECTS OF THE CAMPAIGNS GENERATED THE MOST VALUABLE OUTCOME FOR THE TIME, MONEY AND EFFORT INVESTED?

According to KIs, reach (e.g., the ability to reach many individuals) and various aspects of operations (cost, resources, time) generated the most valuable outcomes for the context of time, money and effort invested.

Operations

KIs highlighted characteristics of operations (n=8) as the most valuable aspects of the campaigns, considering the time, money, and effort invested (see Table 6). This includes the

Cost (n=7), low resources (n=2), and the relatively short time that it takes to setup and run a campaign (n=2). As one KI noted, "It is a safe way of working, it is a cost-effective way of working. We, as a project we embrace it a lot, we kind of have a bias because we speak and work more with adolescence and young people and they are the largest digital users. So, we see quite a lot of positive in working with digital platforms."

Reach

Reach was also mentioned (n=5). While some KIs referred specifically to the total number of beneficiaries that the campaigns can reach, others noted that geo-targeting ensures the correct beneficiaries see the campaigns. One KI noted that when beneficiaries engage with the campaigns, they feel more comfortable disclosing information in this digital space. As this KJI noted, "People are going to express things that they aren't going to say in school setting or church setting, or with a lot of people together. I think you get far more insights that are really interesting, even if it's pro or contra MSF or needs or worries, you get far more information if you do it than other kinds of way."

Other

One KI expressed the need for MSF to stay current in contemporary society, noting, "I also think there is a factor that you can reach a lot of people and cost less money. There is this new generation, that maybe prefers being contacted this way. Maybe it is easier for them to go and message someone through a virtual interface."

Table 6. The most valuable aspects of the campaigns

EQ5: WHICH PARTS OR ASPECTS OF THE CAMPAIGNS GENERATED THE MOST VALUABLE OUTCOME FOR THE TIME, MONEY AND EFFORT INVESTED? (N=10)		
-	KII (n)	Percentage
Operations	8	80
Cost	7	70
Low resources (HR)	2	20
Fast	2	20
Reach	5	50
Number of beneficiaries reached	3	30
Geo-targeted	1	10
Beneficiaries feel more comfortable	1	10
Staying current	2	10
Safety	1	10

MAINTENANCE

LONG-TERM IMPACTS OF DIGITAL HEALTH PROMOTION CAMPAIGNS

EQ6: WHAT ARE THE LONG-TERM IMPACTS OF DIGITAL HEALTH PROMOTION CAMPAIGNS WITHIN MSF AS AN ORGANIZATION?

Overall, KIs agreed that DHP impacts MSF as an organization by creating visibility through the campaigns (see Table 7). While KIs recognized that this is not the objective of the Covid-19 campaigns, they found that they do increase MSF's visibility. As one KI noted, "I mean even like as MSF, I think like in some contexts where we are maybe not known well, in new contexts, especially when you arrive in and are not known well, where MSF is not present and not known, it's interesting also to be able to talk about MSF online, and it's a really good also way to promote the organizations as itself, so this can be also, be used to share principles that we have on the impartiality and with all the values we have and can also permit us to have good access. I think it can be an interesting tool for MSF as an organization."

Some KIs also felt that DHP helps MSF adapt to contemporary trends (n=4), while others indicated that DHP would and should be expanded across the organization because it adds value to the organization

overall (n=3). However, a couple of KIs have their doubts about the how the current model can be incorporated into MSF operations based on budget constraints of field teams as well as limited HR capabilities of the DHPU.

Table 7. Long-term impacts of digital health promotion campaigns

EQ6: WHAT ARE THE LONG-TERM IMPACTS OF DIGITAL HEALTH PROMOTION CAMPAIGNS WITHIN MSF AS AN ORGANIZATION? (N=12)		
-	Documents	Percentage
Creating visibility	11	91.66%
Adapt to contemporary trends	4	33.33%
DHP across the organization	3	25.00%
Concerns about DHP across the organization	2	16.66%
HR concerns	2	16.66%
Budget concerns	1	8.33%

LONG-TERM EFFECTS OF DIGITAL HEALTH PROMOTION CAMPAIGNS

EQ7: WHAT ARE THE LONG-TERM EFFECTS OF THE DHP OUTCOMES ON BENEFICIARIES?

From the perspective of KIs (n=12), beneficiaries build trust in MSF through the DHP Covid-19 campaigns (n=8). They can also access support (n=5), including emotion support and referrals. Some KIs spoke about the way that DHP can empower individuals (n=4) to ask questions they might not normally ask when surrounded by other people in a typical HP setting (e.g., schools and churches). Some (n=4) also recognized that there is no formal assessment process and there is really no way to know what the impacts on beneficiaries are. Finally, a couple of KIs also recognized that beneficiaries may become more aware of MSF as an organization.

CONCLUSION AND RECOMMENDATIONS

Ninety-five per cent of the global population (more than 7 billion people) live in regions with cellular network coverage, and in developing countries, almost 41 per cent of people have mobile broadband subscriptions.[3] Prominent health-centred organizations, including MSF, have used DHP to reach diverse groups of beneficiaries worldwide.[45] Since DHP is relatively new,[46] standards for evaluation are still being developed. This evaluation applied the RE-AIM framework, which has been widely used to assess HP programs,[47] and increasingly DHP campaigns.[48] The five RE-AIM criteria were used to answer the evaluation questions, and included: reach, effectiveness, adoption, implementation, and maintenance. The objectives of this evaluation were twofold; 1) to determine how successful the DHP campaigns in the sample (n=10) have been by identifying good practices and identifying areas of improvement and 2) to co-create recommendations with key stakeholders from/for the Digital Health Promotion Unit, Health Promotion referent, and Medical Directors.

Overall, it was difficult to determine the success of the DHP campaigns due to lack of ME data. However, good practices and areas of improvement were easily identified. From the perspective of the field personnel, the most important factor that contributed to successful campaigns was the support they received from the DHPU, including training, technical support throughout implementation, and the consistent communication between the DHPU and field teams. The DHPU also provided guidance documents to support monitoring, technical training, and troubleshooting during implementation.

The results of the evaluation show that the most common areas for improvement include:

- Monitoring and Evaluation (ME)
- Operations
- Relationships with local stakeholders
- Adapting to local context
- Language

[45] World Health Organization. 2021. *Global Strategy on Digital Health 2020-2025*. Geneva: World Health Organization. https://apps.who.int/iris/handle/10665/344249.
"UNICEF's Approach to Digital Health." n.d. UNICEF. https://www.unicef.org/innovation/media/506/file/UNICEF%27s%20Approach%20to%20Digital%20Health%E2%80%8B%E2%80%8B.pdf.
[46] https://www.un.org/en/chronicle/article/bridging-digital-divide-health
[47] Kwan, Bethany M., Hannah L. McGinnes, Marcia G. Ory, Paul A. Estabrooks, Jeanette A. Waxmonsky, and Russell E. Glasgow. 2019. "RE-AIM in the Real World: Use of the RE-AIM Framework for Program Planning and Evaluation in Clinical and Community Settings." *Frontiers in Public Health* 0. https://doi.org/10.3389/fpubh.2019.00345.,
[48] Vega, Rocio de la, Lee Ritterband, and Tonya M Palermo. 2020. "Assessing Digital Health Implementation for a Pediatric Chronic Pain Intervention: Comparing the RE-AIM and BIT Frameworks Against Real-World Trial Data and Recommendations for Future Studies (Preprint)." Preprint. Journal of Medical Internet Research. https://doi.org/10.2196/preprints.19898.

MONTORING AND EVALUATIONS

As already indicated, the most prominent area for improvement is the ME framework, especially regarding campaign impacts on beneficiaries. According to MSF-OCB, "the sole purpose of digital HP, as part of the general HP objective is to improve well-being of our target population."[49] However, poorly defined baseline data and lack of data on beneficiaries make this objective impossible to measure.

OPERATIONS

The evaluation found that operations surrounding DHP can be strengthened in numerous ways, specifically regarding HR, costs, and technical aspects. The role of the DHP field staff was poorly defined, and it was often unclear where the responsibilities of communications ended and where DHP began within field teams. Some KIs also noted that the campaigns are cost effective overall based on the number of people they can reach in a short amount of time. However, they also indicated that if the field teams had to carry the financial burden of the campaigns alone that they would not be able to reach as many people. FB paid for almost all the DHP campaigns to-date (except 3) as part of their global initiative to help end the pandemic. Technical aspects were also a concern. While field teams reported increased digital literacy as a direct result of training provided by the DHPU, they also noted that this may not work in some settings and that not all members of the DHP field teams received training directly from DHPU, which is something that some KIs (n=2) felt would help their DHP teams with implementation.

RELATIONSHIPS WITH LOCAL STAKEHOLDERS

Some KIs also noted that campaigns should do a better job of aligning themselves with local stakeholders. This includes ensuring that campaign messages are congruent with messages from other organizations, such as the local Ministry of Health, as well as collaborating with stakeholders. In one case, there were campaign delays due to tense relationships with local health authorities.

ADAPTING TO LOCAL CONTEXT

KIs also mentioned that the campaigns could be better adapted to local contexts. In some cases, KIs (n=2) mentioned that expanding campaign languages would have been beneficial. In other cases, KIs mentioned that the changing context of Covid-19 required that continuous research be conducted by members of the field team, which can put a strain on HR. This was necessary to ensure that campaign messages were up to date with the latest evidence-based practices surrounding Covid-19.

[49] Digital Health Promotion, 2021. MSF-OCB, Sherlog.

LANGUAGE

Not only did some KIs note that campaign should provide messaging in other languages, but some KIs noted that DHPU training and guidance documents should be provided in the languages of the field teams. This would ensure that everyone on the field team can participate in trainings and utilize the DHP resources provided by the DHPU.

KEY RECOMMENDATIONS

To address the second objective of the evaluation, the evaluator led a participatory workshop to co-create practical recommendations based on the evaluation results. Participants included the evaluator, members of the SEU, and the commissioners of the evaluation. The recommendations below were identified.

Overall, the recommendations identified during the participatory workshop provide practical examples of how to strengthen MSF's DHP initiatives. While the evaluation identified many gaps that need to be filled in order to determine the success of the programs, it is clear from the desk review (see Annex 13) and semi-structured interviews, that DHP is part of a broader global trend towards digitization of health services and HP. As such, efforts to strengthen DHP activities should be integrated into MSFs HP strategy.

To address the second objective of the evaluation, the evaluator led a participatory workshop to co-create practical recommendations based on the evaluation results. Participants included the evaluator, members of the SEU, and the commissioners of the evaluation. The following recommendations were identified:

1. Develop transversal collaborations within MSF to create a more robust monitoring and evaluation (ME) system for digital health promotion (DHP)
   a. Draw on existing resources to develop and implement ME tools
   b. Strengthen relationships between the DHPU, SEU, MSF-OCB, and MSF to develop an ME framework
   c. Formalize the roles of the DHP field teams within MSF as an organization
2. Enhance the existing strengths of the DHPU by expanding HR
   a. Offer more technical training and support to field teams, which could include a training of trainer's program
   b. Add an additional member of DHPU to manage ME framework
3. Increasing continuity between health promotion (HP) and DHP
   a. Increase accessibility to DHP resources within the HP context
   b. Create more internal awareness about HP and DHP frameworks, guidance documents, and resources

Overall, the recommendations identified during the participatory workshop provide practical examples of how to strengthen MSF's DHP initiatives. While the evaluation identified many gaps that need to be filled in order to determine the success of the programs, it is clear from the desk review (see Annex 13) and semi-structured interviews, that DHP is part of a broader global trend towards digitization of health services and HP. As such, efforts to strengthen DHP activities should be integrated into MSFs HP strategy.

ANNEXES

ANNEX 1: COVID-19 CAMPAIGNS AND CHARACTERISTICS

Table 8. Campaign Characteristics

COVID-19 CAMPAIGN CHARACTERISTICS				
Location	Covid19	Way	KAP survey	Year
Afghanistan/all country	Yes	1-way	NO	2020
Belgium	Yes	2-way	NO	2020
Belgium	Yes	1-way	NO	2021
Brazil/Manaus	Yes	1-way	NO	2020
Brazil-regional (Porto Velho and Ji-Parana)	Yes	1-way	NO	2021
Brazil-Para	Yes	1-way	NO	2021
Brazil-Bahia	Yes	1-way	YES	2021
DRC/Kinshasa/Limeté	Yes	2-way	NO	2020
Ecuador/all country	Yes	1-way	NO	2020
Ecuador/Monte Sinai	Yes	1-way	NO	2020
Greece/Moria	Yes	2-way	NO	2020
Greece/Moria	Yes	2-way	NO	2021
Guinea	Yes	2-way	NO	2021
Haiti	Yes	2-way	NO	2020
Indonesia	Yes	1-way	YES	2021
Iraq/Mosul	Yes	1-way	NO	2020
Mozambique	Yes	1-way	NO	2020
Mumbai	Yes	1-way	NO	2021
Palestine, Gaza	Yes	2-way	NO	2021
Portugal	Yes	1-way	NO	2021
South Africa	Yes	1-way	YES	2021
South Sudan	Yes	1-way	NO	2020
Ukraine	Yes	1-way	NO	2020
USA Detroit and Kent County	Yes	1-way	NO	2020
Zimbabwe, Mbare	Yes	1-way	NO	2020
Zimbabwe	Yes	1-way	NO	2021
Zimbabwe	Yes	1-way	YES	2021

ANNEX 2: TERMS OF REFERENCE

STOCKHOLM EVALUATION UNIT

TERMS OF REFERENCE

Doctors without Borders/Médecins Sans Frontières (MSF) *is an international medical humanitarian organization determined to bring quality medical care to people in crises around the world, when and where they need regardless of religion, ethnical background, or political view. Our fundamental principles are neutrality, impartiality, independence, medical ethics, bearing witness and accountability.*

The Stockholm Evaluation Unit (SEU), based in Sweden, is one of three MSF units tasked to manage and guide evaluations of MSF's operational projects. For more information see: evaluation.msf.org

SUBJECT/MISSION:	DIGITAL HEALTH PROMOTION - COVID-19
Starting date:	1st July, 2021
Duration:	Final report to be submitted by latest August 29th, 2021
Requirements:	Interested applicants should submit: 1) A proposal describing how to carry out this evaluation (including budget in a separate file), 2) a CV, and 3) a written sample from previous work
Deadline to apply:	2359hrs CEST on June 27th, 2021
Send application to:	evaluations@stockholm.msf.org
Note:	Due to the ongoing Covid-19 pandemic it is anticipated that this evaluation will not involve international travel and will require elements of remote data collection.

MEDICAL HUMANITARIAN CONTEXT

Médecins Sans Frontières (MSF) and its Operational Centre in Brussels (OCB) began using digital health promotion in 2018 to complement its existing health promotion strategies. The initial trials in Southern Africa proved to be promising and the experience provided a value opportunity to learn and refine the Digital Health Promotion Strategy.

Before there was an opportunity to absorb the experience from Southern Africa and fully develop the Digital Health Promotion Strategy, Covid-19 began to change the operational environment. The emergence of the novel virus at the beginning of 2020 saw an escalation of the number of countries in which MSF had emergency operations, including in several contexts that MSF had little or no experience working before. These operations had significant health promotion components and MSF needed to reach people quickly and provide health-related information. Many of the new contexts had the potential for use of social media that is not always the case in the contexts MSF works. At the same time the novel virus introduced significant limitations in terms of person-to-person contact, a

willingness from teams to try non-contact approaches. Based on these needs and the positive early pilot projects, MSF chose to significantly upscale its Digital Health Promotion activities in response to Covid-19 and ultimately established a small team at Head Quarters level to provide support to the field teams.

One year on and MSF OCB has implemented numerous campaigns. During 2020 there were 63[1] campaigns in total and were managed in two groups. The first group, 49 small or 'low coverage' campaigns carried out autonomously by the teams in Sothern Africa who had conducted the original pilot projects and had the local capacity to operate autonomously. The second group includes larger 'high coverage' campaigns in relation to Covid-19 and carried out by field teams with support of the newly established Digital Health Promotion Unit. This group includes 14 campaigns during 2020 and an additional seven during 2021, running between June 1, 2020, and June 1, 2021. These campaigns were designed and implemented by Health Promotion staff in the project locations with support from the Digital Health Promotion Unit and various technical referents including Health Promotion, hygiene, sexual health, vaccination, etc. Each campaign aims to be tailored to the local environment and the project objectives and Health Promotion strategy and utilize different social media platforms including Facebook and WhatsApp.

PURPOSE

This evaluation provides an opportunity to reflect transversally on the experience of implementing digital health promotion in a variety of contexts and capitalising on this experience by identifying what works, why, for who, and under what circumstances.

INTENDED USE

This evaluation is intended to determine how successful the DHP campaigns have been in order to identify examples of good practice and areas of improvement. Based upon the evaluation questions and findings, the evaluators should lead a process of co-creating recommendations which can be used by the Digital Health Promotion Unit and Health Promotion referent and Medical Director to make adaptations at the implementation and strategic level.

EVALUATION QUESTIONS

The following evaluation questions (EQs) are indicative and can be elaborated during the proposal and inception phase of the evaluation in collaboration with the stakeholders.

EQ1: How well did DHP address the most important needs? Was it the right solution in all cases?

[1] Medical Activity Report

EQ2: How well designed and implemented were the various campaigns? Were they appropriately adapted to the specific contexts?

EQ 3: What were the results achieved? Were there any unintended outcomes?

EQ 4: What worked best in achieving the results, for who, under what conditions and why?

EQ 5: Which parts or aspects of the campaigns generated the most valuable outcome for the time, money and effort invested?

EXPECTED DELIVERABLES

1. Inception Report
   As per SEU standards, after conducting initial document review and preliminary interviews. It will include a detailed evaluation proposal, including methodology.

2. Draft Evaluation Report
   As per SEU standards. It will answer to the evaluation questions and will include conclusions, lessons learned and recommendations.

3. Working Session
   With the attendance of commissioner and consultation group members. As part of the report writing process, the evaluator will present the findings, collect attendances´ feedbacks and will facilitate discussion on lessons learned.

4. Final Evaluation Report and Presentation
   After addressing feedbacks received during the working session and written inputs. Presentation (remote) to stakeholders within MSF.

5. Other dissemination deliverables
   To be defined in a separate dissemination plan.

TOOLS AND METHODOLOGY PROPOSED

In addition to the initial evaluation proposal submitted as a part of the application (see requirement chapter), a detailed evaluation protocol should be prepared by the evaluators during the inception phase. It will include a detailed explanation of proposed methods and its justification based on validated theory. It will be reviewed and validated as a part of the inception phase in coordination with the SEU.

RECOMMENDED DOCUMENTATION

- Strategic documents and guidelines for Health Promotion, Digital Health Promotion, etc.
- Project documents, including log frames, Health Promotion planning, reporting, etc.
- Individual campaign proposals, reports, capitalizations, etc.
- External literature and documentation

PRACTICAL IMPLEMENTATION OF THE EVALUATION

Number of evaluators	One or two
Timing of the evaluation	1st July 2021 - 29th August 2021

PROFILE/REQUIREMENTS FOR EVALUATOR(S)

The evaluation requires an individual or team of individuals who can demonstrate competencies in the following areas.

Evaluation-related competencies:

- Professional focus - acts ethically, reflectively, enhances and advances professional practice of evaluation.
- Technical focus - applies appropriate evaluation methodology.
- Situational focus - considers and analyses evaluation context successfully.
- Management focus - conducts and manages evaluation projects skillfully.
- Communication focus - interacts and communicates successfully with stakeholders.

Context-specific competencies:

- Humanitarian context - incorporates and acts according to the humanitarian principles.
- Organisational context - upholds the principles and values of MSF.

Subject-specific competencies:

- Results-based management - applies management principles, theory of change/logical framework for program analysis.
- Digital technology – applies appropriate technical solutions to problems.
- Health promotion – knowledge and understanding of health promotion.
- Behavioural change – ability to apply theories of behavioural change in evaluation practice.

APPLICATION PROCESS

The application should consist of a technical proposal, a budget proposal, CV, and a previous work sample. The proposal should include a reflection on how adherence to ethical standards for evaluations will be considered throughout the evaluation. In addition, the evaluator/s should consider and address the sensitivity of the topic at hand in the methodology as well as be reflected in the team

set-up. Offers should include a separate quotation for the complete services, stated in Euros (EUR). The budget should present consultancy fee according to the number of expected working days over the entire period, both in totality and as a daily fee. Travel costs, if any, do not need to be included as the SEU will arrange and cover these. Do note that MSF does *not* pay any per diem.

Applications will be evaluated on the basis of whether the submitted proposal captures an understanding of the main deliverables as per this ToR, a methodology relevant to achieving the results foreseen, and the overall capacity of the evaluator(s) to carry out the work (i.e. inclusion of proposed evaluators' CVs, reference to previous work, certification et cetera).

Interested teams or individuals should apply to **evaluations@stockholm.msf.org** referencing **DIGHP** no later than **June 27, 2021 at 2359hrs CEST**. We would appreciate the necessary documents being submitted as separate attachments (proposal, budget, CV, work sample and such). Please include your contact details in your CV.

ANNEX 3: SAMPLE CHARACTERISTICS

Table 9. Target populations

LOCATION	COVID19	WAY	BLS	YEAR
Belgium	Yes	2-way	NO	2020
DRC/Kinshasa/Limeté	Yes	2-way	NO	2020
Greece/Moria	Yes	2-way	NO	2020
Guinea	Yes	2-way	NO	2021
Haiti	Yes	2-way	NO	2020
Palestine, Gaza	Yes	2-way	NO	2021
Brazil-Bahia	Yes	1-way	YES	2021
Indonesia	Yes	1-way	YES	2021
South Africa	Yes	1-way	YES	2021
Zimbabwe	Yes	1-way	YES	2021

ANNEX 4: TERMS COMMONLY USED IN DIGITAL HEALTH PROMOTION

Reach: The number of people who saw DHP ads on Facebook at least once. Reach is different to impressions, which may include multiple views of ads by the same people.

Impressions: The number of times that DHP adverts were on-screen.

Frequency: The average number of times that each person saw your ad.

Conversations: Number of Facebook Messenger Conversations started by clicking on one of the ads. Not included are Phone calls, WhatsApp that are triggered by the ads.

Costs: Spent campaign budget for Facebook ads.

Link clicks: The number of clicks on links within the ad that led to advertiser-specified destinations, on or off Facebook. IN 2-way campaigns this is usually the opening of the messenger app. Note: Not everybody who opens the messenger apps starts a conversation. Depending on the project the number who start conversations is between 1 – 10 %

ThruPlays: The number of times that your video was played to completion, or for at least 15 seconds.

ANNEX 5: CAMPAIGNE OBJECTIVES

Table 10. Campaign Objectives

CAMPAIGN	OBJECTIVE
Belgium[50]	a) Increase awareness on the best practices to stay healthy during Covid-19 pandemic. b) Counter the most common myths surrounding the Covid-19 pandemic.
Brazil (Bahia)	Not clearly defined according to project documents
DRC[51]	To support the existing medical facilities, dealing with Covid-19 in Kinshasa, as well as to improve the understanding of the disease, facilitate the acceptance of activities and the use of MSF services in the targeted areas by responding to rumours via social networks
Gaza[52]	Increase awareness on Covid-19 and understanding around transmission of the virus and prevention measures: • Encourage correct care seeking and (self-)isolation procedures • Provide concrete and practical instructions of prevention measures (including shielding) • Tackle misinformation and stigma around Covid-19 • Offer platform to ask direct questions to the team through private online 1-on-1 conversation
Greece (Moria) [53]	To attempt to support of the existing and the evolving medical needs and interventions to tackle the transmission of the Covid-19 in Moria Camp and the island of Lesbos; and to raise awareness about Covid-19 protection measures
Guinea[54]	To inform them and raise awareness about prevention, modes of infection or transmission, treatment, the importance of maintaining care and the consequences of stigmatization in relation to key HIV/ Covid-19 topics.
Haiti[55]	• Quickly respond to new rumours • Reach a large number of people we might struggle to reach otherwise • Disseminate critical Covid-19 health promotion messaging through MSF owned channels • Easily reach confined, but online and connected population • Respond to a need for information when the means to reach people are limited
Indonesia[56]	Reach as many people as possible with health promotion videos to raise awareness about protective measures towards Covid-19, and ensure they view the videos without skipping it

[50] COVID19 - Belgium Digital HP campaign brief - final, P. 1: 474
[51] Final_Report_DHP_DRC-Limete_updated en, Pos. 7
[52] Gaza C19 DHP campaign report 2021 07_v2, P. 3: 855
[53] Final_Report_DHP_Moria, P. 1: 826
[54] DHP_GUINEA_FINAL REPORT, P. 1: 2513
[55] Final_Report_DHP_HTI-DRAFT - JH copy, P. 2: 315
[56] Indonesia digital HP report 2021 final, P. 5: 38

South Africa[57]	The aim of this campaign was to disseminate accurate and effective information about how (Covid-19) vaccines work to dispel misconceptions and rumours and to reduce hesitation about vaccination and to motivate people to register for vaccination
Zimbabwe[58]	To disseminate accurate information about how the Covid-19 vaccines work, in order to minimise vaccine hesitancy caused by rumours and misinformation

[57] DHP SA Report 2021 07, P. 3: 251
[58] Zimbabwe vaccination campaign report JH v2, Pos. 4

ANNEX 6: RE-AIM APPROACH

Table 11. RE-AIM Approach

DIMENSION	DEFINITION
Reach	The absolute number, proportion, and representativeness of individuals who are willing to participate in a given initiative, intervention, or program, and reasons why or why not.
Effectiveness	The impact of an intervention on important individual outcomes, including potential negative effects, and broader impact including quality of life and economic outcomes; and variability across subgroups (generalizability or heterogeneity of effects).
Implementation	At the setting level, implementation refers to the intervention agents' fidelity to the various elements of an intervention's key functions or components, including consistency of delivery as intended and the time and cost of the intervention. Importantly, it also includes adaptations made to interventions and implementation strategies.
Adoption	(Setting levels) The absolute number, proportion, and representativeness of settings and intervention agents (people who deliver the program) who are willing to initiate a program, and why. Note- adoption can have many (nested) levels- e.g. staff under a supervisor under a clinic or school, under a system, under a community.
Maintenance	At the setting level, the extent to which a program or policy becomes institutionalized or part of the routine organizational practices and policies. Within the RE-AIM framework, maintenance also applies at the individual level. At the individual level, maintenance has been defined as the long-term effects of a program on outcomes after a program is completed. The specific time frame for assessment of maintenance or sustainment varies across projects.

ANNEX 7: EXAMPLE INTERVIEW GUIDE COVID-19 DHP EVALUATION

EVALUATION PHASE-INTERVIEW GUIDE

Objective: This evaluation assesses Médecins Sans Frontières's (MSF) Coronavirus disease (Covid-19) digital health promotion (DHP) campaigns across a variety of contexts.

The objectives of the evaluation are twofold:

1. Determine how successful the DHP campaigns in the sample (n=10) have been by:
   a. Identifying good practices
   b. Identifying areas of improvement
2. Co-create recommendations with key stakeholders from/for the Digital Health Promotion Unit, Health Promotion referent, and Medical Directors.

Consent (to be read to the interview participant BEFORE beginning the interview)

By starting this interview, you are agreeing to participate. Participation in this interview is completely voluntary and you may withdraw from the interview at any time without consequence. There are no known risks to participate in this interview. All responses will remain anonymous throughout data reporting. Data is also confidential. Data will be stored in a secure database only accessible to the authorized members of the evaluation team. Data will only be used for the purposes of this external evaluation. Once the evaluation is completed, the Head of Evaluation Unit will be responsible for the disposal of data in accordance with MSF policy on the disposal of records.

Can I record this interview for note-taking purposes?

Background and Context

1. What is your current position with MSF and how long have you been in this position?
2. Can you describe your role in the implementation of MSF's DHP campaign in _____?

Reach

3. Was the reach of the Covid-19 DHP campaign adequate according to each campaign's stated objective and target population?
   a. Why or why not?
   b. Based on your experience, how could this have been improved?
   c. What were some of the challenges with reach during this campaign?
4. Was the level of beneficiary engagement within and across the campaigns adequate?
   a. Why or why not?

Effectiveness

5. Did each campaign meet its stated objectives?

   a. What factors facilitated this process?
   b. What factors were barriers or challenges to the campaigns meeting their stated objectives?
   c. Were there any unintended outcomes (positive or negative)?

Adoption

6. Which factors influenced your decision to reach out to the DHPU?
7. Would you contact the DHPU in the future to help with DHP campaigns?
   a. Why or why not?
8. Would you implement another DHP campaign? (with or without the DHPU)
   a. Why or why not?

Implementation

9. Can you please outline the support you and your field team received from the DHPU in developing your campaign?
   a. Were you and your staff able to successfully implement each campaign in accordance with the process outlined by the digital health promotion unit?
10. Can you please outline the HP framework that MSF-OCB uses to guide HP campaigns?
   a. Were you and your staff able to successfully implement each campaign in accordance with the process outlined by MSF-OCB HP best practices?
   b. What factors facilitated successful implementation?
   c. What factors were barriers or challenges to implementation?
   d. Was the campaign appropriately adapted to the specific contexts?
      i. If so, how?
      ii. If not, how could the campaign been better adapted?
11. What was the cost of the evaluation?
12. Which parts or aspects of the campaigns generated the most valuable outcome for the time, money and effort invested?

Maintenance

13. What impacts have digital health promotion campaigns had on you and your team in a field setting?
14. What impacts do you think the DHP campaign has had on beneficiaries?
   a. Why?
15. Do you have anything else to add regarding this DHP campaign?

ANNEX 8: KEY INFORMANTS CONSULTED[59]

Brice de le Vingne
Orlane Van Erps
Camilla Coletta
Faïda Kyamba
Cici Riesmasari
Mbali Jiyane
Joao Pedro Souza de Oliveira
Brian Tafadzwa Hove
Nele Allewaert
André Hoeschele
Ghislain Massotte
Jakub Hein

[59] Additional information on key informants is not provided here as another layer of protection to maintain their privacy.

ANNEX 9: MAXQDA CODEBOOK

The codebook includes the RE-AIM criteria and specific constructs associated with each sub-question (e.g. facilitators and barriers), followed by a round of inductive coding. This technique is used to identify other themes in the data relevant to this evaluation, such as the impacts that capacity-building and technical training have on field teams. See below for the code system.

Table 12. Code System

CODES	
1 Adoption	5
1.1 Ad_challenges	1
1.1.1 Ad_Ch_HR	1
1.2 Ad_future	6
1.3 Ad_impact decision to do dhp	0
1.3.1 Context-specific	1
1.3.2 Internal promotion	3
1.3.3 DHPU always has something to offer	1
1.3.3.1 Relationship with FB	1
1.3.3.2 Skills	1
1.3.4 Positive experiences with DHP	3
1.3.5 Reach many people	3
1.3.6 Word of mouth	2
1.3.7 Advocacy	2
2 Implementation	10
2.1 Im_challenges	0
2.1.1 Local context	0
2.1.1.1 Ch_keeping up with changing contexts	1
2.1.1.2 Ch_People's perception	1
2.1.1.3 Ch_Other priorities	4
2.1.1.4 Ch_Local context of health care support	3
2.1.2 Ch_English	1
2.1.3 Operations	0
2.1.3.1 Ch_Monitoring and reporting	5
2.1.3.2 Turnover	2
2.1.3.3 Lack of HR	3
2.1.3.4 DHP field roles not defined	1
2.1.3.4.1 MedCo and HP	1
2.1.3.4.2 Ch_transition from field hp to digital hp	2
2.1.3.4.3 Ch_HP vs. Comms	5
2.1.4 Ch_Reliance on the DHPU	2
2.1.4.1 Monopolizing	1
2.1.5 Ch_Technical difficulties	6
2.1.5.1 Ch_Privacy	1
2.1.6 Ch_budget	3
2.1.7 Ch_campaign delays	0
2.1.7.1 Ch_Lead time	2
2.1.7.2 Ch_rush campaign	3
2.1.8 Field teams resources	2
2.1.8.1 Computers	1
2.1.8.2 Internet	1
2.1.8.3 Mobile devices	1
2.1.8.4 Skills	1

2.1.9 No Pre-testing or pre-assessment	0
2.1.9.1 Ch_no pre-assessment	1
2.1.9.2 Ch_no pretesting	1
2.1.10 Relationship with stakeholders	0
2.1.10.1 Ch_Tension between emergency and regular mission	1
2.1.10.2 Ch_relationships with local stakeholders	2
2.1.10.3 relationship between DHPU and field team	0
2.1.10.3.1 Power imbalance	1
2.1.10.3.2 Distance	2
2.1.10.3.3 Ch_Agreement between DHPU and field team (+)	4
2.1.10.3.4 Ch_Misunderstanding with DHPU	1
2.1.11 Responding	0
2.1.11.1 Ch_Not knowing how to respond	4
2.1.11.2 Ch_can't give medical advice	1
2.2 Im_most valuable	2
2.2.1 Operations	0
2.2.1.1 Cost	8
2.2.1.2 Low resources	2
2.2.1.3 Fast	2
2.2.2 Staying with the times	1
2.2.2.1 Allowed to have other campaigns	0
2.2.3 Safe	1
2.2.4 Reach	3
2.2.4.1 Geo-targeted	1
2.2.4.2 Beneficiaries feel more comfortable	1
2.3 Im_cost	5
2.4 Im_Better Adapted	0
2.4.1 Using local design content	1
2.4.2 More languages	1
2.4.3 Not to changing context	1
2.4.4 Ch_adapting to context	1
2.5 Im_Adapted	14
2.6 Im_facilitators	0
2.6.1 Fa_Relationships with local stakeholders	1
2.6.2 Following HP Guidelines	0
2.6.2.1 Fa_rapid assessments	4
2.6.2.2 Fa_guidance documents	2
2.6.2.2.1 Fa_non-MSF guidance documents	1
2.6.3 Fa_Multiple languages	0
2.6.4 Fa_information sharing with other offices	1
2.6.5 Fa_HR	3
2.6.6 Previous experience with DHP	3
2.6.7 Fa_Collaboration with DHPU	8
2.7 Im_MSF HP frame	4
2.8 Im_Success	6
2.9 Im_Support DHPU	0
2.9.1 Evaluation	4
2.9.2 Monitoring	8
2.9.3 Guidance documents/content	6
2.9.4 Sometimes too busy	1
2.9.5 Design/content support	4
2.9.6 Regular communication	6
2.9.7 Feedback	2
2.9.8 Technical support	7
2.9.9 Training	17

2.9.10 Accessible and available	6
3 Learning from Communities	1
4 KAP	10
5 Data to inform future work	4
6 Discrepancy in data reporting	11
7 Running time	8
8 HP Manager	1
9 Communications officer	1
10 Coordinator	1
11 HP on Campaign (not manager)	1
12 Dates	7
13 Budget	3
14 Recommendations	3
14.1 Rec_more training	1
14.2 Rec_prepare up-to-date information and contextualized informati	1
14.3 Rec_community management training	1
14.4 Rec_adapt to low literacy	1
14.5 Rec_Align response timing better	1
14.6 Rec_Good introduction package	1
14.7 Rec_Training of trainers	1
14.8 Rec_training should involved the entire hp field team	1
14.9 Rec_Open campaigns up to other platforms	1
14.10 Rec_increase content in local languages	2
14.11 Rec_More information sharing across project	0
14.12 Rec_Other languages	3
14.13 Rec_Build local relationships	2
14.14 Rec_Evaluation	2
14.15 Rec_Increase HR	3
14.16 Rec_additional indicators	1
14.17 Rec_measure beneficiary impact	3
14.18 Rec_Coherent messaging across local stakeholders	1
14.19 Rec_Create links between emergency and local mission	1
14.20 Rec_Increased independence from teams	2
14.21 Rec_Expand DHPU	3
15 Target population	15
15.1 Tar_Pop_stats	12
16 Time with MSF	11
17 MSF HP Framework	6
17.1 Not used	3
17.2 Community management	9
17.3 Situation analysis	1
17.4 Message guide	0
17.5 Sitreps	0
17.6 Monitoring	2
17.7 Community engagement	0
17.8 Indicators	0
18 Objectives	16
18.1 Promote MSF activities	0
18.2 Awareness	1
18.3 Respond to Rumours/myths	1
18.4 Prevention and hygiene	2
18.5 Co-morbidities	0
18.6 Testing	0
19 Other Challenges.barriers	0
19.1 Buy-in	9

20 Facilitators	0
21 Other	7
21.1 Positive feedback on DHPU	1
21.2 Defining roles	1
21.3 Potential of social media	2
21.4 Positive feedback from other stakeholders	1
21.5 Use same FB page after campaign	1
21.6 Technology context-specific	1
22 Background	14
23 Maintenance	8
23.1 Main_Impacts on field	0
23.1.1 better understanding of community perceptions	2
23.1.2 Team is response-ready	1
23.1.3 Reach	2
23.1.3.1 Individuals not reached by MSF before	1
23.1.3.2 Can now reach hard-to reach populations	4
23.1.4 Improve English	2
23.1.5 Depends on the team	1
23.1.6 Incorporate into general HP strategy	11
23.1.7 Positive towards DHP	1
23.2 Main_impacts beneficiaries	0
23.2.1 Access to support	6
23.2.2 Trust with MSF	9
23.2.3 Formal feedback	2
23.2.4 Appreciation in comments	8
23.2.5 Informal positive feedback	9
23.2.6 Comfortable in speaking with team	3
23.2.7 Empowering	6
23.2.8 Service utilization as a result	2
23.2.9 No formal assessment	4
23.2.10 Awareness of MSF	4
23.3 Main_impacts on MSF	0
23.3.1 DHP across the organization	4
23.3.1.1 Adding value	1
23.3.2 Adapt to contemporary trends	4
23.3.3 Not sure if ways of working sustainable	1
23.3.3.1 Ch_cost in non-emergency setting	1
23.3.4 Creating visibility	13
24 Effectiveness	8
24.1 Ef_Unintended outcomes	2
24.1.1 Hotline	2
24.1.2 Relationships built with field team	1
24.1.3 Harrassement	2
24.1.4 Negative comments	1
24.1.5 Reaching a different target group	3
24.1.6 Capacity-building	6
24.1.7 Advocacy in MSF	1
24.1.8 Mental health burden on responders	1
24.1.9 Address other concerns	8
24.2 Ef_challenges	2
24.2.1 Ch_literacy	2
24.2.2 Ch_Lack of beneficiary ssessment tools	4
24.3 Ef_facilitators	0
24.3.1 Fa_context specific	1
24.3.2 Go beyond objectives	1

24.4 Ef_Objectives	4
24.4.1 Y_objectives	4
25 Reach	16
25.1 Impressions	1
25.2 Number of individuals	3
25.3 Conversations	7
25.4 Re_Adequate	17
25.4.1 Representative	0
25.4.1.1 Not representative	1
25.4.2 Y_ target Population	4
25.4.3 fa_pre-assessment	2
25.5 Re_Ben_Engage	17
25.5.1 Y_due to local context at the time	1
25.6 Re_challenges	5
25.6.1 Ch_low education	1
25.6.2 Ch_Cost	2
25.6.3 Ch_Technology	5
25.6.4 Ch_Local context	2
25.6.5 Ch_HR	3
25.6.6 Ch_Culturally or context appropriate	4

ANNEX 10: FACEBOOK DATA LIMITATIONS

Table 13. FB Data limitations

FACEBOOK DATA LIMITATIONS[60]		
Concept	Definition	Limitation
Reach	The number of people who saw your ads at least once.	• This may be based on sampled data, due to the way that FB calculates metrics. Because of this, the total reach for specific ad-sets may not add up to the total reach reported for the campaign overall. • FB de-duplicates overall campaign reach from individual ad-sets, which may target specific sub-populations. Therefore, the total reach for specific ad-sets may not add up to the total reach reported. • Totals are sampled separately from breakdowns.
Frequency	The average number of times each person saw your ad.	• Calculated using sampled data (impressions divided by reach) (see above for explanation regarding this limitation). • Ad fatigue may impact performance by exploring frequency in relation to reach over time. However, it's unclear what impact this has on beneficiaries or behaviour change.
Impressions	The number of times your posts were on screen.	• Videos are not required to start playing to be counted as an impression. • Sometimes it cannot be determined if an ad is on screen, so the video is counted when it is delivered to the devices.
Post Engagement	The total number of actions that people take involving your ads.	• This does not account for unique actions, but total actions taken. This does not reflect the number of individuals, but the number of actions, meaning actions by one individual can be counted more than once. • FB does provide metrics on unique actions. However, these metrics are estimated and sampled and do not account for multiple accounts owned by one individual.[61]

[60] https://www.facebook.com/business/help/1098122253564910?id=35440697209255
[61] https://www.facebook.com/business/help/283579896000936

ANNEX 11: RAW FB DATA ON BENEFICIARY ENGAGEMENT

Table 14. Raw FB data on beneficiary engagement

BENEFICIARY ENGAGEMENT ACROSS CAMPAIGNS								
Project	Reach	Impressions	Frequency	Link Clicks	Post Engagement	Post comments	Post reactions	3-second video plays
Belgium	27,472	296,249	10.78	-	69,100	-	-	-
Brazil (Bahia)	-	-	-	-	-	-	-	-
Brand Awareness	1,530,434	6,638,514	4.34	12,533	15,359	64	2,644	-
Instant experience-reach	1,995,920	4,875,609	2.44	8,894	12,009	40	2,934	-
Instant experience-Traffic	312,337	1,591,842	5.10	13,545	18,843	313	4,710	-
DRC	507,927	1,712,180	3.37	29,295		672	13,755	507,927
Gaza	-	-	-	-	-	-	-	-
	844,591	49,195,429	58.25	353,754	-	7,397	64,667	285,409
	166,153	618,260	3.72	4,919	-	100	783	3,590
	65,028	164,581	2.53	1,128	-	29	246	863
Greece (Moria)	-	-	-	-	-	-	-	-
V1-Messenger	12,276	69,494	5.66	468	1,070	24	539	-
V2-Messenger	10,106	5,548	5.49	256	916	5	213	-
V3-Messenger	7,946	4,4708	5.63	270	846	24	290	-
V1-Phone calls	6,642	13,482	2.03	53	574	2	102	-

V2-Phone calls	5,900	11,542	1.96	25	91	1	64	-
Guinea	1,310,779	8,147,021	6.22	73,500	-	247	4,565	-
Haiti	1,441,857	8,629,737	5.99	41,950	-	1,418	20,109	-
Indonesia	55,347,645	324,385,767	5.86	1,050	-	1,089	119,819	-
South Africa	4,096,185	1,957,5545	4.78	204	-	2,464	11,998	-
Zimbabwe	639,005	2,909,189	4.55	27	-	322	2,344	-
Total	-	406,449,863	129.37	541,640	118,808	11,425	235,440	797,789

ANNEX 12: UNINTENDED IMPACTS

Table 15. Unintended impacts

SQ2: WERE THERE ANY UNINTENDED IMPACTS (POSITIVE OR NEGATIVE)? N=14		
	Documents	Percentage
Address other concerns	7	50.00
Capacity-building	6	42.86
Harassment[62]	2	14.29
Reaching a different target group	2	14.29
Hotline	1	7.14
Advocacy in MSF	1	7.14
Mental health burden on responders	1	7.14
Negative comments	1	7.14

[62] In South Africa, there was an individual who called and harassed the field team.

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Independently written by Allison Cantor

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