PORTFOLIO: MARIE HUBER

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BIO: I'm a social behavioral researcher living in San Francisco, with a background in the international humanitarian and development sector. I've lived and worked in some of the most challenging contexts in the world where I helped experts understand people and their needs to generate and evaluate designs addressing some of the most difficult problems we face as humans. I'm a research methods enthusiast. I'm equally excited sitting in front of a person listening, observing, and learning about their experiences as I am sitting in front of a dataset discovering meaningful insights. I'm also an artist who brings equal parts reasoning and imagination to my work. My unique background and experiences enable me to understand the language of social and cultural values so I can meet people where they're at. This serves me not only as a researcher but also as an effective communicator of data and information.

"Research is how we resist the temptation to believe that our perception is reality. Good research gives objective voice to people's feelings, needs, and experiences. Good design makes sure we hear it so that we can not only find the right solutions, but solve the right problems – and do it with empathy."

VALUES:

Creativity **Efficiency** **Connection** **Empathy** **Empiricism**

CLIFTON STRENGTHS:

Relator **Analytical** **Achiever** **Individualization** **Empathy**

GOALS:

- I want to use my passion for research to contribute to products and services that are out in the world, addressing real problems for the people that use them.
- I want to help people identify, test, and challenge their assumptions with quality information.
- I'm always looking for ways to be a better researcher and communicator. I want opportunities that challenge me to constantly keep learning.

MOTIVATIONS:

- ☺ I love sharing learning that gets people excited and goes beyond delivering information to helping people internalize it.
- ☺ I love when my work is useful and gets used. I thrive when my skills are needed, wanted, and most importantly add value for others.

FRUSTRATIONS:

- ☹ Interesting information presented uninterestingly.
- ☹ 'Validating' instead of testing.
- ☹ The middle seat on a long-haul flight.

INTERESTS:

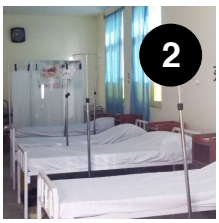
Things I Love: Yoga, Painting, Textile and fiber art, Sushi, Afghan and Persian carpets, Robyn

Art I Love: Eric Fischl, Alec Soth, Michael Borremans, Dorothea Tanning, Balthus, Philip Guston, Gunta Stölzl, Anni Albers, Peter Doig, Helen Frankenthaler, Faig Ahmed

WORK:

DESIGNING FOR HEALTHCARE USERS

Understanding intimate partner and gender-based violence survivors' experiences, needs, motivations, pain points, positive moments, and opportunities for improvement in the provision of healthcare services to inform the design and delivery of a training program for healthcare providers to deliver trauma-sensitive, user-centered services in Afghanistan.



RETHINKING PARENT AND FAMILY ENGAGEMENT

Understanding the experiences, needs, and goals of staff, parents, and families to support a charter school network in Los Angeles to design a re-envisioned approach to parent and family engagement programming and services throughout their network.

DESIGNING FOR COMMUNITIES' DISASTER RESILIENCE WITH A NON-RANDOMIZED CONTROL TRIAL

Understanding Afghan communities' current situation, needs, motivations, pain points, happy moments, and opportunities preparing for and responding to disasters to support a consortium of international and non-government organizations to design a project to build community resilience and test its impact.

DESIGNING FOR HEALTHCARE USERS

MY ROLE: The consulting firm I founded was hired to carry out research to inform the design of a project to address the acceptability, availability, accessibility, and adequacy of healthcare services for survivors of intimate partner and gender-based violence. I led the entire research process, including research design, developing tools, data collection, data analysis, and managing the research team. I carried out client management, stakeholder engagement, and prepared research deliverables.

SKILLS: Mixed-methods research, Attitudinal and behavioral research, Field research, Surveys, Informal and structured interviews, Observational methods, Focus groups, Quantitative and qualitative data cleaning and analysis, Descriptive and inferential statistics, Journey mapping,Theory of change, Designing for behavior change, Data visualization, Proposal development, Project planning and implementation, Budgetary an resource management, People management, Risk management

THE PROBLEM: The Afghanistan Demographic and Health Survey found that only 20% of ever-married women who have experienced physical or sexual violence sought help, and less than 1% sought assistance from medical practitioners.

THE RESEARCH OBJECTIVE: To understand the needs, motivations, pain points, positive moments, and opportunities for improvement in the provision of healthcare for survivors of intimate partner and gender-based violence. The purpose of the research was to inform the design and delivery of a training program for healthcare providers to deliver trauma-sensitive, user-centered services.

What are the experiences of women survivors of intimate partner and gender-based experiences with healthcare services? What are the needs, motivations, pain points, and opportunities?

What are healthcare staff members' experiences providing healthcare services? What do they know, think, believe, and do regarding intimate partner and gender-based violence?

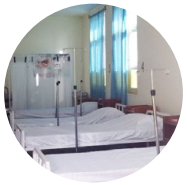
What are the barriers and opportunities for advancing a trauma-sensitive approach in the public health system in Afghanistan?

THE RESEARCH PROCESS: We developed a mixed-methods research design based around two frameworks for understanding trauma-sensitivity and quality of healthcare services. The Creating Cultures of Trauma-Informed Care framework outlines five core values for trauma-sensitivity in every contact, physical setting, relationship and activity with users: safety, trustworthiness, choice, collaboration and empowerment. The 5As framework of quality healthcare reflects the fit between characteristics and expectations of health service providers and clients in five areas: availability, accessibility, affordability, acceptability and adequacy. We carried out desk research, developed a research strategy, workshopped our strategy with project stakeholders, and translated and pilot tested our tools. We presented our plan, tools, and protocols to the Ministry of Public Health review board and received approval.

To carry out the research, we hired an advisor specialized in public health research and a field manager from Afghanistan to advise on and support managing field operations in the local context. We recruited, trained, and managed teams of four female surveyors in three provinces to carry out surveys with patients at each of the four health facilities in the study.

Survey with Facility Staff: We surveyed health facility staff to better understand what they currently knew, thought, and did in providing services in cases of intimate partner and gender-based violence and addressing trauma-sensitivity in their delivery of care. The survey asked health facility personnel to self-assess their facility and services, gauged their knowledge and attitudes regarding intimate partner and gender-based violence, their ability to recognize warning signs, and their behaviors in providing care for survivors and those at high risk.

Journey Mapping with Facility Staff: We held workshops with health facility staff, which included a "walk-through" current state journey mapping exercise to gain an understanding of the current process from the first point of contact with the facility of a woman with physical and/or emotional consequences of intimate partner or gender-based violence and the services and referrals she receives, all that way through discharge and long-term follow-up.



Observing Facilities: We developed a facility checklist and did walk-throughs with staff, observing and assessing the layout, facilities, and materials to assess trauma sensitivity. The checklist also included collecting data on service provision related to intimate partner and gender-based violence within the past year.

Survey with Patients: We carried out a survey with female health facility users. As context and literacy constraints would not allow for reaching users through online or phone-based survey methods, we trained a team of female enumerators to verbally administer the survey in voluntary exit interviews at healthcare facilities. The survey focused on the needs and experience of the user at the facility, trauma-sensitivity of care received, and decision-making and healthcare seeking behaviors.

Focus Group with Survivors of Violence in Shelters: We facilitated discussions with survivors of intimate partner and gender-based violence who were currently residing in shelters. The discussion focused on survivors' decision-making, healthcare seeking behaviors, and experiences receiving healthcare services.

Interviews with Stakeholders: We talked to key stakeholders including facility directors, the Public Health Directorate and Department of Women's Affairs in each province, the Ministry of Public Health, and non-government organizations working in health and provision of shelter services and programs addressing intimate partner and gender-based violence to inform an understanding of the broader systems-level context at different levels of implementation.

WHAT WE LEARNED:

About healthcare facilities and staff:

- Healthcare facility staff had **limited understanding of re-traumatization and potential harm** to a survivor of intimate partner/gender-based violence during an exam.
- Healthcare facility staff had **limited knowledge** on the prevalence of gender-based and intimate partner violence in Afghanistan, physical and emotional consequences, and risk factors. Healthcare facility staff also had harmful **attitudes and beliefs** regarding gender-based violence that may affect their ability to provide trauma-sensitive care.
- Healthcare providers were **not screening for trauma and abuse** in the provision of healthcare services.
- Healthcare facility staff felt they did not have time to assess or provide referrals and care for intimate partner or gender-based violence, and **did not feel it was their place to discuss such issues**.

About users:

- Women **felt uncomfortable seeking treatment for or even talking directly to a healthcare provider** about problems related to gender-based or intimate partner violence.
- Very **few women sought healthcare services for abuse-related concerns, and even fewer reported the abuse** when receiving services.
- Some women had received treatment for physical consequences of abuse, **but very few had received treatment for the emotional consequences** at any point in their life.
- Patients felt that the care they received **did not adequately address their physical and emotional safety**.
- Many women **would not seek treatment if a female healthcare provider was unavailable**.

THE IMPACT: The organization developed and delivered: (1) a training of trainers on trauma-sensitive approaches for 20 health professionals working in public hospitals in Kabul, Mazar-e Sharif and Herat; (2) training for 80 health professionals; and (3) training for 20 hospital managers and the members of the Ministry of Health mental health task force.

Based on the research findings, the trainings initially focused on education and shifting attitudes and beliefs. Then, the training was designed to give staff practical, light touch tools to screening for abuse and interact with all patients in a way that reduces risk of re-traumatization. Participants were trained on actions to take when a survivor is upset, ways to show a survivor they are interested and care, ways to show a survivor they are listening, and assessing intimate partner and gender-based violence risks.

The training materials advanced approaches that were sensitive to the possibility of offending or scaring women by asking directly about abuse, and were directed largely towards female professionals that women would be most likely to interact with, report to, and receive treatment from more easily. The project also focused on systems-level changes needed, including policies and protocols for trauma screening, and trauma-informed hospital administration and human resources.

RETHINKING PARENT AND FAMILY ENGAGEMENT

MY ROLE: Our firm was hired to support a charter school network to design a re-envisioned approach to parent and family engagement programming and services. As the sole researcher on a team with two design strategists, I led the entire research process in the initial learning phase and throughout the design cycle, including research design, developing tools, data collection, and data analysis. I also conceptualized and facilitated learning debriefs with the client team and stakeholders.

SKILLS: Qualitative research, Informal and structured interviews, Participatory methods, Qualitative data analysis, Facilitation, Journey mapping, Personas, Strategy development, Affinity mapping, Project planning and implementation

THE PROBLEM: The charter school network lacked a unified vision and approach to parent and family engagement. As a result, there was wide variation from school to school in the role and responsibilities of staff and the effectiveness of their work to engage parents and families in their children's education and learning.

THE RESEARCH OBJECTIVE: To understand user needs, motivations, pain points, happy moments, and opportunities. We needed to understand staff as the users of the parent and family engagement approach, and parents and families as the ultimate users of the experience they would deliver. The purpose of the research was to inform the design of the re-envisioned parent and family engagement approach, programming, and services.

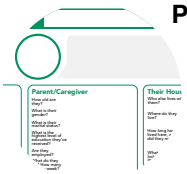
- Who are the parents and families the school serves? What are their goals, motivations, challenges, and experiences with schools and their children's' education?
- What are the current approaches and practices in place across school sites for engaging parents and families? What is already working and what isn't?
- Who are the parent and family engagement staff? What are their goals, motivations, challenges and experiences carrying out their work?
- What are other schools doing to engage parents and families? What are promising practices and lessons learned from the field?

THE RESEARCH PROCESS: We needed to design a research approach that would not only answer these questions, but would also build trust and buy-in across key project stakeholders in the process. We had limited time, budgetary, and human resources to carry out the research and would not have the opportunity to engage directly with parents and families, so we needed to prioritize highly efficient methods that would reliably bring in parent and family perspectives. We were told that staff, parents and families throughout the network have 'survey fatigue', and were asked to develop a highly participatory approach that would ensure key stakeholders felt central to the research process.

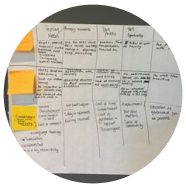
Desk Research and Talking to Experts: We started with a landscape scan of what other schools and broader evidence from the field offered as best practices in parent and family engagement. Considering the context of the communities the schools serve, we particularly wanted to understand what frameworks, approaches, and practices have been effective for low-income, historically marginalized racial and ethnic identity, new or recent immigrant, and English Language Learner families. We also identified and interviewed experts in the field.

Interviews with Network Stakeholders: We worked with central office parent and family engagement staff to identify network stakeholders to interview. We talked to principals, school site staff, central office staff, and parents from schools across the network. We wanted to understand what was currently happening, what stakeholders felt was going well, what could be improved upon, and what they problems they were hoping would be addressed in a re-envisioned parent and family engagement strategy.

Reviewing Existing Analytics and Data on Network Parents and Families: We analyzed existing data from the network's annual parent satisfaction survey, activity monitoring data from school site parent and family engagement staff, data from focus groups and interviews carried out with parents and families over the past five years, and data on parent and family attendance and involvement in events, workshops, and other engagement touchpoints.



Personas Exercise with Staff: We needed to go beyond parents and families by the numbers to understanding them as people, so we brought together school site staff that engage with parents and families on a daily basis to workshop parent personas. We developed persona worksheets, focused on parents and families' contexts, challenges, goals, and what they think/feel and do. We asked staff to fill out worksheets for 'typical' and 'atypical' hypothetical parents or caregivers. We repeated the exercise multiple times, and facilitated discussions. We used the information from this exercise and our research to develop five core personas.



Parent Journey Mapping with Staff: Grounded in the personas, we facilitated a current-state journey mapping exercise with school site parent and family engagement staff. They generated a list of parent and family touchpoints throughout their engagement with the network throughout the year. For each touchpoint, the group discussed what the touchpoint currently looks like, parents and families feelings and needs, pain points, happy moments, and opportunities to improve the experience for parents and families.

SWOT Analysis and Affinity Mapping with Staff: We took all of this information and facilitated an affinity mapping exercise with stakeholders. We put each piece of key information we collected throughout the learning phase and wrote them on sticky notes, color coded according to which information source they came from. Stakeholders worked together to place each note into the category of 'Strengths', 'Weaknesses', 'Opportunities', and/or 'Threats'. Then, they looked for similarities, grouped, and categorized the sticky notes and sticker voted for their top priorities to address in the 'Opportunities' and 'Threats' categories.

Learning Debrief with Stakeholders with a 'Mini Museum': At the design workshop with stakeholders, we developed all of the learning we had produced throughout the learning process into a 'mini museum' of highly engaging, large-scale visual research artifacts. We gave stakeholders time to do a gallery walk with an observations worksheet we developed to help them critically engage with and process the information, and facilitated discussion. The 'Mini Museum' was set up in the workshop space, framing the tea and coffee table to continuously keep stakeholders immersed in the learning throughout the design workshop.

WHAT WE LEARNED:

- School site parent and family engagement **staff were highly dedicated** to their jobs and empathized with parents and families.
- There was **no common job description, qualifications, compensation, or performance evaluation** for staff across sites. Staff were regularly assigned to other tasks that took away from their parent and family engagement work.
- Parent and family engagement staff salaries were inconsistent with the cost of living in their communities, and **many had second and third jobs** to support themselves.
- The **parents and families the network served were highly diverse**, but family engagement practices were mainly addressing the needs, challenges, and goals of key one demographic group.
- Parents and family largely chose this network for their children motivated by high graduation and college attendance outcomes. By and large, they **cared deeply about their children and valued their education**.
- Many of the network's parents and families were **low-income, historically marginalized racial and ethnic identity, new or recent immigrant, and English Language Learner families**. Most parents and families hadn't attended college, and it was not uncommon for parents to have completed very limited elementary and high school education.
- While parents and families valued and were willing to engage in their child's school and education, many **lacked the time, resources, and context** to understand how to do this and to be able to do it effectively. **This and other factors affected parent and family experiences across nearly every touchpoint.**

THE IMPACT: Based on the learning, stakeholders realized that though the network needed a common vision for parent and family engagement, a one-size-fits-all solution wouldn't suit the needs of staff or parents and families. They prioritized an approach and strategies that would be accessible for staff with a broad range of backgrounds, skills, and experiences across sites, and that would empower them to implement parent and family engagement programming responsive to the needs of the individual parent and family in front of them rather than an across the board approach.

They brainstormed possible solutions and developed a plan to address the issues identified in each of the touchpoints of the journey map over the next school year, and identified key areas in which further primary research with parent and family users would be necessary to ensure the solutions they identified were aligned with their realities.

The developed a roll out plan that focused on key stakeholders at the site level to ensure buy-in and engagement of key school leaders that would support parent and family engagement staff in realizing the shared vision across the network.

DESIGNING FOR COMMUNITIES' DISASTER RESILIENCE WITH A NON-RANDOMIZED CONTROL TRIAL

MY ROLE: The consulting firm I co-founded was hired to carry out research to support a consortium of international and non-government organizations to design a program to build community resilience to natural disasters and test the impact of their project. I led the entire research process, including research design, developing tools, training the research team, managing data collection, and data analysis. I carried out client management, stakeholder engagement, and facilitated learning debriefs with the client team and stakeholders.

SKILLS: Mixed-methods research, Experimental research, Attitudinal and behavioral research, Field research, Surveys, Informal and structured interviews, Participatory methods, Focus groups, Quantitative and qualitative data cleaning and analysis, Descriptive and inferential statistics, Data visualization, Infographics

THE PROBLEM: Approximately 40 percent of the Afghanistan's 400 districts are hazard-prone. Since 1980, disasters caused by natural hazards have affected 9 million people and caused over 20,000 fatalities in the country. With chronic conflict, a weak central government, and infrastructural connectivity challenges, communities are the first line of preparedness and the first responders when disasters occur.

THE RESEARCH OBJECTIVE: To understand communities' current situation, needs, motivations, pain points, positive moments, and opportunities preparing for and responding to disasters. The purpose of the research was to inform the design and delivery of a program to support communities' vulnerability assessment, early warning systems and disaster risk reduction planning, Community Emergency Response Teams, and supplies and materials for emergency preparedness and response.

- What disasters are target communities commonly facing? How do they impact individuals, households, and communities?
- How do communities understand, prepare, and reduce risk for common disasters? How do communities respond when disasters occur?
- What do communities need? What is already working and what isn't before, during, and after disasters hit?

THE RESEARCH PROCESS: Our research design was based in the Participatory Disaster Risk Assessment methodology, which includes engaging stakeholders and communities, a hazard assessment focused on the specific types of hazard that the community identifies as causing the greatest damage or loss, an assessment of vulnerabilities and capacities to assess why it is possible for hazards to cause so much damage within the community, and an analysis of the existing strengths and coping mechanisms within the community.

Our design was a clustered non-randomized control trial, with the community as the unit of randomization and analysis and the number of clusters set considering feasibility with the resources we had available for the research. The consortium organizations had already selected geographic areas and communities in which they were likely to work on the project, so assignment to the treatment and control groups was not random. We determined the number of clusters to select in each geographic area proportionate to the planned number of communities and households that would be targeted in each area in the project. We matched communities based on a range of known features and randomly selected communities from the list of possible treatment and control clusters in each area.

We carried out desk research, developed a research plan, workshopped our plan with project stakeholders, and translated and pilot tested our tools. We then trained research teams from each consortium organization to carry out data collection in 96 communities in 25 districts of eight provinces.

Participatory Exercises with Community Leaders: In Afghanistan, community leadership is organized into a Community Development Council. These councils are either mixed gender, or separated into two gender-separated councils. In each community, we convened the council/s and facilitated a series of structured participatory exercises. For each type of disaster experienced in the community, the councils discussed which elements in the community were at risk, what impacts the disaster typically has on that element, and discussed what allowed those impacts to occur. We explored the individual, social, natural, physical, and economic impacts of disasters, as well as coping strategies and resources the community was already utilizing to mitigate them. Community leaders mapped the roles of various actors and institutions before, during, and after disasters.

Survey with Community Members: We carried out household surveys with community members in each community cluster. Given constraints related to literacy, telecommunications availability, and lack of household information within communities, field teams carried out surveys in-person using a random walk sampling method to select households in each community. We asked households about the types of disasters that commonly affect their community, the impacts on their household, and their household's coping capacity and strategies. We asked about what they felt their communities needs were, roles and responsibilities for disaster preparedness and response in their community, as well as what they felt was working and what wasn't.

Interviews with Stakeholders: We talked to key stakeholders including school administrators and Provincial Disaster Management Committee members. In these interviews, we carried out hazard assessments addressing the types, significance, history, frequency, severity, duration, location, warning signs, and trends for common disasters in the area. We also asked more specific questions about the resources and processes in place, as well as community needs.

WHAT WE LEARNED:

- Farmers, children, people living close to water sources, and households living in poverty were the **groups communities felt were most vulnerable to the impacts of disasters**. People with disabilities and women were also highly vulnerable groups.
- Housing structures, buildings, natural resources, infrastructure, and livelihoods were the **elements most at risk when disasters occurred.**
- Very few households were aware of any warning signs for common disasters, and **few had plans in place at the household level to prepare for and mitigate impacts of common disasters, or to respond when they occur**.
- Households' ability to absorb shocks and resilience to disasters was severely limited due to a **lack of resources and reliance on livelihoods that were highly vulnerable to disasters**. Households often had to resort to coping strategies that reduced their resilience in the long-term in order to deal with the immediate aftermath of disasters.
- **Few communities were taking measures to prepare for disasters or had contingency plans in place to respond when they occur.**
- **Capacity of institutions responsible for disaster preparedness and response were low** at the district, provincial, and national level.
- Nearly a quarter of the households surveyed had a **history of displacement**, and one in ten were currently displaced. Nearly one out of every five households had a **household member with a long-standing disability**.
- The community **needs were different for different types of disasters**. We identified and developed **profiles for each different type of disaster commonly experienced**.
- Needs were also different in different geographic areas. We identified and developed **profiles for each of the eight main geographic areas**.

THE IMPACT: Building on the findings of this research, the consortium developed a four-year project combining national and sub-national institutional strengthening and policy planning with the provision of direct disaster risk reduction and humanitarian assistance to more than 400,000 people across the 25 disaster prone districts in eight of Afghanistan's most vulnerable provinces. The project had four components, including institutional capacity building, practical community- and school-based disaster preparedness, livelihoods support for the extreme poor and vulnerable households, and advocacy and public outreach on the disaster risk reduction and climate change adaptation.

The project was designed with a particular focus on supporting vulnerable households to develop more resilient livelihoods, as well as providing intermediate assistance to mitigate the need to resort to the negative coping strategies observed in the research. The project was also designed with special consideration for groups that were found to have different needs, especially the high proportion of people living with disabilities, and women, who faced different mobility restrictions and ability to participate in community-based activities.

The project was designed to support communities to undertake community-level disaster planning. The organizations working in different provinces catered their activities to the need profiles for each geographic area, and different approaches were taken according to the need profile for the types of disasters communities considered to be of greatest threat.

We also developed the findings of the research into an infographic that was widely shared with government, non-government, and international organization stakeholders to advocate for more investment and programming to address the widespread needs identified based on the findings of the trial.