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National HIV/AIDS Council Behaviour Centered Programming Capacity Assessment Index Report

August 2013

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1. Introduction

The main objective of the United States Agency for International Development-funded Communications Support for Health (CSH) project is to strengthen the capacity of the Government of the Republic of Zambia's (GRZ) Ministry of Health (MOH), Ministry of Community Development, Mother and Child Health (MCDMCH), National HIV/AIDS/STI/TB Council (NAC) and National Malaria Control Centre (NMCC) to develop and implement evidence-based behaviour change communication (BCC) interventions. To help measure progress towards this objective, CSH administers an annual assessment of the capacity of MOH, MCDMCH, NAC, and NMCC to plan, implement, and manage BCC interventions.

1.1. Overview of the Capacity Assessment Index

The Behaviour Centred Programming (BCP) Capacity Assessment Index was developed by the CSH project. It is a tool for assessing the capacity of an institution to plan, implement, monitor, and evaluate BCC interventions/programmes. The index provides an overall score (out of 100) and summary scores for each of the following specific capacity areas: BCC planning and design, programme implementation, and monitoring and evaluation (M&E). The results from the assessment are tracked within CSH's Performance Monitoring and Evaluation Plan (PMEP). The assessment is administered annually. This was the first time the assessment was administered with NAC as in previous years it was a challenge scheduling a fruitful meeting to conduct the assessment.

1.2. Objectives of the Assessment

1.2.1. Main Objective

The main objective of the capacity assessment is to identify gaps in GRZ's capacity to design, implement, and monitor and evaluate behaviour change interventions, with the aim of strengthening capacity in the areas that are identified as in need of improvement.

1.2.2. Specific Objectives

Specifically, the objectives of the assessment are to

- Identify gaps in planning, designing, implementing, and monitoring and evaluating BCC interventions; and
- Inform the design of CSH's capacity-building initiatives for GRZ, such as providing further trainings in BCC and systems development.

1.3. Methodology

The BCP Capacity Assessment Index tool was administered in a workshop setting to selected members of staff of NAC by the CSH M&E Unit. Although NAC currently does not have a designated IEC/BCC unit, staff members who have a role in IEC/BCC design, implementation, and management of BCC programmes were invited to participate. The NAC Director General attended the introductory session to the meeting, however did not participate in the assessment due to the potential for affecting participant responses. The CSH Research and M&E Director, Kevin Chilemu and the NAC embedded CSH BCC Advisor, David Dube facilitated the workshop. The tool was administered to the staff within the target institution to ensure that responses given on the tool represent the views of the institution and not those of the individual participants. The assessment tool was projected on a wall using an LCD projector so that all participants and the facilitator, Kevin Chilemu, could read through the assessment items together one by one and discuss as a group. The discussion was recorded and transcribed. A summary of the major findings from the assessment are presented in this report.

The assessment was administered at the NAC conference room on August 4th 2013.

1.4. Key Assessment Domains

There are 10 key capacity domains in the capacity assessment, grouped within three main sections:

Section 1: Planning and Design

- 1.1. Health problem definition and situation assessment
- 1.2. Conducting behavioural analysis
- 1.3. Programme definition and communication strategy development
- 1.4. Detailed communication planning
- 1.5. Establishment of strategic partnerships

Section 2: Programme Implementation

- 2.1. Implementation of communication strategies
- 2.2. Staff capacity
- 2.3. Supervision of quality and service delivery

Section 3: Monitoring and Evaluation

- 3.1. M&E frameworks and systems
- 3.2. Data use

2. Findings

An overview of the scores for each of the three main sections (BCC Planning and Design; BCC Programme Implementation, and Monitoring and Evaluation), as well as the subsections (10 domains), is provided in Table 1. With regards to the three main sections, 'BCC Planning and Design' scored the highest at 75 percent, while 'BCC monitoring and evaluation' scored the lowest, 48 percent. The highest performing domain areas were establishment of strategic partnerships (100 percent); health problem definition and situational assessment (75 percent); conducting behavioural analysis (75 percent); and staff capacity (75 percent). ; Overall, the different monitoring and evaluation domains scored the lowest, particularly in terms of use of data generated from M&E systems and provision of feedback (Data Use Domain).

Table 1: BCC Capacity Assessment Scores for NAC

Section No.	Section	Average Score (%)
1	BCC Planning and Design	75
1.1	Health problem definition and situation assessment	75
1.2	Conducting behavioural analysis	75
1.3	Programme definition and communication strategy development	60
1.4	Detailed communication planning	58
1.5	Establishment of strategic partnerships	100
2	BCC Programme Implementation	58
2.1	Implementation of communication strategies	61

Section No.	Section	Average Score (%)
2.2	Staff capacity	75
2.3	Supervision and quality of BCC intervention delivery	25
3	BCC Monitoring and Evaluation	48
3.1	M&E frameworks and systems	54
3.2	Data use	38
Overall Score		62

The key findings from the assessment were:

1. NAC showed strengths in conducting health situational assessments to better understand a health problem that the institution wishes to address through a BCC intervention. As a national HIV/AIDS coordinating body, NAC convenes its multisectoral partners and ensures that behavioural analysis is conducted when developing an intervention. Furthermore, many of NAC's partners such as the UN joint team and USAID funded projects with which the institution collaborates conduct situational assessments that NAC is fully involved in.
2. Another domain in which NAC demonstrated strengths included the development of BCC communication strategies. NAC provides a forum for the IEC/BCC technical working group comprising multisectoral partners (including for example, civil society organisations, NGOs, MOH, and faith based organisations), to develop and review communication strategies. For example, communication plans are developed collaboratively when commemorating national events such as VCT and World AIDS Day.
3. As a national coordination body, NAC is mandated by the 2001 Act of Parliament to establish strategic relationships. NAC has a solid base of strategic relationships with cooperating partners.
4. Other notable strong capacities are the existence of a national M&E plan and an electronic database that is linked to all provincial and district level stakeholders. Furthermore, NAC has a web-based portal that contains a mapping of its relevant stakeholders and through which it collects activity monitoring data on its activities/programs. Further, the electronic reporting system is able to determine the reporting rate from amongst the mapped stakeholders.
5. NAC does not directly implement programs but coordinates all stakeholders that conduct HIV/AIDS-related business. On this premise, BCC program implementation through collaboration with stakeholders is relatively strong. However, coordination of implementation in the last two years has not been as effective due to financial constraints that NAC experienced in 2012 and 2013. Due to these financial constraints, several planned activities could not be undertaken by NAC.
6. Some staff members who received formal training in BCC are no longer with the institution. On the other hand, members of staff do have clearly defined job descriptions (this is only recent due to the restructuring of NAC in 2012) and do undergo annual performance assessments.
7. Another area that showed room for improvement is the feedback mechanism based on data generated from routine monitoring systems. For example, the assessment revealed that regular program/data review meetings are no longer held on a regular basis, as happened in the past. The participants cited an example where Provincial AIDS Coordinators Advisor (PACA) review and feedback meetings have no longer been held since 2011.

8. Further, another weakness noted in their M&E systems is that the institution does not develop any M&E plans for specific BCC campaigns or programs by NAC except campaigns that are directly implemented by partners such as CSH. The 'Safe Love' and 'Brothers Alive' campaigns were cited by participants as examples of campaigns that have specific M&E plans.
9. In terms of field supervision of the quality of BCC interventions, it was found that the funding constraint experienced in 2012 hampered such activities. In addition, participants stated that there was no standard tool for carrying field supervisory visits.
10. Program evaluations, such as the review of annual workplans were not conducted in the previous 12 months due to funding constraints. Participants cited the Joint partners annual program review as an example. However, NAC did manage to conduct a thematic review culminating into the bi-annual United Nations General Assembly Special Session on HIV/AIDS (UNGASS) report.
11. Other areas that showed a need for improvement were the utilisation of data generated from monitoring systems and the dissemination of critical information to stakeholders, particularly those at sub-national levels.

3. Challenges of Conducting the Assessment

No major challenges were experienced in conducting this capacity assessment. The inability to administer the assessment in previous years has been a challenge. This has been due to difficulty in scheduling a mutually convenient time for both NAC and CSH.

4. Conclusions

In general, NAC demonstrated strengths in evidence-based planning and implementation of BCC-related activities. In addition, the institution does have in place a strong monitoring and evaluations system and staff capacity for managing the system is strong. However, there were notable areas of improvement, such as the need for providing formal training for staff involved in implementing and managing IEC/BCC interventions; capturing data specific to IEC/BCC activities; providing data use and dissemination feedback mechanisms; and developing standard supervisory tools and checklists for supervising stakeholder activities, among others.

Through its coordination role and reinforcement from the 2001 Act of Parliament, NAC has a strategic institutional positioning to coordinate all stakeholder HIV/AIDS program activities. This includes IEC/BCC interventions and ensuring they are evidence-based and aligned to the national response to HIV. However, this coordination role is weakened where financial resources are limited.

5. Recommendations

Based on the assessment findings, CSH has developed a list of recommendations for NAC. The recommendations are aligned to the findings stated above. These recommendations outline specific steps of action that CSH believes will help to improve the NAC's capacity to design, implement, and monitor and evaluate its BCC programmes and interventions. The recommendations are as follows:

1. NAC should strengthen and continue to use its coordination role in the national HIV/AIDS response to ensure that health approaches are always evidence-based. NAC can establish an information sharing forum with partners to know what programs partners have planned and whether the programs including BCC interventions are evidence-driven.

2. It is encouraging to note that NAC has strategic relationships with cooperating partners such as the UN joint team, USG Family, Global Fund and other key partners. NAC should continue to harness these relationships to draw on technical expertise and resources to conduct for example health problem situational assessments, gather data on IEC/BCC interventions, hold review meetings, etc.
3. There is need for NAC to ensure that all communication plans that are developed include measureable indicators such as measuring the number of clients accessing treatment, care and support, clients counselled and tested during VCT and World AIDS Day. It would also be useful if NAC collects other BCC outcome data such as individuals changing from risk taking behaviours or at least individuals expressing intent to change behaviours. Other aspects could include measuring changes in attitudes, self-efficacy and knowledge.
4. It is encouraging that NAC has an electronic database that captures routine monitoring data however there is need to strengthen the feedback mechanism to ensure stakeholders who submit data through the database are provided with feedback.
5. Mechanisms should be explored that will ensure that funding for NAC operations is sustained. Financial viability will help to ensure that its coordination role is effective. Inadequate funding makes it difficult for NAC to carry out its coordination role. For example review of BCC materials and convening of partners for important national events to meet national or regional reporting requirements.
6. It is further recommended that staff whose job descriptions have BCC-related aspects, either in planning, human resources, M&E receive formal training in Behaviour-centered programing. CSH can provide technical support if NAC arranged for such a training.
7. It is recommended that NAC develop (or collaborate with partners to) M&E plans for specific long-term campaigns and actively track BCC indicators as opposed to just focusing on implementation.
8. Lastly, it is recommended that NAC develop standard tools for supervising the quality of BCC implementation by its partners or its sub-national structures. If such a tool exists, it needs to be reviewed, updated as necessary and operationalized. CSH can provide technical assistance in developing a tailor-made supervisory tool for NAC.

6. Way Forward

Based on the above stated recommendations, CSH proposes to take a number of steps to support NAC in implementing these recommendations. These steps include:

1. Provide technical support to NAC staff in BCP design, and M&E of BCC programmes if NAC conducted such a training;
2. Assist NAC in developing a feedback mechanism based on data generated by their monitoring and evaluation system;
3. Assist NAC to convene IEC/BCC technical working group meetings by embarking on a cost-sharing mechanism to ensure that the IEC/BCC TWG carries out its mandate; and
4. Provide technical support for developing a standard supervisory checklist for NAC to ensure BCC activities implemented are of high quality.

As an immediate next step, CSH suggests that NAC, together with CSH, develop and agree upon an action plan and timeline that outlines all of the steps that both partners will need to take to implement each of the recommendations.

Annex 1: Participants of the Capacity Assessment Index

#	Name	Designation
1	Catherine Muyawala	Knowledge Management and Information Coordinator
2	Charles Nkunta	Management Information Systems Coordinator
3	Scriviner Kambikambi	Provincial and District Response Coordinator
4	Rita Kalamatila	IEC Specialist
5	John Banda	Provincial and District Response Officer
6	Nachilima Felisho	HR Manager
7	Bwalya Mubanga	M&E Coordinator
8	Justine Mwiinga	PR and Donor Coordinator
9	Emmanuel Sakala	Management Information Systems Officer

Capacity Assessment Index Facilitators

#	Name	Designation
1	Kevin Chilemu	Director of Research, M&E
2	David Dube	NAC BCC Advisor

Annex 2: Capacity Assessment Index Tool (Attached separately)