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National Malaria Control Centre Behaviour Change Programming Capacity Assessment Index Report

October 2014

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1. Introduction

The main objective of the U.S. 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), National Malaria Control Centre (NMCC), and National HIV/AIDS/STI/TB Council (NAC) 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, NMCC, and NAC to plan, implement, and manage BCC interventions.

1.1. Overview of the Capacity Assessment Index

The Behaviour Change Programming (BCP) Capacity Assessment Index was developed by the CSH project as a means for assessing the capacity of an institution to plan, implement, monitor, and evaluate BCC interventions and 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 in CSH's Performance Monitoring and Evaluation Plan. The assessment is administered annually with each of the three GRZ entities in order to track progress and determine whether identified weaknesses are improving.

1.2. Objectives of the Assessment

1.2.1. Main Objective

The main objective of the capacity assessment is to identify both strengths and 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 needing 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 training in BCC and technical support in systems development.

1.3. Methodology

CSH administered the BCP Capacity Assessment Index tool in a workshop setting to NMCC staff in the BCC, research, and M&E units. The selected staff were invited to participate because they are responsible for the design, implementation, and management of BCC programmes. Three members of the CSH M&E unit facilitated the workshop in order to be able to probe for more details, review responses, attempt to address discrepancies, and gain consensus on the scores awarded. This method of administering the assessment tool was perceived to be effective, and adequate information was obtained from the NMCC staff who participated in the assessment. The assessment tool was projected on a wall using an LCD projector in the CSH boardroom so that all participants and the assessor, Collins Muntanga (M&E advisor), could read through the assessment items together with the participants. For each item in the assessment, NMCC staff members were asked to give a score that they felt reflected their capacity to conduct the

specific task and to provide a justification for the score they gave. The staff then engaged in a discussion regarding each item in order to agree upon the final score that would be recorded in the assessment tool. The entire assessment exercise was recorded to facilitate the translation of the discussion afterwards for recordkeeping purposes. In addition, the assessment included documentation verification for relevant items. This was done in order to generate evidence to support the scores provided by NMCC staff.

The assessment was administered in a workshop setting at the CSH office on 29 August, 2014. The venue was conducive to the assessment, as it allowed NMCC staff to participate fully, free from disruptions that could have arisen if the workshop had been held at the NMCC office. The assessment lasted approximately three hours. Three of the expected six participants from NMCC attended the assessment workshop. Due to the difficulties encountered in previous attempts to carry out the assessment, CSH decided to proceed without the remaining three staff members.

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: M&E

- 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 of the assessment (BCC Planning and Design, BCC Programme Implementation, and M&E), as well as the subsections (10 domains), from both 2013 and 2014 is provided in Table 1. Overall, the M&E section recorded the lowest score in 2014, with an average of 76 percent. However, it is important to note that there was a significant improvement in BCC M&E capacity, from 45 percent in 2013 to 76 percent in 2014. The overall score for the Planning and Design section improved from 68 percent in 2013 to 89 percent in 2014, while that of the Programme Implementation section recorded an improvement of approximately 37 percent, from 59 percent in 2013 to 96 percent

in 2014. Across all 10 capacity domains, NMCC saw an overall improvement, from 61 percent in 2013 to 88 percent in 2014.

Table 1: 2013 and 2014 BCC Capacity Assessment Scores for NMCC

Section No.	Section	Average Score (%) 2013	Average Score (%) 2014
1	BCC Planning and Design	68	89
1.1	Health problem definition and situation assessment	75	88
1.2	Conducting behavioural analysis	58	75
1.3	Programme definition and communication strategy development	55	75
1.4	Detailed communication planning	75	100
1.5	Establishment of strategic partnerships	75	88
2	BCC Programme Implementation	59	96
2.1	Implementation of communication strategies	57	96
2.2	Staff capacity	83	100
2.3	Supervision and quality of BCC intervention delivery	38	88
3	BCC Monitoring and Evaluation	45	76
3.1	M&E frameworks and systems	46	79
3.2	Data use	44	75
Overall Score		61	88

The key findings from the assessment were:

1. NMCC has stronger capacity to conduct situational assessments to better understand the health problems that they wish to address through BCC interventions. To conduct the assessments, the NMCC information exchange communication (IEC)/BCC unit uses existing research results from studies conducted by its own institution and studies of partner organisations. Despite support from MOH research staff in most cases, the unit needs to rely on existing research to inform situational assessments due to the unit's lack of funds to conduct new research. Staff members within the unit have received formal training in formative research as well as M&E of IEC/BCC interventions with CSH support.
2. Similar to the finding above, NMCC relies on existing research when conducting behavioural analysis to inform BCC interventions. When the unit encounters gaps in the research for a particular BCC intervention being designed, it sometimes is able to conduct new formative research. For example, the unit conducted research in the Eastern Province to better understand the behaviour of particular communities with a high incidence rate of malaria to inform an IEC/BCC intervention. However, studies such as these are dependent on the availability of financial resources for research.
3. Overall, NMCC has good processes in place for defining objectives, target audiences, and appropriate communication channels for its BCC interventions. NMCC also has good processes for developing detailed communication plans that link its activities directly to the objectives of its BCC interventions. Currently, NMCC is using the NMCC 2012–2014

Strategic Plan, which has been revised to include more details on objectives, target audiences, and M&E indicators, and has been extended for an additional two years to serve as the plan document until 2016.

4. NMCC reported that communication activities are only sometimes developed based on the information needs of end users. Reaching out to the end users is not always done due to limited financial resources. However, with support from CSH and other partners, NMCC has in the past two years been working on strengthening the provincial and district malaria task forces to ensure that all IEC/BCC materials and interventions designed at the national level are adapted for local or end user needs.
5. NMCC is a national programme that collaborates with local and national stakeholders to coordinate and/or implement malaria BCC activities. NMCC also partners with relevant organisations, including the private sector, to implement activities, demonstrating overall high capacity in developing strategic partnerships to strengthen the implementation of its activities. The private organisations that NMCC has partnered with in past years include Melcome Pharmaceuticals, Beyers, Barclays and Stanbic banks, First Quantum Mine, and Morten.
6. This assessment revealed the following other strengths that were also identified during the baseline assessment conducted in 2013. NMCC uses multiple communication channels to reach target audiences, such as radio, TV, posters, and brochures. Furthermore, NMCC conducts periodic reviews of its IEC/BCC strategies using guidelines for developing and reviewing IEC/BCC materials that were developed with support from the CSH project. Over the past two years, the unit has collaborated with CSH to strengthen the malaria Technical Working Group (TWG), which is now reviewing NMCC IEC/BCC materials and interventions and those of partner organisations involved in implementing various malaria interventions in the country.
7. For staff IEC/BCC capacity, all staff members working in IEC/BCC have received formal training in BCC. This is an improvement from the 2013 assessment, which revealed that only one member had undergone formal BCC training. Additionally, the M&E and research officers have also received formal training in M&E for BCC programs or formative research with CSH support.
8. Supervision of BCC activity implementation by the unit still remains limited due to inadequate financial resources to conduct field supervisory visits. Additionally, the staffing levels in the BCC unit do not allow for adequate supervision due to competing priorities and other activities that staff in the BCC unit have to attend to.
9. The BCC unit has developed field supervisory checklists and guidelines for supportive supervision, demonstrating that there are standards in place for quality supervision. Following the baseline Capacity Assessment Index that was conducted in 2013, which revealed the absence of any tools to guide field supervisory visits, NMCC worked with CSH and other collaborating partners to develop a checklist.
10. NMCC has made progress in developing an M&E system for BCC activities, including the creation of an M&E plan that contains indicators for BCC interventions. Furthermore, NMCC is beginning to develop tools for tracking the progress of implementation and reach of BCC interventions. To date, however, no monitoring data on BCC interventions have been collected. Furthermore, NMCC does not have a database to capture M&E data specific to BCC interventions. Rather, it currently only captures routine clinical data

through the Health Management Information System. Due to this, there are no data available on BCC programme activities to use to inform programme management and/or improvement. The quarterly reviews that NMCC conducts are based on IEC materials produced.

3. Challenges

Scheduling a date to conduct this assessment with NMCC was a major challenge, as it was difficult to find a time when all staff would be available.

4. Conclusions

NMCC has undergone a number of positive changes in terms of its ability to design and implement effective IEC/BCC interventions since 2012, when CSH started working with NMCC to build its capacity for various aspects of malaria IEC/BCC interventions. The specific areas in which NMCC recorded positive change include planning and design, implementation, partnership, and staff capacity, as well as supervision of IEC/BCC interventions in the country. NMCC has enhanced its ability to rely on or use research findings to inform IEC/BCC interventions. This includes the use of existing research findings, and where existing research data have gaps, NMCC has been conducting fresh research to bridge identified research gaps, particularly where funds are available to undertake such research. The biannual Malaria Indicator Survey that NMCC conducts in collaboration with its cooperating partners remains the major study that the agency relies on to formulate its interventions. The trainings provided by CSH in formative research as well as M&E were cited as having had a very positive effect on NMCC staff in terms of enhancing staff appreciation of the importance of research and M&E in BCC interventions. However, the agency remains underfunded and understaffed in the area of research.

Using its own resources, as well as the resources of its cooperating partners, and with capacity-building training provided by CSH in BCP, NMCC demonstrated enhanced capacity in its ability to implement effective malaria BCC interventions in the country. The NMCC BCC unit has managed to establish partnerships as well as revamp the provincial and district malaria task forces, which are now providing oversight at the respective levels in terms of design, implementation, and supervision of malaria BCC interventions. The NMCC malaria TWGs at both the national and sub-national levels have been vitalised with CSH support. Furthermore, NMCC has enhanced its ability to ensure that all partners are brought on board during the planning, design, and implementation processes of its malaria IEC/BCC interventions, and has now managed to bring on board various private sector partners who are supporting its activities, including Barclays and Stanbic banks and Melcome Pharmaceuticals

In terms of supervision of BCC interventions across the country, there are positive changes that NMCC has recorded over the course of CSH project support. NMCC has developed field supervisory checklists and conducted a number of supervisory visits in provinces and districts across the country, despite limitations in financial and human resources that NMCC experiences when trying to fully undertake this task.

However, NMCC has not recorded notable progress in terms of development and implementation of a routine M&E system and tools. NMCC has not implemented an M&E system to target progress towards achieving the M&E indicators as outlined, despite CSH's support in providing M&E training and guidance for BCC interventions.

5. Recommendations

Based on the findings from the assessment, CSH has developed a list of recommendations for specific actions that CSH believes will bridge capacity gaps that were identified during the capacity assessment. With the CSH project closing soon, NMCC needs to address these recommendations in order to enhance the BCC unit's capacity to plan, implement, and monitor and evaluate its BCC programmes and interventions. The recommendations are as follows:

1. NMCC needs to develop a routine monitoring plan that tracks process and output indicators from ongoing BCC interventions. This entails developing routine monitoring data collection tools and a database to store and track M&E data, and analysing and reviewing routine data to inform programme implementation.
2. NMCC faces resource challenges that constrain the institution's ability to undertake fresh research activities to bridge information gaps in existing research data or results. Currently, there is an over-reliance on results from previous studies to inform a future malaria communication intervention that has the potential to compromise the quality of BCC interventions being designed. There is a need for NMCC to lobby for increased budget allocations for research activities from MOH and collaborating partners beyond their work on the Malaria Indicator Survey.
3. NMCC has quality control processes/systems for BCC activities, which include guidelines for developing and pre-testing IEC/BCC interventions and field supervisory checklists that can be used in observing and monitoring the quality of BCC interventions being implemented. However, operationalizing these quality control measures from the central level is challenging due to limited resources for conducting field supervisory visits to provinces and districts. Therefore, there is a need for NMCC to continue strengthening the provincial and district malaria task forces in order to build its capacity to monitor and supervise malaria IEC/BCC interventions in its provinces and districts, other than by relying solely on the central-level staff to conduct supervision visits on a regular basis.

6. Way Forward

Based on the recommendations put forth from the assessment, CSH proposes NMCC develops an action plan, with input from CSH, for how the organisation will produce a routine M&E system, routine data collection tools, and a database to store and track outcome indicators from ongoing BCC interventions being implemented by both NMCC and the partner organisations. CSH and NMCC should work together to develop a timeline that outlines all of the steps that both partners will need to take to implement each of the recommendations and action plan.

Annex 1: Capacity Assessment Programme Agenda

Date: 29 August 2014

Venue: CSH Office, Lusaka

NMCC BCC Capacity Assessment Index Agenda

Time	Activity	Facilitator
09:00–09:05	<ul style="list-style-type: none">Arrival of Participants	All
09:05–09:20	<ul style="list-style-type: none">Welcome RemarksTea and Coffee	Mr. Collins Muntanga/ All
09:20–09:50	<ul style="list-style-type: none">Review of Meeting ObjectivesIntroduction to Capacity Assessment	Mr. Collins Muntanga
09:50–10:20	<ul style="list-style-type: none">Part 1 of Capacity Assessment: Planning and Design of BCC Interventions	Mr. Collins Muntanga
10:20–11:00	<ul style="list-style-type: none">Part 2 of Capacity Assessment: BCC Programme Implementation	Mr. Collins Muntanga
11:00–12:00	<ul style="list-style-type: none">Part 3 of Capacity Assessment: Monitoring and Evaluation of BCC Intervention	Mr. Collins Muntanga
12:00–12:05	<ul style="list-style-type: none">Closing RemarksWay ForwardLunch	Mr. Collins Muntanga

Annex 2: Participants and Facilitators of the Capacity Assessment Index

NMCC Participants in the Capacity Assessment Index

#	Name	Designation
1	Pauline Wamulume	BCC Specialist
2	Mercy Mwanza	M&E Officer
3	Ketty Ndhlovu	ITN Officer

Capacity Assessment Index Facilitators

#	Name	Designation
1	Collins Muntanga	M&E Advisor
2	Victor Peleka	M&E Specialist
3	John Manda	Research and Design Specialist