

Measuring social and behaviour change communication capacity in Malawi

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Background. In the context of the burden of disease and the need to promote health among the Malawian population, Health Communication for Life in 2016 embarked on a 5-year social and behaviour change communication (SBCC) project to support the Malawian government's effort to expand access to sustainable health services. As part of this support, a capacity assessment was conducted in the Ministry of Health.

Objectives. To obtain a baseline measurement of current SBCC competencies, and to inform skills building for SBCC.

Methods. Two standardised participatory tools were developed to capture SBCC competencies at the national and zonal/district levels, based on a collective competency framework. The national assessment was conducted with 8 health promotion officers based in the Health Education Section of the Ministry of Health. At district level, 30 district health promotion officers from 28 districts participated in the assessment.

Results. The capacity assessment showed that health promotion officers had on average low capacity to plan, implement and evaluate SBCC interventions. However, there was variation within different domains, where the institutional capacity to lead and co-ordinate at both national and district levels was fairly strong, yet organisational capacity to evaluate, scale and sustain SBCC interventions was relatively weak. Participants also provided input to improve the assessment tools.

Conclusion. By presenting the process and results of the capacity assessments, this article highlights the need for articulating SBCC requisite skills, and establishing a baseline measurement of these skills as a step towards strengthening SBCC capacity at different levels of government.

Strengthen Health Syst 2018;2(4):69-73. DOI:10.7196/SHS.2018.v2.i4.64

Although many health indicators have improved in Malawi over the years, the burden of disease still weighs heavily on the Malawian population, negatively affecting people's welfare and development. For example, under-5 mortality has decreased from 234 deaths per 1 000 live births in 1992 to 64 deaths per 1 000 live births in 2015 - 2016.^[1] However, this rate still remains one of the highest in the world.^[2,3] Similarly, Malawi's HIV/AIDS prevalence of 8.8% is one of the highest in the world, and it ranks as one of Malawi's top three killers, together with malaria and TB.^[4,5] A disproportionately high burden of communicable diseases and high child and maternal mortality require high-quality health promotion interventions.^[6]

The field and practice of health promotion is evolving and has expanded, necessitating a review of the competencies (knowledge, skills and values) required of health promotion personnel. By recognising health as encompassing not merely the absence of disease, but a state of complete physical, mental and social wellbeing, the World Health Organization (WHO)'s Ottawa Charter shifted the emphasis from health education towards a broader definition of

health promotion that recognises and seeks to address the (social) determinants of health.^[7] With time, health promotion has become a key component of social and behaviour change communication (SBCC) – an approach that develops, implements and evaluates appropriate, evidence-based interventions to improve population health.^[8] Countries such as Malawi have integrated SBCC framing into how they seek to promote health.

SBCC is influenced by three approaches, namely health promotion, communication for development (C4D) and health communication.^[9] Effective SBCC therefore requires practitioners to have the set of requisite skills and competencies that cut across these fields. The Galway conference, which brought together 29 leading authorities in health promotion, health education and public health, recommended eight domains of competency for effective health promotion, namely: catalysing change, leadership, assessment, planning, implementation, evaluation, advocacy and partnerships.^[9] C4D competencies include facilitating dialogue and community participation, while health communication competencies and skills include the development,

dissemination and evaluation of health information to and from audiences.^[8] Health and non-health practitioners working in SBCC are therefore required to possess these skills. Accordingly, there is a further need to have a common lexicon and measurement of these skills to facilitate effective monitoring, evaluation and strengthening of the capacity of practitioners, with the aim of improving health promotion.^[8-10]

Therefore, competent and motivated human resources are one of the prerequisites for achieving high-quality SBCC interventions to address the disease and mortality burden. Evidence, however, shows that there are numerous challenges and skills gaps among health practitioners that hamper SBCC efforts.^[11] A review of the implementation of the health promotion strategy for the African region during the period 2001 - 2010, for instance, revealed numerous human resource challenges.^[6] Among these were inadequate leadership from health ministries to co-ordinate health promotion activities across sectors, a paucity of human resources to carry out health promotion activities at community level and inadequate application of qualitative and quantitative approaches in research monitoring and the evaluation of health promotion activities.^[6] The WHO therefore recommended strengthening health promotion capacity for health and non-health personnel as one priority intervention area in the strategy for health promotion in Africa. Recent efforts have also shown that there is a demand for capacity strengthening in SBCC not only from individuals, but also organisations, in the global south who are keen to deliver quality evidence-based SBCC interventions.^[9] As a step towards strengthening the capacity of health and non-health practitioners in health promotion and SBCC, it is imperative to have a clear idea of the requisite skill sets, as well as their baseline measurement at different levels.

Recognising the burden of disease in Malawi and the potential effectiveness of SBCC in promoting population health, in 2016 Health Communication for Life (HC4L) embarked on a 5-year SBCC project to support the Malawian government's efforts to increase demand for and expand access to quality and sustainable health services. As part of this support, the University of the Witwatersrand, in partnership with FHI360, conducted capacity assessments for HC4L key partner,

the Health Education Section (HES) within the Ministry of Health (MoH), at both the national and district levels, as a baseline and to inform skills-building for SBCC. This paper presents the process of designing the tools and the findings of the baseline SBCC capacity assessments. Finally, the paper draws lessons from the assessment, and highlights implications for SBCC capacity-strengthening effort.

Methods

The Malawian HES within the MoH, at national and district levels, was assessed through separate capacity-assessment processes between January and March 2017. At national level, 8 health promotion officers based in the HES participated, while at district level, 30 district health promotion officers (DHPOs) from 28 districts attended the assessment, totalling 38 health promotion officers. Two standardised participatory tools were developed to capture SBCC competencies at the national and then zonal/district levels, with the idea that the levels would work together towards a collective competency in SBCC. Both tools contained four discrete domains of competency, namely: (i) institutional systems; (ii) planning and designing; (iii) implementation and monitoring; and (iv) evaluating, scaling and sustaining. Within each domain, several sub-domains were defined, which varied slightly in terms of items. A description of the domains is provided in Table 1. While the district tool was designed taking into account local-level competencies, it was also refined based on the experience of the national level assessment. Additional documentation was used to verify the information generated at the capacity assessment workshops.

At the national level, a workshop was held to conduct the assessment. The purpose of the workshop was to assess the current SBCC capacity of the HES to both create a baseline measurement for the project and to prioritise action areas for SBCC capacity strengthening. The tool was reviewed by participants collectively. Each of the four domains and their sub-domains was given a score from 1 (having no capacity) to 4 (having full capacity) by HES and an expert in SBCC from the University of the Witwatersrand, with the scores recorded and then weighted. Within a domain, sub-domains considered fundamental to SBCC were given higher weight than those considered 'nice to have.'

Table 1. SBCC capacity assessment domains descriptions

Institutional systems	Institutional systems within the Ministry of Health that are essential to lead, co-ordinate and harmonise SBCC. Improved SBCC involves more than strengthening individual SBCC competencies, but must also have strong institutions to conduct SBCC programming. Systems that directly influence communication intervention planning were considered, namely: internal communication mechanisms; human resource systems (recruiting, supervising and supporting personnel and volunteers); and management information and reporting systems.
Plan and design	SBCC competencies needed to effectively plan and design SBCC programmes. This includes conducting a situation analysis to guide/build a programme around evidence, setting priorities designing an appropriate communication approach to address the identified health or other social barriers to change.
Implement and monitor	Best practices for implementing and monitoring SBCC programmes, including the development and use of programme implementation and monitoring plans, co-ordinating implementation with other SBCC programmes, supervision and mentoring and SBCC development plans.
Evaluate, scale and sustain	SBCC competencies needed to evaluate SBCC programmes and to scale and sustain SBCC programme progress, including evaluating programmes, documenting and disseminating results and adapting and adjusting programming based on data for sustainability to scale up.

SBCC = social and behaviour change communication.

The assessment process involved members of the HES reaching consensus on the scores based on discussion that was recorded to document the reasoning for the scores. Given the role of national government, these domains for SBCC were further disaggregated into the HES's technical ability to deliver on these domains (technical capacity) and their ability to co-ordinate other stakeholders (co-ordinating capacity). Based on the resulting scores, the emerging organisational SBCC capacity was appraised through a reflective discussion, which led to planning priority actions. SBCC experts provided their own scores for each item and domain based on the discussion and evidence provided by the HES, such as examples of communication strategies. These scores were averaged to result in a final score.

For the district assessments, the DHPOs from 28 districts were divided into their 5 MoH administrative zones to provide zonal and district perspectives of trends in capacity strengths and needs. In contrast to the consensus-building approach adopted at national level, the DHPOs used self-assessment to reach their district score, using the same 1 - 4 scoring scale as was used at national level. The number and wording of items was slightly different from those in the national tool, as theoretically their responsibilities for SBCC were different. Individual district scores were then discussed and debated within their respective zonal groups, and a range of district scores was recorded to show the diversity of capacity across the districts.

The MoH approved the data collection. As the assessment was part of a programme activity and not research, separate ethics approval was not sought. Names and positions of individuals as well as districts are anonymised in this reporting.

Results

The results of the assessment are presented at national and district levels.

National level results

Fig. 1 summarises the capacity scores for each domain and sub-domain at national level. Through application of the participatory tool, several key SBCC capacity

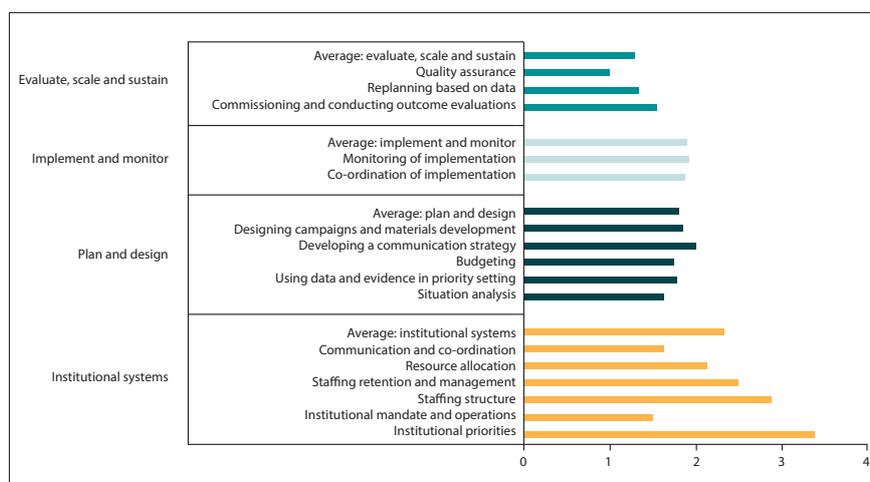


Fig. 1. Summary of capacity scores for each domain and sub-domain at national level.

gaps were detected both within and across domains.

It was evident that overall capacity was low, with average scores below 2 for three of the four domains. The institutional system was the best capacitated, with an average score of 2.33. Organisational capacity to evaluate, scale and sustain was the lowest overall and in all sub-domains, while implementing and monitoring, and planning and design scored close to 2 each. In some areas, capacity gaps could be linked directly to areas for health systems strengthening. For example, a lack of organisational plans within the HES was evident, and reflected both institutional and skills limitations. Having neither a strategic nor monitoring and evaluation plan limited the work of the unit (institutional and implementation domains). The absence of a dedicated budget for the HES, including for SBCC training, was an additional gap identified across domains. The low scores for conducting situational analyses and for use of data reflect a lack of research capacity, which was also observed in the monitoring and evaluation domains.

District level results

Twenty-one of the 28 districts that participated in the capacity assessment submitted a completed self-assessment tool. Findings from the district self-assessments are presented in Table 2. As at national level, the strongest domain was institutional priority, with more than half of the districts scoring over 2. More districts scored 0 - 1 for 'evaluate, scale and sustain'

than for any of the other domains, again reflecting findings at national level.

The percentages of districts in each scoring category for domains and sub-domains are presented in Table 3. As at national level, capacity pertaining to institutional systems was strongest, while evaluation, scaling up and sustainability were reported as weak. A large proportion of districts had very little capacity in terms of developing a communication strategy and commissioning and conducting outcome evaluations. At this level, staffing, retention and management was weak, despite institutional system capacity being relatively strong.

Discussion

The evolution and expansion of health promotion over the years has demanded human resources with specific skills and competencies to effectively implement health promotion interventions. The Malawian government set up the HES within the MoH in 1969, with the aim of providing health education to the Malawian population. With the evolution of the field, moving beyond health education towards health promotion, as per international conventions such as the Ottawa Charter, the HES has accordingly evolved to include health promotion activities.^[1,2] The previously named health education officers in HES are now called health promotion officers. This paper has shown that the skill set needed to plan and implement an effective health promotion and SBCC intervention is wide and complex – ranging

Table 2. District-level capacity self-assessments

District	Institutional systems	Plan and design	Implement and monitor	Evaluate, scale and sustain
1	+	++	++	++
2	++	++	++	+
3	++	++	++	+
4	++	++	++	++
5	++	+++	+++	++
6	+++	++	++	+++
7	+++	+++	+++	+++
8	+++	++	+	+
9	++	++	++	++
10	+++	++	+++	++
11	+++	++	++	++
12	+++	++	++	++++
13	+++	++	++	+
14	+++	++	++	+++
15	++	++	++	++
16	+++	++	++	++
17	+++	++	++	++
18	++++	++	++	+
19	+++	++	++	++
20	+++	++++	+++	+++
21	++++	++	++	++

Score key: + = 0 - 1; ++ = >1 - 2; +++ = >2 - 3; ++++ = 3 - 4.

Table 3. District scores 1 - 4 within capacity domains and sub-domains (N=21)

Domains and subdomains, %	1	2	3	4
Institutional systems				
Institutional priorities	0.0	26.1	56.5	8.7
Zonal and district level planning	0.0	39.1	60.9	0.0
Staffing structure	4.3	65.2	30.4	0.0
Staffing retention and management	30.4	65.2	4.3	0.0
Resource allocation	8.7	47.8	39.1	4.3
Communication and co-ordination	8.7	78.3	13.0	0.0
Plan and design				
Situational analysis	13.0	60.9	26.1	0.0
Using data/evidence in priority-setting	21.7	60.9	17.4	0.0
Budgeting for SBCC	21.7	60.9	13.0	4.3
Developing a communication strategy	78.3	21.7	0.0	0.0
Designing campaigns/materials	15.2	30.4	17.4	0.0
Implement and monitor				
Co-ordination and implementation	21.7	65.2	13.0	0.0
Monitoring of implementation	21.7	78.3	0.0	0.0
Evaluate, scale and sustain				
Commissioning and conducting outcome evaluations	56.5	39.1	4.3	0.0
Re-planning based on data	26.1	65.2	8.7	0.0

from leadership, assessment, planning, implementation, monitoring and evaluation, advocacy and forging partnerships, to community dialogue and participation.^[7-10] This places huge demands on health promotion staff, and accordingly, calls for the need to involve other stakeholders beyond the MoH.

The results of the capacity assessment of health promotion staff in the Ministry of Health show that HES practitioners had, on average, low capacity to plan, implement and evaluate SBCC

interventions. However, there were variations among different domains of competencies, where the practitioners were fairly strong in institutional capacity to lead and co-ordinate, yet weak in organisational capacity to evaluate, scale and sustain SBCC interventions. This pattern was consistent between national and district levels. Much as this finding confirms the well-documented need for capacity strengthening in health promotion and SBCC among health practitioners in Africa,^[6,8,13] it also starts to articulate

and expose specific domains of skills that need special attention at different levels in the process of capacity strengthening for SBCC.

Although there have been efforts in Malawi to develop a health promotion framework outlining human-resource requirements, capacity gaps remain. The Malawi Health Sector Strategic Plan (2011 - 2016) recognises the importance of health promotion.^[14] As part of implementing this plan, the Malawi Health Promotion Policy of 2013 states, among other things, the intent to build 'comprehensive capacity in policy formulation and implementation, intersectoral partnerships, political commitment, health promotion, management of health problems, quality research, workforce development and evaluation' at national, district and community levels among all relevant stakeholders.^[15] Similarly, the Malawi National Health Communication Strategy (2015 - 2020) attempts to operationalise the Health Sector Strategic Plan by harmonising diverse communication approaches and messages in the health sector.^[16] These instruments, however, are not clear on the set of skills in health promotion or SBCC required for specific personnel at different levels in the MoH. Furthermore, it is not clear how and whether the policy frameworks have been implemented effectively enough to produce the desired outcomes.

There have also been initiatives supported by non-governmental organisations and donors to capacitate HES personnel in SBCC.^[17,18] Despite these initiatives, it is not clear how and whether the capacity strengthening initiatives have resulted in HES personnel acquiring the necessary skills at the required level to implement effective health promotion and SBCC interventions. This may be a result of inadequate systematic research to monitor and evaluate the capacity-strengthening policies and interventions. The HC4L capacity assessment reported in this article therefore begins to fill these gaps, by attempting to articulate a set of skills in SBCC required at different levels, and establishing the current baseline level of these skills. This is useful in monitoring, evaluation and subsequent strengthening of SBCC capacity.

The HC4L capacity assessment tool was also powerful in that it was able to establish the baseline of the HES capacity in SBCC by blending participatory self-assessment discussion with quantitative scoring. In the case of HES, this also included validation scores by experts.

Given the paucity of published literature on the capacity of Malawian health personnel in health promotion and SBCC, this article therefore contributes to knowledge in this field of health system measurement and strengthening.

Conclusion

This article has highlighted the process and findings of the SBCC capacity assessment among health promotion practitioners in the Malawi MoH at the national and district levels. In doing so, the paper has emphasised the importance of articulating the skill set required for SBCC at different levels and the need to establish baseline measurements, and has presented those current skill measurements. This process, which seems to be missing in many policies and interventions on SBCC, is necessary in

planning, implementing, monitoring and evaluating any capacity development initiative in SBCC for health promotion.

Acknowledgements. The Malawian Ministry of Health Education Section capacity assessment was conducted with support from the United States Agency for International Development (USAID) and the following FHI360 staff members: Emily Bockh, Barney Singer, Emily Davis and Robert Chizimba. We would also like to acknowledge the health promotion officers who participated in the assessments and provided feedback on the tools.

Author contributions. MJ authored the paper, with all co-authors contributing to the manuscript. NC, SN and WK developed the data collection tools, and together with AC were involved in facilitating capacity assessments and reports. RW and MJ conducted further analysis for this paper.

Funding. This article was made possible by the support of the American people through USAID. The contents of this paper are the sole responsibility of FHI 360, and do not necessarily reflect the views of USAID or the US government.

Conflicts of interest. All authors are employed by the HC4L project. This paper describes their experiences. No other conflicts are declared.

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Accepted 14 August 2018.

