Building
Institutional
Capacity
for Stronger Health Systems

HFG Series:
Advances in Health Finance & Governance

Authors:

Sara Bennett, Johns Hopkins Bloomberg School of Public Health

Fred Rosensweig, Training Resources Group

April 2018

About the Health Finance and Governance Project

The Health Finance and Governance (HFG) Project works to address some of the greatest challenges facing health systems today. Drawing on the latest research, the project implements strategies to help countries increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. The project also assists countries in developing robust governance systems to ensure that financial investments for health achieve their intended results.

With activities in more than 40 countries, HFG collaborates with health stakeholders to protect families from catastrophic health care costs, expand access to priority services – such as maternal and child health care – and ensure equitable population coverage through:

- Improving financing by mobilizing domestic resources, reducing financial barriers, expanding health insurance, and implementing provider payment systems;

- Enhancing governance for better health system management and greater accountability and transparency;

- Improving management and operations systems to advance the delivery and effectiveness of health care, for example, through mobile money and public financial management; and

- Advancing techniques to measure progress in health systems performance, especially around universal health coverage.

The HFG project (2012-2018) is funded by the U.S. Agency for International Development (USAID) and is led by Abt Associates in collaboration with Avenir Health, Broad Branch Associates, Development Alternatives Inc., the Johns Hopkins Bloomberg School of Public Health, Results for Development Institute, RTI International, and Training Resources Group, Inc. The project is funded under USAID cooperative agreement AID-OAA-A-12-00080.

To learn more, visit **www.hfgproject.org**

About this series

HFG's Advances in Health Finance & Governance series is designed to highlight learning and lessons from the HFG project in nine core areas: domestic resource mobilization, strategic health purchasing, health financing strategies, expanding coverage through health insurance, financial data for decision making, governance, institutional capacity building, workforce and efficiency, and building understanding for universal health coverage.

Building Institutional Capacity for Stronger Health Systems

Executive Summary

Without strong national institutions, health systems strengthening is likely to fail. While institutional capacity development is integral to strengthening health systems and transitioning to self-reliance, it can be difficult to deliver effectively.

The experience of the Health Finance and Governance (HFG) project suggests that the key to success is focused, intentional, and tailored institutional capacity-development strategies that align institutional ambitions with the resources and time available, and with the demands of the client organization.

Key Lessons

1 **INSTITUTIONAL CAPACITY DEVELOPMENT OFTEN FAILS BECAUSE OF A LACK OF LOCAL DEMAND.** Demand from low- and middle-income country governments for stronger institutions is critical to the success of capacity-development initiatives. Demand must come not only from senior leaders, but also from office directors and their staffs – particularly those who are the targets of capacity-strengthening efforts.

2 **ATTENTION MUST BE GIVEN TO BUILDING CONSTITUENCIES FOR CHANGE.** While high-level leadership may be key to getting reforms started, an institutional capacity-development strategy needs to pay particular attention to building constituencies for change across multiple levels of the organization.

3 **THE INSTITUTIONAL CAPACITY-BUILDING ELEMENTS OF TECHNICAL ACTIVITIES SHOULD BE MADE INTENTIONAL AND EXPLICIT.** Much work on institutional capacity development occurs implicitly as part of an activity, and this can limit effectiveness. Projects such as HFG should develop mechanisms that enable staff to recognize when there is an implicit capacity-building element to their work and make it explicit to better plan and track progress.

4 **INSTITUTIONAL CAPACITY-DEVELOPMENT STRATEGIES SHOULD CONSIDER A RANGE OF TOOLS AND APPROACHES.** Successful institutional capacity-development strategies make use of a range of capacity-development tools and approaches. Select those that are consistent with the objective, resources available, and time frame, and avoid apparently easy but often less effective methods, such as individual training alone.

5 **INSTITUTIONAL CAPACITY SHOULD BE MEASURED AT BASELINE AND AT REGULAR INTERVALS THROUGHOUT THE CAPACITY-DEVELOPMENT PROCESS.** It is important to measure institutional capacity throughout the capacity-development process to build consensus about the need for institutional capacity building, select capacity-development tools and approaches, and assess the impact of interventions.
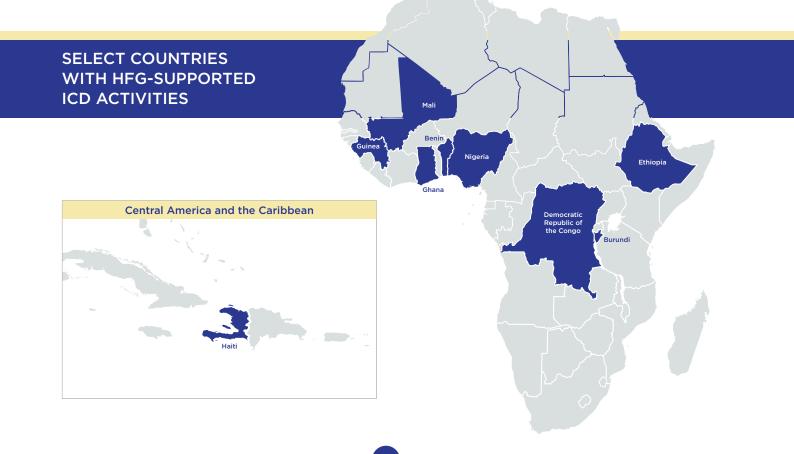
Introduction

Building institutional capacity in developing countries is at the heart of development in general, and health systems strengthening interventions in particular. Institutional capacity development (ICD) is key to sustaining donor-funded interventions and their effects. ICD is fundamental to meet rising expectations from all sides, and for low- and middle-income countries to transition away from donor-funded health programs (Burrows et al. 2016). In his confirmation hearings before the U.S. Senate Foreign Relations Committee, Mark Green, now USAID Administrator, noted that one of his three priorities would be to ensure that USAID plans for eventual transition of programs to countries and that a critical part of this was emphasizing "programs that incentivize local capacity-building and implementation" (Green 2017).

According to the Organization for Economic Cooperation and Development (OECD), *"Capacity is the ability of people, organizations and society as a whole to manage their affairs successfully. Capacity development is the process whereby people, organizations and society as a whole unleash, strengthen, create, adapt and maintain capacity over time"* (OECD/DAC 2011). Similarly, PEPFAR distinguishes between three main levels of capacity: individual, organizational, and system (PEPFAR 2012). Both definitions talk about capacity development in general. Our focus here is on 'institutional capacity development,' within which we include both the organizational level (meaning the multiple dimensions of capacity possessed by organizations such as ministries of health or health insurance agencies) and the systems level (meaning the capacities that cut across and connect multiple different organizations that are seeking to achieve shared goals). This brief addresses individual capacity building only when conducted as part of a broader institutional effort.

The scope of the Health Finance and Governance (HFG) project's ICD activities varies. Accordingly, we have organized the activities into three groups: 1) broad 'systems' scope, addressing multiple levels and/or organizations in the health sector;

SELECT COUNTRIES WITH HFG-SUPPORTED ICD ACTIVITIES

Mali

Benin

Guinea

Nigeria

Ethiopia

Ghana

Democratic Republic of the Congo

Burundi

Central America and the Caribbean

Haiti

2) focused 'organizational' scope, for example, addressing one particular office (such as the Ministry of Health's (MOH) HIV/AIDS Program in Burundi) or one dimension of ICD; and 3) narrow 'technical work stream' scope, for example, activities addressing one or two particular functions of an organization, or predominantly technical interventions that have an often-implicit capacity-development component associated with them. This brief draws upon a sample of HFG's ICD activities from across this spectrum (Table 1).

Notably, the primary focus is on ministries of health since they dominate HFG's ICD experience.

Some of the HFG activities described in the table were very successful in achieving and, in some cases, going beyond the intended results, whereas the implementation of other activities stalled, or activities were implemented but not with the level of success hoped for. In reviewing HFG experiences, we sought to understand what factors supported strong ICD initiatives and what factors hindered success.

Table 1: HFG's ICD Activities: Scope of Activities and Illustrative Countries and Methods

SCOPE OF CAPACITY DEVELOPMENT			
	BROAD SYSTEMS CAPACITY DEVELOPMENT	FOCUSED ORGANIZATIONAL CAPACITY DEVELOPMENT	CAPACITY DEVELOPMENT WITHIN TECHNICAL WORK STREAMS
COUNTRIES WHERE HFG WORKED	• Guinea (central MOH) • Democratic Republic of the Congo (central MOH and provinces) • Haiti (central MOH)	• Burundi (MOH HIV/AIDS Program) • Mali (MOH secretary general's office)	• Benin (MOH planning department) • Ethiopia (MOH) • Ghana (National Health Insurance Agency) • Nigeria (state MOH and other state agencies involved in domestic resource mobilization)
ILLUSTRATIVE TOOLS AND METHODS	• Functional/institutional assessments • Strategic and operational planning • Organizational restructuring • Leadership and management development • Constituency building for reform • Training of trainers	• Team building • Strategic planning • Development of job descriptions • Leadership and management training • Coaching • Networking with other entities performing similar functions	• Development of systems and tools • Training in use of tools • Hands-on coaching

A mother gazes at her healthy newborn following delivery by the head nurse at a health center in Democratic Republic of the Congo. Ultimately, the point of institutional capacity building is to ensure good health outcomes like this.

Lessons Learned in Building Institutional Capacity for Stronger Health Systems

Lesson 1

Institutional capacity development often fails because of a lack of local demand.

The most successful instances of institutional capacity building within the HFG project have been cases where there was very strong demand for ICD by both the USAID mission and the client institution. For example, in Guinea, the Ebola outbreak highlighted for all actors the institutional capacity challenges within the MOH (and the government more broadly) and drove ICD to the top of both the government's and development partners' agendas. Similarly, in the Democratic Republic of the Congo (DRC), the whole USAID mission strategy is heavily focused on ICD, and the MOH is keenly aware of the new capacities needed to reorganize the central directorates and decentralize functions to health authorities in the provinces.

"We should emphasize programs that incentivize local capacity-building and implementation… and ensure that our host-government partners have 'skin in the game.'"

Mark Green, USAID Administrator

In other contexts, such as Mali, capacity development was not front and center for the MOH and USAID mission, but rather ICD was designed to serve their priority goal of universal health coverage (UHC). Because demand for ICD was not explicit, HFG initially found it more difficult to advance ICD. HFG overcame this obstacle by focusing narrowly on the Secretary General's priority of increasing the number of technical advisors in his office. Where ICD is not perceived as central to the agenda, it may end up falling off the agenda altogether.

The level of local demand for ICD needs to be commensurate with the scope. Broad ICD requires buy-in from high levels of government, certainly the minister of health or permanent secretary, and in some instances the prime minister, whereas capacity development with more limited scope requires commitment from the leadership of the targeted office such as the planning department in the MOH.

Lesson 2

Attention must be given to building constituencies for change.

ICD often represents change and arises when an institution requires new capacities. While high-level commitment is necessary, ICD efforts must quickly build a constituency for change at multiple levels. This is necessary in all situations, but essential when there is frequent turnover in top leadership. In many of the contexts where HFG has done ICD work, leadership has changed frequently. For example, in Mali, the minister of health and secretary general changed three times in the space of 18 months. In Haiti, there have been numerous changes at the office director level over the course of five years, often resulting in a loss of momentum. When ICD initiatives depend on one or two key individuals, shifts in leadership can undermine the whole process.

ICD initiatives need to take into account the possibilities of leadership change and plan for it by developing shared leadership, where individuals at all levels within the organization become champions for change. In Guinea, for example, one of the early initiatives under the ICD program was training all senior ministerial staff and regional directors in leadership and management, which helped to build a leadership team and strengthen the base for reform. HFG then created a pool of in-house trainers for leadership, management, and operational planning to roll out the training to mid-level MOH staff. Similarly, in DRC, HFG has worked to embed capacity in the central MOH for strengthening the newly established provincial health divisions by using central MOH staff as trainers and coaches at the provincial level for a range of subjects, including financial management, results-based management, and supervision.

In addition to building a constituency among MOH staff, key stakeholders outside the target institution can form a critical constituency. External stakeholders such as political leaders and civil society can act to hold the institution accountable. Without such support and accountability, staff may resist change and find ways to undermine it. In Burundi, the MOH HIV/AIDS Office explained to local partners the changes it sought so as to enlist the support of its external stakeholders by involving them in the development of its annual operational plan and the establishment of a regular coordination mechanism to monitor its implementation

Unfortunately, in some low- and middle-income countries, senior leadership does not always recognize the need to build constituencies for ICD, thinking that top-down approaches to change will work. For example, in DRC, at the outset the HFG team pushed for one component of the ICD strategy to be focused on "constituency building," but ministerial leadership did not initially recognize the importance of this. While leadership ultimately supported the publication of a newsletter that described the ongoing initiative, more strategic approaches to constituency building that might have sought not just to inform staff about the proposed reforms, but also secure their commitment to reform from the beginning, were not able to move forward. HFG has often had to work hard to convince ministerial leadership of the importance of communicating with MOH staff, building constituencies for institutional capacity and reform and developing shared leadership. Where leaders accept this reality, such as in the HIV/AIDS Office in Burundi, it has had significant pay-offs.

Building a Constituency for Change in Guinea

In Guinea, widespread support for ICD was built through participatory workshops, on-the-job training, mentoring of counterparts, meaningful engagement with counterparts, and a train-the-trainers approach.

Health Officer Getachew Anteneh discusses HIV/AIDS prevention with a patient at a health center in Ethiopia's Amhara region.

Lesson 3

The institutional capacity-building elements of technical activities should be made intentional and explicit.

ICD occurs within most development projects. However, within technical streams of work, there is often a lack of intentionality, potentially limiting the effectiveness. Examples of technical streams of work under HFG include a multi-year activity to improve the financial sustainability of the National Health Insurance Agency in Ghana, the development of a monitoring and evaluation (M&E) system to track implementation of the National Health Development Plan in Benin, and a five-year effort in Ethiopia to increase utilization of health services through health financing and governance interventions. All of these activities did a substantial amount of capacity building but without a clearly articulated capacity-building strategy and plan.

There are a number of shortcomings to the lack of intentionality. First, projects are unlikely to conduct a formal assessment of institutional capacity to determine capacity needs, and so may end up making assumptions about what kind of interventions are likely to be effective. Second, if there is no capacity assessment, there may be no baseline information on existing capacity, so it can be very difficult to ascertain whether capacity-development

Capacity Building and Health Accounts

HFG routinely implemented an institutional capacity-building plan in countries where it supported Health Accounts. The project has developed a capacity-assessment tool that defines performance in seven dimensions and is used at the outset to establish a baseline and develop a capacity-building plan, and at the end to measure progress. This approach occurred in Burundi and Namibia, among other countries, where HFG built the capacity of the national health accounts team.

interventions are effective or not in improving institutional performance (see Lesson 5). Third, a clearly articulated capacity-development approach at the outset provides a framework against which the project can determine what's working and make adjustments. In activities where ICD is a primary and explicit focus, such as in Burundi, DRC, Haiti, and Guinea, assessments and ICD strategies and plans are routinely done, but not in all activities where ICD occurs within technical streams of work.

HFG has a capacity-building advisor available to all country teams, but this resource was not always accessed when a technical activity had an implicit capacity-building element within it. Donors and their implementing partners such as HFG should require that an explicit ICD strategy and plan be developed at the beginning of the activity. For activities where capacity development is not a large component of the work, the ICD plan or strategy may be very simple, and may propose streamlined ways to identify ICD needs and measure progress.

Lesson 4

Institutional capacity-development strategies should consider a range of tools and approaches.

Some ICD strategies are easier than others to pursue. For example, skill-building workshops with ministerial staff, or the development of job tools and standard operating procedures, can make important contributions to ICD, but such strategies by their very nature are quite narrowly focused and typically do not challenge the status quo. Further, they are unlikely to address the underlying issues that affect institutional performance, such as rightsized staff, organizational structure, legal mandate, and institutional arrangements. This does not mean these types of interventions are not worthwhile, but it is important to realize that alone they may achieve limited benefits. Often improvement in performance requires a revised mandate, an increase in number of staff or autonomy to hire/fire staff, a change in organizational structure, an increased budget, or shifts in organizational culture. There is a tendency within many development projects to rely on a

Beyond Training

In DRC, one of the most appreciated ICD interventions was the development of employment reference documents for two reconfigured central directorates. These documents specify the revised organizational structure, staffing plan, and job descriptions for each position. They are essential documentation required by the Ministry of Public Service for approval and must be based on a set of agreed-upon functions of the office.

short list of relatively "easy" capacity-development strategies, especially those that generate countable outputs—"10 job aids delivered" or "80% of staff trained"—and are more within the control of the implementing partner.

The larger-scale and more successful ICD efforts that HFG led employed a broader array of capacity-development approaches – including functional assessments, leadership development programs, team-building events, organizational structure, and updating of job descriptions – that may shift power between different actors within a large organization, fundamentally alter working relationships, and begin to shift organizational culture. Some of these shifts take a long while to take effect (two to three years, based on HFG's experience), and are not feasible within a short-term activity lasting, say, six months to a year. ICD initiatives need to diagnose the challenges that they seek to address, estimate the time frame and resources available to them, and choose the best strategies available. Which brings us to the next lesson.

Much of the work of institutional capacity development happens in workshops, where key players come together to hash out issues and develop strategies. Here, participants exchange ideas at an HFG-supported meeting in Nigeria.

Lesson 5

Institutional capacity should be measured at baseline and at regular intervals throughout the capacity-development process.

Both funders (such as USAID) and governments sometimes appear reluctant to take on ICD activities due to perceptions about the probability of success and the ability to show evidence of success once achieved. While there is limited objective evidence on the relative effectiveness of different ICD strategies, M&E can be built into implementation to track progress and identify lessons learned. For the purpose of measuring the effect of ICD, HFG defines seven dimensions of institutional capacity (Table 2). A highly effective institution would meet the definition of each dimension. Successful ICD activities would improve institutional performance in these dimensions.

Within its major capacity-development projects, HFG consistently assessed institutional capacity at baseline, and where possible reassessed capacity at a later point in the project. HFG employed a standard capacity-assessment tool that covers the dimensions listed in Table 2, and can be tailored for use across different countries, institutions, and mixes of ICD strategies (HFG n.d.). It measured institutional capacity by asking respondents to assess their own institution on each dimension, complemented by individual interviews and focus groups. This assessment tool helped prioritize the dimensions where capacity development was most needed, and measured progress as well as areas that were struggling. Responses to the survey were on a five-point Likert scale (HFG n.d.). Table 3 (next page) shows the impressive results achieved by the HIV/AIDS Office in Burundi.

Table 2: Dimensions of Institutional Capacity

SCOPE OF CAPACITY DEVELOPMENT	
DIMENSION	**DEFINITION**
ORGANIZATIONAL MANDATE	Clearly defined official authority
INSTITUTIONAL ARRANGEMENTS	Clearly defined roles and responsibilities and authorities, as well as the arrangements for coordination between different entities, and the rules governing how they work together
STAFFING	Adequate number of staff with relevant skills, and well-defined individual roles and responsibilities
IMPLEMENTATION CAPACITY	Organization and staff with the capacity to carry out relevant functions
SYSTEMS AND PROCESSES	Operational systems and processes consistent with available resources
RESOURCES	Adequate operating resources
COORDINATION, COMMUNICATION, STAKEHOLDER ENGAGEMENT	Capacity to engage internal and external stakeholders

Table 3: Results of Web-based Survey of Burundi HIV/AIDS Office at Baseline and End Line Scale from 1 (lowest capacity) to 5 (highest capacity)

DIMENSION	BASELINE SCORE (2013)	END-LINE SCORE (2016)
1. ORGANIZATIONAL MANDATE	3.24	4.05
2. STRATEGY AND PLANNING	3.42	4.08
3. PROJECT MANAGEMENT	3.07	3.94
4. COORDINATION AND COMMUNICATION	2.96	3.95
5. ORGANIZATIONAL STRUCTURE	3.38	4.02
6. LEADERSHIP AND MANAGEMENT	2.58	3.8
7. RESOURCES	2.39	2.82

HFG also has tracked the production of outputs that reflect institutional performance, as an additional means to assess the effects of capacity-development interventions. In an activity in DRC aimed at strengthening the financial management capacity of the Kinshasa School of Public Health, these outputs included, for example, an updated procedures manual, an annual budget, and regular monthly financial reports. In Burundi, the outputs of the MOH HIV/AIDS office were an annual operational plan, quarterly coordination meetings with stakeholders, and weekly meetings of the senior management team (HFG 2017).

Beyond documenting the impact of ICD interventions, measurement of institutional capacity can also help build consensus about capacity-development needs and thus lend focus to a capacity-development plan. If the measurement tool is accompanied by focus group discussions or workshops, then it may also help build recognition of the need for capacity development, and provide a common language for discussing capacity development. In Burundi, HFG reviewed results of the baseline assessment and then met yearly with the full staff (38) of the HIV/AIDS Office to review progress and agree on the capacity-building interventions for the coming year.

Conclusion and Recommendations

Institutional capacity development lies at the heart of health systems strengthening as well as longer-term development. Technical assistance and products are unlikely to translate into better services unless organizations have the institutional capacity to execute their mandates, and motivated and qualified staff who are able to adopt and implement the technical innovations. ICD should be tailored to the institution's current capacity gaps and expected role to improve the performance of the health system over time. Development partners rightly demand measurement of ICD efforts and changes in institutional capacity. Based on HFG's experience, significant impacts can be achieved and measured. Drawing on the discussion above, we present a number of recommendations to strengthen the engagement of different actors in capacity development (Table 4).

Table 4: Recommendations for Different Actors

DEVELOPMENT PARTNERS AND LOCAL HEALTH REFORM ADVOCATES*	PRACTITIONERS OF INSTITUTIONAL CAPACITY BUILDING	IMPLEMENTING PARTNERS
• Recognize that ICD lies at the heart of health systems strengthening and development, and is more likely to succeed when intentionally supported and measured. • Employ your influence as a development partner or local voice for health system reform to help stimulate demand for institutional capacity building at senior levels of government to create an environment for successful work.	• Use strategies to explicitly stimulate and sustain demand for ICD, develop champions for change across institutions, and build supportive constituencies. • Use a baseline assessment, and consider a broad array of ICD strategies and interventions instead of reflexively using just those that seem familiar and safe. • Continually assess what's working and what's not, and make changes as needed.	• Recognize that capacity development is embedded within many technical activities, and that intentional capacity-development strategies are likely to work better. • Consider using a standard assessment tool that can be applied to different contexts (countries and institutions) so that project staff consider, and respond to, a full array of capacity-assessment needs.
ALL		
Integrate M&E into ICD to understand the effects of the ICD activities, help build understanding and consensus about what kind of capacity development is needed, and measure how performance of the institution improves with capacity development.		

*   Development partners include donors. Local health reform advocates include, among others, NGOs, universities and research institutes, think tanks, professional associations, and media.

References

Burrows D. et al. 2016. *Transitions from donor funding to domestic reliance for HIV responses: Recommendations for transitioning countries*. Mascot, Australia: APM Global Health. http://www.aidspan.org/publication/transitions-donor-funding-domestic-reliance-hiv-responses---recommendations

Green, Mark. 2017. *Statement for the Record of Mark Andrew Green, Nominee for USAID Administrator, before the Senate Foreign Relations Committee.* https://www.foreign.senate.gov/imo/media/doc/061517_Green_Testimony.pdf

Health Finance and Governance project. N.d. Measurement of Organizational Capacity. Unpublished.

Health Finance and Governance project. February 2017. *Strengthening National Leadership of Burundi's HIV and AIDS Response.* Bethesda, MD: Health Finance and Governance project, Abt Associates Inc. https://www.hfgproject.org/strengthening-national-leadership-burundis-hiv-aids-response/

Organisation for Economic Co-operation and Development/Development Assistance Committee (OECD/DAC). 2011. Perspectives Note: *The Enabling Environment for Capacity Development.* Paris: OECD. https://www.oecd.org/dac/accountable-effective-institutions/48315248.pdf

President's Emergency Plan for AIDS Relief (PEPFAR). 2012. *Capacity Building and Strengthening Framework V2.0.* https://www.pepfar.gov/documents/organization/197182.pdf