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Lessons Learned in Institutional Capacity Building



Introduction

Institutional capacity building (ICB) has been a core element of the Health Finance and Governance (HFG) project since its inception in 2012. HFG recognizes that for health systems interventions to be sustainable, building institutional capacity is essential. The focus on ICB has taken on increased urgency with the current focus on transition of donor-funded programs managed by US-based organizations to direct country control.

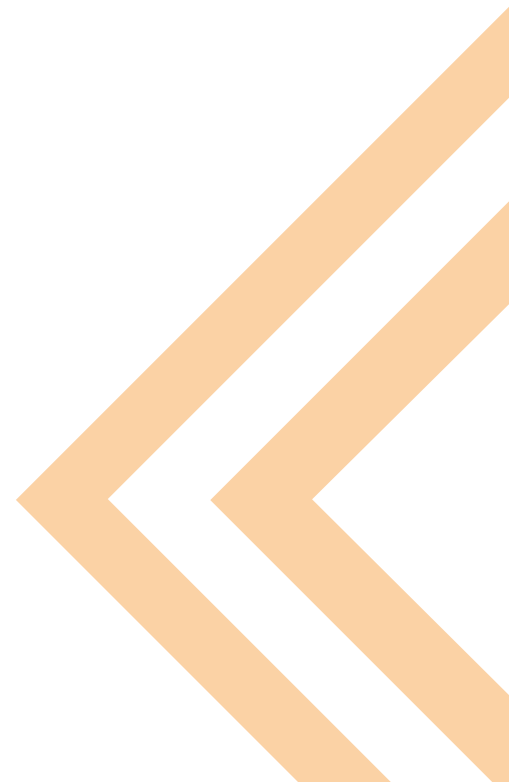
HFG's ICB work has been divided into two broad areas. The first has been developing foundational institutional capacity: vision, strategy and planning, structure, roles and responsibilities, performance management, and stakeholder engagement. It includes both systems capacity development aimed, for example, at multiple operating units in a ministry of health and targeted ICB aimed at a single operating unit. The second area has focused on building institutional capacity to sustain technical streams of work such as health accounts, health insurance, and domestic resource mobilization. ICB interventions for this area typically include training and development of systems and procedures and in some cases, ensuring adequate staffing, clarifying roles and responsibilities, and stakeholder engagement.

The objective of this document is to present lessons learned based on HFG's ICB experience, and to provide practical guidance that will inform future work in health systems strengthening. Ultimately, improved health system governance and management lead to improvements in the quality of essential health services and in expanding universal health coverage (UHC).

The graphic on the next page depicts a conceptual framework for foundational ICB.

Inside

<i>Introduction</i>	1
<i>Methodology</i>	2
<i>Summary of Institutional Capacity-Building Activities</i>	3
<i>Lessons Learned</i>	4
<i>Recommendations for ICB Practitioners</i>	16



Conceptual framework for foundational ICB



Methodology

The approach used to develop these lessons comprised the following activities:

- ▶ Selection of 12 HFG country programs in which ICB had a prominent role. Seven of the country programs focused on foundational institutional capacity and five were in support of a technical stream of work.
- ▶ Development of data collection protocols to interview three informants per country: HFG country or activity manager, lead HFG practitioner, and a key host country client.
- ▶ Desk review of project documents.
- ▶ Interviews of key informants.
- ▶ Analysis of the interview data to determine the lessons learned and best practices.

Summary of Institutional Capacity Building Activities

The table below summarizes the ICB activities reviewed for this study. Note that most of the activities focused on ministries of health (MOHs) since that represented most of HFG's ICB experience.

Category	Institution	Focus
Comprehensive Institutional Capacity Building	Democratic Republic of Congo, Ministry of Health	Institutional strengthening of two central directorates and two provincial health divisions under decentralization
	Haiti, Ministry of Health	Strengthen five central ministry operating units technically and managerially
	Guinea, Ministry of Health	Strengthen five central ministry operating units to carry out core functions
Focused Organizational Capacity Building	Burundi, HIV/AIDS Program, Ministry of Health	Organizational strengthening to play leadership role and carry out core functions
	Bangladesh, Health Economics Unit, Ministry of Health and Family Welfare	Repositioning/restructuring in response to universal health coverage mandate
	Mali, Secretary General's Office, Ministry of Health	Improve performance of Secretary General's Office
	Health Systems Global	Strengthen organizational governance of international professional society
Institutional Capacity Building within Technical Work Streams	Ghana, National Health Insurance Authority	Evidence-based strategic purchasing
	Namibia, Ministry of Health Policy, Planning, and Human Resources Directorate	Health accounts
	Ethiopia, Ministry of Health and Ethiopian Health Insurance Agency	Capacity building in support of health insurance, oversight boards of health facilities, evidence generation, and health financing
	Indonesia, Center for Policy and Health Management	Implementation research in national health insurance
	Nigeria, ministries of health and other health agencies in 12 states	State-level domestic resource mobilization

Lessons Learned



ICB is more likely to be sustainable when taking into account the larger system in which the organization operates.

Institutions like MOHs are living systems with multiple interacting components. They also are in a continuous interchange with a dynamic, external environment. Viewing ICB from a systems perspective means looking internally at all the components of an organization, how each component functions, and how they interact with each other. A systems perspective also includes an external view of the other organizations that have a key impact on the functions of the institution. In many instances, it also includes an understanding of the institutional arrangements and mandates that govern the interactions between different organizations. In the context of the countries where HFG works, these stakeholder organizations can be governmental, non-governmental, or private. In some cases, changes in other parts of the system may be required in order to achieve results. When requests for ICB support include both the scope and resources to allow a system wide perspective, the chances for meaningful progress increase.

In the Democratic Republic of Congo (DRC), the ICB effort supported government-wide policy reform based on decentralization, which involves several ministries at both the national and subnational levels. The primary focus of HFG was supporting the MOH decentralization process. The specific objectives were to strengthen two central MOH directorates and two provincial health divisions that have increased authorities under decentralization.

In building institutional capacity at the central and provincial levels, HFG took a systems perspective, with a particular focus on the roles and relationships between the different levels. For example, HFG decided to participate in three of the six commissions under the national steering committee that provides overall leadership and coordination in the health sector. The commissions are responsible for validating and approving policies, strategies, and guidelines. Working with the commissions legitimized HFG's ICB efforts and opened the door for coordination with both internal and external stakeholders.

In Mali, HFG strengthened the functioning of the Secretary General's (SG) office. Because this office interacts with all parts of the MOH and with external entities, the approach needed to be system-wide. One of the key issues was the ability of SG advisors to process documents from central directorates for decisions by the Minister and the SG. It was therefore essential to assess not only how well the advisors functioned, but also to understand how they related to the directorates that initiate most requests. The recommendations that emerged ultimately led to greater communication among the advisors, who realized they shared a common burden, and between the SG's office and other parts of the ministry. The systems perspective eventually led not just to improving the performance of the SG advisors, but also to improving the performance of the directorates through the assignment of technical assistants who reviewed documents before they reached the SG's office. The result was a reduction in review time and increased speed in decision-making.

In Bauchi State, Nigeria, where the HFG activity aimed at increasing domestic resources for health, the project supported the establishment of a multi-sectoral health finance technical working group. This working group

brought together the executive, legislative, and judicial branches of the government so they would be more unified in their advocacy for increased government spending on health, including state-supported health insurance, an innovative financing mechanism in Nigeria. Previously, the various branches worked independently of one another and were not organized around a common health sector goal. The efforts of the multi-sectoral working group contributed to the growing percentage of capital released for health expenditure in Bauchi State from 3.1 percent in 2016 before HFG to 18 percent in 2017. The systems perspective that informed HFG's approach promotes access to diverse stakeholders whose continued collaboration increases the likelihood of success of health financing reform.

When planning for ICB, it is critical to consider a systems perspective, allowing for a broad reach among multiple stakeholders, including the multiple parts of an institution, and its relationships with external partners. A comprehensive diagnostic process to inform project planning should involve a wide range of stakeholders to facilitate the identification of solutions.



Engagement of senior leadership can have a major impact on the success of the ICB activity.

The success of an ICB activity depends to a large extent on the level of continuous engagement by senior leadership. When the activity focuses on the MOH, senior leadership often includes the minister or permanent secretary. Given the multi-year nature of ICB activities, leadership transitions are inevitable, thus making it essential to build and maintain relationships at all levels for continued support. Investing in ICB at the most senior tier, such as the ministerial and directorate level, where the resources and positional authority to either institutionalize or derail change efforts reside will increase the chances for long term success.

In Guinea, the success of ICB activities was attributable in large part to having the same Minister of Health and his senior leadership team intact during the two-year period of HFG performance. This leadership team showed a keen interest and commitment to



HFG's activity, including through the team's active presence during an entire leadership and management training and through their full engagement during implementation. This came about in part because of the Minister's request to delay the leadership and management training for several months to allow an institutional audit to be completed as well as progress on restructuring the MOH. HFG quickly realized that a several-month delay was well worth high-level MOH participation in the leadership training because of its potential to open the door for high level engagement and support.

Conversely, frequent changes in senior-level positions can disrupt progress. For ICB practitioners, a change may mean starting over when new leaders take over. Shifting priorities, overall changes in the policy environment, the time new leaders need to adjust to the complexities of their position, and their variable level of understanding and commitment to ICB can interrupt the momentum of activities. The result is often a delay in key decisions and in some cases a reduction in the scope and impact of interventions.

In Haiti, inconclusive presidential elections led to an unelected caretaker government that served for a year. Over a period of two years, three sets of top MOH leaders from the minister to director levels served, with varying degrees of commitment to ICB efforts. Local HFG staff showed resilience in the face of these disruptions and were able to get activities back on track; however, some ICB activities had to be dropped and others were significantly delayed, limiting the achievement of desired outcomes.

Navigating changes in senior leadership and in the political environment places a premium on having local knowledge and continuous contact with senior officials. Local staff and consultants who are

knowledgeable about the local context and skilled in ICB are uniquely positioned to manage shifts in policy and personnel. By developing and sustaining relationships, these local staff resources contribute to sustainability of ICB activities, countering the disruptions caused by frequent changes in leadership.

In Mali, the ICB activity focused on the SG's office. After starting with a strong commitment by the Minister of Health and SG, turnover in both positions early in the ICB process led to nearly a year of inactivity. As ICB activities started gaining momentum, there were more personnel changes. Fortunately, strong follow-up by local HFG staff made it possible for the ICB activities to eventually start anew with the prospect of promising outcomes.

In Ghana, ICB efforts helped the National Health Insurance Authority (NHIA) become a more strategic, evidence-driven purchaser of health services. A key to this success was the decision early in the project to pivot activities in support of NHIA senior staff whose goal was to 'turn anecdotes into evidence.' Through a combination of awareness-raising workshops, training, coaching, and the development of management guidance and dashboard tools, HFG improved the NHIA's capacity to capture and use the large amount of data at its disposal for decision-making. With technical assistance from HFG in strategic purchasing, the NHIA was able to develop and test provider payment mechanisms that aim to make the NHIA more financially sustainable. This success is attributable to HFG's ability to build relationships with a succession of leaders (representing different governments), align ICB activities with current institutional priorities, and manage the dynamic tension between producing timely deliverables and the time needed for fostering ownership.



Getting an ICB effort off the ground requires a diagnostic, discussion of the results with the client, and agreement on the capacity-strengthening plan and expected results.

A participatory diagnostic establishes the framework for an ICB endeavor. The diagnostic is best conducted in person and as rapidly as possible. It involves clients at the outset to establish the purpose, areas of inquiry, respondents and data sources, and audiences for dissemination of findings, and considers the vested interests of various stakeholders. The findings indicate what is working well and critical areas for improvement. Client and stakeholder involvement in the diagnostic process can increase awareness of issues, compel analysis and problem-solving, engender ownership, and instigate timely decisions on actionable issues. Failure to conduct a diagnostic prior to ICB intervention can result in inefficient or improper use of time-constrained and limited ICB resources. The practitioner might solve one problem, inadvertently create others, or fail to address priority capacity development needs that are mission critical. The diagnostic is the foundation for developing a capacity-strengthening plan that is aimed at fostering sustainable improvements.

In the DRC, HFG conducted an institutional analysis for 10 organizational entities, including two central MOH directorates, two provincial health administrations, the Faculty of Medicine, Kinshasa Reference Hospital, and several MOH disease-based programs. Because of the participatory self-assessment nature of the institutional assessment tool used, interventions addressed what staff saw as the most

important needs and people at all levels had buy-in. This approach made implementation work more smoothly and increased possibilities for lasting change. Typical interventions recommended in the capacity-strengthening plans included: strategy development for both central and provincial entities; leadership and management training; new organizational structure and job definitions; coaching; and provision of information technology equipment and training in its use.

In Mali, the organizational assessment and feedback process was the primary intervention aimed at improving the functioning of the SG's office. Because frequent changes in government interrupted the project, it was not possible to carry out other interventions. Nevertheless, the momentum created by the diagnostic exercise was a very important outcome. The recommendations based on the assessment results led to greater communication among advisors, who realized they had a common burden and needed to collaborate rather than work in silos. This led to more efficient decision-making, improvements in the efficiency of responding to requests, and better working relationships with other parts of the ministry.

“A key intervention was the diagnostic at the beginning. The consultants worked at several levels – interviewing the director, deputy, division chiefs, conducting focus groups with staff, and meeting with external stakeholders. The result was an accurate picture of PNLS.”

- Richard Manirakiza
Deputy Director
MOH HIV/AIDS Program (PNLS)
Burundi

In Bangladesh, HFG partnered with the Health Economics Unit (HEU) in the Ministry of Health and Family Welfare (MOHFW) to revise the HEU business plan and structure. An excessively broad scope and severe staffing limitations inhibited the HEU's effectiveness. To strengthen and reposition the HEU in the context of its changing role relative to UHC, HFG conducted an institutional assessment that encompassed other MOHFW officials, donors, and technical partners. Stakeholder involvement in data collection and feedback workshops revealed early resistance to aspects of the proposed new role for the HEU. The outcome was a set of revised recommendations that limit the scope and core functions of the HEU to the financial protection aspect of UHC. The recommendations align with stakeholder input regarding the HEU's new structure and with the unit's core competence in health economics. Had the focus of the institutional assessment been purely technical in nature, and not involved key stakeholders at each phase of the process, the adoption of the recommendations and implementation of the new HEU structure and role would have less chance of success.

Well-executed institutional assessments that involve staff meaningfully are indispensable in any ICB activity. These assessments should also be conducted for activities that are fundamentally technical in nature to establish a baseline and develop a capacity-strengthening strategy and plan at the outset of the intervention.



ICB requires a specific set of skills in organizational development and training.

The knowledge and skills necessary to conduct ICB activities varies, depending on the objectives and the role of those involved. Managers who plan and oversee ICB activities require at least a basic understanding of the ICB process to be able to effectively plan and support implementation of ICB activities. Implementers of ICB activities need a range of skills depending on their background. They may be experts in organization development (OD) or they may be technical experts. If they are technical experts, the deeper their ICB skillset, the more effective they will be in carrying out both ICB and technical activities.

In the DRC, HFG had an OD specialist on staff who conducted interventions and oversaw the work of short-term local OD consultants. He also oversaw the work of MOH trainers who specialized in supervision, financial management, and results-based management and conducted training in the provincial health divisions. Because of his background, the OD specialist provided broad oversight and quality control, and oriented others in the HFG office such as the Chief of Party, a public finance and governance expert who became very conversant with ICB. Consequently, the Chief of Party was instrumental in facilitating not only the introduction of ICB processes but also follow-up, visiting clients frequently to learn about their progress, identifying areas of ongoing support, and encouraging them to continue their efforts. A key client in the ministry voiced his deep appreciation for the Chief of Party's involvement and noted the critical importance of her contribution in maintaining the momentum of ICB throughout the ministry.

Health Systems Global (HSG) is an international professional society of health policy and systems researchers, advocates, implementers, and policymakers whose aim is strengthening health systems research and policy and building communities of practice. Much of HSG's work is done virtually, and its initial needs were to strengthen organizational governance by clarifying the responsibilities of its Board and Secretariat and to develop and begin the implementation of a strategic plan. HFG provided the services of senior OD consultants who had worked extensively to support institutional governance and management in international/multicultural organizations. Over a three-year period, the OD consultants worked with the HSG Board, Secretariat, and Thematic Working Groups through the challenges of establishing a framework for a new global institution.

The OD consulting skills critical to the success of the activity were knowledge and expertise working with boards, addressing board/staff relationships, undertaking systematic online quantitative surveys with a 360 tool, and conducting Board/Secretariat retreats. The deep reservoir of OD consultant expertise made it possible for HSG to navigate the change process to a new Secretariat, coaching Board and Secretariat leaders throughout the transition.

“It was most useful to have a neutral individual who could conduct anonymous interviews, offer an independent view, function as a sounding board, and offer organizational development expertise.”

- George Gotsadze
Executive Director
HSG

The Secretariat Executive Director, a health professional with MD and PhD degrees, was already well versed in ICB approaches. One example is that he undertook the development of a comprehensive and high-quality new Board member orientation packet that ensures clarity about mutual responsibilities and expectations. The overall results of the consultant contributions and the ability of the executive director to sustain ICB efforts are that HSG is now able to function effectively on its own, has the capacity to sustain itself financially, and has established assessment mechanisms to ensure continued performance.

In Nigeria, states play a crucial role in facilitating progress toward the national goal of UHC. While it is generally understood that an effective health insurance scheme or other form of financing must be in place to attain that goal, and that funding solutions must be accompanied by policy and service delivery reform at different levels of the health system, this systems perspective is not always evident in practice. State-level actors with complementary roles in health financing reform are often unaware of the role and involvement of other key actors.

When HFG began working with the health financing unit in Lagos State, the unit had strong staff capacity and several years of experience, but it largely worked in isolation with no direct engagement with the Legislature or Treasury. It assumed that other stakeholders would just ‘fall in line’ with health financing reform – no consideration was given to understanding the capacity of other partners and stakeholders or determining how to productively interface with them. Had there been adequate stakeholder engagement, the unit might have detected much sooner that the funding had not been secured.

To address this challenge, HFG employed a full complement of OD approaches: a diagnostic assessment involving stakeholders; training on governance and oversight; and consultation to develop a health financing framework, legislative agenda, and roadmap for health sector reform that built upon health financing interventions. In collaboration with the Federal Ministry of Health, the National Health Insurance Scheme, and the National Primary Health Care Development Agency, HFG conducted a five-day training on health care financing with state-level participants from the public, private, and legislative sectors. The training set the stage for building legal, institutional, and policy frameworks for supporting health care financing reforms, and established the conceptual linkage between governance and health systems performance.

Projects like HFG should ensure that its staff have a basic understanding of OD and ICB more broadly in order to better plan for and implement ICB activities.

“Before HFG, people would talk about governance and I would say what is this ‘stuff’ you’re talking about. Having worked with this project, I understand governance is everything.”

- Commissioner of Health
Lagos State



System-level ICB efforts have much greater impact if they are designed and implemented over a longer period than the typical three-to five-year project cycle.

Meaningful organizational change takes time and dedicated effort. ICB, by definition, is a longer-term change process. Whether capacity building is aimed at modifying individual behavior or re-engineering systems within an organization, people and systems can be resistant to change, at any scale. People, predictably, revert to old behaviors and ways of thinking even if they recognize the need for change or see the limitations in current ways of doing business. The change process inherent in ICB can be complex within a single institution, requiring, in general, three to five years. When introducing, for example, a new national policy that spans multiple institutions or levels of government, even a five-year time frame may not be adequate.

The HFG project in Ethiopia and its predecessor health financing reform projects illustrate the benefit of a longer time frame. Three five-year projects played a significant role in establishing and making functional the Ethiopian Health Insurance Agency (EHIA) and its branch offices. The initial five-year bilateral project from 2004 to 2008 generated in-country evidence, provided lessons from other countries, supported policy consultations, and assisted in the development and endorsement of the Health Insurance Strategy. Over the next five years, 2008-2013, another USAID bilateral helped the Federal MOH in drafting the laws and designing the organizational framework for the EHIA. The EHIA was established as an independent parastatal body and undertook the complex process of organizing its central operations and developing a nationwide health insurance agency. Now, in the third five-year cycle under HFG, the emphasis has been on supporting the establishment and operationalizing 29 branch

offices throughout the country that work with the decentralized regional health bureaus; operationalizing health insurance including facilitating the rapid expansion of community-based health insurance schemes; increasing utilization of health services; and ensuring adequate reporting of insurance membership enrollment and renewal, membership contribution payments, claims processing, and reimbursement to health facilities. Over the 15 years and three project cycles, the cumulative result is a fully operational health insurance agency with 29 branch offices and operational procedures to support implementation of reforms on a sustainable basis.

In Guinea, HFG was asked to support the strengthening of the institutional capacity of the central MOH over a two-year period. Although the gains were significant given the limited time frame, the time was not sufficient to fully strengthen the five operating units that were HFG's focus and institutionalize new management practices across the central MOH. HFG was successful in engaging decision-makers and introducing leadership and management practices to senior and mid-level managers across key entities in the MOH. However, the short time frame did not allow time to ensure implementation of policies, adjustment of organizational structures, and time for changes in behavior to become part of everyday practices across the ministry.

Most donor agencies do not program beyond five years although strategies such as USAID/DRC's Country Development Strategy Statement (CDSS) do look at the longer term. USAID/DRC's CDSS recognizes explicitly the need for a longer time horizon, realizing that building institutional capacity of national-level agencies and effective subnational health structures will take much longer than the standard five years. More targeted efforts aimed at a single operating unit of the MOH, for example, will not typically require more than three to four years. System-wide changes aimed at building overall institutional capacity across an entire MOH need a longer time horizon.



ICB efforts have better results when there is consistency in the approach over time.

Changing consultants and counterparts can be disruptive.

Continuity of consultant support and ongoing engagement of in-country staff throughout the ICB process ensures consistency of methodology, evolution of trusting relationships, and deeper understanding of issues. Where this consistency exists, the chances are greater that ICB activities will gain momentum and achieve desired results. When the same key counterpart staff work with ICB consultants using a consistent approach over time, it contributes to both individual and organizational capacity. Where consultants and staff change frequently, the impact is often not only disruptive on relationships, but it can also alter the ICB approach, slowing down the process and confusing clients.

In Burundi, the same external OD consultant worked on the three-year ICB activity from beginning to end. His consultancies often lasted three weeks, which made it possible to develop strong relationships with key stakeholders. He collaborated closely with the local HFG coordinator, ensuring regular follow-up. Another key factor contributing to success is that the Deputy Director of the National HIV/AIDS Program (*Programme National de la Lutte contre le SIDA*, PNLS) remained the same throughout the process, continually building his own skills, maintaining continuity, including managing the transitions of three new directors.

In contrast, in Haiti, mid-course changes interrupted the ICB process. After a group of external OD consultants conducted initial organizational assessments and began conducting interventions for five MOH operating units, the MOH requested that HFG engage a local consultant known to them.

The consultant was asked to conduct a new assessment in five offices and recommend interventions. This development coincided with the transition of both the HFG Chief of Party and local Capacity Building Specialist. The local consultant was not able to honor the agreed-upon timetable and never fully completed the assignment. As a result, the ICB effort lost momentum. Furthermore, his approach was expert-led, rather than engaging fully with stakeholders and with in-country HFG staff. There was neither full consultation nor the capacity strengthening that happens when stakeholders participate in the needs analysis, review its conclusions and identify possible solutions. In-country staff tried to compensate for the lost time and momentum after the consultant's departure by conducting an intensive series of activities with external consulting support, but their efforts were hampered by the limited time remaining in the project.

In Namibia, HFG and its predecessor project Health Systems 20/20 supported six rounds of health accounts covering a total of 15 years of health spending data. MOH capacity to produce and utilize health accounts data is now developed to the point that the results have been used to develop the Health Sector Strategic Plan, the National Development Plan, and National Strategic Framework for HIV. Two contextual factors that helped make Namibia fertile ground for health accounts to take hold included *continuity* – consistent involvement of HFG practitioners through several rounds of health accounts – and *low turnover* – consistent engagement of core ministry staff throughout the project. Notably, over the past four years, the MOH health accounts team developed more efficient data collection processes, built capacity to produce health accounts on a regular basis, developed competency in using the *Health Accounts Production Tool* to support data analysis, and secured greater involvement of key stakeholders that produced improved results in a relatively short time.

Turnover in host country government agencies is a fact of organizational life, and it is difficult to ensure consistent engagement of consultants over the long term. Nevertheless, projects like HFG should promote continuity of staff and consultants (e.g., scopes of work for multi-year engagements and with continuity as an explicit goal). When there is government turnover, focused efforts to develop relationships with and brief the incoming leaders will mitigate against some of the disruption.



ICB efforts, which include the need for regular follow-up, are often more effective when carried out by local staff and consultants.

Capacity building and organizational change are gradual and iterative processes, requiring timely, skillful, and consistent intervention to achieve results that will endure over time. The effectiveness of ICB endeavors increases where ICB practitioners consistently engage with counterparts in the client system. Ongoing contact includes both formal and informal occasions that enable consultants and staff to develop close working relationships with client counterparts.

External, short-term consultants often bring a deep reservoir of expertise resulting from experience across a range of countries, which clients value highly. Another asset is their perceived neutrality and objectivity. However, local consultants or staff have the distinct advantage of intimate knowledge of the organizational, cultural, and political contexts, and existing relationships with many key stakeholders. External consultancies typically last one to three weeks, perhaps for multiple visits; therefore, time spent in country is often tightly programmed and time-constrained. Local consultants have the advantage of being accessible to stakeholders within and outside

their organizations, in real time, and on a continuous basis. Accessibility is critical given the frequent and often unanticipated changes that disrupt the plans and schedules of ministry staff and other stakeholders, with the resulting impact on ICB and reforms in progress.

In some countries where local consulting expertise in a given area is not readily available, partnering between local staff and external consultants is necessary, with each playing a complementary role. The biggest challenge is when there is no local project office or local consultants, which makes it harder for external consultants to build ongoing rapport with local counterparts, and to ensure follow-up support. Given their episodic and more limited exposure to the client system, the support provided by external consultants is also much more vulnerable to changes.

In the DRC, HFG identified a full-time local OD specialist and a team of local OD consultants who worked on a part-time basis. They had the advantage of being present continuously. Their contributions were supplemented by local subject matter specialists who provided training in areas such as financial management, supervision, and results-based management.

In Indonesia, HFG carried out implementation research to support policy reform happening concurrently with the roll-out of the national health insurance scheme. Due to complex power dynamics within the local political system, and specific language requirements for data collection, technical support had to be deeply embedded in the local culture and context. HFG partnered with the University of Gadjah Mada and the Center for Policy and Health Management (CHPM) to conduct two cycles of research and analysis, and strengthen CHPM's capacity and the MOH's capacity to undertake this type of research. Most stakeholders involved in this activity had no prior exposure to implementation research. The first research cycle focused on educating the university's partners and stakeholders about research concepts and laying the foundation for continued collaboration. HFG built the capacity of CHPM to assume the lead in managing, interpreting, and processing collected data with supportive technical reviews by the HFG home office team. In the second research cycle, HFG continued to invest heavily in building capacity to conduct implementation research, even though ICB was not explicitly in the original project scope. By the end of the second cycle of research, the local university partner had acquired basic capacity to use software to support data analysis and data management, which previously was done manually. They also built the capacity of the Health Policy Network, a group of district university partners, through hosting webinars, allowing district university partners to participate in data collection and analysis. Finally, HFG built capacity of the MOH's research unit in implementation research as well. This shows how integrating ICB into short-term external consultancies can engender trust, ownership, and build local partner capacity to play a more substantial partner role.

“What worked particularly well was having HFG ‘boots on the ground,’ with the Chief of Party taking on a major role, and the ongoing work of the local OD consultant and HFG OD Specialist. We were able to stick closely to our work plan thanks to their close support.”

- Epiphane Ngumbu
Director

Human Resources Directorate
Ministry of Health
Democratic Republic of the Congo



Coaching and follow-up are essential components to ensure application of new systems and tools.

Developing institutional capacity requires more than the development of systems and procedures and training in new skills. It also requires coaching and follow-up as organizations and individuals implement new systems and ways of operating. Too often such coaching and follow-up is not planned and budgeted for and, as a result, the gains are not sustained over time. The type of coaching practitioners offer can vary. Coaching is valued for discussing strategies, for identifying ways of overcoming challenges, and for applying new skills. HFG explicitly planned several coaching interventions with positive results in several country programs.

In Namibia, HFG relied heavily on a close practitioner-client relationship to strengthen client capacity for conducting health accounts exercises, using a new methodology. Given the MOH's desire to lead the effort, HFG practitioners devoted a great deal of time to one-on-one meetings with country counterparts. Those meetings led to greater trust through discussions of objectives, challenges, desired results, identifying stakeholders, and ensuring ownership by continually clarifying that HFG would support the MOH to lead the activity. The activities that followed included training at different levels, planning sessions for data collection, analysis and information management, and participation in the process. Coaching and consistent support were key to ensuring momentum and reinforcing learning by doing, particularly through the data collection and analysis process. The coaching was done both in person and virtually when practitioners were not in country.

In DRC, HFG helped to train national-level coaches who in turn were assigned to assist provinces in taking on new responsibilities and systems, such as planning and reporting, consistent with decentralization reform. The national coaches were trained in the fundamentals of coaching and in supporting the systemic institutional changes. Since most coaches were medical doctors or other health professionals, none had ever been trained in how to be an effective coach. Similar training was then provided to staff in each provincial health division unit responsible for developing the capacity of the health zones. The aim was to improve the way they supervised the zonal health teams and improve their performance. In recognition of the value of coaching, the central ministry asked HFG to train all central directors in coaching, so they could better manage their offices.

In Guinea, HFG implemented a clinical coaching program for 36 teaching staff from health training institutions. The aim was to use coaching as a complement to formal medical and paramedical training, especially for staff assigned to rural areas without access to ongoing professional development. Staff received training in the skills required to be an effective coach of clinicians. Unfortunately, there was not sufficient time to assess to what degree the coaching training had an impact on provider performance in rural areas.

These examples illustrate the different forms that coaching can take to support institutional change. Coaching requires a specific set of skills, the basics of which can be learned in a workshop several days in length. When used intentionally and as a follow-up to other interventions, coaching can increase prospects for sustainability.



Donors have an essential role to play in prioritizing ICB in development projects.

Donor organizations can play a supportive role in elevating ICB within a health development project. Understandably, technical staff in donor agencies may tend to prioritize activities that produce tangible, measurable results, linked to increased demand and use of priority health services, or improved quality and coverage of care. Project scopes of work and funding often align with those priorities. Where the focus is not explicitly capacity development, support for activities that are principally non-technical may tend to be limited. However, donors increasingly recognize that health indicators and capacity indicators are inextricably linked, especially if transition from donor assistance is the goal.

In the DRC, the USAID Mission Director insisted that all projects build institutional capacity and made it the core tenet of the mission's country strategy. This resulted in strong support from USAID staff for ICB activities. One practical application of this is the use of a standardized institutional assessment tool across all projects in all sectors. As a result of the strong support for ICB, the HFG project had sufficient resources and a broad enough reach across the MOH to achieve significant impact, strengthening key offices such as the Human Resources Directorate, Management of Health Care Services Directorate, and two provincial health divisions.

In Burundi, USAID/Burundi recognized the importance of strengthening the institutional capacity of the MOH's PNLS to carry out its core functions. The comprehensive ICB approach used by HFG was instrumental in turning the organization around to

the point where the Global Fund awarded Principal Recipient status to the PNLS. Throughout the three-year activity, USAID/Burundi was steadfast in its technical and material support for the HFG activity, which enabled the project to invest in several activities that strengthened the PNLS, with long-term benefits to the institution.

Donors and implementers are under constant pressure to produce concrete results in a relatively short period of time. The dynamic tension between producing results and building capacity is ever present. In Nigeria, the HFG project generated substantial evidence in helping establish the State Health Accounts. Health accounts allow a country to understand the source, magnitude, and flow of funds through its health sector. The project completed the actuarial analysis needed for the design of the state health insurance scheme and instructed key stakeholders in how the evidence is used; however, there was neither the time nor the resources to train others to do the analysis, and still meet the timeline set by the donor. Sustainability objectives are better served when underlying capacity development needs are factored into project funding and timelines.

The lesson drawn from the DRC, Burundi, Nigeria, and other project experiences is to recognize at the project design stage that ICB is an indispensable element of most development projects. Donor actions that elevate ICB within development projects include: incorporate capacity building into project scopes of work and ensure sufficient funding for these activities; establish project timelines that take capacity-building investments into account; understand capacity building is a dynamic process and respond favorably to needed adjustments in the implementation plan or schedule; include capacity metrics in project evaluation instruments; and promote the use of ICB methods and tools across projects in the health sector, and across sectors.

Recommendations for ICB Practitioners

The lessons presented in this document have specific implications for the planning and implementation of ICB activities by practitioners. Taken as a whole, they offer a set of recommendations for strengthening the effectiveness of ICB efforts. While the context for these lessons is health systems strengthening, they clearly have application in other areas of development assistance.

- ▶ When planning and implementing an ICB activity, determine the institutional ecosystem within which the organization sits. A rapid mapping exercise will identify the organizations that are central to success and describe how they relate to the target organization.
- ▶ Engage senior leaders to ensure political and material support for the ICB effort. Ideally, engagement will happen from the outset and be sustained over the course of the activity. This engagement can take the form of periodic briefings on progress and challenges.
- ▶ Begin all ICB efforts with an institutional assessment tailored to the situation. The assessment will not only establish a baseline, but it will also identify the strengths and weaknesses and provide the information needed to develop a capacity-strengthening plan.
- ▶ Ensure that staff and consultants working on ICB activities have a basic understanding of OD and ICB more broadly, in order to better plan and manage ICB activities. This may require in-service training and the provision of ICB materials and examples.
- ▶ Plan for a time horizon that allows enough time for meaningful change. Large-scale ICB efforts such as those supporting decentralization may need a full five years or more, whereas targeted efforts aimed at a single operating unit or NGO may require three years or more.
- ▶ Ensure consistency of approach and methodology. Where this consistency exists, the chances are greater that ICB activities will gain momentum and reach desired results. To the extent possible, minimize changing staff and consultants. Where consultants and staff change, the impact is often not only disruptive on relationships, but it can also alter the ICB approach, slowing down the process and confusing clients.
- ▶ Maximize the use of local staff and consultants. Local consultants add particular value when working on complex, long-term reform efforts that require continuous skill development and coaching to engender ownership and institutionalization of new tools, processes, or approaches.
- ▶ Build in coaching and follow-up to ICB efforts. When coaching and follow-up are planned and budgeted, the gains are more likely to be sustained over time.
- ▶ Seek active donor support for ICB by incorporating it into project scopes of work, proposing sufficient funding, and clearly articulating the essential role of ICB in sustainability and transition.

About HFG

A flagship project of USAID's Office of Health Systems, the Health Finance and Governance (HFG) Project supports its partners in low- and middle-income countries to strengthen the health finance and governance functions of their health systems, expanding access to life-saving health services. The HFG project is a six-year (2012-2018) global health project. The HFG project is led by Abt Associates Inc. in collaboration with Avenir Health, Broad Branch Associates, Development Alternatives Inc., Johns Hopkins Bloomberg School of Public Health, Results for Development Institute, RTI International, and Training Resources Group, Inc. To learn more, please visit www.hfgproject.org.

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