TECHNICAL BRIEF

CAPACITY DEVELOPMENT

An Integrative Approach to Building Capacity in Liberia

RBHS capacity building assistance included providing training workshops targeting specific cadres of staff and specific knowledge and skill sets.

Background

When the Rebuilding Basic Health Services (RBHS) project began in 2008, Liberia was still recovering from its protracted civil war, which had ended in 2003. Because the health system had been almost completely destroyed during the civil war, the first three years of the project focused on making sure Liberian citizens had increasing access to health care services. The MOHSW introduced performance-based contracting (PBC) as a component of its five-year transitional National Health Policy and Plan in 2007. Initially, RBHS approached this by entering into performance-based contracts with NGO partners, who were responsible for ensuring that quality health services were delivered to the population. Later on, as the RBHS managed performance-based financing mechanism became more consolidated, RBHS turned it over to the Liberian Ministry of Health and Social Welfare (MOHSW), which created an internal performance-based financing unit in charge of managing the performance-based contracts with NGOs. With the Ministry now responsible for managing health services delivery in the country, RBHS shifted its focus to help strengthen the overall health system.

At the same time, RBHS also began to engage the MOHSW to build the capacity of its employees to implement the newly introduced National Health and Social Welfare Policy and Plan 2011-2021 (NHSWPP). The NHSWPP highlighted decentralization as a key policy in which Liberia's county-based health and social welfare teams (CHSWTs) would incrementally increase their responsibility for managing all aspects of county health service delivery.

At this time USAID also began providing direct government to government (G2G) assistance to the MOHSW through a mechanism called a fixed amount reimbursement agreement (FARA). FARA delivered financial assistance to the MOHSW to conduct a set of mutually agreed activities intended to improve the health status of Liberians. The preparation for FARA highlighted capacity-building needs at the central and county levels to enable the MOHSW to carry out required activities and meet deliverables.

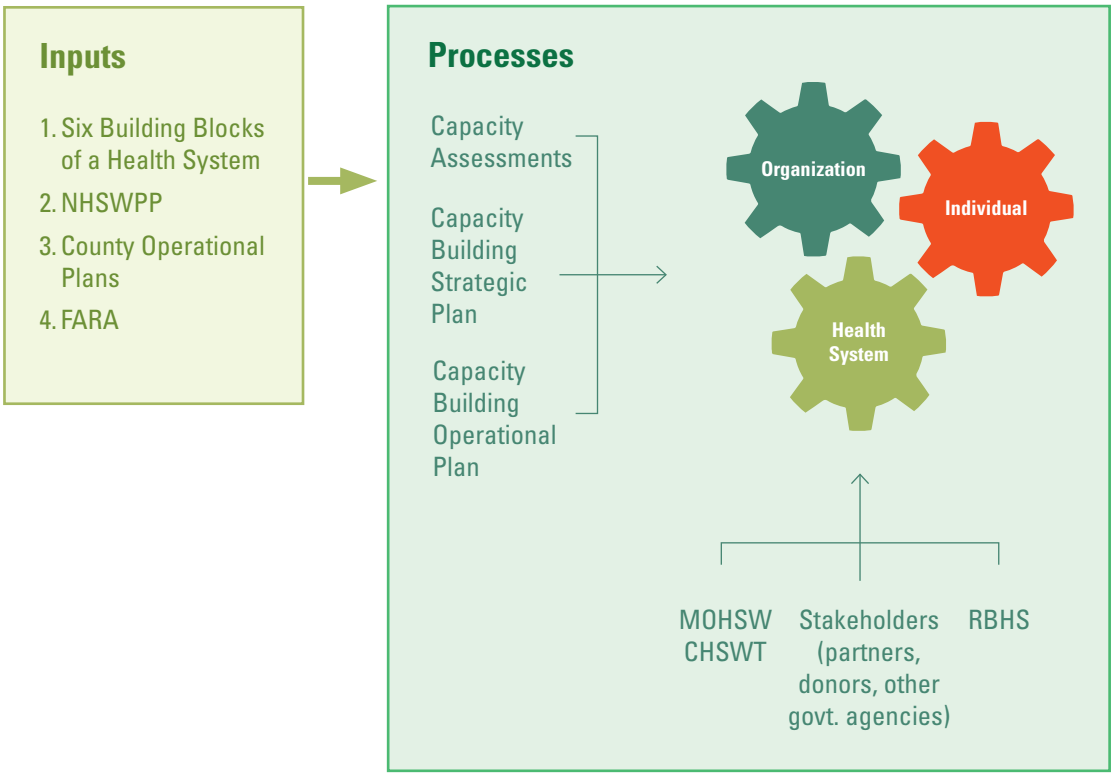
Recognizing the complexity of decentralization challenges and the multi-level solutions necessary to address them, MOHSW, donors, and partners—including RBHS—expanded their strategies to include county-and central-level capacity-building. RBHS efforts focused on efficient use of investments, health system strengthening, and performance improvement, thereby leading to better processes and health outcomes.

Approach

The MOHSW developed and led a comprehensive and integrated capacity-building approach that focused on simultaneous capacity-building at three levels: individual, organizational, and system (see Figure 1). This integrated approach was chosen because it was believed to have the best chance of being sustainable as donor funding decreased.

After a thorough literature review, the MOHSW and RBHS agreed upon the following definition of capacity-building: Capacity-building is a process of **workforce development** (capacity of individual health workers to meet objectives); **organizational strengthening** (activities to improve the structures and processes of implementing organizations); and **systems strengthening** (activities that enhance the formulation of policies, strategies, and operational plans of the overall health system). Focusing on all three levels enable the health sector to improve its performance resulting in improved health outcomes for Liberia. The diagram below illustrates the approach.

Figure 1: MOHSW Capacity-Building Framework



In addition to the six building blocks of a health system, the capacity-building framework is driven by inputs such as the NHSWPP, the county operational plans, and FARA. The creation of these inputs stimulated the capacity-building process, which involved assessing baseline capacity and creating capacity-building strategic and operational plans. The capacity assessments provided data for identifying a baseline and specific areas in which to build the capacity of the MOHSW.

Together, RBHS and the MOHSW took a health systems strengthening approach to deliver capacity-building services. The WHO identifies six building blocks of a country's health system (see Figure 2): 1) delivering essential health services; 2) health workforce; 3) health information systems; 4) access to essential medicines; 5) health systems financing; and 6) governance and leadership. The theory is that building capacity—at the individual, organizational, and system levels—within each of these six building blocks will contribute to strengthening the entire health system. As such, the MOHSW identified the capacities it needed to acquire using this "six building blocks of a health system" framework.

The goal of the capacity-building process was to build capacity holistically—at the individual, organizational, and health system levels. Each level is closely related to the others, building capacity at the individual level happens simultaneously with building capacity at organizational and health system levels. This comprehensive, integrated approach helps build effective, efficient, and sustainable capacity in priority areas.

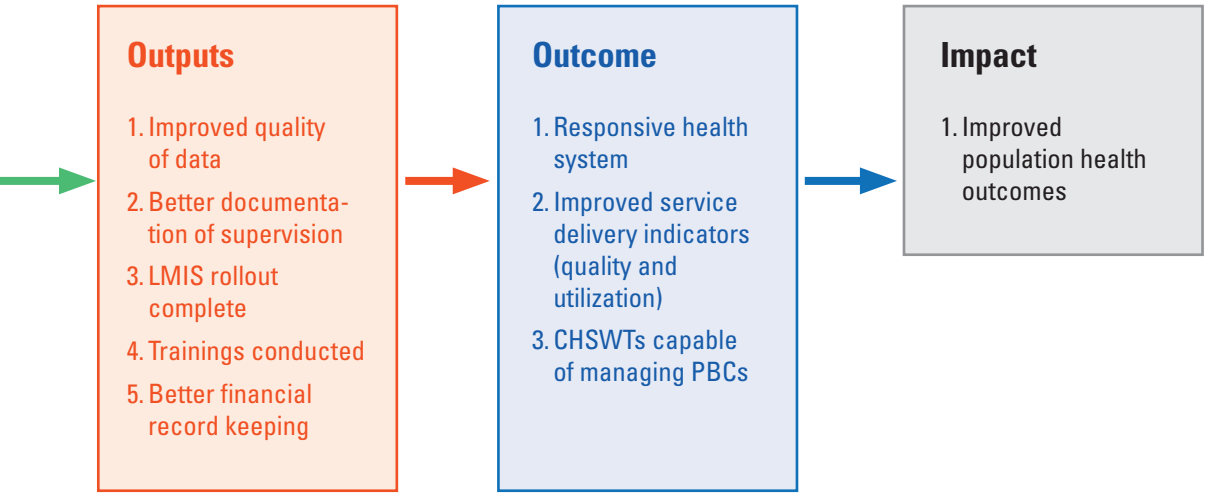
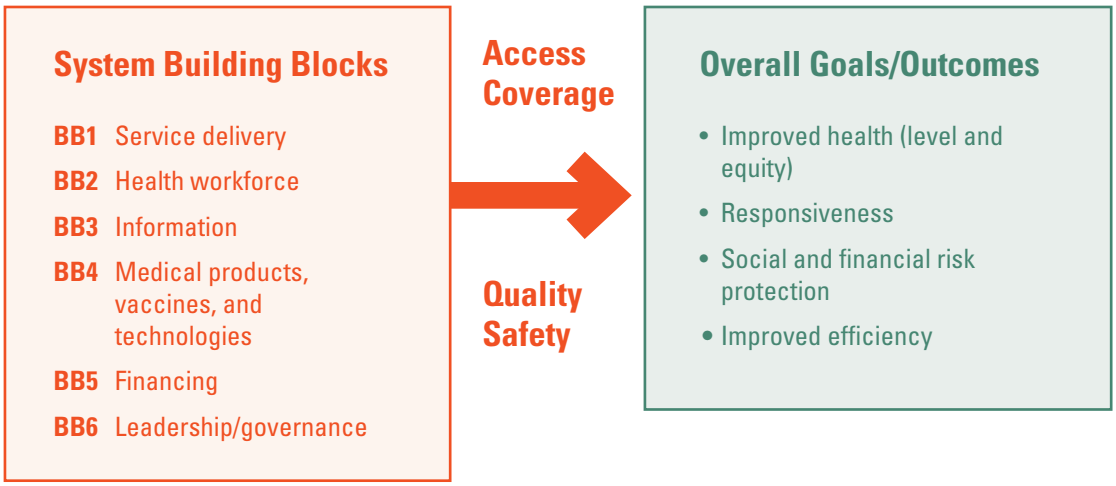


Figure 2. WHO Health System Framework

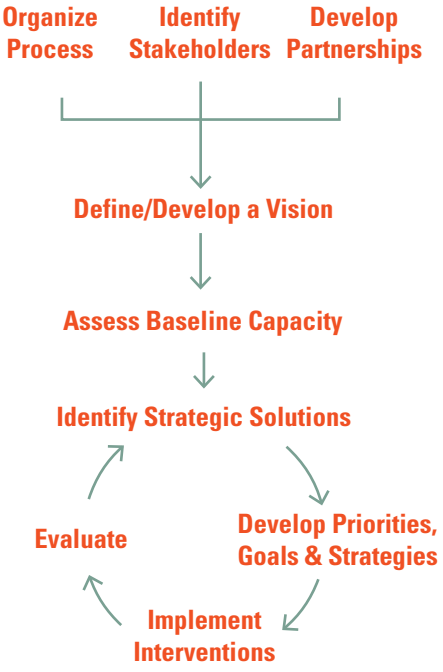


Implementation

The capacity-building process, developed jointly by the MOHSW and RBHS, was structured to identify causes of performance gaps, address those gaps through a wide array of performance solutions, and enable cyclical processes of continuous performance improvement through the establishment of performance monitoring systems. RBHS provided technical assistance to the MOHSW to develop a process to organize capacity-building interventions (see Figure 3).

In 2012, RBHS conducted a baseline capacity assessment at the central MOHSW and in Bong, Lofa, and Nimba counties. The assessment identified and prioritized capacity strengths and weaknesses at both the central and county levels according to the six WHO building blocks of a health system. The baseline assessment found wide variation in capacity between the central MOHSW and counties. For example, the central MOHSW scored much higher in the sixth building block, leadership and governance, than did the counties. This is likely because decentralization was new and still not fully implemented, giving counties little chance to develop leadership and governance experience and skills. Among the counties, the variations in capacity were narrower but still apparent.

Figure 3. Capacity-Building Processes



Based on the assessment results, the MOHSW prioritized areas to build capacity with technical assistance from RBHS. Following prioritization, a strategic plan was developed to address capacity-building in the priority areas. The strategic plan was implemented with the help of an operational plan, whereby MOHSW and RBHS jointly identified interventions to build capacity in the priority areas. A work plan with activities and a monitoring and evaluation plan with indicators were developed to track progress of capacity-building activities.

The implementation approach involved root cause analysis and stakeholder meetings at the start of each of the proposed interventions. The list below illustrates interventions by building block that occurred at the central and county levels.

- **BB1:** Strengthen quality through supportive supervision and introduce performance-based financing (individual, organizational, and systems)
- **BB2:** Upgrade the professional qualification of midwives, with needed changes in the pre-service curriculum (individual and organizational)
- **BB3:** Analysis and visualization of data to improve use of information for decision-making (individual, organizational, and systems)

By simultaneously addressing each of the six WHO health system building blocks, RBHS aimed to strengthen leadership and governance, promote an evidence-based information culture, and enhance management systems supporting sustainable, equitably distributed quality services and programs, and ultimately improved health outcomes.

- **BB4:** Stakeholder consensus building in FARA counties on gradual transfer of supply chain management (SCM) functions from central level (SCMU-NDS) to the CHSWTs (organizational)
- **BB5:** Support implementation of an electronic accounting system at county level (organizational and systems)
- **BB6:** Improve communication between central and county levels (individual and systems)

The specific interventions described below were used to address agreed-upon capacity gaps and their root causes. The interventions were multifaceted and included appropriate combinations of the following:

- Training workshops targeting specific cadres of staff and specific knowledge and skill sets.
- Training pairs or trios of staff from the same or related work units to form a network of implementers who are able to apply training to the work place.
- Embedded technical assistance at the central and county levels. At the central level a performance-based financing (PBF) advisor helped establish and operate the PBF unit. At the county level RBHS assigned full-time monitoring and evaluation and capacity-building officer to the CHSWT. They provided continuing onsite support for implementing the district health Information system. The capacity-building officers ensured that county operational plans leveraged RBHS capacity-building interventions.
- Intermittent short-term TA provided by the same consultant to a consistent group of work units and staff over a sustained period of time. Sequenced TA provides organizations the opportunity to complete critical internal steps in a process, e.g., policy development, consensus building around a new practice. MOHSW staff have the opportunity to practice on their own, deepening their awareness of the new practices as well as nuanced challenges in implementation.

- Early identification and engagement of the staff and/or organizational units expected to sustain the results of a technical assistance assignment or an RBHS intervention.

A critical success factor was MOHSW ownership of the capacity-building process. At the outset, the MOHSW convened a capacity-building core group to drive the process. The group was chaired by an assistant minister and included staff and partners representing the six building blocks. This was the platform for ministry engagement and ownership of the process from assessment through operational planning and implementation. As discussed above, individual, organizational, and systems capacity development are interconnected and RBHS intentionally sought to create linkages among all three levels.

Results

RBHS project interventions provided extensive training and mentorship of MOHSW staff at both the national and county levels and aimed to strengthen both systems and processes to ensure sustainability is not personnel dependent. RBHS implemented an inclusive and integrated approach where all proposed interventions and activities were conducted in collaboration with the MOHSW and were in alignment with the NHSWPP.

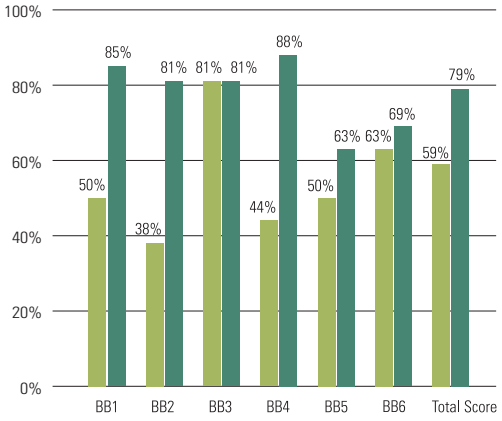
The same capacity assessment tools that measured the baseline were used to assess capacity improvements in an endline assessment, which was completed in June 2014. The assessment reinforced the understanding that strengthening capacity is an iterative process, and measurement of capacity gains is inherently imprecise. However, the self-assessment nature of the process ensured stakeholder buy-in, and facilitated introspection and a genuine desire to improve. Group and individual discussions, which were part of the endline assessment, gave staff an opportunity to reflect on the system and come to a mutual understanding of key accomplishments and remaining gaps. The assessment process promoted an expanded understanding of what can be achieved.

The organizational learning process is not linear, nor does it occur at the same pace for all stakeholders. Numerous factors promote or hinder the process at all levels.

As shown in the graphs below, the endline assessment found increases in all six building blocks at both the central and county levels, though the changes were uneven at both levels and across building blocks.

An endline assessment conducted by RBHS showed MOHSW capacity improvement at both the central and county levels.

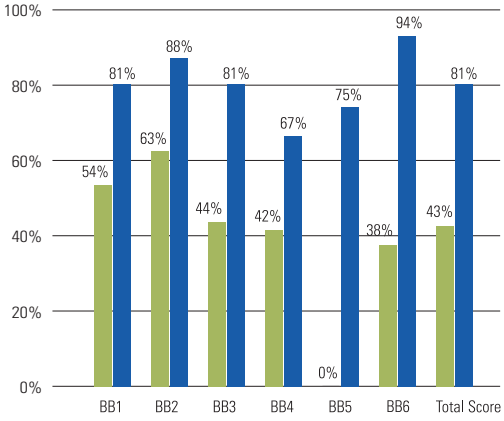
Central MOHSW Capacity Scores



BB1: Health Services
BB2: Workforce
BB3: HMIS
BB4: Essential Medicines
BB5: Health Financing
BB6: Governance Leadership

2012
2014

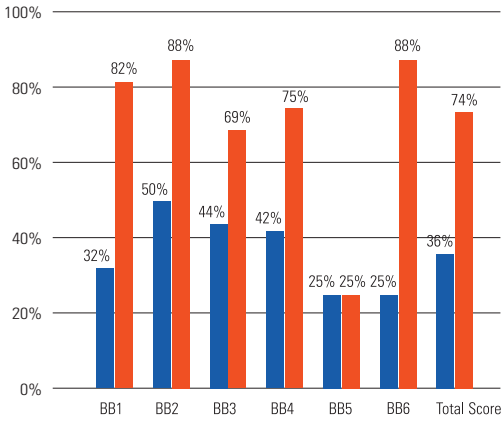
Bong CHSWT Capacity Scores



BB1: Health Services
BB2: Workforce
BB3: HMIS
BB4: Essential Medicines
BB5: Health Financing
BB6: Governance Leadership

2012
2014

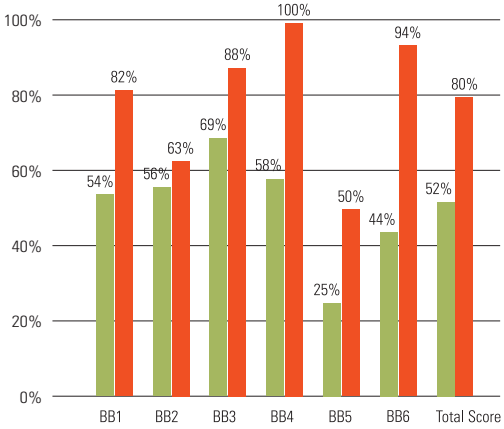
Lofa CHSWT Capacity Scores



BB1: Health Services
BB2: Workforce
BB3: HMIS
BB4: Essential Medicines
BB5: Health Financing
BB6: Governance Leadership

2012
2014

Nimba CHSWT Capacity Scores



BB1: Health Services
BB2: Workforce
BB3: HMIS
BB4: Essential Medicines
BB5: Health Financing
BB6: Governance Leadership

2012
2014

Capacity-building is an ongoing MOHSW focus, evidenced by the hiring of a full-time capacity-building coordinator for the County Health Services Division. This position provides leadership and visibility to capacity-building process efforts, especially for the counties. In addition to the capacity-building core group discussed above, the MOHSW put several mechanisms in place to help sustain and expand the gains in capacity development. Regional support teams (RSTs), led by senior ministry staff, have been assigned to the five regions (clusters of three counties). Each team is comprised of representatives from various units in the MOHSW, RBHS advisors, and WHO advisors. RSTs are responsible for working with the counties to identify and respond to support and capacity needs. The RSTs then obtain responsive support from the MOHSW and/or its partners and follow up and document the results. Though initiated toward the end of RBHS in 2014, this mechanism has the potential to be a "one stop shop" for county communication with the central ministry.

A third mechanism is the contracting-in readiness assessment working group, which was established to assess county readiness for contracting-in to deliver health services (as opposed to NGOs delivering services). This interdepartmental working group took the lead in completing the first round of county contracting-in readiness assessments and has the tools and skills to strengthen county capacity for contracting-in.

Both the regional support teams and the contracting-in readiness assessment working group show how the dialogue on capacity development has shifted within the MOHSW. These mechanisms are systems interventions with the potential to lead county capacity development. They are also indicators of the significance of continuous capacity-development within the MOHSW, especially in terms of moving counties toward decentralized management of health service delivery.

Way Forward

It is critical that the MOHSW maintain momentum in its expanded approach to capacity development. This can be done by continuing interdepartmental collaboration and strengthening the structures and processes that drive collaboration. RBHS prepared a transition plan that specifies mature, developing, and newly initiated capacity-building activities in each of the six building blocks. For each activity there is a set of recommendations for sustainability, maintenance, and quality improvement within mature activities, recommendations for institutionalizing developing activities, and recommendations for collecting evidence and analyzing the success and/or challenges of emerging practices.

While substantial achievements have been produced in a relatively short period, capacity-building will continue to need more support beyond the life of RBHS. In this spirit, USAID and the MOHSW have jointly agreed to new multi-year projects to be awarded in 2014 to bolster capacities at all levels of the health system, including communities, local organizations, CHSWTs, and the central MOHSW. These recommendations will be led by the MOHSW and can be supported by new projects and partnerships.

Continued momentum on capacity-building is needed to realize the vision of the NHSWPP: a healthy population with social protection for all. Importantly, the assessment tools, strategy, and implementation approach used by the Liberian MOHSW to improve the capacity of its workforce at all levels has the potential to be adapted to other post-conflict countries.

The Rebuilding Basic Health Services (RBHS) project was a six-year project funded by the United States Agency for International Development (USAID) and implemented by JSI Research & Training Institute, Inc., in partnership with the Johns Hopkins Center for Communications Programs (JHUCCP), JHPIEGO, Management Sciences for Health (MSH), and the Institute for Collaborative Development (ICD).

Photos by Robin Hammond