Measuring Capacity Building in Health and Population Programs

Summary of a meeting held by MEASURE Evaluation

November 16-17, 1999
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Summary

In November 1999, the MEASURE Evaluation project hosted a two-day meeting on Measuring Capacity Building in Health and Population Programs. The objective of the meeting was to present, analyze, and build consensus on a conceptual framework and indicators for measuring capacity building in the population, health and nutrition (PHN) sector. Participants included representatives from USAID, UNICEF, The World Bank, CIDA, Cooperating Agencies, and NGOs working in the PHN area (Annex A). The results of this meeting will contribute to the design and testing of Guidelines for Measuring and Evaluating Capacity Building in the PHN Sector. This report summarizes the presentations and main points of discussion at the meeting.

The proposed MEASURE framework of capacity measurement analyzes capacity at four levels of society: health system, organizational, health professional, and client (Annex B). During the meeting, participants reviewed the basic structure of the framework and made a number of substantive recommendations about specific relationships between components, the definition of capacity levels, and the description of elements of capacity for each level.

Five practitioners from cooperating agencies and private voluntary organizations (PVOs) reported on specific tools and experiences related to capacity measurement at different levels. There are few, if any specialized tools for measuring capacity at the system level. However, many well-developed tools exist for measuring organizational capacity. These instruments all approach the organization by breaking it into component parts and measuring each component based on self-identified goals or stages of development. Capacity measurement at the health professional level centers primarily on assessing the knowledge and performance of health professionals. The presentation on measuring client capacity made use of Participatory Research Assessment (PRA)-type methods to assess change in client behavior and knowledge.

In small group exercises, meeting participants chose a specific capacity building outcome to refine the proposed framework at each level. Using the structure of the framework, groups identified the inputs, processes and outputs that contribute to specific capacity outcomes. The framework enabled participants to map the relationships between different levels. The meeting concluded with recommendations for

refining and adapting the conceptual framework and defining the content of the proposed guidelines for measuring capacity building.

MEASURE Evaluation would like to thank all participants for their contributions to the meeting and suggestions for revision to the proposed document.

I. Conceptual Framework for Measuring Capacity

Background

In early 1999, MEASURE Evaluation conducted a literature review of capacity building and capacity measurement, an inventory of capacity assessment tools, and a consultation with various organizations involved in capacity measurement. The resulting paper on the "state of the art" of capacity measurement in the health sector and conceptual framework for evaluating capacity building efforts (Annex B) formed a basis for discussion during the meeting on November 16 and 17, 1999.

The draft paper reports that capacity building is an elusive concept, particularly because of the difficulty of defining elements of capacity. As noted in the literature, capacity has four key characteristics. It is multidimensional, dynamic, linked to performance, and contributes to sustainability. The conceptual framework for the PHN sector suggests that capacity is required at four levels of "society": health system, organizational, health professional and client. It graphically illustrates the interaction between these four levels and their link to health system performance (access, equity, quality and efficiency) and ultimately, health status. The framework assumes that if capacity remains adequate over time, health system performance will be sustained, as will improvements in health status of the population. Contextual factors relating to culture, society, economy, political systems, laws and regulations, and the environment that influence capacity in the health sector are also represented.

For each level, the framework suggests critical elements of capacity that should be present to ensure health system performance. Capacity at each level is broken down into four elements: *inputs*, *processes*, *outputs* and *outcomes*. The inputs and processes represent the resources and resource management functions required in order to produce capacity-related outputs and outcomes (Annex B, Figures 2-5). The addition of the *client* and the *systems levels* sets this framework apart from previous approaches to capacity measurement.

Summary of discussion from meeting

During the meeting, participants reviewed the basic structure of the framework and made a number of substantive recommendations about specific relationships between components, the definition of capacity levels, and the description of elements of capacity for each level. The following presents the key points of the discussion:

- The conceptual framework depicts elements of capacity required for health system performance independent of any specific capacity building intervention. It should be used to identify the focus of capacity building efforts and areas to monitor and evaluate whether capacity has changed over time.
- Inputs, as depicted in the conceptual framework, therefore represent resources required to ensure performance, rather than external capacity building interventions whose aim is to build capacity.
- There is not always a direct causal relationship between individual inputs, processes, outputs and outcomes in the framework. In reality, few of these relationships are linear, and capacity outcomes rely on combinations of inputs and processes.
- Contextual factors are critical to capacity building but are not well depicted in the framework.
- Although the health system consists of organizations, health professionals and clients, it is treated as a separate level of capacity in the framework. Authors of the framework noted their interest in representing functions that were specific to the health system that did not reflect functions inherent to others levels.
- It will be difficult to capture system-level interventions and performance since there is little overall agreement on what constitutes ideal system performance.

Specific changes to the framework suggested by participants are detailed in Annex C.

II. EXPERIENCE IN MONITORING AND EVALUATING CAPACITY BUILDING

Five practitioners from Cooperating Agencies and PVOs reported on specific tools and experiences related to capacity measurement at three of the four levels of society presented in the conceptual framework. (We were unable to identify a presenter for the system level.) There are few, if any, specialized tools for measuring capacity at the system level. The following presents summaries of each presentation:

Organizational Capacity Level

Gerry Rosenthal, Management Sciences for Health (MSH)

Rosenthal presented MSH's management assessment tool - Management and Organizational Sustainability Tool (MOST) - which was developed as part of an effort to measure an organization's "future capacity" or sustainability.

Drawing from the organizational development literature, MSH identified 13 critical management components that reflect four essential organizational functions:

- Mission (knowledge by staff and application to programs and priorities)
- Strategy (links to mission and links to clients, community and markets)
- Structure (distribution of roles and responsibilities and distribution and delegation of authority)
- Systems (organizational planning, collection and use of information, quality assurance, management of supplies, financial management, revenue generation and human resource development)

For the organization as a whole, MOST looks at three elements: efficiency (what comes in and goes out), effectiveness (what happens), and sustainability (future capacity). MOST is a facilitated exercise that develops common understanding of management, indicators to assess performance, and interventions to improve performance among members of an organization.

The MOST framework assesses organizations against four developmental stages using examples of the characteristics of an organization

at each stage of development. The development stages use an ordinal scale that is not entirely objective or reproducible. In addition, organizations define their own indicators (although common indicators exist for service organizations). These indicators are then monitored over time. MSH experience with MOST suggests that not every intervention yields a change in performance. However, there is mounting evidence that better management leads to sustainability or better future performance.

Alfredo Fort, International Training in Health Program (INTRAH)

Fort introduced a framework and tool developed by INTRAH that has been applied in the field over the last year. The purpose of the framework and tool is to measure progress in an organization's training capacity. The model examines three organizational components (financial, physical and human resources) and three developmental stages. INTRAH developed an index of training capacity that is composed of 20 indicators representing all the dimensions of capacity. Each of the indicators is measured with a descriptive scale ranging from, for example, "no guidelines" to "complete, up-to-date guidelines" scored on an ordinal scale.

The assessment produces a numeric score, which can be graphed to show how each program performs on each component of training capacity in a given place in time. The scores are valid relative to their region, but not valid across regions. INTRAH has analyzed capacity scores before and after interventions to determine effects over time. Currently each indicator has an equal weight in the index. To date INTRAH has not validated this weighting scheme.

Evan Bloom, Private Agencies Collaborating Together (PACT)

Over the last 30 years, PACT has been working to build the capacity of all types and sizes of organizations working in a wide variety of health and development areas. Bloom explained that PACT experience has shown that the most powerful results are obtained when a community of organizations works together on building capacity. PACT has developed a self-assessment tool that involves bringing together the members of organization over a one-week period to identify strengths and weaknesses and to develop indicators. A facilitator guides the organization through the assessment process,

which is a cross between a focus group and a polling session. The group discusses events in their organization and then each individual responds to a series of survey questions.

PACT's instrument measures two dimensions: perceived capacity and objective capacity. Perceived capacity measures the strengths and weaknesses of the organization as perceived by its members. The level of agreement and consensus among the members regarding the areas in need of improvement within the organization are also identified. Organizations use the data generated from the assessment to guide decisions about how to build their capacity.

PACT has learned that their tool is effective in creating champions within an organization and in promoting change. However, it is less effective at monitoring change over time, and is not well suited for depicting radical change. The tool's inability to show dramatic changes may limit its use for policymakers.

Discussion

Many of the existing tools to measure organizational capacity, including the three presented here, capture the more concrete or tangible elements of organizational capacity such as financial accounting systems. Further development is needed to measure the more subtle organizational characteristics, like leadership.

Health Professional Capacity Level

Jennifer Macias, JHPIEGO

Macias presented JHPIEGO's general approach to helping health professionals perform up to standards in service delivery, followed by their approach to monitoring and evaluating health professional capacity.

JHPIEGO works within a framework for strengthening reproductive health in national programs. At the center are national policy and service guidelines, which impact in-service training for practicing health professionals and pre-service education in health professional schools. These activities take place at service and clinical training sites, and the final outcome is assessed at the service delivery points. Evaluations, needs assessments, and international resources all feed into the national policy and service guidelines.

JHPIEGO developed an approach to monitoring and evaluating health professional capacity building, based in part on Kirkpatrick's (1959) four levels of training evaluation (1) participant reaction, (2) participant learning, (3) on-the-job performance, and (4) outcome of training. The monitoring approach consists of assessing the national training system, the professional's understanding of principles and facts, demonstration of the professional's skills, and the overall system for follow-up and supervision. In addition they assess the national program's automated monitoring system.

JHPIEGO's evaluations of health professional capacity at the *outputs* and *intermediate outcomes* levels assess on-the-job performance. Several evaluation tools are used to assess three areas: knowledge and attitudes of students and facilitators, sentinel skill areas, and training experiences. The tools used include questionnaires, open-ended clinical questions, simulations, role-plays and case studies.

Client Capacity Level

Kate Bond, FOCUS

Bond presented her experience working with the Bangladesh Rural Advancement Committee (BRAC) in Bangladesh on an adolescent health assessment in which she examined how the Adolescent Family Life Education (AFLE) program built the capacity of the adolescents (clients) to address their own health concerns and seek care when needed.

By first mapping out how the program works, the assessment team learned that the development of youth capacity can be a catalyst for normative change and that capacity should be thought of in terms of *relationships*, not just *inputs* and *outputs*. There are linkages between different client groups that reinforce the adolescent's capacity. The assessment team verified that students' knowledge increased based on indicators developed by BRAC and the research team. They conducted interviews, applied a checklist and conducted group exercises. In discussions with community members, FOCUS found that their understanding of adolescent health had also increased. Finally they reviewed the program's own checklists aimed at classes, students and parents, and changes in clinic utilization. Adolescents exposed to the BRAC program were more likely to know where health services were located and the types of services offered.

Summary

From the five presentations on measuring capacity at different levels of society, it seems clear that there are numerous well-developed tools available for measuring organizational capacity. These instruments all approach the organization by breaking it into component parts and measuring each component based on self-identified goals or stages of development. Capacity measurement at the health professional level centers primarily on assessing the knowledge and performance of health professionals. The example for measuring client capacity made use of PRA-type methods to assess change in client behavior and knowledge.

The tools presented are largely based on defined criteria of capacity rather than indicators. They also demonstrate the importance of collecting both quantitative and qualitative information. In further developing tools to measure capacity at all levels, these experiences should be elucidated and fed into the conceptual framework and guidelines.

Finally, networks appear to be important at all levels, as they appear to speed up change and diffusion of information. In the future it may be helpful to learn more about the key characteristics of these networks (e.g., structure, membership, nature/web of relationships) and their role in capacity building.

III. PARTICIPANT ANALYSIS OF THE LEVELS OF CAPACITY

On the second day of the workshop, participants broke into two groups to examine each level of capacity measurement more closely. Groups were asked to choose one capacity outcome related to a specific level (organizational, professional and client) and, working backwards, identify the inputs and processes that contribute to that particular element of capacity. The resulting framework could then provide a guide to determining the focus and scope of capacity building interventions, as well as the focus of monitoring and evaluation of capacity building activities. Graphics representing these discussions are found in Annex D.

Organizational Level

The group concentrating on the organizational level reclassified outcomes into three groups: effectiveness, efficiency and relevance, noting overlap between classifications. The group then chose the outcome "financial self-reliance" and identified inputs, processes and outcomes that are linked to this particular element of organizational capacity. Observations following the exercise included

- A particular capacity outcome can be influenced by or may depend on numerous inputs and processes. The group determined that one should identify the inputs and processes that are most strongly linked to capacity and monitor changes in these areas. The choice of variables should be updated over time based on empirical studies of capacity development.
- Although it was understood that inputs generally represent resources available for ensuring financial self-sufficiency of an organization, some contextual elements were placed in the inputs box due to their relative importance.

The group repeated the same exercise with a second outcome: *community involvement*. The resulting graphic (Annex D) lists the inputs, processes and outputs that lead to this intermediate outcome.

The Health Professional Level

The group suggested revising the term "health professional" to include all professionals in the health field. Health Program Personnel

or HPP was chosen. They added outcomes to the original framework and chose to concentrate on one technical skill: Correct Waste Disposal. The resulting graphic lists the inputs or "antecedent factors," processes and outputs that lead to this intermediate outcome.

The Client Level

For the client level, the group split the outcomes into two different types: health-seeking behavior inside the health system and health-seeking behavior outside the health system. Under the first type, the group tracked one outcome: greater utilization of services by those who previously did not have access to health services. The resulting graphic lists the inputs or "antecedent factors," processes and outputs that lead to this intermediate outcome.

Summary of Experience

The exercise revealed that there are many elements that influence capacity, and that many of these variables are interdependent. This interdependence exists within individual levels and between levels. Examination of the elements of capacity also encourages a move away from pure linear thinking despite the structure suggested by the evaluation framework (using inputs, processes, outputs and outcomes). It also suggests the need for mapping out capacity elements at the early stages of project design to assist in defining appropriate capacity building interventions. Once critical elements of capacity are identified, indicators can be developed that reflect changes in inputs and processes, as well as outputs and outcomes. This exercise will help in the development of field guidelines.

IV. Conclusions and Next Steps

The following points summarize the discussions during the two-day meeting:

Conceptualizing capacity

- The group reached a general consensus on conceptual framework to measure capacity. Modifications were suggested in the areas of system capacity and client capacity.

- Difficulties in conceptualizing capacity include representing the stages of capacity building, representing the inter-relationships between levels and within levels, and representing the relationship between contextual variables and the health system.

- To understand the measurement of capacity building, it is necessary to take a step backward and define essential functions and capacities required for effective health system performance at all levels. This process of conceptualizing capacity is a departure from devising a typical project-level conceptual framework; however, it is critical to designing capacity building interventions and plans for monitoring and evaluating their effectiveness.

Capacity measurement

- Measuring capacity for monitoring and evaluation purposes remains relatively uncharted territory. Tools to assess capacity exist particularly at the organizational and health professional level. However, there is considerable interest in finding better approaches to understanding the role of capacity building in health system strengthening, and appropriate methods and indicators to measure progress at all levels.

- Both quantitative and qualitative, objective and subjective assessment strategies are needed to obtain a full picture of capacity at different levels.

- MEASURE Evaluation should collect experiences in measuring capacity building efforts and feed this information back into the framework.

Next steps

- Revise "state-of-the-art" paper and conceptual framework based on the meeting participants' observations, comments and discussions. Identify areas for further review, particularly at the system and client levels.

- Engage UNICEF, United Nations Development Program (UNDP), International Development and Research Center (IDRC), and WHO in further discussion on measuring capacity building; follow their work in this area, and share new developments in PHN Center/MEASURE initiative.

- Develop Guidelines for Capacity Measurement for review by informal USAID group, field staff and USAID partners

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Annex B: Conceptual Framwork

Figure 1. MEASURing Capacity Building: Overview
Conceptual Framework

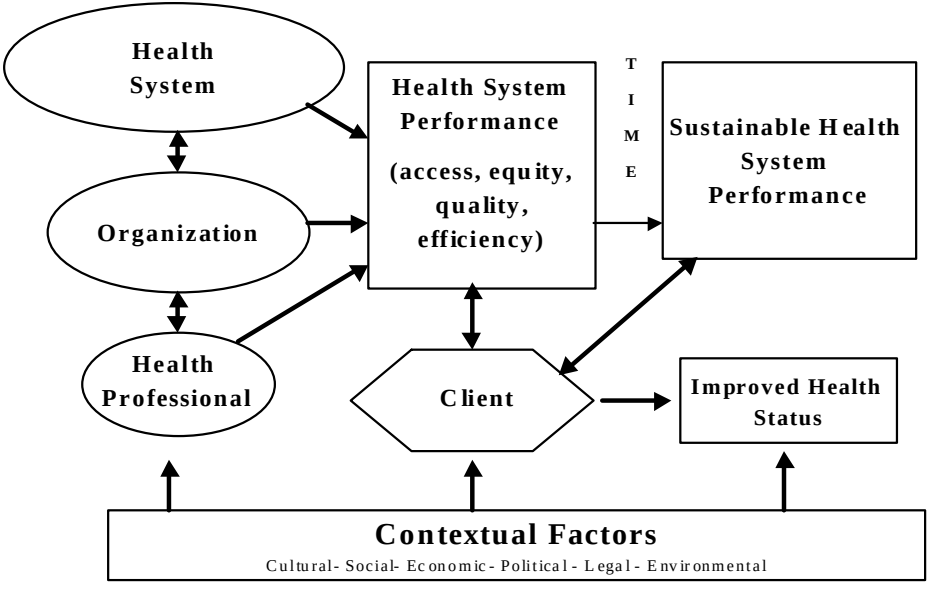


Figure 2: Health System

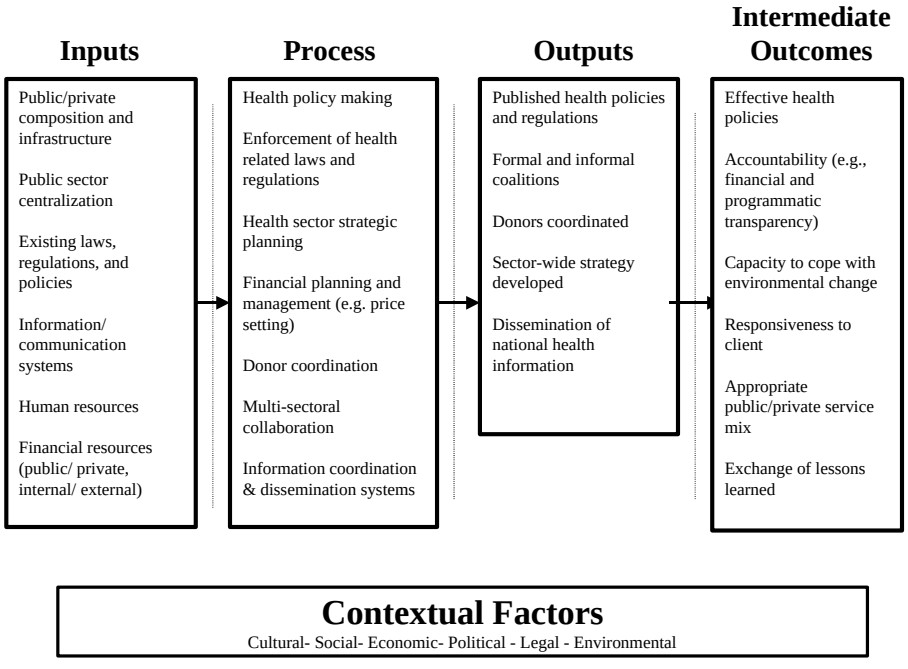


Figure 3: Health Service and Civil Society Organizations

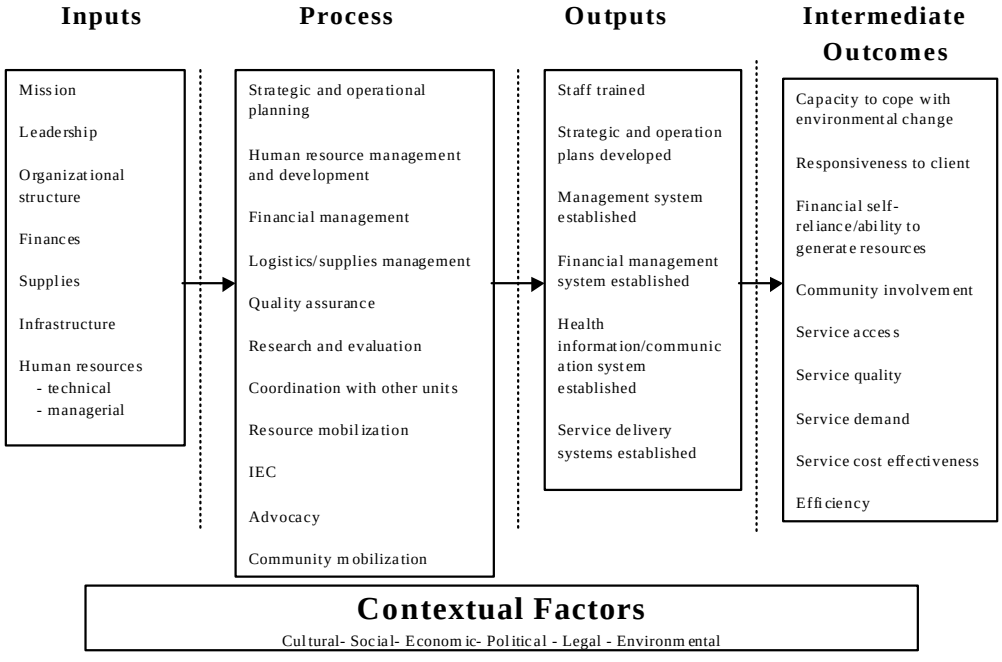


Figure 4: Health Professional

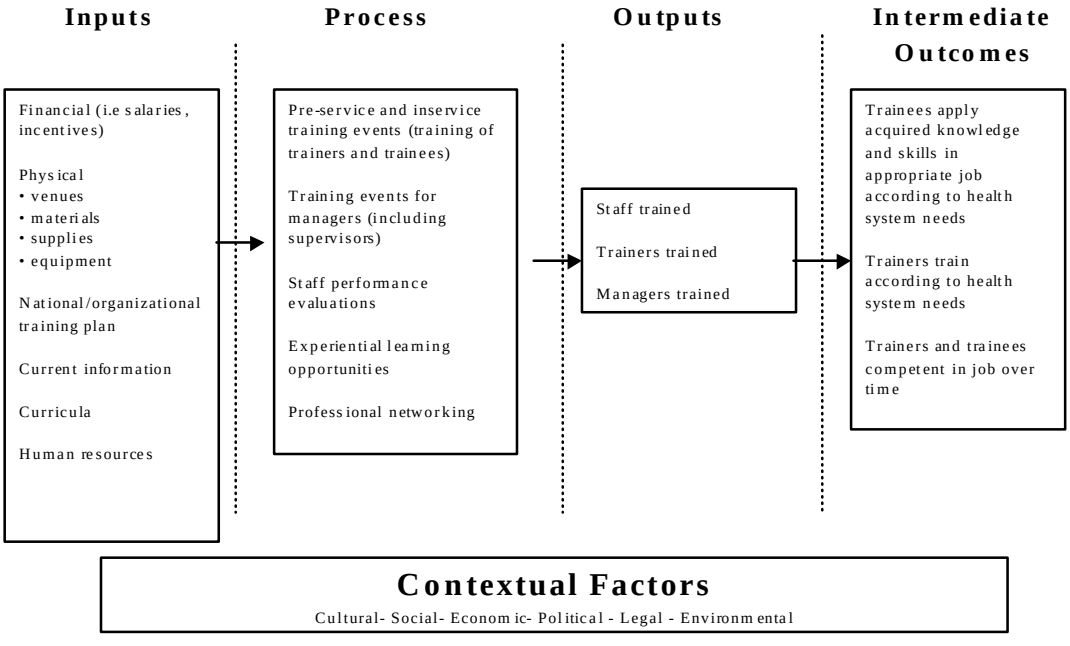
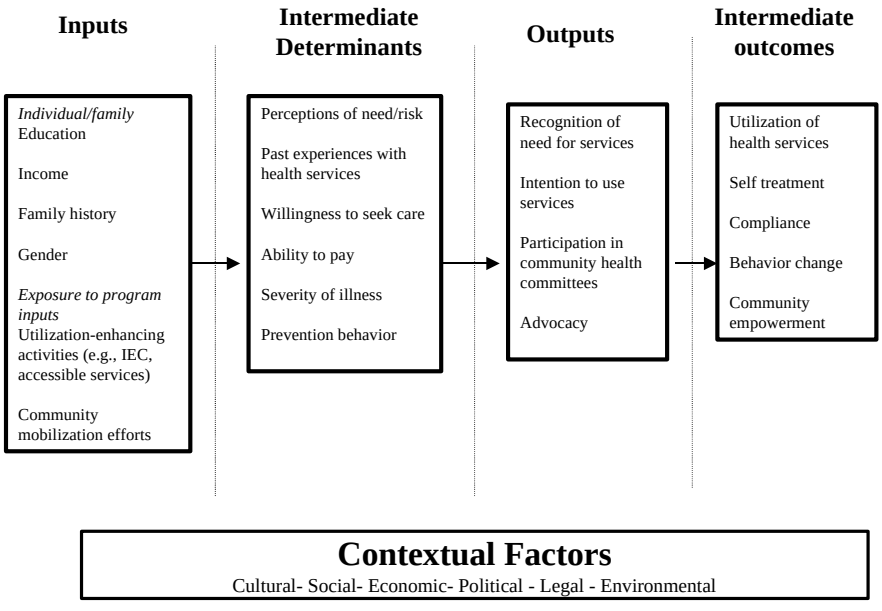


Figure 5: Client



Annex C: Specific changes to the framework suggested by participants

- At the client level, participants suggested that the framework explicitly note the relationship between the client and health professional.
- Replace the terms *Systems*, *Organizational*, *Professional* and *Client* with *National*, *Organizational* and *Individual*.
- Add client involvement in the inputs box at the health system level.
- Add *behavior change* as an intermediate outcome at the health professional level.
- The titles of the boxes - *Input*, *Outputs*, *Process* and *Outcomes* - are most familiar to people from the project design framework and may be confusing in this context. Instead the titles should be changed to *Resources*, *Functions/Processes*, *Status/Outputs* and *Intermediate Outcomes*.

Annex D: Breakdown of Capacity Elements at Various Levels

Organizational Capacity
Outcome: Financial Self-Sufficiency

Inputs	Process	Outputs	Intermediate Outcomes
• Leadership • Finances • Infrastructure • Human resources • *Financial policy context* • *Organizational culture context*	• Strategic & operational planning • Financial management • Research & monitoring & evaluation • Coordination w/other internal units • Resource mobilization • *Creation/ maintenance of linkages (external)* • Advocacy • Quality assurance	• Staff trained • Financial management system established • External linkages established (to donors, partners, clients, community) • Strategic & operational plans developed	***Effectiveness*** • Service quality • Service access • Service demand • Responsiveness to clients • Community involvement ***Efficiency*** • Responsiveness to client • **Financial self-reliance (ability to generate resources & healthy funding basis)**

Inputs	Process	Outputs	Intermediate Outcomes
	• Community mobilization • Human resource management & development		• Service cost-effectiveness • Efficiency ***Relevance*** • Service quality/demand • Capacity to cope/anticipate changes in the environment • Community involvement • Responses to client

Organizational Capacity
Outcome: Community Involvement

Inputs	Process	Outputs	Intermediate Outcomes
• Mission • Leadership • Organizational structure • Human resources (technical, managerial, *allocation/designation*) • *Organizational culture* • *Culture of participation & organization at community level*	• Strategic & operational planning • IEC • Advocacy • Community mobilization • *Creation/maintenance of external linkages*	• Staff trained • Management systems established • *External linkages established*	**Community involvement**

Professional Capacity

Inputs or "Antecedent Factors"	Process	Outputs	Intermediate Outcomes
• Written/established guidelines • Equipment • Organizational/mgt. commitment • Awareness of importance by all personnel • System support beyond act of HPP • Materials: poster/job aides ~~~~~~~~ • Education • Income • Residence • Beliefs of social network • Connection to a social network • Ethnicity	• Pre-service education • In-service training (on specific skill, orientation for all staff) • Supervision • Periodic mgt. meeting (solicit input from staff on this issue) • Self/peer evaluation	• HPP aware and trained to correctly dispose of waste	• **HPP apply knowledge and skills in appropriate job according to health system standards and client needs (interpersonal skills, financial/program mgt., counseling/ technical skills)** • Job satisfaction • Commitment to & understanding of organizational goals • Self-efficacy in job performance • HPP feel involved & empowered in health program improvement • HPP able to advocate & influence organizational functioning

Inputs or "Antecedent Factors"	Process	Outputs	Intermediate Outcomes
• Language • Religion/religiosity • Alcohol use/drug use • Smoking • Partner dynamics (sexual/physical abuse) • Self-efficacy, Psy-chosocial factors • Depression/loneliness • Sexual orientation • Genetic • Gender • Age • Marital status			

Client Capacity

Inputs or "Antecedent Factors'	Process	Outputs	Intermediate Outcomes
• Education • Income • Residence (rural/urban) • Gender • Knowledge of where services are • Perceptions of health system (cost, how you'll be treated) • Perceived need for service • Belief service works • Atmosphere of facility (hours open) • Availability of transport • Ethnicity • Language	• Study antecedent factors (participatory learning) • Educate client/communities about RH rights, risks, responsibilities, behaviors (clients share expenses, distribute health system information, outreach to community) • Educate clients to be better health service consumers	• "Super Villager" A client who is knowledgeable, resourceful, and strategic in their health seeking behavior.	***Health-seeking behavior within the health system*** • Increased demand for quality health services • Increase in appropriate utilization of services • **Greater utilization by those who previously didn't have access** • Increased involvement and understanding of health system functioning (advocacy, involvement in management, feedback) • Feel empowered communicating their health status and interacting with HPP

Inputs or "Antecedent Factors'	Process	Outputs	Intermediate Outcomes
	• Community organizing to increase transportation opportunities, advocate that services meet their needs, change negative norms & beliefs about services		***Health-seeking behavior outside the health system*** • Increase in preventive behaviors (compliance, hygiene, nutrition, contraceptive use, not having sex, bednets, no FGM, condom use) • Decrease in risk behaviors • Improved partner communication • Improved family communication • Increased use of appropriate treatments outside the health system