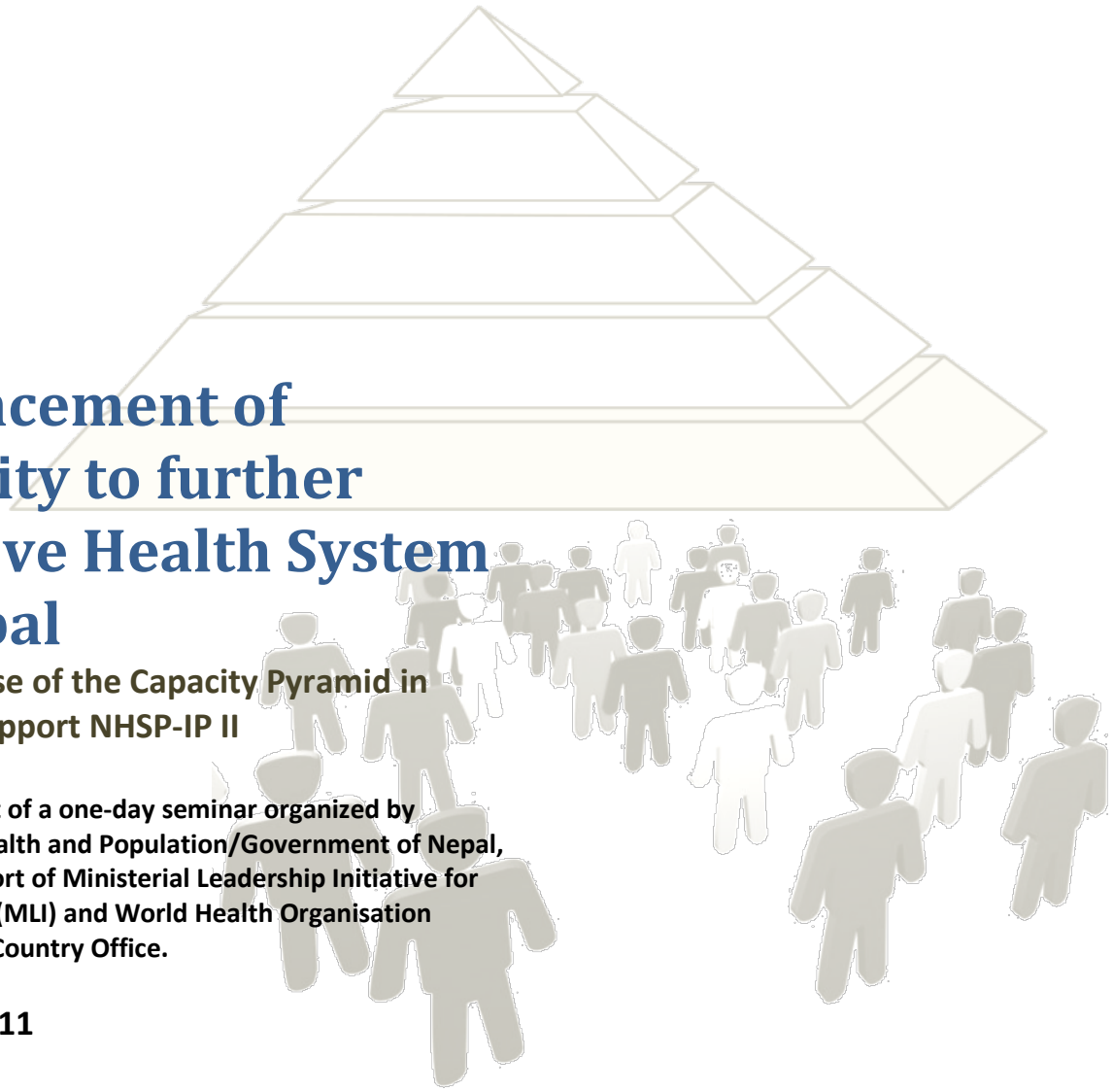


Enhancement of Capacity to further improve Health System in Nepal

Potential use of the Capacity Pyramid in Nepal to support NHSP-IP II

This is a report of a one-day seminar organized by Ministry of Health and Population/Government of Nepal, with the support of Ministerial Leadership Initiative for Global Health (MLI) and World Health Organisation (WHO) Nepal Country Office.

January, 2011

MLI
Ministerial Leadership Initiative
ASPEN GLOBAL HEALTH AND DEVELOPMENT

World Health Organization
Country Office for Nepal

Context

The Government of Nepal (GoN) has finalized the second five-year health sector strategic plan, Nepal Health Sector Programme 2010-2015 (NHSP II), and has begun its implementation. The overall goal of NHSP II is "*to improve the health and nutritional status of the Nepali population, especially for the poor and excluded*."[1]

Ministry of Health and Population (MoHP), as a lead institution in-charge of implementing NHSP II, is in the process of developing a Capacity Enhancement Strategy to better realize the vision and meet the specific objectives of NHSP II. MoHP requested Ministerial Leadership Initiative for Global Health (MLI) to support in developing the capacity enhancement strategy. As part of this support, MLI is exploring suitable models for capacity enhancement. To look into the potential use of one such capacity development model, the Capacity Pyramid, a one day seminar was organized by MoHP with the support of MLI and World Health Organisation (WHO) Nepal Country Office.

Expected outputs and format of the seminar

The seminar had the following expected outputs:

- Provide a broader understanding of the Capacity Pyramid, understanding that Capacity Development is more than just training;
- Work on a selected topic applying the Capacity Pyramid to see its application in practice;
- Gather ideas and share experiences that could assist with the development of a comprehensive Capacity Enhancement Strategy

The seminar was divided in two sessions:

- Morning session to share the concept of the Capacity Pyramid and illustrate its practical use from around the world;
- Afternoon session for a group exercise to gauge the potential use of the Capacity Pyramid as a tool to develop comprehensive Capacity Enhancement Strategy for NHSP II

Two international resource persons, Dr. Christopher Potter and Dr. Richard Brough, facilitated the seminar to share the concept of the Capacity Pyramid and discuss its potential use for the capacity enhancement for NHSP II. *Bios of the resource persons are includes as annex I*

More than 50 officials from GoN and External Development Partners (EDPs) attended the seminar. *The list of participants is includes as annex II*

[1] *Nepal Health Sector Programme – Implementation Plan (NHSP-IP 2) 2010-2015*

Proceeding

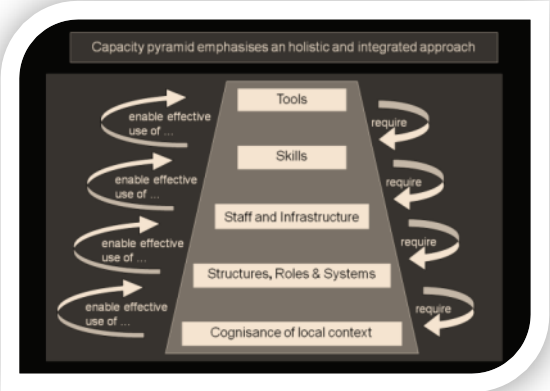
Dr. Baburam Marasini, chief of Health Sector Reform Unit/MoHP, welcomed the participants on behalf of the organizers. Health Secretary of GoN, Dr. Praveen Mishra, and WHO Country Representative, Dr. Lin Aung, made the inaugural remarks.

Both the speakers were unequivocal about the need for capacity enhancement to meet the objectives of NHSP II. Dr. Aung said the capacity enhancement process should go beyond individual capacity building to include organizational development, elaboration of management structures, and institutional and legal framework development. He affirmed WHO's commitment to support MoHP in enhancing the capacity of Nepal's health sector.

Health Secretary Dr. Mishra stressed the importance of capacity enhancement to tackle the existing challenges in Nepal's health system. He highlighted the need for capacity enhancement in delivering quality health care services, achieving universal coverage and health equity, human resource development, improved logistics management, building better health information systems, and health care financing. He shared his concern that because of weaknesses in the health system, the vast network of the health sector, which expands up to the grassroots, could not be properly utilized. Proper institutional capacity development, he said, would be vital to improve the health system. He further said that lack of adequate capacity has resulted in poor utilization of available resources in the health sector. He wrapped up his remarks expressing hope that the seminar would provide necessary insight and impetus to move forward with the comprehensive capacity enhancement for NHSP II.

Presentation

Dr. Christopher Potter introduced the concept of the Capacity Pyramid and Dr. Richard Brough presented the use of the Capacity Pyramid, illustrating it with real life examples from around the world. *The complete presentation is attached as annex III.*



Dr. Potter at the outset said that there is already ample capacity in the health sector which can be further enhanced to achieve the objectives set forth in NHSP II. In fact, he defined 'capacity' as *"the power or potential to achieve an objective and adapt to changing conditions."* He highlighted a few emerging challenges to the Nepalese health sector which warrant systematic capacity enhancement. Talking about capacity development, he reiterated it to be more than 'training' or personal capacity building. He urged the participants to think holistically and consider an integrated approach to capacity development to encompass the entire organization or a thematic area. Explaining different tiers of the Capacity Pyramid, he drew the attention of the participants towards the bottom of the pyramid which represent soft aspects of capacity development, i.e. local context, prevalent institutional culture, power dynamics, etc. He said these soft aspects often become more crucial to address than the tangible aspects of capacity development (tools, technology, resources, etc.) that sit at the higher tiers of the pyramid.

Dr. Richard Brough presented the use of the Capacity Pyramid. He underlined four explicit uses of the pyramid: ***diagnosing the problem; designing the strategy; sequencing of implementation; monitoring progress; sustaining capacity; and evaluation***. He said, the pyramid enables managers and decision makers to accord the necessary attention to all areas of capacity development (so no critical area is overlooked), and also to identify potentially problematic areas early on. This allows the managers to anticipate forthcoming issues and devise ways to deal with them right at the inception stages of capacity development. He further said that, as implementation progresses, the key is to make the pyramid 'stable' ensuring that capacity developments at the lower (system / local context) levels are not neglected in favour of the easier activities at the upper levels; but also to strike a judicious balance between the need for systems development and the need to maintain project momentum partly through achieving some 'early results' at the upper levels. Dr. Brough explained that the Capacity Pyramid can be applied at various levels for systematic capacity enhancement. Quoting examples from Uganda and India, he said it can be applied at the national level such as to structure the entire sectoral plan; at technical or programmatic level e.g. to strengthen immunization services; at a particular management level like district health management; or to manage integrated approaches to service development in an area like HIV prevention and cure. Dr. Brough concluded his presentation by summarizing different advantages of the Capacity Pyramid model.

Group Exercise

In order to gauge the potential use of the Capacity Pyramid model to develop a comprehensive Capacity Enhancement Strategy for NHSP II, the participants selected three topics that are among the emerging challenges within the sector (*Information management and data quality; Immunization and vaccination; and District health management and urban health*) for a group exercise.

Responses and feedback received from the group exercise and participants in general, vis-à-vis potential use of the Capacity Pyramid in Nepalese health sector, were as follows:

- A problem affecting capacity may be identified at one level of the pyramid, while the solution to that problem may lie at another level. For example, an attitude problem may be diagnosed at the bottom (local context) level of the pyramid, while the issue may be addressed partly through a training intervention at the (skills) level higher up the pyramid.
- Initial confusion may arise on where to start in the pyramid;
- The Capacity Pyramid provides a logical framework to look at issues that have been discussed many times before; it offers new viewpoint and perspective;
- The pyramid provides a holistic platform, but in practice some modules (tiers) can also be applied in their own entirety for specific capacity development needs;
- The bottom tiers of the pyramid are more challenging to implement, yet they may also be the most important aspects to tackle;
- The tool is compatible with other existing approaches e.g. results based monitoring.

Conclusion

Dr. Marasini expressed MoHP's willingness, and expected cooperation from the development partners, to develop adequate systemic capacity to implement NHSP II. To conclude the event, Dr. Marasini thanked all the participants, resource persons, MLI and WHO.

Impression

Overall impression gathered from the seminar is as follows:

- Good turn-out of the invitees – participation from both the GoN and EDP was good;
- The health secretary was very enthusiastic about capacity enhancement, which he saw as a vital investment necessary to bolster different aspects of the existing health system;
- Undivided attention of the participants during morning presentation session – relevant anecdotes and real-life examples to illustrate the concept of capacity development throughout the presentation captivated the audience;
- A lot of queries, especially with regards to implementing the pyramid in the local context, came from the participants during presentation which signified their interest to work with the tool;
- During group exercise and discussions, the participants candidly shared sensitive issues associated with capacity enhancement such as power dynamics, undue political interference, roles and attitudes of service providers and clients, etc;
- There was a general sense of concern among the participants on practically applying the pyramid in a politically volatile context where certain decisions are taken (*or need to be taken*) without adequate preparations or consensus;
- There was a general understanding on the essence and usefulness of the Capacity Pyramid among the participants.
- The following general ideas on the pyramid came through during the day:
    - The pyramid can be applied at different levels – sector wide, institution wide, or within a particular project or thematic area;
    - It provides a foresight to the managers and decision makers on potential issues that may surface during capacity development process. Similarly, it enables them to identify areas requiring more attention during the planning stages of capacity development;
    - Soft-aspects of capacity development that sit in the lower tiers of the pyramid (power, attitude, institutional culture, etc.) are of paramount importance; however they are usually more difficult to tackle than tangible aspects like tools and skills that sit at the top of the pyramid;
    - There is no concrete blueprint on how to implement the pyramid (or where in the pyramid to start); local context and issues at hand dictate the actual use;
    - The pyramid is a flexible tool and should be applied that way; in fact strict mechanistic implementation of the tool may not produce desired results;
    - Sub-optimal capacity enhancement is where adequate attention is not accorded to different tiers of the pyramid.
    - The experience of other countries successfully using the tool makes it very promising for Nepal

- If the general perception of the participants towards the Capacity Pyramid is taken into account, and similarly if the output of the group exercise is seen as a yardstick, then it can be inferred that the Capacity Pyramid may prove useful in identifying capacity gaps and in subsequently developing a comprehensive Capacity Enhancement Strategy for NHSP II.

Insights and observations of the resource persons

Ever since the resource persons Dr. Potter and Dr. Brough have published their paper ***Systemic capacity building: a hierarchy of needs***[2] in 2004, academic literature about capacity development has grown and different insights and thoughts on the subject matter have emerged. A particular insight that has emerged since, which needs mentioning here, is regarding pace of change in the political, social, technological and economic environments within which organizations and systems operate. It points out that it is not enough for organizations to have capacity to deliver services and perform effectively in the short term or within a relatively stable policy environment, but to have the capacity to adapt to changing circumstances. Organizations are open systems, and this is as true of health systems and organizations as any other. Capacity to detect changes and respond to them is an essential requisite for survival, as well as for growth. Nepal is not isolated from this requirement; in fact, the number of new demands there are on the health system within the country and the changing socio-political context within which the health sector must operate are very much reflective of this.

One heartening feature of Nepal's improving capacity is the progress towards MDGs in recent years, and the awards it has been given in this regard. Clearly capacity exists, but building on it by taking into account aforementioned new demands on the health system and changing socio-political context of the country, and working systematically and not in an ad hoc, stop-go manner is vital.

Several health programmes were identified by respondents the resource persons interviewed, or during the seminar, as especially needing capacity enhancement: Non Communicable Diseases (NCD) programmes; immunization & vaccination programme; oral health services; laboratory services; and mental health services. These are relatively discrete activities and would lend themselves to analysis using the Capacity Pyramid model and tools, perhaps as p showing how the approach could be used more widely.

Several respondents mentioned systemic problems faced by the Nepalese health sector. Among those mentioned were lack of a coherent, robust evidence based planning system and human resource management including shortage of skilled health workers, lack of higher level skills, distribution and retention, skill mix, and lack of skills in dealing with emerging health challenges. In dealing with such overarching issues, Capacity Pyramid tool would help to develop consensus on what are the underlying causes, priorities and remedial actions. Use of the tool in a frank exchange of views between key partners and officials would show what the system constraints might be, and more importantly, the sorts of actions that might be taken to improve the situation in collaboration with relevant actors. Furthermore, more effective use of the 3,000+ NGOs operating in the health sector and better regulation of the private sector were also reported as being significant challenges

[2] POTTER, C. & BROUGH, R. 2004. Systemic capacity building: a hierarchy of needs. *Health Policy and Planning,* 19**,** 336-345.

faced by the MoHP. Again, further analysis using the Capacity Pyramid would help identify the range of issues that would need addressing to support such changes.

Capacity needs identification is best carried out by those involved in trying to work on organizational issues in an interactive manner building ownership, not by commissioned external 'experts' to impose their diagnosis on the system. Within the spirit of Sector Wide Approach (SWAp), EDPs can provide coherent and systematic support as partners committed to develop Nepal's health sector. There also needs to be a commitment that where system constraints (as opposed to resource constraints) are identified, MoHP will seek to remove them and encourage better processes and ways of working for capacity enhancement.

Nevertheless, in order to facilitate participative analysis rather than to prescribe specific solutions, MoHP may consider availing external expertise and may also consider identifying unit or institution within Nepal to act as the lead agency for capacity enhancement and to provide support on Capacity Pyramid tool. Further on, there is also a possibility for MoHP to link with institutions in other countries who have been successfully implementing Capacity Pyramid tool; e.g. Infectious Diseases Institute, Makerere University of Uganda. In this way technical assistance could also be sought on a 'south to south' basis.

Suggested Next Steps

Based on the outputs of the seminar and pre and post seminar discussions, the international resource persons suggest a few next steps which MoHP and its development partners may consider to further the use of Capacity Pyramid as a viable tool for capacity enhancement of NHSP II.

1. The capacity pyramid tool may be used within a smaller group (e.g. a thematic group involved in health sector information management or a district health office) as a trial. The users can then give feedback at three months and six months interval to MoHP on:
    a. the use of the tool
    b. results obtained
    c. capacity enhancement challenges and opportunities identified
    d. new practices or policies needed to address the capacity
2. Identify and setup a lead unit or agency to impart support on Capacity Pyramid tool
3. The lead agency can be trained on the use of Capacity Pyramid approach by an external institution in the UK. Similarly, institutional partnership can be developed with Makerere University of Uganda.
4. The lead agency can provide the following capacity enhancement support to MoHP and its development partners:
    a. Diagnose the capacity problem in partnership with all stakeholders in, including systematic identification of capacity gaps at various levels;
    b. Design the comprehensive strategy to enhance capacity for NHSP II and beyond;
    c. Sequence implementation of measures to enhance capacity (including clear phasing of change at the various tiers over time so that the pyramid is stable and momentum for change is maintained);
    d. Monitor implementation (including when to reschedule change at the higher levels if change at the lower levels should be, and is not taking place);
    e. Plan how to sustain and update capacity systematically at the various levels

Annex I: Bios of the Resource Persons

Dr. Richard Brough

Richard Brough has been Head of Strategic Planning and Development at the Infectious Diseases Institute (IDI), Makerere University, Uganda since 2005. He has over 25 years experience of planning and management of health services in Europe and in lower income countries. Dr Brough's professional background is operations research (PhD from University of Warwick, UK); specialising in computer simulations of health services for planning and training. Dr Brough spent seven years with a management consultancy in central London designing, marketing and managing implementation of a range of computer simulations for the planning of hospitals, community services, and the medical workforce. Since 1992, Dr Brough has worked full-time in health planning and programme management in lower income countries (Fiji and the South Pacific, the Philippines, India, and Uganda) for a range of development agencies (UK Department for International Development, European Commission (EC), and the Asian Development Bank (ADB)); and in both Government and NGO sectors. His particular interests are systemic capacity building, mathematical modelling, planning methods, institutional autonomy, information for planning, monitoring and evaluation, and programme management. Sample achievements include : facilitating autonomy at the regional Fiji School of Medicine; securing a EC 40m euro grant for Gujarat State; turning round an ADB health project which was in serious difficulties; providing technical leadership for the largest EC international health development programme globally at the time; and supporting a substantial increase in grants acquired by IDI from a wide range of funders.

Dr. Christopher Potter

Christopher Potter is a public health professional who has worked in over 20 countries in a variety of management, academic and consultancy roles, including Team Leader of a number of major programmes including introducing the hospital licensing and accreditation system in the Philippines, leading the European Commission's technical advisory team in India for more than four years, and hospital and regional health system reconstruction in post-tsumani Banda Aceh. He has held a number of academic roles in various universities including Visiting Professor at the University of Minnesota and and currently directs the global health module within Cardiff University's Masters in Public Health Programme, which he co-directed. Within the British UK he has been a hospital manager, the head of HR for the NHS in Wales and is currently Director of Public Health for Powys Health Board, which covers the central, rural quarter of Wales. With a PhD in Organisational Development his interests include health policy, hospital autonomy, capacity building, and effective international development. He has worked with most of the major aid organisations and has published on a variety of topics as well as being involved in research activities.

Annex II: Participants List

No.	Name	Organisation
1	Dr. Praveen Mishra	Health Secretary – Ministry of Health and Population (MoHP)
2	Mr. Surya Acharya	Joint Secretary – MoHP
3	Mr. Padam R. Bhatta	Joint Secretary – MoHP
4	Dr. Padam B. Chand	Joint Secretary – MoHP
5	Dr. Senedra R. Upreti	Joint Secretary – MoHP
6	Dr. Damodar Pokharel	Vice Chancellor – National Academy of Medical Sciences (NAMS)
7	Dr. Bal Krishna Subedi	Deputy Director General – Department of Health Services (DoHS)
8	Mr. Bhupendra B. Thapa	Chief – Drugs Quality Control/MoHP
9	Dr. BR Marasini	Chief – Health Sector Reform/MoHP
10	Mr. Shiva Prasad Adhikari	Chief – Finance Section/MoHP
11	Mr. Kabiraj Khanal	Under Secretary – MoHP
12	Dr. Ram Biccha	Director – Child Health/DoHS
13	Dr. Bhim s. Tinkari	Director – PHC Revitalization/DoHS
14	Dr. Lakshmi Narayan Deo	Director – National Health Education, Information and Communication Centre (NHEICC)/DoHS
15	Dr. Geeta Shakya	Director – National Public Health Laboratory/DoHS
16	Dr. RP Shah	Director – Department of Ayurveda
17	Mr. Radha Raman Prasad Teli	Director – Department of Drugs Administration
18	Dr. Ramesh Kharel	Deputy Director – NHEICC/DoHS
19	Mr. Ghana Shyam Pokharel	Sr. Public Health Administrator – DoHS
20	Ms. Chandra Kala Chaulagai	Section Officer – MoHP
21	Ms. Srijana Gyawanli	Section Officer – MoHP
22	Dr. Bibek Lal	Medical Officer – National Tuberculosis Centre (NTC)
23	Dr. R.C. Adhikari	Ayurvedic Doctor – Department of Ayurveda
24	Ms. Gabriel Mallapaty	Country Lead – Ministerial Leadership Initiative (MLI)

No.	Name	Organisation
25	Mr. Sanjay Thapa	Consultant – MLI
26	Mr. Sudip Pokhrel	Consultant – MLI
27	Dr. Lin Aung	Country Representative – WHO
28	Dr. Gunawan Setiadi	Public Health Administrator – WHO
29	Dr. Suraj M. Shrestha	National Project Officer – WHO
30	Dr. Min Thwe	Medical Officer – WHO
31	Dr. Damodar Adhikari	National Project Officer – WHO
32	Dr. Kishori Mahat	National Project Officer – WHO
33	Dr. Atul Dahal	National Project Officer – WHO
34	Dr. William Schluter	Medical Officer (EPI) – WHO
35	Dr. Nihal Singh	Medical Officer – WHO
36	Ms. Hyo-Jeong Kim	Technical Officer – WHO
37	Mr. Umesh Gupta	Administrative Officer – WHO
38	Mr. Shrawan K. Ranjitkar	Support Staff – WHO
39	Mr. Rudra Thakuri	Support Staff – WHO
40	Mr. Yugesh Rajbhandari	Sr. Assistant – WHO
41	Mr. Matt Gordon	Basic Services Adviser – DFID
42	Dr. Amit Bhandari	Health Adviser – DFID
43	Dr. Pankaj Mehta	Chief (Health & Nutrition) – UNICEF
44	Mr. Deepak Paudel	Programme Specialist – USAID
45	Dr. Paul Ametepi	ICF Macro
46	Mr. Dambar Singh Gurung	Project Manager – Rural Health Development Programme/Swiss Development Cooperation (SDC)
47	Dr. Nancy Gerein	International Lead – National Health Sector Support Programme (NHSSP)
48	Dr. Maureen Dariang	EHCD Adviser – NHSSP
49	Dr. Suresh Tiwari	Health Finance Adviser – NHSSP
50	Mr. Ajit Pradhan	M&E Adviser – NHSSP
51	Mr. Greg Whiteside	QA – NHSSP
52	Dr. Mark Zimmerman	Executive Director – Nick Simons Institute (NSI)
53	Mr. Stephen J. Knoble	Training Consultant – NSI

Annex III: Presentation on Enhancement of Capacity

Enhancement of Capacity to further improve the Health System in Nepal

Introduction

- Focus of day is potential use of Capacity Pyramid in Nepal to support NHSP-IP 2
- 9.30 – 11 : Concept, background, use to date, illustrative examples
- 11.15 – 12.30 : Potential application in Nepal
- 12.30 – 1pm : Discussion of possible way forward
- 1 – 2pm : lunch
- 2 – 4.30 : Practical session in use of pyramid to issues in Nepal
- 4.30 – 5 : Final discussion and close

Introduction

- We are here to :
  - share a practical concept which we find useful for systematic, strategic capacity enhancement
  - to discuss how it may be used to build on existing work in Nepal
- We are not here :
  - to provide the 'answer' to capacity enhancement
  - to repeat previous work, or to suggest revisions to existing health plans and policies

Meaning of 'Capacity'

The power or potential to :

1. achieve an objective
2. adapt to changing conditions

Annex III

Genesis of Pyramid

- Developed during major EU health project in India (2000 to 2006); €240m; focus on health sector reform (largely systems strengthening)
- Published 2004 in *Health Policy and Planning*; London School of Hygiene and Tropical Medicine
- An evolving tool … to structure capacity enhancement, especially in the face of new challenges and shifting priorities

Possible emerging challenges to the health system in Nepal

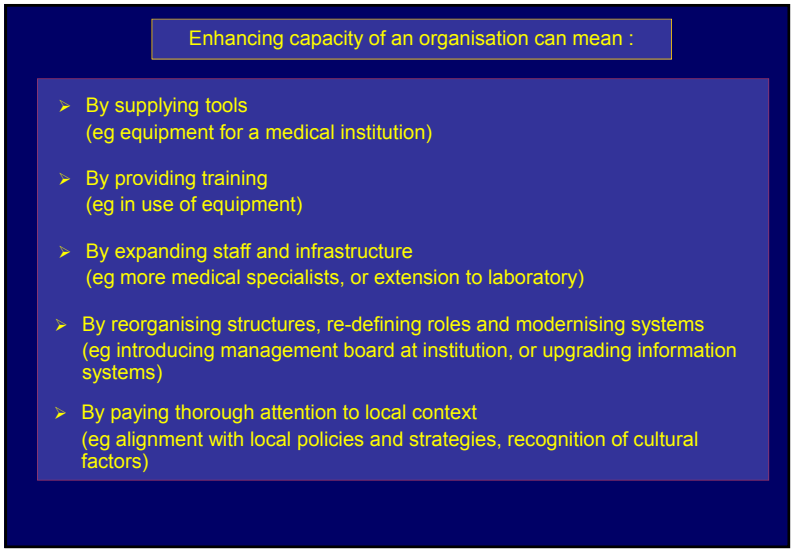
- needs related to Non-Communicable Diseases
- further strengthening of SWAp process (post Paris / Accra)
- decentralisation in federal context
- recruitment and retention of staff
- internal migration and urbanisation
- meeting the challenges of the health equity and rights-based approaches and 'hearing the voice of the people'
- information management and data quality for policy and planning
- health financing and PPPs to improve service coverage and social health protection
- emerging diseases and new technologies

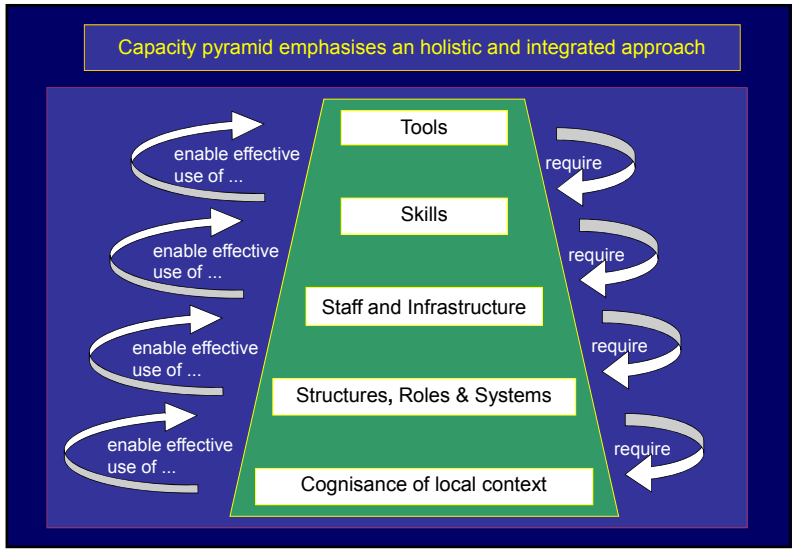
Capacity Pyramid

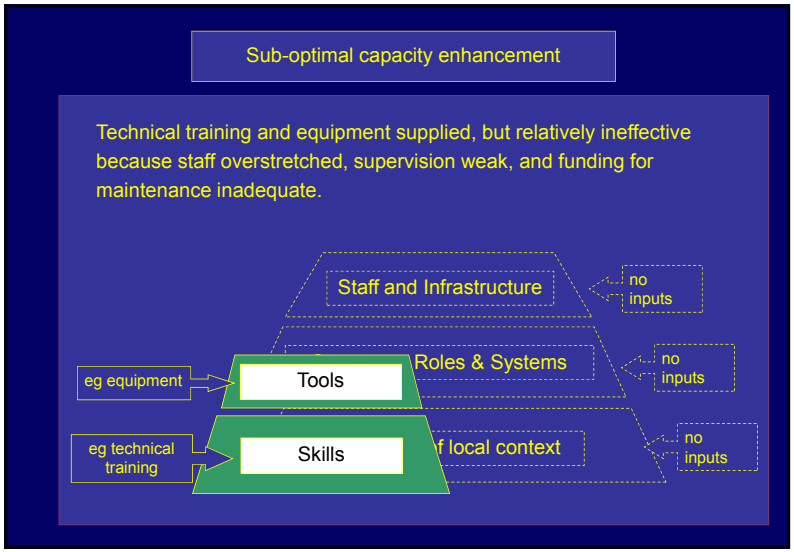
Capacity Building / Development

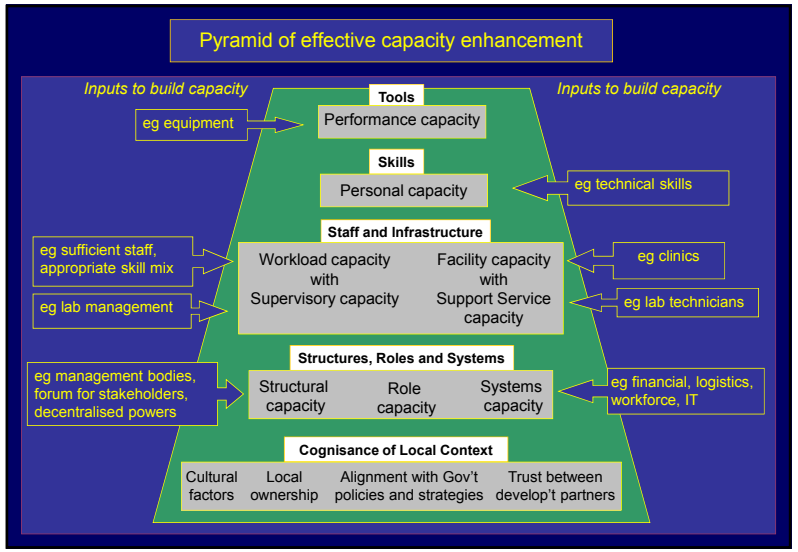
- Sometimes used rather vaguely and loosely
- Often synonymous with 'training' : personal capacity building
- But training can be relatively ineffective if underlying system issues unresolved (for example : frequent staff transfers)

Annex III

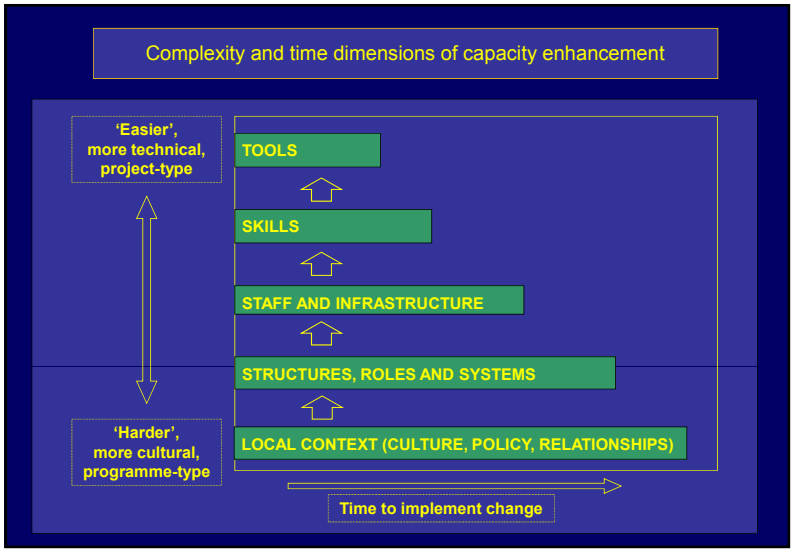

Enhancing capacity of an organisation can mean :
By supplying tools
(eg equipment for a medical institution)
By providing training
(eg in use of equipment)
By expanding staff and infrastructure
(eg more medical specialists, or extension to laboratory)
By reorganising structures, re-defining roles and modernising systems
(eg introducing management board at institution, or upgrading information systems)
By paying thorough attention to local context
(eg alignment with local policies and strategies, recognition of cultural factors)


Capacity pyramid emphasises an holistic and integrated approach
Tools
Skills
Staff and Infrastructure
Structures, Roles & Systems
Cognisance of local context
enable effective use of ...
require


Sub-optimal capacity enhancement
Technical training and equipment supplied, but relatively ineffective because staff overstretched, supervision weak, and funding for maintenance inadequate.
Staff and Infrastructure
Roles & Systems
f local context
Tools
Skills
eg equipment
eg technical training
no inputs


Pyramid of effective capacity enhancement
Inputs to build capacity
Tools
Performance capacity
eg equipment
Skills
Personal capacity
eg technical skills
Staff and Infrastructure
Workload capacity with Supervisory capacity
Facility capacity with Support Service capacity
eg sufficient staff, appropriate skill mix
eg lab management
eg clinics
eg lab technicians
Structures, Roles and Systems
Structural capacity
Role capacity
Systems capacity
eg management bodies, forum for stakeholders, decentralised powers
eg financial, logistics, workforce, IT
Cognisance of Local Context
Cultural factors
Local ownership
Alignment with Gov't policies and strategies
Trust between develop't partners

Annex III



Harder to measure and harder to address issues of power

'But many capacity development activities, such as organisational restructuring, downsizing, skills development, privatisation and transparency, are intertwined with issues of power, politics and vested interests … Elegant technical solutions can make things worse rather than better'

Study Report : Capacity, Change and Performance; April 2008
H Baser and P Morgan
European Centre for Development Policy Management

Uses of the Capacity Pyramid

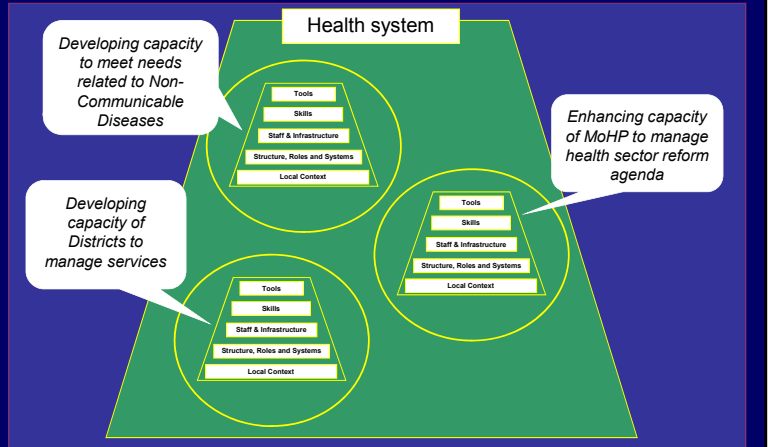
- Diagnosing the problem
- Designing the strategy
- Sequencing of implementation
- Monitoring, sustaining and evaluating

Levels of applicability of pyramid

- **National**
- **Technical area or Programme** … examples :
  - Lab services
  - Immunisation
  - Disease surveillance
- **Service management unit**
  - Local Government Unit such as District
  - Health facility
- **Integrated service development**
  - Introduction of HIV prevention and care

Annex III

Pyramid of the whole system or parts of it



Uses of the Capacity Pyramid

- **Diagnosing the problem**
  - Structured and rapid situational analysis / checklist
  - Systematic identification of capacity gaps
- **Designing the strategy**
  - A logical overview … builds confidence that nothing major left out
  - Ensures the more difficult lower levels are considered … may prompt debate that might not otherwise have happened
  - Pyramid can give structure to a short briefing document … or to a strategic plan
- **Sequencing of implementation**
  - Clarifies phasing of change at the various levels over time
  - Is the pyramid 'stable' over time ? Will the momentum for change be maintained ?

Uses of the Capacity Pyramid

- **Monitoring implementation**
  - If there is insufficient progress at the lower levels then should inputs at the higher levels be re-scheduled ?
- **Sustaining and updating capacity**
  - Continuous and systematic process … never finished
  - Increased chance of sustained improved performance; investments not undermined by failure to address underlying issues
- **Evaluation**
  - was there appropriate attention to all aspects of capacity development ?
  - were scarce resources prioritised effectively ?

Ways the pyramid has been used in Uganda

- Strategic Plan of Infectious Diseases Institute (IDI) in Uganda structured around pyramid (2008)
- Pyramid central to IDI project funded by US in 2010 to develop capacity of urban clinics in Uganda … 90% rating from funder … secured $22m
- Currently being used :
  - To implement rapidly more advanced HIV services in all regional referral hospitals in Uganda (donor pooled funding)
  - To organise major lab services capacity enhancement in NGO facilities across Uganda (40% of sector) (USAID funding)
  - To apply for continuation of support from Government of Uganda (basis of IDI Strategic Plan)
- Pyramid is default approach at IDI … funders have not questioned the approach

Annex III

Why use the capacity pyramid ?

- Pyramid is tool for :
  - enhancing capacity for turning plans into action … and monitoring progress
  - communication of key aspects of capacity enhancement
  - structuring proposals for funding (both to Govt and EDPs) … demonstrates that investments sought are integral with a plan to build the capacity of the organisation
  - analysing and reviewing reports, proposals and plans

Other advantages

- Logic and momentum … the need for some 'early success' … pyramid helps to achieve a balance for results
- Pyramid can fit with other approaches … such as WHO building blocks of health system
- In the rush of a pressured manager's life … gives a rapid and holistic view … enables you to 'see the whole chess board'
- Applying the pyramid is low cost and low risk … it is the product of experience; it is a route into complicated issues; it does not preclude the use of other methodologies, but supports them

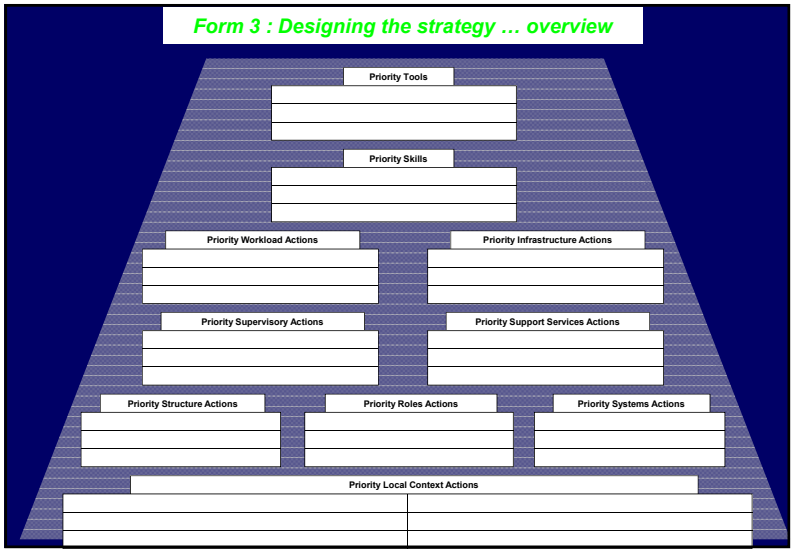
The exercise

Areas for capacity enhancement ?

We may need to enhance our capacity :

1. to meet needs related to Non-Communicable Diseases ?
2. to further strengthen SWAp process (post Paris / Accra) ?
3. to manage District services at local level ?
4. to better respond to the needs of the urban poor / marginalised communities ?
5. to meet the challenges of the health equity and rights-based approaches and 'hearing the voice of the people' ?
6. to improve information management and data quality for evidence-based policy and planning ?
7. to reduce stock outs, and to procure and distribute essential supplies and equipment efficiently ?
8. to raise the quality and scope of reproductive and sexual health services ?
9. to enter into successful and sustainable PPPs to improve service coverage ?
10. to recruit and retain essential staff ?
11. to strengthen mental health services ?
12. … other ?

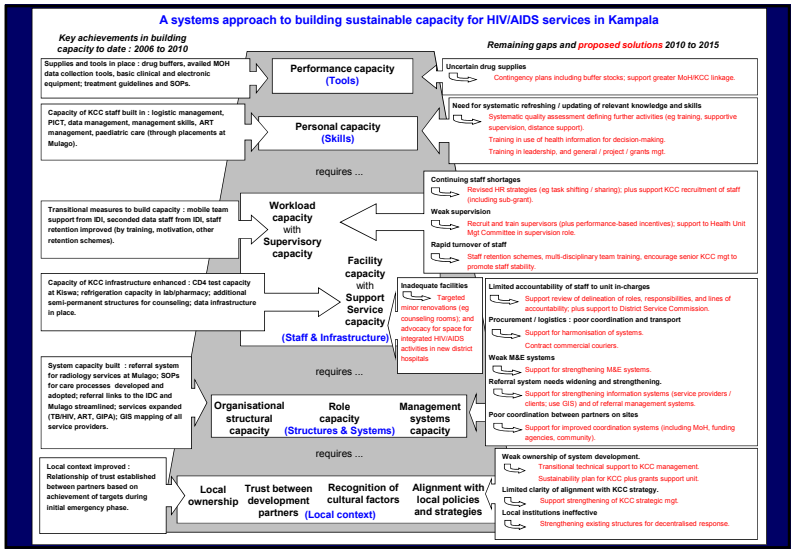
Annex III



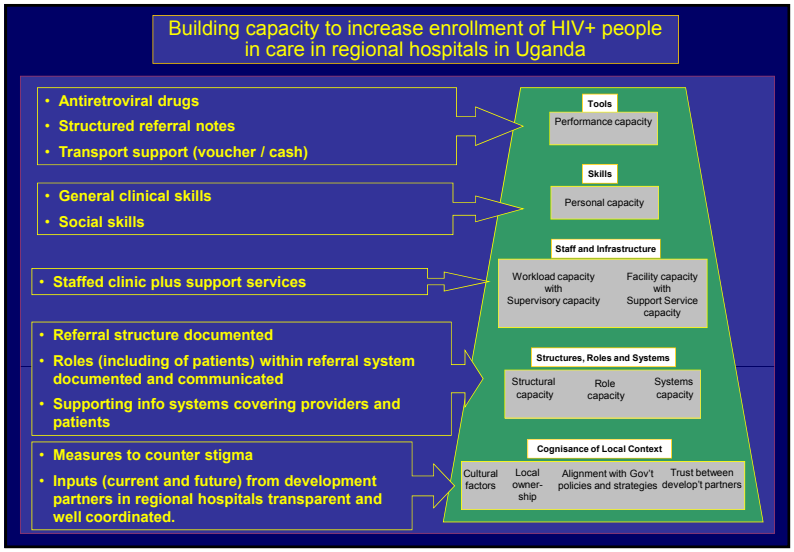
Structured checklist for diagnosing the problem and for enhancing capacity to solve it

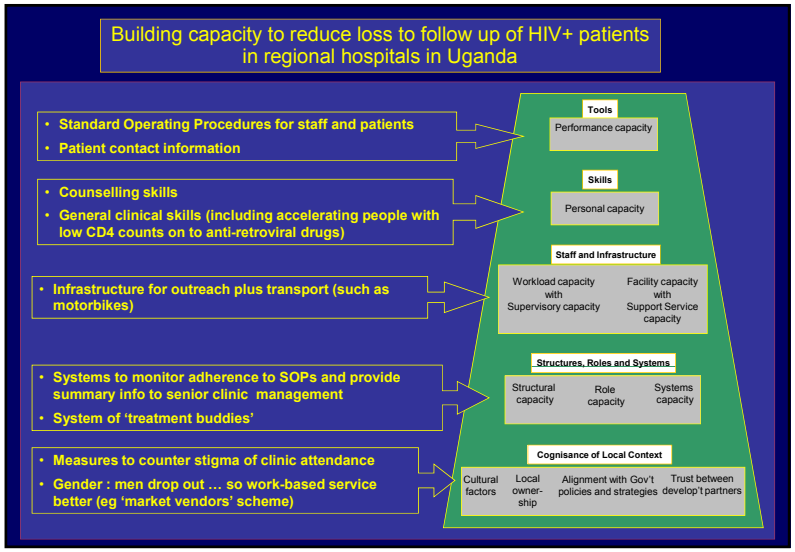
- For each major problem area identify systemic bottlenecks / obstructions
- … then to free each bottleneck use the pyramid to check :
  - Level 1 : What factors in local context need to be addressed (if possible) ?
  - Level 2 : What management issues need to be addressed ?
  - Level 3 : Are staff (including supervision) and infrastructure adequate ?
  - Level 4 : What skills need to be developed ?
  - Level 5 : What tools need to be available ?
- … then identify priority action

Hyperlinks



Annex III


Building capacity to increase enrollment of HIV+ people in care in regional hospitals in Uganda
• Antiretroviral drugs
• Structured referral notes
• Transport support (voucher / cash)
• General clinical skills
• Social skills
• Staffed clinic plus support services
• Referral structure documented
• Roles (including of patients) within referral system documented and communicated
• Supporting info systems covering providers and patients
• Measures to counter stigma
• Inputs (current and future) from development partners in regional hospitals transparent and well coordinated.
Tools
Performance capacity
Skills
Personal capacity
Staff and Infrastructure
Workload capacity with Supervisory capacity
Facility capacity with Support Service capacity
Structures, Roles and Systems
Structural capacity
Role capacity
Systems capacity
Cognisance of Local Context
Cultural factors
Local owner-ship
Alignment with Gov't policies and strategies
Trust between develop't partners


Building capacity to reduce loss to follow up of HIV+ patients in regional hospitals in Uganda
• Standard Operating Procedures for staff and patients
• Patient contact information
• Counselling skills
• General clinical skills (including accelerating people with low CD4 counts on to anti-retroviral drugs)
• Infrastructure for outreach plus transport (such as motorbikes)
• Systems to monitor adherence to SOPs and provide summary info to senior clinic management
• System of 'treatment buddies'
• Measures to counter stigma of clinic attendance
• Gender : men drop out … so work-based service better (eg 'market vendors' scheme)
Tools
Performance capacity
Skills
Personal capacity
Staff and Infrastructure
Workload capacity with Supervisory capacity
Facility capacity with Support Service capacity
Structures, Roles and Systems
Structural capacity
Role capacity
Systems capacity
Cognisance of Local Context
Cultural factors
Local owner-ship
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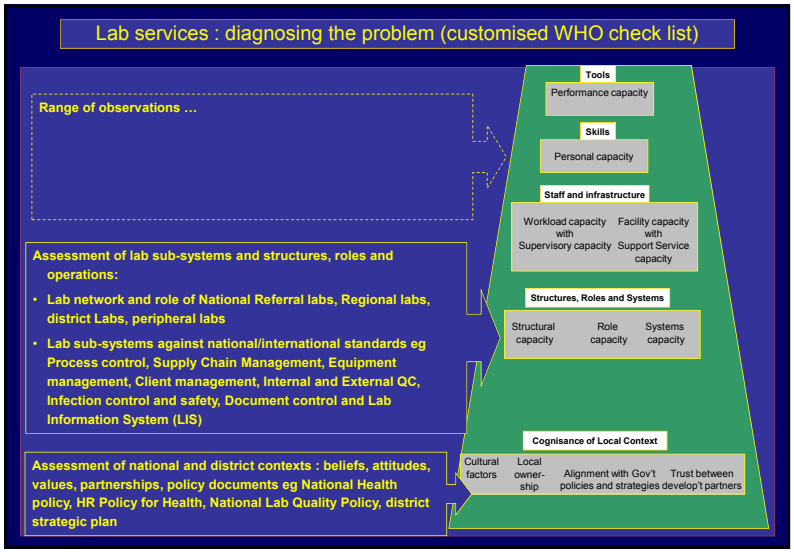
Trust between develop't partners


Lab services : diagnosing the problem (customised WHO check list)
Range of observations …
Assessment of lab sub-systems and structures, roles and operations:
• Lab network and role of National Referral labs, Regional labs, district Labs, peripheral labs
• Lab sub-systems against national/international standards eg Process control, Supply Chain Management, Equipment management, Client management, Internal and External QC, Infection control and safety, Document control and Lab Information System (LIS)
Assessment of national and district contexts : beliefs, attitudes, values, partnerships, policy documents eg National Health policy, HR Policy for Health, National Lab Quality Policy, district strategic plan
Tools
Performance capacity
Skills
Personal capacity
Staff and infrastructure
Workload capacity with Supervisory capacity
Facility capacity with Support Service capacity
Structures, Roles and Systems
Structural capacity
Role capacity
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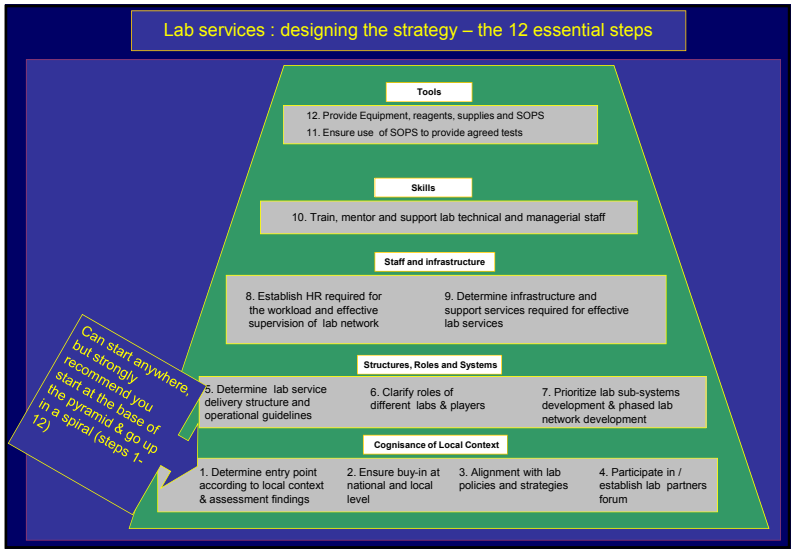
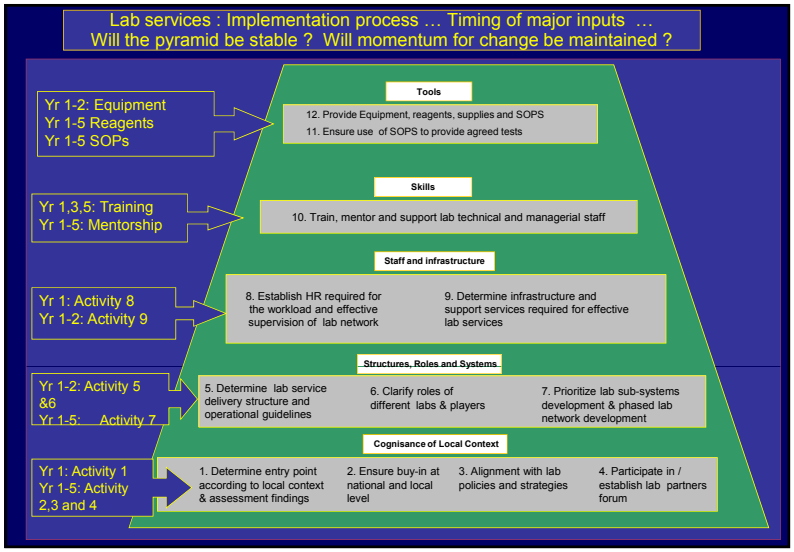
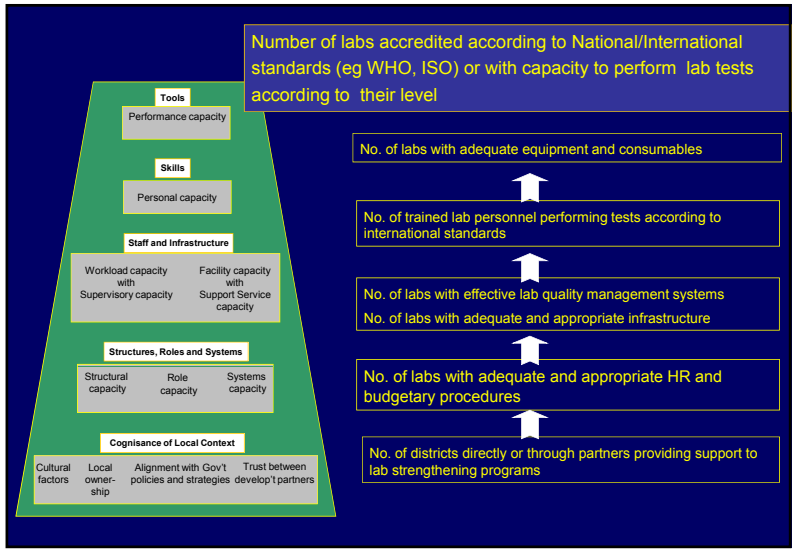

Lab services : designing the strategy – the 12 essential steps
Tools
12. Provide Equipment, reagents, supplies and SOPS
11. Ensure use of SOPS to provide agreed tests
Skills
10. Train, mentor and support lab technical and managerial staff
Staff and infrastructure
8. Establish HR required for the workload and effective supervision of lab network
9. Determine infrastructure and support services required for effective lab services
Structures, Roles and Systems
5. Determine lab service delivery structure and operational guidelines
6. Clarify roles of different labs & players
7. Prioritize lab sub-systems development & phased lab network development
Cognisance of Local Context
1. Determine entry point according to local context & assessment findings
2. Ensure buy-in at national and local level
3. Alignment with lab policies and strategies
4. Participate in / establish lab partners forum
Can start anywhere, but strongly recommend you start at the base of the pyramid & go up in a spiral (steps 1-12)

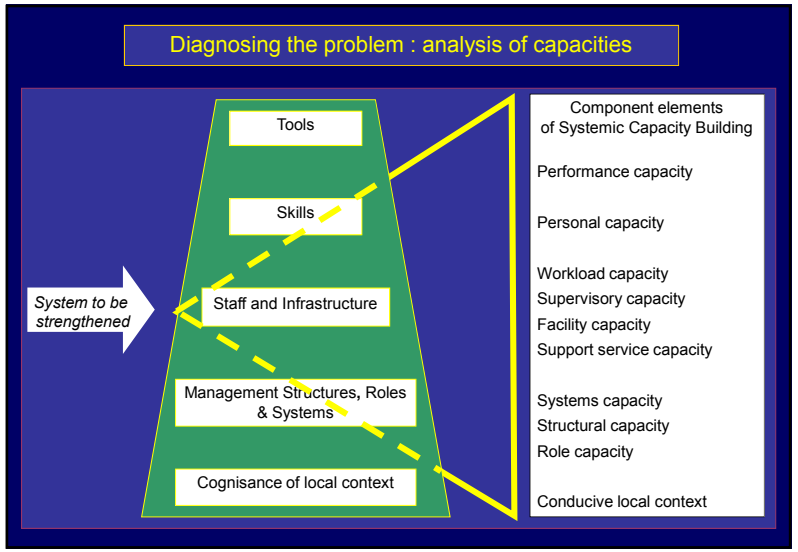
Annex III





Linking the Building blocks of Health System (WHO) and the Capacity Building Pyramid (IDI)

WHO : Blocks of health system	*IDI : Level of capacity pyramid*	Key Gaps in Capacity : September 2006	Capacity building achieved : 2006 to 2010	Continuing (or new) gaps : 2010	Proposed solutions during 2010 to 2015 *(to be achieved through the proposed project (highlighted) or other related projects in KCC)*
Service delivery	***Tools***	Inconsistent supplies (drugs, kits, lab reagents)	Drug buffers provided through grant.	Uncertain drug supplies; especially as CD4 threshold for initiation on ART rising.	**Contingency plans including buffer stocks.**
		Limited clinical equipment	Basic equipment provided and handed over to units	Maintenance schedules to service the equipment.	**Develop and execute service contracts for equipment.**
		Lack of official means of transportation for patient referral	Not provided under project.	Still no official means of patient transportation for referral.	**Assist KCC management to identify a donor to procure means of transport.** Support running costs (fuel, maintenance) through project.
	Skills	Limited ART management skills	ART management training offered to KCC staff KCC staff participate in ART (switch) meeting at IDI routinely	Gaps in specific clinical areas (management of co-infections e.g. TB, Hepatitis, etc).	**More on-site mentoring of KCC staff by short term TA team from IDI.**
		Weak supervisory skills	Management training offered to KCC staff KCC health unit in-charges drew up post-training management plans for their units	Poor follow-through with the post-training management plans	**Facilitate the activation and implementation of management plans with emphasis on support supervision.**
		Limited logistics and supplies management skills	Logistics and supplies management training offered to KCC staff	--	--
		Limited paediatric HIV management skills	Paediatrics HIV clinical placements at Baylor Uganda offered to KCC staff	New KCC staff have not had placements at paediatric HIV clinical sites.	Offer clinical placements for KCC staff at Baylor Uganda.
		Limited palliative care skills	Palliative care training offered to KCC staff	Skills have not been exercised due to poor facilitation of palliative care activities at the sites.	Refresher course in palliative care. Facilitate a palliative care plan within the health unit work plans.



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