**Technical Report 16:
Capacity Building
In Training:
A Framework And
Tool for Measuring Progress**

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November 1999

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ACKNOWLEDGMENTS

ABBREVIATIONS

DA	Development Associates
W&S	Water and Sanitation
MCH	Maternal and Child Health
MSH	Management Sciences for Health
HHRAA	Health and Human Resources Analysis for Africa
IPPF/WHR	International Planned Parenthood Federation/Western Hemisphere Region
FPA	Family Planning Agency (an IPPF affiliate)
SDP	Service Delivery Point
TNA	Training Needs Assessment
HRD	Human Resource Development
LOP	Life of Project
EDD	PRIME's Evaluation, Documentation and Dissemination initiative
MOH	Ministry of Health
FHI	Family Health International
JHPIEGO	Johns Hopkins' Program for International Education in Gynecology & Obstetrics

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EXECUTIVE SUMMARY

The PRIME project was entrusted with training and supporting primary providers of reproductive health around the world through a capacity building strategy. In order to assist project managers and host country staff with assessing the base and progressive levels of institutional capacity for training, a new tool to measure capacity building was devised and tested in several countries.

An extensive review was made of the published literature on *Capacity Building, Institutionalization* and *Sustainability*. Common components found in models were built into a "contextual" framework and 21 indicators were selected to represent all dimensions of capacity. An *index* was created by assigning score values to each indicator, corresponding to different levels of capacity. A first "dry-run" was carried out requesting PRIME's regional directors and senior project officers to fill in the scores for a number of countries in their respective regions. Country and regional bar charts were produced as a result of this exercise. A subsequent opportunity for further testing the model came about through an Evaluation, Documentation and Dissemination (EDD) initiative within PRIME that assessed the overall impact of the project on institutions. Extensive Interviews were carried out with policy makers and officers from these institutions, as well as from other cooperating agencies and USAID country missions. The *index* was reduced by 1 indicator to a total of 20 and levels of capacity were assessed at two points in time: at or before the intervention period and at the end of the intervention. Scores were aggregated for each agency interviewed and then averaged. So far, the *index* has been applied in the Dominican Republic, El Salvador, Mexico, Tanzania and Ghana. Further applications are expected in India and Morocco.

Results are presented in this report for El Salvador. The project had a considerable impact on the scope and quality of MOH FP/RH service delivery. It helped to reduce medical and other barriers to service provision, revised out of date service norms and improved management and logistics of contraceptive supplies. The project directly built capacity and helped to ensure the sustainability of training. Access to, availability and quality of FP services were improved by the project. The *Index* was applied among the MOH, USAID and FHI staff. Summary results revealed a nearly 60% increase in the ability of the MOH to organize and conduct training in FP/RH in the country (i.e. from an initial score of 35.8 to a final of 56.7, over a maximum total of 80). A table and graph also show the absolute levels and relative growth for each component.

It is expected that the use of an *Index* of Capacity Building will help project managers, in-country training managers and policy-makers understand where absolute and relative changes occur and guide them in concentrating future efforts (e.g. re-assessment of interventions for low increase areas and more input of resources for low areas of capacity). Some limitations of the model and future efforts to increase the validity and accuracy of measurements are also discussed.

BACKGROUND

A well known paradigm in international development states that project interventions become more effective as they increase the self-reliance of institutions. Thus, development agencies, and among them training institutions, strive to design projects that achieve "institutionalization" of efforts. However, there are two intrinsic shortcomings to the use of "**institutionalization**" as a working tool for assessing training self-reliance. First, the concept seems to allude to a more structured and end-product status, thus it does not address the processes that lead to such structural outcome. Secondly, it is unclear how institutionalization may relate to self-reliance and the ultimate outcome, **sustainability**. Thus, users may not find it productive to concentrate efforts on a concept that is difficult to grasp or does not address the origin and evolution of structures. At the same time, increasing preoccupation in recent years for identifying initial and intermediate stages that *create conditions* for institutionalization of training in specific settings has given way to a new term: **Capacity building**. Examples of a variety of definitions and use of these terms in different contexts (and the difficulty of discriminating relationships between the three) will be reviewed below.

MODELS AND DEFINITIONS OF CAPACITY BUILDING, INSTITUTIONALIZATION AND SUSTAINABILITY IN TRAINING: DIFFERENT USES

Uses by international development agencies and projects

The United Nations Development Program (UNDP) has as its mandate the promotion of self-reliance in developing countries. VanSant (1990), speaking on behalf of the organization's goals, laid out a framework and indicators to measure **institutional self-reliance**, defining an institution as "an entity (or group of related entities) having a legal framework, an organizational structure, operating systems, staff, and resources, and constituted to fulfill a set of related functions valued by a client or constituent group." **Institutional capacity** is then referred to as "the extent of competence that institutions have to perform effectively the functions for which they exist, with self-reliance as the ultimate goal." In his paper he utilizes the terms *institutional capacity building* and *institutional development* interchangeably. He states there are external and internal factors that affect the condition of an institution. Among the external factors he cites the strategies for its development and environmental factors. Intrinsic dimensions for institutional self-reliance are basically three: Institutional Formation (made up of stock, human and financial resources), Institutional Functioning (comprised of management, environmental mastery and program delivery) and Institutional Condition (constituted by institutional character and leadership). Another UNDP document referring to **capacity building**, aside from citing "Institutional

Development" as a central element, invokes the need for human resource development, the strengthening of managerial systems and the creation of an enabling environment, with appropriate policy and legal frameworks as complementary elements (UNDP, 1991).

In the Water and Sanitation (W&S) sector, a document putting forward guidelines to assess status of the sector's institutions includes such crucial components as Organizational Autonomy, Leadership, [solid] Management and Administration, Consumer Orientation, Technical Capability, the Development and Maintenance of Staff, Organization Culture and Interactions with Key External Institutions (WASH, 1988). Another W&S technical report specifically addresses **training capabilities** as the ability to go beyond isolated activities and advocates training as being an investment for job enhancement, a component of an "institutional improvement program." In developing a training capability, the report recommends looking carefully at the vision from top management, involvement of key supervisors, how training fits into the overall goals of the organization, its costs and the issues of staff recruitment and development (WASH, 1990). During a UNDP Symposium of **Capacity Building** for Water Resources, initiatives were presented to encourage external support agencies to create capacity in "client" countries (Okun, 1991). Interestingly, apart from the expected components (improve policy environment, establish an appropriate legal situation and develop human resources) there are two others which encourage institutions to "look out" into positive external influences: one is the concept of "twinning" or linking with a "sister-city" (or a sister organization, by analogy) to cross-benefit from cooperation and the second one is to foster consumer/community participation to amplify program effects and create ownership. In a related field, Karel and Thomason (1992) talk about **capacity building** in health systems research as "dependent on national commitment, development of individual competence, a supportive institutional infrastructure and creation of demand...among policy makers and managers."

The term**, Sustainability**, on the other hand, has also been quoted and utilized extensively in the arena of international development. In particular, USAID has included the concept in most of its programming for the nineties. Thompson et al (1990) for example have listed a number of factors that encourage the sustainability of projects and programs, namely "host government policies...national and/or local commitment to project goals, managerial leadership...collaboration at all staff levels in program management, financial resources..., appropriate program technology, integration of the program with the social and cultural setting of the country, community involvement with the program, sound environmental management, technical assistance oriented at transferring skills and increasing institutional capacity, perception by the host country that the project is 'effective,' training provided by the project to transfer skill needed for capacity-building, integration of the program into existing institutional framework, and external political, economic and environmental factors."

However, the long listing does not benefit from priority or sequence criteria for application to a specific situation, thus serving mostly for reference purposes.

Uses by FP/RH Agencies

During a training evaluation meeting, Management Sciences for Health (MSH) presented a single-plane **institutionalization of training** working framework, comprised of formal and informal components such as "purpose," "motivation," "affective," "organizational robustness," "effective[ness]," "efficiency" and "demand and access," and described the need for political and social *legitimization,* strong leadership and systematic plans as crucial preconditions. Participants also differentiated **Capacity** (equipment, structures and resources) from **Capability** (knowledge and skills) (MSH, 1992). In an attempt to systematize experiences from technical assistance to institutional capacity building with a foreign organization, MSH's National Training Center for Reproductive Health (NTCRH) later organized a "**Sustainability** Plan" revolving around eight steps:

1. Criteria for Selecting Strategic Directions (e.g. contribution to national goals, quality of care)
2. Driving forces of the institution
3. Organizational issues: focus on clients, institutional collaboration, internal assessment of the NTCRH
4. Strategic Directions (e.g. a regional training and consulting center for Francophone Africa)
5. New program development within NTCRH (e.g. more international profile; long-term training in FP)
6. Recommendations and schedule (e.g. develop financial systems, marketing strategies, new areas of expertise, pilot projects)
7. Scenarios for 2006 (e.g. from predominantly government programming, government-private, to predominantly private)
8. Need for a Budget Model

(Hoey et al, 1996).

In a recent report of related contents, MSH reviews traditional components of **organizational development** and actually defines it as "the process of organizational and management changes which increases the organization's ability to continue effective performance [in spite of other] changes." **Sustainability** to them is "the organization's ability to continue effective performance, for example, in a reduced donor support" environment (MSH, 1997). The Family Planning Management Development Project (FPMD) of the same institution developed the Management and Organizational Sustainability Tool (MOST), a self-assessment instrument used to assist organizations in achieving higher states of management capacity. The tool is a matrix of 12 *management components* and four stages of development according to

reference criteria set in advance. The components bear scores and are organized around 4 distinct dimensions of capacity: **Mission** (Knowledge and Application), **Strategy** (Links to Mission and Links to Markets), **Structure** (Allocation of Responsibility and Delegation of Authority), and **Systems** (Collection and Use of Information, Supply Management, Financial Management, Revenues (Sources of Funds), Planning and Human Resources).The assessment is conducted as part of a 3-day workshop, which includes the organization's plans for moving ahead to higher stages of development (FPDM, 1998). It is interesting to note that the instrument allows for the organization to select indicators best describing the status arrived at each component. While this may make the instrument easier to apply, it may also reduce the potential for wider application across the board, as a lack of standardization of indicators may lead to inconsistent results depending on the user.

Development Associates (DA) defines **Institutional Training Capability** as "the ability of an agency to plan, implement, evaluate and maintain effective training programs," and **Capacity** as "volume and types of training over a specified geographic area" (Development Associates, 1994). In reviewing the efforts to build capacity in the area of MCH services in Tanzania and the problems it has encountered, Mukandala (1996) defines **Capacity** as referring to "the ability to perform tasks effectively, efficiently and sustainably" and **Capacity building** as having the following dimensions: "the broad context in which tasks are performed; the institutional environment; the task environment; organizational structures, processes, resources, technologies, and management styles which affect how individual talents and skills are used; and the training and recruitment of managerial, professional, and technical talent."

Even in the field of postabortion care (PAC), Ipas, a PRIME partner, has utilized a **sustainability** framework to view the long-term effects of its programs. Their model is based on a framework built by Shepperd in 1991 that has the Health System at its core. Subsequently, **capacity** is divided into Strategic Capacity (in turn made up of Policy Development and Resource Allocation constituents) and Operational Capacity (composed of Health System Infrastructure and Technical Competence components). In their model, both capacities are supported by the degree of Political Will and Leadership (Ipas, 1997).

The Health and Human Resources Analysis for Africa Project (HHRAA) developed a **Sustainability** Conceptual Model where Sustainability is one of four conditions (other three: Access, Quality and Demand) for use of services and improved practices leading to health status (HHRAA, 1998). For the Working Group, sustainability in turn is subdivided into "Sustainability of Systems" (supply) and "Sustainability of Demand." Interestingly, one of the three components of the Systems' sustainability is the **Institutional Capacity** of entities. The other two components are Financial Sustainability and Enabling Environment (in which there are Policy and Community Empowerment aspects that affect the environment). **Capacity Building** is defined in this document as "a set of

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activities and actions that assists the receiving institution or individual to enhance their ability, competence, and aptitude to plan, implement, and evaluate programs or policies" (page 40).

At IPPF, Western Hemisphere Region (WHR), a carefully designed project phasing out from USAID support, the Transition Project, looked at **Sustainability** of its family planning agencies (FPAs) as its main objective. They defined sustainability as "the ability of an FPA to replace (with local income) the cost of services which were previously funded by USAID, in order to continue providing the same volume and quality of services to needy clients" (IPPF/WHR, 1997). Clearly, this definition orients the direction of interventions by emphasizing the financial aspect of sustainability (thus, the need for cost recovery) and identifying the agency withdrawing the funds (thus, the need for partnering with other institutions and for budget diversification).

THE MEASUREMENT OF CAPACITY BUILDING, INSTITUTIONALIZATION AND SUSTAINABILITY: EFFORTS, DIFFICULTIES AND RESULTS

Despite the profusion of terms and applications of the Capacity Building, Institutionalization and Sustainability concepts in numerous projects and programs, few have attempted to measure them. The difficulty lies in a) the facts that there are no consensus definitions for the three terms (though there seems to be broad understanding of underlying factors and elements); and b) the profusion of dimensions involved in their measurement.

The Lapham/Mauldin/Ross Program Effort Scores

A classical and long-standing enterprise to measure the effect of "program efforts" on family planning use and its influence on fertility is the development of a 30-item index applied in 81 countries around the world by Freedman, Berelson, Maulding, Lapham and Ross since 1976 (e.g. see Lapham and Mauldin, 1985; Mauldin and Ross, 1991 and Ross and Maulding, 1996). Although the authors did not utilize those terms, the "strong" **program efforts scale** depicted countries in which the **institutionalization** of family planning programs had become a reality (e.g. Thailand, Mexico, Indonesia). The program effort scale, though conceptually simple and straightforward and applying equal weight to all dimensions, measured aspects as diverse as "Favorable statements by leaders," "Other ministries/government agencies involved," "Involvement of private-sector agencies and groups," "Administrative structure, whether "there were adequate training programs for each category of staff in the family planning program1," "Supervision," "Management use of evaluation findings" and several estimates of the availability and accessibility of contraceptive methods. The scales have been used quite successfully over time to construct matrices of state of FP program

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1 *Adequate* meant to the authors that the training provided personnel "with the knowledge, information, and skills necessary to carry out their jobs effectively, and that facilities exist to carry out the training" (Lapham and Maulding 1985, page 134).

development and social settings throughout the developing world, multivariate analyses of components of program effort and contraceptive and fertility outcomes, and so on. The initiative is a good example of how to combine qualitative (e.g. perceptions of strengths) and quantitative (e.g. # of CYP, range of methods, etc.) assessments and convert them into simple but robust quantifiable tools aiding FP analysts and managers alike.

The EVALUATION Project Institutionalization of Training Indicators and Sustainability Indices

Other efforts to build systematic frameworks and indicators for family planning evaluation come from the USAID-funded EVALUATION Project. The first effort came from the Working Group on the Evaluation of Family Planning Training (WGEFPT), which met in 3 occasions in 1992 to review a conceptual framework developed earlier by the CMT Division of USAID. The framework identified internal training levels and external factors influencing the FP service delivery network. Interestingly, one of the overarching aspects recognized as linked to improved service networks was the "Institutionalization of Quality Training" (Bertrand and Brown, 1994, page 8). A Work Group subcommittee on the institutionalization of training met separately to further advance definitions and indicators. "Capability" was defined as the ability to "organize, implement, evaluate, and maintain effective training programs", while "Capacity" was conceptualized as the ability to "handle a certain volume of participants for different types of training". The group also identified a "big picture" scenario, referred to as the ability to "integrate training and service delivery activities into an interactive, dynamic system, in which training is based on service delivery needs and more specifically service delivery guidelines". In addition, this group came up with a list of indicators which "will serve as a basis for further indicator development in this area" (op cit, page 27). The list draws indicators from different dimensions such as Quantitative Inputs, Evidence of Responsive Planning, Adequacy of Training Materials, MIS for Training, and so on. Unfortunately, the list lacked order and hierarchy, thus limiting its potential for immediate application to measuring capacity building.

A further effort by the EVALUATION project used a rationale similar to the Lapham et al effort scores to measure the effects and impacts of interventions on institutions and the population. They developed a framework and deployed indicators such as the "number/percentage of trainees that deliver services according to national FP policy and guidelines" as an intermediate "Trainee Level" output and "number/percentage of functional FP service sites where national guidelines are in place" as an intermediate "System Level" output. A more comprehensive conceptualization of the **sustainability** of family planning programs comes from a recent study by the same group (Knight and Tsui, 1997). With the USAID results orientation in mind, the authors define sustainability of programs at three levels: at the *outcome* level (country conditions that support continued decline in fertility); at the *program* level (national program conditions to

deliver quality services over time); and at the *organizational* level (organizational characteristics supporting the organization's ability to achieve its mission and deliver quality services over time). Indices are created to measure progress in each area. For the outcome sustainability index the study uses a framework based on the degree of country development and the strength of the program; both will interact with infant and child mortality and the fertility of populations to reach the Population Stabilization goal. Programs are influenced by implementing organizations and they in turn are aided by donors.

The Organization level framework (Capacity to Provide Services) utilizes four factors developed by the Family Planning Management Development project at Management Sciences for Health (MSH): Mission, Strategy, Structure and Systems. Finally, the Program Sustainability Index (the one more relevant to our discussion) assumes that program efforts seek to **sustain** access to contraceptive services (see below) and this is dependent on Finances (providing the basic resources for operation), Management (supervision and execution of tasks and activities, trained staff, adequate record keeping, performance evaluations and utilization of evaluation to maximize access to contraceptive services) and Cooperation (coordination/collaboration with other sectors to ensure efficient use of resources).

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                        ┌─────────────────────┐
                        │  Program            │
                        │   ┌───────────┐     │
  ┌──────────┐          │   │ Finances  │     │       ┌──────────┐
  │ Donors   │─────────▶│   └───────────┘     │──────▶│ Access to│
  └──────────┘          │  ┌────────────┐     │       │ Services │
                        │  │ Management │     │       └──────────┘
  ┌──────────┐          │  └────────────┘     │
  │ Demand for│◀───────▶│   ┌────────────┐    │
  │Contraception│        │   │ Cooperation│    │
  └──────────┘          │   └────────────┘    │
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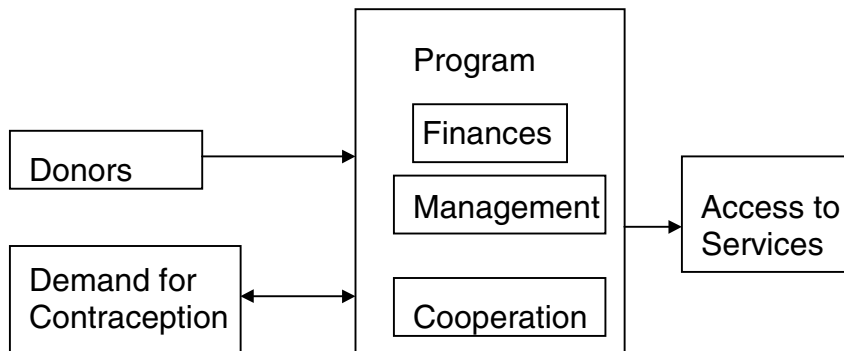
Using multivariate analysis, the authors utilize five variables (Contraceptive access score, Management Index, Percentage of in-country FP budget, involvement of private sector in FP and involvement of other ministries in FP) that summarize the above three dimensions plus two other variables, USAID per capita funding and the Total Fertility Rate lagged two years prior (as a proxy to contraceptive demand), to build their index model. Regression coefficients estimate relative weights of each variable, which are then used in a revised equation to arrive at the **Program Sustainability Index**, and applied for different periods for 56 developing countries for which complete data exist. The result is a table ranking countries with the most sustainable programs at the top and the

least sustainable at the bottom (Knight and Tsui, page 18). Such index permits assessing the vulnerability of countries in case external funding would suddenly cease. Theoretically, a similar exercise could be conducted to obtain a Capacity Building (or Sustainability) Index for Training.

The JHPIEGO Benchmark Approach

JHPIEGO defines capacity building as "bringing together the educational and health systems of a country to prepare a cadre of health-care providers who can deliver standardized, high-quality services. In this framework, pre-service and in-service training are coordinated, and service delivery and clinical training are guided by a set of up-to-date, nationally accepted service delivery guidelines." **Sustainability**, on the other hand, is described as "countries being able to carry on their own reproductive health education and training programs without outside support." JHPIEGO's framework for Integrated Reproductive Health Training has at its center National Policy and Service Guidelines that feed their two main areas of work: In-service Training for Practicing Health Professionals and Pre-service Training in Health Professional Schools; these two areas in turn interrelate with Service and Clinical Training Sites (that eventually converge into Service Delivery Points or SDPs). The Guidelines are influenced by Training Needs Assessment (TNA) and International Resource Materials, and Evaluation from the SDPs feedback into the TNA. Their **Capacity Building** in Training model is based on this framework and offers an interesting grid for allocating countries in different stages of training development. JHPIEGO utilizes program *benchmarks* to monitor project progress and accomplishments in their four mentioned areas: National Policy and Service Guidelines, Pre-service Training for Health Professional Schools, In-service Training for Practicing Health Professionals, and Service and Clinical Training Sites (see example graph for *Development of National Service Guidelines*...)2. Each of the four levels in each area sequentially represents a completed benchmark, thus a level 4 (e.g. National RH/FP Service Guidelines have been officially endorsed by policymakers) depicts a higher state in the area as compared to level 1 (e.g. Country officials sensitized about the need for revising guidelines; knowledge updated; consensus reached). Although the actual scoring or system for allocation of countries is not presented, on average 19 countries are placed in different levels and examples of individual countries are presented for each area. As with the "Program Effort Scores" the appeal of such a model is that senior managers are supposedly able to track the "move" of countries (or institutions) from lower to higher levels of "capacity" in training and thus be better informed to take appropriate decisions about relative levels of effort and resources to be put into place according to specific benchmarks accomplished.

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2 The Pre- and Inservice Training areas are subdivided in *Curriculum Development*, *Faculty/Tutor Classroom Presentation Skills*, *Clinical Trainer/Preceptor Capability to Transfer Reproductive Health and Family Planning Skills*, and *Development of Training Materials* components, and the Service and Clinical Training Sites area is made of a *Strengthening Clinical Training Sites* component for each the Preservice and Inservice aspect of work.

PRIME's Approach

Over the years, INTRAH has conducted numerous training interventions in countries around the world. As a result of the experience accumulated in working with training institutions in developing countries, concerns arose about the degree of self-reliance attained by these institutions. Thus, INTRAH in 1992 laid out a working definition and elements of the "**Institutionalization** (or 'Big Picture') of Training" (see below).

Institutionalization of Training

"Having in place an evolving training system that reliably anticipates and responds to, and interacts with, the service system in order for the service system to carry out its functions."

Elements

1. The degree to which there exist central and decentralized training teams performing training functions according to performance standards, and with the central team technically assisting the decentralized systems.
2. Official designation of training teams and official sanctioning of their functions.
3. The training strategy is based on the service strategy, service plan and results of training and service needs assessments.
4. Existence of short and long-term training plans that show how, when and by whom training needs in the service system are identified and acted upon.
5. Number and types of training curricula revised or developed consistent with service guides and guidelines and service needs.
6. Systematic follow-up of trained personnel to confirm that their deployment is consistent with what they have been trained to do.
7. Training practicum sites are directly related to the service functions of trainees.
8. The training practicum ration of trained preceptors to trainees is based on expectations contained in practicum objectives.
9. Ongoing monitoring and evaluation of the performance and progress of the training system regarding responsiveness to service needs.

Source: INTRAH, 1992

The above definition and elements highlight some of the core preconditions of institutionalized training:

- Training strategies and activities have to be linked to service delivery in order to produce impact

- Training should reflect improved provider performance
- Training teams need official recognition
- Training improves through monitoring and evaluation

However, this approximation required a more elaborate framework. As the PRIME project built more experience from field interventions, other definitions of self-sustained training emerged. Thus, in February 1997, a definition and indicators of **Technical Sustainability** are drafted. Thus, technical sustainability defined a training system that "is fully able to operate and to plan for its future, which is linked to service and other expected results and impacts. The system is able to improve its performance without continuous external advice and assistance." Five components are attached to this definition:

1. Diminished need for external technical assistance and greater reliance on host country resources
2. Appropriate management and monitoring capabilities
3. Existence of a training strategy
4. Evaluation is used to improve training effectiveness and efficiency
5. Technical capability to generate ideas, technologies, approaches and applications

Here, the definition and components do not include financial or social conditions required for sustained training operations. Also, the mention of capabilities necessitated some definition of **Capacity**. Capacity is defined in the same document as "the infrastructure and operational effectiveness of the training system that enables it to respond to training opportunities, challenges, needs and problems and to produce intended results." In this case, seven components further describe the term:

1. A national training strategy, plan and budget addressing service priorities and needs
2. Decentralized and varied training
3. Training teams appropriately deployed and performing according to required standards
4. Availability of skilled trainers
5. Training sites adequately equipped and supplied
6. Training systems that responds to training requests
7. Documentation and evaluation

In these descriptions, new elements such as the need for a strategy, the existence of physical and human resources and the important role of evaluation are brought into the picture. However, there is an element of *reaction* rather than forward planning in this definition.

At this point PRIME starts talking about "sustainable national training systems" and the need to "identify where each PRIME country project fits into the

framework" (Newman, 1997). Three sequential frameworks are developed in an attempt to present a flow ranging from activities to a sustainable FP/RH program (see Figures 1, 2 and 3).   Figure 1 depicts an array of activities that lead into six major components (strategy, policies, monitoring, networking, finances and HR) of such a "sustainable national training system." Activities are presented as "capacity-building" to the components and training system. Figure 2, in turn, utilizes the six previous components to describe "other essential systems and support functions" (e.g. logistics, IEC, supervision, publications, social marketing system, etc.) to arrive at "Service Outputs" (comprised of Access, Quality of Care, Image and Acceptability). This is the first time a continuum of Capacity Building → Institutionalization → Sustainability is presented (the **Capacity Building** stage being placed under the six components, **Institutionalization** under the Other Systems and Support Functions, and **Sustainability** under the Service Outputs). Finally, Figure 3 starts with the systems and support functions in the left side, brings in external factors such as political and economic (incl. donor) situations into the Service Outputs arena and moves onto Institutionalization of Service Outputs and Use and a Sustainable FP/RH Program for improved reproductive health of women and men.

FIGURE 1. PROGRAM ACTIVITIES FRAMEWORK FOR NATIONAL TRAINING SYSTEM SUSTAINABILITY

Linked service, training and contg. Ed. Plans
pre-service forecasting
defined implementation roles
R&D activities…
curricula/materials development
annual work plans
training follow-up…
training models
local govt commitment…
coordination committee…

NATIONAL TRAINING STRATEGY

review and /or update every 2 to 3 years
budgets for updating SOP
new or updated curricula
diversification of training models
evaluations & OR…
new types of requests in TA…
expanding training infrastructure…
inventories and standard lists…
training and reference libraries…
training documentation…

NATIONAL POLICIES, STANDARDS, & PROCEDURES

SUSTAINABLE NATIONAL TRAINING SYSTEM

staff development plan
budgeting & monitoring…
training follow-up & refreshers
in-service training forecasting
performance reviews and plans
supervisory checklists

SYSTEMS TO DIAGNOSE, INTERVENE, & RESOLVE PERF. PROBLEMS

contracts/MOA for training
NGO/PVO expansion
private-sector training
training accreditation
decentralized training & sites

INSTITUTIONAL ALLIANCES, TRAINING NETWORKS, & STAKEHOLDER INVOLVEMENT

self sufficiency/cost efficiency plans
phasing out donor provided goods…
budget to support plan…
decentralized disbursements
targeted allocations

NATIONAL FINANCIAL PLAN FOR TRAINING

job descriptions
clear lines of supervision
selection criteria for training
performance reviews and plans
decentralized mgt. Committees
employee representation…
opportunities for advancement…
opportunities for skill development

HUMAN RESOURCE GUIDELINES & REGS.

Capacity Building → Institutionalization → Sustainability

FIGURE 2: SYSTEMS DEVELOPMENT FRAMEWORK FOR IMPROVING FP/RH SERVICES

NATIONAL TRAINING STRATEGY		

SUSTAINABLE NATIONAL SERVICE AND SUPPORT NETWORK
TRAINING SYSTEM
SERVICE DELIVERY SYSTEM
LOGISTICS SYSTEMS
HUMAN RESOURCE FORECASTS & DEVELOPMENT SYSTEM
IEC COMMUNICATIONS SYSTEM
SUPERVISORY SYSTEM
SOCIAL MARKETING SYSTEM
PROCUREMENT, REPAIR/REPLACEMENT SYSTEM
HEALTH MANAGEMENT INFORMATION SYSTEM
RESEARCH AND EVALUATION
PUBLICATIONS
ALLIANCES, PARTNERSHIPS, & STAKEHOLDERS & COMMUNITY INVOLVEMENT
POLICY AND PROGRAM ADVOCACY
PLANNING AND MANAGEMENT SYSTEMS
FINANCIAL MANAGEMENT SYSTEM
EQUITY PROMOTION

NATIONAL POLICIES
STANDARDS & PROCEDURES

SYSTEMS TO DIA DIAGNOSE,
INTERVENE, & RESOLVE
PERF PROBLEMS

INSTITUTIONAL ALLIANCES &
TRAINING NETWORKS

NATIONAL FINANCIAL
PLAN FOR TRAINING

HUMAN RESOURCE
GUIDELINES & REGS

SERVICE OUTPUTS
ACCESS TO SERVICES
QUALITY OF CARE
IMAGE & ACCEPTANCE

CAPACITY   INSTITUTIONALIZATION   SUSTAINABILITY

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Figure 3: INSTITUTIONALIZATION FRAMEWORK FOR PLANNING AND IMPLEMENTING REPRODUCTIVE HEALTH PROGRAMS

| POLITICAL WILL, NATIONAL COMMITMENT & LEGISLATION |
| ECONOMIC IMPERATIVES |
| TRADITIONS, POLICIES & PRACTICES |

| ORGANIZATIONAL RESOURCES |
| DONOR ASSISTANCE |

SERVICE OUTPUTS

ACCESS TO SERVICES

QUALITY OF CARE

IMAGE & ACCEPTABILITY

SUSTAINABLE NATIONAL SERVICE AND SUPPORT NETWORK

TRAINING SYSTEM

SERVICE DELIVERY SYSTEM

LOGISTICS SYSTEMS

HUMAN RESOURCE FORECASTING & DEVELOPMENT SYSTEM

IEC AND COMMUNICATIONS SYSTEM

SUPERVISORY SYSTEM

SOCIAL MARKETING SYSTEM

PROCUREMENT, REPAIR/REPLACEMENT SYTEM

HEALTH MANAGEMENT INFORMATION SYSTEM

RESEARCH AND EVALUATION

PUBLICATIONS

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BREASTFEEDING

ADOLESCENT RH SERVICES

PATTERN OF SERVICE UTILIZATION

SUSTAINABLE

FP/RH PROGRAM

IMPROVED

REPRODUCTIVE HEALTH OF WOMEN AND MEN

CABACITY BUILDING → → → → INSTITUTIONALIZATION → → → → SUSTAINABILITY

The attempt is formidable and speaks of the conceptual difficulty of the framework. Unfortunately this model is still complex and multiphasic, and incorporates many elements ranging from detailed training (e.g. training documentation) and process (e.g. job descriptions) activities to support systems (e.g. procurement, repair/replacement system), external influences and service contents (e.g. pattern of service utilization: contraceptive use, postabortion care, etc.) without any organized flow or order, to allow an easy grasp. Also, measurable indicators are not developed, thus it is not possible to see how the objective of "fitting" PRIME countries in the model could be accomplished. Later refinements to integrate the three frameworks into one (see Figure 4) suffer from a similar complexity and sense of "random crossover" from a variety of original components (now called "Capacity Building Inputs"), into only one Sustainable National Training System (now termed "Capacity Building Output"), into numerous support systems (now "Systems Development Inputs"), and finally onto a mixed dimension of service characteristics, coupled with actual contents of care (called "Systems Development Outputs"). This time, without it being able to show how each stage is accomplished, the continuum situates Capacity Building at the extreme right of the figure to Sustainability, at the "Sustainable FP/RH Program" site. Unfortunately, at this attempt the terms do not get to be operationalized and are further defined using the terms under definition.

Lately, an INTRAH regional working group effort (WGEFPT, 1998) attempted to describe components of Training **Institutionalization** as:

- Quantitative (e.g. adequacy of staff, physical plant, etc.)
- Evidence of Responsive Planning (e.g. training needs identified, training selection appropriate, etc.)
- Adequacy of Training Materials (e.g. trainers develop, adapt curricula/training materials, teaching aids and references used appropriately, etc.)
- Quality of Training (e.g. trainers competent in content and training approach)
- Relevance to Service Needs (e.g. training based on performance standards, curriculum related to job tasks, etc.)
- Quantitative Output (e.g. Number/variety of training courses offered, organization able to train other trainers, etc.)
- Institutional Support (e.g. Leadership supports and promotes appropriate training)
- MIS for Training (e.g. System for tracking training events exists and is used) and
- Application of Evaluation (e.g. Trainers and trainees evaluate training event, system in place to monitor the application of skills, etc.)

Although there are more practical elements in this breakdown, clearly derived from fieldwork experience, they do not build an integrated picture for lack of a conceptual framework. Hence, though several crucial elements had been identified, there was clearly a need to provide some simpler framework that would take into consideration the range of different components of training and

training capabilities but at the same time be sequential enough to allow allocation of countries and institutions to differing stages of capacity building in training. This is where a "contextual" model begins to materialize.

A CONTEXTUAL FRAMEWORK FOR CAPACITY BUILDING IN TRAINING

Taking into account the wide range of definitions and conceptualizations reviewed above, it became apparent that what was needed was a framework that would have at its core the essential **resources** (i.e. Financial, Physical and Human) that are prerequisites to any training enterprise but that also incorporated the different **dimensions** that build capacity of training into an institution and, ultimately, into a country. One way of visualizing these dimensions is in the form of *concentric* layers that includes a core component but provide a wider context to the picture. Thus, a **contextual framework** for Capacity Building in Training was developed, that incorporated these components into a comprehensive picture (see Figure 5).

As can be seen from the graph, aside from Resources, there are three other important "contextual" dimensions to capacity building in training: Institutional Development, Community Involvement and Participation, and Legal and Policy Support. The role of each dimension and components within each dimension are explained below.

A. RESOURCES
Financial Resources. It cannot be stressed enough the importance of this "core" resource component. The existence and sufficiency of a training budget is at the foundation of any training capacity. However, how diversified and independent this budget is from external sources will be a further indication of capacity.

Physical Resources.
     <u>Venues</u> — Continued training needs accessible and available venues with standard quality of commodities (i.e. power, lighting, acoustics, seating capacity, A-V equipment).
     <u>Materials/supplies</u> — There should be appropriate (pertinent, updated and adapted to local culture) and sufficient materials for event participants, as well as a regular system to replace and upgrade them.

Human Resources. Trainers and preceptors need to have updated and standardized technical and presentation knowledge and skills, in order for the system to be self-generating.

Curricula and Training Plans. These are crucial resources. Updated and standardized curricula that are officially used by training institutions, and training plans that are periodically reviewed all speak of the training capacity of an organization.

Figure 5

Contextual Framework for Capacity Building in Training

International Resources and Technology Development

Overall State of Country Development and Conditions

Legal and Policy Support

Community Development and Involvement

Organizational Development: Infrastructure, Vision, Leadership, Managerial Systems

Basic Components

Training Capacity Building Stages

other work place factors

Capacity Building →

Institutionalization →

Sustainability →

Resources:
- Financial
- Physical
  - Venues
  - Materials
  - Supplies
  - Equipment
- Human
- Curriculum

Pre- and inservice training events

Pre- and inservice training interventions

Capable and sustainable training system

P E R F O R M A N C E

Accessible High Quality FP/RH Services

INITIAL

INTERMEDIATE

ADVANCED

SUPPLY

DEMAND

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B. ORGANIZATIONAL DEVELOPMENT

Leadership. Leadership within an organization plays a pivotal role in building training capacity. Leadership expresses the critical vision of linking training to service improvement, incorporating training into an institution's strategic planning and the promotion of networking and cross-collaboration of other institutions to its enterprise.

Infrastructure. Minimum infrastructures are needed in order for a training organization to survive. As these training units develop, they require to develop as much decentralized modes of operation as possible to create improved conditions for sustainability.

Human Resource Development. This is one of the building blocks of institutionalization of training. An integral HR policy and system that seek to improve human performance will lay an important foundation to self-reliance.

Administration. Aside from the need for a solid financial structure and processes, administration of the training efforts will provide information on its evolution. Thus, needs assessment and monitoring systems for trainees, venues, materials and so forth will need to be developed with time.

Technical capability. An institution that is able to create and maintain contacts with other education and training institutions and uses technological developments to their advantage is certain to improve their own training agenda (e.g. trainee selection, training contents and formats).

Track Record. As young institutions accumulate training experience, their capacities become enhanced in their ability to design and conduct/replicate training courses and schemes independently. This is the "demonstrative" indicator of capacity.

> **Note:** To this point the resources and organizational development dimensions jointly contribute to the "supply" side of a health service delivery system. Both aspects are reflected on providers' side of the equation. However, a contextual approach necessitates the client/community perspective, seen next.

C. COMMUNITY DEVELOPMENT AND PARTICIPATION

Any training system that pretends to build capacity requires a close exchange with its surrounding community. It is well known that *legitimization* of activities by these communities (especially by organized groups) will add to the sustainability of operations. Community participation can occur in a variety of manners, from assisting managers and providers with information on sociocultural and environmental factors affecting the health of inhabitants to a full range

partnership in health extension schemes and clinics quality improvement initiatives. Examples include the development of integrated community health agents, the inclusion of community representatives in setting providers' performance standards, involvement in training, attending quality circles in clinics and so on. This is the **demand** side of a health service delivery system.

D. LEGAL AND POLICY SUPPORT

Training projects that do not address the wider policy and legal matters influencing training will exert limited impact. Thus, the model incorporates the existence of updated and official national FP/RH service and training guidelines as prerequisite for continued operation and expansion. Also, indicators of political support (verbal and written) from high-ranking officials are included, in the belief that it can affect the importance assigned to training in the country.

To this model other, larger concentric layers could be added such as the national and international conditions and resources that may affect capacity building. However, since those dimensions often lie outside the scope of project interventions (but have to be kept in mind when assessing progress in this area), they will not typically conform part of the measuring model and are mentioned as outer influences to capacity building.

DEFINITIONS

Having reviewed previous definitions and models of capacity building, institutionalization and sustainability of training in PRIME and other institutions, and presented the above contextual framework, the following definitions ensue:

Training Capacity: "The ability of an organization to effectively conduct training for personnel, based on a standardized curriculum, sufficient resources and the institutional support of adequate infrastructure and managerial systems. Such ability is anchored in increasing levels of community participation and demand, and facilitated by a conducive legal and political environment. The purpose of the training is to ensure such personnel improve their performance3, increase their motivation for work and provide better quality services."

Capacity Building: The process by which organizations enhance their technical capabilities, resources, infrastructure and managerial systems, in the appropriate community, legal, political, and socioeconomic, contexts, in order to deliver effective training for improved provider performance and service access and quality.

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3 The framework thus presented is heavily oriented toward training. However, it could be extended to the wider arena of Performance Improvement (PI), which would require adding indicators of "other Workplace conditions."

Training Capability: The individual knowledge, skill and overall competence of trainer(s) to effectively conduct training for required personnel.

Training Institutionalization: The process by which an *institution* incorporates training, resources, infrastructure and management systems into its strategic planning to produce improved provider performance, service access and quality.

Sustainability in Training: The on-going capacity of an organization in the provision of inputs and generation of resources for improved training, provider performance, and service access and quality.

Note: In the present framework, the emphasis on dimensions and indicators of Capacity Building assumes that they can help to explain when an organization is passing from **building capacity** to **institutionalizing** of training (i.e. when capacity is reaching the "organizational development" dimension). Likewise, once training is legitimized by policymakers and/or the community, and the resources (financial, physical, etc.) are in place and there is a track record of independent activity, then and only then can the training efforts (and the institution) be said to be reaching **sustainability** of operation. In that sense, the three terms describe a *continuum* of development, overlapping among them.

OPERATIONALIZING THE FRAMEWORK

In order to operationalize the framework to fit the countries and institutions with which PRIME is working, precise indicators were added to each dimension and component. In addition, in a similar fashion to the program effort scores developed by Lapham/Mauldin/Ross, each indicator was assigned a value score ranging from 0 to 4, 0 being the most basic state of condition found at baseline and 4 the maximum capacity for training in an advanced situation (see Appendix 1). Since there are 21 indicators in the model, the scores have a range of 0 to 84 points. The sum of scores yields an *Index of Capacity Building*. Such *index* will help managers and evaluators assess the relative degree of capacity in training in each applied example.

FIELD-TESTING THE INDEX

The fact that PRIME works in more than 20 countries around the world using a Capacity-building philosophy in every intervention (Adamchak et al, 1999), provided the appropriate context in which to test the model. In-country training institutions assisted by the project (e.g. Ministries of Health, other public or private institutions) in four regions (Asia, West Africa, East Africa and Latin America) were selected for field-testing. In its first version, the index was tested internally among the PRIME regional directors and project officers, pooling together their perceived scores and averaging the values.

The method for presenting results is as follows. Scores were added for all indicators and components. Since there were unequal number of indicators for different components producing differing self-selected weights, all scores for each of the 13 components were standardized to the unit, resulting in each bearing the same weight at the final analysis (see Table 1). The results were plotted into a bar chart (see Graph 1).

The bar chart gives both an overall picture of capacity as well as a view of its specific components, for different regions and countries. For example, it illustrates that, in respect of capacity as a whole, the East, Central and Southern Africa (ECSA) regions of PRIME have achieved relatively higher levels (average of 9.3) as compared to the West, Central and Northern Africa (WCNA) region (9.1), the Asia and Near East (ANE) region (7.7) and the Latin America and Caribbean (LAC) region (4.7). Obviously, results are highly influenced by particular intervention situations of institutions. For example, PRIME's work with the Training Division of the Moroccan MOH since 1996 resulted in a substantially strengthened institution with tutors and trainers updated in training and curricula development, a national training strategy and an overall leading role in the coordination of training activities that lied scattered in different units in the past. In contrast, recent activities with the training unit at the MOH in El Salvador revealed an institution with weak HR capabilities, outdated RH guidelines and little influence on the quality of services delivered throughout the nation.

The chart can also provide information on relative strengths and weaknesses of individual components of capacity. For example, Peru and Ghana share difficulties with finding appropriate venues for training of providers, while Benin is still grappling with lack of sufficient human resources for training and does not involve local communities in the planning and implementation of training. In the Dominican Republic, PRIME is supporting the first steps taken by the *Instituto Dominicano de Seguridad Social* (IDSS) in their recent creation and development of a reproductive health unit, thus the IDSS scores nearly zero on overall level of capacity. However, as will be discussed below, relative comparisons between countries and regions may be constrained by a number of limitations of the index, showing the need for its further testing and refinement.
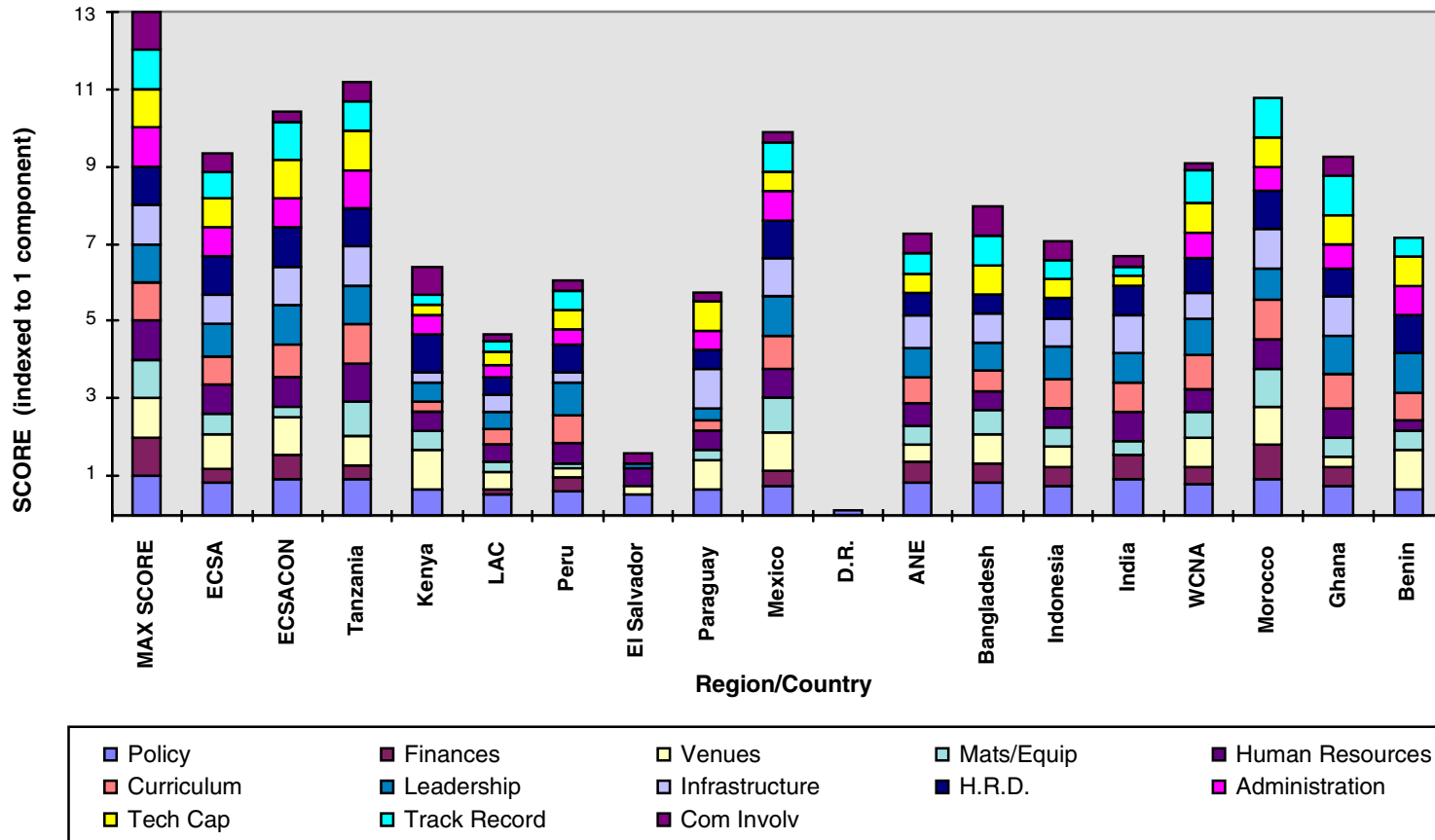
Table 1

PRIME - INDEX OF CAPACITY BUILDING (STANDARDIZED TO UNIT SCORES) BY REGION AND COUNTRY - NOVEMBER 1998

REG/CNTRY	POLICY	FINANCES	RESOURCES				ORGANIZATIONAL							TOTAL
			VENUES	M.E.S.	HUMAN	CURR/T.P.	L'DERSHIP	I'STRUCTRE	H.R.D.	ADMIN	TECH.C	TRACK R.	COMM.DV	
MAX SCORE	1	1	1	1	1	1	1	1	1	1	1	1	1	13
ECSA	0.83	0.33	0.92	0.54	0.75	0.71	0.83	0.75	1.00	0.75	0.75	0.67	0.50	9.33
ECSACON	0.92	0.63	1.00	0.25	0.75	0.88	1.00	1.00	1.00	0.75	1.00	1.00	0.25	10.42
TANZANIA	0.92	0.38	0.75	0.88	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.75	0.50	11.17
KENYA	0.67	0.00	1.00	0.50	0.50	0.25	0.50	0.25	1.00	0.50	0.25	0.25	0.75	6.42
LAC	0.52	0.15	0.45	0.25	0.45	0.38	0.45	0.45	0.45	0.33	0.35	0.25	0.20	4.67
PERU	0.58	0.38	0.25	0.13	0.50	0.75	0.83	0.25	0.75	0.38	0.50	0.50	0.25	6.04
SALVADOR	0.50	0.00	0.25	0.00	0.50	0.00	0.08	0.00	0.00	0.00	0.00	0.00	0.25	1.58
PARAGUAY	0.67	0.00	0.75	0.25	0.50	0.25	0.33	1.00	0.50	0.50	0.75	0.00	0.25	5.75
MEXICO	0.75	0.38	1.00	0.88	0.75	0.88	1.00	1.00	1.00	0.75	0.50	0.75	0.25	9.88
D.R.	0.08	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.08
ANE	0.83	0.54	0.58	0.50	0.58	0.67	0.78	0.83	0.58	0.29	0.50	0.50	0.50	7.70
B'DESH	0.83	0.50	0.75	0.63	0.50	0.50	0.75	0.75	0.50	0.25	0.75	0.75	0.75	8.21
INDONESIA	0.75	0.50	0.50	0.50	0.50	0.75	0.83	0.75	0.50	0.25	0.50	0.50	0.50	7.33
INDIA	0.92	0.63	0.50	0.38	0.75	0.75	0.75	1.00	0.75	0.38	0.25	0.25	0.25	7.55
WCNA	0.78	0.46	0.75	0.67	0.58	0.88	0.94	0.67	0.92	0.67	0.75	0.83	0.17	9.06
MOROCCO	0.92	0.88	1.00	1.00	0.75	1.00	0.83	1.00	1.00	0.63	0.75	1.00	0.00	10.75
GHANA	0.75	0.50	0.25	0.50	0.75	0.88	1.00	1.00	0.75	0.63	0.75	1.00	0.50	9.25
BENIN	0.67	0.00	1.00	0.50	0.25	0.75	1.00	0.00	1.00	0.75	0.75	0.50	0.00	7.17
TOTAL	9.92	4.75	9.00	6.38	8.00	8.63	9.92	9.00	9.75	6.76	7.75	7.25	4.50	101.59
AVERAGE	0.71	0.34	0.64	0.46	0.57	0.62	0.71	0.64	0.70	0.48	0.55	0.52	0.32	7.26

Graph 1

Capacity Building Index by Region/Country

SCORE (indexed to 1 component) vs **Region/Country**

Legend:
- Policy
- Finances
- Venues
- Mats/Equip
- Human Resources
- Curriculum
- Leadership
- Infrastructure
- H.R.D.
- Administration
- Tech Cap
- Track Record
- Com Involv

Categories (x-axis): MAX SCORE, ECSA, ECSACON, Tanzania, Kenya, LAC, Peru, El Salvador, Paraguay, Mexico, D.R., ANE, Bangladesh, Indonesia, India, WCNA, Morocco, Ghana, Benin

USE OF THE *INDEX* TO DOCUMENT PROGRESS

Despite some potential limitations discussed below, the Capacity Building *Index* can be also utilized to assess the progress in building capacities over time. By comparing measures obtained at the start of an intervention with others at later stages or at the end of the in-country project life, stakeholders should be able to assess advancement of the institution(s) in incorporating structures and systems over time, and examine those individual components that may require further strengthening.

The opportunity to further test the ability of the *Index* to track progress over time presented itself through a project evaluation, documentation and dissemination (EDD) initiative. The EDD was a concerted effort between PRIME's Evaluation and Research unit and the Communications unit to bring together the results and impact of the project in a number of countries at the end of the LOP. Through the EDD, outside consultants were hired in each of the four regions of PRIME to interview officials at the host country institutions (public and/or private) assisted by the project, as well as existing cooperating agencies (CAs) and USAID officials. Through applying the instrument in Appendix 1 (adapted to the particular setting), these knowledgeable individuals were asked about their perception of effects and impacts the PRIME project had on the institution in question. Questions about changes in *access, quality* and *integration of RH services* as well as the *style* of intervention by the project were asked to the selected individuals. In addition, consultants applied a revised Capacity Building Questionnaire (See Appendix 2 for an example of a questionnaire applied in El Salvador) that asked about capacity status *at 2 points in time:* at the start and toward the end of interventions. At the time of writing this paper, EDD interviews had been applied in 4 countries (El Salvador, Ghana, Dominican Republic and Tanzania) and were planned 3 other (Morocco, Mexico and India). Here, results on the Capacity Building Index from the El Salvador EDD report are presented (see Table 2 and Graph 2). For a full description of the capacity building process that occurred in the country, as well as the complete application of the methodology and interviews, see PRIME's Technical Report 13 (Catotti, 1999).

Table 2
Capacity Building Index for El Salvador MOH - 1997 and 1999

	INDICATOR	MOH Aggregate		USAID/EL Salvador		W Conn, FHI		Average Score	
		1997	1999	1997	1999	1997	1999	1997	1999
1	Updated FP/RH Guidelines	2	3	2	3	2	3	2.0	3.0
2	Official Training Policy*	2	2	1	1	1.5	1.5	1.5	1.5
3	Positive Public Statements	1	4	1	4	3	3	1.7	3.7
4	Internal Training Budget	2.5	2.5	2	2	2	2	2.2	2.2
5	Adequate Training Venues	4	4	4	4	3	3	3.7	3.7
6	Materials, Equipment & Supplies (MES)	2	3	2	3	1	2.5	1.7	2.8
7	Capability for Updating MES	2	3	2	3	2.5	2.5	2.2	2.8
8	Updated Trainer Knowledge & Skills (TOT)	2	3	1	3	2.5	2.5	1.8	2.8
9	Training Plan Exists	2	3	4	4	2.5	2.5	2.8	3.2
10	Standard Training Curriculum	1.5	4	1	4	2.5	2.5	1.7	3.5
11	QOC Linked to Training Plans	1	4	2	4	4	4	2.3	4.0
12	Training Is Part of Strategic Plan	2	3	1	2	2	2	1.7	2.3
13	Public-Private Collaboration	1.5	2	1	2	2	2	1.5	2.0
14	Decentralized Training Units	3	4	1	4	2	3	2.0	3.7
15	Human Resource Development as Part of PI	1	3	1	3	1	1.5	1.0	2.5
16	Training Needs Assessment	2	4	1	4	1	1.5	1.3	3.2
17	MIS for Training	2	2.5	2	3	1.5	2	1.8	2.5
18	E&R Feeds Training	1	2	1	2	1	2	1.0	2.0
19	Replicate Training Independently#	1	3	1	3	1	4	1.0	3.3
20	Community Involvement	1	2	1	2	1	2	1.0	2.0
								35.8	56.7
								1.8	2.8

Scores are translated from the EDD Questionnaire on a 4 point scale: a=1; b=2; c=3; d=4.

*Because FHI entered a don't know response, the average score for MOH and USAID was used.

#Because FHI and USAID entered a don't know response, the score for MOH was used.

Graph 2

El Salvador Capacity Building

1997-99 Scores for each of the 20 Indicators and Average Score (21) - Logarithmic Scale
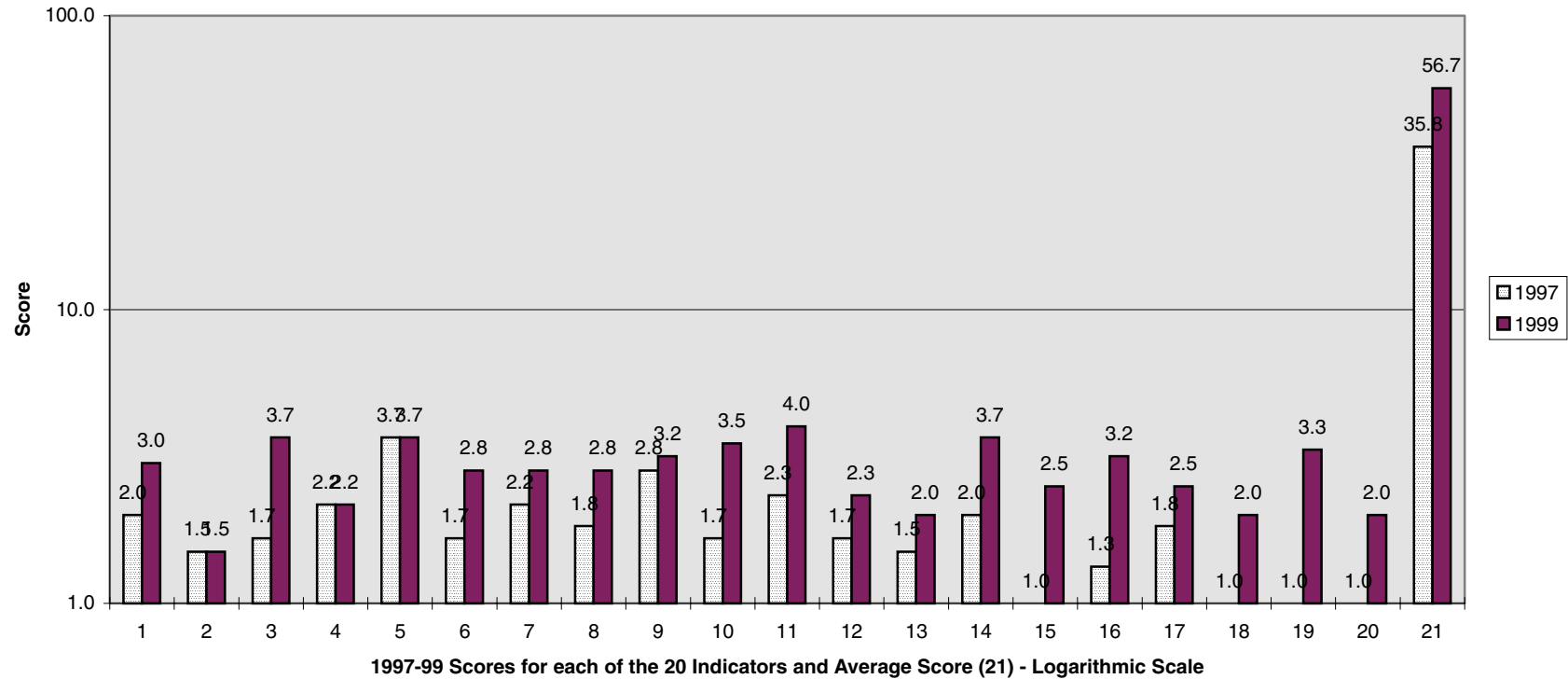
(Source: Catotti, 1999)

The table and graph above describe the evolution and status of capacity achieved by El Salvador Ministry of Health (MOH) during the course of PRIME's intervention up to the interview date (i.e. from Jan '98 to May '99). It can be clearly seen how stakeholders acknowledge a nearly 60% increase (56.7 : 35.8 x 100) in the ability of the MOH to organize and conduct training in FP/RH in the country. However, the table and graph also show the relative growth of each component (the revised index had 20 indicators and the scores range from 1 to 4). For example, in absolute terms the highest capacities are seen in indicators 11 (QOC linked to Training Plans), 14 (Existence of Decentralized Training Units), 5 (Adequate Training Venues) and 3 (Positive Public Statements by Officials) and the lowest in indicators 2 (Existence of an Official Training Policy) and 13 (Evidence of Public-private Collaboration), 18 (Evaluation and Research feeds Training) and 20 (Degree of Community Involvement). Highest *increases* are seen in indicators 19 (Ability to Replicate Training Independently) = 3.3 times), 16 (Customary use of Training Needs Assessments) and 15 (Human Resource Development is part of Performance Improvement of providers) = 2.5 times, and 3 (Positive Public Statements) = 2.2 times. No changes were perceived in indicators 2 (Official Training Policy), 4 (Existence of Internal Training Budget) and 5 (Adequate Training Venues). Such absolute and relative changes will guide managers and policy-makers to concentrate future efforts (e.g. re-assessment of interventions for low increase areas and more input of resources for generally low areas of capacity).

DISCUSSION

The *Index* is a tool in progress. Results so far are encouraging in that the framework and graphical representation allow identification of relative weaknesses and strengths of each component. However, the tool and methodology have a number of caveats and limitations worth discussing:

a) Validity: Indicators come from a theoretical review. However, their validity to gauge the differing stages of capacity building remains to be tested. For example, there may be other areas not considered here (like the actual quality of training). Also, all indicators have been assigned equal weights, which may not be realistic. Multivariate analyses with larger datasets may provide relative weights to assign to each indicator.

b) Subjectivity. Due to the nature of the components, some indicators can be objectively verified while others depend more on assessments by perception. More work is needed to validate these assessments, possibly by triangulation or document review. It also remains to be seen whether comparisons across countries and regions are warranted with this model.

c) Complexity: Though intended as a tool to monitor progress toward capacity building in training institutions, it may still be a complex instrument for program managers. It is hoped that further analyses may find components and indicators that are highly inter-correlated thus making it possible to drop some indicators and arrive at a smaller set of components.

d) Usefulness: In part due to the problems discussed above, it is not certain whether the *Index* can be used as a self-evaluating tool. More objective and easily measured indicators may be needed to develop.

e) Relevance to Performance and Quality of Care: The Index *per se* may be insufficient to ascertain whether a capable and sustainable training institution trains providers that achieve improved performance, including delivering appropriate quality of care to their clients.

The *Index* is only one of the tools to assist program managers in measuring program effectiveness. Further work will be required to make it a simple instrument to be used regularly (e.g. yearly) to measure the progress toward institution capacity building as a basis for sustainable interventions in developing countries.

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Appendices

PRIME

CAPACITY BUILDING IN TRAINING - DIMENSIONS AND INDICATORS

Instructions: Please complete the scoring for all the dimensions and indicators. Do not leave any area without score. The object of evaluation is the INSTITUTION with which the project is working. (e.g. the Training Unit within a Ministry of Health, an NGO, a university). At this stage, please add notes on the margins or at the back if you have comments on specific indicators (e.g. how relevant, clear or applied they are) or if you feel there are other indicators that could be included. Thank you.

COUNTRY:　　　　　　　　**INSTITUTION:**　　　　　　　　**MAJOR FIELD/AREA:**

DIMENSION	OBJECTIVE	INDICATOR	SCORING	SCORE	MEASUREMENT
I - LEGAL-POLICY SUPPORT	National FP/RH service guidelines and training are official	1. Existence of updated official FP/RH service and training guidelines	0=Inexistent guidelines (both service and training), to 4=Complete/updated, disseminated and official guidelines		Document reviews
	Political support for training institutionalization	2. Official (written) policy supporting institutional training capacity (e.g. training units, cadre of master trainers, venues, etc.) for health providers	0=Inexistent written policy, to 4=Written/updated, disseminated and official.		In-depth interviews (key informants)
		3. Favorable public statements on FP/RH training (for the improvement of services) at least twice a year by senior officials	0=no mention, to 4=mentioned on several private and at least twice on public occasions.		Media and documents content analyses

DIMENSION	OBJECTIVE	INDICATOR	SCORING	SCORE	MEASUREMENT

DIMENSION	OBJECTIVE	INDICATOR	SCORING	SCORE	MEASUREMENT
II - RESOURCES	Financial Existence of sufficient and diversified Training Budget	4. ≤20% of training budget comes from external assistance	0=No in-country training budgets; funds are allocated on *ad hoc* basis 4=Existence of in-country budget for training relying no more than 20% on external assistance		
		5. Budget covers all aspects of training (including materials and equipment, travel and per diem by consultants and staff, venue hire and maintenance, etc.)	0=Budget does not cover all aspects of training, to 4=Budget covers all training costs		Institutional documents
	Venues/Equipment Adequate venues	6. Accessible and available (own, rented) venues (at least one local venue in each training area) that are of standard quality (continuous power, good lighting, acoustics and sufficient capacity), accessible to participants and available when needed	0=Inexistence of venue, [incrementally scoring accessibility, capacity and/or quality or venue]. to 4=Fully accessible, high quality and sufficient capacity local venue for training events		Reporting and Observation
	Materials, equipment and supplies (MES) Appropriate and cost-efficient MES (incl. AV equipment & teaching aids)	7. MES are pertinent, updated, sufficient and adapted to local culture (incl. locally produced)	0=MES are insufficient and/or outdated, to 4=MES of standard technical and material quality and readability are available for each event participant		
	Systems are in place for	8. Financial, printing and	0=There are no or		

DIMENSION	OBJECTIVE	INDICATOR	SCORING	SCORE	MEASUREMENT
	replacement and upgrading of MES	planning capabilities exist for replacing and upgrading MES	insufficient means for replacing MES, to 4=The means exist to produce, replace and upgrade MES		Observation-verification
	<u>Human</u> Trainers/preceptors formed have updated and standardized technical and presentation K&S*	9. Trainers/preceptors are constantly formed (TOT) and do periodic refresher courses and pass standard tests on FP/RH technical & presentation K&S	0=Trainers/preceptors not regularly formed and/or do not update their technical & presentation K&S, to 4=Trainers/preceptors constantly formed and undergoing periodic (at least once every two years) refresher courses		
III - TRAINING PLANS & CURRICULUM	Updated and periodically reviewed training plan	10. Training plan exists and is reviewed annually	0=There is no training plan *per se* (training conducted on *ad hoc* basis), to 4=Training plans are drawn periodically (at least annually) and reviewed		Institutional documents and
	Updated curriculum is official standard for training institutions	11. Existence of a standard official training curriculum guiding training institutions	0=There is no standard training curriculum, or is inadequate/outdated, different ones used by different institutions, to 4=There is a standard curriculum, reviewed periodically (at least once every 2 years) and used officially by training institutions		interviews

DIMENSION	OBJECTIVE	INDICATOR	SCORING	SCORE	MEASUREMENT
IV -	<u>Leadership</u>	12. Training plans are	0=Providers' training		

DIMENSION	OBJECTIVE	INDICATOR	SCORING	SCORE	MEASUREMENT
ORGANIZATIONAL	Vision of training as a means to improve services	linked with quality of care and increased service access	plans are not coupled with service and quality of care objectives, to 4=Training plans form part of Quality of Care and service improvement strategies		
	Training is an integral part of organization's strategic planning	13. A training plan and activities are part of the organization's strategic plans	0=Training is not part of the organization's strategic plan, to 4=Training is part of the organization's long-term strategic plan (multiannual)		
	Promotion of public-private collaboration	14. Evidence of public-private collaboration	0=No evidence of public-private collaboration, to 4=Evidence of public-private collaboration		
	Infrastructure Existence of decentralized training units in all areas	15. Active training units exist at central and peripheral levels	0=There are no decentralized training units (even if there is one at central level), to 4=Active training units exist in central and peripheral levels		Institutional documents Cross-referencing
	Human Resource Development HR training (TOT, formative and refresher courses) is an integrated part of a Performance Improvement system (e.g. incentives, follow-up & supervision, efficacy)	16. HR development is part of a PI strategy	0=Training is not coupled with providers' improvement objectives, to 4=Training is part of HR development and performance improvement		Document review & field assessment Personnel inventory and interviews

DIMENSION	OBJECTIVE	INDICATOR	SCORING	SCORE	MEASUREMENT
	Administration • Existence of a reporting system for tracking number and characteristics of trainees and materials, according to needs	17. Existence and use of a Training Needs Assessment (TNA) 18. Existence of an MIS for trainees and materials matching TNA	0=There is no TNA customarily done, to 4=TNA is integral and continuous part of training strategy 0=There is no MIS for tracking progress, to 4=There is an MIS system for training		
	Technical Capability • Technological transfer and development through networking, evaluation & research (E&R)	19. Contacts with other training institutions and institution's E&R feed into training improvement (e.g. trainee selection, training contents and formats)	0=No/little use of E&R or information from other training institutions to improve, update training capabilities, to 4=Extensive use of internal and external data & resources for improvement		Document review and observation
	Track Record • Proven capacity to conduct/replicate courses autonomously	20. Replica/other courses carried out independently (w/institutional resources)	0=No replica or independent courses carried out by the organization (or only done with foreign assistance), to 4=Evidence of ongoing replica/expansion of courses with institutional resources		
V - COMMUNITY	• Community	21. Evidence of	0=No/little community		Document review,

DIMENSION	OBJECTIVE	INDICATOR	SCORING	SCORE	MEASUREMENT
DEVELOPMENT-PARTICIPATION	representatives are involved in planning and execution of training activities, are aware of their rights and/or demand competent provider performance	community involvement in providers' training and/or performance assessment (e.g. quality of care circles)	involvement, to 4=Extensive involvement/participation in provider training and/or performance assessment; organized demand/petitions to improve services, etc.		in-depth interviews with leaders and Focus Groups

TOTAL SCORE _____

* K&S: knowledge and skills
NOTE: Indicators cover all dimensions of capacity building, some of which may lie outside direct influence by the PRIME project

Appendix 2

INTRAH/PRIME
CAPACITY BUILDING IN TRAINING QUESTIONNAIRE

> **Instructions:** *These are the illustrative descriptions for each of the capacity building indicators. Please respond with the letter that describes as close as possible the status of your institution, providing examples and illustrations to your answers as required. Remember, what is needed is an **objective** assessment of where the institution stands on each indicator. <u>There is no "positive" or "negative"</u> answer, just a measure to help explain the present <u>and real</u> status of an institution. Do **NOT** leave any answers blank, as it would not permit completing the entire assessment. Thank you.*

COUNTRY: El Salvador   **INSTITUTION:**

NAME AND POSITION OF THE PERSON COMPLETING THE REPORT:

I - LEGAL-POLICY SUPPORT

- **National FP/RH service guidelines and training are official**

1. Existence of updated official FP/RH service and training guidelines

Whether a) there are no guidelines for service delivery; b) guidelines are in initial/incomplete stage or are outdated; c) guidelines exist but have not been made official or have not been fully disseminated; d)guidelines are complete, updated, official and fully disseminated.

Status in 1997 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

- **Political support for training institutionalization**

2. Official (written) policy supporting institutional training capacity (e.g. training units, cadre of master trainers, venues, etc.) for health providers

Whether a) there is no written policy supporting development of a national training strategy/capacity; b) there is some policy but is timid, not enforced or has not translated into actual support; c) there is a definite policy but it has not been made official or has not been fully disseminated; d)there is a strong, official policy that is put into practice through norms, regulations and implementation plans.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	**Explain:**

3. Favorable public statements on FP/RH training (for the improvement of services) at least twice a year by senior officials

Whether a) there has been no mention by senior officials favoring/supporting FP/RH training (related to the improvement of services); b) there has been an occasional, timid or "wishful" statements only; c) statements have been made by either medium ranking officials or by high level officials but not in public or only occasionally; d) high level officials mentioned their ample support for FP/RH training on several private and at least twice on public occasions.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	**Explain:**

II - RESOURCES

Financial

- **Existence of sufficient and diversified Training Budget**

4. The training budget relies mostly on internal (in-country, institutional) sources

Whether a) Training relies entirely on foreign assistance and/or there is no training budget; b) training relies heavily (at least 50%) on foreign assistance and/or training funds are allocated on ad hoc basis; c) in-country resources/budget account from between 50 and 80% of total training funds; d) in-country budget for training provide more than 80% of the budget. (One other way of looking at it is whether budget covers all aspects of training (including materials and equipment, travel and per diem by consultants and staff, venue hire and maintenance, etc.).

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

Venues/Equipment

- **Adequate venues**

5. Accessible and available (own, rented) venues (at least one local venue in each training area) that are of standard quality (continuous power, good lighting, acoustics and sufficient capacity), accessible to participants and available when needed

Whether a) there are no adequate venues for training of health providers; b) there are few occasional venues and/or often unavailable; c) there are venues of adequate quality but cannot be readily secured for training; d) there are local venues that are fully accessible, of high quality and sufficient capacity for training.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

Materials, equipment and supplies (MES)

- **Appropriate and cost-efficient MES (incl. AV equipment & teaching aids)**

6.   MES are pertinent, updated and adapted to local culture (incl. locally produced)

Whether a) materials, equipment and supplies are outdated and/or not adapted/produced locally.... to d) MES are technically superior, updated/current and are adapted to the local/cultural context.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

7. Financial, printing and planning capabilities exist for replacing and upgrading MES

Whether a) there are insufficient means for making MES available and/or replacing old ones; b)MES are made available, but either insufficient or not of adequate quality; c) MES of standard technical and material quality and readability can be made available for each trainee, although there are occasional shortages; d) Systems are in place locally for continuous replacement and upgrading of quality MES, which are available as and when required.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

Human

- **Trainers/preceptors formed have updated and standardized technical and presentation K&S***

8. Trainers/preceptors are constantly formed (TOT) and do periodic refresher courses and pass standard tests on FP/RH technical & presentation K&S

Whether a) Trainers/preceptors are not regularly formed and/or do not update their technical & presentation K&S... to d) Trainers/preceptors constantly formed and undergoing periodic (at least once every two years) refresher courses.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	**Explain:**

III - TRAINING PLANS & CURRICULUM

- **Updated and periodically reviewed training plans**

9. Training plan exists and is reviewed annually

Whether a) There is no training plan per se (training conducted on ad hoc basis), to... d) Training plans are drawn periodically (at least annually) and reviewed

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	**Explain:**

- **Updated curriculum is official standard for training institutions**

11. Existence of a standard official training curriculum guiding training institutions

Whether a) There is no standard training curriculum, or is inadequate/outdated, different ones used by different institutions, b) there are some updated curricula, but not standardized or officially endorsed, c) A standardized curriculum is in place, but either not reviewed periodically or is not officially used by training institutions, to d) There is a standard curriculum, reviewed periodically (at least once every 2 years) and used officially by training institutions

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	**Explain:**

IV - ORGANIZATIONAL

Leadership

- **Vision of training as a means to improve services**

11. Training plans are linked with quality of care and increased service access

Whether a) Providers' training plans are ad hoc-not coupled with service and quality of care objectives, to... d) Training plans form part of Quality of Care and service improvement strategies.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

- **Training is an integral part of organization's strategic planning**

12. A training plan and activities are part of the organization's strategic plans

Whether a) Training is not part of the organization's strategic plan (or the training institution has a strategic plan), to ...d) Training is part of the organization's long-term strategic plan (not yearly but multiannual)

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

- **Promotion of public-private collaboration**
13. Evidence of public-private collaboration

Whether a) There is no (or no evidence) of public-private collaboration in training, b) there is some public-private collaboration, but is haphazard and loosely coordinated within the training institutions, c) public-private collaboration exist at different levels, however efforts are still disintegrated or not guided by joint planning/programming , d) there is ample public-private collaboration, guided by extensive planning/programming.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

Infrastructure
- Existence of decentralized training units in all areas

14. Active training units exist at central and peripheral levels

*Whether a) There are no decentralized training units (even if there is one at central level, b) there are a **few** training units at peripheral levels but are administratively/financially weak (incl. documentation center and computerized equipment), c) **several** decentralized training units exist but are administratively/financially weak, d) Active and strong training units exist in central and peripheral levels.*

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	Explain:

Human Resource Development

- **Training (TOT, formative and refresher courses) is an integrated part of a Human Resource Development/Performance Improvement system (e.g. promotion and incentives, follow-up & supervision, efficacy)**

15. HR development is part of a HRD/PI strategy

Whether a) Training is not coupled with HRD or providers' improvement objectives, ...to d) Training is part of HR development and performance improvement system

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	**Explain:**

Administration

- Existence of a reporting system for tracking number and characteristics of trainees and materials, according to needs

16. Existence and use of a Training Needs Assessment (TNA)

Whether a) There training is not based on some form of TNA, b) TNA is seldom done, or on a casual basis or results are not fed into the training plans, c)TNA is a regular practice in the institution, however their results are not fully exploited, d)TNA is customarily done to tailor training strategies and improve performance.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	**Explain:**

17. Existence of a Management Information System (MIS) for training that includes information on trainees and materials

Whether a) There is no MIS for tracking training progress, b)there are some data on courses, trainees, materials, etc. but not integrated in a system, c)there is initial integration of data into an information system that helps evaluate progress and assists planning, to d) There is a fully automated and effective MIS for training.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	**Explain:**

Technical Capability
- **Technological transfer and development through networking, evaluation & research (E&R)**

18. Contacts with other training institutions and institution's E&R feed into training improvement (e.g. trainee selection, training contents and formats)

Whether a)there is no/little use of E&R or information from other national/international training institutions to improve and update training capabilities... to d) Extensive use is made of internal and external data & resources for quality assurance and technical improvement of the institution.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	**Explain:**

Track Record
- Proven capacity to conduct/replicate courses autonomously

19. Replica/other courses carried out independently (w/institutional resources)

Whether a)There have been no replica or independent courses carried out by the organization (or only done with foreign assistance)... to d) There is ample evidence of ongoing replica/expansion of courses to wider areas and with institutional resources.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	**Explain:**

V - COMMUNITY DEVELOPMENT-PARTICIPATION

- **Community representatives are involved in planning and execution of training activities, are aware of their rights and/or demand competent provider performance**

20. Evidence of community involvement in providers' training and/or performance assessment (e.g. quality of care circles)

Whether a)There is no/little community involvement contributing to curricula contents, drawing of training plans, or provider performance b)community representatives are included in training needs assessments and/or are aware of their rights in relation to CPI; c)Initial community involvement in shaping provider training and service needs, to d) Extensive involvement/participation in provider training and/or performance assessment; organized demand/petitions to improve services, etc.

Status in 1997 (a-d):	Status in 1999 (a-d):
Explain:	**Explain:**