AFRICAN COLLABORATIVE FOR HEALTH FINANCING SOLUTIONS

Insights from the **ACS Capacity Building Approach on How to Strengthen Stakeholders' Abilities to Adapt and Apply Tools & Methodologies to a Country Context**

October 2021

Table of Contents

List of Tables

Lists of Figures

List of Acronyms

ACS	African Collaborative for Health Financing Solutions
AIDS	Acquired Immune Deficiency Syndrome
CB	Capacity Building
CERRHUD	Centre de Recherche en Reproduction Humaine et en Démographie
COVID-19	Coronavirus disease
DHMT	District Health Management Team
GoB	Government of Botswana
FM	Financial Manager
HIV	Human Immunodeficiency Virus
HR	Human Resource
HRT	Harmonised Resource Tracking
MoH	Ministry of Health
MoHSS	Ministry of Health and Social Services
MoHW	Ministry of Health and Wellness
NAHPA	National Aids and Health Promotion Agency
NASA	National AIDS Spending Assessment
PFM	Public Financial Management
RT	Resource Tracking
SHA	System of Health Accounts
SSA	Sub-Saharan Africa
ToTs	Training of Trainers
TNA	Training Needs Assessment
TWG	Technical Working Group
UHC	Universal Heath Coverage
UNAIDS	Joint United Nations Programme on HIV and AIDS
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

Capacity Building is a type of change process that is described as increasing the ability of individuals, organisations, or societies to achieve the goals set by providing the stakeholders with the knowledge to define problems and formulate solutions over time. It is a complex, multi-layered process through which individuals, organisations, and societies mobilise their own capabilities for driving structural changes and managing their own sustainable development processes. It is worthy to note that strengthening stakeholders' capacity to adapt and apply tools/methodologies to country context is not as straightforward as it sounds, and constructive discussions and action on learning about capacity building are held back by the lack of a shared and comprehensive understanding. This report seeks to contribute to filing this gap by examining five capacity building approaches used by the ACS project: coaching, mentoring, training, knowledge sharing and knowledge exchange and presenting lessons learned from this experience on how to strengthen UHC stakeholders' abilities to adapt and apply tools/methodologies to a country context. This report will provide a framework for understanding the individual and organizational level of capacity building, and finally pull learnings on what has/hasn't worked in ACS to inform future capacity building strategies.

A cross-sectional study design that employed both qualitative and quantitative research methods was adopted to analyse the insights from the five capacity building activities. This study sought to answer the research question: *What are the insights from the ACS capacity building approaches on how to strengthen stakeholders' abilities to adapt and apply tools/methodologies to a country context?*

The following are the insights and lessons learned distilled from the collected information.

Training

- Training as an approach can increase participants' beliefs (or confidence) in their capability to adapt and apply knowledge.
- Effective metrics for assessing individual and organisational improvement in capacity is needed to determine progress in knowledge adaptation and application.
- Building capacity to effectively adapt and apply tools/methodologies within a system requires a critical mass of local technical experts who can contribute expertise and generate evidence through a specific process. It is also crucial that such capacity is aligned to health system priorities.
- Capacity building requires sustained commitment, interest, and organisational support for those who incorporate knowledge as acquired into their daily practices.
- Linking capacity-building content to participants' professional or work-based tasks is directly associated with increased confidence in knowledge adaptation and application.
- Training efforts have better results when there is flexibility and time to internalise the concepts.

Knowledge Exchange

- Openness towards collaboration across organisations can have a major impact on the success of knowledge application.
- Knowledge exchange requires creating settings conducive to interactions or relationship-building, which can augment knowledge adaptation through social learning.

Knowledge Sharing

- Knowledge sharing is enabled by networks with peer learning e.g., from one government agency to another government agency.
- Knowledge sharing efforts are often effective when facilitated by local knowledge brokers with sufficient understanding of political agendas and priorities.
- Availability of financial, human and physical resources to carry out the capacitation strategy is crucial for sustainability of knowledge adaptation and application.

Coaching and Mentoring

- Coaching and mentoring should not be a one-off but a continuous process happening over a period of time supporting confidence building among stakeholders in their ability to adapt knowledge.
- Coaching and mentoring plays a facilitative role in contextualising evidence to the specific practice issues participants were facing.
- Similar to the training approach, coaching and mentoring requires individual and organisational support.

This finding draws four key enabling factors in strengthening stakeholders' abilities to adapt and apply knowledge to a country context (a) committed relationships among key stakeholders and an enabling environment to foster such interactions, (b) access to evidence and technical assistance (c) in-country demand for capacity building, and (d) ample financial resources to carry out the capacitation strategy.

Finally, capacity building involves more than just increasing the skills and competencies of individuals within an organization: a conducive policy environment as well as informal practices, beliefs, values, and attitudes must be understood to inform capacity building efforts. Of course, building knowledge, skills, and attitudes can have a positive effect on an individual or organization but to achieve and sustain change those individuals need an enabling environment and the proper mix of incentives and opportunities in which to apply the acquired knowledge and skills.

Definitions of Capacity Building Approaches

1. Training

In the context of ACS, training is defined as a transfer of knowledge from an entity to another for the purpose of capacitating the receiving entity to undertake activities that advance a given country/region's march towards universal health coverage (UHC). The ACS project conducts two types of training:

a) One-off intensive training course: A structured event held in the workplace or another venue. Often following a training needs assessment, it is designed around several learning objectives. Each session has predefined objectives and content materials, with a detailed session plan to guide the trainer.

b) Modular training course: Based on an action-reflection cycle1, this is a series (mostly interlinked or related topics) of structured events held over a pre-defined period. Participants often are asked to do an exercise on the topic of each module between each time they meet or put the content of the module into practice in their workplace.

2. Coaching and mentoring

Coaching and mentoring occur when a "country stakeholder" works with national and regional experts related to their actual responsibility related to UHC. The coaching and mentoring approach is anchored in the project's core tenets and stakeholder-led approach. More specifically, each of the terms is defined as follows:

a) Mentoring: Mentoring involves continuous passing on tips from experience, attitudes, knowledge, contacts, etc. from more experienced individuals to less experienced ones. The 'mentor' is a recognized expert in the specific field and is bringing that expertise and experience to the process or challenges that the "mentee" is facing. As such, the mentee normally sets the agenda, timing, etc. Mentors intervene at critical moments, turning points to provide strategic direction, guidance based on his/her expertise and knowledge both specific to that country and/or similar environments.

b) Coaching: It is an approach in which a coach engages with the country stakeholders consistently over a defined period of time for a specific technical task. The coach needs to have appropriate technical knowledge and skills, and experience relevant to the country. A primary feature of the coaching approach is related to "who" provides the support. This approach is carried out by a coaching team, often a mixture of country and regional experts supporting the country partners, who may bring in global experts and other technical resources as needed. The second feature of the approach is related to "how" the support is provided. The coach does not do the work directly, but rather stands side-by-side with country partners and provides support, advice, and contextualized evidence along the way. This approach recognizes that countries have their own processes in place to make decisions, implement policies, and carry out all of their other day-to-day functions. A key feature is thus not creating parallel processes, structures, or institutions, and avoiding cut-and-paste solutions, models, and rigid advice.

3. Knowledge exchange

It is an approach that consists of increasing participants' knowledge through social interactions with peer members of a network. It draws on compiling available evidence and knowledge gained through implementation and contextualization into usable knowledge formats that are disseminated within and beyond the project to inform decision-making processes relative to UHC. The following are the different types of knowledge exchange initiatives undertaken by the ACS project:

a. Exposure or exchange visit: A pre-arranged visit aiming to learn about a specific experience, or gain exposure to the ways of working of another organization, institution, team, etc.

b. Peer support groups and peer assists: In general, peer support groups can be time-bound, 'virtual' gatherings of people working in similar areas who are open to supporting each other. Peer assists is when an individual with something to move forward brings together others with experience in that area to help him/her think about alternatives.

---

1 Action -reflection cycle is an iterative learning process whereby learners continuously improve their thinking and act intentionally and responsibly, moving over time towards long-term goals that contribute to collective well-being. The cycle has four repeatable elements: Plan what to do, Do the work, reflect on and learn from the work experience, evaluate results.

4. Knowledge sharing

Knowledge sharing is the provision of information and materials related to a specific ask or theme, or the indication of where to gain access to such materials and information i.e., a UHC resource center. This is often a starting point for the adaptation of existing knowledge to a specific context or problem.

1 Introduction

1.1 Background

African Collaborative for Health Financing Solutions (ACS) is a 5-year (2017-2022) USAID-funded project that provides support to regional and country stakeholders in sub-Saharan Africa (SSA) to better navigate their paths to universal health coverage (UHC). Capacity building or capacity development/strengthening is a key 'tenet' under the ACS project's theory of change. It is a complex, multi-layered process through which individuals, organisations, and societies mobilise their own capabilities for driving structural changes and managing their own sustainable development processes. ACS recognizes that for health systems interventions to be sustainable, building individual and organisation capacity is essential. It is also worth noting that strengthening UHC stakeholders' abilities to adapt and apply tools/methodologies to their country context is not as straightforward as it may sound. It involves having the ability to mobilize (a) sufficient numbers of stakeholders who possess the necessary knowledge and skills, (b) appropriate and adequate technical and management systems, (c) suitable physical infrastructure, and (d) ample financial resources to carry out the capacitation strategy2. It follows therefore, that there is no single approach to capacity building but rather a spectrum of support activities targeted to the different objectives, roles and skill sets of those involved in the process.

1.2 Overview of ACS capacity building activities

Prior to diving into the specifics of how ACS builds capacity in the countries where the project provides support, it is useful to first paint a picture of the project's capacity building intervention areas. To conduct a thorough analysis of the project's support activities and implementation strategies, the workplans of all countries where ACS operates were used to generate a list of all the different types of interventions implemented at the country level For harmonization purposes, those activities were grouped into seven strata3. It is important to note that, with its anti-fly-in fly-out principles, ACS supports countries by providing technical assistance tailored to countries' needs under the following capacity building formats: coaching, mentoring, knowledge exchange, knowledge sharing, and training with the goal of maximizing countries' abilities to autonomously reach their UHC objectives. As such, the different capacity building approaches were cross-tabulated with the aforementioned activity strata. The cross-tabulation yielded summary statistics that allowed for the identification of the most recurrent types of support ACS provides as well as the most recurrent type of capacity building approach.

As shown in Figure 1 below, a sample of 40 workplan activities in Benin, Namibia, Botswana, and Uganda were analysed. Of those 40 stratified activities, more than 60 percent of them were spread across interventions around technical work relative to the optimization of country health financing approaches and tools (33%), development and wide circulation of UHC-related activities' plans (18%), and creation and dissemination of knowledge products for institutionalization/sustainability of interventions (13%). Further, these statistics demonstrate that the vast majority of ACS activities facilitated country stakeholders in navigating their UHC process while providing them with technical assistance to catalyse progress toward UHC. It is important to note that ACS conducted other types of support activities to advance UHC such as strengthening UHC dialogue platforms, assessments for adaptive learning, and capacitation on key UHC areas beyond health financing.

---

2 Wing, K. T. (2004). Assessing the effectiveness of capacity-building initiatives: Seven issues for the field. Non-profit and Voluntary Sector Quarterly, 33(1): 153-160.

3 1) Creation/reinvigoration of multisectoral platform, 2) Stakeholder engagement (validation and priority setting), 3) Priority identification relative to the optimization of country health financing approaches and tools, 4) Technical work relative to the optimization of country health financing approaches and tools, 5) Creation and dissemination of knowledge products for institutionalization/sustainability of interventions, 6) Development and vulgarization of UHC plans, 7) Evaluations/Assessments for UHC, 8) Stakeholder capacitation on key UHC areas.

Figure 1. Stratification of ACS activities per intervention strategies.

Stratification of ACS activities per intervention strategies
N = 40

Strategy	Count
Stakeholder capacitation on key UHC areas	3
Evaluations/Assessments for UHC	3
Development and vulgarization of plans (UHC and UHC components such as communication)	7
Creation and dissemination of knowledge products for institutionalization/sustainability of interventions	5
Technical work relative to the optimization of country health financing approaches and tools	13
Priority identification relative to the optimization of country health financing approaches and tools	2
Stakeholder engagement (validation and priority setting)	3
Creation/reinvigoration of multisectorial platform	4

Figure 2. Distribution of capacity building approaches per activity

Mentoring 28%
Knowledge Sharing 13%
Training 7%
Knowledge Exchange 7%
Coaching 45%
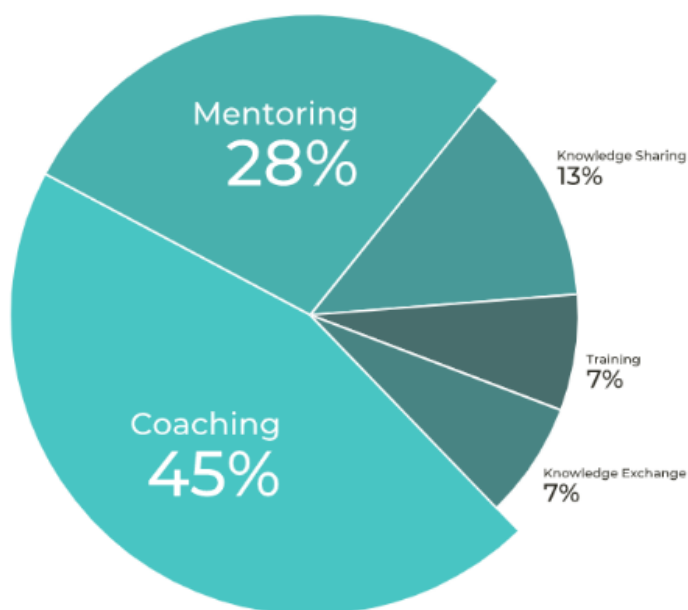
As ACS projects activities are organized around five capacity building approaches, Figure 2 shows the frequency with which each was used across different types of activities. Of the 40 stratified activities, 73 percent of them were implemented using a coaching and/or mentoring capacity building approach.

To reach objectives, ACS often used a hybrid strategy combining multiple approaches. While 35 percent of the stratified activities had only one approaches the other 65 percent combined between two and five implementation approaches. Namibia and Botswana are the countries that have activities that combine the highest number of capacity building approaches.

Figure 3. Number of capacity building approaches per activity and per country

Number of interventions approaches per activity and per country
N = 40

	1 intervention (N = 14)				2 interventions (N = 15)				3 interventions (N = 5)				4 interventions (N = 5)				5 interventions (N = 1)			
	Benin	Botswana	Namibia	Uganda	Benin	Botswana	Namibia	Uganda	Benin	Botswana	Namibia	Uganda	Benin	Botswana	Namibia	Uganda	Benin	Botswana	Namibia	Uganda
	5	4	3	2	3	5	5	2	1	1	3	0	0	4	1	0	0	1	0	0
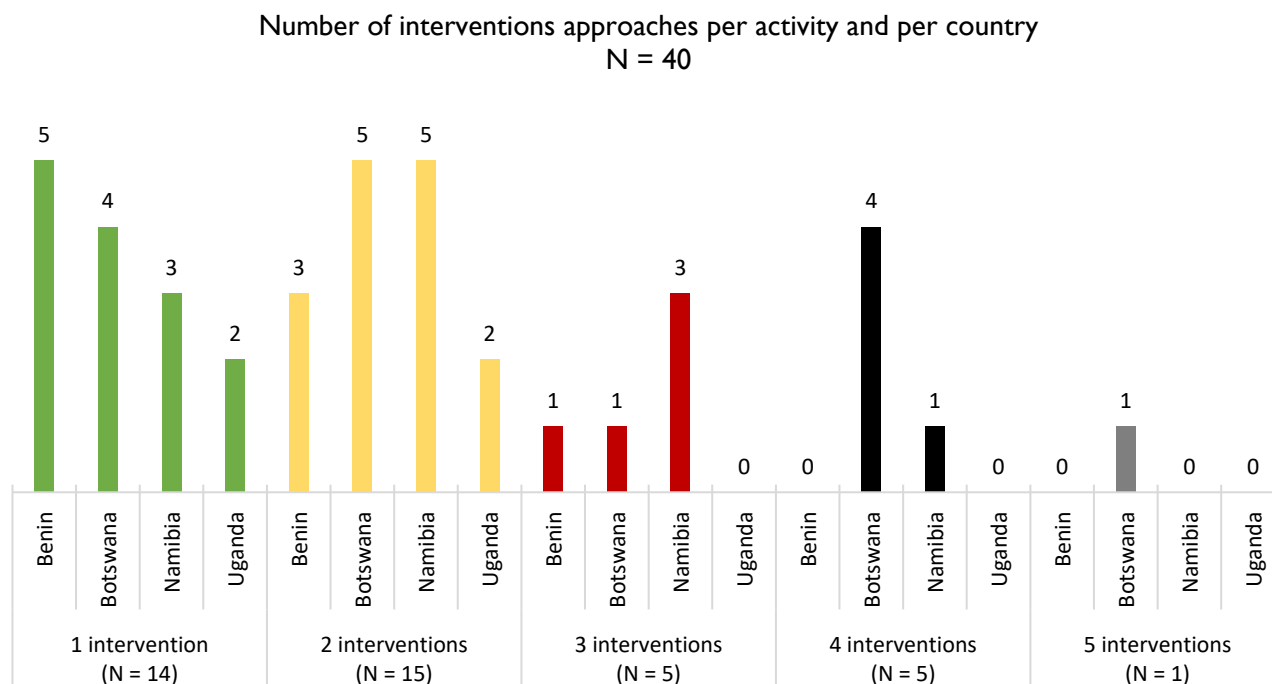
1.3 Purpose of the study

Strengthening stakeholders' capacity to adapt and apply knowledge is not as straightforward as it sounds, and constructive discussions and action on learning about capacity building are held back by the lack of a shared and comprehensive understanding. This report seeks to contribute to filling this gap by examining five capacity building approaches namely coaching, mentoring, training, knowledge sharing and knowledge exchange and presenting lessons learned based on ACS's experience on how to strengthen UHC stakeholders' abilities to adapt and apply knowledge. This report will provide a framework for understanding the individual and organizational level of capacity building, and finally pull learnings on what has/hasn't worked in ACS to inform future capacity building strategies.

2 Methodology
2.1 Study design

To respond to the purpose of the study, the following research question was posed: "*What are the insights from the ACS capacity building approaches on how to strengthen stakeholders' abilities to adapt and apply tools and methodologies to a country context?*" As such, a cross-sectional study design that employed a mixed research methodology was used to map and analyse insights from the literature and ACS's experiences. For the primary data collection, due to the COVID-19 safety measures and travel restrictions, all information was collected virtually and electronically through mail from providers and recipients of the capacity building approaches.

2.2 Sample selection for the study

It was not feasible to have a fully representative sample of all the activities given time and resource constraints. The selection of both the ACS activities to be assessed and the key informants was done through a purposive-sampling strategy. A total of nine activities were sampled. The participants were selected based on their active involvement in planning, executing and overseeing the implementation of the mapped capacity building interventions. A total of 12 respondents were interviewed.

2.3 Data collection

2.3.1 Rapid Literature Review

A rapid literature review was conducted to examine the existing relevant regional, and local ACS's documentation, manuals, and data to understand the components and processes around capacity building approaches. A desk review was also performed to map the capacity building activities that took place in the ACS supported countries.

2.3.3 Key Informant Interviews

In addition to the literature review, semi-structured interviews were conducted with 12 key informants to get their perspectives on what worked well or did not regarding ACS's capacity building approach. It is important to note that the data collection tools for key informant interviews were piloted to test the effectiveness of the process and the comprehensiveness and user-friendliness of the tool. The pilot test provided the opportunity to review the validity, reliability, appropriateness, sufficiency, and relevance of the interview questions, as well as the logical flow. The pilot also allowed an estimation of the time it would take to carry out the interviews, the clarity of information provided to set up the context of the study, and the wording of the questions. Problems and potential errors observed during the pilot were addressed and resolved by the study team prior to full-scale data collection.

2.4 Data analysis

Primary data responses from KIIs were structured according to the evaluation questions and a thematic analysis was done manually to capture emerging themes. Secondary data gathered through literature review were also arranged thematically and analysed for recurring trends and patterns. In addition, secondary data were drawn into the narrative and triangulated with the primary data findings to gain deeper insight into dominant messages and themes. Insights were drawn out into a word narrative and a concise report was prepared, validated by and disseminated to the key respondents.

3 Findings

Insights and lessons learned

In this section we discuss how the applied capacity building approaches in the mapped nine ACS activities may have resulted in strengthening the recipients' abilities to adapt and apply knowledge to their country context, and the contextual and intervention factors that helped or hindered program success. Lessons and insights were distilled. Table 2 summarises the capacity building activities reviewed for the study. Note that most of the activities focused on building capacity at individual and at organisational level, based on ACS's principles and experience.

Table 1: Capacity building approaches, level of organisational support, and tools/methodologies for adaptation and application per intervention areas

Nº	Intervention	Capacity Building Approach	Support Level	Focus	Target end user
1.	Public Financial management training in Botswana.	Training	Individual and organization level	PFM modules adaptation and application	Regional Health Management Teams
2.	System of Health Accounts (SHA) / National AIDS Spending Assessment (NASA) harmonized data collection training in Botswana.	Training, Knowledge Exchange, Knowledge Sharing, Mentoring	Individual and organization level	Harmonized methodology application and SHA/NASA data collection tools	RT-TWG, MoHW, National AIDS and Health Promotion Agency (NAHPA)
3.	Training on costing concept and methodologies including GOALS in Botswana.	Training	Individual and organization level	GOAL model adaptation and application	RT-TWG, MoHW, NAPHA
4.	Harmonization of SHA/NASA Methodologies in Namibia	Training, Coaching and Mentoring	Individual and organization level	Harmonized methodology application and SHA/NASA data collection tools	MoHSS, RT -TWG
5.	Country stakeholders training on policy dialogue facilitation modules/ Creation of the Consultative Committee in Benin	Training/ Knowledge Sharing	Individual and organization level	Process facilitation modules adaptation and application	AM-ARCH Consultative committee
6.	Provision of knowledge translation support to the policy dialogue platforms' discussions	Training, Coaching and Mentoring, Knowledge Sharing	Individual and organization level	Evidence integration into decision-making	AM-ARCH Consultative committee
7.	Learning exchange on accountability between Benin, Burkina, and Togo	Knowledge Exchange	Individual and organization level	Exchange sessions on priority themes related to health system governance for UHC	Country stakeholders/UHC dialogue platforms in Benin, Burkina, and Togo
8.	Development of UHC hubs to support countries policy dialogues	Training, Knowledge Sharing, coaching and mentoring	Individual and organization level	Development of UHC resource hubs	AMREF, CERRHUD, RAME, RESADE, ACHAP, WHO/AFRO, CABRI
9.	Creation and validation of the Package for HIV/AIDS Epidemic Control (PHSEC)	Knowledge Sharing	Individual and organization level	Development of HIV/AIDS Benefit package	MoHSS

3.1 Insights and lessons learned from the training approach

Training increases participants' beliefs (or confidence) in their capability to adapt and apply knowledge.
Training interventions conducted by ACS provided evidence from self-assessments to suggest that the approach had improved the related skills and knowledge, which can be understood through the mechanism of 'self-efficacy'. Self-efficacy refers to improving participants' beliefs (or confidence) in their capability to perform a certain task or handle a particular situation. Evidence (mainly from pre-and post-course surveys) showed that participants felt that their resource tracking skills had improved. In Namibia, ACS worked hand-in-hand with Ministry of Health and Social services (MoHSS) stakeholders to harmonize both HIV/AIDS and broader health expenditure tracking (HRT) methodologies and trained resource tracking staff on the combined methodology to ensure the sustainability of the intervention. The objective of the training was to build capacity among Namibian health officials on how to optimize health financing by tracking the flow of resources effectively and efficiently within its health system, both for specific disease areas but also in a comprehensive manner. After the training, there was on improvement in pre-post test scores by 56 percent (27.5 percent for pre and 83.5 percent for post)4, demonstrating an increase in participants' capability in the use of the combined tools. A similar training in Botswana showed an improvement in pre-post test scores by 50 percent demonstrating an increase in participants capability to use the harmonised tools. One respondent noted that, "*After having attended a series of training workshops recipients demonstrated improvement in the understanding of concepts. This was shown through their ability to articulate concepts, their ability to take over the leadership of activities that the training focused on, as well as improvement in their pre-post-test ratings/marks over time*". These illustrations demonstrate the impact of the training approach in building stakeholders' confidence and attitudes in knowledge adaptation.

Effective metrics for assessing individual and organisational improvement in capacity are needed to determine progress in knowledge adaptation. The finding indicates that access, appraisal and use of knowledge provide more objective evidence to measure an individual and organisational increase in skills and knowledge than using pre-post-test ratings/marks. In both Namibia and Botswana, as much as pre-post surveys were used to measure improvements in skills through scores results, they may not necessarily have been the most reliable measure, as individuals may have overestimated improvements in capacity (known as 'self-esteem bias'). Hence, in an effort to build capacity on institutionalization of resource tracking (RT), the training approach was combined with coaching and mentoring to ensure that stakeholders within the resource tracking technical working group (RT-TWG) had a solid understanding of the combined methodologies and were able to conduct RT exercises themselves using the newly harmonized tools. This effort led to the publication of a brief sharing the project's learnings on combining methodologies and a guidance manual that outlines step-by-step the process for RT in the Namibian context. A trained multidisciplinary technical team made up of staff from ministerial directorates such as the policy and planning, special programs, tertiary health care and clinical support services, finance and procurement, and primary health care services then used these materials (harmonised guide and brief) to conduct RT for the financial year 2017/18, providing a more objective measure of individual and organisational increase in skills as compared to just test scores. Ensuring that capacity is built through planned capacity-building activities also requires thinking carefully about how to effectively measure the desired improvement in skills and knowledge.

Building capacity to effectively adapt and apply tools/methodologies within a system requires a critical mass of local technical experts who can contribute to expertise and generate evidence. In Botswana, the lack of technical capacity at the Ministry of Health and Wellness (MoHW) had hindered the implementation of rigorous health expenditure tracking led by national experts. The recent expenditure tracking exercises were led rather by international health financing experts. Unfortunately, the over-reliance on external consultants consequently crowded out the development of domestic expenditure tracking capacity, which is vital for its institutionalization. Secondly, Botswana was conducting parallel methodologies for health expenditure tracking. As such, the dual expenditure tracking methodologies were draining the health system's resources, duplicating the efforts needed to acquire data, and overburdening the involved stakeholders. As a result, the MoHW decided request ACS' support to harmonize the country's resource tracking methodologies. To assist the Government of Botswana (GoB) plan and implement a harmonization process for health expenditure tracking, ACS built the technical capacity of MoHW through training and mentoring the RT-TWG members on the harmonized tools

---

to transfer all the technical competencies they need to carry out the future RT exercises by themselves. This led to a more efficient, sustainable data collection process. Currently, there is an established team by MoHW of nine local staff dedicated to conducting the exercise and the GoB also has allocated a national budget for the exercise.

Organizational-level capacity building efforts have much greater impact if their design and implementation plan align to health system priorities. It is important to tailor capacity building support for health system priorities or policy decisions to their contexts to increase confidence and attitudes towards knowledge adaptation. In Botswana, ACS supported the GoB to establish a public financial management (PFM) training team comprising of MoHW senior officials, National Aids and Health Promotion Agency (NAHPA), ACS country staff, and a local consultant. This approach exemplified how tailoring the training course outline to policy decision-making contexts can increase post-course ratings of self-reported practice, knowledge, confidence, and attitudes[5]. Prior to training, the team conducted a training needs assessment (TNA) to assess specific PFM training needs at the national as well as the regional level of government. This step was crucial to align the development of PFM training modules with the government policy directions on PFM. The team then delivered three training of trainers (ToTs) workshops to a total of 46 participants (budget owners and managers from 18 Regional Health Teams). The training was intended to build the financial management capacity of national and district level budget holders within the system including District Health Management Teams (DHMTs) with a focus on value for money and results-based management. One respondent noted that, *"the PFM training was successful due in part to a locally recognized institutional PFM needs with the MoHW for capacity building."* It was also important to align the training outline with the national priorities with regard to meeting the HIV/AIDS global target of Ending AIDS by 2030, including the achievement of the UNAIDS 95-95-95 targets. The importance of aligning the capacity building approach with health system priorities was also emphasised in the development of the basic package of HIV/AIDS services in Botswana where one respondent noted that*, " It was important to coordinate and align similar ongoing work in country, for example the development and costing exercise of the basic package of HIV/AIDS services happened when government was costing the national operational plan for HIV/AIDS, so they made sure those aligned."* Another respondent in Botswana noted in relation to resource tracking, *"We undertook this exercise when the country leadership was expected to develop their own HIV/AIDs transition plan, so there was a large buy-in as the country needed to know how to reach epidermic control post-donor support."*

Linking capacity building content to participants' professional or work-based tasks is directly associated with increased confidence in knowledge adaptation and application. The combination of workshop-based training and on-site practical tasks was linked to self-reported skills and confidence increases as participants felt the content was directly applicable to their work. One notable example of this insight comes from Botswana's experience in PFM training; participants applied their new skills in developing and facilitating a nationwide PFM training plan to staff at the regional level after the training of trainers. As one respondent said, "*The training help increased participant's familiarization with financial policy and structural guidance as appropriate, and increased skill levels through practical exercises."* On average, the magnitude of change between the pre- and post-tests after these trainings was found to be a 9 percent[6] improvement, demonstrating an increase in participants confidence in use of PFM tools. Another respondent noted in regards to RT in Botswana, "*Some of the procedures and learning systems put in place to ensure that the recipient's benefit continues after-training support was to subject recipients to the 'learning by doing' process where they had to apply the skills acquired during the workshop trainings to do the actual work i.e. their involvement in technical discussions on related concepts that were trained on, training the research assistants on the SHA/NASA harmonization tools, supervising the research assistants during data collection process as well as doing the actual data collection*". This illustration signifies that participants' confidence and motivation in adapting and applying knowledge can be increased through the use of practical and work-based related tasks, and also through linking content directly to participants' professional roles.

Capacity building requires sustained commitment, interest and organisational supports. High level technical support is crucial for knowledge adaption. A number of contextual factors were identified to affect country stakeholder ability to adapt and apply knowledge. For instance, several respondents stressed the

---

[5] Pettman, T.L. et al., 2013. Cochrane update: building capacity in evidence-informed decision-making to improve public health. Journal of public health (Oxford, England), 35(4), pp.624–7.
[6] PFM post training report

importance of participants working in supportive organisations – particularly in terms of managers being aware of and supportive of their participation, or being willing to adjust workloads to enable participants to fully engage with course activities. In Botswana for instance, this was seen as one of the factors enabling participants to achieve training outcomes in the process of harmonising SHA/NASA data collection tools, as other work commitments constituted a major obstacle to consistent participation in all sessions. Participants had to balance attending trainings with routine work assignments, partly due to a shortage of public health professionals in regional offices.

Similarly, part of the reason for the high attendance of PFM training (92 percent response level) was the involvement of senior officials from the MoHW. One respondent noted, "*The success of the training was due to the involvement of the MoHW's Training and Development Unit who were part of the participants working to cascade and institutionalize the PFM training program to the regional level. They participated in the design of the program and content development.*" However, whereas ACS was targeting finance managers (FM) as participants, the relevant government departments were only able to dispatch some of their human resource (HR) personal who only occasionally perform financial tasks. Some FMs were unable to join the training due to the current country context: in addition to efforts to contain the COVID-19 pandemic, Botswana was also carrying out vaccination campaigns for both measles and rubella. As such, the FMs were needed at their posts to perform their procurement duties. Thus the magnitude of changes between the pre and post-tests (9 percent improvement) are at least partially explained by the fact that the participants sent by the MoHW lacked some of the basic knowledge that would have enabled them to fully absorb all of the concepts in the training modules. An important predictor of success is thus the level of engagement by the participants' organisations identifying key frontline staff who will have direct impact on the knowledge adaptation. This assessment emphasises that while gaining this buy-in may take time; drop-out rates of trainees are reduced when their home institutions make active commitments to support them in the training.

Capacity building efforts have better results when there is flexibility and adequate time. Flexibility needs to be integrated into activities in order to allow room for learning and adjusting to changing circumstances. In determining the estimated cost of reaching HIV/AIDS epidemic control in Botswana, ACS trained recipients to understand the approaches to costing and specifically application of the GOALS model. After the training 50 percent of targeted GoB officials demonstrated skills in costing measured through pre-post assessments with a 33 percentage points increase. These knowledge and skills were successfully applied to the costing of the basic HIV/AIDS benefits service package. After training the team were provided with the following tools to be used post training: Slide deck on GOALS Costing Methodology, GOALS costing software and manual, costing excel file which they can continue to use. There were also several follow-up sessions to mentor those who had been trained. The costing team of experts did much of the work to produce the costing report, which helped to finalise and deliver it to the GoB. One respondent noted that "*It would be important to encourage and help all participants to set up and maintain their own costing files rather than only inputting into the experts' costing file. However, this would have taken more time that they did not appear to have*". Similarly in the RT harmonisation process participants in general felt that the training workshop went well, however additional time for practice on using harmonized tools was needed as only 36 percent of participants had previous experience with expenditure tracking process. As one respondent noted "*Training on a new concept requires a series of training sessions or a longer training period (more than one week) and should not be a once-off event.*"

3.2 Insights and lessons learned from the knowledge exchange approach

Openness towards collaboration across organisations has an impact on the success of knowledge adaptation. Keenness and willingness of organisations to explore collaboration can lead to effective and routine knowledge application. In Botswana, the success of exchange visits in Kenya was attributable in large part to having the Permanent Secretary-MoH in both countries and their senior leadership team showing a keen interest and commitment to collaborate. As part of a multifaceted approach in coming up with an actual RT institutionalization framework that has realistic timelines and a budget, the MoHW–Botswana had requested support from the ACS project to activate a study tour in Nairobi, Kenya on the institutionalization of RT. The purpose of the exposure visit was to provide a selected group of the resource tracking TWG core team members the opportunity to learn from the MoH Staff Kenya as it has successfully managed to institutionalize resource tracking. Kenya was selected as the choice for networking for the following reasons: as an African country, Kenya has been able to institutionalize resource tracking, it has an HIV/AIDS coordinating agency, It's

English speaking, the bilateral cooperation between Kenya and Botswana in various areas of development, including Agriculture, Trade & Investment, Tourism, Defence & Security, Health, Mining and Education and the existing memorandum of understanding between the Republic of Kenya and the Republic of Botswana on Public Health and Medical Services covering on cooperation and consultation on health care financing models. This could perhaps demonstrate how the enabling environment created by the host country influence the willingness to collaborate. The insights from the study tour were useful for the members in the development and implementation of RT institutionalisation plan.

Additionally, for there to be keenness and willingness to collaborate, management and coordination capacity are crucial factors to successfully implement knowledge exchange. A key factor during the initial stages of facilitating connections and knowledge exchange among countries (Burkina Faso, Togo, and Benin) on priority topics related to UHC was the need to take into account country priorities to ensure ownership and commitment to engage. One respondent noted that, *"You really need to take into account that countries have different agendas and priorities. This requires flexibility in planning activities but also a lot of dialogue with national stakeholders"*. ACS team therefore facilitated online exchange sessions where participants from each country identified topics related to UHC governance that were priorities for country learning. They also selected topics for which they felt they could share knowledge with other countries. From these themes, common priority learning themes were identified across countries with the aim of promoting networking and continuous knowledge exchange among stakeholders from different countries.

Building capacity requires creating settings for interactions or relationship building that facilitate knowledge adaptation through social learning. Just like health systems are rooted in the society and in people, capacity building is people centered. Strengthening internal connections among people can play a role in decisions and practices on how knowledge is adapted and applied. One notable example came from a participant in the Botswana study tour to Kenya who said that "*the study tour played a role in shaping the way to discuss, promote and facilitate institutionalization of resource tracking – not only through developing skills, but raising much more awareness among MoHW and NAHPA leadership,*" which resulted in leaders becoming more supportive of efforts to harmonization the process. Moreover, the visit made the RT-TWG more comfortable and familiar with both NASA and SHA methodologies, as the 'language' of harmonization resonated with the represented leadership from MoHW and NAPHA7. Further, based on the interactions between Botswana and Namibian TWGs, Botswana stakeholders then agreed to adapt the Namibian harmonised tools based on the SHA tools and adapted to collect HIV data (health and non-health), with disaggregation using the NASA classifications.

This networking arrangement brought together key actors through creating settings or enabling environment where decision makers and technical experts could interact and exchange ideas leading to the outcome of improved understanding and communication on the harmonised approach. One respondent noted "*A lot of knowledge exchange occurred between Namibia and Botswana on combining the methodologies to ensure compatibility with their systems. It was also important in bringing WHO and UNAIDS along*". This interaction played a role in 'social learning' suggesting that learning occurs in when opportunities to discuss/exchange ideas with and observe the behavior of others, results in increases in individual or collective knowledge and understanding shifting towards a consensus.

3.3 Insights and lessons learned from the knowledge sharing approach

Knowledge sharing is enabled by networks with peer learning. This approach to capacity building involves learning through information sharing: collecting and processing information and preparing for its use and dissemination to meet specific learning aims in the health system. In Botswana, shared information developed in the Namibian context, including a policy brief, RT tools and the guidance manual on RT was used to inform strategic decisions around the framing and adaptation of resource tracking, demonstrating how cross-country linkages can facilitate knowledge adaptation. ACS teams in both countries facilitated in the creation of an interface for knowledge sharing between the RT-TWGs in the two countries. Learnings by the RT-TWG in Botswana, in this case, included how to ensure that health financing data needs are integrated into the broader Health Management Information Systems (HMIS) to support institutionalization of health financing analysis such

---

7 The organization included the MoHW, NAHPA, University of Botswana, BOMAID

as routine expenditure tracking and costing. One respondent noted that, *"the information shared enhanced skills and the ability to articulate issues and make valuable inputs to technical discussions and meeting."* To internalize and contextualize this information, the ACS Botswana team held periodic meetings with technical working groups, with government focal points, and sought exchanges and interactions with peers at regional, and HQ level, with technical advisors and peers across ACS countries. Further, through networking, the learnings from Namibia and subsequently Botswana drew interest from Kenya (a non-ACS supported country) wanting to learn about and use the combined RT method. This finding does imply that information sharing is enabled by networks with peers' input e.g., from one government agency to another.

Knowledge sharing efforts are often effective when facilitated by local knowledge brokers with sufficient understanding of local political agendas and priorities. Another key initiative ACS supported in Namibia to move the country closer to UHC was the creation and validation of the package for HIV/AIDS epidemic control (PHSEC). This package dictates the list of services that all patients can access to control the HIV/AIDS epidemic in Namibia. The design of the package of services was informed by shared local and global evidence, and it was built from an existing package of interventions and service entitlements within the Namibia health system. Experts gathered external information (from evidence synthesis) and combined it with internal data sources to propose the benefit package. This strategic approach facilitated its validation and endorsement by the MoHSS. It was, however, critical for the expert team to walk through each step of the process with key local counterparts within the government. Co-creation ensured not only the technical support but also political and operational feasibility to guarantee that the package is accepted by the end users. The learning in this process was that highly technical evidence such as systematic reviews and statistical data was more easily accepted and used by the group when this evidence resonated with existing local experience, or was communicated by a person considered to be a 'local expert' or someone with exceptional interpersonal and communication skills. In this case, the involvement of the MoHSS-Deputy Director of Special Program *"local expert"* acted as a knowledge broker facilitating information sharing.

Availability of financial, physical, and human resources is crucial for sustainability of knowledge adaptation. Tools and methodologies without resources allocated for their adaptation do little more than sit on shelf. It is crucial when developing tools and methodologies to simultaneously consider the level of resources necessary for their adaptation to the specific context. For example, to form a strong and diverse African ecosystem of institutions capable of supporting UHC on the continent, ACS' 5 African institutional partners are forming a network to support African countries in their UHC journey. Three of the 5, the Center or Research in Human Reproduction and Demography (CERRHUD) in Benin, the research center *"Recherche, Santé et Développement"* (RESADE) and the NGO AMREF Africa will serve as complementary and collaborating UHC resource hubs in this network. The key objectives of these hubs are to build a strong and diverse interlinked African ecosystem of institutions and networks that supports countries' journey towards UHC. Specifically, the hubs aim at facilitating the generation and use of context-sensitive and relevant evidence for supporting UHC in Africa, knowledge sharing within and between African countries, and provision of strategic guidance and technical assistance tailored to countries' needs across the different areas of expertise. The need for financial and in-kind resources to identify user requirements, to design/adapt the UHC hub in response to user needs, to create additional resource materials, and to have dedicated staff for the hub were cited as crucial for their sustainability. Respondents from the 3 institutions cited the need to leverage on internal staff and resources to support the hub at the beginning stages as well as to launch fundraising efforts to continuously grow the hub and build on its resources. Other options cited to make the hubs financially sustainable was to explore a fee-for-service strategy/structure for members to access the hub or receive special services of the hub.

3.4 Insights and lessons learned from the coaching and mentoring approach

Coaching and mentoring should be a continuous process happening over a period of time to support confidence building. One of the key aspects in the adaptation of harmonized resource tracking tools in Namibia and Botswana was ensuring that the process was country-led, and building sufficient local capacity to undertake expenditure tracking analyses sustainably. Part of ACS support was strengthening technical capacity among government officials and key members of the RT-TWG through coaching and mentorship in the SHA and NASA methodologies. Building consistent understanding of the two methodologies was critical to highlight the specific HIV/AIDS (NASA) data needs that were not able to be adequately addressed by SHA exercises. The use of a

coach and mentor in this process appeared to help promote the behaviour change that facilitated the adaptation of the tools. This seems to have occurred through the direct transfer of expertise as the mentor worked hand-in-hand with country stakeholders, transferring knowledge to inform decision-making processes which resulted in increased skills. The coach helped to informally build the confidence among stakeholders in their ability to apply knowledge, mitigating the anxiety inherent in learning something new. This was done through personalised, in-person coaching and mentoring to both the ACS staff and TWGs. One respondent noted, "*Coaching and mentoring was very instrumental during the learning-by-doing stage in building the confidence of the recipients to apply the skills acquired*".

Ongoing personalized support also plays a role in contextualising evidence to the specific issues participants were facing, suggesting that coaches and mentors build confidence through direct provision of relevant contextualised evidence that decision makers need and want. In Botswana, there was a need for mentor post-training support for both the resource tracking and costing activities. In order to consolidate the contextualisation of evidence in Botswana, the country team set up progress review updates between coaches/mentors and recipients to provide ongoing guidance as challenges arose. A Whatsapp group was also created for recipients to seek help from the coaches and mentors on any challenge they were facing. There was also a coach assigned as to as the reference point for each of the tools developed.

Coaching and Mentoring requires individual and organisational commitment. Similar to the findings on the training approach, experience from both Namibia and Botswana shows that existing work commitments could interfere, as recipients of the approach would often get absorbed back into routine workplace tasks. Post-training coaching and mentoring support visits were essential to mitigate this, by helping participants to use and refine their new skills in work-based projects.

4 Key Emerging Themes on Knowledge Adaptation to a Country Context

The following are the key emerging themes in strengthening stakeholders' abilities to adapt and apply knowledge to a given country context.

4.1 Relationships/Building, nurturing, and sustaining effective partnerships or collaboration

- Each of the mapped activities demonstrates that close interactions between the providers and receivers of the capacity building, whether formal or informal, are at the centre of any capacity building approach. Mutual trust, confidence, and respect are necessary factors to successful support to knowledge adaptation. Building these relationships requires compromise, humility and careful investments of time and attention.
- It is important not to over-promise the benefits of transferred skills, tools, or methodology, which can undermine organizational change processes. Spelling out specific objectives is thus a critical step, as the identified knowledge to be adapted may not be the solution to all challenges being faced. Therefore, countries should carefully consider pros and cons, the advantages and disadvantages of both the skills/tools/methods to be adapted, as well as the different capacity building options to take into account their context specificity.
- Finally, the findings indicate that it is also important to create settings or enabling conditions to foster interactions and relationships that can build and consolidate results from knowledge adaptation through social learning.

4.2 Access to evidence and technical assistance

- Our findings show that individual motivation to adapt and apply knowledge can be enhanced when evidence is clearly valued within an organisation. This argues for a deliberate process to source and review local evidence in line with the context and setting. Having a critical mass of local technical experts who can contribute to expertise and generate evidence leads to more effective knowledge application and adaptation.
- The findings indicate also that this evidence is more likely to be accepted and used by the group when it resonates with existing local experiences and/or is communicated by a person considered to be a 'local expert' with good interpersonal and communication skills, suggesting the importance of identifying and

including knowledge brokers8 with sufficient understanding of local political agendas and priorities in the evidence-sharing process.

- Further, health policymakers are more likely to adopt evidence if the proposed solutions were compatible with the wider policy agenda of central government.
- Aligned and coordinated partner technical assistance improves the efficiency of support to country stakeholders' adaptation of knowledge. For instance, the aligned collaboration among the technical expertise from R4D, USAID, WHO and UNAIDS was valuable for framing the harmonization discussion in Botswana and remains an important success factor for the ongoing institutionalization process.

4.3 Demand-driven/context-specific

- Adaptation is likely to occur in a context in which individual and organizational interest exist. For instance, the confluence of constrained public resources, national priorities, and donor expectations led to the demand for technical assistance and support in resource tracking.
- Further, organisational ownership and leadership plays an important role in facilitating knowledge adaptation and application by providing support and permission for key frontline staff who have a direct role in adaptation. However, this study indicates that building this leadership buy-in takes time.
- Nurturing and developing local leaders as coaches and mentors lay the foundation for champions and a favourable environment for applying and adapting evidence to local needs and priorities.
- It is also important to promote stronger in-country and regional institutional and organizational linkages to build demand and legitimacy for adaptation of tools and methodologies.
- Finally, the way in which capacity building is facilitated is key to the effectiveness and sustainability of those interventions. Organizations receiving capacity building support need to work collaboratively with those providing it to identify needs, appropriate approaches, etc. for the given context.

5 Conclusion

Capacity building can be understood as complex and multi-dimensional, involving change at individual, organisational and societal levels. A core concept for ACS in regard to capacity building involves the ability of individuals or organisations to continually develop necessary skills, behaviours, and networks that enable them to adapt and evolve alongside local UHC priorities and processes. Developing the capacity to adapt knowledge to context leads to more effective, well informed policy decision-making.

The study shows that adaptation is not done in a vacuum; it is commissioned, created, framed, conducted, and conveyed by individuals who have their own notions about what is significant and what isn't, as well as their own beliefs and assumptions about the tools/methodologies and the desired goal. It is therefore important to involve all relevant stakeholders to ensure buy in and legitimacy. Sharing insights about how a particular tool or methodology being considered for adaptation worked in another specific context can help in deciding whether it may be applicable in the given country context. More evidence on how capacity-building contributes to individual and organizational change can also be useful for making a stronger case for knowledge adaptation.

Finally, capacity building involves more than just increasing the skills and competencies of individuals within an organization: the policy environment as well as informal practices, beliefs, values, and attitudes must be understood and factored into the design and delivery of capacity building efforts. While simply building knowledge, skills, and attitudes can have a positive effect on an individual or on an organization, achieving and sustaining gains also requires a conducive work climate and the proper mix of incentives9 and opportunities for the application of newly acquired knowledge and skills.

---

8 Identified individuals who can support change, have skills to carry out technical delivery and mandated tasks effectively
9 Trained individuals need good leadership, support tools, equipment and operational budgets to enable them to perform within the established procedures, rules and by-laws

References

Bridges, W. (1998). Leading organizational transitions. Retrieved from www.wmbridges.com

Bruch, H., Gerber, P., & Maier, V. (2005). Strategic change decisions: Doing the right change right. Journal of Change Management, 5(1), 97–107.

1Deans, F. & Ademokun, A., 2011. Investigating capacity to use evidence: Time for a more objective view ? INASP, 1, pp.1–4.

Fullan, M. & Miles, M. (1992) Fullan, M. G., & Miles, M. B. (1992). Getting reform right: What works and what doesn't. Phi Delta Kappan, 73, 745–752.

Higgs, M., & Rowland, D. (2005, June). All changes great and small: Exploring approaches to change and its leadership. Journal of Change Management, 5(2), 121–151

LaFond, Anne and Brown, Lisanne. A Guide to Monitoring and Evaluation of Capacity-Building Interventions in the Health Sector in Developing Countries. MEASURE Evaluation Manual Series, No. 7. Carolina Population Center, University of North Carolina at Chapel Hill. 2003.

Maiese, M. (2005, August). Capacity building: Beyond Intractability. G. Burgess & H. Burgess (Eds.) Conflict Research Consortium, University of Colorado, Boulder.

Pettman, T.L. et al., 2013. Cochrane update: building capacity in evidence-informed decision-making to improve public health. Journal of public health (Oxford, England), 35(4), pp.624–7.

Wing, K. T. (2004). Assessing the effectiveness of capacity-building initiatives: Seven issues for the field. Non-profit and Voluntary Sector Quarterly, 33(1): 153-160.

Yee, J. A. (1998). Forces motivating institutional reform. ERIC Digest (ED 421179)

Annexes

Annex 1: Interview Guide for the Recipient of the Capacity Building Approach

Insights from the ACS capacity building approach on how to strengthen stakeholders' abilities to adapt and apply tools/methodologies to a country context

Interview No:	**Respondent Name(s):**
Organisation(s):	**Date:**

Informed consent:

As a learning project, ACS values the feedback from stakeholders on the approaches the project team uses to support the advancement of key UHC processes. With a view to understanding the strengths of the ACS capacity building approach, the project aims to document the lessons learned from the application of contextualized evidence at the country-level. This documentation will seek to identify insights on how to strengthen stakeholders' abilities to adapt and apply tools to a country context. The learnings that ACS derives will be shared back with country and regional stakeholders in order to inform other knowledge translation and contextualization activities. It is from that perspective that you were chosen for a short interview to share your experience and insights on ACS's capacity building approach (*Attached is the list of ACS capacity building approaches and their description*). That being said, do we have your verbal authorization to ask the questions we have prepared?

For data collection purposes and ensuring that we have captured the entirety of your insights, we wanted to record this conversation. Rest assured that no one, beyond the data collection and analysis team, will have access to this recording and the latter will be stored in a safe password-protected digital platform and destroyed as soon as we are done with the analysis of the data. That said, do we have your verbal authorization to record this conversation?

Questions

1(a) What capacity building approaches were use to carry out this activity (*Interviewer to specify the activity here*) *(Tick as appropriate as per the Capacity building definitions, you can tick more than one*) ?
   a) *Training approach*   **[   ]**
   b) *Coaching or Mentoring Approach [   ]*
   c) *Knowledge Exchange Approach* **[   ]**

1(b) What level was the capacity building approach done?
   a) *Individua level* **[   ]**
   b) *Organisation level* **[   ]**
   c) *Both individual and organizational level* **[   ]**

2(b) If it is training, *in your opinion*
   i.   How did the trainings increase your ability to perform own professional duties?
   ii. What procedures, regulations, learning systems, etc. did the trainers put in place to ensure you benefit continuous after-training support for the initial topics and/or access institutional 'home' for new training courses?

Tools
   iii. What tools did you receive to be used after training (*Prompt: guidance notes, templates, checklists, assessment criteria, etc.)?*
   iv. How easy were they to use?
   v.   How relevant were they to advance your individual performance, your organization's performance?
   vi. To what extent has targeted activity outcomes occur as a result of the training approach?

Incentives
   vii. What kind of incentives did you receive to apply newly acquired skills (*Prompt: dedicated time for practice, periodical performance reviews, rewards, compensation, etc.)?*

If it is Coaching or Mentoring *in your opinion*
   i.   How did the coaching or mentoring increase your ability to perform own professional duties?

ii. What procedures, regulations, learning systems, etc. did the coachers or mentors put in place to ensure you benefit continuous after-training support for the initial topics and/or access institutional 'home' for new training courses?

Tools
iii. What tools did you receive to be used after the Coaching or Mentoring (Prompt*: guidance notes, templates, checklists, assessment criteria, etc*.)?
i. How easy were they to use?
ii. How relevant were they to advance your individual performance, your organization's performance?
viii. To what extent has targeted activity outcomes occur as a result of the coaching or mentoring approach?

Incentive
iii. What kind of incentives did you receive to apply newly acquired skills (Prompt: dedicated time for practice, periodical performance reviews, rewards, compensation, etc.)?

If it is knowledge exchange, in your opinion

i. What kind of knowledge exchange approach did you received from the facilitators *(Prompt: Exposure or exchange visit, Peer Support groups and Peer Assists, Signposting information, and resources)?*
ii. How did the knowledge exchange approach increase your ability to perform own professional duties?
iv. How relevant was the knowledge exchange to advancing your individual performance, your organization's performance?
v. To what extent has the targeted activity outcomes occur as a result of the knowledge exchange approach?

Incentive
vi. What kind of incentives did you or your organization receive to apply the newly acquired knowledge (Prompt: dedicated time for practice, periodical performance reviews, rewards, compensation, etc.)?

Networking
vii. How did this knowledge exchange approach increase opportunities for you discuss ideas with and observe the behaviour of peers across the continent?

Facilitation
viii. What approach did ACS use to facilitate interactions with peers?
ix. How did you use the new learnings that came out of your interactions with peers? What change did that make in improving your personal skills as well as your organization's abilities?

Insights from the ACS capacity building approach on how to strengthen stakeholders' abilities to adapt and apply tools/methodologies to a country context

Interview No: **Respondent Name(s):**
Organisation(s):   **Date:**

Informed consent:
As a learning project, ACS values the feedback from stakeholders on the approaches the project team uses to support the advancement of key UHC processes. With a view to understanding the strengths of the ACS capacity building approach, the project aims to document the lessons learned from the application of contextualized evidence at the country-level. This documentation will seek to identify insights on how to strengthen stakeholders' abilities to adapt and apply tools to a country context. The learnings that ACS derives will be shared back with country and regional stakeholders in order to inform other knowledge translation and contextualization activities. It is from that perspective that you were chosen for a short interview to share your experience and insights on ACS's capacity building approach *(**Attached is the list and definitions of ACS capacity building approaches**).* We hope you will agree to participate in this study because your opinion is very important. Your participation is completely voluntary, and you can stop the interview at any time or refuse to answer a specific question, without any consequences.
That being said, do we have your verbal authorization to ask the questions we have prepared?

Questions
1(a) What capacity building approaches were used to carry out this activity (*Interviewer to specify the activity here*) *(**Tick as appropriate as per the Capacity building definitions, you can tick more than one**)* ?
   d) *Training approach* **[   ]**
   e) *Coaching or Mentoring Approach* **[   ]**
   f) *Knowledge Exchange Approach* **[   ]**

1(b) What level was the capacity building approach done? Kindly specify.
   d) *Individua level* **[   ]**
   e) *Organisation level* **[   ]**
   f) *Both individual and organizational level* **[   ]**

2(b) If it is training, *in your opinion*
   ix.   How did the trainings increase ability to perform own professional duties of the recipients?
   x.   What procedures, regulations, learning systems, etc. did you put in place to ensure the recipients benefit continuous after-training support for the initial topics and/or access institutional 'home' for new training courses?

Tools
   xi.   What tools did you provide to be used after training (*Prompt: guidance notes, templates, checklists, assessment criteria, etc.)?*
   xii. How easy were they to use?
   xiii. How relevant were they to advance individual performance, organization's performance?
   xiv. To what extent has targeted activity outcomes occur as a result of the training approach?

Incentives
   xv.   What kind of incentives did you provide for the recipient to apply newly acquired skills (*Prompt: follow-up sessions, periodical practice reviews, rewards, etc.)?*

If it is Coaching or Mentoring *in your opinion*
   iv.   How did the coaching or mentoring increase ability to perform own professional duties of the recipient?
   v.   What procedures, regulations, learning systems, etc. did you as a coach or mentor put in place to ensure coachees/mentees benefit continuous after-training support for the initial topics and/or access institutional 'home' for new training courses?

Tools

vi. What tools did you provide to be used after the Coaching or Mentoring (Prompt: *guidance notes, templates, checklists, assessment criteria, etc.*)?

x. How easy were they to use?

xi. How relevant were they to advance individual performance, organization's performance?

xvi. To what extent has targeted activity outcomes occur as a result of the coaching or mentoring approach?

Incentive

xii. What kind of incentives did you provide to apply newly acquired skills (*Prompt: follow-up sessions, periodical practice reviews, rewards, etc.*)?

If it is knowledge exchange, in your opinion

iii. What kind of knowledge exchange approach did you provided to the recipients *(Prompt: Exposure or exchange visit, Peer Support groups and Peer Assists, Signposting information, and resources)?*

iv. How did the knowledge exchange approach increase ability to perform own professional duties of the recipient?

xiii. How relevant was the knowledge exchange to advancing individual performance, organization's performance?

xiv. To what extent has the targeted activity outcomes occur as a result of the knowledge exchange approach?

Incentive

xv. What kind of incentives did you provide to apply the newly acquired knowledge (*Prompt: follow-up sessions, periodical practice reviews, rewards, etc.*)?

Networking

xvi. How did this knowledge exchange approach increase opportunities for the recipients to discuss ideas with and observe the behaviour of peers across the continent?

Facilitation

xvii. What approach did ACS use to facilitate interactions with peers?

xviii. How did the recipients use the new learnings that came out of their interactions with peers?

xix. What change did that make in improving their personal skills as well as your organization's abilities?