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SCALE-UP OF LOCAL CAPACITY STRATEGY

Local Health System Sustainability

Task Order 1, USAID Integrated Health Systems IDIQ

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Local Health System Sustainability (LHSS)

The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support universal health coverage. The project works with partner countries and local stakeholders to reduce financial barriers to care and treatment, ensure equitable access to essential health services for all people, and improve the quality of health services. Led by Abt Associates, the five-year, $209 million project will build local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity.

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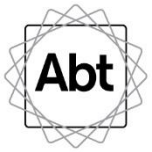

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ACRONYMS

CHPS	Community-based Health Planning and Services
CLA	Collaboration, learning, and adaptation
GHS	Ghana Health Service
GUC	Grants Under Contract
G2G	Government to Government
HSS	Health Systems Strengthening
IP	Implementing Partner
LHSS	Local Health System Sustainability Project
MEL	Monitoring, Evaluation, and Learning
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NGO	Non-Governmental Organization
NUPAS	Non-U.S. Organization Pre-Award Survey Guidelines and Support
OCB	Organizational Capacity Building
QA	Quality Assurance
TA	Technical Assistance
TAG	Transition Advisory Group
TO	Task Order
UHC	Universal Health Coverage
USAID	United States Agency for International Development
USG	United States Government

1. INTRODUCTION

This document outlines the Local Health System Sustainability Project's (LHSS) strategy for scaling-up local capacity and transitioning health system functions to local, country-based organizations. We will supplement this document with a step-by-step project implementation guide, the LHSSS Guide to Organizational Capacity Building (OCB) for health system strengthening (HSS). Designed for use by LHSS staff and locally contracted partners, we will develop the guide during Year 1. The guide will include details on proven approaches to building and measuring local capacity, along with templates and guidance for co-developing Local Partner Sustainability and Transition Plans.

The purpose of this strategy is to guide LHSS project managers and partners, ensuring that scaling up local capacity is central to the design and development of HSS activities, including: core activities; country program scopes of work; local partner selection and management; and activity implementation. The strategy will also guide the monitoring and evaluation (M&E) of local partner capacity, commitment, and progress towards sustainability and ownership. The strategy is a living document; we will revisit it annually as part of our approach to collaboration, learning, and adaptation (CLA), specifically when we develop our annual sustainability and transition report.

In implementing this strategy, LHSS will communicate with and work in close collaboration with current USAID mechanisms, such as the Accelerating Support to Advanced Local Partners project, other USAID Integrated Health Systems Activity Task Order (TO) holders, and others, to share adapted capacity development tools and lessons learned, standardize capacity measurement, and provide integrated, coordinated support to local partners at the country level.

2. RATIONALE

Scaling-up local capacity and transitioning health system functions to local public and private sector partners is essential for sustainable HSS and achieving progress towards universal health coverage (UHC). Improving health system performance through sustainable local change supports countries as they transition away from reliance on donor aid and technical assistance (TA). As the first task order under the USAID Integrated Health Systems Activity, LHSS furthers USAID's goal of improving health and transitioning capacity to local partners. LHSS will help build country capacity and commitment—which is at the heart of supporting countries on their journeys to self-reliance—by measurably increasing local capacity and sustainably improving health system performance.

3. VISION FOR SUCCESS

LHSS activities support a vision where people lead healthier and more productive lives thanks to stronger, more self-reliant health systems. Scaling-up local capacity is central to LHSS' success. By the end of the period of performance, a minimum of 20% of LHSS work will be implemented by local organizations either through subcontracts, through grants or local consultants. In addition, supported countries will have in place long-term plans for making progress on UHC independent of donor support.

LHSS will increase the technical and administrative capacity of local partners to successfully design interventions, allocate or plan for resources, implement and monitor interventions, and efficiently manage activities. Ultimately, local individuals, organizations, and systems will set priorities and be at the forefront of planning, financing, managing, implementing, and monitoring health system functions, including knowledge management. By the end of the project, more organizations central to a functioning, growing health system will be on the path to being self-sustaining entities.

4. STRATEGIC APPROACHES

4.1 OVERVIEW

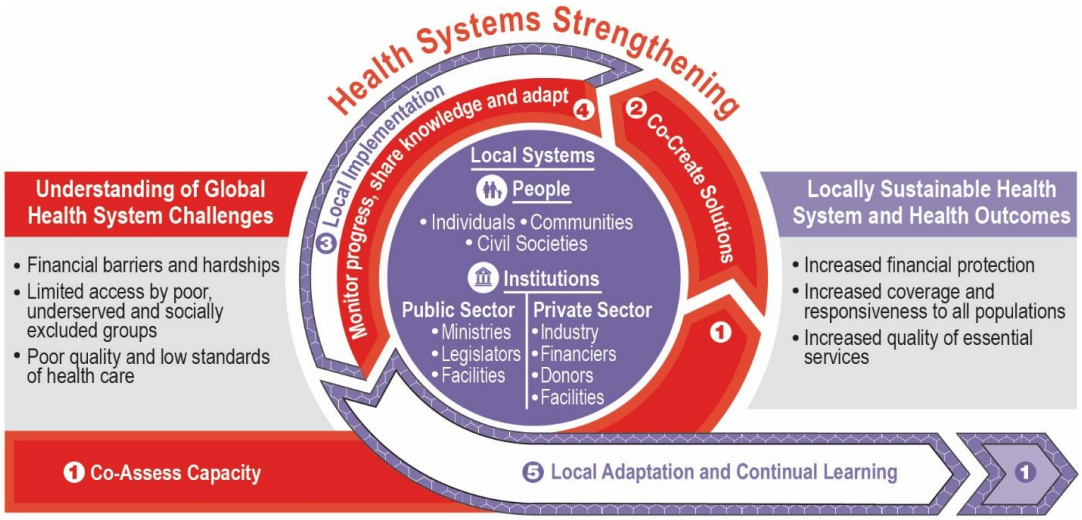
As illustrated in Figure 1, LHSS will work collaboratively with local partners at all stages of LHSS implementation to: 1) co-assess capacity and commitment; 2) co-create solutions; 3) implement solutions locally; 4) monitor progress and share knowledge; and 5) adapt and learn within a locally sustainable health system. The LHSS approach to scaling up local capacity embodies systems thinking and a blended approach that follows human and institutional capacity development principles for sustainable results, including human-centered learning coupled with strengthening organizational structures, processes, systems and tools.

While specific interventions and approaches may change over time as we learn, the following six requirements will underpin our approach to scaling up local capacity throughout the five year project:

1. Increasing local financial ownership of project activities and health system functions;
2. Integration of OCB techniques into intervention designs (not as a standalone activity);
3. Collaborative assessment, design, planning, and delivery of TA and incorporation of quality assurance (QA) oversight;
4. Rigorous M&E;
5. Engagement of local actors in knowledge management for increased effectiveness and learning within and among countries; and
6. Integration of gender equality and social inclusion principles in all activities.

LHSS goals for transition will be realistic and will vary from country to country depending on the length, size, and goals of the program, as well as the levels of local capacity. We will use a multi-year horizon to allow sufficient time to make noticeable and sustainable improvements. We will develop the LHSS Guide to OCB for HSS in the first half of Year 1; it will include guidance to develop a Results Framework that links specific capacity building activities, outputs, and outcomes to the objectives of the project in each country.

Figure 1: Scaling Up Local Capacity is a Central Feature of LHSS



Capacity refers to:

1. Policies, strategies, and processes;
2. Organizational structures, including supportive structures and processes to facilitate exchange between organizations;
3. Resources (financial, information, and physical infrastructure); and
4. Knowledge and skills of the human resources.

LHSS will build capacity in all four areas through the provision of TA, support for implementation design, and grants and sub-contracts. In the case of #3 – Resources – the project will strengthen the ability of local partners to sustainably finance their health systems through TA to build capacity to generate domestic financing and realize efficiencies, We will infuse each core activity and country program with measureable capacity building interventions, and devote country program and core resources to ensure their implementation. Each country program will have a Local Capacity Building and Transition Plan (which will be monitored), and a local Transition Advisor (see Section 5).

Our approach uses USAID's definition of local organizations, including both public and private sector organizations, government entities, private for-profit companies, non-profit organizations, and networks or associations.[1] Local partners may include Ministry of Health (MOH) operating units, sub-national levels of government, non-governmental organizations (NGOs), private providers, professional and private sector associations, academic institutions, social franchises, health insurance organizations, and distributors and sellers of priority health products. We will apply and adapt—where essential—existing tools and processes (e.g., the LHSS OCB framework, USAID's Organizational Capacity Assessment tool, the Capacity Solutions Platform, the ProCap Index, Humentum's NGO financial management training, Banyan Global's Business for Health Toolkit). This will enable our team to co-assess rapidly with local partners capacity and performance against organizational capacity standards, and provide standardized measurements of improvements.

We will work side-by-side with local partners to understand their context, role, and functions to swiftly identify performance improvement priorities and the best pathways to achieve them. For private commercial partners, NGOs, and networks, we will support these local partners to: function in concert with a network of strategic partners to support their growth; have diverse revenue streams to maintain organizational health; deliver optimal technical and service delivery performance; manage finances with transparency and controls; and make data-driven adaptations. We will co-develop targeted action plans to accelerate development so that local partners have the capacity to become reliable stewards of direct United States' government (USG) funding.

To support local partners' transition to direct USAID funding, LHSS will engage technical experts in OCB, financial management, human resource development, sub-contracting and procurement for USAID awards, and M&E and strategic information management, as needed. These experts will strengthen the capacity of local partner NGOs, companies, and government entities to achieve demonstrable and measurable institutional improvements building their ability to partner directly with USAID. This includes improved risk management, and the ability to take on sustainable leadership roles in their countries' health system.

As much as possible, LHSS will work with local organizations as implementing partners (IPs) rather than beneficiaries. This will be through sub-contracts and grants initially, and ultimately through direct grants or cooperative agreements with USAID missions. A subset of local partners will "graduate"—they will develop sufficient capacity to serve as direct recipients of separate HSS transition awards funded by

[1] USAID Integrated Health Systems' IDIQ Task Order No.: 7200AA18D00023/7200AA19F00014, August 29, 2019.

USAID. In the case of non-profit and for-profit private entities, we will work with them to achieve the benchmarks needed to be direct recipients of USAID funding, as measured using USAID's Non-U.S. Organization Pre-Award Survey Guidelines and Support (NUPAS). In addition, we will build abilities and qualifications of MOH units at all levels to receive direct funding or Government to Government (G2G) funding (post-intervention or even post-project).

4.2 ORGANIZATIONAL CAPACITY BUILDING APPROACH

Capacity building is "the process through which individuals, organizations, and societies obtain, strengthen, and maintain the capacities to set and achieve their own development objectives over time."[2] According to USAID, organizational capacity relates to the ability of an organization to accomplish its objectives and to grow and adapt over time to further its mission. LHSS will build capacity at the individual, organization, and system levels, taking a systems-thinking approach to identify the appropriate level of intervention. Although activities may be focused on a particular level, consideration is given to the relationships among levels in all activities undertaken. For example, individual capacity building, whether through training, coaching, or any other intervention, is done for the purpose of strengthening the individual's contribution to a stronger organization.

The LHSS approach to OCB is founded on the framework summarized in Table 1. LHSS will focus on all three capacity building levels—system, organization, individual—but we will direct most efforts towards the organizational level. Specifically, we will focus on performance, using assessment-based plans and baselines to measure progress, with systematic follow-up to drive improvements across three domains:

1. *Organizational development*, including organization-wide efforts to increase effectiveness and accountability for achieving strategic goals;
2. *Technical capacity*, including the ability to provide quality health system support (e.g., TA, research, and service delivery), and the ability to generate and use knowledge for adaptive approaches, especially as ownership increases and the scale of an organization's work grows; and
3. *Financial management*, business planning, and compliance, including the systems needed to receive USAID and other donor funding, and for the organization's long-term viability, credibility, and protection of staff and clients (e.g., providing training in the prevention of sexual abuse and exploitation).

Table 1: The LHSS Organizational Capacity Building Framework

Dimension	Definition
Organizational Development	
Organizational mandate	Clearly defined official roles and responsibilities, accountability, and functions.
Strategy and planning	Vision and long-term strategic direction with strategies and plans to implement and/or modify.
Structure and staffing	Adequate organizational structure and staffing to carry out core functions.
Implementation capacity	Capacities to plan, manage, monitor, and improve the quality of activities implemented.

[2] Capacity Development: A UNDP Primer, October 13 2009.

Dimension	Definition
Leadership and management	Leadership that sets direction, motivates, and aligns staff behind strategic direction; management that works together, monitors staff, assures the quality of performance, and shares information.
Gender and inclusion	Explicit gender and social inclusion practices and functions.
Resources	Adequacy of basic operating resources in the short- and long-term.
Coordination and stakeholder engagement	Capacity to engage and coordinate internal and external stakeholders.
Organizational governance	Existence of a structure that provides oversight and ensures accountability.
Technical Capacity	
Technical capacity	Technical skills and systems commensurate with functions (e.g., health financing, quality improvement)
Financial Management, Business Planning, and Compliance	
Management systems, including for financial management	Well-defined and used systems for financial management, human resources, IT, and procurement.
Compliance	Systems and capacity to ensure compliance with government and USAID requirements.
Measuring Capacity	
Scoring system will be devised on a 1-5 scale for each framework dimension. Initial assessment will establish baseline. Yearly participatory self-assessments will measure progress and provide information for learning and making adaptations, per our CLA management approach. Final end-line assessment will show overall progress. Data collection tools will include a survey, possibly complemented by key informant interviews.	

LHSS will use a range of capacity building techniques that include but go beyond training. See Table 2 below. Key to OCB is accompanying institutions and organizations as they carry out their functions in a learning-by-doing model of capacity building. This includes designing organizational structures, staffing plans, assigning roles and tasks, and helping managers build their skills to assess, oversee, support, and hold staff accountable for the effective implementation of assignments. We will also incorporate emerging digital and technological approaches into our interventions where appropriate. We will describe the range of interventions in the forthcoming OCB implementation guide.

Table 2: LHSS Sample Menu of Capacity Building Techniques

Capacity Development Techniques	Benefit	Illustrative Use
Training (in-person and web-based)	Local partner leaders and staff build the knowledge and skills to effectively function as a prime USAID partner. Uses existing training programs/tools for easy access.	LHSS provides three-day training to management and accounting staff of two local partners in one country on financial management, data collection, reporting, and use.
Mentoring	Local partners become stronger managers and leaders.	An LHSS Chief of Party based in-country mentors a local partner director for nine months, meeting monthly, on leadership strategies in the context of change management add professional growth. Local wholesalers are linked with international suppliers for mentoring on supply chain management techniques.

Capacity Development Techniques	Benefit	Illustrative Use
Coaching (short-term technical assistance or embedded)	Task-oriented, targeted, individualized support, which can be provided remotely. Institutionalizes skills and knowledge	An LHSS partner embedded advisor works alongside the local partner M&E team to co-develop an M&E plan that aligns with program targets, "leading from behind". LHSS facilitates use of assessments and action planning.
Cross learning (peer to peer)	Contextual feasible solutions based on lessons learned.	Establishment of a remote local partner affinity group via WhatsApp to share experiences in scaling up.
Job aids / resources	On-going guidance / reference for implementing new skills and processes. Existing online reference tools that can support local partners are easy to access.	Job descriptions paired with a guiding document for a recruitment process, including interview evaluation forms and others. LHSS directs local partners to online resources.

4.3 SUB-CONTRACTS

LHSS will build local capacity through sub-contracts with local organizations and institutions, focusing on key actors in the health system and/or those that can be a resource to key actors, thus contributing to HSS. Each country program over $500,000 will engage at least one local sub-contractor. Each member of the LHSS team of international partners already has an extensive roster of local organizations they are working with. In addition and in anticipation of LHSS, Abt released calls for expressions of interest in three countries to support HSS. We received over 50 responses. Immediately upon start-up in each country, and in consultation with USAID missions, we will further expand our database of existing local partners. We will consult with USAID missions and vet potential local partners for sub-contracting. When working with sub-contracted local partners, we will seek to identify key champions within organizations for developing leadership and management skills. Additionally, we will identify skills and capabilities to be developed in order to position these partners for eventual direct USAID funding, and where program funds and mandate allow, build a plan for doing so that goes hand-in-hand with the sub-contract award.

4.4 TRANSITION AWARDS

At the outset of country programs, USAID will indicate whether a transition award is expected to result from LHSS support. In preparation, we will begin by understanding the vision of national stakeholders and USAID for transition awards, and by developing a timetable for transition from donor support and external TA.

We will ensure that local partners identified for transition awards by USAID receive special project focus. This includes building their capacity to respond to both USAID's stringent performance, contractual, and reporting requirements; and to national government requirements for receiving external donor funding (such as for formal registration). We will combine our OCB efforts in most cases with Grants Under Contract (GUC), and in some cases, with a sub-contract. We will use and adapt our OCB approach as needed to address the capacity requirements for direct USG awards and contracts, using supplemental tools such as USAID's NUPAS.

For local organizations in this category, we will seek to co-design a financial management support action plan if program funding allows. The action plan uses targeted best-fit solutions to strengthen local partner capacity overall, improving compliance, and increasing audit-readiness, and helps local partners achieve a strong NUPAS score on their prime readiness.

4.5 GRANTS UNDER CONTRACT

LHSS will deploy GUCs to achieve locally agreed objectives, encourage engagement with non-traditional partners (e.g., fledgling groups undertaking implementation research), build local partner capacity, and foster innovative solutions. We will work with these partners to identify capacity gaps to expand or improve their abilities to contribute to the health system and/or to be ready for sub-contracts or direct USAID funding. As shown in Table 3, we will use a combination of in-kind, fixed amount, simplified, and standard grants as appropriate and consistent with the administrative and financial capacity of each prospective grantee, as well as its ability to meet accountability and reporting requirements.

Table 3: Illustrative Approaches to Using Grants Under Contract

Approach	Purpose and Methodology
Directed Grants	We will use directed grants with partners with insufficient capacity to receive sub-contracts, such as fledgling groups undertaking research or private sector associations. We will include in-kind grants, such as TA to build the institutional capacity of governments and local partners, to prepare them for USAID transition awards.
Results-Based Grants	We will use results-based grants to complement other funding sources and create incentives for better performance by providing additional funds to deliver additional results. We will build on performance-based funding experience.
Umbrella Arrangements	We will use umbrella arrangements for organizations that fund and oversee networks of non-traditional partners, which individually do not have the capacity to receive a grant. This could include, for example, groups working with people living with HIV/AIDS, injecting drug users, or men who have sex with men. This will enable grant funds to reach more beneficiaries and strengthen the leadership of the recipient group.
Challenge Funds	We will use challenge funds to call for innovative solutions to systemic problems (e.g., using new technology for maternal, neonatal, and child health services). We will include country leaders in choosing awardees, demonstrating proof of concept, assessing results, and determining eligibility for scale-up funding.

LHSS will use GUCs as a mechanism to develop the administrative and management capabilities of local organizations so that they can successfully compete for and implement direct awards from USAID. This is another essential aspect of sustainable HSS.

4.6 CO-LOCATING WITH LOCAL PARTNERS

We will work side-by-side with our local counterparts, and where technically and managerially possible, co-locate some or all of our country program staff. Working alongside our local partners—be they recipients of TA, sub-contractors, and/or grantees—we will establish priorities, develop plans, and implement project activities. We will learn from each other, adapt activities as needed, and introduce or strengthen successful approaches to HSS.

5. COUNTRY PROGRAM IMPLEMENTATION

We will engage local IPs throughout each country program. In some cases, these partners will be at the forefront of implementation, with continuous quality and performance oversight from the LHSS team. Once LHSS and USAID have identified local partners and agreed their project roles, LHSS will work with the partners to co-assess their capacity and agree on the types of support they need. We will also jointly agree their role post-project, and integrate this information into a country-level local partner sustainability and transition plan.

5.1 LOCAL PARTNER SUSTAINABILITY AND TRANSITION PLANS

Each LHSS country program of $500,000 or more will develop a brief *Local Partner Sustainability and Transition Plan*, which will be monitored annually. These plans will catalogue local partners, their roles related to LHSS, the capacity building objectives and intermediate results per local partner, types of capacity building support the project will provide to enable local partners to meet their objectives, and the expected mutually agreed upon capacity milestones reached over the duration of the activities. LHSS Regional Managers, in consultation with USAID and local partners, will establish realistic timelines that reflect the local partners' baseline capacity, objectives of the program, centrality of capacity development to the specific country program, project resources devoted to capacity building, length of project activity, and the enabling environment. Illustrative examples of the content for transition plans, including interventions and timelines, are contained in Annex 1, which shows "transition" for potential partners in three countries (Ghana, Uganda, and the Dominican Republic).

In the following paragraphs, we describe our step-by-step guide to local capacity scale up and transition.

5.2 STEP-BY-STEP GUIDE TO COUNTRY CAPACITY SCALE UP AND TRANSITION OF LOCAL PARTNERS

Step 1: Identify the need and scope for capacity building. The need for organizational capacity building is not always apparent to health system practitioners. Recognizing this, LHSS will ensure that the underlying need for improved organizational capacity is identified early on. We will review each country buy-in through a capacity building lens, and together with USAID, agree on a work plan that reflects this need. Each country program (and core activity) will prioritize local organization capacity building at different levels, and will allocate time and resources accordingly depending on the core objective of the intervention. ALSHS will therefore use a flexible process for establishing capacity development needs. This will include applying at times a rapid capacity assessment metric, and at other times, a more comprehensive organizational capacity assessment tool.

If a country scope of work does not allow for extensive capacity building activities, we will integrate capacity building into our program activities. We will vet these capacity building ideas, their rationale, and their intended results with our local partners.

Step 2: Co-assessment. LHSS staff will work with key counterparts to co-assess local capacity to achieve LHSS goals. The co-assessment process will encourage consensus on capacity gaps, engender broad ownership of and accountability for results, and strengthen relationships between systems actors. The process will also nurture productive relationships by engaging a range of institutions, including local organizations that could become eligible for transition awards.

If there is limited time, resources, or priority allocated to capacity development, we will review basic metrics to assess capacity development needs. We will take cues from missions where local partners already have a historic relationship with USAID health programs and/or there is an existing organizational assessment to review; in these circumstances, we will conduct a brief interview with the leadership of the organization to determine capacity development priorities.

When mission program priorities and funding allow, we will employ the full OCB framework described earlier as the basis for co-assessment; the OCB generates the necessary data to guide selection of appropriate interventions according to each organization's role within the health system.

In all cases, we will establish benchmarks for measuring progress towards sustainability and transition. The benchmark data, supplemented by other assessments as necessary, will form the baseline that we will monitor through our Sustainability and Transition Index (described below).

In Year 1, we will develop a categorization metric for these local partners, described in Box 1.

Step 3: Validation and prioritization of assessment findings. OCB co-assessment results will include measurement on a 1-5 scale of capacity in each framework dimension, with recommendations for methods to build capacity. We will share assessment results honestly and sensitively with key stakeholders, and together we will establish priorities for interventions based on the organization's perception of what is important, urgent, and feasible.

Box 1: Illustrative LHSS capacity building packages of support for local partners

1. *Introductory:* Local partners that are not prime recipients, and have limited or no experience as sub-contractors or grantees. These local partners may be non-traditional partners and/or innovators that have important roles to play in HSS, but have not had USG sub-contracts and need external funding and/or TA to strengthen their capacity to function at scale, expand services, and be more resilient and sustainable actors in their local health systems.
2. *Standard*: Advanced local partners that are not prime recipients of USAID funding (e.g., government stakeholders with limited or no previous USAID sub-award experience who are expanding collaboration with USAID and/or preparing for G2G funding). The *Standard* package of assistance will encompass focused training on core OCB components with some emphasis on financial management systems and compliance, weekly intensive coaching, job aids, and embedded advisors.
3. *Advanced:* Local partners with experience as grantees and/or sub-contracting experience on USAID project work. These partners are building technical capacity and financial management systems, knowledge, and ability to be a sub-contractor on a USG contract. These local partners will receive mentoring that includes the *Standard* OCB support, plus strengthened support on capacities required to be a compliant USG IP. Support will also likely be complemented by an LHSS sub-contract or GUC.
4. *Fast Track*: Prior or current local prime partners that are increasing capacity to expand their scope or scale, increase resilience, and/or become less donor-dependent. These may include G2G recipients, current prime contractors, or those deemed ready to be a prime USAID recipient per a recent NUPAS. We will address identified weaknesses from their NUPAS—for example, any USAID special award conditions. The *Fast Track* package of assistance will include training and coaching in selected OCB components, advanced training in selected concepts, and a focus on leadership and management for growth, reporting, and using data for decision-making. This will include remote support and mentoring, as well as south-to-south learning opportunities.

Step 4: Local capacity and transition plan development. After validation of the assessment findings, LHSS will work with local partners to develop an intervention plan that will be included in a country-level LHSS local capacity and transition plan (Annex 1). Within that plan, we will articulate an individualized approach and expected capacity building outcomes, including timelines for achieving those outcomes, for each local partner. The specifics will depend on a number of factors, including the USAID mission's goals, budget, and timeline, as well as local partner priorities. We will agree to a capacity building plan with each local partner that factors in their current capacity, the duration of LHSS, country program resources and priorities, and the ultimate goal of becoming a direct recipient of USG funding and/or being independent of donor support. Within these plans, LHSS will work with individual local partners on a realistic and appropriate timeline towards increasing capacity for direct USAID funding.

Step 5: Implementation, collaboration, learning, and adaptation. As mentioned earlier, we will integrate capacity strengthening interventions into HSS activities, rather than implementing standalone activities. LHSS will build the capacity of all program staff in the principles of human and institutional capacity development and OCB, supplemented by regular sharing with staff of information, lessons learned, and other institutional capacity building materials. At the local partner level, we will encourage establishment of a small group to lead implementation efforts, and will offer orientation and support to that group throughout the program. LHSS will meet quarterly with the local Transition Advisor (see Section 6) to monitor implementation and identify both successes and challenges, and the Transition Advisor will meet often with local partners to monitor the same. Together, we will identify underlying success factors or bottlenecks and identify areas for adaptation of plans and/or approaches.

Step 6: Annual reporting. On an annual basis, LHSS and the partner organization will co-assess organizational capacity, comparing results against the baseline established at the outset of the work. Together we will analyze results and agree adjustments to the transition plan as appropriate. We will track the amount of project funding going to each organization to feed into country and project-level reporting, including the percentage of project funds that are going to local partners. Section 8 elaborates on the monitoring and reporting of LHSS local capacity building efforts.

6. LEADERSHIP, MANAGEMENT, AND STAFFING

6.1 CORE MANAGEMENT AND TECHNICAL OVERSIGHT

The LHSS Transition and Sustainability Director will oversee implementation and M&E of this strategy, and ensure that core activities and country programs include a well-designed, feasible, and cost-effective approach to support the scaling up of local capacity. The Capacity Building Director will provide technical oversight for all OCB interventions, and report to the Transition and Sustainability Director. Both will have frequent and regular communication with Regional Managers, the monitoring, evaluation, and learning (MEL) Specialist, knowledge management experts, and core activity leads. The LHSS Technical Director will provide technical QA. The project Operations and Finance Manager will oversee implementation of the GUCs component. The Project Director will co-chair the quarterly Transition Advisory Group meetings, facilitated by the Transition and Sustainability Director.

Using core funds, LHSS will build the core capacity of key program staff in OCB and other forms of capacity building. Specific activities that we will undertake to achieve this include:

- Training all LHSS regional managers and selected technical staff in the basic principles of OCB and how to infuse them into country program design, implementation, and MEL;
- Developing guidance materials that can be used by local staff (e.g., assessment tools, intervention materials); and
- Regularly sharing capacity building project information, lessons learned, and materials with all staff.

6.2 COUNTRY PROGRAM STAFFING

Upon USAID mission approval, we will develop a roster of local partner staff and consultants with the expertise to carry out specific capacity-building interventions to support country programs. Their expertise will include business management support, conducting and preparing for financial audits, USG contract compliance, grants management, reporting, and technical capacity development. In addition, the Capacity Building Director or Local Partner's Capacity Building Advisors can provide training in: co-facilitating action planning; financial planning; coaching skills; using data for decision-making; meeting preparation and management; conducting role play briefings and feedback activities with counterparts; and other organizational tools to enhance knowledge. In addition, we will use mentoring and other techniques for working with government and private sector counterparts to build the capacity of technical staff, e.g. using workshop co-design and co-facilitation, coaching, and supportive organizational development.

6.3 TRANSITION ADVISORY GROUP

We will form a project-wide Transition Advisory Group (TAG) to enable continuous monitoring of transition progress. The TAG will include one representative of local IPs—a Transition Advisor—in each supported country. TAGs will provide feedback on the appropriateness and adequacy of transition strategies and mechanisms, along with contributing to the annual report on sustainability and transition. We will hold quarterly virtual meetings through Webex, co-chaired by the LHSS Project Director and local partner representatives, and facilitated by the LHSS Transition and Sustainability Director.

7. KNOWLEDGE MANAGEMENT

Local partner capacity building and transition will both contribute to and benefit from the learning and knowledge management efforts of the wider project. We will support partner countries on their journeys towards self-reliance and improved health system performance by jointly facilitating the exchange of good practices and innovations across countries.

In addition, we have built CLA into the LHSS program design. Our OCB framework includes building institutional capability to: analyze and reflect on behaviors and successes, use this feedback to learn and refine processes, and provide input to management at the national level, especially where such information should inform systems and policies.

8. MEASURING AND MONITORING LOCAL CAPACITY

We will rigorously measure and monitor implementation of this strategy. Project level annual work plans and activity work plans will include a description of proposed interventions to achieve measurable progress in sustainability and transition to local partners.

Country-specific MEL plans will include metrics to assess capacity development, transition to local partners, country ownership, and sustainability of interventions introduced with program support. See the LHSS Year 1 Annual Report MEL Plan for details.

In Year 1, LHSS will develop the Sustainability and Transition Index, which will be a core element of our MEL Plan. The index will allow LHSS to monitor progress through a dashboard, which tracks progress in each dimension of sustainability and transition. In the first year, we will consult with other USAID IPs and USAID's Office of Health Systems on measurement tools for tracking organizational capacity, transition, and sustainability to ensure we align with other approaches, and possibly to employ the same or similar tools.

LHSS will embed the measurement of local capacity into our technical approach. Our OCB framework includes the establishment of benchmarks for measuring progress toward sustainability and transition readiness. It integrates organization-selected specific performance targets, such as for gender equality and social inclusion, fundraising, geographic expansion, beneficiary satisfaction, or diversification of partners. The OCB Framework defines twelve competencies. For each, we identify relevant questions and score the answers on a 1 to 5 scale. Scores on each competency, and an overall score, provide a baseline and allow measurement of change over time. Throughout, we will work with our local partners to identify capacity constraints and co-create solutions, and identify strengths and successes

This is a proven measurement technique adapted from the Health Finance and Governance project's (HFG's) activities in the Democratic Republic of Congo and elsewhere. HFG used the technique to measure the capacity of NGOs in the Caucuses as they transitioned from support from both USAID and the Global Fund to Fight Malaria, TB and HIV. This activity specifically tracked the sustainability and organizational capacity of NGOs, as well as their ability to contribute towards HSS efforts as a resource to other NGOs, governments, and communities in Georgia, Azerbaijan, and Armenia.

As discussed, we will establish baseline data through an initial co-assessment. Yearly participatory self-assessments will measure progress and provide information for learning and making adaptations, in alignment with our CLA management approach. The annual LHSS Sustainability and Transition Report will reflect the results of these assessments for all organizations and institutions, both public and private. In addition, LHSS will facilitate quarterly joint monitoring meetings to ensure that interventions are

adapted in real time based on local feedback, USAID input, changes in the environment, and consultation with our individual country Transition Advisors and TAG.

In addition, we will use other tools for measurement as required. For example, we will employ the rigorous metrics-driven ProCapacity IndexTM Tool as appropriate for NGOs and smaller service providers, and NUPAS for organizations seeking to receive USG grants or contracts directly.

The results of the assessments—together with indicators that assess progress across the three health system dimensions will form the basis of an aggregated country-wide Sustainability and Transition Index.[3] The aggregated index is an easy-to-read summary dashboard of progress of all LHSS country programs.

[3] Summarized in the Performance Indicators Tracking Table of the annual LHSS MEL report

ANNEX: ILLUSTRATIVE LOCAL PARTNER TRANSITION PLANS

We expect to develop local partner transition plans for each country program. In the illustrative examples provided below, we have identified local IPs and their project roles, the types of capacity building they need, and their envisaged role post-project. Specifically, the second column summarizes the local partners' roles (both in the health system in general and under the TO), while the third column lists the types of support we will provide to maximize their capacity during Years 1–3. The last column shows our expectations for the partners' transition status during Years 4–5 to enable them to undertake at least 20 percent of country work by the end of the LHSS intervention(s).

Table A-1: Illustrative Examples of Local Partner Transition Plans

Illustrative Local Partners	Illustrative Local Partner Roles in HSS and under the TO	LHSS Illustrative Role Years 1–3: Capacity Building	Partner Status Years 3–5: Transition
GHANA			
Ubora Institute (via IHI)	Deliver TA to MOH, service providers, regulatory agencies, and professional associations to implement the National Health Quality Strategy	Expand capacity to deliver TA (through sub-contract)	Have in-country funding for TA practice to meet local demand from providers and government
Associations (e.g., Ghana Registered Midwives Association, Community Practice Pharmacists Association)	Assist public and private providers to institutionalize roles in National Health Quality Strategy; engage in community-based service learning model and rational pharma; form/strengthen networks to offer full primary health care packages and adopt managed care	Strengthen institutional capacity and add value to members by building ability to make and execute business plans, provide TA to members, and raise revenue (through sub-contracts and TA)	Have growing TA practice with members and payers; experience revenue growth; and be recognized as active partners with MOH to implement national quality and National Health Insurance reforms
Public and private health service providers (Christian Health Association of Ghana, other faith-based organizations); Ghana Health Services (GHS)	Provide high-quality primary health care; Integrate quality improvement into patient care; expand use of DHIS2 and e-records; engage in community-based service learning model; adopt managed care methods to succeed under fixed payment system	Support investments in staff capacity, internal systems, and infrastructure (through in-kind GUCs, funds to private providers, and TA to public providers such as GHS	Have institutionalized continuous quality improvement; be accredited by the Health Facilities Regulatory Agency; and hold long-term contracts with University for Development Studies and other academic institutions
Eligible private providers and/or community organizations; GHS	Create new/revitalize existing Community-based Health Planning and Services (CHPS) facilities through public-private partnerships with GHS; and CHPS participate in community-based service learning model	Mobilize private resources (through results-based GUCs and commercial banks) to invest in CHPS facilities, to allow them to contract with and provide TA to GHS	Operate independently with GHS co-funding recurrent costs; and receive direct donor funding (private organizations)

Illustrative Local Partners	Illustrative Local Partner Roles in HSS and under the TO	LHSS Illustrative Role Years 1–3: Capacity Building	Partner Status Years 3–5: Transition
University for Development Studies; University for Health and Allied Services	Maintain and expand community-based service learning model to new districts to add, retain, and train health workers in underserved areas	Build University for Development Studies and private academic institutions' organizational and technical capacity (through GUCs and TA)	Operate self-sustaining practices through contracts with providers (employers), community, and tuition revenue
Ghana Pharmacy Council; Pharmaceutical Society of Ghana	Support licensed chemical sellers to expand access to essential medicines at lower prices	Build organizational and technical capacity to support licensed chemical sellers to partner with facilities (through GUCs)	Have business plans to sustain solutions, such as partnerships with facilities
Local journalists (Internews Fellows); community, digital, and commercial media	Communicate complex policy changes and messages to transform attitudes about gender, healthy behaviors, and quality	Build technical capacity in journalism through a challenge fund (with TA)	Continue using skills to affect public attitudes and behaviors
MOH; University of Ghana	Engage in evaluation, implementation research, and collaborative learning	Build capacity to design and conduct research (sub-contract to University of Ghana)	Lead research independently
DOMINICAN REPUBLIC			
Instituto Dominicano de Dermatología y Cirugía de la Piel Dr. Huberto Bogaert	Build capacity of smaller NGOs and firms in grants management, administration, and organizational development	Support training, tools and processes to strengthen consulting business management (through umbrella GUCs and TA)	Receive GUCs and USAID transition awards; and prepare for direct contracts from the Government of the Dominican Republic, and fees from NGOs for TA
Insalud and its 57 member non-profit associations implementing USAID's Local Capacity Initiative	Provide technical capacity building for smaller NGOs	Build capacity to provide TA (through QA and umbrella GUCs); strengthen management of USAID grants; and strengthen financial and organizational development (through TA)	Receive GUCs and USAID transition awards for TA; prepare for contracts from Government; and prepare for collection of fees from NGOs for TA
GIS Grupo Consultor	Deliver TA for supply chain, social insurance; and support national policy formulation	Build capacity to provide TA (through GUCs); and build capacity for management of USAID grants and contracts (through TA and QA and sub-contract)	Receive sub-contracts for TA, followed by USAID transition award; Receive Government contracts
Fundación Plenitud	Deliver TA for health financing and economics; support national policy formulation; and provide capacity building	Support expansion into new technical areas; and build systems for business growth (through TA and QA)	Receive direct government TA contracts

Illustrative Local Partners	Illustrative Local Partner Roles in HSS and under the TO	LHSS Illustrative Role Years 1–3: Capacity Building	Partner Status Years 3–5: Transition
UGANDA			
Civil Society Budget Advocacy Group	Engage citizens in budget allocation, expenditure, and use	Strengthen organizational and technical capacity (Years 1 and 2) (through TA; and build technical capacity in advocacy (Years 3 and 4) through GUCs and QA	Receive GUCs and USAID transition awards to lead citizen engagement
Straight Talk Foundation	Mobilize political and religious leaders, village health teams, and others at the community level to engage in UHC advocacy	Strengthen organizational and technical capacity (Years 1 and 2) through TA; and build technical capacity for TA in citizen engagement (Years 3 and 4) (through GUCs and QA)	Receive GUCs and USAID transition awards for self-sustaining TA practice in advocacy
Save for Health Uganda	Explore options to expand community-based health insurance coverage, and maintain financial viability of schemes	Build capacity to advocate for: 1) local leaders to increase community-based health insurance enrollment, and 2) an MOH/National Health Insurance Task Force to explore strategies and mechanisms to optimize existing insurance and voucher schemes (through QA)	Prepare for direct contracts from the Government of Uganda to generate (and help MOH interpret) evidence for pooling community-based health insurance schemes into National Health Insurance
Private Sector Foundation of Uganda; Uganda Health Care Federation	Engage private sector in service delivery and insurance enrollment; and build capacity of private providers	Build technical capacity to: 1) help private health providers participate in community-based health insurance and increase access to credit; and 2) roll out and enforce minimum quality standards through strategic purchasing mechanisms (through results-based GUCs and QA)	Lead development of public-private partnerships with MOH; and support institutionalization of continuous quality improvement among members