

**BUILDING CAPACITY
FOR HEALTH SYSTEM
STRENGTHENING:
A STRATEGY
THAT WORKS**

**THE WORLD BANK INSTITUTE'S
FLAGSHIP PROGRAM ON HEALTH SECTOR REFORM
AND SUSTAINABLE FINANCING, 1997-2008**

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LEARNING FOR DEVELOPMENT



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ABSTRACT

Between 1997-2008, the World Bank Institute's "Flagship Program on Health Sector Reform and Sustainable Financing" delivered 319 short-term training events to more than 19,400 policy-makers, analysts and implementers in 51 Bank client countries. Resource persons from more than 34 technical and implementation partners from around the world have collaborated to develop and deliver learning materials, approximately half located in developed countries and half in developing countries. This paper reflects on the design, implementation, impact, and lessons learned from the "Flagship Program," widely regarded as the World Bank Institute's most successful and longstanding capacity-building initiative in health in developing countries. Such a review is timely given current calls for Health System Strengthening and the paucity of serious efforts to scale up training and capacity building to this end.

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A Strategy for Capacity Building in Health that Works

BACKGROUND

In 1995, several bi-lateral donors requested the World Bank Institute (WBI) to develop a training and capacity-building program for low and middle income countries to address a burgeoning interest in health sector and financing reforms.² Their motivation was to (i) offer a more systematic treatment of health systems across many countries at different levels of development, (ii) share perspectives on the pros and cons of different options for improving performance, (iii) foster a more evidence based approach to implementing change, and (iv) contribute to regional and national level capacity building in the area of training and information services. WBI responded by launching an ambitious program called the “Flagship Program on Health Sector Reform and Sustainable Financing.” It includes a global course held annually in Washington DC; regional courses in all five major geographical regions served by the World Bank; “senior policy seminars” and country-specific courses on selected themes; distance learning and a web-based learning program. Figure 1 depicts the Program’s delivery arrangements.

Development of the Program’s learning platform was guided by yearlong consultations with donors, government officials, and training institutions in different parts of the world. In 1997, for example, a “demand assessment” solicited views on the need for training and priority issues in health systems development and related financing from 100 officials (including 12 Ministers of Health) from more than 30 countries at a World Bank conference held in Washington DC.³ In addition, officials of bi-lateral and multi-lateral donor agencies—including DANIDA, DIFD, NORAD, IrishAID, CIDA, USAID, WHO, UNICEF, UNFPA—were consulted regarding the types of capacity-building activities they viewed as essential. These consultations led to agreement on five premises, all of which still apply today:

- The Flagship Program would offer “executive level” training to middle or senior level policy makers or administrators working in Ministries Health, Planning, Finance, Social Security, NGOs, health insurance agencies, the private sector, donor agencies and World Bank staff.
- Learning would focus primarily on performance and development of the health system, acknowledging the importance of factors other than *health services* per se.
- There would be no pretense that the World Bank has a proven solution for health

sector reform or that “one size fits all.” Nor would any kind of World Bank blueprint or agenda for reform be advocated. Rather, the importance of national values, culture, politics, and history, and the pros and cons of different country approaches to improving performance would be emphasized.

- Economics, resource mobilization, and allocation of public finance would feature prominently in the learning agenda in view of the World Bank’s comparative advantage in these areas.
- Impact of training and capacity building would be evaluated using participant satisfaction ratings, cognitive testing as well as various forms of follow-up to assess usefulness at the country level.

Most important, the Program established three specific capacity-building objectives:

OBJECTIVE 1

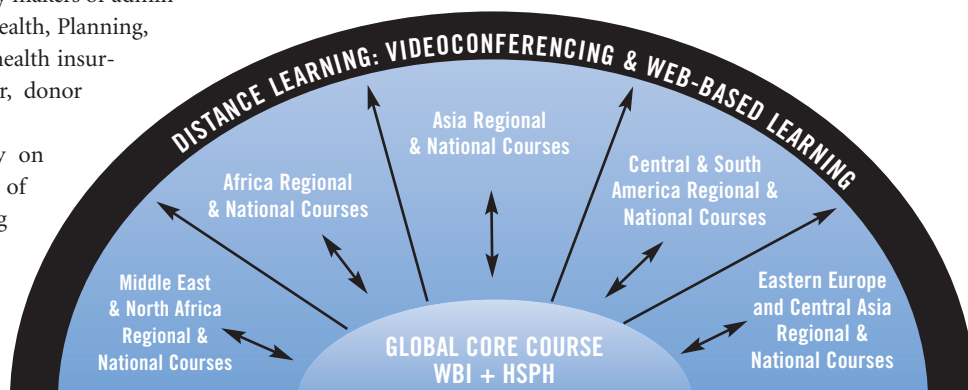
Facilitate the transfer of cutting edge knowledge on health sector reform and sustainable financing to developing countries;

OBJECTIVE 2

Empower country clients to implement policies and programs to render their national health systems more equitable, efficient, qualitative and financially sustainable;

OBJECTIVE 3

Strengthen the capacities of partner institutions and networks of professionals in Bank client countries to take the lead in designing, adapting, and sustaining Flagship learning programs in local areas and local languages.



In the early years, several different “brain trusts” contributed to the development and delivery of the Program’s learning framework, including McMaster University (Canada), York University (UK), Capetown University (South Africa), Bitran y Asociados (Chile), American University of Beirut (Lebanon), Chulalongkorn University (Thailand), the Harvard School of Public Health (USA), and various thematic teams working on health in WBI and the World Bank. These

The fundamental approach of the Flagship learning framework is to engage participants to think and debate in new ways about how to improve performance of the health system.

arrangements became unwieldy, however, resulting in a much closer partnering between WBI and the Harvard School of Public Health (HSPH). The Global course now operates as a joint WBI/HSPH offering, drawing on resource persons from universities, NGOs and the World Bank. Conversely, regional and country partners took the lead in adapting core course materials to local conditions, enlisting local expertise, preparing case studies, translating materials, and identifying relevant themes and participants (more on partnering to follow).

At the heart of the Program is the Flagship learning framework, developed for the global core course and published as *Getting Health Reform Right: A Guide to Performance and Equity*, by Oxford University Press.⁴ As explained in more depth in Annex 1, it contains several components including identification of core health system goals and outcomes to be attained, performance bottlenecks that stand in the way, and reform levers or “control knobs” to activate desired change. In addition, ethical foundations of problem definition, as well as the politics of mobilizing stakeholders to action, play an important role in the learning framework.

The fundamental approach of the Flagship learning framework is to engage participants to **think and debate** in new ways about how to improve performance of the health system, such that options for change can be more directly linked to desired outcomes. The pedagogy results in four distinct learning benefits. First, it shifts health sector reform thinking from a traditional emphasis on inputs to a focus on higher order outcomes that society is failing to achieve. Second, it helps participants to rethink the laundry lists of health sector problems they typically perceive, and to prioritize those most relevant to achieving the central societal outcome(s) they desire. Third,

it enables them to formulate an action oriented strategy to attain their desired outcome (e.g., reduce maternal mortality rates) using a parsimonious set of reform levers based on a causal diagnosis of problems. And, fourth, it enables participants to anticipate how changes in one dimension of a health system (eg., payment or hospital reform) can impact other dimensions.

Participant involvement is assured through the Harvard Business School “case method of learning” as well as membership in a country group that lasts the entire duration of the training. The country group work plays a prominent role in the effectiveness of Flagship learning because participants must apply each dimension of the learning framework to their country (or a country in their region), making use of latest social, economic and health system data. Flagship training events at the global, regional and national level typically conclude with presentations by participant groups of their country-specific strategies. Necessarily, this is a workshop exercise, though a large number of groups have transferred their country group strategies back to their countries in the form of presentations to their colleagues, to Secretaries and Minister’s of Health, and to actual implementation of pilot activities.

While the Flagship learning framework figures prominently in virtually all training events, an increasing number of training activities “drill down” into specific health system issues of immediate concern to client countries have been offered. Table 1 illustrates theme-specific Flagship training that has taken place around the world, with technical backstopping from faculty of the Global course as well as Flagship regional partners, the World Bank and WBI.

TABLE 1: THEME-SPECIFIC ISSUES ADDRESSED BY THE FLAGSHIP PROGRAM

Themes	Country or Region Offered
Strengthening Health Chapters in National Poverty Reduction Strategies	Sub-Saharan Africa
Public-Private Partnerships	Pakistan, Burkina Faso, India, Lebanon
Decentralization	Egypt, Turkey
Public Health Challenges	Lebanon
Quality Improvements	Tunisia, Lebanon, Hungary
Health Insurance	Nigeria, Ghana, South Africa, China
Provider Payments	Philippines
Contracting	Senegal, Madagascar
Hospital Reform & Financing	Benin, Senegal, Mexico
Performance-Based Contracting	Mali
Health Financing & Targeting Public Subsidies	Bangladesh, China
Health Systems Policy & Management	India
Public Policy & the Private Sector	China
Immunization in Eastern Europe	Hungary
Financing, Organization & Primary Health Care	Russia Oblasts
Basics of Health Economics	E-learning

The Flagship Program’s capacity-building strategy has several components, as summarized in Table 2. At the heart of the Program, the Global Course takes the lead in identifying new content, learning targets and evaluation. Regional courses, delivered by Flagship training partners, take the lead in prioritizing issues relevant to countries in their region, and adapt training to country needs. National courses tend to “drill down” into issues that are of immediate relevance to national planners and implementers. Each of these levels involves considerable exchange of faculty, “training-of-trainers,” sharing of resource materials (for example, country case studies designed for learning events), and subsequent networking of participants and faculty.

Shorter-term training in the form of video-conferencing via WBI’s Global Development Learning Network (GDLN), and e-Learning courses aim to be more flexible, providing “just in time” training on new tools, techniques, or special policy issues, as well as north-south and south-south networking. The duration of “distance” learning activities ranges from 2-5 days, compared to 2-3 weeks for the abovementioned face-to-face courses.

Finally, the Program offers “senior policy seminars” and conferences on occasional basis. Senior policy seminars provide earmarked training for national policy makers on a strategic issue of importance to a country, such as the pending launch of social health insurance. Occasional conferences are usually international in nature, focusing on broader themes of importance to health systems development such as new financing trends or scaling up efforts to attain the MDGs.

Overall, this capacity-building strategy is shaped by and responds to demands of Bank client countries. The more the program has become known and established, the more countries have requested regional and national training events, and the more distance learning technologies have come into play to satisfy short term training needs closer to where people live and work. To our knowledge, no other executive training programs on health systems strengthening have the same scope and reach as offered by the Flagship Program. It is through this strategic approach that the Program aims to achieve its capacity-building Objectives 1 and 2, as noted previously.

TABLE 2: FLAGSHIP CAPACITY-BUILDING STRATEGY

Learning Modality Type	Contribution or role in overall capacity-building strategy
Global Course	Takes the lead in identifying new content areas, setting protocols and standards for training and evaluation.
Regional Courses	Takes the lead in prioritizing issues relevant to countries in their area and adapt training to local needs. Content feeds back to global course enriching its coverage of new developments.
National Courses	“Drill-down” into issues of immediate relevance to a country tackling a particular health system issue or capacity gap. Content feeds back to global course enriching its coverage of new developments.
Video-Conferencing Via WBI’s Global Development Learning Network (GDLN)	Best suited to short-term “just in time” training on particular issues, as well as north-south and south-south networking.
e-Learning Courses	Highly demanded and promising route to introducing participants to new tools, techniques, and paradigms while accommodating a more flexible time schedule.
Occasional Senior Policy Seminars	Earmarked policy discussion seminars for senior policy makers on strategic issues of importance to the country.
Occasional Conferences	Earmarked learning event to share and disseminate knowledge products on topics of national or international significance (e.g., latest research on health financing issues, latest policies on a communicable disease).

During the period 1997-2008, WBI and its collaborating partners delivered 314 short-term training events on “health sector reform and sustainable financing” to 19,400 participants in 51 countries. Table 3 conveys that approximately 10% of total training took place at the annual, global course, 44% at regional partner institutes serving a variety of countries in their immediate region, 35% at country-specific courses, 6% at video-conference sites via WBI’s “Global Development Learning Network,” 2.3% at major conferences and workshops, and 3% in recent e-learning seminars.⁵ Adjusting participant days by “average duration of training” shows the program has delivered a total of approximately 134,000 participant training days on health systems development and sustainable financing.

The 257 regional and country-specific training activities summarized in Table 3 have been delivered in all major geographic regions served by the World Bank. As depicted in Table 4, they have been delivered in 12 countries in Asia, 13 in Africa, 8 in the Middle East and North Africa, 9 in Central and South America, and 10 in Eastern Europe and Central Asia. Since many participants originate from countries *other than* the country hosting the Flagship training activity, the “reach” of the Flagship Program is even greater. In other words, the total number of countries with participants that have benefitted from Flagship training is probably closer to 100.

The 41 videoconferencing and major workshops/conferences summarized in Table 3 pertain largely to networking and knowledge sharing from “north-to-south” and “south-to-south.” These tend to be shorter duration events, tapping into networks, connecting various parties with a common interest in reform themes, and so on.

TABLE 3: TRAINING ACTIVITIES, PARTICIPANTS AND TRAINING DAYS, 1997-2008

	# Activities	# Participants	Average Training Days per Participant	Total Participant Training Days	% Share of Training Days
Annual Global Core Course	11	860	15	12,900	9.6
Regional Courses	132	5944	10	59,440	44.3
Country-Specific Courses	125	6225	7.5	46,687	34.8
Video-Conference Courses ^b	31	4008	2	8,016	6.0
Major conferences/workshops	10	1559	2	3,118	2.3
E-learning	9	813	5	4,065	3.0
TOTAL	319	19,409	--	134,226	100.0

TABLE 4: REGIONAL & COUNTRY ACTIVITIES BY COUNTRY OF DELIVERY, 1997-2008

Asia	Africa		Middle East & North Africa	Central & South America	Eastern Europe & Central Asia
	Anglophone	Francophone			
Afghanistan	Ethiopia	Benin	Egypt	Argentina	Bosnia
Bangladesh	Ghana	Burkina Faso	Iran	Bolivia	Hungary
China	Kenya	Cote d'Ivoire	Iraq	Chile	Kazakhstan
Hong Kong	Madagascar	Mali	Lebanon	Dominican Rep.	Kyrgyz. Rep.
India	Nigeria	Mauritania	Morocco	El Salvador	Macedonia
Indonesia	South Africa	Senegal	Saudi Arabia	Guatemala	Romania
Malaysia	Uganda		Tunisia	Honduras	Russia
Mongolia			Yemen AR	Mexico	Turkey
Pakistan				Panama	Ukraine
Philippines					Uzbekistan
Singapore					
Thailand					

Source: WBI Databases.

PARTNERING ARRANGEMENTS

The Flagship Program owes much of its success to extensive partnering arrangements. Over the years, this has included 12 technical partners, 21 implementation partners, and 19 advisory and financial partners. These are summarized in Annex 2.

The Program's implementation partners have been the major force in building capacities at regional and national level. Their selection has been guided by three criteria. They should demonstrate sufficient technical capacity and expertise to contribute to knowledge of health reform and financing issues in their respective region or country. They should occupy a "strategic niche" where-

by they can potentially bring influence and "value-added" to health policy and implementation in their respective region or country. And, they should be willing and able to deliver training activities at a satisfactory venue. While few partners are able to satisfy all of these criteria at the outset, collaboration and capacity building has resulted in stronger partners over time. The Program's partnering strategy has been the lynchpin of its strategic orientation to achieve capacity-building **Objective 3**, as stated previously.

Common arrangements involving the Program's implementation partners can be illustrated as follows:

FLAGSHIP REGIONAL PARTNER INSTITUTES

In Lebanon, a partnership was formed with the Faculty of Health Sciences at the American University of Beirut. Serving as a regional partner institute since 1999, AUB has delivered 12 regional Flagship courses to 457 leading health professionals from countries of the Middle East and Northern Africa and collaborated on the delivery of 16 national courses in Iran and Egypt, reaching about 685 Iranian and Egyptian health professionals.

NATIONAL FLAGSHIP TRAINING NETWORKS

In China, a partnership was formed with the "China Network for Training and Research in Health Economics and Finance" that, today, comprises 29 network-affiliated Chinese universities, research institutes, and professional journals. As a Flagship regional partner institute since 1999, the China Network has delivered 34 national Flagship courses to almost 2500 health decision makers and executives. Due to the country's population size and language, China was granted permission by WBI to operate a full-fledged Flagship learning program on a national level administered by the Ministry of Health.

COUNTRY-SPECIFIC INTENSIVE TRAINING

In Iran, a partnership was formed with the Iranian Ministry of Health and Medical Education and the American University of Beirut to design and deliver seven, one-week courses over a nine month period to a cohort of 50 senior managers and implementers in 2004. This resulted in the translation and dissemination of training materials into Farsi to more than 2,000 health workers at provincial and district levels. Follow-up courses were delivered in 2005 and 2007 to an additional 289 health officials.

Similar arrangements have been launched in more than 15 countries, among which Bangladesh reaching 224 participants, Egypt (335), India (361), Philippines (280), Turkey (617), and Russia (202). In addition to establishing partnerships with national training institutes to design and deliver training programs, this approach fostered strong collaboration between the Bank's Operations and WBI in serving Bank client countries.



The Program’s relevance and impact can be assessed in terms of the three capacity-building objectives stated at the beginning of this paper. Intended effects take time to build momentum, of course, to yield results on the ground. Moreover, appropriate ways of measuring impact of short-term training tend to be widely disputed, are often ineffectual, and lack guidelines on “best practice.”

Acknowledging the above, the Flagship Program combines information from several sources to reflect on relevance and impact as follows:

- ▶ **Does demand for course offerings, participant satisfaction, and perceived learning suggest the Flagship Program offers cutting edge learning to participants? This relates to the Program’s capacity-building Objective 1.**
- ▶ **Has the learning framework contributed to the capacity of participants to implement changes in their health systems? This relates to capacity-building Objective 2.**
- ▶ **Has the Program helped to strengthen the capacity of partner institutes to serve as centers of excellence in their respective regions? This relates to capacity-building Objective 3.**

DEMAND, PARTICIPANT SATISFACTION AND LEARNING GAINS

A simple “market test” of the demand for Flagship training combined with an assessment of participant satisfaction at the conclusion of training events, suggests the Global course remains cutting edge. On the one hand, demand for Flagship training has increased dramatically over the last ten years—by participants and client countries alike—with strong and often oversubscribed enrollment. This confirms ability and willingness to pay by individuals or their sponsors.⁷ On the other hand, participant assessments of the relevance, utility and quality of Flagship training typically reveals high levels of satisfaction. This is conveyed in Table 5 which reports the proportion of participants scoring the learning activity a “4” or a “5” on a five point scale (“0” being lowest, “5” being highest). Satisfaction ratings for the Global course are consistently above 80 percent on two key questions “relevance to your work” and “overall usefulness of the course.”⁸

For the most part, regional and country Flagship learning activities have received similar participant satisfaction ratings, even during the early days when Flagship regional partners were launching new activities. To illustrate, satisfaction ratings for 17 regional and national activities conducted in 2008 were 83%, on average, for “relevance to your work,” and 88%, on average, “for overall usefulness” (see Annex 3 for country-specific data).

To complement the above, the Program employed various tests to measure cognitive learning gains. For example, organizers of learning activities (i) prepared a set of substantive questions—for example, 40

questions—with multiple choice answers applicable to the training matter, (ii) randomly selected half of the questions for a pre-course and half for a post-course test, and (iii) quantified learning gains between the two tests. The international literature suggested that cognitive learning gains of approximately 20% or more are acceptable for short term training. Table 6 conveys that both the Flagship global course as well as regional partner offerings performed well overall on such tests (see Annex 3 for more detailed information). Results not presented here further reveal that largest relative learning gains took place in the areas of “analyzing health sector performance” and “reforming and managing health institutions.” This mode of evaluation, however, was dropped by the World Bank Institute after 2002 for reasons discussed later.

TABLE 5: SATISFACTION RATINGS WITH FLAGSHIP GLOBAL COURSE TRAINING, 1998-2008*

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Relevance to Your Work	89	90	86	90	no course	91	79	98	81	81	90
Overall Usefulness of the Course	90	90	85	90	no course	94	84	92	88	88	77

* Proportion of respondents ranking the learning activity a “4” or “5” on a 5-point scale; the global course was not offered in 2002 to allow for major revision and development of new materials.

TABLE 6: COGNITIVE LEARNING GAINS*

GLOBAL ANNUAL CORE COURSES	Average Pre-Course	Average Post-Course	Average Relative Growth
Four Global Core Courses 1998-2001	45.5	57.3	25.8
Nine Regional Partner Courses, 2000	39.8	55.4	39.3
Four Regional Partner Courses, 2002	38.0	54.4	43.2

* Data pertain to proportion of respondents who selected the correct answers to test questions.

EMPOWERING COUNTRY CLIENTS TO BETTER IMPLEMENT POLICIES AND PROGRAMS

To assess this dimension, feedback has been solicited from participants and country-level organizers on the value-added of Flagship training in working environments. Three examples highlight the kinds of impact the training appears to be having in the area of implementation:

INDIA

A tracer study of 100 high level state and federal officials from India that had attended the annual Flagship Global courses from 1997-2006 was conducted in 2007.⁹ On a seven-point scale, eighty-three percent ranked their prior Flagship training as relevant and useful to their work (a score of “4” or more); none said the training was not relevant. In the words of one participant, “The discussions on financing strategies of health sector, experience-sharing of different countries and case studies are the three things I found most valuable... It gave me insight into the various options of financing, their pros and cons and their suitability to various work-environments. After this training, I vigorously pursued the policy changes in Health Department and I successfully changed the payment system to service providers from fixed salary system to salary plus performance-based incentive system. That system is working well even after one year of leaving the department.”

IRAN

The past director of Iran’s “Health Sector Reform” unit in the MOH, now a Member of the National Board of Pharmoeconomics, provided feedback on the value added of intensive Flagship training for 40-50 high level officials that attended nine, one week, sequenced sessions between 2001/02. This official claims the training contributed to the country’s health sector reform strategies by:

- Establishing a common language on “health sector reform” among different stakeholders;
- Building capacity of managers and experts in the ministry of health at both central and local levels, with roll-out training building capacity of hundreds of managers and expertise in key provinces;
- Establishing a short course for political people inside the MOH as well as special sessions for parliamentarians, management and planning organizations, and the association of physicians on reform options;
- Utilizing new concepts and common language on health sector reform in the Country’s Fourth Five Year Plan; and
- Application of some of the concepts and new vision from the Flagship learning framework, such as provider payments and contracting, in the expansion of health insurance coverage to 22 million people in rural areas of the country in 2004.



TANZANIA

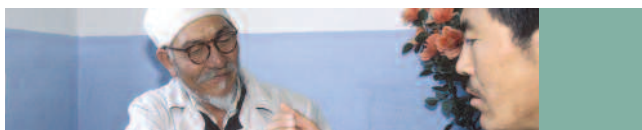
The head of the Health Sector Reform Section of Tanzania’s Ministry of Health and Social Welfare provided feedback on the relevance of the training to Tanzania’s on-going efforts to design, pilot and roll out cost sharing initiatives involving health insurance for the poor. This official attended the very first Global course and has overseen Tanzanian participation for the last ten years during which a team of between three to six participants, annually, has attended the Global course or Flagship courses offered in the region. This official claims, “The Flagship courses have served us well. Firstly, to allow us, as a team, to have a baseline understanding of the theories of financing and, secondly, to learn new developments in the financing fields, and thirdly, to allow us to manage the health reforms we are mandated to (implement).” He further points out that the Flagship training added value by:

- Clarifying roles of “finance” versus “provider payments” in health system performance, contributing to the formulation of payment strategies by health insurance fund holders as well as “service agreements” to engage the private sector;
- Contributing to understanding of regulatory procedures as an input into improved governance, now manifesting in the development of a regulatory framework for Tanzania’s insurance schemes;
- Emphasizing the importance of politics, ethics and behavior in improving health outcomes, including tools to position health concerns more strategically, proactive interventions to improve healthy behaviors, and enforcement of stronger ethical codes among providers;
- Drilling down into key areas, such as pharmaceuticals, and showing how the Flagship “control knobs” apply to the performance of key commodities.

To complement feedback from country officials, the Program has further solicited feedback from World Bank “task team leaders” (TTLs) who manage health system development projects in regions and countries served by the Program. Bank TTLs are a hard crowd to please because they demand that WBI—as the Bank’s pre-eminent “learning arm”—demonstrates value-added through capacity building that improves day-to-day collaboration with clients as well as performance on the ground. Their views are invaluable because they have extensive contacts in Bank client countries, they help identify participants for Flagship training, and they have the opportunity of observing both large scale and small-scale changes in client countries. They too provide strong confirmation of the positive effects of Flagship training, as exemplified in Annex 4.

STRENGTHENING THE CAPACITY OF PARTNER INSTITUTES

To assess this dimension, the Program has solicited feedback from regional implementation partners to flesh out various ways their capacities have been strengthened, thus yielding benefits to clients they serve in their respective regions. The following examples underscore the Program’s capacity-building effects.



FLAGSHIP PARTNER IN CHINA

Managers of the China Health Economic Network claim that collaboration with the Flagship Program from 1999 onwards contributed to an increase in network membership from an original seven institutions to twenty-nine, greatly increased the number of health sector courses offered, and led to the training of more than 2,000 executives from various ministries and more than 300 academics and trainers. These outputs have led to significant outcomes including:

- An increasing number of network-trained faculty members/researchers have become recognized senior advisors to central and local governments on policy decisions in China.
- Attraction of China’s policy and academic community to network courses has led to exploration of technology (China’s internal video conferencing system) to expand reach to more policymakers with good content (given the size and needs of the country).
- Translation of network training materials for use in network courses has led to their adaptation for use in regular graduate and undergraduate courses by training centers and universities.
- Researchers in health economics and finance have used the network’s annual meeting to exchange findings and ideas and to build teams for seeking research grants.
- The international development community, including the World Bank, WHO, DIFD, and UNICEF, increasingly rely on Network researchers to conduct policy research in the health sector and assist them in their operations in China.

The most visible impact of the Network on China’s health system is the recent introduction of rural sector reforms by policymakers assisted by the long-term research done by the Network’s faculty and the Flagship senior policy seminars.



FLAGSHIP PARTNER IN SENEGAL & BENIN

The Flagship program has worked closely with the “Centre Africain d’Etudes Supérieures en Gestion” and the “Ecole National d’Economie Appliquée” in Sénégal, and the “Institut Régional de Santé Publique” in Benin to design and co-deliver a variety of Flagship activities for countries of Francophone Africa. Following introductory training on the Flagship learning framework in 2002, countries requested more focused training on “public-private partnerships through contracting of health services,” “health insurance,” and “hospital reform.” Accordingly, with the help of the Flagship Program, the regional partners developed eight learning activities on contracting of health services between 2003-08, involving approximately 200 participants. They included officials in Ministries of Health as well as non-governmental organizations who subsequently delivered such training in their own countries. The organizers convey that several countries formulated a policy on contracting as a result, including Benin, Burkina Faso, Burundi, Madagascar, Mali, Niger and Senegal. Of these, the policy was formally adopted by the governments of Benin, Burundi, Madagascar, and Senegal. In addition, the regional partners facilitated “training of trainers” workshops and subsequently launched national training events on contracting in Niger, Madagascar, Mali, Morocco and Senegal.¹⁰

FLAGSHIP PARTNER IN HUNGARY

Directors of the “Health Services Management Training Center” (HSMTC) at Semmelweis University claim that “Without WBI support (via the Flagship Program), through training of trainers, content development and continuous hands-on capacity building, HSMTC would not be an internationally recognized training institute in Central and Eastern Europe and beyond.” HSMTC has assisted new Flagship partner arrangements in Russia, Kyrgyzstan and the Ukraine. The Directors further claim that of the 850 “leading professionals” that received Flagship training from countries in Eastern Europe, “... many have designed, implemented or participated in the implementation and evaluation of health sector reforms since then. Others have used their newly acquired knowledge and skills to spread new ideas, share experience or simply build the Flagship course material into their own training programs, hence multiply the outreach effect of the Program.” These impressions are confirmed by management of WHO/EURO who claim it is “...immensely helpful when the new Deputy Minister or Minister (of Health in Eastern European countries) has been a former participant in the Flagship training.”

LESSONS LEARNED

Ambitious in scope and determined to bring value-added to capacity building in Bank client countries, the Flagship Program has devoted ten years to establishing “proof of concept” and demonstrating relevance. It embodies a vast repertoire of knowledge not only on pedagogical issues and health reform challenges in developing countries, but on the process of institutional capacity building as well. Nevertheless, the journey has not always been an easy one. Several hurdles continue to challenge the Program, as detailed in Annex 6. **KEY LESSONS LEARNED INCLUDE THE FOLLOWING** ▶▶▶

FIRST.

DEMAND FOR FLAGSHIP TRAINING REMAINS STRONG AMONG BANK CLIENT COUNTRIES, BANK STAFF, AND STAFF OF DONOR AGENCIES AND INTERNATIONAL NGOS.

At the same time, enrolling and satisfying participants have involved some resilient challenges. It has been easier to enroll and satisfy public officials than representatives of NGOs and the private sector; there is a gap in the number of high level officials enrolled versus desired; and wide differences in participant skill levels and interests—especially in the Global course—make it hard to satisfy audience expectations.

SECOND.

THE PROGRAM'S OVERALL CAPACITY-BUILDING STRATEGY AND RELATED “DELIVERY ARRANGEMENTS”—as summarized in Table 2—HAS BEEN EFFECTIVE.

The global core course, involving close collaboration between WBI and the Harvard School of Public Health, plays a central role in identifying new content areas, setting protocols for training and establishing standards for evaluation. The regional courses have worked well to provide training in local languages and to address regional and country concerns. The national courses, though more demanding of faculty and resources, have responded to specific country needs, providing “drill-down” into more applied issues. The video-conferencing and e-learning courses have provided highly efficient modes of training on specific issues and topics. And occasional senior policy seminars and conferences have allowed the Program to reach out to senior policy makers and implementers on topics of special policy relevance.

A caveat, however, is that national courses are considerably more demanding of faculty time and effort than are the regional courses or just-in-time training on specific technical issues. Greater familiarity with the political economy of national reforms is required, deeper knowledge of implementation issues is involved, and in-depth knowledge will be demanded by participants. This raises questions about the Program's comparative advantage and cost-effectiveness of preparing more time consuming training at the national level.

THIRD.

THE FLAGSHIP PROGRAM HAS SUCCEEDED IN PURSUING BROAD-BASED PARTNERING ARRANGEMENTS.

The Program's partnering strategy has involved multiple technical partners working together to develop content, as well as collaboration of main, regional partners in the updating and delivery of learning materials.

Identifying a strong partner, or at least one that can evolve rapidly into a strong partner, has been critical to the success and “brand name” of the Flagship Program.

If a regional or national partner is overly weak in terms of staffing, reputation, and venue, it will likely remain so and will require constant hand-holding from the center to perform adequately. A challenge, however, is that the Program's capacity to provide much needed financial assistance and technical backstopping to its “delivery partners” has always been stretched thin. This has been most problematic in Anglophone Africa where the Program fell short of establishing a strong regional partner. To a lesser extent, this problem also manifested itself in South Asia.

FOURTH.

THE LEARNING STYLE AND PEDAGOGICAL METHODS EMPLOYED BY THE PROGRAM HAVE WORKED WELL OVER THE YEARS.

Beyond pedagogy, however, the Program struggles with two major challenges. The most important challenge lies in the question of the “how to do it” rather than the “what to do.” **Participants are relentless in their demands for more specific information on implementation experience** and ways of overcoming myriad bottlenecks, and they expect an organization like the World Bank to deliver on this demand. The same applies to participant demands for more evidence-based learning and distillation of “best practice.” A problem faced by the faculty in all training activities is there is only so much time available to cover the broad spectrum of implementation issues involved, let alone distill the evidence based needed to do so. To grapple with this major lacuna, the faculty is now contemplating ways of offering “conditional guidance” on the design of strategic interventions—conditional on key factors known to enable or inhibit implementation success.

FIFTH.

THE TEACHING AND LEARNING EXPERIENCE OF ALL FLAGSHIP ACTIVITIES IS ENRICHED BY DRAWING ON RESOURCE PERSONS FROM DIVERSIFIED BACKGROUNDS. THIS REQUIRES A “BALANCING ACT”

whereby faculty with strong theoretical orientations (e.g., principles of designing social health insurance) are paired with resource persons with applied experience in developing countries (eg., day-to-day management of social health insurance). It also requires selection and preparation of resource persons who are good at training and able to synchronize their contributions with the learning objectives of the Flagship learning framework. Neither of these requirements is easy to fulfill, and when not done adequately, participants complain loudly.

FINALLY,

FINALLY, FUNDS TO RE-INVIGORATE, RE-TOOL, AND RE-VITALIZE THE PROGRAM ARE IN EXTREMELY SHORT SUPPLY.

While efforts to financially sustain the Flagship Program have been successful in the past—through donor contributions, cost-cutting and user fees—the non-profit nature of the Program, combined with balanced budget cost-recovery, has yielded virtually no surplus.

SIXTH.

CLOSE WORKING RELATIONS AND PROXIMITY TO THE BANK'S OPERATIONS HAS BEEN EXTREMELY VALUABLE IN IDENTIFYING POLICY MAKERS, MANAGERS AND ADMINISTRATORS CURRENTLY ENGAGED IN NATIONAL HEALTH SYSTEMS WHO ARE IN A POSITION TO EFFECT CHANGE AND IMPROVE PERFORMANCE.

This has been greatly facilitated by World Bank “task team leaders” who have nominated officials that would benefit from training, often taken the training themselves, and subsequently worked alongside Flagship alumni in client countries. In addition, a strong connection to the Bank's Operations has helped apprise the Flagship Program of changing country needs and new reform efforts on the ground.

SEVENTH.

AS IN ALL DEVELOPMENT WORK, MONITORING AND EVALUATION (M&E) OF THE IMPACT OF FLAGSHIP TRAINING REQUIRES MORE ATTENTION AND MORE EARMARKED RESOURCES.

Experience from the Program suggests that M&E falls far short due to:

- ▶ corporate pressures to expand volume of training without satisfactorily ascertaining its value added,
- ▶ absence of incentives to motivate staff to undertake high quality M&E, especially follow-up surveys, and
- ▶ lack of earmarked funding for M&E within WBI's regular operating budget as well as donor trust funds.

CONCLUSION AND NEXT STEPS

THE FLAGSHIP PROGRAM WAS WBI'S FIRST MAJOR LEARNING INITIATIVE THAT FEATURED AN IN-DEPTH CORE COURSE, A NETWORK OF REGIONAL TRAINING PARTNERS IN EACH MAJOR GEOGRAPHICAL REGION, AND SUBSEQUENT ROLL-OUT OF COUNTRY-SPECIFIC ACTIVITIES.

The Program's capacity-building strategy has been successful in combining a variety of training instruments to support health system delivery in Bank client countries. Strong partnering arrangements have facilitated development of cutting-edge learning materials, adapting learning to regional and local needs, and responding to changing demands. It has a well-recognized "brand name" and few competitors. While the journey has not always been an easy one and important hurdles remain, the Program is well positioned to contribute to current priorities of health systems strengthening.

LOOKING AHEAD, SEVERAL ACTIONS ARE REQUIRED TO ENABLE THE FLAGSHIP PROGRAM TO SERVE BANK CLIENTS BETTER ►

FOR IMMEDIATE ACTION

AN EXPANDED COALITION OF PARTNERS,

combining selected multi-lateral agencies, (eg., WHO, UNICEF, UNFPA), and international NGOs (Gates Foundation, Global Fund, GAVI), to explicitly recognize and support the Flagship Program's objectives as well as the institutional collaboration needed to attain them.

ADAPTATION OF THE PROGRAM'S LEARNING FRAMEWORK

such that it addresses current debates over "health systems strengthening" more explicitly, as well as the identification of policies and activities known to result in strengthening.

BROADEN THE PROGRAM'S LEARNING MATERIALS

such that they provide more attention to the political economy of implementation, including conditional guidance on necessary and sufficient conditions for strategic interventions to succeed.

REVISIT AND REINFORCE PARAMETERS FOR THE SELECTION OF FLAGSHIP PARTICIPANTS,

such that audiences who stand to benefit most from the training will be involved.

RENEW THE DRIVE TO MOBILIZE DONOR TRUST FUNDS

to help sustain and scale-up the Program, with commensurate emphasis on providing more support to regional partner institutes.

MEDIUM AND LONGER-TERM GOALS

ESTABLISH A REPOSITORY OF FLAGSHIP LEARNING MATERIALS,

dedicated to systematic distillation of studies on evidence-based reforms and implementation issues—what works, what doesn't, and why—in areas of financing, payments, organization, regulation and behavior modification.

UNDERTAKE MORE SYSTEMATIC "TRAINING OF TRAINERS"

to strengthen faculty at regional partner institutes and to prepare resource persons capable of serving client demands at country level.

INTRODUCE FOLLOW-UP MECHANISMS TO ENHANCE "HANDS-ON" LEARNING

to strengthen faculty at regional partner institutes and to prepare resource persons capable of serving client demands at country level.

LAUNCH A MORE AMBITIOUS PUBLICATION SERIES

to disseminate Flagship research, analysis and learning materials.

DESIGN AND EXECUTE A COMPREHENSIVE MONITORING AND EVALUATION PLAN

to better assess the relevance and value-added of training and capacity building at country level.



The Flagship learning framework begins by engaging participants in a discussion about ultimate as well as *intermediate* health system outcomes and what their society is achieving and failing to achieve. Ultimate outcomes are broadly classified into three categories—improving health status, financial risk protection, and client satisfaction. Each of these ultimate outcomes has both a “level” (such as the population average) and a “distribution” (the disparities between groups). It is through the notion of distribution that equity is introduced as an ultimate outcome.¹¹ Intermediate outcomes are also addressed under three broad categories—efficiency, access and quality—each affecting the capacity of health systems to attain desired outcomes. Focusing on the extent to which client countries are failing to achieve both ultimate and intermediate outcomes relative to their own goals is defined as their “health system performance.”

The next step probes the ethics underpinning the “the problem statement” to better understand the ethical foundations that different stakeholders (citizens, providers, politicians and bureaucrats, drug manufacturers) may have in support of, or at odds with, the importance given to these and other performance shortfalls or health system problems. Ethical positions weigh heavily on the kinds of problems stakeholders identify, the extent to which they are serious about changing them, and the kinds of ethical priorities they will enlist in support of appropriate strategy. Likewise, the Flagship framework stresses that “politics matters,” that tactics will be required to mobilize different stakeholders to agree on and tackle problems in a determined manner. To assist in developing a political strategy, participants are introduced to a planning software called “Policy Maker.”¹² Attention to both ethics and politics is thus central to the learning experience.

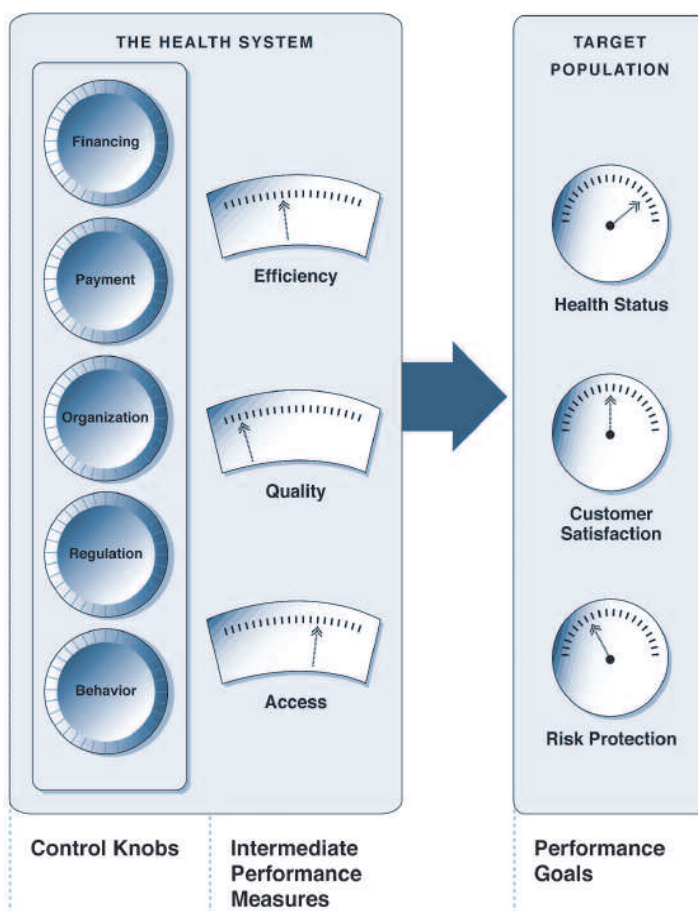
Considerable energy is then devoted to applying a “diagnostic tree”—an analytic tool—to understand health system obstacles and bottlenecks that stand in the way of solving the problems and attaining the desired societal outcome (improved performance), for example, reducing maternal mortality in rural areas. Participant engagement is key here, made operative in the form of a country group exercise whereby participants evolve a country-specific strategy using real data and real concerns to (i) identify and prioritize a problem, or an unattained outcome, for action, (ii) justify selection of the priority problem from an ethical standpoint, (iii) formulate a strategy to achieve the goal, and (iv) undertake a political analysis to determine feasibility of success. The country group work spans the entire duration of the course with different clusters of participants each working on a selected country.

Strategic intervention to produce change involves action on five “control knobs” or reform levers in the Flagship framework. As depicted in Figure 3, these are:

- **FINANCE**—resource mobilization, resource allocation, sustainability issues
- **PAYMENTS**—financial incentives, such as supply side payments to providers, demand side payments, pay for performance
- **ORGANIZATION**—the structure of health service delivery including the composition of the mix and interactions of the organizations that produce inputs like human resources, and the micro levels of within-organization functioning
- **REGULATION**—government regulation, self-regulation by financial or providers
- **PERSUASION AND BEHAVIOR CHANGE**—providers and clients (households)

Each “control knob” is explored through presentations, country case examples, and latest empirical evidence regarding various interventions. “Drill-down” sessions typically devote one or two days to illustrating how the control knobs apply to special topics, such as “social health insurance,” “public private partnerships,” or “pharmaceuticals.” It is our perspective that the five control knobs, though parsimonious, capture the main levers of reform. We have yet to add an additional control knob.

FIGURE 3: THE ROLE OF THE CONTROL KNOBS IN HEALTH SECTOR REFORM



ANNEX 2: LIST OF FLAGSHIP PARTNERS 1997-2008

TECHNICAL PARTNERS

- ▶ MCMASTER UNIVERSITY, Canada
- ▶ HARVARD SCHOOL OF PUBLIC HEALTH, USA
- ▶ YORK UNIVERSITY, England
- ▶ CAPETOWN AND WITWATERSRAND UNIVERSITIES, South Africa
- ▶ CHULALONGKORN UNIVERSITY, Thailand
- ▶ BASYS, Germany
- ▶ WHO, Geneva
- ▶ MANAGEMENT SCIENCES FOR HEALTH, USA
- ▶ BITRAN Y ASOCIADOS, Chile
- ▶ INSTITUTE FOR HEALTH SECTOR DEVELOPMENT, UK
- ▶ SWISS DEVELOPMENT CORPORATION, Switzerland
- ▶ ABT ASSOCIATES, USA
- ▶ HEALTH, NUTRITION, AND POPULATION HUB, WORLD BANK, USA

ADVISORY AND FINANCIAL PARTNERS

- ▶ DANIDA, Denmark
- ▶ Ministry of Foreign Affairs, Netherlands
- ▶ Ministry of Foreign Affairs, Norway
- ▶ Ministry of Foreign Affairs, Belgium
- ▶ Ministry of Foreign Affairs, Finland
- ▶ Ministry of Foreign Affairs, France
- ▶ Swedish International Development Cooperation Agency (Sida), Sweden
- ▶ Swiss Agency for Development and Cooperation (DSC), Switzerland
- ▶ World Health Organization, Switzerland
- ▶ Department for International Development (DFID), UK
- ▶ Canadian International Development Agency (CIDA), Canada
- ▶ IrishAid, Ireland
- ▶ Ministry of Foreign Affairs, Singapore
- ▶ Multilateral Financial Institutions, Ministry of Economy and Finance, Spain
- ▶ Johnson and Johnson
- ▶ Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), Germany
- ▶ Open Society Institute, Soros Foundation, Soros, NY, USA
- ▶ U.S. Agency for International Development, Department of State (USAID), USA
- ▶ Gulbenkian Foundation, Portugal
- ▶ Japanese Government

IMPLEMENTATION PARTNERS*

- ▶ **CHINA:** *The China Network for Training and Research in Health Economics and Financing* (comprising 29 universities, research institute and professional journals), and in Hong Kong: the Chinese University of Hong Kong, and the University of Hong Kong
- ▶ **CHILE:** *University of Alberto Hurtado, and Bitran Y Asociados*
- ▶ **THAILAND:** *Chulalongkorn University*
- ▶ **PHILIPPINES:** Department of Health, the Asia Institute of Management, the Development Academy of Philippines
- ▶ **INDONESIA:** University of Gadjah Mada
- ▶ **SINGAPORE:** National University of Singapore
- ▶ **MONGOLIA:** Mongolia Public Health Professionals Association (PHPA) and the School of Public Health (SPH)
- ▶ **INDIA:** National Institute for Health and Family Welfare
- ▶ **BANGLADESH:** International Center for Diarrheal Disease Research (ICDDR,B), BRAC
- ▶ **SRI LANKA:** National Institute of Health Policy
- ▶ **SOUTH AFRICA:** *Universities of Cape Town and of the Witwatersrand (HEU/CHP)*
- ▶ **SENEGAL:** Centre Africain d'Etudes Supérieures de Gestion (CESAG)
- ▶ **LEBANON:** *American University of Beirut (AUB)*
- ▶ **EGYPT:** National Training Institute
- ▶ **IRAN:** Ministry of Health
- ▶ **YEMEN:** Ministry of Health
- ▶ **HUNGARY:** *Semmelweis University (SOTE)*
- ▶ **RUSSIA:** Health Foundation, Moscow Medical Academy, and Higher School of Economics
- ▶ **KYRGYSTAN:** The Center for Health System Development (CHSD); The Chubakov Centre for Post-Graduate Medical Training (ChC), and The Kyrgyz State Medical Academy (KSMA)
- ▶ **KAZAKHSTAN:** The School of Public Health
- ▶ **TURKEY:** School of Public Health, Ministry of Health
- ▶ **UKRAINE:** School of Public Health, Kyiv Mohyla Academy

*The original six Flagship regional partner institutes are in italics.

ANNEX 3: PARTICIPANT SATISFACTION RATINGS AND COGNITIVE LEARNING SCORES

PARTICIPANT SATISFACTION RATINGS, SELECTED COURSES, 2008

Venue	Activity	Relevance*	Overall Usefulness*
Kyrgyzstan	National	88	98
Turkey	National	58	64
Turkey	National	68	78
Morocco	National	85	100
Guinea	National	91	94
Philippines	National	96	98
Hong Kong	Regional	82	77
Burkina Faso	Regional	94	100
South Africa	Regional	92	96
India	National	93	73
India	National	86	90
India	National	68	79
India	National	86	90
India	National	74	80
India	National	86	80
e-learning	Global	91	98
e-learning	Global	81	88

* Proportion of participants rating the training event a "4" or "5" on a 5-point scale, with "1" being lowest and "5" being highest.

COGNITIVE LEARNING GAINS

Global Annual Courses	Pre-Course (%)	Post-Course (%)	Relative Growth (%)
Global Core Course 1998	49	59	20
Global Core Course 1999	50	61	22
Global Core Course 2000	44	58	32
Global Core Course 2001	39	51	33

REGIONAL PARTNER COURSES 2000

South Africa	53	70	32
Chile	36	54	51
Lebanon	39	49	27
Hungary	35	63	82
Thailand	32	47	45
India	37	56	54
Kazakhstan	32	44	37
Malaysia	53	61	16
Poland	41	55	35

REGIONAL PARTNER COURSES 2002

Cote d'Ivoire (February)	55	64	16
Cote d'Ivoire (April)	42	57	37
Lebanon	37	50	35
Thailand	33	51	55
Hungary	25	50	99

ANNEX 4: PERCEPTIONS OF VALUE-ADDED OF FLAGSHIP TRAINING BY BANK STAFF

EASTERN EUROPE

In 2008, the World Bank's manager of HNP activities in Europe observed:

"Almost in every country I have visited, I have come in touch with people who are currently working on health who are alums of one of WBI's Health Flagship Courses. I know this is impossible to quantify in a satisfying way for an econometrician, but it takes only one conversation per alum to see how this (training) is having an impact on policy development and implementation in these countries."

CHUVASH AND VORONEZH REPUBLICS, RUSSIA

In 2008, the Bank task manager responsible for health activities in these republics observed:

"As noted by the regional authorities, the courses improved the capacity of local staff as they allowed policy makers, administrators and service delivery personnel to get acquainted with and learn about concepts and methodologies that were useful for the design and implementation of strategic plans and activities for restructuring the regional health care delivery systems.... The capacity of Flagship partners that were involved in curriculum and materials development and training (eg., Russian Health Care Federation, Moscow Higher School of Economics, Chuvash Republic Ministry of Health, Vornonezh Oblast Department of Health...) was enhanced through learning by doing to play a more effective or influential role in leadership, training, and networking in the area of health policy, strategy, planning and implementation of institutional reforms.... It is noteworthy that the experience and lessons learned during the implementation of the reforms in these two pilot regions were incorporated in the design of the ongoing Federal Government-funded 'National Health Priority Pilot Project' in 19 regions of the Russian Federation."

PHILIPPINES

At the opening of the second Flagship course in the Philippines, Joachim von Amsberg, the Country Director for the Philippines, commented that the delivery of the Flagship Program in the Philippines, is:

"consistent with the World Bank commitment to support the country's health reforms. It is serving as a 'just-in-time' complementary capacity-building support activity to the World Bank funded National Sector Support for the Health Reform Project; building the capacity of key movers at the national, regional and local levels." (The course was delivered 4 times in a series in the Philippines, covering all 16 provinces where the national health reform plan, Formula One, has been rolled out, to which the Bank is one of the donor supporters.)

INDIA

In 2005, the Flagship Program began to collaborate with India's "National Institute of Health and Family Welfare" (NIHFW) to provide critical training to state and district officers responsible for India's "National Rural Health Mission" (NRHM). The NRHM involves a significant scale-up of public funding for health and is a major new initiative to strengthen health systems in the country. Initial planning was facilitated by a "Situational Analysis of Existing Health Management Capacity Building in 2005, followed by training of 250 state and district level officers, including many faculty members from Indian training institutes. The training has been targeted to officials from the states of Uttar Pradesh, Orissa, Rajasthan, Jharkhand, Uttarakhand and West Bengal—all considered lagging in health systems performance.

In 2008, the World Bank's Lead Economist for HNP¹³ in India observed:

"The idea was to use the "India Flagship Program" (NIHFW) as one vehicle for introducing new thinking and new knowledge and skills to take action. In each of the courses being offered—on "health systems policy and management," "public-private partnerships in health," "strengthening human resources," "improving quality"—we are seeing people coming from both district and state level who are really eager to get new ideas and learn more about how to do things. This is really the only executive program the government is doing which is systematically introducing such training. Another thing worth mentioning is that the Minister of Health insisted very strongly that the India Flagship program be developed with significant India case material and Indian faculty—not only outsiders. We have delivered on that and so one side effect is better dissemination within India of their own innovative experiences."

ANNEX 5: LEVERAGING WORLD BANK FINANCING FOR THE FLAGSHIP PROGRAM

The World Bank Institute—as the World Bank's "Learning Arm"—has been able to leverage several sources of financing in support of country participants attending training activities. To illustrate, an analysis of financing sources between 2003-05, reveals that WBI learning programs in "health, nutrition, and population" (HNP) were able to leverage several millions of dollars from the Bank's Operations Departments to support the development and delivery of its country focused activities. More specifically, funds available from the "Technical Assistance" components of Bank loans and/or credits have been tapped to support the delivery of more than 25 national activities of direct benefit to client countries. Three modes of financing from these sources can be illustrated as follows:

1 PROJECT FINANCING (TA COMPONENTS)

The activities delivered under this mode of financing have been requested by World Bank "Operations" to support the implementation of projects or facilitate policy dialogue on HNP in these countries. Bank "Task Team Leaders" working on countries typically agree with WBI staff on the course to be delivered and work closely with national Ministries of Health to customize the course content to the specific needs of the country. Usually, Loan/Credit funds have been used to finance the entire cost of the course preparation and delivery which includes experts, participant's costs, and local costs. To this end, the HNP team in WBI was able to mobilize up to \$350K to support its in country activities. This applies to countries like Nigeria (\$250K), Yemen (\$50K), and Afghanistan (\$50K). In Nigeria more specifically, these funds have been used to support a long term capacity-building initiative, including support to capacity of local institutions to design and delivery the activities in collaboration with MOH.

2 WBI HNP PROGRAM IDENTIFIED IN PROJECT DESIGN

Activities delivered under this mode of financing are much more integrated with Bank projects as they are identified by government from the on-set of project design, in recognition of the need for capacity building in Health Sector Reform. In most cases, Flagship

Program activities have been delivered to support this objective. About \$875 thousand has been mobilized to deliver to deliver about 15. In Iran, for example, about \$375 thousand was made available from the Bank's Iran Health Project to support activities described previously in this paper. In Turkey, about \$500 thousand was \$500 made available from project funds for the design and delivery of the Flagship Program in Turkey, largely to strengthen the country's "School of Public Health" (SPH). Capacity building included (i) developing and strengthening the skills of the SPH's faculty in the area of analyzing health sector reform, decentralization, and hospital reform which are aligned with the health sector reform process taking place in Turkey, (ii) further developing the capacity of the SPH to design and deliver such learning programs, (iii) providing a series of learning activities to key decision makers and managers, and, (iv) helping the SPH to re-gain prestige and credibility at the country and regional level.

3 TFS MANAGED BY OPERATIONS MADE AVAILABLE

WBI's HNP program was able to leverage donor "trust funds" that are managed by Bank Operations to support the delivery of country focused activities. This reflects the strong demand for WBI skills and a recognition of the value added of its various learning platforms. In Bangladesh, for example, roll-out of Flagship learning activities was supported by the CIDA Trust Fund held by Operations in the amount of about \$300,000. This involved a multi-year learning program identification of a local partner institute, and customization of the learning program to meet the Bangladeshi needs.

1 INITIAL FUNDING AND SUSTAINABLE FUNDING

Initial financing for the development and start-up costs of the Flagship Program was fully adequate, thanks to the financial support of various donors, especially DANIDA, technical support of USAID through Abt Associates, staff secondments paid by CIDA and Norway, and World Bank support in the form of staff salaries and free use of office and conference facilities. This financing allowed the organizers to resist pressures to skimp on the development of learning materials, and permitted much needed subsidies to regional partner institutes to prepare staff and adapt learning materials for the start-up of regional courses. As the Program has matured, however, pressures have mounted to sustain financing through improved efficiency and new, creative modes of financing. Strategies to sustain financing included the following:

- Recurrent costs of face-to-face training were reduced through various cost cutting measures, including shortening the duration of training, reducing numbers of resource persons, and increased use of experts with minimal travel costs. These economies had consequences, such as reducing the range of faculty who could be brought in from outside. As depicted in Figure 2, unit costs per “participant day of training” dropped from \$650 during the initial start-up and piloting of the Global core course in 1997, to around \$200, on average, between 1999-2003, and then to about \$160, on average, between 2005-08.¹⁴ In comparison, unit costs among regional partner institutes averaged about \$215 during the first year of operation in 1999, declining to approximately \$190 by 2000 and about \$150 by 2001 onwards. Based on several years of experience, the organizers conclude that a unit cost of between \$150-175 per participant day of face-to-face training represents the *lower* end of the Program’s efficiency scale. Beyond that, it becomes exceptionally difficult to reduce unit costs more without compromising quality. Unfortunately, benchmarks from other major training initiatives were seldom available for comparison, either within WBI or internationally.
- New technologies were harnessed to deliver training, especially video-conferencing using WBI’s “Global Development Learning Network” (GDLN). Approximately 16 GDLN sites were launched in Bank client countries around 2000, increasing to about 120 learning affiliates by 2008. Accordingly, the share of participant days of training provided through the Flagship Program increased over the years, totaling about 4000 participants in regional distance learning events, 1,400 in conference venues, and about 370 in recently launched e-learning courses. Theoretical arguments in support of GDLN came on strong initially, maintaining that unit costs per participant day of training could be reduced by up to 50% compared with face-to-face training. (Unfortunately, WBI does not calculate unit costs for its various forms of distance learning.) It was also maintained that, done right, quality could be maintained. Our experience has been:

▶ Training via GDLN video-conferencing works better for relatively short versus longer periods of time, for example, 2-5 days versus 5-15 days.¹⁵

▶ Quality of training is greatly enhanced or reduced, depending on the presence of a top notch facilitator at the receiving site who understands the material. This becomes acutely important the longer GDLN training becomes.

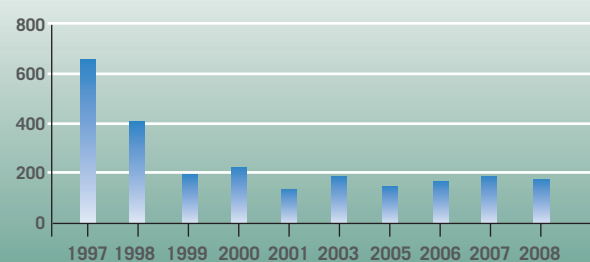
▶ Consistency of participation tends to be more variable because (i) face-to-face accountability between participants and presenters is reduced, and (ii) participants tend to be in close proximity to their places of work, with workplace demands competing with “classroom” demands.

▶ Preparation and delivery of learning materials is no less demanding than face-to-face, but the capacity for presenters to interact and engage participants tends to be less particularly if audiences at multiple GDLN sites are involved.

▶ When participants at different video-conferencing sites were recruited by GDLN managing staff rather than health-related counterparts that WBI or the Bank health operations team usually work with, the quality and relevance of the participants vary more, thus affect the outcomes of training.

- The Program increased cost-sharing through user fees. This was prompted by the premise that initial donor financing of the Flagship Program should have an “exit strategy,” that such support should not go on ad-indefinitum. Accordingly, WBI and its partner institutes began charging fees to cover the recurrent costs of delivering each activity. Fee schedules were based on analysis of unit costs to deliver activities and differed according to venue. Initial fees for the three week Global core course in Washington DC, were only about half the estimated unit cost, however, meaning the other half was fully subsidized by donor trust funds and World Bank regular budget (for staff and facilities). Gradually, fees have been increased to about \$3,500 in 2008, representing about 80% cost-recovery, with the World

FIGURE 2: UNIT COSTS PER PARTICIPANT DAY IN US\$, GLOBAL COURSE, 1997-2008



Bank and donor trust funds picking up the rest. Likewise, some form of continuous subsidy was essential for the Program's "non-profit" and "for-profit" private partners in view of the "public goods" nature of the training as well as difficulties they faced recouping costs in relatively poor countries. This point merits emphasis because the Program's best performing "for-profit" private partner ceased being a regional partner because it could not adequately recoup its costs.

- The Program has been able to leverage several sources of financing, in sync with the World Bank's own "Operating Departments," in support of national participants and capacity building. Three modes of such financing are illustrated in Annex 5, totaling several million dollars.

As positive as the Program's financing dimensions may seem, they mask a problem that has become increasingly important over time. The non-profit nature of the Program, combined with balanced budget cost-recovery, has yielded virtually no surplus. Accordingly, funds to re-invigorate, re-tool, re-vitalize the Program have always been in extremely short supply. This is taking a toll on the capacity of the Global Core Course to keep its technical content "cutting edge" and compromises capacity building of current and future regional and country partner institutes. The bottom line is that the Flagship Program today is operating on a shoe-string budget. More resources are needed to refresh and scale-up the Program and to accommodate ever-present demand.

2 PARTICIPANT MIX

The primary emphasis in selecting participants has been to identify policy makers, managers and administrators currently engaged in national health systems who are in a position to effect change and improve performance. This has been greatly facilitated by WBI's access to World Bank "task managers" who, in turn, have identified officials that would benefit from training. In many cases, this resulted in the nomination of "country teams" comprised of individuals known to one another and likely to interact upon completion of the training. To a lesser extent, staff of other donor agencies have also identified country participants known to them, usually individuals rather than country teams. The link between the Flagship Program organizers and Bank staff has been one of the most valuable inputs to the success of the program.

A secondary emphasis has been to provide training to World Bank staff, as well as other donor agencies, along-side country client participants. During the ten years of the Global course offerings, for example, approximately 120 of the 860 participants have been Bank staff, with another 60 from various donor agencies. Equally important, Bank staff have attended more than half the Program's 260 regional and national Flagship courses. This provides a clear message that the training is equally relevant to both cadres of participants, yielding an important cross-fertilization of ideas and debate. It also contributes to a common language on health systems development among both Bank staff and clients, enhancing communication between them in their working environment.

Participant selection has also involved some resilient challenges, however, as follows:

- It has been easier to enroll and retain middle-to-senior level public officials than Principal Secretaries and Minister's of health. Duration of the training is problematic for highest level officials, and when they do attend, they are often "called" back to duty during the training which becomes disruptive. Accordingly, the Program is viewed as more relevant to training "tomorrow's leaders" than today's leaders and, as conveyed previously, increasing numbers of Flagship participants are indeed rising to senior levels with the passing of time. Even so, the Program faces

The bottom line is that the Flagship Program today is operating on a shoe-string budget. More resources are needed to refresh and scale-up the Program and to accommodate ever-present demand.

a gap in the proportion of senior people enrolled versus desired, and this gap may be growing over time. An appealing idea would be to offer a special, short term Flagship agenda for Ministerial level participants in a convenient venue, such as following the WHO's annual General Assembly in Geneva.

- It has been easier to enroll and satisfy public officials than representatives from NGOs and the private sector. Each group tends to have different priorities, with public officials embracing bigger picture societal goals (e.g., MDGs, government's role in subsidizing the poor), versus other groups tending to have narrower organizational interests, such as managing private clinics, private insurance, etc. Juggling these different interests and expectations continues to be a major challenge to the Flagship program organizers. Nevertheless, larger numbers of non-governmental participants are enrolling, enriching interaction and overall learning in the process.
- The composition of participants—by skill level and interests—tends to be less uniform at the annual Global course than at regional and national training events. One reason is that participants attending regional activities tend to come from national health systems with similar challenges and capacities. Another reason is that regional and country activities are more likely to be subject-specific, for example, focusing on health insurance, which attracts participants most concerned with this subject. In contrast, the Global course brings people from all over the world, mixes country participants and Bank staff, and often consists of people at different levels of seniority and experience. The bottom line is that training at the regional and country level is less demanding of faculty presenters and easier to focus on topics of common interest to participants.¹⁶

3 LEARNING STYLE, METHODS AND CONTENT

The learning style and pedagogical methods employed by the Flagship Program have worked well over the years. Beyond pedagogy, however, the Program struggles with three important "content" challenges:

- The first has to do with the use of evidence-based studies and country cases. As might be expected, alignment of the Flagship Program with the World Bank’s “Operating Departments” places a premium on being up-to-date with evidence-based pilots, strategic interventions and large scale reforms in Bank client countries. In addition, Flagship participants demand more knowledge-based evidence about what’s been tried, what’s working, what constitutes success. Trying to keep abreast of such information, on a global, regional and country scale, is a major challenge for the Flagship faculty, especially in view of limited funding for the extensive review work entailed.

Identifying partners that wish to take “ownership” of the Flagship learning agenda pays huge dividends versus partners more content to collaborate on a “contractual” basis.

- A second and more difficult content challenge has to do with translating the “what to do” into the “how to do it,” in other words “how to implement.” The Flagship Program promises clients it will take this issue up squarely but the reality is that training on this dimension falls short, sometimes bordering on superficial. To grapple with this major lacuna, the faculty is now contemplating ways of offering “conditional guidance” on the design of strategic interventions—conditional on key factors known to enable or inhibit implementation success. Again, however, this entails a broad research agenda of its own.
- A third issue stems from the “new” global aid architecture in health. While the focus of the Flagship Program on health system strengthening per se seems just right, it’s also true that increasingly powerful financing and organizational coalitions are impacting national health systems—for good and bad. Huge new infusions of funds are being mobilized by “Development Assistance Committee” (DAC) members of the OECD to achieve the MDGs, as well as the “International Financial Facility for Immunisations” (IFFm) and the “Advanced Marketing Commitment” (AMC). These funding sources are being complemented by new financing modalities for health such as HIPC debt relief and donor sponsored buy-downs of country-debt if agreed health targets are met, as well as “results based financing” arrangements at the World Bank and USAID. Numerous international NGOs such as the Global Fund (GFATM), GAVI, and the Gates Foundation are spending enormous amounts of money through country-level contractual arrangements to implement programs and projects—often in parallel with national health systems. And, finally, new initiatives such as “joint programming for health system strengthening (HSS)” by GAVI and the Global Fund aims to provide more than a billion dollars over the next 8 years to support HSS as it relates to controlling AIDS, TB and Malaria, and expanding vaccination coverage. As yet, the Flagship Program has not directly addressed or clearly integrated these developments in its learning framework. This requires new curriculum design work.

4 PARTNERING STRATEGIES

An essential and largely successful component of the Flagship Program has been its partnering strategy. Initially, six regional partner institutions were identified in major geographical regions served by the World Bank to serve as collaborators in the delivery of training (see Annex 2).¹⁷ Thereafter, partnering expanded to include local-level institutions and activities in individual countries. From the Program’s perspective, the benefits of partnering were seen to include greater outreach to regional and local level clients, improved mapping of training onto different regional and national priorities, and access to partner input into the design and delivery of Flagship learning materials. Partnering was also seen as a mechanism to transfer skills and capacities from a centrally funded and managed Flagship Program in Washington DC to more decentralized levels that could become self-sustaining. From the partner’s perspective, benefits were expected to include capacity building through association with the World Bank Institute, including access to Flagship learning materials, training of trainers, and networking with other Flagship partners. And to a large extent, these benefits have materialized, as illustrated previously.

The road to good partnering is not an easy journey, however. Principle lessons learned include:

- Identifying a strong partner, or at least one that can evolve rapidly into a strong partner, has been critical to the success and “brand name” of the Flagship Program. If a regional or national partner is overly weak in terms of staffing, reputation, and venue, it will likely remain so and will require constant hand-holding from the center to perform adequately. This seemingly straightforward lesson is worth underscoring because several donors argued that the Flagship program should intentionally select weak partners over strong ones and then build them up as part of national capacity-building efforts. In reality, however, without a broad base of financial and technical assistance, weak partners can translate into a management nightmare and can significantly compromise continuity of Flagship activities in key areas.
- Identifying partners that wish to take “ownership” of the Flagship learning agenda pays huge dividends versus partners more content to collaborate on a “contractual” basis. Two regional Flagship Partners, one at Semmelweis University in Hungary, the other involving a consortium of 29 institutions in China, were eager to adapt the Flagship Program to serve their regional/country clients and to pursue a broad and extensive range of learning activities as a result. In contrast, another regional partner allocated discrete portions of time to single activities, as if on contract, and then shifted its attention entirely elsewhere in response to funding opportunities. In effect, this contracting orientation was at odds with ownership and continuity of Flagship activities in the region.
- Initial and sustainable financing of Flagship activities at regional and national level has always been a major challenge, as noted previously. On the one hand, initial financing or “seed capital” was critical to help partner institutes gear up to adapt and deliver learning activities. In the early years, donor trust funds were

available for this purpose. On the other hand, sustainable financing of recurrent costs requires a *combination* of cost-recovery through user fees (from participants or their sponsoring agencies) as well as long-term subsidies to support the “public goods and services” functions provided by partner training institutes. Regrettably, many donors seem more adept at “talking the talk” of long-term capacity building than committing long-term financial support to such ends.

- A major benefit to partnering with the Flagship Program, according to the regional and national partners, lies in prestige gained through association with the World Bank and WBI, as well as the prominence of the Harvard School of Public Health (HSPH) in the design and delivery of the Global core course. Close alignment with HSPH has worked well to reduce the number of resource persons to manageable proportions, develop consistent and coherent training, and provide top notch resource persons to assist the design and delivery of regional and national activities. And yet, some critics have lamented close alignment of the learning activities with HSPH, preferring a looser assemblage of leading edge institutions at the helm of the Program from a variety of countries. This wishful thinking neglects the early years when the Global core course was 4.5 weeks, involved several institutions and up to forty resource persons. It was a costly arrangement and a management nightmare. Moreover, it generated a highly uneven, incoherent learning experience because so many “chefs” with different perspectives, teaching styles, and superficial knowledge of the Program’s objectives were involved.

5 MONITORING AND EVALUATION

As noted previously, WBI and the Flagship Program have employed several methods to monitor and evaluate the learning program over the last decade. None of these are ideal, however. The fact remains that measuring the impact of *short-term training* on individual participants, let alone the benefits such training brings to the performance of their national health systems, remains exceptionally difficult and time consuming. In the case of measuring cognitive learning gains, for example, procedures were extremely time consuming to manage and execute. Moreover, reliability was always threatened by the prospect that individual trainers would “teach to the questions” towards boosting test scores and, thus, making the trainer appear more effective. And most important, the faculty doubted that cognitive learning gains, based on correct answers to multiple choice questions, captured more significant learning benefits of the Flagship learning framework, including shifts in paradigm thinking, relevance of multi-pronged strategies to improve performance, etc. At best, cognitive testing helped to uncover trainers or training practices that were ineffectual in the extreme.

Monitoring and evaluation challenges should not, however, deter more systematic follow-up and assessment of impact. Experience from the Flagship Program suggests enemies of more systematic evaluation include (i) a lack of earmarked funding within the regular budget of the World Bank Institute as well as donor trust funds for monitoring and evaluation, and (ii) continual corporate pressure to expand volume of training without satisfactorily ascertaining its value added. In short, staff simply don’t have the

resources, time or motivation to do adequate monitoring, evaluation and quality control.

6 DELIVERY ARRANGEMENTS

The Flagship “delivery arrangements,” depicted in Table 2 (page 4), represent an expansionary path that began with the launch of the Global course in 1998. Regional training activities began to roll out from 1999 onwards, national training events and distance learning via video-conferencing from 2000 onwards, and e-learning commencing in 2006. Experience suggests the full scope of these arrangements complement one another and should be retained. The Global course, for example, often takes the lead in identifying new content areas and setting protocols and standards for training and evaluation. The regional courses take the lead in prioritizing key issues relevant to countries in their area and develop and adapt training materials accordingly. The national courses usually “drill-down” into issues of immediate relevance to a country tackling a particular health system development issues or capacity gaps. Regional and national training content feeds back to the Global course, enriching its coverage of new developments in client countries. The video-conferencing events via WBI’s “Global Development Learning Network” are best suited to short-term (2-3 days), “just in time” training on particular issues, as well as north-south and south-south networking. And the Program’s e-learning activities appear to be a particularly promising and well-received route to introducing participants to new tools, techniques and paradigms while accommodating a more flexible time schedule.

The only question concerning the Program’s “operating model” has been raised over the centrality and continuation of the Global course. A technical brainstorming was therefore convened with the Program’s major partners to deliberate on questions such as: Would termination of the Global course be a wise decision? Would regional and national training partners benefit without the presence of the Global course, perhaps by eliminating competition for participants? A consensus emerged from the meeting that the Global course should be retained for at least four reasons. First, the Program’s regional and national partners welcomed the learning materials, training guidelines, and access to resource persons associated with the progressively revised Global course. Second, the partners valued the opportunity to send their own resource persons to the Global course as it helped “train future trainers.” Third, the partners viewed the Global course as an opportunity to “showcase” Flagship training to initial country participants that expressed interest but weren’t clear what a national Flagship training activity might entail. And fourth, as noted previously, partners conveyed that the prestige of networking with WBI/HSPH strengthened their own reputation and ability to attract participants.

¹ The authors are affiliated with the World Bank Institute and were instrumental in the design and management of the Flagship Program from 1997-2008. They wish to thank the following for helpful comments and inputs; Thomas Bossart and Marc Roberts, Michael Reich (Harvard School of Public Health); Tamas Evetovits (Hungary); Hamidreza Jamshidi (Iran); Faustin Njau (Tanzania), Peter Berman, Alexandra Humme, Patricio Marquez, Finn Schleimann, Abdo Yazbeck (World Bank); Maria-Luisa Escobar, Tazim Mawji, Chialing Yang, (World Bank Institute), Joseph Kutzin (WHO/EURO), and Gilles Dussault (Universidade Nova de Lisboa).

² Operating as the World Bank's "learning arm," WBI has a staff of about 250 professionals serving all Bank client countries.

³ This was complemented by a global review of existing training institutions to identify important gaps in available training around the world and to assure that WBI could bring real value-added to training and capacity building in this area.

⁴ M. Roberts, W. Hsiao, P. Berman, M. Reich, 2003, *Getting Health Reform Right: A Guide to Performance and Equity*. (Oxford: Oxford University Press).

⁵ Beginning in 2000, WBI's Global Development Learning Network (GDLN) now includes approximately 120 videoconferencing sites in dozens of countries.

⁶ We assume the average video-conferencing activity involves about 2 days of training even though the duration of such training activities often takes place over 2-5 days, and sometimes for 5 or more days. This is because video-conferencing sessions usually last only 3-4 hours per day.

⁷ Sponsors typically include donors, governments, and non-governmental organizations.

⁸ As a benchmark of quality, WBI has established an agency wide target of at least 80 percent of participants ranking learning activities a "4" or "5" on a "5" point scale.

⁹ Fifty of these alumni were located, with 61 percent currently in senior level positions and an additional 22 percent at highest level of seniority.

¹⁰ In addition, the regional partners engaged country teams in health insurance workshops between 2002-05, which strengthened skills and helped put health insurance on the policy agenda in countries like Burkina Faso, Mali, Mauritania, and Niger. More recently, the Flagship partners in Senegal and Benin launched another set of learning activities focusing on hospital reform, involving approximately 300 participants from countries in the region between 2005-08.

¹¹ The outcomes map closely to the redefinition of health system goals by WHO's 200 World Health Report.

¹² M. Reich, Policy Maker Software, Harvard School of Public Health.

¹³ One of the Flagship global course directors from the Harvard School of Public Health joined the World Bank in 2004 as the Lead Economist for HNP in India and helped develop an India-based program building on the Flagship framework.

¹⁴ Costs are not reported for 2002 and 2004. In 2002 no Global core course was delivered. In 2004, a change in venue from Washington DC to Boston resulted in a significant drop in participants and thus unusually high unit costs (\$500). In response, the venue was moved back to Washington DC.

¹⁵ Courses offered by GDLN usually involve less than a full day of training, many lasting around 3-4 hours. See footnote 3.

¹⁶ A caveat is that presenters at regional and especially country activities must be sufficiently prepared to discuss complex political, cultural and organization issues that participants tend to be well informed about.

¹⁷ The Program's six initial regional partner institutes are identified in italics in Annex 2, under "implementation partners"

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