Bangladesh’s current national strategy emphasizes the importance of institutional strengthening for local ownership. Further, the country intends to reach middle-income country status by 2021. Historically, the focus of capacity building has been on strengthening state institutions; however, as the vision for state-building has become increasingly pluralistic, attention has shifted to capacity building of non-state actors. Strengthening Bangladesh’s nongovernmental organizations (NGOs)—which have played a significant role in Bangladesh’s health sector development—is necessary for continued progress toward middle-income country status.

The Pathfinder-led and USAID- and DFID-funded NGO Health Service Delivery Project (2012–2017) aimed to increase local ownership of health service delivery while improving health outcomes, particularly for the poorest of the poor. This brief will examine the project’s approach to and experience of organizational capacity building in the private sector.
CONTEXT

Bangladesh intends to achieve middle-income country status by 2021, 50 years after securing its independence. However, significant gaps remain—particularly in the economic and health sectors—and this new economic categorization may have implications for future international assistance to the country. To mitigate the potential negative impacts of the middle-income country label, and to address its persisting health sector challenges, Bangladesh is seeking to build the capacity of its health system.

Bangladesh has made remarkable progress in its health indicators. For example, the country has decreased the maternal mortality rate from 569 maternal deaths per 100,000 live births in 1990 to 176 in 2015. Contributing to this decline in maternal mortality are increased contraceptive prevalence rates and decreased total fertility rates. The percentage of currently married Bangladeshi women between the ages of 10 and 49 who are using a modern method of contraception increased from 5 percent in 1975 to 54.1 percent in 2014. Further, Bangladesh’s 1999–2000 Demographic and Health Survey (DHS) reported a total fertility rate of 3.3 among women ages 15 to 49—a rate that decreased to 2.3 among the same population by the time of the 2014 DHS.

Despite Bangladesh’s achievements, health systems weaknesses and inequitable uptake of services remain, contributing to poor health outcomes—particularly for reproductive, maternal, newborn, child, and adolescent health (RMNCAH). For example, total health expenditure in Bangladesh, as a percentage of GDP, is low, at approximately 3 percent, and the country’s limited health workforce is unequally distributed across its geography. While the World Health Organization recommends 2.3 physicians, nurses, and midwives per 1,000 population, Bangladesh reported 0.39 physicians and 0.21 nurses and midwives per 1,000 population in 2012.

Further, Bangladesh continues to experience high rates of poverty. Nearly one-third of Bangladesh’s population lived below the national poverty line in 2010, according to World Bank data. Finally, data shows that people living in lower wealth quintiles experience particularly poor RMNCAH outcomes when compared with their wealthier counterparts (see Table 1).

The Bangladeshi government has traditionally relied on NGOs to complement state-provided health care. In fact, experts posit that the country’s pluralistic health system has contributed to the health successes the country has experienced in recent decades. Since independence, the government has created a space for the development of Bangladeshi NGOs. Today, Bangladesh is home to some of the world’s largest and most notable NGOs, such as BRAC and Grameen.

Global development efforts continue to prioritize capacity building as a key driver for sustainable development. This is exemplified by the 2010 USAID Forward agenda and the Sustainable Development Goals. Given Bangladesh’s desire to transition to middle-income country status and that such a label might impact future overseas support, strengthening the capacity of local institutions and systems is increasingly important. This is especially true for NGOs that have received both local and international support in their efforts to develop solutions for improved health service delivery. Bangladesh’s NGOs will need to possess the institutional strength—meaning the financial, programmatic, and administrative capacity—to continue to support the country’s health system in this time of transition and sustainable development.

<table>
<thead>
<tr>
<th>TABLE 1: MATERNAL AND CHILD HEALTH INDICATORS IN BANGLADESH.</th>
<th>Wealth Quintile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Highest</td>
</tr>
<tr>
<td>Women 15 to 49 who received any antenatal care prior to birth 10</td>
<td>95.2%</td>
</tr>
<tr>
<td>Children ages 12 to 23 months who received all basic vaccinations 11</td>
<td>91.9%</td>
</tr>
<tr>
<td>Live births delivered in health facility 12</td>
<td>70.2%</td>
</tr>
</tbody>
</table>

(a) Data from 1975 refers to currently married women between the ages of 10 and 49, whereas data from the 2014 Bangladesh DHS refers to currently married women between the ages of 15 and 49.
Pathfinder International has been working with local partners in Bangladesh since the 1970s to harness the potential of NGOs to improve health outcomes. In 2012, Pathfinder, USAID, and the Surjer Hashi NGO Network began the NGO Health Service Delivery Project (NHSDP), which aimed to increase access to RMNCAH services in Bangladesh, and to improve sustainable country ownership of quality health service delivery through strengthening local NGOs.

Development literature suggests a shift in policy commitments away from a focus on developing capacity of state institutions for state-building and toward the recognition that state-building benefits from strengthening non-state institutions as well. This technical publication will explore the project’s successes and challenges in capacity building in the private sector, and will offer lessons learned based on the implementation experience to inform future capacity building efforts and contribute to a growing body of evidence for capacity building with non-state actors.

THEORY OF CHANGE

At the core of Pathfinder’s approach to capacity building is a belief that partner organizations are the best experts regarding their needs. Therefore, not all organizations’ capacity growth efforts will look the same. In addition, Pathfinder approaches capacity building with the intent to achieve not only improved outcomes related to Pathfinder project objectives, but also the internal organizational growth goals of local partners. In the case of NHSDP, this meant tying the organizational capacity building of NGOs to increased access to an essential services package and improved health outcomes.

The project proposed an institutional strengthening strategy that focused on building the institutional, programmatic, and financial capacities of the 26 NGOs in the Surjer Hashi NGO Network, which collectively manage 388 clinics, and offer services to a catchment area of approximately 22 million people—almost 14 percent of the country’s population—across 65 of Bangladesh’s 66 districts. By working with NGOs to strengthen their organizational capacity, the project intended to contribute to improved sustainability and improved capacity to deliver a quality essential services package, especially to the poor and underserved, both of which will ultimately contribute to improved RMNCAH outcomes in Bangladesh.

The project’s theory of change rests on the belief that there are four dimensions of NGO performance—institutional strength, coverage, equity, and quality—and progress within these four dimensions would move NGOs toward local ownership and sustainability goals while ensuring a quality essential services package is delivered in Bangladesh. Institutional strength—in addition to being a dimension of NGO performance—itself contributes to coverage, equity, and quality. In other words, institutional strength is simultaneously a dimension of what constitutes NGO performance and an effort that contributes to broader NGO performance.

Under this theory of change, coverage refers to reaching the breadth of an NGO’s catchment area and the NGO’s capacity to generate demand for and uptake of services. Quality refers to ensuring delivery of care that meets the quality standards of the Surjer Hashi Network and the Bangladeshi government. Equity refers to an NGO’s consideration of often vulnerable and marginalized populations—such as adolescents and youth, and the poor—in its service delivery mechanism. Finally, institutional strengthening refers to the strengthening of programmatic, financial, and operational capacity of NGOs, as such capacity is crucial to success in the other three dimensions of performance, as well as to NGO sustainability.

To address coverage, equity, and quality, the project designed robust interventions targeted at both the demand for and supply of health services, as well as behavior change components to encourage service-seeking behavior and to address beliefs that have negative impacts on health outcomes. To address institutional strengthening, the project deployed educational opportunities that would cover core elements of organizational functionality. These educational components were designed to be responsive to individual needs of NGOs toward local ownership and sustainability.

Fig. 1: Progress within coverage, equity, quality, and institutional strengthening moves NGOs toward local ownership and improved performance. Institutional strengthening is simultaneously a dimension of NGO performance and a contributor to coverage, quality, and equity.

(b) Surjer Hashi means Smiling Sun in Bangla. (c) DFID joined the project as a donor in its second year of implementation. (d) The components of the government of Bangladesh’s essential services package prioritized by NHSDP are: long-acting and permanent methods of contraception, maternal, health, nutrition, newborn and child health, and treatment for acute respiratory infections. (e) At project start, the network comprised 26 NGOs. However, during implementation, two NGOs left the network and most of their clinics were transferred to remaining NGOs, and one new NGO was added to the network.
NGO contexts, meaning they varied according to an NGO’s size, location, and technical and managerial capacity. In addition, the project designed a process to transition two network NGOs from recipients of grants under contract to direct USAID grantees. Finally, the project planned an incentive program to create an enabling environment for capacity building.

What follows is an exploration of NHS-DP’s efforts to strengthen NGOs through the project’s capacity building strategy and theory of change. Specifically, this brief will explore the implementation experience of the three aforementioned project components contributing to organizational capacity growth. In addition to the numerous internal variables contributing to the complexity of capacity building within this NGO network, the organizational capacity of NGOs is also influenced and impacted by a range of external pressures, opportunities, and threats—many of which are out of organizations’ and implementers’ control. This brief documents deviations from and adaptations to the project’s original implementation plan as such changes may help inform future capacity building initiatives.

IMPLEMENTATION PLANNING

The project planned a capacity building strategy with three components. The primary component was technical assistance and customized follow-up support to improve organizational performance. Second, in line with USAID’s initiative to increase funds to local organizations and in line with the project goal to increase local ownership, two NGOs were mentored through a process to apply for direct USAID funding, representing to other NGOs a potential positive outcome of capacity building efforts. Finally, this technical assistance was complemented by a program to incentivize improved performance and to create an environment that enables organizational growth.

Technical assistance to improve organizational performance

To strengthen institutional, programmatic, and financial NGO structures, the project first developed an initial capacity assessment; second, a customized training plan for each NGO; and third, a series of workshops to address key topics for capacity building as well as individual, tailored onsite and remote mentoring to address the specific needs and challenges of individual NGOs. The 26 NGOs in the network are the experts in how best to operate in their given contexts. As such, the project designed a baseline analysis to provide an opportunity for the project and the NGOs to collectively identify areas of strength and opportunities for growth that aligned with the context in which each NGO was operating. This analysis also ensured that the technical assistance and follow-up provided by the project was responsive to the varied needs of individual NGOs as well as the project’s overall goals.

Baseline analyses involved review of organizational capacity assessments from previous iterations of the project, and an analysis of individual NGO strengths, weaknesses, opportunities, and threats. The baseline analysis allowed the project and NGO staff members to collectively assess NGO capacity within each of NHS-DP’s core areas for organizational functionality: governance, management, human resources (including support for organizational gender equity), customer focus, quality of customer service, project management and monitoring, external relations, financial management, revenue stability, and cost consciousness. Findings from the baseline analyses contributed to a categorization of NGOs into four stages along an organizational maturity spectrum: nascent, emerging, expanding, and mature. Further, these analyses helped capture gaps in NGO capacity across the project’s core areas of organizational functionality. Finally, the project and NGO staff created capacity building teams composed of NGO staff in positions to create organizational change (e.g., project directors, financial and administrative managers, quality assurance managers). These teams were intended to meet regularly to plan, coordinate, and implement capacity building activities with the project team, and communicate progress within and outside the organization.

FIGURE 2: FOUR PHASES OF ORGANIZATIONAL DEVELOPMENT

<table>
<thead>
<tr>
<th>Nascent</th>
<th>Emerging</th>
<th>Expanding</th>
<th>Mature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earliest stages of organizational development. Major systems are rudimentary or nonexistent.</td>
<td>The organization is developing capacity. Basic systems and structures are in place and functioning.</td>
<td>The organization has a solid track record of achievement. Systems and processes are developed and functioning. The organization is responsive to stakeholders and connected to its constituency.</td>
<td>The organization is fully functioning and sustainable with a diversified revenue base, multiple partnership relationships and varied regional and/or national networks.</td>
</tr>
</tbody>
</table>
Based on the capacity building needs identified by the NGOs, the project and NGOs designed tailored plans for technical assistance and related follow-up support. Technical assistance was provided through a variety of modalities. All NGOs participated in workshops addressing the core areas of organizational functionality. Examples of these workshops include governance and leadership management training for senior management and boards of directors and the review of recruitment processes for board and management team members to mainstream gender equity across the organization. Workshops were planned to occur annually, after annual capacity assessments took place as described below. The workshops were to be led by the project’s capacity building team as well as external experts hired as consultants and included mostly didactic training with some role-playing and practical sessions. The project grouped NGOs by size, location, and technical and managerial capacity to tailor trainings to NGOs facing similar contexts. Because each NGO had different needs, technical assistance also included tailored mentorship for individual NGOs through onsite visits or remote support via phone or email.

The technical assistance plans included benchmarks to enable measurement of progress in each area. The training and capacity assessment process was intended to be iterative. Technical assistance began in the project’s first year. Annual assessments using a modified Organizational Capacity Assessment Tool (MOCAT) and plan reviews were proposed to allow for the content and schedule of technical assistance to be altered based on the needs and progress of NGOs.

To support monitoring and coordination of technical assistance needs, the project designed an NGO “Help Desk,” to be staffed by the project’s capacity building manager, monitoring and evaluation specialist, organizational development specialist, and clinical training specialist. This help desk was designed to receive requests for additional technical assistance, to coordinate and track trainings, to monitor trainings and progress through onsite visits, and to document best practices and lessons learned to be shared with external audiences.

**Transitioning NGOs to direct grantee status**

In line with the government of Bangladesh’s strategy to become a middle-income country through greater collaboration with the private sector, and as part of USAID’s initiative to increase funding to local organizations, one contractually required component of the project was selecting two network NGOs and supporting them to become direct USAID grant recipients. The project therefore aimed to develop the systems and processes necessary to establish a pathway for two local NGOs to transition to directly receiving external donor support, one in the project’s second year and the second in the project’s third year. To build NGO capacity to function as future direct USAID grantees, the NGOs and the project developed additional technical assistance plans, and NHSDP provided intensive onsite mentoring to prepare NGOs to be USAID implementers, as well as how to manage new operational systems. Specifically, NGO senior management and boards of directors received training in USAID project management, procedures, compliance, and reporting. The project monitored NGO progress against the transition plans and revised the plan as necessary. Following a year of closely monitored progress, the project worked with the two selected NGOs to respond to the anticipated USAID request for applications. In addition, the project led the two NGOs through a mock pre-award assessment process and planned for a month of intensive proposal skills and competency development in anticipation of the USAID request for applications.

**Performance-based grants**

Successful capacity building—resulting in sustained change—requires that involved parties have similarly aligned motivations. In the case of NHSDP, the project and NGO network identified NGO capacity building goals through the baseline analysis. To move
NGOs toward local ownership and sustainability while ensuring improved provision of quality services (project goal), the project strategically tied performance-based grants (PBGs) to the four dimensions of NGO performance—coverage, equity, quality, and institutional strengthening (NGO goals). In this way, the PBG mechanism acted as a facilitator—NGOs would be more receptive to technical assistance and capacity building support to improve technical, financial, and managerial capacity because it would help them reach their PBG targets, thus making them eligible for financial rewards.

IMPLEMENTATION EXPERIENCE

The project began in 2012, and at the time of publication, the project is ending after five years of implementation. Project implementation rarely goes as planned; however, documenting and learning from deviations and adaptations helps prepare us for better future implementation. What follows is a description of the experience of implementing the project’s capacity building activities.

Adapting technical assistance to improve organization performance

The project implemented three notable changes to its original technical assistance plan regarding delivery of technical assistance, support for NGO capacity building teams, and capacity development monitoring. Initially, the project planned to group NGOs during training and technical assistance activities by their characteristics—for example, their size, location, and baseline capacity level—to facilitate trainings tailored to NGOs working with similar capacities and in similar contexts. However, before training began, the project determined it could not afford to lose the economy of scale for trainings. As a result, NGOs of varying characteristics were trained together; and trainings were supplemented by additional technical assistance and follow-up as needed to ensure that individual NGO needs were met. While this was not part of the original plan, the unexpected benefit of this approach was that NGOs were able to learn from their peers, and hear examples of how fellow NGOs were tackling some of the same challenges that they themselves faced, despite their different demographic and capacity characteristics. However, the differences between NGOs also meant that they had differing technical assistance needs and it became a challenge to manage the diversity of NGOs present at workshops. The project adapted by prioritizing onsite individual technical assistance in addition to the workshops.

The NGO capacity building teams were originally created such that each NGO had champions who could ensure the capacity building needs of the NGO remained front and center in project activities, who were aware of the NGO’s benchmarks, and who could rally colleagues around achieving these benchmarks. These teams were originally composed of 11 members. Despite the importance of these teams to NGOs’ capacity building process, the project learned that they were meeting infrequently and did not communicate effectively with the project. In addition, some of the NGOs managed multiple projects, whereas others only managed one—NHSDP. The capacity building teams in NGOs that managed multiple projects had a difficult time engaging NGO staff not directly involved with NHSDP. The project adapted by working with the NGOs to redefine the terms of reference for these teams. Collectively, they decided to decrease the size of the teams so they were easier to manage, and to make it mandatory for each team to have one representative from NGO management. The addition of the management representative also gave capacity building team members greater influence in the NGOs that managed several projects. In addition, the project implemented an intensive communication strategy with NGO capacity building teams—via email, telephone, and onsite support.

Finally, the project intended to monitor the contributions of technical assistance and follow-up to NGO performance through monitoring visits and supportive supervision, routine report checks in management information systems, and annual MOCAT assessments. However, before the first post-baseline MOCAT was completed, the project’s capacity building team experienced budget and staff cuts and the annual MOCAT assessments were removed from the project implementation plan. The project adapted by putting resources toward an endline MOCAT during the project’s final year; and by using benchmark progress reports. An additional impact of these staff and budget cuts was an overall reduction in intensity of technical assistance—particularly as that technical assistance related to capacity areas not measured by the institutional strengthening benchmarks.

Failure to transition NGOs to direct grantee status

Between 2013 and 2015, the project created a process to transition two selected NGOs from grants under the NHSDP contract to direct grantees of USAID. Within the first few months of the project, the donor requested a change in the implementation plan. Instead of transitioning one NGO at the end of the second year of project implementation, USAID requested that both NGOs be transitioned at the end of the project’s second year. The project identified six NGOs as eligible for transition using organizational performance data, and of these, the project selected two based on their results from a
USAID-approved organizational capacity assessment tool.

The condensed timeline for transition led to a work-intensive year, both for the project and the NGOs. Transition plans were developed for each NGO based on findings from the preliminary assessments. The technical assistance plans called for additional trainings and extensive onsite technical assistance, which had to be completed in addition to the capacity building efforts of the other 24 NGOs.

The USAID requests for application for the selected NGOs were released in October 2014. The NGOs submitted their proposals in November 2014, and responded to subsequent USAID questions through January 2015. During this time, the communication from NGOs to the project decreased. The project learned that NGOs made significant changes to their proposals, against NHSDP recommendations. In addition, one of the NGOs experienced internal management issues that distracted staff from the transition process. Finally, per standard proposal review procedures, USAID asked the NGOs several questions about their proposals. Being unfamiliar with this process, NGOs interpreted this communication as a sign of positive outcomes—and their subsequent behavior jeopardized their applications. USAID ultimately determined that the NGOs were not ready to transition and, in April 2015, decided to remove this transition process from the project entirely.

**Performance-based grants**

In the project’s first year, a request for applications was issued to the Surjer Hashi NGOs for participation in the PBG program. All 26 eligible NGOs applied. First, applications were reviewed by a technical committee, then NGOs and the project participated in an orientation and negotiation process in which staff discussed budgets and collaboratively decided on performance targets, and, finally, USAID approved the issuance of all 26 PBGs.

The project planned to pay incentives on an annual basis, depending on performance against eight indicators. For every target met, NGOs would receive 1 percent of their total annual budget. If all eight targets were achieved, NGOs would receive an additional 2 percent award, for a total of 10 percent of the NGO’s annual budget. The project and the NGOs agreed upon indicators to be incentivized and each indicator was aligned with one dimension of NGO performance (see Figure 4). Distribution of incentives was determined by individual NGOs, however, the project required that all NGO staff—clinical and non-clinical—receive a portion of the bonus, and that distribution plans be submitted for review to the project prior to distribution of incentive funds.

The project also identified three administrative indicators. Administrative indicators included: on-time submission of complete financial reports, on-time submission of statistical data and program narratives, and staff retention for the quarter. For each administrative target not met, the NGO would be penalized by 1 percent of the total annual budget. The previously mentioned trainings and workshops supported NGO capacity to reach these performance targets.

**FIGURE 4: STRATEGY FOR IMPROVED NGO PERFORMANCE:**
PBGs added the potential for the NGOs to be awarded for taking steps towards improved performance.

**Improved FP/RMNCH outcomes**

**Incentivized indicators**

- **Coverage**
  - Number of service delivery approaches successfully implemented to reach adolescents and youth
  - Percent increase of women receiving fourth ANC visit
  - Percent increase in PNC provided by a skilled provider

- **Quality**
  - Percent of clinics implementing a continuous quality improvement plan

- **Equity**
  - Percent of service contacts who qualify as poor
  - Percent increase of number of youth (15 to 25 years) accessing reproductive health services

- **Institutional Strengthening**
  - Percent increase in cost recovery through program income and other sources
  - Absence of questioned costs in annual report

**Administrative Indicators**

- On-time submission of complete financial reports
- On-time submission of statistical data
- Staff retention during the quarter
The project faced constraints in designing a PBG program that adequately covered all four dimensions of NGO performance. While service delivery indicators easily covered uptake and coverage, quality, and equity, it was more challenging to select indicators for institutional strengthening. For that dimension, the project wanted to tie incentives to capacity building benchmarks set by NGOs after baseline analyses to strengthen the link between PBGs and capacity building outcomes, and incentivize the capacity building progress. However, the project needed to identify indicators that were easily countable and verifiable to enable efficient issuance of awards tied to performance. Yet, many capacity building benchmarks relied on project involvement—meaning NGOs did not have full control over whether they could achieve these benchmarks—and the ultimate impact of many benchmarks tied to institutional strengthening is difficult to measure quickly and quantitatively. For example, one benchmark was related to women in NGO leadership positions. Though this can be counted quickly, how can we measure whether women in leadership positions translates to change with regard to gender equality across a given institution?

In addition, the project faced certain realizations that made it necessary to change some performance-based grant indicators. NGOs demonstrated difficulty meeting the staff retention target, in part because salaries and benefits offered to clinic staff in the Surjer Hashi network were not considered competitive with those of other clinics. In response, some clinics rushed hiring processes, resulting in the hiring of providers with skills that did not meet the needs of the clinic. As a result, the project dropped the staff retention indicator and tied PBGs to a separate set of indicators that still pertained to the four dimensions of NGO performance.

**FINDINGS**

The project aimed to build the capacity of a network of diverse NGOs to sustainably provide quality RMNCAH services. It is worth noting that efforts to measure or quantify organizational capacity are often challenged by the intangible nature of some capacities as well as the subjectivity of such judgments. To minimize subjectivity, the project employed a variety of quantitative (e.g., review of documents such as audited financial records and meeting minutes) and qualitative (e.g., interviews with NGO staff and stakeholders) data collection methods. To monitor how technical assistance contributed to NGO performance, the project looked at baseline and endline MOCAT assessments—which measured institutional, programmatic, and financial capacity change. To complement this, the project conducted focus group discussions and interviews with NGO staff at the end of the project to better understand how NGOs felt capacity building interventions impacted their programming.

Additionally, after USAID removed the transition process from the project, the project conducted an after-action review to learn from this experience and to inform future endeavors—both by Pathfinder and globally as other organizations pursue this work as part of USAID Forward. Three focus group discussions were conducted with participants from the two targeted NGOs, project staff, and USAID/Bangladesh staff.

To monitor performance-based grant progress, a third-party was enlisted to verify data submitted by NGOs. To complement the quantitative data collected, the project planned for a series of semi-structured interviews and focus group discussions with clinic and NGO staff at multiple points during the project to better understand if, how, and why the project’s capacity building interventions impact NGO and clinic performance. In these focus group discussions, 279 people participated, representing 20 of 24 NGOs, 35 clinics, and 6 divisions of Bangladesh.

**Technical assistance to improve NGO performance**

The project implemented two MOCAT assessments—one in the project’s second year and the second in the project’s last year. The project’s two MOCAT assessments measured NGO institutional, financial, and programmatic capacity to determine overall NGO capacity. Each assessment provided a score (0 to 4) that corresponds with a stage along the organizational maturity spectrum. Between baseline and endline MOCAT assessments, all NGOs improved their MOCAT scores. Notably, disaggregated scoring data shows that NGOs improved the most in institutional capacity, followed by programmatic capacity, and finally, financial capacity.

In addition, the majority—75 percent—of NGOs improved their MOCAT stage. All those that improved moved from “emerging” to “expanding.” Of those that did not improve, one NGO remained “emerging,” and five remained “expanding,” possibly reflecting the increasing difficulty of progressing along the stages (see Figure 5).

The project also looked at increase in MOCAT scores by NGO size and funding, and found that NGOs with one funder (NHSDP) and that managed ten or fewer clinics had a greater increase in MOCAT scores than the bigger NGOs with multiple donors. These trends suggest that more stakeholders and competing priorities increase the difficulty of achieving organizational change, particularly when those changes are driven by one of those stakeholders.

In addition, two focus group discussions were conducted with representatives from six...
NGOs to better understand the impact of capacity building. Participants felt that their policies, manuals, and tools had improved; that there was more gender equality on their boards; and that the NGO capacity building teams successfully cascaded knowledge across NGO staff. For example, select participants offer:

“At NGO level, they helped us develop our updated policies—like conflict of interest, whistleblower, human resources policy, staff retention, organogram, mission, vision, updating organizational structure.”
– Financial Administration Manager

“Those who are regularly going to [capacity building] meetings are cascading their knowledge to the organization. It is helping them know everything about these processes.”
– Clinic Manager

With regard to what could have been done better, participants felt that NGO management and executive committees could have been more involved in the capacity building process, and there could have been more focus on proposal writing. For example:

“We are project staff. But decisions that could improve the NGO are made by the management team. If we could provide an action plan for them so they know what they need to do to reach that point, they could follow it.”
– Monitoring and Evaluation Officer

“Someday you will go and we will need to sustain. If we have help writing project proposals, it will be very helpful for NGOs.”
– Project Manager

Finally, feedback from project capacity building staff suggests that NGO capacity building teams could have been more effectively engaged to support the project’s capacity building efforts. If included in the project’s capacity building intervention design, implementation, and monitoring process, these NGO capacity building teams may have been able to provide additional human resources support to the project’s staff while gaining experience to be applied within their own NGOs. For example, rather than NGOs relying exclusively on technical assistance from the project, an NGO that cultivated a vibrant, active community support group could deploy their capacity building teams to mentor other NGOs on methods to effectively engage the community. In addition, project staff suggests that NGO capacity building teams might benefit if future capacity building efforts trained NGO teams on adult learning, for example.

**Transitioning NGOs to direct grantee status**

Per its contractual requirement, the project intended to transition two network NGOs to direct grantee status, meaning that these NGOs would no longer receive funds through NHSDP. When the transition failed, NGOs were left without project and USAID funds, requiring them to use reserve funds to remain operational. A project-initiated after-action review—conducted through a series of focus group discussions with NGO, project, and USAID staff—helped elicit lessons learned from this experience. Focus group discussions yielded three key themes: the effects of over-confidence on stakeholders, the challenges inherent in the project design, and finally, the positive outcomes resulting from the process. First, participants from each focus group discussion had expected the transition process to end successfully. NGO participants were particularly reflective on how this confidence impacted their process. On the one hand, the expectation of success may have contributed to high levels of commitment to the process. However, some NGO participants felt that this expectation had contributed to a false confidence, leading to significant changes to their project design against NHSDP recommendations and decreased engagement and communication with NHSDP staff, which ultimately hindered progress.

Second, discussions with project and USAID/Bangladesh staff revealed challenges with the transition process in the context of the overall project design. For example, by mandating that NHSDP select two NGOs in advance for possible transition, rather than establishing a competitive process, they...
limited their chances for success. In addition, participants felt that there was insufficient engagement with NGO management staff as individuals with power to make change at an organizational level—which was a reflection of the fact that NHSDP had limited authority with partner NGO leadership. Finally, all discussion participants considered that preparing plans for multiple outcomes might have helped decrease the potential negative impact of failure to transition.

Finally, participants from each discussion revealed that the transition process itself, despite its negative outcome, yielded several positive benefits to the different stakeholders. Participants from NGOs felt they gained knowledge and skills through exposure to the USAID proposal process, and they appreciated the support that helped them identify what areas there were for growth in order to be competitive in this space. Participants from the project felt proud of NGO staff commitment to this process, which was a significant responsibility on top of their other capacity building efforts and their regular work in NGO and clinic management. Finally, USAID staff explained that this process helped them think critically about how to design future projects, and the importance of having more explicit discussions of roles, responsibilities, and expectations with all stakeholders at the beginning of the process.

**Performance-based grants**

Project data shows that NGOs met an average of 76 percent of their PBG targets. The intention of the PBGs was to align project and NGO goals—local ownership of improved quality service delivery and increased capacity, respectively—by incentivizing performance improvement. This helped to create an enabling environment for capacity building by creating additional drivers toward organizational success—including financial payments. To understand the effects of this incentivization on NGO performance, the project looked at quantitative and qualitative data as it relates to NGO technical, financial, and managerial capacity.

Data suggests that financial motivations served as a facilitating factor for NGOs engaging with the project to improve their internal management. Comparisons between MOCAT scores—indicator of overall capacity—and PBG achievement shows that NGOs achieve their PBG targets, overall capacity increases. Qualitative data from focus group discussions suggest this is because PBGs increased NGO and clinic staff’s intrinsic and extrinsic motivations, increased pride and autonomy leading to locally developed solutions, and contributed to better reporting and monitoring practices. NGO and clinic staff explain below:

“Staff retention is increasing. Staff satisfaction is felt. When they received the bonus, they could buy a TV or other large purchase.”  
– NGO Project Director

“We are more proactive on follow-up visits for ANC and PNC [antenatal and postnatal care]. Previously, we waited for the clients to come. If a client came to the clinic, we provided her with the service. Now, we track the expectant mothers and do active follow-up to encourage them to come in for services like ANC and PNC.”  
– Counselor

“From the M&E perspective, the use of data and data analysis has significantly increased during the PBG due to the fact that to reach the indicators they have to monitor regularly. And they have to know what parts to improve. So the computer-based analysis of data has improved.”  
– Monitoring and Evaluation Officer

**LESSONS LEARNED**

This project sought to build the capacity of a network of NGOs in Bangladesh so that they could better support the public health sector in ensuring equitable access to quality health services for those most in need. Implementation experience and performance data offer lessons for future implementers seeking to build organizational capacity in the private sector in similar contexts. These lessons pertain to local ownership of capacity building efforts, human resource needs for capacity building, the complexity of capacity building, and monitoring and evaluation of capacity building.

**Increasing local ownership of capacity building efforts for sustainability**

Local ownership of capacity building is that which is driven by local demands, needs, and priorities, and the local leadership has control of resources and modalities for technical assistance. Such ownership is crucial for sustainable organizations to develop. The project attempted to move toward this ownership with PBGs to align motivations, by inclusive and collaborative needs assessments and capacity building planning, and by creating capacity building teams of NGO staff to be responsible for encouraging and monitoring capacity building progress among individual NGOs. However, implementation experience and focus group discussions reveal that these teams were often challenged in their progress due to lack of participation of NGO management and executive committee members—this was especially true for NGOs that managed multiple projects and therefore had more stakeholders and more competing priorities. NGO staff felt that increased buy-in and involvement from NGO leaders as decision makers would better enable institutionalization of some changes for improved capacity.
The attempt to transition two NGOs to direct grantee status further provides opportunity for reflection on the importance of locally driven capacity building efforts for sustainability. While the intention was to create a pathway to sustainability for the NGOs, the NGOs themselves had little say in how this project element was implemented. Perhaps because it was understood as part of the project, rather than a key to NGO sustainability, or perhaps because it was mandated by the donor and not designed by the NGOs, the collective focus was on achieving the target and not on creating contingency plans. As a result, the NGOs ended up in a challenging financial situation that impacted their clinics as well.

**Customized capacity building requires significant human resources, but is necessary for sustainability**

The project’s capacity building plan required human resources to develop capacity building plans, to lead capacity building workshops, and to provide tailored mentorship through onsite visits and remote support via phone or email. Changes during implementation meant that the project’s capacity building team had to provide the planned support as well as manage workshops with NGOs with varied technical assistance needs due to their demographic differences. Anecdotally, the project staff reveal that though these efforts strained their team, they felt that the best approach was one that responded to individual NGOs’ technical assistance needs. As a result, the project’s capacity building team provided follow-up visits to NGOs after workshops to ensure that the workshop setting with demographically different NGOs did not result in some capacity building needs not being met. In other words, the project’s capacity building team needed to possess contextual knowledge of different NGOs, in addition to the logistical skills needed to plan and implement workshops, as well as onsite and remote technical assistance. In sum, while capacity building efforts that are customized to the needs of each supported organization require significantly more staff time, the improvement within supported organizations is more likely to last beyond the period of capacity support with this tailored approach.

Project staff suggests that one way to better meet the demands of tailored capacity building would be to strengthen a project’s human resources by including those whose capacity is being built (in this case, NGO capacity building teams) in the design and implementation of capacity building efforts so they can learn from the experience. Future projects may also consider providing these capacity building partners with additional training in fields such as adult learning and organizational development to strengthen the delivery of their capacity building efforts.

**Complex organizational capacity building requires alternative forms of monitoring and evaluation**

Capacity building is complex, and implementers cannot control all the variables that will certainly impact outcomes. Implementers and evaluators must adapt their questions and methods to learn why or how something worked, rather than whether it worked. This could be done by including more measures to capture unintended outcomes and including more qualitative measures in data collection. For example, findings from the qualitative data collection suggest that the PBG incentive mechanism and the transition process yielded positive impacts experienced...
by NGO staff that are difficult to objectively measure but are no less important to capacity building. Some focus group participants reported an intrinsic motivation to achieve performance-based grant targets—reaching a target suggests their performance has improved and therefore clients receive better quality services. Similarly, despite the failure of the transition process, several focus group participants suggested they felt pride because of the work they did and the commitment they demonstrated, and they felt they had still gained knowledge and skills despite not meeting the intended target. If we continue to measure our performance exclusively with quantitative data or by results-based outcomes—in other words, was the transition successful or not—rather than by the process, we may lose insights that could be instructive to future capacity building efforts. For example, what might the long-term impacts of these intrinsic motivations and renewed commitment and pride be on organizational change?

CONCLUSION

NHSDP capacity building interventions yielded mixed outcomes; while many organizations successfully progressed along the stages of organizational development, two organizations were unable to transition to direct grantee status—a would-be mark of increased sustainability and ownership. Exploration of the project’s implementation experience, and asking how or why a process worked or didn’t, help us as implementers create a picture of what components of our interventions contributed to organizational development and what hindered it. For example, tailored technical assistance and the intrinsic and extrinsic motivations associated with financial rewards can contribute positively to organizational development while the absence of consistent alignment of priorities across local, implementing, and donor stakeholders can hinder it.

Capacity building is inherently complex because of the involvement of multiple stakeholders and their competing priorities. These elements make lasting change increasingly difficult, not only because they contribute to a constantly changing environment, but because competing priorities sometimes mean we do not always measure or observe the right things. It is unrealistic to think that donor priorities and local priorities will always align, or that multiple donor priorities will align with each other. In the case of capacity building, this misalignment of priorities can impact the magnitude of sustainable organizational development as well as what project outcomes are monitored—for example, achieving a quantifiable project output versus a change in how the private sector supports the public health system. As implementers working with these complex systems, we must continue to refine our processes and methods to understand “why” and “how” change occurs within specific contexts.

END NOTES


4. Ibid.


11. Ibid.

12. Ibid.


14. Ibid.

15. Ibid.


ABOUT THE PROGRAM: The NGO Health Service Delivery Project (2012–2017) is a five-year project, funded by USAID and DFID, which aims to provide technical assistance and capacity building to NGOs to provide a quality essential services package to the poor and underserved populations in Bangladesh. Pathfinder International manages and directs the USAID-DFID NGO Health Service Delivery Project and the implementing partners are: Bangladesh Center for Communication Programs, CARE Bangladesh, Johns Hopkins University Bloomberg School of Public Health, Center for Communications Programs, and Brandeis University.

CONTRIBUTORS

Mohammed Ahsan Ali
Brak Brom
Rashed Reza Chowdhury
Julia Monaghan
Shiril Sarcar
Anna Tomasulo
Sarah Uminnayar


USDA-DFID NGO HEALTH SERVICE DELIVERY PROJECT

House 15A, Road 33
Gulshan 2
Dhaka 1212, Bangladesh
Phone: +880-2-9892176

PATHFINDER INTERNATIONAL, WATERTOWN

9 Gaten Street
Watertown, MA 02472, USA
Phone: 1-617-924-7200
TechnicalCommunications@Pathfinder.org