

What do we know about capacity building?  
*An overview of existing knowledge and good practice*



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June 2001

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## Executive summary

The World Health Organization as an intergovernmental specialised agency has the task and challenge to support its member governments in strengthening their capacity to steer their health systems. This figures prominently in the recent World Health Report, in which stewardship is ranked as the most important of the health system functions. In the Report, stewardship is defined as a “function of a government responsible for the welfare of the population, and concerned about the trust and legitimacy with which its activities are viewed by the citizenry”. This overview on capacity building covers the recent thinking on the issue and provides information relevant to strengthening capacities also in the stewardship role of the governments.

This paper is written primarily to the participants of a WHO project which aims to develop, in partnership with countries, ways to support senior policy makers and managers of health systems.

Major developments have taken place in capacity building during the 1990s. Most information on the topic is recent and appears in grey literature. This overview aims to present the current knowledge on the concepts and practice in capacity building. The first part of the document discusses some major changes in the international thinking. The second part links the concepts and frameworks to the state of the art in practising capacity building.

For effective capacity building, a fundamental question is how **capacity** is defined: capacity to do what? One of the most widely used new definitions sees *capacity as an ability of individuals, organisations or systems to perform appropriate functions effectively, efficiently and sustainably*. Current thinking links capacity with performance of the defined and appropriate functions and tasks, i.e. they should contribute to the achievement of strategic objectives of the entities.

The thinking about **capacity building** has moved from a focus to individual training to development of institutions and further to the complex systems thinking of today. *The new definitions emphasise the continuing process of strengthening of abilities to perform core functions, solve problems, define and achieve objectives and understand and deal with development needs*. The concept overlaps with and includes human resources development and various management approaches and trends. It is broader than organisational development. It is essentially an internal process, which may only be accelerated by outside assistance. Capacity needs to be built on what exists.

The current concepts of capacity and capacity building as well as much of the current actions in capacity building are based on **two major shifts in paradigms** since the mid 1990s. Emphasis on local ownership of programmes and genuine partnerships between the donors and recipients emerged from the analysis of failures in development cooperation. Ownership and partnership rhetoric is now widely adopted in development cooperation, but implementation is difficult. The other paradigm emphasises that the performance and the capacity of an individual, team, organisation or a system is influenced by factors both within the entity of the primary focus and by external factors in the broader environment. **The main impulses, which led to the extensive international debate and analysis** on capacity building, were: 1) the failures in development cooperation to produce sustainable results and 2) the need to strengthen the state and its institutions after the negative experiences of structural adjustment policies, which emphasised the minimalist role of state and radical downsizing of the public sector. The rethinking and self-assessment processes have led to the renewed emphasis on capacity building in development cooperation by the main international organisations, donor agencies and several developing countries.

Capacity development programmes consist essentially of three phases. The phases are interlinked and overlap to form a continuous cycle. According to the current thinking they all include the same elements of working in genuine partnerships, involving stakeholders, examining capacity as part of a wider environment, adopting the process thinking and having a long-term perspective and commitment.

The first phase, **needs assessment** for capacity building is a basis for designing a strategic plan. Capacity gaps are identified by first defining the essential capacities at individual, team, organisation and system levels for achievement of policy or organisational or programme goals and objectives. Assessment of existing capacities is then compared with the future needs. In practice, this process may take several rounds. A number of assessment tools have been applied at systems, organisational and individual levels. The challenge in capacity assessment is to link the assessment with planning of strategies and tasks, to examine enabling and hindering factors for good performance at all levels, to choose appropriate methods, and to keep in mind that the purpose of the assessment is to lead to improvement of performance. A recent study on capacity gaps in health sector reforms is summarised to illustrate the new thinking.

In the second phase, **strategies and actions** in capacity building are tailor-made for each situation on the basis of identification of capacity gaps. A wide consensus has been built on the essential approaches for successful capacity building, listed in Chapter 9. As root causes for capacity gaps occur usually at different levels, several types of activities are required. Some may be more conventional such as workshops, courses, technical assistance, but they need to be planned in a broader context than before. The sector-wide approach and twinings between institutions are examples of promising modalities to promote genuine partnerships. Their full potential in capacity building still needs to be realised.

The last part of a capacity building cycle, **monitoring and evaluation**, has been largely neglected and is now only emerging. It is important to focus on the motivation for the evaluation: the capacity development process itself, the programme management process, or donor agency reporting needs. General evaluation methodologies can be applied. However, for instance the long time scales in capacity building have to be kept in mind: outcomes may take up to 20 years to show, while processes can be changed in a couple of years. Use of mixed sets of qualitative and quantitative measurements and output, outcome and process indicators are recommended in the recent literature. Some current concerns in monitoring and evaluation are presented.

**Conclusions** drawn for the capacity building in policy development and strategic management of health systems emphasise the opportunity to build on the recent broad international consensus on best practice and to avoid falling into the pitfalls of the previous years.

Some key factors for successful capacity building include:

1. building local ownership and national self-reliance,
2. practising genuine partnership,
3. understanding the context specificity of capacity and its development,
4. examining capacities in a context of systems and strategic management,
5. having a long-term commitment of partners and
6. exercising the process thinking in all phases of capacity building.

WHO as an intergovernmental specialised agency should be, in principle, in a unique position to support its member governments to build their capacities in equal partnership. How this opportunity is realised depends on the clear articulation of needs and demands of the member states, on the capacity of WHO and its partners to respond, and on the commitment of all partners to work together.

## Purpose of the overview

*“We have learned that successful development programmes are more likely in a sound policy environment. We have learned that the quality of policies in a developing country is influenced by the political processes by which decisions are made, and that the decision making process, in turn, is influenced by the capacity of the people and institution, not only to formulate decisions but also to carry them out on a sustained basis. We also know that capacity means more than technical competence. It extends to the capacity to sustain a dynamic and productive interaction among political leaders, the institutions of government and civil society.”(OECD 1996)*

The World Health Organization as an intergovernmental specialised agency has the task and challenge to support its member governments in strengthening their capacity to steer their health systems. This figures prominently in the recent World Health Report, in which stewardship is ranked as the most important of the health system functions (WHO 2000). In the Report, stewardship is defined as a “function of a government responsible for the welfare of the population, and concerned about the trust and legitimacy with which its activities are viewed by the citizenry”. This overview on capacity building covers the recent thinking on the issue and provides information relevant to strengthening capacities also in the stewardship role of the governments.

The paper is prepared primarily for the “Forum for Senior Policy Makers and Managers of Health Systems” organised by the WHO. The project aims to 1) identify the critical challenges in health systems development, 2) examine ways in which capacities for effective policy making can be improved and 3) identify the possible modalities of support that WHO and its partners can provide. The overview aims to offer the participants of the project the most recent information on the concepts and practice in capacity development in order to facilitate planning and implementation of capacity building in policy making.

Capacity building of a particular group, in this case senior policymakers and managers of health systems, is best examined in the context of general capacity development discussion. During the last 10 years the conceptual framework has radically expanded. Furthermore, recent extensive and systematic analysis of experience in capacity building in various fields has provided evidence, which has changed our understanding of the best practices. An often-expressed claim in discussions that massive capacity building has been implemented, but very little is known about how it should be done, proves not to be the case.

This document has two parts. Part One deals with concepts: what do we mean by the basic terms of capacity and capacity building, how are they defined according to the current thinking. The two paradigm shifts that have had a fundamental impact on this thinking are introduced, namely 1) the approach that sees capacity in a wider context of systems and strategic management and 2) the partnership approach. The two main reasons in the international environment that led to the deep changes in international understanding about capacity building are briefly discussed: 1) the disappointment in results of development cooperation and 2) the experiences on structural adjustment programmes, which were raised the need to strengthen the role of state.

Part Two links the previous discussion on concepts and frameworks to the practice of capacity development. State of the art practice culled from the recent literature sources is introduced. First, we examine how capacity gaps can be identified in the current context. A case study relating to policy making and strategic management further illustrates the capacity assessment and its results in practice. Second, the overview introduces overall approaches and strategies for capacity building action, which have emerged from the evidence from systematic analysis of extensive international experience in capacity development. Third, some recent issues and concerns in monitoring and evaluation of capacity building efforts are presented. The main factors for successful capacity building are summarised and some conclusions drawn.

## Part one: New thinking and how it emerged

How capacity is defined determines what kind of strategies and actions should be taken to build capacity. Current thinking on capacity is significantly broader than the definitions applied ten years ago. Capacity is tightly linked with performance. Improvement and development of capacities is in turn linked with strategic management to ensure that performance directly reflects the objectives of the organisation and the system.

### 1. What is capacity?

Many capacity building activities have faced great difficulties, as the partners have understood capacity quite differently from each other. A fundamental issue in capacity building is how we define capacity: what is it that we are trying to build, capacity to do what? Organisations and experts sought to redefine capacity and capacity building throughout the 1990s, resulting in a mix of conceptual and operational definitions. Consequently, there are a multitude of projects and programmes in the name of capacity building, which are based on quite different concepts, assumptions and expectations of results (ECDPM, 2000).

*“Capacity is defined as ability of individuals, organisations or systems to perform appropriate functions effectively, efficiently and sustainably.”*

Among the most widely applied definitions is the one used by UNDP (1998). It lies between the broadest view that equates capacity with development and the narrowest perspective that equates capacity with training. An important addition of the term “appropriateness” emphasises that the functions have to be specified and defined in each case and they have to be appropriate on the basis of some criteria (Hilderbrand and Grindle 1997). In practice, appropriateness of functions is operationalised to mean that capacity should be related to defined core tasks and functions of a job, team, organisation or a system. Essential in the current thinking is the link with strategic management: hence functions are considered to be appropriate if they contribute to the achievement of the mission and strategic objectives of a team, an organisation or a system. However, emphasizing the need to define core tasks and functions should not mean that less attention is given to the need to **adapt capacities** to new needs and challenges.

Capacity has various dimensions. It is not static but is part of a **continuing dynamic process** and thus the capacity of an individual, organisation or system is never complete or in a steady state but requires continuous renewal and investment. Capacity does not exist on its own, but is **linked with performance**: for example, poor performance of an individual, organisation or system in relation to the objectives or criteria set for performance may be due to various capacity gaps. Capacity is an **instrument** for an individual, team, organisation or system to achieve objectives. It can be characterised by **complexity**, which reflects the understanding that organisations are embedded in intricate, overlapping environments composed of political, bureaucratic, economic, social and cultural factors that interact in only partially predictable ways to influence how organisations and their people behave (Brinkerhoff 1995). Capacity **contributes to sustainability**: it is the ability of individuals, organisations or societies to set and implement development objectives on a sustainable basis.

Applied in the field of health, capacity could be defined as following:

*Capacity of a health professional, a team, an organisation or a health system is an ability to perform the defined functions effectively, efficiently and sustainably and so that the functions contribute to the mission, policies and strategic objectives of the team, organisation and the health system.*

## 2. What is capacity building?

For decades, capacity building was seen as assistance to local organisations primarily by providing funding and equipment, increasing financial accountability and strengthening technical skills. However, there has been a growing recognition amongst international and local organisations that while technical and financial inputs are often critical for improving performance, they alone are not sufficient to help organisations or systems to define their vision and design effective strategies to adapt to dynamic environment.

The terms capacity development, capacity building and capacity strengthening appear in the literature with slightly different connotations. Here they are used interchangeably.

### Defined in a new way

Capacity development can be defined narrowly as training- increasing knowledge and skills in general. However, most of the current definitions- and capacity building actions- are based on the fundamental concepts of strategic management. In this overview the definition by the UNDP (1997) and the OECD Development Assistance Committee is used:

*Capacity development is the process by which individuals, groups, organisations, institutions and societies increase their abilities to:*

1. *Perform core functions, solve problems, define and achieve objectives*
2. *Understand and deal with their development needs in a broad context and in a sustainable manner.*

The core competencies, according to this definition, of an organisation or a system consist of: analysing the environment, identifying needs and key issues, formulating strategies, implementing actions, monitoring performance, ensuring performance, adjusting courses of action to meet objectives and acquiring new knowledge and skills to meet evolving challenges.

It is important to note that capacity building is broader than organisational development since it includes an emphasis on the overall system, environment or context within which individuals, organisations and societies operate and interact (UNDP 1998).

### Characteristics

Just as capacity is not static but requires continuous renewal, so is capacity building a **continual process** of improvement within an individual, organisation or institution, not a one-time event. It is essentially an **internal process**, which only may be enhanced or accelerated by outside assistance, for instance by donors. Capacity building emphasises the need to **build on what exists**, to utilise and strengthen existing capacities, rather than arbitrarily thinking of starting from scratch. However, in some situations radical and extensive changes may be needed. Human-centered development strategies emphasise that besides being a means to an end, i.e. improvement of organizational performance, capacity building has an **intrinsic value on its own** in fostering job satisfaction and self-esteem. In a fast changing, globalising world, an essential aspect of capacity building should be to build capacity **to cope with change** and to inculcate more **integrated and holistic approach** rather than traditional, sectoralised ways of thinking in addressing problems at hand.

Hence, capacity building is a **broad concept**, which overlaps with and includes human resource development and various management issues and trends such as strategic management, change management, quality management, organisational re-engineering, knowledge management, information management, etc. The relationships between the “parts-to-be-improved” and the “whole” within a country and international frameworks are often lost. Capacity development is an attempt to see that “whole”(Qualman and Bolger, 1996).

## Important practical implications

From the current definitions of capacity building it is clear that the question is about complex processes of changing people's mindsets and behaviour and introducing more efficient technologies and systems. This has two important implications emphasised widely in the literature. First, capacity building takes a **long time** and requires a long-term commitment from all involved. Second, success of capacity building efforts should not be measured in terms of disbursements or outputs with little attention to sustainability. Long-term change takes into account not only short-term but intermediate and long-term results. These results can be **measured**, but they require a broader selection of measurements and indicators than only quantitative ones.

The thinking about capacity building has moved from the great enthusiasm of provision of high-profile individual training opportunities to the development of institutions and to the complex systems thinking of today.

## 3. Two fundamental frameworks for capacity building

Around the mid 1990s, two major developments in thinking about capacity building took place. First, a new paradigm started to emerge in development cooperation towards **partnership and ownership**. Second, the definition of capacity was broadened and linked with the systems thinking. **Capacity initiatives were to be examined in a wider context of interlinked levels**. Adopting these two frameworks is gradually but deeply changing the ways capacity building is being planned, implemented and evaluated.

### A. Partnership framework

The analysis by the international community of the poor results of technical cooperation led to the emergence of a new approach: working in genuine partnership between the donors and the beneficiaries. Close to this concept is the one of local ownership.

A statement by the OECD in 1996 illustrates this thinking: *"Sustainable development... must be locally owned. The role of external partners is to help strengthen capacities in developing partner countries. To give substance to our belief in local ownership and partnership we must use channels and methods of co-operation that do not undermine those values. Acceptance on partnership model... is one of the most positive changes we are proposing in the framework for development co-operation... In a true partnership, local actors should progressively take the lead while external partners back their efforts to assume greater responsibility for their development."*

The partnership rhetoric is now widely adopted in development cooperation; for instance the European Union has named partnerships as desired relationships between EU countries and the ACP countries (EC 2000). Some problems encountered in putting the principle of partnership into practice are introduced in Section 7.

### B. Framework of levels and dimensions

The other approach that is fundamentally changing capacity building is the framework of levels. **Any capacity initiative has to be examined as part of a wider system by "zooming out" to the outer levels or layer to find the root causes for capacity constraints. How the existing capacities are utilised or how effective the capacity building efforts are, is influenced as much by forces external to the individual, team, organisation or system as by internal forces. Poor performance of an individual, team, organisation or system are thought to have root causes both within the entity but also in the wider layers or levels**. This has fundamental consequences on how capacity gaps are identified and how capacity building strategies are designed.

UNDP in its guidelines for capacity building uses three levels: systems level, organisation level and individual level (UNDP 1998). Here, another framework is used as it better takes into account the complex environment in the public sector (Hilderbrand, Grindle 1997). It defines five levels that have an impact on any capacity:

**a) Action environment**

Other methodologies refer to this level also as situation, market or system. It sets the economic, political and social milieu in which governments carry out their activities. Issues that are likely to have an impact on public sector capacities include e.g. international economic relations, policy values in the country, role of public and private sectors, labour market, political stability, leadership support, overall human resource development, social conflict etc.

**b) Institutional context of the public sector**

This is broader than the organisational level and includes such factors as rules and procedures set for government operations, resources (human, financial, information) and structures of formal and informal influence on public sector functions. This context can constrain or facilitate the accomplishment of a particular task.

**c) Task network (or a system)**

Task network refers to the set of organisations involved in accomplishing any given task, for example the health system. How well the system achieves its goals, or performs, depends on inter-relationships, inter-dependencies and inter-actions amongst the entities within the system, all influenced by the flow of information, formal and informal networks of people etc. as well as by the performance of each individual organisation. Network may include also the private sector and NGOs.

**d) Organisation**

Traditional capacity development and organisational strengthening focus their development resources almost entirely on human resources, processes and organisational structuring matters. The modern approach examines all dimensions of capacity at the entity level (mission, strategy, culture, management styles, structures, human resources, finances, information resources, infrastructure) including inter-actions within the broader system, usually with other entities, stakeholders and clients. These factors affect how the organisation establishes goals, structures its work, defines authority relations and provides incentive structures. They promote or constrain performance, because they affect organisational output and shape behaviour of those who work within them.

### Human resources or individual level

This level focuses on how people in an organisation are educated, how their current knowledge and skills fit with the needs of a task or a job. The focus is on technical, professional, managerial and communication and networking knowledge and skills. It also deals with attracting people to the public sector, utilisation of their knowledge and skills and retention of individuals.

### All levels to be included?

The thinking about levels does not imply that capacities at all levels need to be addressed at the same time or in one huge capacity building programme. On the contrary, the current thinking suggests an incremental approach rather than a wholesale action. It emphasises the need to search for root causes of poor performance also in the higher levels or outer circles from the primary focus. An effort to improve the performance of an organisation, for example, needs to take into account the enabling and hindering factors in the system that the organisation is part of (e.g. roles of organisations in the health system), in the

institutional context (e.g. public sector decentralisation policies) and wider environment (e.g. political and economic aspects in the country). Furthermore, looking inward is needed as well: the organisational and individual capacities have to be examined. This approach links any capacity building initiative with higher level goals. A training course, for example, can be an important component in a capacity development programme, but would need to be linked strategically to higher level organisational, sectoral and societal goals.

An important addition to these levels has been introduced, namely the people, clients or the civil society. It emphasises the need for empowerment of people as part of a capacity building effort to achieve the mission of, for example, improving health (brown et al 2001).

## Dimensions

Another approach elaborates the concept of capacity building along four dimensions (Paul, WHO 1995). It is based on the same thinking as that of the levels.

**Human and institutional capabilities** are both needed for good performance of a staff. If the organisation where people work has major weaknesses such as no clear vision, inadequate structures, weak internal systems, practices and management, no incentives, culture which does not promote good performance, the staff is not likely to perform well regardless of its knowledge and skills. The approaches and steps required for the development of human and institutional capacities are different.

**Planning and implementation capabilities** are distinct from each other but interdependent. Strong links between policies, plans and their implementation are essential. Both capacities need to be addressed but neither one overemphasised.

**Micro and macro dimensions** point to the need to diagnose capacity with reference to the relevant level. At the micro level (e.g. a programme) different capacities are needed than at the higher level, where policy and planning capabilities need to receive greater attention.

**Cognitive vs. practice dimensions** pinpoints the need to expand capacity building beyond formal or informal training. Trial and error, learning by doing, design of new systems and practices, internalising ways of working etc. are ways to apply and adapt knowledge and are part of capacity building. They take a long time, which explains why a long-term perspective is essential in capacity building.

The levels and dimensions are essential to keep in mind, “to zoom in and out” of each of them, in assessing capacity needs and planning capacity building strategies and actions.

## The new framework in the health literature

Some recent publications have addressed capacity building issues in the health systems using the holistic approach of levels or external and internal factors. A publication by WHO/SEARO from 1999 gives guidelines on building capacity of national health authorities for Sustainable Development and Health for All (Shaefer 1999). A WHO publication on health sector reform in Sub-Saharan Africa reviews experiences on reforms and expresses serious concerns on capacity building issues (Sikosana et al.1997). The “Management Effectiveness Programme” by WHO is based on the current thinking on capacity building (WHO 1999). A research report including case studies on capacities to undertake strategic planning of health reforms applies the framework of inter-linked levels and external and internal factors (Mills et al 2001). This report is briefly summarised in Section 6. A review by Bennett (2000) on governments` capacity constraints in health sector reforms illustrates further the importance of the levels external to the organisation or system:

*Factors external to the Ministries of Health play an important role in limiting health reforms to take place. Bureaucratic regulations covering health sector operations, imposed by central government, often govern purchasing, budgeting, accounting, etc. This may be particularly troublesome if the health sector is the only reforming one in the country. Centralised civil service structures are also important external constraints. They provide “limited recourse in the event of non-performance and no incentives for good performance.” However, there are also examples of successfully “going around” the regulations, for instance in a health care programme Brazil, in which personnel were recruited on the basis of merits (Tendler and Freedheim 1994).*

*Lack of commitment to reforms amongst the key actors, notably ministry of health civil servants and politicians, may impede the reform. However, Bennett asks if failures in reforms are due to lack of interest or lack of internal capacities on how to go about the reform. The fourth external factor affecting capacities for health reform is corruption. Bennett states that corruption can be very costly in terms of direct leakage of funds and in terms of efficiency of service delivery. It also creates vicious circles.*

*In conclusion, the author asks fundamental questions which analysts are only just beginning to address: How can reform programmes be phased so that they are best able to build upon the limited existing capacities? Rather than bringing the reform in confrontation with external constraints, how can such constraints be worked around?*

## 4. Impulses for rethinking

In the previous chapters the current concepts of capacity and capacity building were introduced on the basis of very recent development work. The concept of capacity building had remained the same for decades in development co-operation: it was equated with individual training and restructuring of organisations. What led to the serious and thorough rethinking and to the drastic change during the 1990s? There are two main reasons: deep disappointment in development co-operation in the ability to enhance sustainable development and the experiences in structural adjustment in many countries.

### Failures in the development cooperation

In the 1990s, highly critical views were expressed on capacity development initiatives that involved technical assistance. Extensive investments had produced little in terms of the increased capacity of the public sector to perform effectively and efficiently (Grindle 1997). Some critics went as far as noting that technical assistance is useless. Continuous dependence on expatriates for performing centrally important functions in government was questioned. Also, donor projects were criticised for often robbing government of its most committed and highly qualified talent. Training of individuals was the most prevalent method of capacity building. As an international expert involved in development assistance puts it:

*“Organising workshops and seminars on one disease after another is rewarding to donor agencies. They are easy to do, outputs are easily measurable, at least in terms of number attendants, and visibility and publicity are high. Knowledge and skills seem to improve. Only problem is that the whole effort seems to have little impact on improving the actual performance of the people in their work.” (personal communication 1998).*

### A senior manager in a Ministry of Health adds:

*“To me having as many workshops and seminars as possible with external funding is a welcome tool in my human resource management. Extra income through allowances gives a way for a more decent salary and less moon- and day lighting. On the other hand, I am fed up with people not being in their workplaces and doing their work. I am fed up with sending our promising future leaders to training abroad and returning with knowledge irrelevant to the country.” (personal communication 1998).*

The need to better understand why the focus on individual training or restructuring public organisations did not produce sustainable changes led to extensive efforts to analyse experiences and to learn from the past. New methods for development co-operation have been urgently requested also by increasing calls from politicians, the public and lobby groups who demand as well better results and greater accountability

for development assistance expenditures. The major cuts in funds for development cooperation, made on political grounds, have nevertheless increased pressures to do more with less: for example aid to Africa has fallen from \$32 per person in 1990 to \$18 per person in 1998. Furthermore, the recent strong emphasis on results-based management within many donor agencies has pushed to strive for measurable results in capacity building.

### Experiences in structural adjustments

The emergence of capacity development in the late 1980s and 1990s was, in part, a response to the experience of structural adjustment. It became clear that many developing countries did not have the management skills and organisational resources to adjust to the shifts in the global economy (Morgan and Carlan 1994). The first wave of reforms dealt with economic crisis and economic policies. Experiences in implementing these structural adjustment policies of the 1980s, which emphasised the minimalist role of the state and radical downsizing of the public sector, failed to give enough attention to the **need for capable states and their institutions** (for several references, see Hilderbrand and Grindle 1997). Hence, the focus since the 1990s has shifted to the second wave of reforms, reforming institutions.

In the first round of economic reforms, policies were in many cases designed and put in place by an elite team of technocrats. Undertaking the second round of reforms in strengthening public institutions has been referred to as a quantum leap beyond the requirements of the first one (Brinkerhoff 1995). Policy makers and public managers responsible for implementation of the institutional reforms in various sectors face changes in their roles, severe institutional constraints and demands for new interaction patterns with other public agencies and civil society. New skills are required from public managers to deal with consensus building, participation of stakeholders, compromise, planning, flexibility, etc. (Brinkerhoff 1995, Hoover and McPherson 1999). Capacity building is seen as providing means of addressing the need to develop these skills (CIDA 1996). Despite of these imperatives, knowledge about how to improve public sector capacity has been uncertain.

## 5. New trust on capacity building

As a consequence of admitting failures in capacity building and facing new demands for building capacities of institutions and systems much rethinking and analysing has taken place since the mid 1990s. Many reports have been written by individual experts, research and development institutions and international agencies. Most of the literature is, however, grey. The analysis is almost exclusively based on past experiences in undertaking capacity building in projects and programmes.

### Self-assessment by donors

Many donor agencies have taken a critical look at the methods they have used in capacity building. Also, the United Nations undertook an extensive evaluation of its capacity building in six countries (Maconick and Morgan 1999). Some donor agencies have analysed the ways their administrative systems may have hindered national efforts: for instance, pooling funding to support national plans on capacity building often has not been possible as agencies have been required to report their separate activities. Some agencies have undertaken a process of self-assessment, for example DFID and CIDA, and developed policies and strategies for their capacity building efforts to give capacity building a greater role and a new direction (for example GTZ 1999).

## New enthusiasm on capacity building

Donor agencies and international organisations have renewed their emphasis on capacity building as an important tool in sustainable development. Simultaneously, the organisations show a major shift in their approach to capacity issues. The OECD and its Development Assistance Committee (DAC) have undertaken extensive work to develop guidelines for technical assistance and capacity building. Capacity building has emerged as a core concern in all the UN system operational activities. The UN General Assembly in 1998 reaffirmed the need to strengthen national capacities e.g. in the field of policy and programme formulation. Flexible responses of the UN to specific capacity building needs have been called for (ECOSOC 1999). A Guidance Note has been addressed to all involved in UN capacity building activities emphasising new guiding principles such as national ownership and commitment and capacity building as a goal, not as a by-product of programmes (UN, ACC 2000).

Moreover, **developing countries have recently expressed strong interest** in capacity development. For instance, an initiative by the African Governors to the World Bank on capacity issues set in motion the conduct of national capacity assessments in a number of African countries (ECDPM 1998). Some countries have also prepared national strategies. The initiative led in the early 2000 to an extensive programme “Capacity Building in Africa”, which is a collaborative effort of 14 African governments, UNDP, World Bank and bilateral donors. It is being implemented by the African Capacity Building Foundation in Zimbabwe, which for instance advocates capacity building, organises regional workshops and provides funding for national and regional initiatives in capacity building.

Another indication of growing interest in capacity building is the “Regional conference on brain drain and capacity building in Africa” held in 2000. It gathered decision and policy makers from 29 African countries (ECA 2000). They urged serious steps to be taken to develop critical institutional and human capacities in countries and stated that “Africa’s main resource to carry it through the next millennium will be its human resources.” The meeting expressed a great concern on the large amount of investments being lost each year to other countries through brain drain. The participants called for more systematic and comprehensive capacity building in Africa, more focus on national development needs and for adaptation of specific measures to address the related concerns of capacity building, retention and utilisation and brain drain. The vast epidemic of HIV/AIDS and its dramatic impacts on for example the public sector capacity to function in many countries call for new strategies in capacity building.

Review of the current literature has shown that very little information is available on capacity building programmes initiated, implemented and funded by developing countries. The literature is biased towards reports on donor funded projects, often written by Western experts. Capacity building seems to appear only in relation to development cooperation and not as actions by developing countries themselves. Increasing international information and knowledge from the developing country perspective would be most beneficial for the further development of the thinking in capacity building. Furthermore, capacity building literature concerning the developed countries is scarce: in the Western countries the less holistic terminology of strategic management, human resource management, institutional development, change management, etc. are used in this connection. This double approach could be questioned.

## Part two: Capacity development in practice

Capacity development consists of phases: assessment of capacity gaps, designing strategies and implementing actions, and monitoring and evaluation. The phases are closely interlinked and do not occur in linear sequence but form a continuous cycle. All phases include same elements of working in partnership, having an integrated and holistic ways of thinking, adopting the process approach and taking a long-term perspective.

### 6. Identification of capacity gaps

#### General principles

Capacity assessment should be an integral component of any capacity development initiative (UNDP1998). As each situation in capacity building is different, it is clear from the literature that there are no systems in capacity assessment fit for every situation. Several specific tools and techniques are available for situation analysis of individual, organisational and system level capacities and their various dimensions. A consensus seems to exist on the overall process of identifying capacity gaps. A detailed description of the process is presented in the recent UNDP guidelines on capacity development; it is used as a basis in this chapter.

#### Continuous process

Capacity assessment is a basis for designing a strategy plan. As strategies should be flexible, also capacity assessment should accompany the process, supporting decision-making, reviewing and redesigning, rather than being a one-off, externally driven event. It should address defined policy or programme goals or visions: capacity needs to be assessed in relation to these. Consequently, the nature of the assessment to be performed varies according to the nature of those goals and visions.

#### All levels involved

Based on the current framework of levels, discussed earlier, any capacity activity, be it focused on an individual, team, organisation or system, should involve the other levels as well. In addition to the primary focus, enabling and hindering factors for good performance are examined at lower and higher levels also. For example, the interest may be to strengthen capacity of a local government to deliver health services more cost-effectively. The primary focus is on the organisations, but it is essential to examine the dimensions of capacity in the broader environment: clients of the service, role and relationships with the higher levels of government (e.g. policies, legislation, budgeting), relations with the private sector and civil society, etc.

The logic behind extending the capacity analysis beyond the primary focus is to seek for root causes for poor performance and/or ensure that in a new system or programme other capacities in the environment enable a good performance. The conventional approach to identifying capacity constraints has been to focus on individual lack of knowledge, low salaries or poor organisational structures. The new approach implies that the root causes for the identified poor ability to perform have to be searched within the circle and from the outer and inner circles. For example, reasons for a poor ability of the Ministry of Health to produce policies acceptable to decision makers may lie in various places: the experts formulating the policies lack certain knowledge or skills, the information they get from a policy research institute may be inappropriate or mistaken, the politicians lack understanding on the professional reasoning behind the policy, the policy may not be in line with the overall policy developments in the country, etc.

Extending the analysis beyond the primary focus is perhaps the most difficult part of the process, as it requires extensive knowledge and understanding of the organisation or system in question but also of the whole society in general. This can not be undertaken by one or few persons but requires involvement of several persons and use of several methodologies. Experience has shown the great value of local experts and local community groups.

### Stakeholders involved

As in the entire process of capacity building, also in identification of the capacity gaps various stakeholders need to be involved. A stakeholder analysis could be carried out to determine who should be involved, their roles, accountabilities and responsibilities and magnitude of involvement. There are a number of techniques, tools and methods available, in addition to using common sense (UNDP 1998).

### Performed in stages

Capacity assessment usually needs to be performed in stages because the nature and detail of the process depends on the current stage of the organisation or system. For example, an organisation lacking the strategic core management capacity (vision, mission, and strategies) requires a quite different approach for capacity assessment than an organisation with good management capacity.

The first stage of capacity assessment needs to be performed from two perspectives: some preliminary estimate of required future capacities and an assessment of the existing capacities from the perspective of the future needs. Depending on the aim of the assessment, existing capacities may be assessed on the basis of defined criteria for good performance. The comparison of information gives an indication on which dimensions of capacities need attention. It also shows the extent of capacity gaps that would need to be filled. On the basis of combined assessments of capacities at individual, organisational and system levels, preliminary alternative strategies could be formulated for developing these capacities. Defining the future capacities in more detail often need to be left to the later stages of the process. In small capacity initiatives focusing for example on a single organisation, capacity gaps may be possible to identify in a short period.

The next stages concentrate on determining the future situations, and consequently the capacity needs, at the systems, organisation and individual levels to be able to identify the capacity gaps more precisely. For example, at this stage a new health system situation may be defined in terms of long- term objectives, goals and outcomes. This future scenario would then be related to the assessment of existing capacities and its major deficiencies, dysfunction, problems, opportunities, etc. The possible strategies for filling the gaps can be refined.

### Approaches and tools for assessment

Different approaches are needed for capacity assessment at different levels: individual, organisation or system level. For systems, possible methods include for example SWOT analysis, performance assessment, legal/regulatory assessment, stakeholder assessment, network and information flow assessment, risk assessment and cost/benefit assessment (UNDP 1998). For assessment of capacities of an organisation, there are several established management, evaluation and audit approaches such as management audit, systems analysis, strategic planning, business reengineering (Lusthaus 1999, Land 1995, UNDP 1998). For assessment of individual capacities, a number of tools have been developed to focus on different areas such as job requirements and skill levels, training, career progression, incentives, interdependencies, accountability and ethics, values, integrity and attitudes, access to information, etc.

Tools and indicators are specific for different fields and purposes. The point is to know which techniques to use for which purpose and when and how they collectively contribute to the success of a capacity assessment and development process.

The process of assessing capacity and identifying capacity gaps in practice meets many challenges: time and effort are easily underestimated, and there may not be a common understanding of what is meant by capacity building by the partners. The most important factor for success is local ownership, as the results of capacity assessment should lead into actions in capacity building, which has not always been the case (Rohdewohld 2000).

In the following, some findings of a recent study on five countries and their capacities to undertake health sector reforms are summarised (Mills et al. 2001). The study gives a good picture on the complexity of capacity issues and the need to examine capacity aspects at different levels. The authors have applied the current thinking on capacity: their analysis is based on the broad definition of capacity and they use the framework of levels in analysing key capacity constraints faced by governments in designing, preparing and implementing health sector reform programmes.

### **Capacity gaps in health sector reforms- five country cases**

In their book “The Challenge of Health Sector Reform” published in 2001 Mills co-workers report results of their studies on five developing countries and their health sector reforms. They have looked at reforms from different angles, one of them the capacity to undertake reforms. Although the authors warn that the application of the study findings to other countries needs to be done with considerable care, the types of capacity constraints that emerge are important to consider in any setting.

Some parts of the capacity building component are summarised here. The studies focus on four policy areas: bureaucratic commercialisation (autonomous hospitals), user fees, contracting out services and enabling and regulating the private sector. The set of capacity constraints observed varied from country to country but some general key issues can be seen.

#### **Internal capacities in designing and preparing for reforms**

The authors defined the basic internal capacities needed for design of reforms: capacity to develop a clear policy framework, capacity to generate commitment to the policy from both internal actors such as health staff and external actors such as politicians, and capacity to design an implementation strategy. They note that in several instances the failure to perform effectively even one of these tasks had suspended the implementation of the reform. Lack of ability to elaborate the policy framework (on the four policy areas studied) was a commonly perceived problem. For regulatory policies, a lack of legal skills had often impeded the progression from policy intention to detailed policy framework. Development and elaboration of implementation strategy had “all too often” been omitted altogether or given only superficial attention. For several of the policies considered, it was clear that political support was limited and there had been no attempt to communicate the policy to other interest groups to gain their support. None of the case study countries had a proper communication campaign.

#### **External factors affecting policy process capacities**

Several of the problems identified in policy development actually stemmed from constraints in the broader environment. The authors conclude that under the difficult economic circumstances, where politicians perceived overall reforms externally imposed, it is hardly surprising that there was no true political commitment or local ownership of health reforms. Health workers themselves did not buy into reforms. Furthermore, this phenomenon of policy making in time of crisis often meant that there were unrealistic time frames for implementation. Also, economic crisis tended to prevent adequate investments in change, for example resources to building new capacities for the reform were insufficient. The case studies showed that economic crisis can create windows of opportunity for health reform. Countries, which have a stronger

capacity to start with, seemed to be more able to benefit from these windows. However, in many instances the crisis also weakens government capacity to plan for and implement change.

A broader political environment also affected progress in reaching consensus on policy reform. The political cycle of elections affected the reform paths: in one case a contracting out policy was temporarily abandoned during the election period, while in another country multiple changes of government did not have a strong impact as a broad mandate in reforms was given to the bureaucrats. In general, bureaucratic structures did not encourage popular consensus building: ordinary people had very limited voice or influence, policy-making was very top-down and governments had made few attempts to consult civil society institutions. In some instances, very active NGO sector and a free and active media had helped to broaden out the debate.

## Capacities to implement new structures

Capacity assessment in implementing new delivery structures, showed various internal capacity gaps related to number, skills and motivation of staff. Root causes behind these problems are discussed in the book. Another set of capacity problems is weak information and financial systems. These basic functions are essential to have in place before any new capacities are developed for reforms. In general, the authors consider over-bureaucratic and over-complex administrative systems to induce an organisational culture that is not conducive to successful implementation of New Public Management approaches. External factors affecting capacity to implement reforms, were again, noticed to be behind most of the internal capacity gaps. These included issues such as highly centralised bureaucratic systems, e.g. personnel and financial systems. But also informal values, norms and conventions, which contribute to the management culture of the bureaucracies, tended to be centralised. Thus in spite of substantive formal reforms, the informal norms often meant that actually only little changed in style of work. A variety of political, economic and social aspects were seen to impede government's capacity to implement new delivery structures. Examples of other factors discussed in the book include private sector development and corruption.

## Key issues for capacity building in health sector reform

Mills and co-workers in their book have identified a number of key issues for capacity building for health sector reform which emerge from the country case studies.

### 1. Recognising the importance of, and developing skills to manage the change process

This includes skills such as development of clear policy frameworks, good communication of reforms, and garnering political and stakeholder commitment and development of rational and realistic implementation.

### 2. Ensuring adequate basic capacities

Severe decay in government performance of basic routine administrative functions has taken place in countries, which have experienced acute economic crisis. The authors emphasise the need to rebuilding basic government roles before any reforms are planned.

### 3. Addressing organisational culture

It takes a long time for people to come into terms with reforms, which are designed to change the very culture of their work place. In all countries studied the organisational culture was based on hierarchy, command and duty, favours and patronage, with little incentive for staff to innovate. Capacity building needs to pay attention also to intangible aspects of an organisation such as culture.

### 4. Coping with external constraints

On the basis of case studies, it seems that frequently the binding capacity constraints lie outside the health sector. This stresses the importance not to only focus on skills and organisational restructuring - as was the case in the traditional approach to capacity building. The authors name over-centralised regulations, entrenched corruption and the instability associated with frequent political change as some factors which may inhibit effective reform regardless of the level of internal capacity.

## **5. Phasing reforms**

None of the countries studied had paid much attention to phasing of reforms. Taking into account the capacity constraints identified in the study, the authors recommend the reforms to be carefully planned and phased so as to build upon available capacity while gradually expanding capacity to undertake new tasks.

## **7. Strategies and actions for capacity building**

Strategies and actions to undertake capacity building are developed on the basis of careful analysis of what the existing capacities are, what they should be and why there are gaps. As the capacity gaps and especially the causes for them are context specific, capacity building strategies and actions need to be developed for each situation. We have general principles and approaches to guide in the planning. We also have tools and methods to implement actions, but we can not have standard programmes with standard strategies and actions, as was the case before.

### **Good evidence on general approaches**

Decades of extensive investments and experience in capacity building all over the world combined with recent thorough analysis and genuine self-assessments have provided ample evidence on what has not worked in capacity building in development cooperation. On the basis of these lessons learned, it is possible to identify general principles and approaches, which may lead to better results. However, the experience in how these principles are put into practice and how these new methods work is too short to draw strong conclusions. For example, one of the lessons has been that poor ownership by the local partner of a capacity building intervention is one of the main reasons for unsustainable results. Enhancement of local ownership is thus to be aimed at. But how this is done in practice, what it requires from both partners, and what are the results, is only rather recently being experimented. These general principles and approaches are summarised in Section 9.

### **About partnership**

One of the most important general approaches in undertaking capacity building within development cooperation is partnership, which is seen to strengthen local ownership of programmes. At a conceptual level, there seems to be general agreement on what is meant by genuine partnership. It is associated with long-term commitment, shared responsibility, reciprocal obligation, equality, mutuality and balance of power (Fowler 2000). Partnership between the North and the South helps to build local ownership and thus increase sustainability of development as well as to improve donor co-ordination (Hauck and Land 2000). The key partnership principles, according to OECD/DAC, are that: 1) developing country priorities should be at the centre, 2) donor funded activities should fall within the framework of a locally owned strategy and approach, 3) planning and implementation processes should include both state and non-state actors to ensure a high level of local ownership and 4) strengthening local capacity to undertake development initiatives is essential.

In practice, building genuine partnership faces many challenges. Also, critical views have been expressed on the reality of the partnership approach. Some criticisms relate to structural inequalities, which make building any genuine partnerships between the donors and the recipients difficult as the North retains financial, technological and institutional advantage over the South (James 2000, Fowler 2000, Hauck and Land 2000). Interestingly, the United Nations has emphasised its comparative advantage over other organisations in building true relationships as an intergovernmental neutral organisation (UN, ACC 2000). The other critique relates to features of the aid system that work against the attainment of long-term capacity development objectives by undermining the managerial autonomy and performance of the Southern partner (James 2000). This reflects a broader contradiction between the pressure placed on donors to demonstrate quick results and the requirement for long-term commitments in capacity building.

Later the partnership approach has expanded to promote cooperation within a country. For example, the African Capacity Building Foundation undertakes programmes and projects to strengthen public-private sector interface in Sub-Saharan Africa (Sako 2001).

### No model programmes

There is a clear consensus in the recent literature that it is not possible to develop any model programmes that would fit into every situation, be it in a developed or a developing country. Moreover, it is not even desirable. The systems thinking in capacity issues imply that each situation is unique by definition. Capacity is task specific and capacity constraints are specific as they are related to the factors in a particular organisation, system or action environment in a particular time. Consequently, capacity building programmes have to be tailored to the situation.

### Strategies in public sector reform

Although there are no standard solutions in developing capacity building strategies, previous experiences on using some approaches in the public sector may be useful. Very broadly speaking, four doctrines can be identified to be on the basis of designing and reforming large organisations, public or private (Moore 1996). They are: traditional bureaucracy, “Japanese” organisation model, professionalism and new public management. They are related to ideas, culture and ideologies. Most organisations are a complex mix of them. Moore emphasises that there is a considerable disagreement about the value and feasibility of each of these sets of ideas, tried also in the public sector. While there is no disagreement that public sector needs to be made more effective and efficient, there is no common agreement on what it means. As Moore argues: “There is no single desirable direction or strategy for public sector reform; circumstances matter a great deal.”

The public sector reform for developing countries became widespread in the 1980s and was based mainly on the so called conventional strategy (Moore 1996). The three main objectives of this approach were: 1) reduction in the number of public employees, 2) increased salary differentials and 3) restoration of the key elements of traditional bureaucracy, namely order, hierarchy, formal procedure, accountability etc. The experience of the strategy has been disappointing for several reasons and it has run up against the successful resistance of the public service itself, Moore concludes.

**An alternative public sector reform strategy- an incrementalist focus** on doing what is feasible in particular circumstances- has been introduced. Moore summarises the major distinctions between the conventional and the incrementalist approach in the following table. The characteristics of the incrementalist strategy to public sector reform are very similar to the characteristics of a good capacity building programme (*see Chapter 9*).

Table 1. Alternative strategies for public sector reform (Moore 1996).

Incrementalist strategy	Conventional strategy
Internally motivated	Externally motivated
Experimental	Blueprint-based
Incentive-based	Authority-based
Locally adaptive	Generic to all circumstances
Incremental and continuous	Time-bound
Piecemeal	Wholesale
Priority emphasis on political tactics	Reliance on government authority
Cooperation with employee organisations	Confrontation

### Several methods needed

Tools and methods to implement various activities have been developed and they are useful and relevant in many situations, both in the developed or developing countries. As a consequence from the new approach to identify root causes for the capacity gaps within an organisation but also from its action environment, a variety of methods in capacity building usually needs to be used. Dealing with some constraints may require the use of conventional methods of capacity building (or development assistance) such as workshops, training courses, technical assistance, etc. Some may be better dealt with more complex, recent methods such as mentoring, networking, building joint ventures, new types of twinning arrangements.

### Some words about conventional methods

**Training**, especially focusing on skill development, has been the most widely used method in capacity building for decades. However, the new approach of searching for root causes for poor performance of individuals and organisations not only from the knowledge gaps of individuals but also from within the organisation and even from the wider action environment has seriously questioned the usefulness of isolated training activities. Studies based on the broader analysis of hindering and enabling factors suggest that the traditional focus on organisations or on training may not be the most effective site for action. In some situations working towards economic, social and political stability may be the first priority, while in others overall public sector employment mechanisms may need changes. Strong organisational cultures, good management practices and effective communication networks seem to have a large impact on performance (Grindle 1997).

Another conventional method in capacity building in developing countries has been the use of **external technical experts**. This is also poorly justified if it is an isolated activity. As such, technical expertise may still be an appropriate method in many situations. What has changed in the thinking is the purpose of using this modality. Rather than performing the work of national experts and filling gaps, external experts are needed to facilitate work as part of a wider programme addressing capacity issues in a broader environment. For example in policy development, rather than actually developing national policies or imposing their content, external experts could facilitate the development of local capacities in the policy formulation process with stakeholder involvement, negotiations, policy analysis etc.

## Twining- a renewed modality

The emphasis on necessity to build development cooperation on partnership has materialised in recent attempts to create new types of twinning arrangements between organisations in the North and South (for example ministries of health). These have encountered many problems as mentioned above, but also positive results have been seen as well (Helland 2000, Hauck and Land 2000). Some earlier experiences have not always enhanced genuine partnership. The main lessons learned emphasise the need for careful consideration and openness by both partners of self-interests, expected benefits and profits, and incentives before engaging the resources in an effort with relatively high opportunity costs, particularly to the Southern partner. Funding and power relations, responsibilities and leadership, creating transparency and openness, sharing possible profits and failures equitably and defining and measuring results are some issues that need to be thought of in a totally new way. A key question is to what extent capacities of the Southern partner are strengthened to be able to take the lead. The literature indicates that new partnership twinning is a promising mode for better capacity building, but also warns that the experience is yet too short to draw conclusions.

Better use of the potential of twinning arrangements in strengthening capacities in health policy reform in Sub-Saharan Africa has been suggested in a report by WHO (1997). It notes also that twinning is possible not only between industrialised and developing country institutions but also between developing countries and between institutions within a country. Thus the better-developed institutions of training, research and consultancy can play a useful role in upgrading of other local institutions through long-term collaboration.

## Sector-wide approach

Another recent attempt to put the partnership approach into practice is the sector-wide approach, SWAP. A lot of misconceptions exist on the approach. SWAP represents a diversity of approaches and cannot be described as a single aid instrument or indeed a blueprint for sectoral development. SWAPs in general have two goals: to ensure that policies, resources and organisational arrangements can lead to attainment of sectoral goals and to create conditions conducive to different forms of interaction between governments and donors. This means that donors give up selecting projects for funding but in turn participate in developing national policies and strategies and in negotiations on spending national and donor funds. Generally, experiences have been positive in demonstrating a move from fragmented, donor-driven approach (DAC/ICD Network 1999). From the point of view of capacity building, SWAPs have been implemented, by and large, through local structures. National execution of programmes has, in some cases, enhanced accountability of government, facilitated learning by doing, encouraged sustainability and enhanced ownership. However, SWAPs have been criticised for not having included sufficient attention to strengthening local capacities. On this ground, the DAC Network has suggested that capacity building should be an explicit objective of SWAPs and that donors should make clear commitment to work through local institutions and use local capacity. Tension between ownership as an objective and the tendency of donors to provide extensive technical cooperation needs to be dealt with. More "capacity friendly" indicators need to be developed and donor personnel need to be trained in approaches for strengthening capacity, suggests the Network of experts.

There are examples in capacity building in which sector-wide has been "sector-narrow": capacity building that includes only the sector in question has been insufficient by itself (Teskey 2000). Unless the wider environment, for example the rules, norms, values and pay structures of public sector, is changed, capacity is unlikely to be built as has been demonstrated for example by the Tanzania Civil Service Reform Programme and the Education Strategic Investment Programme in Uganda.

On the basis of experiences in the health sector SWAP in Ghana, it has been concluded that the transition from project assistance to the new partnership represents a major change to all actors. It transforms the Ministry of Health from "reactive recipient of aid to master its own destiny" (Asamoah-Baah and Smithson

1999). Another analysis calls for attention in SWAPs to mainstreaming local participation, to translating partnership to decentralised levels of service delivery and to emphasising learning by doing. Also, defining boundaries of external partner involvement and influence and the need for external partners to move towards wider institutional involvement and dialogue have been emphasised (Annan 1999). Some health sector donors, for instance Danida, have recently shifted a great part of their capacity building support from project activities to take place under the framework of SWAPs. This includes support to capacity building in policy development and strategic management at the top level through a variety of measures such as workshops and seminars, joint planning sessions and reviews with donors and nationals, targeted study tours, provision of technical assistance, etc. Some donors increasingly see capacity building as a part and parcel of the SWAP process, in which joint working and policy dialogue enhance local capacities in analytical processes and priority setting (personal communication 2001).

## 8. Monitoring and evaluation

Monitoring and evaluation of the changes the capacity building efforts may produce in relation to the set objectives have very often been neglected. Monitoring and evaluation has been performed mainly for the purposes of the development assistance agencies, not for the purposes of evaluating the capacity building itself.

Some of the capacity building efforts are likely to contribute significantly to the capacity of countries. Others may have little or no effect; some may even deplete capacity. Aid agencies and governments themselves are increasingly interested in evaluating the results of capacity building efforts, especially in the time of diminishing funding for development assistance. The importance of monitoring and evaluation is not questioned, but there remain conceptual and methodological difficulties. This part of the capacity building development process is only emerging, and little has yet been written about it.

### Key issue: what is the evaluation for

Different uses or purposes of evaluation lead to the design of different kinds of monitoring and evaluation systems (ECDPM, 1998). These include supporting:

- programme management to set objectives and monitor progress
- the capacity development process itself- by involving local actors in looking at ways to improve organisational performance
- donors own accounting and reporting and project preparation requirements

The first two are the most relevant to the process of local capacity development, and should provide a basis for designing a monitoring and evaluation system, including indicators. The reporting needs of external agencies should be built on these processes, rather than vice versa. Otherwise, there is a risk that the system and the related indicators are not relevant to local stakeholder needs, and may thus discourage local level ownership and commitment.

It has been noted, for example in connection with HIV/AIDS programmes that lack of consensus amongst local organisations and external donors on defining appropriate capacity building indicators emerges from their different priorities and programme objectives (WHO 1995).

It is **important to be clear on the purpose and the ultimate users of evaluation**, who are the participants and beneficiaries whose capacities are being evaluated.

## General evaluation methodologies

There is a substantial literature available on programme evaluation approaches and methodologies in general: formative and summative, objectives-oriented, management-oriented, expertise-oriented, etc. (Worthen, Sanders and Fitzpatrick 1997). Adapting evaluation methodologies to take account of institutional development and capacity questions is not easy (Land 2000). Difficulties include for example selecting appropriate time scales, choosing suitable indicators and dealing with issues of attribution. Also, as the strategies to strengthen capacities have become more complex, the challenge of measuring effective capacity building efforts has intensified.

## Some current concerns

As monitoring and evaluation are gaining importance and as the main purpose of any evaluation should be clear, several concerns on the relevancy of the current practices have been raised.

### 1. More emphasis is needed on measuring processes instead of only on results

Most of the evaluation experience has been gained through donor evaluations that have focused mainly on accountability issues and inputs such as resource use and the achievement of project objectives set often in a blueprint style. In recent years, impact assessment has become a major evaluation priority due to the emphasis on results-based management by donor agencies. The often long, unpredictable and “soft” character of capacity development processes leaves it open for criticism because of the difficulty of demonstrating quantifiable results in the short-term. It has been estimated that a systems level initiative of incremental capacity development and change may be implemented and readily measurable usually in 5-10 years. A transformational change in capacities involving many entities takes typically a generation or two- in excess of 15-20 years (UNDP 1998). However, **this holds to changes in outcomes while changes in processes can be achieved in much shorter time.**

Furthermore, appropriate methods need to be developed for measuring institutional and capacity development processes (Land 2000). When the focus of capacity development is on building up new institutional relationships or changing attitudes and mindsets, suitability of performance measures may be questioned. In these cases, demonstrable change may take decades to show through. In a civil society-strengthening programme, as an example, the purpose was defined as delivering processes, not products. Results were therefore defined in terms of people being able to influence the decision-making that affects their lives. Six dynamic outcomes were presented with qualitative and quantitative indicators. These process indicators are about how organisations behave, rather than what they deliver (Land 2000). Much of capacity building is experimental and should be monitored as such.

### 2. Evaluation of capacity building- not of donor projects

The emphasis on accountability in donor evaluations- gauging compliance with logical frameworks and demonstrating socio-economic and environmental impacts- shifts attention from the areas in which evaluation can play its most important role- learning and decision support. It turns evaluators into auditors (Horton 1999). Current thinking on capacity development emphasises organisational self-learning as a critical element. Consequently, evaluation should be used as a strategic instrument in building organisations capacities to identify, plan and implement their own development objectives- rather than a tool to record results to outside stakeholders.

Many experts are now emphasising creative and flexible management as a critical factor for successful capacity building. Consequently, careful monitoring and reflective evaluation in support to responsive management are more important to success and impact of efforts than are detailed planning and effective control over implementation processes.

### **3. Evaluations to be done in genuine partnership**

Evaluations of capacity building (be it in connection with development cooperation or not), which do not take account of local priorities and do not involve partners in genuine partnership, risk undermining of ownership, which is according to the current knowledge the most important single factor in building sustainable capacities. Evaluation processes in development cooperation, which have the partners to jointly decide the terms of evaluation and to jointly consider the results, are critical in transforming Southern partners from beneficiaries to actors.

#### **Participatory evaluation and self-assessment**

An approach, which is seen to provide a potential solution to many of the problems in current evaluations, is participatory evaluation and self-assessment (Jackson and Kassam 1998). It integrates evaluation into the capacity building programmes and employs self-assessment and participatory evaluation methods, in which various actors and stakeholders in the programme also participate in the evaluations. Experience has shown that strong evaluation component may be one of the greatest assets of capacity building programmes. On the other hand, a programme without an internal capacity building programme runs a risk of being irrelevant, ineffective and highly inefficient (Knowledge, technology and policy- special issue, 1999). When people are confident that the purpose of an evaluation is to improve a programme, they are often eager to participate in it (Horton 1999). Participatory evaluation requires strengthening of local capacities in undertaking evaluations and using a variety of methodologies.

#### **Evaluation of capacity building in the health sector**

Literature in this field is very scarce. It seems that methodologies for monitoring and evaluating capacity building interventions are still in the early stages of development in the health sector and that experience of monitoring changes in capacity over time is very limited. There have been recently attempts to develop measurements in the health sector for capacity building in developing countries (Brown et al. 2001). The authors conclude that there is little consensus on approaches to measuring effectiveness. According to them, understanding capacity measurement in health field is hindered by 1) lack of common understanding of the nature of the relationship between capacity and performance, 2) variation in what constitutes adequate performance and 3) the influence of the external environment on capacity and performance.

#### **Mixed method evaluation**

There have been recent efforts to harmonise participatory evaluation and results-based management by developing frameworks (Jackson 1998, Kotellos et al. 1998, Brown et al. 2001). These use a matrix of inputs, processes, outcomes and impacts by the level of capacity building, i.e. system, organisation, individual. A mixed method evaluation, according to Kotellos et al. allows for more insightful assessment of capacity building and more comprehensive evaluation (of HIV prevention programmes). In a model designed in an extensive project for development of capacity measuring in the health sector by Brown et al., the capacities and their changes are evaluated at four levels: inputs, processes, outputs and intermediate outcomes. For a health system capacity, for example, processes include functions such as policy-making, enforcement of laws and regulations, strategic planning. Outputs might include published policies and regulations, formal and informal coalitions, donor coordination meetings. The intermediate outcomes that represent the health system capacity include effective health policies, ability to cope with the external changes or pressures, rational allocation of resources, etc.

## Donor agencies to monitor their performance

Not only need the capacity building programmes to be evaluated, but also donor agencies should monitor their own progress in implementing their capacity development principles, such as enhancing local ownership. A self-assessment tool has been developed to assist the agencies and their staff for improving their performance in this field (OECD, DAC 1999). These rather detailed criteria emphasise the need for the donor agencies to have a clear strategy and common understanding on what capacity building is, to invest in internal capacity building to meet the requirements of the new thinking of partnerships and to ensure stakeholders involvement in all stages of programmes. Also, flexible administrative systems are required to allow adjustments in programmes due to the dynamic nature of capacity building. Different donor agencies have made different progress in adjusting their staff and internal systems into the modern ways of capacity building, which ask for flexibility, genuine partnership, long-term commitment and evaluation focusing on processes and measuring increase in local capacity and sustainability.

## 9. What makes capacity building successful?

Experiences of decades of capacity building as part of development cooperation have been extensively analysed during the recent years. These experiences have originated from projects and programmes from various sectors, from various countries and situations and from capacity building at individual, organisational and systems levels. Various donors and international organisations have funded and participated in the interventions. There is a wide consensus in the international forums on approaches that have not worked. On that basis, there is also a broad consensus has been reached on key issues that are most likely to be critical for successful capacity building efforts. The most important ones are listed in the following.

### Ownership and responsibility

- A government, system or organisation seriously interested in improving its performance invests in capacity building. Strong national commitment is demonstrated in the form of priority setting, skills, resources and energy. This remains the single most important determinant of the effectiveness of capacity building.
- Governments, organisations and communities build on their own capacity and competence to formulate their own development plans and agenda and to coordinate donors commitments to those plans.
- A country, system or organisation says no to projects and programmes that overtax people, institutions and resources, and which are not assimilated into the country's strategic agenda for capacity development.
- External funding, advisors etc. are used only as complementary to local inputs.
- Leadership is visible and there is commitment and ownership at the political and senior bureaucratic levels, sustained throughout the process. National authorities sit behind the steering wheel. (This is because, capacity building, if perceived to be more than organising training, is a holistic approach strongly and deeply linked with all levels of that society. Therefore, external experts, how good their technical qualities may be, do not possess the capacity to steer a process in another country than in their own.)
- The ultimate responsibility is borne by the leaders in charge of the system or organisation.

## Partnership

- A comprehensive approach is applied with a wide variety of actors within a country contributing their particular skills and resources. Creative partnerships, alliances, networks and joint ventures are used instead of the conventional donor agency- beneficiary approach.
- A country or an organisation works in true partnership with external actors, i.e. donors, advisors etc. This means a mutual understanding of issues and a greater sharing of goals and a shift of decision-making authority and control of programme resources to the national actors.
- The process is organisation-wide and participatory by being highly consultative, and involving all impacted parties or stakeholders.
- All stakeholders are aware of and understand the capacity initiative, the implied changes and capacity needs. Internal and external communication are strong.

## Capacity

- Capacity for what- the fundamental question- has been clearly defined. The people and the organisations involved gain better capacities, which are relevant to the mission of the organisation or the system. (Health systems aim to improve peoples health- not all capacities being developed at present are contributing to that goal.)
- Importance of capacity has been realised. Capacity building is one of the principal and explicit goals of activities, not a component or a by-product of the programme.

## Qualities of participants

- Participants have the following qualities: dedicated attention and resources, commitment, supportive environment, strategic thinking, focused energy, technical skills, political sensitivity and persistence and patience over time.
- External advisers have a capacity to facilitate. (As an example, in policy formulation field there are numerous examples of external advisors being able to develop technically excellent policies but not being able to take into account the political realities of a country or to take the policies through the decision making process.)
- Existing country capacity in the form of individual expertise or organisational ability is fully utilised in the programme.

## Process of capacity building

- Capacity interventions are crafted and customised with flexibility, a sense of experimentation and imagination and openness to learning. It is understood by all that there are no models or predetermined solutions in capacity issues. Most effective approaches emerge incrementally based on accumulated experience and adaptation during implementation. In programme design and management, the fact that development of sustainable capacity needs long lead times is taken into account.
- A careful process-type analysis of the existing capacities and the future capacities required has been made before implementation. It is made at all levels: individual, organisational, system and wider environment regardless of the primary focus of the initiative. A clear understanding of the problem has been ensured before commencing activities.
- The programme has clear set of objectives and priorities. They are built into plans, and work is incremental and phased.

- Basic functions in a system or an organisation have been ensured first before trying to build new capacities.
- The process is open with no hidden agendas, and decision making is transparent.
- The role of outside intervention is not only provision of technical advice and support but paying more attention to process management, facilitation and even mediation. Donor involvement has as much to do with management of relationships, encouragement of learning and shaping of values as it did have previously with installation of organisational systems or design of training programmes.
- Appropriate methodologies are used: management methods are appropriate and flexible, tools and techniques are adapted to the local situation and needs, there is allowance for early successes and pilots, monitoring and evaluation are appropriate to the needs.
- A major error in many capacity building initiatives is unrealistic and short timeframes (often linked to the funding, budgeting or lending cycles of governments and or funding agencies). Capacity building requires long-term commitment from all partners.
- There is an iterative and flexible approach to respond to changing needs and changing perceptions of needs. Local participants determine the agenda, the pace, and the rhythm.
- Expectations in terms of size, scope and timetable are scaled to meet local capabilities. Starting small is often more effective with growth coming only as local resources and structures are able to absorb and manage it and as new learning experiences are shared among emerging stakeholders.
- Emphasis must be balanced between capacity building process and capacity outcomes and substantive development outcomes.
- Results, especially when measured as impacts, take a long period to be measurable: initiatives based on incremental changes of a system takes at least 5-10 years, and those based on transformational change in capacities at least 15-20 years.
- Mix of methods, measures and indicators in monitoring and evaluation are used as they seem to produce a more holistic picture on what is happening and why than use of single quantitative measuring of inputs, outputs or outcomes.

### Donor agencies

- International donor agencies act as facilitators. New capacities have been built: there has been a fundamental change in thinking about capacity building and partnership, changes in administrative systems to enable the holistic approach instead of requiring and measuring individual outputs or promoting strict and blueprint project designs and cycles allowing little flexibility needed in capacity building actions.

## Conclusions

Over the years, much international knowledge has accumulated on capacity building. The experience and learning come from different sectors but reinforce each other in a synergistic relationship. Hence, in future capacity building we are better able to avoid falling repeatedly into the same pitfalls than has been the case in capacity building actions for decades. According to the current knowledge, the following principles are key factors for successful capacity building and should be taken into account in developing capacity building in policy making and strategic management of health systems:

- Building local ownership and national self-reliance.
- Practising genuine partnership.
- Understanding the context specificity of capacity and its development.
- Examining capacities in a context of systems and strategic management.
- Having a long-term commitment of partners.
- Exercising the process thinking in all phases of capacity building: setting objectives, planning strategies, taking actions and evaluating results.

Building genuine partnerships in capacity development is difficult in the context of structural inequalities existing between the partners in the so-called donor-recipient relationships. The relationship between the World Health Organisation and its member states is different. WHO as an intergovernmental specialised agency should be, in principle, in a unique position to support its member governments to build their capacities in equal partnership. How this opportunity is realised depends on clear articulation of needs and demands of the member states, on the capacity of WHO and its partners to respond, and on the commitment of all partners to work together.

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