

# After Ebola: towards a smarter model of capacity building

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## Key messages

- As a common tool of international development, capacity building often produces meagre returns when attempting to improve services
- This is because it is practiced in a narrow, technical way which ignores the capacity of systems, the human face of service delivery, and the complexities of seemingly simple change processes
- The delivery of quality services demands a smarter model of capacity building that is both *people-centred* and *systemically aware*

**The West African Ebola crisis has exposed both the weak state of the sub-region's health systems, and the flawed design of dominant approaches to capacity building.**

The first of these has received considerable global attention. International NGOs have framed the crisis as a 'wake-up call' to the development community, arguing that more investments are needed to build 'resilient health systems', not only in the three hardest-hit countries – Guinea, Liberia and Sierra Leone – but also in fragile and low-income countries more generally. They reason that health sectors have been deprioritised in processes of national development; that failures to deal with public health crises are rooted in years of chronic underinvestment.

The second has been far less talked about – but is no less important. In fact, it partly accounts for why strong or 'resilient' health systems have yet to emerge in places like Sierra Leone. Our analysis shows that the way in which development partners often think about and operationalise ideas of 'capacity' and 'capacity building' is problematic. It has led to straightjacketed policy making and an over-reliance on a narrow set of standardised interventions. Too often, capacity building is reduced to training programmes, in the process crowding out more creative and contextually sensitive methods of development.

Post-Ebola health sector recovery and development in the three hardest-hit countries will take money and resources. However, it will also take new approaches to capacity

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building; approaches that are more *people-centred* and *systemically aware*. Business-as-usual is not an option. Future funding must be spent in a way that learns from the ‘blind spots’ of past support – that is, the issues and areas that have been overlooked – rather than simply replicating them.

**So, how might that be done?**

Drawing on two years of research on state capacity in Sierra Leone’s health sector, with a focus on malnutrition, this briefing paper proposes four ideas for how external capacity support to Sierra Leone’s post-Ebola health sector can be improved.<sup>1</sup> We hope that these ideas might be useful to policy makers working in countries other than Sierra Leone and on sectors other than health. For those interested in more detailed analysis, this paper is based on a longer report (see Denney and Mallett, 2015).

**Why do we need a smarter model of capacity building? Three things the dominant approach gets wrong**

The policy community typically defines the concept of capacity in very broad terms. In their widely cited definition, the Organisation for Economic Cooperation and Development (OECD) refers to capacity as ‘the ability of people, organisations and society as a whole to manage their affairs successfully’. However, in practice it is operationalised in a far more limited way, often reduced to the training of individuals (like health staff) and the material development of organisations (like health clinics).

The practical application of capacity building also largely fails to internalise the many insights and lessons generated by an extensive body of theoretical and empirical research on the subject (see, for example, Morgan, 2006; Petersen and Engberg-Pedersen, 2013). For the most part, helpful evidence – much of it based on rigorous research methods – has yet to filter into policy making and programming.

Broadly speaking, the way in which ideas of ‘capacity’ and ‘capacity building’ have been operationalised in the context of health systems strengthening in Sierra Leone reflects this narrow application. This has been the case since the end of civil war in 2002. While important progress has been achieved since then, the strong degree of global attention currently focused on the region’s health systems creates an opportunity to reflect on the limits of external capacity support to date.

Our own analysis suggests that the dominant approach to capacity building falls short in three key areas.

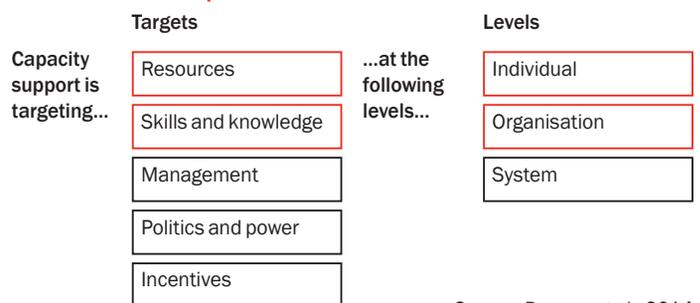
**Systemic problems need systemic solutions**

Existing theoretical frameworks posit that capacity exists at three levels: that of the agent, the organisation, and the system (Morgan, 2006). The first two of these respectively refer to: human beings and the knowledge, behaviour and autonomy they possess; and the structures within which those human beings are housed, including firms, government ministries, NGOs, community-based organisations and aid agencies (to name but a few). Together, they can be considered ‘the units’ of the system.

On the other hand, systems tend to be harder to support, because they are less immediately visible. They are not only the sum of all those specific units, but also the relationships between them, the mechanisms that connect them, and the established patterns of behaviour (that is, formal and informal institutions) which govern how things work.

Because of the accepted difficulties of thinking and working in a ‘systemically aware’ way, it is typically done much less. We found this to be the case in the Sierra Leonean health sector. The majority of capacity building is targeted towards agents and organisations: health workers are trained, health clinics (or Peripheral Health Units) are equipped with drugs and equipment, and community-based organisations are created across the country (for example, development partners establish Mother-to-Mother Support Groups, which are designed to help prevent malnutrition at the local level). These are visible activities with tangible, measurable outputs (see Figure 1).

**Figure 1: Dominant approaches to capacity building often overlook some important issues**



Source: Denney et al., 2014

However, public health problems – whether of the chronic, slow-burning ‘stressor’ kind (such as malnutrition) or the acute, rapid ‘shock’ variety (such as Ebola) – are deeply systemic in nature (AGI, 2015). When a health clinic lacks medicine, it is the supply chains, procurement systems and staff incentive structures we must look to (and the politics around their dysfunction). When a virus spreads, weak surveillance mechanisms become painfully apparent. When a family fails to provide adequate care and nutrition to their children, it is the nature of gendered (and deeply embedded) expectations, roles and responsibilities that form a key part of the explanation.

Yet, dominant approaches to capacity building see systems as *modular* constructions. They break systems down into discrete units – modules of something bigger – and target investments accordingly. They also assume that systemic capacity can be built by strengthening those units, despite the literature demonstrating that it does not work this way: capacity does not simply ‘aggregate upwards’. The central problem here is that the focus of analysis and engagement is placed squarely on the units, rather than on the connections between them – which we know to be important.

**Technical fixes conceal the ‘human face’ of capacity**

Development is not (just) a question of tackling technical deficits. Development problems are deeply social and political.

This does not mean that technical approaches are irrelevant, but it does mean that they are inadequate in and of themselves.

Capacity building has a tendency to focus on the technical. This is partly accounted for by the fact that technical interventions fit easily into logframes: they are visible and measurable, neatly corresponding to the demands of the 'tick-box nature of the aid effectiveness agenda' (Wild et al., 2015). In Sierra Leone, this translates into capacity support being used to enhance the technical knowledge of health workers, supply health clinics with equipment, or develop protocols and procedures to monitor staff absenteeism. These are all sensible uses of capacity support, but they do not reflect any thinking about the 'softer', less visible dimensions of capacity. This might refer to the way in which health workers deal with patients, or the relationships between key people within the health system.

For example, when the time comes for annual health sector planning and budgeting, District Nutritionists with weak influence in the District Health Management Team and District Council – both prominent structures in the health system – often fail to secure sufficient funding for nutrition-related activities. Or when a nurse 'looks down upon' her patient – as we were told happens in some of our research sites in Kambia district – that patient not only becomes less willing to use the government-run health system in the future, but also shares their negative experience with family members, friends and neighbours, thereby deterring others from using the clinics.

So, people's health-seeking behaviour is driven by things other than the 'objective quality' of health services. Sierra Leone is characterised by a plural health system: in addition to government-run health clinics, there are traditional healers, traditional birth attendants, community health workers (mobilised by government, but unpaid) and drug peddlers. Although one might not consider these providers to offer an objectively good service, people use them – and often for reasons which cannot be understood through biomedical perspectives. Traditional healers, for example, can play multiple functions within their own community; in some cases, they are also the local Imam, and social expectations can play a strong role in dictating who you go to first when you or a family member fall ill.

The point here is that systems are made up of people – and people relate to each other. Technical fixes alone do little to engage with this relational aspect of healthcare. As a result, models of capacity building which see the world's challenges as engineering problems, requiring a certain kind of 'technically correct' response, are misunderstanding a complicated socio-political reality.

### **Behaviour change is more complicated than capacity building suggests**

Capacity building efforts often assume a more straightforward relationship between knowledge and behaviour change than actually exists. They simplify what are in fact quite complex processes, glossing over multiple assumptions and steps in complicated chains of causation. This results in a largely

technocratic approach to capacity building, in which a deficit-based logic is applied to the identification and analysis of problems: 'weakness exists because a certain input or condition is missing'.

This narrow understanding of capacity is at odds with contemporary thinking about dynamic, non-linear theories of change, which particularly apply when we are dealing with 'complex adaptive systems' (Barder, 2012).

We saw this clearly in the Ebola response. Surveys indicated a high level of citizen awareness of protocols vis-à-vis what to do if a family member develops Ebola-like symptoms, is found to have Ebola, or dies from suspected Ebola (Focus 1000, 2014a; 2014b). Yet, in practice, the spread of the disease has been largely attributed to a lack of adherence to such measures.

We found a similar story in relation to Mother-to-Mother Support Groups. These groups are designed to prevent malnutrition by spreading knowledge about infant and young child feeding practices throughout communities. Yet, in practice they operate unevenly from one place to the next, and often do not work according to plan.

There are more steps between 'providing technical knowledge' and 'desired behaviour change' than such capacity building efforts imply. But rather than acknowledge these steps, multiple assumptions are made, reducing a complex behavioural change process into a neat intervention that has been uncritically replicated nationwide.

In short, policies that attempt to change people's behaviour often assume the answer to be: 'more information'. This fails to see the ways in which behaviour is subject to forces other than technical knowledge. Cultural institutions, for instance, are both powerful and resilient. While one might disagree with how they are practiced and what they mean, if policies ignore their influence – and the social determinants of people's behaviour more generally – we cannot realistically expect to see intended results.

### **What needs to be done differently? Four ideas for better capacity building in Sierra Leone's health sector**

Health systems are not easy things to strengthen. They are both 'complex' and 'adaptive'. Attempts to reshape the way in which they work must first grasp the difficulty of the challenge, and internalise a policy design which reflects that. As things stand, our dominant models of capacity building – a central pillar of development policy and practice, and an organising concept of the mainstream development discourse – are falling short. They do not reflect the complexity of the task at hand; their design does not do the messiness of the real world justice.

**Training, training,  
training...how much  
training does one  
person need?!**

(Health worker, Freetown,  
September 2013)

What we need is a smarter model of capacity building – one which is more *people-centred* and *systemically aware*. But what might that actually look like in the context of post-Ebola health systems strengthening in Sierra Leone? Our analysis has generated four ideas in response to that question. These can help to inform the various post-Ebola recovery and development plans currently in gestation. But more than that, they offer some different thinking on the core yet contested ideas of ‘capacity’ and ‘capacity building’.

- 1 Accept that a ‘business-as-usual’ approach to capacity building will not be enough.** As the Government of Sierra Leone and development partners begin to plan post-Ebola health support, more of the same will not help to overcome the blind spots of past capacity building. There is now an opportunity for a step-change in how capacity support is designed and delivered. But this will require serious critical reflection rather than a fall-back into familiar comfort zones. It will demand engagement with the complexity of how the health system actually functions. Developing more nuanced theories of change that capture these elements will be critical to more effective programming.
- 2 Capacity building should pay closer attention to the intangible and invisible dimensions of capacity, including the nature of state-society relations.** Public perceptions of the quality of a service quality matter as much as its ‘objective quality’ (e.g. numbers of trained staff, availability of medicine, environmental hygiene). When people have little confidence in the capacity of a provider to deliver quality care, they are unlikely to use that service. The Ebola outbreak has underscored the fragile trust that exists between state and society in Sierra Leone, and post-Ebola support to the health system must address this underlying issue. This might be achieved, for instance, by engaging community members in service delivery meetings and activities, which research suggests are often associated with better perceptions of government (Mallett et al., 2015).
- 3 Capacity building should engage with how people and communities actually use services.** In Sierra Leone, the

international community focuses overwhelmingly on the government health system to the detriment of the plurality of providers that people actually use, from traditional healers to drug peddlers. Building a more *people-centred* health system will require government and development partners to engage with this reality, and to build a nuanced understanding of how people navigate the services available to them. This does not necessarily mean validating their ways of working, but rather brokering discussions about how alternative providers can best work together to deliver quality services.

- 4 Lose the modular approach to capacity building. Support should not only target the units within a health system but also the connections between them.** Capacity building often takes a modular approach, attempting to improve the performance of discrete organisations and individuals in the hope that this will ‘aggregate up’ into stronger systems. This is optimistic thinking based on reductive assumptions that typically do not hold in practice. More attention needs to be paid to the connections, feedback loops and relationships between different individuals and different organisations across the local, district and national levels. Priorities for attention include: data reporting and management; sustained supportive supervision of health workers; integration of grievance mechanisms and other social accountability tools into public services; and coordination methods that actually facilitate coordination rather than just information sharing.

Peeling back the dominant ways of working – and questioning the assumptions embedded within them – will take sustained commitment from development partners. It will require them to think reflexively about their own capacities, and to seriously consider the ways in which these might need to be reshaped. This is no mean feat. But attempting to do so will not only help smarten up the way in which we think about this vague idea of ‘capacity’ – it will also help us see the contribution that more *people-centred* and *systemically aware* forms of capacity building can make to the delivery of quality services.

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- 1 The Secure Livelihoods Research Consortium’s Sierra Leone programme is funded by Irish Aid and is led by the Overseas Development Institute (ODI) in partnership with Focus 1000 and Valid International. From 2013 to 2015, this programme examined how to strengthen state capacity to prevent malnutrition. It involved four stages of in-country fieldwork, which respectively focused on: [the nature of international capacity support](#); [a semi-quantitative survey on barriers to preventing malnutrition](#); [the social drivers of malnutrition and people’s health-seeking behaviour](#); and what Ebola has revealed about the limitations of capacity support (Denney and Mallett, 2015). Across these four stages of research, a total of 130 interviews and focus groups (not including those undertaken for the survey) were conducted in Freetown and our focus district, Kambia, in Northern Sierra Leone. All outputs from this project can be accessed through [this link](#).