

Researching livelihoods and
services affected by conflict

After Ebola: why and how capacity support to Sierra Leone's health sector needs to change

Report 7

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Secure Livelihoods Research Consortium (SLRC) aims to generate a stronger evidence base on how people make a living, educate their children, deal with illness and access other basic services in conflict-affected situations (CAS). Providing better access to basic services, social protection and support to livelihoods matters for the human welfare of people affected by conflict, the achievement of development targets such as the Millennium Development Goals (MDGs) and international efforts at peace- and state-building.

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- State legitimacy: experiences, perceptions and expectations of the state and local governance in conflict-affected situations
- State capacity: building effective states that deliver services and social protection in conflict-affected situations;
- Livelihood trajectories and economic activity under conflict

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Acronyms



BAN	Budget Advocacy Network	NERC	National Ebola Response Centre
CAG	Community Advisory Group	NGO	Non-Governmental Organisation
CDC	Centers for Disease Control and Prevention	NTD	Neglected Tropical Disease
CHC	Community Health Centre	ODI	Overseas Development Institute
CHP	Community Health Post	OECD	Organisation for Economic Cooperation and Development
DFID	Department for International Development	PBF	Performance Based Financing
DHMT	District Health Management Team	PHU	Peripheral Health Unit
ECDPM	European Centre for Development Policy Management	SECHN	State Enrolled Community Health Nurse
GoSL	Government of Sierra Leone	SLRC	Secure Livelihoods Research Consortium
FFS	Farmer Field School	SMART	Standardised Monitoring and Assessment in Relief and Transition
FHCI	Free Health Care Initiative	SQUEAC	Semi-Quantitative Evaluation of Access and Coverage
IPC	Infection Prevention and Control	TBA	Traditional Birth Attendant
IRCBP	Institutional Reform and Capacity Building Project	UNFPA	United Nations Population Fund
IYCF	Infant and Young Child Feeding	UNICEF	United Nations Children's Fund
M2M	Mother-to-Mother support group	UNWOMEN	United Nations Entity for Gender Equality and the Empowerment of Women
MCHA	Maternal and Child Health Aide	WDI	World Development Indicators
MCHP	Maternal and Child Health Post	WHO	World Health Organization
MDGs	Millennium Development Goals		
MICS	Multiple Indicator Cluster Survey		
MoHS	Ministry of Health and Sanitation		

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Executive summary



The West African Ebola crisis has shone a global spotlight on Sierra Leone's health system. [Deep-rooted and long-running fragilities have been identified](#) which have persisted despite several years of international aid intervention. Since the end of civil war in 2002, the country has received more than \$360 million of external support to the health sector. While this has supported [some impressive progress](#) – including the launch of the Free Health Care Initiative in 2010 – the Ebola crisis has also underscored deficiencies in the dominant approaches to capacity building that have informed much development partner support over the last 13 years.

In this paper – the final outcome of two years of research on state capacity in Sierra Leone's health sector, with a particular focus on malnutrition – we argue that the Ebola crisis provides an opportunity for the international aid community to reconsider the ways in which ideas of 'capacity' and 'capacity building' are thought about and operationalised. A number of aid organisations, including Save the Children, Oxfam and Christian Aid, have been making the case for greater health investments in the three hardest-hit countries (Sierra Leone, Liberia and Guinea), calling for a sustained, collective commitment to building more 'resilient' health systems across the sub-region. We support these calls, but also believe that to address many of the persistent weaknesses in Sierra Leone's health system, approaches to capacity development need to change – more of the same will simply not be enough.

The central argument is that, to date, ['capacity building' has been thought about and operationalised in a limited manner](#). Although there are constraints on the methods and functions of development partners, an overly technocratic, narrow and linear way of thinking about capacity and how it might be developed has resulted in a focus on building technical skills and knowledge at the 'individual' and 'organisational' levels of the health sector. Critically, this overlooks other targets of capacity, such as politics, power and incentives at the 'systems' level. This has led to a series of ['blind spots' in policy and practice](#). These include: taking the complexity of seemingly basic interventions for granted; overlooking the plurality of health providers that people actually use; focusing on the discrete units of the health system rather than the connections between them; and failing to grapple with the human or social dimensions of the health system, which play a strong role in how it ultimately works (or does not).

Based on our research since 2013, most recently including a series of interviews carried out in Freetown in March 2015, we argue that future approaches to capacity building need to incorporate [five recommendations](#) that will help them avoid these blind spots in the future (more detailed recommendations are provided in section 5). These are likely to also have relevance to development actors working on capacity development in countries other than Sierra Leone, as well as in sectors other than health.

1. [Accept that a 'business-as-usual' approach to capacity building will not be enough. Future capacity support needs to be smarter.](#) As the Government of Sierra Leone and development partners begin to plan for post-Ebola health support, more of the same will not help to overcome the persistent blind spots. 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 falling back into familiar comfort zones.
2. [Ensure that the emergency mindset does not distort programming.](#) The Ebola response has seen the return of the emergency community to Sierra Leone to deal with the humanitarian crisis. This has been critical in the short term. However, there is a danger that, if this extends into the post-Ebola period, the focus of health policy and programming could be: i) distorted towards more immediate targets and objectives in an ahistorical manner; and ii) away from longer-term health system priorities. It is critical that development partners draw on those with a detailed knowledge of pre-Ebola health programming in order to avoid seeing all problems through an 'Ebola lens'.
3. [Quality healthcare exists when people trust the health system. Capacity building should pay closer attention to the intangible and invisible dimensions of capacity, including the nature of state-society relations.](#) 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 trust deficit. Public perceptions can matter as much as the 'objective' condition of the health system – that is, the number of operational clinics, the technical expertise of health workers, the supply of equipment and medicines – and improving people's perceptions of the health

system will be critical both in the immediate post-Ebola recovery period as well as in the longer term.

4. It is not just governments who provide health services. Capacity building should engage with the health system as it actually works – and how people actually use it. Too often, capacity support focuses on developing systems as they ought to be, rather than starting with an understanding of how they work in reality. In Sierra Leone, this is demonstrated by the international community's overwhelming preoccupation with the government health system, to the detriment of the plurality of providers that people actually use, from traditional healers to traditional birth attendants to drug peddlers. Building a more people-centred health system will require the Government of Sierra Leone and development partners to engage with this reality, and to build a nuanced understanding of how people navigate the health options available to them.
5. Lose the modular approach to health systems strengthening. Capacity building 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 somehow '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.

Health systems are complex. Strengthening them does not happen in a linear fashion, but is ultimately a product of deeply social and political processes. Health systems are not only strengthened by equipping staff with technical know-how or supplying health clinics with medicine. The process is also about ensuring that people trust the health system enough to use it, that when patients arrive at clinics they are treated well, and that coordination across the plurality of health providers – as well as between the local, district and national levels of the health system – facilitates service delivery.

As it stands, the dominant models of capacity building are failing to do justice to the complex reality of health systems strengthening. They are too simplistic, based on naïve assumptions about how change happens. And they reframe the question of development as an engineering problem, in which solutions are reached by filling capacity deficit x with input y . The standard 'fixes' have become stale, narrow in scope and insufficient on their own,

crudely reduced to a limited number of standardised interventions, such as technical training programmes, which pay little attention to an individual's wider environment. As we were told by one Freetown-based health worker in 2013, 'Training, training, training ... how much training does one person need?!' The persistence of multiple weaknesses within the Sierra Leonean health system calls for a fresher, more creative approach. In short, we need a smarter take on capacity building.

A rare degree of political commitment has emerged in the wake of the Ebola crisis around health systems strengthening in Sierra Leone, the West African sub-region, and in fragile states more generally. In order to make this commitment count, and to ensure that it translates into better quality healthcare for the world's poorest and most vulnerable people, it is critical that we rethink current approaches to capacity building. While more investment is certainly needed, more of the same support is not. This paper is intended to encourage critical reflection on the dominant capacity building approaches to date, and to provide some ideas for what else might be required to build more resilient health systems in future.

Introduction

The Ebola crisis in Sierra Leone not only created a public health emergency, but also exposed a series of underlying weaknesses and vulnerabilities within the country's health system. These have persisted despite a huge international investment of more than \$360 million in capacity support to the health system since the end of the civil war in 2002 (in constant prices (OECD.Stat, 2015)). The persistence of these weaknesses has, in turn, shone a spotlight on the ways in which ideas of 'capacity' and 'capacity development' have been thought about and operationalised by the international community, pointing to some serious flaws in the dominant approaches. With the international community now busy developing plans for the future of health sector support in a post-Ebola landscape, it is critical that the *nature* of that support is carefully considered.

We argue here that a 'business-as-usual' approach is simply not enough. Capacity support needs to be done differently. Change is required not only on the part of those working in the Sierra Leonean state health structures, but also on the part of the donors, non-governmental organisations (NGOs) and private sector firms that design, finance and implement policy.

Rooted in two years' worth of empirical research (see below), this report presents some ideas for what that change might look like and how it might be achieved. It develops these ideas over the course of five sections:

- In Section 1, we highlight [what the Ebola outbreak has shown us about pre-existing vulnerabilities within the Sierra Leonean health system](#), from staffing issues to a crisis of confidence in state structures.
- In Section 2, we demonstrate that these vulnerabilities exist despite significant international investments that have sought to 'build the capacity' of the country's health system. Here, we discuss [the dominant characteristics of international capacity support since the end of civil war in 2002](#).
- These investments have seen some genuinely impressive gains that should not be overlooked. In Section 3, we highlight some of [the key achievements of health sector policies and programming](#) since 2002.
- But despite this progress, there have been some clear limits to the dominant ways in which capacity has been thought about and operationalised, with implications for how development partners have sought to 'build' it. In Section 4, we explore [four 'blind spots' of international capacity support to date](#).
- In the paper's final section, we lay out [five ideas for how we might think about 'capacity' and 'capacity building' differently](#) – and what that means for health sector policy and practice in a post-Ebola context. As part of this, we propose a series of specific

recommendations for donors, implementers and the Government of Sierra Leone (GoSL) related to each of the five ideas.

This report comes at the end of two years of research conducted by the Secure Livelihoods Research Consortium (SLRC) on how to strengthen state capacity to prevent malnutrition in Sierra Leone. Malnutrition has long been a serious problem in Sierra Leone, since well before the onset of Ebola. In a country that is home to one of the world's most malnourished populations, malnutrition – or, to be more accurate, *undernutrition* – is the leading cause of child mortality, responsible for almost half of all under-five deaths (Boima, 2014). According to a 2010 nationwide survey, 44% of all children under five in Sierra Leone were found to be stunted, too short for their age as a result of malnutrition (Statistics Sierra Leone and UNICEF, 2011). The reasons behind this unacceptably high figure are multiple, rooted simultaneously in social, economic and deeply gendered contextual circumstances (Denney and Mallett, 2014). The consequences, too, are equally wide-ranging: being stunted as a child can compromise early brain development and school attendance, making it harder to get a decent job later in life (Martins et al., 2011). For all these reasons, our study of malnutrition (and state capacity) has not simply been about a narrow health sector issue; malnutrition may constitute a major public health problem, but it is also fundamentally a question of economics, geography, society and power. Our findings from the last two years support the idea that preventing malnutrition will not be achieved by treating it exclusively as a health problem (or a 'health sector' problem), but rather by engaging with the wider political, social and economic dynamics that cause it in the first place.

Part way through our research, Sierra Leone and its immediate neighbours were affected by the world's largest outbreak of the Ebola virus to date, which focused global attention on the health systems of Sierra Leone, Liberia and Guinea. As a result, this final synthesis paper goes beyond an examination of the nutrition sector alone, to consider what the Ebola crisis reveals about wider capacity support to the health sector. It aims to contribute to this ongoing reflection by asking: ***what has the Ebola epidemic, as well as more persistent health challenges, revealed about the nature and limits of international capacity support to date?***

In answering that broad question, this report draws on the last two years of research under the SLRC Sierra Leone country programme. This has involved qualitative and survey work in the capital city, Freetown; and Kambia District, in the north of the country and on the border with Guinea (see Figure 1). Previous to this final paper, the programme produced three reports. The first, based on 62 qualitative interviews in Freetown and Kambia, examines what international capacity support to the country's nutrition sector looks like, and tries to provide a

sense of just how 'fit for purpose' the dominant approach is (Denney et al., 2014). The second looks more closely at barriers that make it difficult for organisations to prevent malnutrition in Kambia District (Binns et al., 2014). It is based on a standardised methodology that will be familiar to those working on nutrition: a semi-quantitative evaluation of access and coverage (SQUEAC). The third report builds on the SQUEAC survey, setting out to answer a similar research question but from a more qualitative perspective (Denney and Mallett, 2014). Using multiple focus groups and individual interviews in three villages of varying degrees of remoteness from state health facilities, we shed light on some of the social drivers of malnutrition in Kambia, and dig deeper into the question of how Sierra Leoneans experience the health system at the community level (see Annex 1 for more detail).

Those studies inform the bulk of the analysis found in this paper. However, in order to get a more up-to-date sense of what the Ebola crisis means for the current and future state of the country's health system – that is, to better understand the shifting context for capacity development – we carried out an additional 23 interviews and five focus groups March of this year in Freetown and London (see Annex 2 for list of interviewees). We talked to a range of people, including representatives from government, academia, the donor and local / international NGO communities, as well as with the Council of Paramount Chiefs and the Traditional Healers Union.

We cannot claim to be providing an exhaustive autopsy of all the issues here, nor are we proposing a fool-proof, ten-point plan for 'how to build a more resilient health system'. This report represents a limited analysis of the vast amount of programming that has been implemented since 2002. However, the specific substance of our more detailed findings around capacity support to the nutrition sector bear an uncanny resemblance to the issues being discussed in relation to Sierra Leone's health system more widely. We believe that our analysis of the way in which ideas of capacity and capacity development have been understood and applied might help form the basis for future investments. By connecting the dots across these areas of research, we hope that the report offers some new, or re-energised, ways of thinking about how to approach the herculean task of strengthening Sierra Leone's health system.

Figure 1: Map of Sierra Leone, highlighting Kambia District



1 What the Ebola crisis tells us about the weak points in Sierra Leone's health system

The Ebola outbreak that has plagued Guinea, Liberia and Sierra Leone since March 2014 has, as of 3 June 2015, directly resulted in 11,149 deaths across the three most affected countries (CDC, 2015; see also Table 1). A gender assessment conducted by the GoSL, UNWOMEN and Oxfam in December 2014 found that 56.7% of cases are female, highlighting the higher risks the virus can pose to women given their roles as primary caregivers (GoSL, 2014a: 11).

Table 1: Case counts of Ebola in West Africa

Country	Total cases (suspected, probable, and confirmed)	Laboratory-confirmed cases	Total deaths
Guinea	3,664	3,228	2,431
Liberia	10,666	3,151	4,806
Sierra Leone	12,859	8,624	3,912
Total	27,189	15,003	11,149

(CDC, 2015)

This is to say nothing of the figures we have less information on. There are, for example, more than 12,000 additional 'probable and suspected' Ebola cases, and a range of further health problems have been exacerbated by the outbreak (as well as by some of the responses to it). For example, thousands of children across Sierra Leone have not been vaccinated over the last year due to restrictions preventing national immunisation days. This translated into child vaccinations being down by 17% nationally (27% in the worst affected districts) and prompted justifiable concerns about outbreaks of measles and polio (MoHS 2015: 7; UNICEF, 2015). A recent study by Takahashi et al. (2015) estimates that vaccine-preventable diseases, such as those just mentioned, may cause more victims than the Ebola virus over the next 18 months. In addition, as people stopped using Peripheral Health Units (PHUs) for routine health needs due to fears of contracting Ebola, 17% fewer pregnant women attended antenatal visits and 7% fewer gave birth at PHUs compared to the pre-Ebola period (MoHS 2015: 7). This rose to 29% and 19% respectively in the three worst Ebola-affected districts of Port Loko, Bombali and Western Area (ibid.), leading to higher levels of complication and maternal and child deaths. A Ministry of Health and Sanitation (MoHS, 2015: 9) survey found that:

... modeled projections indicate that more than 4,000 additional deaths among children under 5 years of age may occur if current trends hold for a 12 month period, corresponding to an estimated 13% increase in the number of children under-five dying as a result of reduced utilisation of health services.

Projecting from these figures, this equates to an under-five mortality rate of 181 per 1,000 live births in 2014 – a deterioration from 161 per 1,000 live births in 2013 (ibid.). In addition, there was a 28% reduction in the number of children attending growth monitoring programmes between October 2014 and January 2015, and numbers of children treated for malaria were down by 31% nationally (47% in most affected districts) (MoHS, 2015: 6-8). It is also believed that school closures since July 2014 have contributed to higher rates of teenage pregnancy (U-report, 2015). And there are concerns that disruptions to farming, markets and transport (see Glennerster and Suri, 2015), as well as any resulting reductions in income, may have caused higher rates of malnutrition – although again, there is currently insufficient data to give an accurate picture across the country.

In short, there is potentially a range of severe health challenges that will be left in the wake of Ebola. But it is important to remember that, in many cases, these are indeed *potential* as opposed to *actual*. Due to constraints on data collection across the country, there is an extreme paucity of good quality, accurate and up-to-date information. This makes it difficult to build a clear picture of the situation. While many concerns seem intuitively plausible, there is a risk that we end up adopting an ‘Ebola narrative’, where all problems are seen and understood through the lens of the virus. It is important to remember that Ebola will explain some things, but it will not explain everything. In order to guard against the dangers of treating Sierra Leone as a blank slate, it is worth remembering that both the progress and problems which existed *prior* to the outbreak constitute important elements of people’s experience of the health system (and indeed of the state more broadly). Ebola will have influenced that experience in many cases, but it will be one among many other influences. And indeed, there may even be some limited positive health outcomes from the outbreak. For instance, the introduction of routine hand washing may result in lower gastrointestinal illnesses, which can be a key trigger of malnutrition, especially in children. The abiding message, however, is that it is simply too soon to tell.

In addition to these (*potentially*) new health problems, the Ebola crisis has also revealed a range of vulnerabilities and weak points in the health system that have been exacerbated by, but predate, Ebola. Many of these are weaknesses that we identified over the last two years of research into efforts to prevent malnutrition in Sierra Leone. While they might have been brought to the fore by the Ebola crisis, they have in fact been limiting the effectiveness of health service delivery in the country for some time. As we were told by one senior-level NGO worker in Freetown: ‘Ebola blew everything out, but before people were struggling in secret’.

In this first section, we are interested in what the Ebola crisis tells us about Sierra Leone’s health system. There will likely be a great deal of national and international learning from the Ebola response vis-à-vis the importance of having good infection prevention and control (IPC) measures, effective screening and contact tracing practices, functioning surveillance systems, and a range of other components integral to the containment of infectious diseases. But seeing the health system through an ‘Ebola lens’, and developing post-crisis strategies in accordance with that, will not address its *underlying* weak points and vulnerabilities. And it is simply not enough to assume that these underlying problems, which have long hampered effective delivery of basic health services, will automatically disappear once the country ‘gets to zero’.

The Ebola crisis has highlighted at least six major weak points in the existing health system¹:

- Insufficient health workers
- Low access to healthcare facilities
- Poor infection prevention and control measures
- Widespread lack of confidence in the health system
- Weak communication between local, district and national levels of the health system
- Insufficient funding to support the health sector.

1.1 Insufficient health workers

There are quite simply not enough health workers and trained health professionals in Sierra Leone. According to Sierra Leone’s Minister of Finance (GoSL, 2014b):

Sierra Leone needs 3,300 medical doctors. There are at present 386 doctors including only nine dental surgeons in the country, leaving a gap of 2,914 doctors. The estimated number of nurses and midwives is 1,365. Estimates from the Ministry of Health indicate that an additional 8,615 nurses and midwives are required.

In order to respond to the Ebola epidemic, the GoSL has had to recruit an estimated 21,000 additional personnel, according to the National Ebola Response Centre (NERC), many of whom have had little or no previous health experience. Yet, the numbers of trained health staff in Sierra Leone are insufficient even to deliver the basic package of essential healthcare services.² According to the WHO (2011: 122), Sierra Leone has just 1.9 physicians, nurses and midwives for every 10,000 people,

1 Many of these are captured in the MoHS’ Post-Ebola Health Recovery Plan currently being finalised.

2 This includes all health services that the GoSL agrees to provide (not necessarily for free) under the Basic Package of Essential Health Services delivered through District Hospitals, the three levels of PHUs (see Table 2) to the community level by community health workers and traditional birth attendants.

which sits in stark contrast to the recommended ratio of 23 providers per 10,000 people required to deliver basic maternal and child health services. Indeed, there are more Sierra Leonean health workers in the UK than in Sierra Leone itself (Pailey 2014: 2). The loss of 221 Sierra Leonean health staff to the Ebola virus is thus all the more significant, affecting not just the delivery of health services, but also the training of future health staff (many of those who died also doubled as trainers at the country's only medical school).

1.2 Low access to healthcare facilities

There is weak penetration of health services in many parts of the country, with just 1,185 PHUs covering the entirety of Sierra Leone. Of these, 265 are Community Health Centres (CHCs), 343 are Community Health Posts (CHPs) and 577 are Maternal and Child Health Posts (MCHPs) (MoHS 2014: 16; see Table 2). While many communities may have access to a Maternal and Child Health Aide (MCHA) or a traditional birth attendant (TBA) linked to the MCHP, they may not have easy access to nurses or curative medical services, to say nothing of a qualified doctor.

Table 2: Services delivered by levels of PHU

Health facility	Functions	Staffing	Servicing population
MCHP	Coordinates TBAs to assist in delivery at the PHU	MCHA	500-5,000 in 3 mile radius
CHP	MCHP services plus some curative functions	State Enrolled Community Health Nurse (SECHN)	5,000-10,000 in 5 mile radius
CHC	Preventive, promotive and curative functions	Community Health Officer, State Registered Nurses, midwives.	10,000-30,000 in 5-10 mile radius

(MoHS, 2010: 9)

With few functional ambulances, it falls to households and communities to transport the sick and injured to health facilities (in 2014, the Minister of Information and Communication claimed that each of the 14 districts had at least one ambulance, with some boasting 'as many as three'. This would add up to – at most – 42 ambulances for the entire population of 6.1 million people (Forna, 2014)). In one community we visited in Kambia in May 2014, the nearest PHU was five or six miles away, and the nearest district hospital an hour away by car. No one in

the village owned a vehicle, and motorcycle taxis (*okadas*) only visited the town on an ad hoc basis – and not on Fridays, Saturdays or Sundays (Denney et al., 2014: 22). Community members recalled three mothers who had given birth while walking to the PHU, and one case where the baby died (*ibid.*). As the Ebola virus spread, this lack of transport became a critical blockage in getting patients to early treatment.

1.3 Poor infection prevention and control measures

The lack of attention given to infection prevention and control (IPC) protocols and supplies at PHUs – including things as basic as rubber gloves, sanitised equipment and clean running water – became strikingly apparent during the Ebola crisis, and almost certainly contributed to the spread of the virus (Pathmanathan et al., 2014). While the MoHS survey highlights relatively good IPC readiness at most PHUs, this is undermined by the critical lack of basic amenities: only 62% of PHUs reported having water available within 50 metres of the facility; only 41% of PHUs had two latrines; only 40% possessed a refrigerator for vaccine storage; and just 34% were equipped with electricity (MoHS, 2015: 7). As the virus spread, the absence of IPC measures was made clear in an email sent by Dr Sheik Umar Khan, from Kenema Government Hospital, to colleagues based overseas. This was just weeks before he became one of 221 health staff in Sierra Leone to die of Ebola (WHO, 2015). In that email, he requested supplies of the most basic resources: gloves, body bags, goggles and chlorine for disinfection (Grady and Fink, 2014). The lack of IPC procedures more generally within the health sector exposes both patients and staff to infection, which can contribute to the perception that PHUs, rather than representing places where one goes to get well, are themselves a source of illness or disease.

1.4 Widespread lack of confidence in the health system

The Ebola crisis has revealed a widespread lack of confidence in government health services, which can be considered, at least in part, a hangover from civil war (Wurie, n.d.). This is not altogether surprising: when people's experience of the health system is one in which PHUs are located some distance from the communities they are meant to serve, where medicines are often not available, and where staff are sometimes rude and may extract informal user fees, it is hardly surprising that the system is not always seen as a source of health and recovery (Denney and Mallett, 2014). Such perceptions have most recently been exacerbated by at least two additional factors.

First, early public health messaging to address the outbreak was confusing, sparking rumours which undermined trust in the state health authorities even further, ultimately contributing to the spread of Ebola. As Wauquier et al. (2015) point out in a recent analysis of the virus's 'journey': 'Often, insufficient communication and dissemination of inaccurate information [especially at the very beginning of a suspected epidemic] are significant impediments to public health initiatives'. Initial messages focused on getting people to acknowledge that Ebola was real and deadly, with messages including 'Ebola is real', 'Ebola kills' and 'There is no cure for Ebola'. While these messages might have been critical at the time in terms of raising awareness of the severity of the disease, it also had the unintended effect of making people complacent by engendering a sense of what medical specialists call 'therapeutic nihilism': if nothing can be done, why bother seeking medical attention? (Especially when the nearest clinic is several miles away.)

Public health messaging eventually became more nuanced, incorporating a focus on survivors, prevention strategies, and the importance of early treatment. But by that point, the apparent contradiction of being told to go to the health clinic even though a cure does not exist had already bred an atmosphere of panic and confusion. It is under such conditions that rumour can quickly spread. Thus it was that during the early stages of the Ebola outbreak, people drew on a number of narratives to try and explain the origins of the virus: that Ebola was started by the All People's Congress government in eastern Sierra Leone to kill opposition supporters; that Ebola was a ruse being used to allow the international community to harvest organs; and that Ebola Treatment Centres were in fact injecting healthy people with Ebola. The authorities' attempts to discredit such 'theories' were made all the more difficult by the fact that their own public messaging helped to create the conditions under which they gained some degree of popular legitimacy in the first place. As the Director of Sierra Leonean health NGO Focus 1000 noted, 'one piece of wrong information requires ten to correct it'.

Second, the deaths of health workers themselves – while making people aware of the severity of the disease – caused an additional degree of panic, further deterring people from using health clinics for fear of contracting the virus (Ground Truth, 2015). Their sense was that if doctors themselves could not protect themselves from the disease, then what hope did they, as ordinary citizens, have.

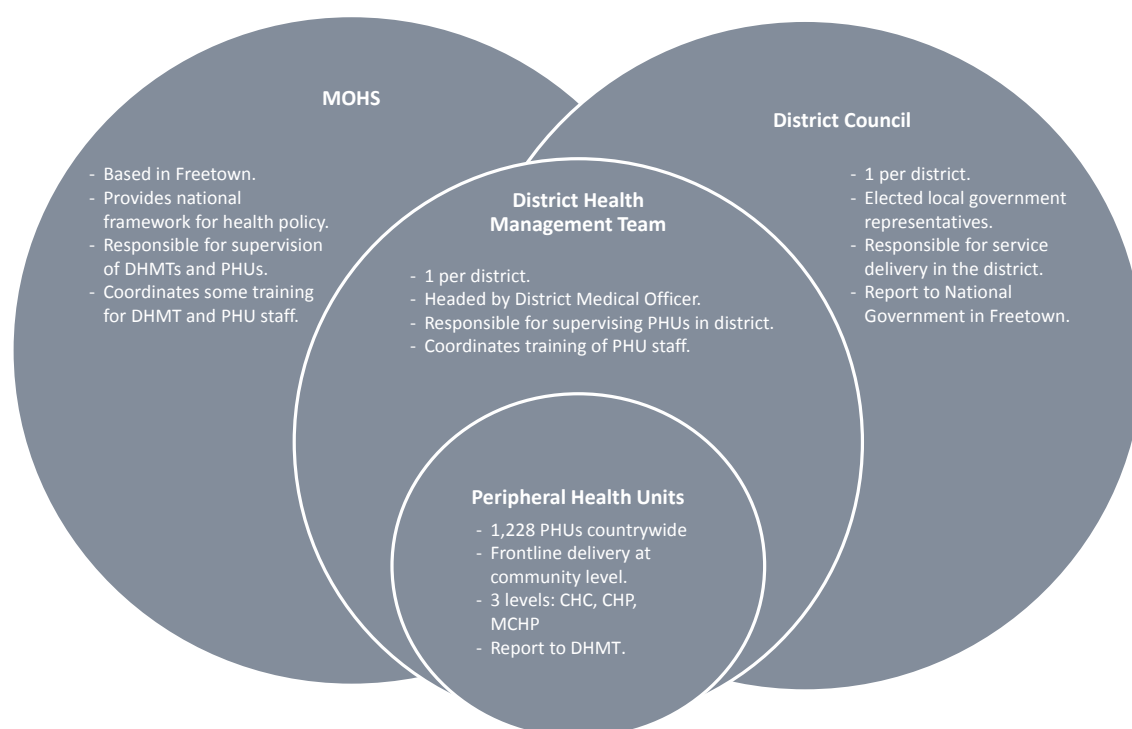
All those we spoke with in Sierra Leone reported a decline in uptake of health services since the Ebola outbreak. A number of surveys have recently emerged which appear to verify this. For example, one Ground Truth survey carried out in May 2015 suggests that 70% of respondents were scared to visit health facilities for non-Ebola concerns due to fears of contamination

(this figure has not been below 70% since the question was first asked in an earlier survey in March 2015) (Ground Truth, 2015: 3). This fear appears to have had real consequences. An MoHS (2015) survey found that between May and September 2014, attendance at PHUs dropped significantly, reaching their lowest levels in September 2014. An ACAPS survey (2015: 4) similarly found that, 'Fewer people are currently seeking health care assistance when faced with a serious health problem than they did before the crisis: only 50% of the population, compared to 80% before the Ebola outbreak'. Based on this finding, ACAPS estimates that 3.5 million people are at risk of having serious unmet health needs (ibid.). Clearly, a great deal of work will need to be done in order to start (re)building public trust in the agents and structures of the state health system; a narrow focus on improving physical infrastructure and increasing the quantity of health workers will not achieve this.

1.5 Weak communication between local, district and national levels of the health system

The Ebola crisis has magnified existing problems with coordination between the levels of the health system – from local to district to national. Poor communication flows from the PHUs to the District Health Medical Teams (DHMTs) to the national MoHS put the government on the back foot in responding to the outbreak in a timely manner, especially between early and mid-2014 at the beginning of the outbreak. For background, Figure 1 below illustrates the major state structures which constitute the formal health system in Sierra Leone.

Figure 2: Government health structures in Sierra Leone



Source: Denney et al. (2014)

Through our research on malnutrition over the last two years, we also observed poor communication between and coordination across the different levels of the sector. In particular, we found that the district level represented a kind of ‘missing middle’ in the health system, with resources and support concentrated largely at the local level (where delivery happens) and at the national level (where management, donor coordination and strategic planning happens). Yet, the district is the site at which district level plans and budgets are produced, and where reporting from PHUs is collated. It represents, to all intents and purposes, ‘the centre’ for the majority of Sierra Leoneans living in rural areas – an estimated 3.7 million people, or 61% of the national population (WDI, 2015). At the same time, however, it is also the site where key blockages occur, with district health budgets (which fund staff salaries), for instance, often delayed for up to several months. Efforts to rebuild the health system will need to pay greater attention to how these levels work together, pinpoint exactly where the blockages are, and analyse how they might be eased.

1.6 Insufficient funding to support the health sector

Finally, and underpinning many of the aforementioned problems, is the insufficient government funding allocated to the health sector. During the Ebola outbreak, it became necessary for government resources to be diverted from other parts of the health sector to respond to the Ebola crisis. Given the unprecedented nature of the crisis, this might have been understandable. However, the

health sector in Sierra Leone was also underfunded prior to the Ebola outbreak. In 2001, Sierra Leone committed to invest 15% of its national budget to the health sector, along with other African governments that signed the Abuja Declaration (Pailey 2014: 2). Despite this commitment, however, in 2012 the GoSL allocated just 6.8% to health, and in 2013 just 7.5%. And what is more, actual disbursements were even lower than these allocated figures (Villani, 2015).

While the GoSL's latest Poverty Reduction Strategy Paper (the Agenda for Prosperity) affirms the Abuja Declaration target, no timeline or strategy is set out for how this will be reached (BAN, 2015: 10). Indeed, while the 2015 health budget represents an increased allocation of 9.7% of the national budget, this still represents a government contribution of just \$9.50 per person (BAN 2015: 11). The World Health Organisation (WHO) recommends that a minimum spend of \$34 per capita is necessary to provide essential health services (WHO, 2001). These low allocations are explained by a number of domestic factors, including the relatively low priority status of health compared to other sectors, notably security (Poates et al., 2008) and private sector development around the extractive industries (Allouche, 2015). However, a recent article published in The Lancet suggests they are also connected in part to the terms of economic reform programmes implemented by the international community, and the International Monetary Fund (IMF) in particular (Kentikelenis et al., 2014).

There are undoubtedly additional weaknesses in the health system, but these six represent those most apparent at the time of our research, and most cited by those we spoke with in Sierra Leone. They highlight that while Ebola itself represents a huge health challenge, so too do the problems it has exposed (and which have hampered the health system for much longer). There has been a huge international investment in the (albeit slow) response to the Ebola crisis: the World Bank Group alone has mobilised in excess of \$1.6 billion, including \$318 million specifically for Sierra Leone (just \$40 million short of the total value of external support to the country's health system since 2002) (World Bank, 2015a). Once the investments and interest starts to wane, there will be a further need to ensure that the underlying weak points of the system are properly addressed. This will not be achieved through a 'business-as-usual' approach to health systems strengthening. While significant investments in Sierra Leone's health sector since 2002 have returned some vital gains (Section 3), the kinds of persistent weaknesses described here call not just for continued support, but also for an approach to capacity development that looks and works differently.

2 The nature of international capacity support to the health sector since the end of civil war

When Sierra Leone's then President, Ahmad Tejan Kabbah, officially declared an end to civil war in 2002, the country's health system sat at 'the wrong end of almost every health-related "league table"' (Rushton, 2005: 442). This was a health sector that produced the world's lowest life expectancy (34.0 years) and the highest level of child mortality (332 boys per 1,000 and 303 girls per 1,000 before the age of five) (WHO, 2003). The situation was no secret amongst the political elite: coming to power in 2007, President Ernest Bai Koroma, described how the health sector he inherited remained 'in shambles' (quoted in Donnelly, 2011: 1394).

In the years since the end of the war some important strides have been made in countering Sierra Leone's unenviable reputation of having the world's worst health system. These are described in the following section. And yet, despite the progress made since 2002, the Ebola crisis has exposed in starker terms than ever before a series of chronic vulnerabilities within the system. So, what happened in those intervening years? In this section, we provide a brief characterisation of the dominant forms of capacity support to the Sierra Leonean health sector in the thirteen years following the end of civil war.³ We identify four key characteristics:

- A focus on [restoration and rehabilitation](#) of health infrastructure and basic services, especially at the primary healthcare level and, at least in the initial post-war years, on districts heavily affected by the conflict.
- [A fragmented, project-oriented approach](#) to health sector rehabilitation and development, which privileged certain public health problems (such as maternal and child health, malaria, HIV and AIDS), undermining the development of a more comprehensive sector-wide approach.
- Some limited support to reforming and [strengthening certain components of the wider health system](#), linked in particular to the roll-out of the Free Health Care Initiative in 2010.
- A focus on the 'hard' dimensions of individual and organisational capacity, such as [technical knowledge delivered through training and the provision of equipment to health clinics](#).

³ This section draws on three data sources: interviews and focus group discussions conducted in Freetown in March 2015 with a range of stakeholders involved in the health sector (see interview list in Annex 2), as well as follow-up interviews with individuals working in the health sector during the 2000s; a brief review of key documentation; and the findings of our first SLRC Sierra Leone report, which looked at the same questions in more depth in relation to the nutrition sector (see Denney et al., 2014).

2.1 Restoration of the basics, particularly at the primary healthcare level in the worst affected districts

In the immediate aftermath of civil war, health policy and programming focused on the restoration of basic services. Although narrow in focus, this targeted approach was understandable given the urgency of providing some basic level of care and the unavoidable need to prioritise. Civil war had resulted in the destruction of local health infrastructure, as well as an 'emptying out' of many others as staff fled. According to Vincent (2012: 32): 'Some communities had health centres, but with no community health workers ... The NGOs used to come as the people hadn't the opportunity to go to hospitals or health centres'. Concerted efforts were thus made to improve primary healthcare, and some important gains were made. However, the focus of investments and commitments was not evenly spread: in the words of one major international NGO country head, there was 'a complete lack of comparable response in secondary healthcare', partly because of the longer term investments this would have, in turn, demanded in the education sector.

The largest initiative was the World Bank's Health Sector Reconstruction and Development Project. According to the Bank's project documents, the project's 'overall development objective was to help restore the most essential functions of the health sector delivery system', with particular priority given to 'war-torn and underserved' districts, which included Bombali, Koinadugu, Kono and Moyamba (World Bank, 2010: 1). In addition to the headline objective of basic restoration, which was budgeted at around \$15 million, the project also sought to develop domestic capacity in a few key areas, including health sector management expertise within the MoHS and performance of the DHMTs. The budget for this second component was lower, at around \$6 million.

This project has been described by Waters et al. (2007) as an example of what should ideally happen in any post-conflict environment where the health sector has crumbled: immediately improve performance in order to meet the most urgent needs at the same time as investing in longer-term aspects of the health system, such as management, financing and health policy. The Bank's own project completion report suggests that the initiative had some success in boosting the capacity of the Ministry, particularly in relation to its ability to fulfil planning and budgeting functions (although this claim is not substantiated). However, it also raises concerns over the sustainability of some of the project's results and outputs. For example, while the project itself was implemented by the MoHS rather than a separate, external Project Implementation Unit – a reflection of the somewhat unique decision to not directly contract out health services to donors and NGOs after the war (Bertone and Witter, 2013)⁴ – the staff involved



People wait outside a PHU in Kambia district.
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nonetheless received higher salaries relative to those working elsewhere within the MoHS. With the closure of the project, staff returned to receiving a (lower) government salary, and the report raises questions about the potential impacts this is likely to have on their motivation and willingness to remain in their jobs. One interviewee who was working within the MoHS between 2006 and 2008 suggested that the Bank probably knew how problematic this situation could be, but it was nevertheless the case that 'everyone had to align with it'. Similar questions are now being asked of the thousands of health workers receiving (or at least supposed to be receiving (see Maxmen, 2015)) hazard pay – also provided by the Bank – for their participation in the Ebola response: what will happen once it is withdrawn?

with NGOs and the MoHS during the post-conflict period, at least in its early phases. Second, and again particularly during the early stages of the war-to-peace transition, the 'chaos' of the general environment led to an extreme lack of coordination between NGOs and the MoHS, with many NGOs simply operating on their own, often employing workers directly without consulting or even telling the government (Bertone and Witter, 2013).

4 Two qualifiers apply here. First, many health workers held dual positions

2.2 A fragmented, project-oriented approach to health sector rehabilitation and development

Particularly up to 2007, capacity support to Sierra Leone's health sector was patchy, both in a geographical and programmatic sense. For example, the aforementioned World Bank completion report flagged questions about whether the results obtained in the 'World Bank Districts' could be replicated elsewhere. This reflects wider concerns voiced in our interviews regarding a lack of properly 'joined up' or 'sector-wide' thinking at the time. Indeed, throughout most of the 2000s, support to the health sector was characterised, in the words of one recent study, by 'political uncertainty, incremental policies, and stop-gap measures' with support focused on particular issues rather than the system as a whole (Bertone et al., 2014). Similarly, DFID Sierra Leone's engagement in the health sector between 2002 and 2007 centred on the support of 13 small projects, with one third of this commitment focused on malaria prevention and support to orphans and vulnerable children. This targeted but also rather piecemeal approach was described as a fallout of 'strong financial commitments to the security sector', which, according to a review of DFID's performance during the early post-war years, 'were in part responsible for crowding out human development' (Poate et al., 2008; see also Table 3). Donors and NGOs acted largely independently, with poor coordination both amongst each other as well as with government (Bertone and Witter, 2013).

Table 3: Percentage expenditure by DFID in Sierra Leone and Africa between 2002/03 and 2006/07, by broad input sector

Sector	% expenditure by DFID	
	In Sierra Leone	In Africa
Economic	17	17
Education	6	14
Health	6	21
Governance	41	14
Social	11	6
Humanitarian	15	20
Livelihoods	3	5
Environment	0	1
Unallocated	1	2

Source: Reproduced from Poate et al. (2008)

Fragmentation of policy and practice was aggravated by the way in which the state handled policy making in the health sector. Policies were developed with the support of the international community, but largely stayed on paper (Bertone and Witter, 2013). While efforts were made to decentralise the health system as part of wider

GoSL decentralisation efforts, some have questioned the degree to which decision-making power was actually devolved to district and community level structures. Indeed, despite the rhetoric and promise around decentralisation in the years following civil war (see Srivastava and Larizza, 2011), it has been argued that, in practice the MoHS retained centralised control over policy reforms throughout the 2000s (Bertone and Witter, 2013). In other circumstances, this approach might have helped to address problems of fragmentation. Yet, because so much attention at the time focused on the *design* rather than the *implementation* of policies, little effort was made to understand how they were 'translated into practice at facility level' (ibid.: 6). Accompanied by weak buy-in from and involvement of the sub-national state structures (DHMTs, PHUs, District Councils) – according to one survey in 2008, for example, just one in four PHUs received a visit from a councillor in the year preceding data collection (IRCBP, 2010) – the conditions for further fragmentation and policy unevenness were thus (re)produced. This failure to 'follow the policy' – to process the way in which policies and programmes 'mutate' across space and time (Peck, 2011) – is a recurring theme of our analysis, and an important characteristic of how capacity support to the country's health sector works (or rather does not).

Interviews with those working in the health sector in 2007/08 suggest that from 2007 efforts were made to move away from the piecemeal approach towards more comprehensive sector-wide engagement in the health sector. In the words of one DFID representative, 'At the time [around 2007], there was a sense that we – the donors, implementers and key agents of change – could all pull together and achieve something'. A health sector development partner group was established in order to plan a sector-wide approach, and a shared focus on addressing maternal and child health took shape. This was driven in large part by the Millennium Development Goals (specifically MDGs 4 and 5) which, while effective for building a collective commitment to key issues, meant that the bulk of activity and investment in the health sector was focused on specific areas that were essentially donor-driven. Evidence from our interviews additionally suggests the MoHS had relatively little power when it came to setting priorities. As one government interviewee put it, 'The World Bank and DFID ruled the show. WHO and UNFPA could throw their weight a bit. To a certain extent, so could UNDP'. UNICEF was also a major player at the time, responsible for much of the funding behind the increasingly strong maternal and child health focus.

This fragmented, piecemeal approach meant that projects focusing on particular health issues (such as maternal health and malaria), while important, effectively crowded out wider strengthening at the systems level. It was not until 2009 that this really started to change.

2.3 The Free Health Care Initiative and accompanying support to strengthening the wider health system

Driven by high level political commitment from President Koroma – as well as substantial financial backing from DFID – the Free Health Care Initiative (FHCI) was launched in April 2010, in which healthcare costs for pregnant women, lactating mothers and children under five were abolished. According to Bertone and Witter (2013: 4), the Initiative can be understood as ‘the defining moment that shaped the healthcare system’, lending a more energised and strategic approach to policy making across the sector, and representing ‘an opportunity to address the issues that previously were partially solved with piecemeal reforms’ (ibid.). In order to enact the FHCI, a number of long-running human resourcing problems had to be addressed. Several significant measures were introduced, including fast-track recruitment and deployment to fill staffing gaps, resulting in some impressive increases in workforce numbers (see Table 4 in following section); payroll cleaning to address the problem of ‘ghost’ workers; and salary increases to ensure that (a) health workers were motivated, and (b) that users were not charged informal fees for service (Witter et al., 2015a).

Evidence suggests that the FHCI proved to be a catalyst for much-needed shifts and reforms within the health system more generally, particularly in relation to human resourcing (Bertone et al., 2014). For example, as part of wider support to the FHCI, DFID launched a £10.3 million, five-year programme in 2010 designed to increase the availability of frontline health workers. To achieve this, DFID’s investments have been used to fund salary uplifts for workers, maintain a ‘clean’ payroll, and improve attendance through absentee monitoring systems. One recent evaluation found that this programme helped reduce unauthorised absenteeism, generate savings of \$408,200 over a 27-month period, and provide the basis for improved human resource management and workforce planning within the MoHS (Stevenson et al., 2012). At the same time, however, improper charging of some patients continues, a situation made worse by poor regulation of formal user fees and weak community awareness of what is included under the FHCI (see Denney and Mallett, 2014). In light of this, the evaluation recommends a policy shift:

For that to occur [elimination of improper charging] there would need to be a change in institutional culture throughout the government health system, which might be brought about by a systematic set of policies driven from the top (Stevenson et al., 2012: 22, emphasis added).

Other efforts have been made to try and improve performance (rather than just availability) of health

workers. The Performance-Based Financing (PBF) mechanism, funded by the World Bank, has been a dominant focus since the introduction of the FHCI. The PBF mechanism was designed to change the behaviour of health providers at facility level in order to improve the delivery of quality services under the FHCI, and revolves around a tool that assesses each PHU against a set of six output indicators.⁵ While a recent external verification of the mechanism reported improvements in several areas, including greater PHU autonomy and better work environments in a material sense (e.g. better hygiene, better equipped facilities), it also identified problems regarding the nature of the system in which the policy has been operationalised (Cordaid, 2014). It notes, for example, that both the implementation of PBF as well as the monitoring process on which it depends are undermined – again – by weak buy-in from District Councils, who often do not feel engaged in the programme, and DHMTs, who tend to operate in isolation.

None of this is to suggest that the GoSL and its development partners should have been working on everything at once. Clearly, there has been a need to prioritise and sequence. As such, development partners have focused on building up certain ‘sub-systems’ (or ‘building blocks’⁶), particularly those of a technical nature closely linked to the FHCI (payroll, attendance monitoring). This approach is consistent with conventional modes of thinking about capacity building in the context of health systems strengthening in low-income countries, where the focus is typically on ‘human resources for health’ and ‘human resource management’, developing ‘hard’ management expertise, and generally making health staff work more effectively and efficiently. Yet, at the same time, other ‘sub-systems’ have been deprioritised and overlooked – another characteristic of the way in which health systems strengthening has more generally been practised by global health actors over the last two decades (Marchal et al., 2009; Mikkelsen-Lopez et al., 2011). These include systems that create, govern and sustain: grievance mechanisms and feedback loops; accounting at the PHU level; supply and procurement chains; and engagement of MoHS staff working at the district level (see Stevenson et al., 2012). This is in turn linked to a preoccupation with developing the ‘hard’, tangible dimensions of capacity at a relatively granular or modular scale, beneath the level of the system.

5 The PBF awards funding to PHUs which make progress against the following: (1) women of productive age using modern family planning; (2) pregnant women receiving four antenatal consultations; (3) deliveries conducted under safe conditions; (4) women receiving three postnatal consultations; (5) children under one year of age receiving full and timely course of immunisations; (6) outpatient visits with curative services for children under five years of age according to the Integrated Management of Newborn and Childhood Illness.

6 A ‘building blocks’ approach to health systems strengthening was outlined by WHO in 2006. The approach disaggregates health systems into six ‘building blocks’, each of which demands attention if health systems as a whole are to be strengthened. These ‘building blocks’ include: service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance (WHO, 2007).

2.4 Developing the 'hard' capacity of individuals and organisations

For the first phase of the SLRC Sierra Leone programme, we asked what forms of external capacity support to the country's nutrition sector were most dominant (see Denney et al., 2014). We were interested in understanding what was being provided by development partners, through what means it was being delivered, and to what ends it was working. Having asked similar questions about the broader health system during our last visit to Freetown, these original findings appear relevant to understanding how capacity (building) has been thought about and operationalised outside the nutrition sector (which is not, of course, neatly partitioned off from the rest of the health system).

Using frameworks developed by the European Centre for Development Policy Management (ECDPM) (see Morgan, 2006), we concluded that the bulk of capacity support to the Sierra Leonean nutrition sector targets resources and skills and knowledge at the individual and organisational levels (see Figure 2). What this means in practice is that major investments have been made in trying to develop the technical expertise and assets of individuals (for example, managers, focal persons, frontline staff) and organisations (for instance, line ministries, directorates, community-based groups) within the health system.

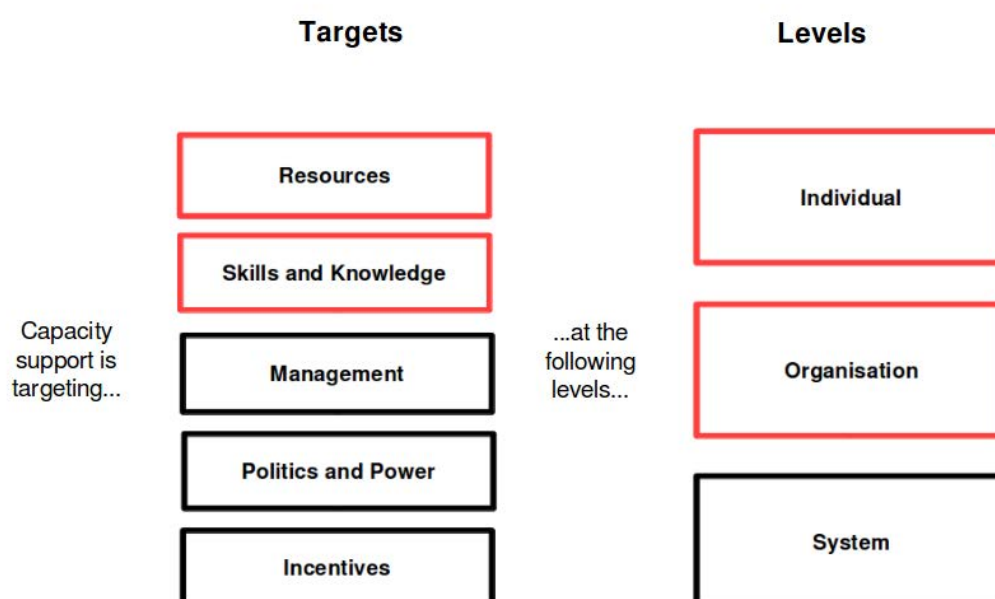
Although there are some exceptions, development partners working in the nutrition sector by and large appear to avoid the messier, much more difficult business of systems strengthening and institutional reform. Based on numerous interviews with Ministry and head office

personnel, it was our sense that stakeholders are fully aware of how important engaging at a systemic level is, but that in practice various barriers prevent them from doing so properly. These range from the persistence of treatment (rather than prevention) as the dominant focus of nutrition practice, to the bounds placed on legitimate action by donor reporting structures, to a lack of any kind of shared understanding of what 'systemic capacity building' might actually look like in practice (Denney et al., 2014: 10-13).

Subsequently, external capacity support to the nutrition sector has primarily sought to engage agents and organisations through a fairly standardised set of interventions, including technical knowledge transfer via training – often based on cascade models – and the provision of basic supplies and equipment. It was also apparent that development partners and line ministries have been attempting to shore up the country's health system from the ground level through the creation of new community-based organisations, such as the Mother-to-Mother Support Groups (M2M) and Farmer Field Schools (FFS), both of which have been assigned community sensitisation mandates. The M2Ms especially are viewed as central to the promotion of best practice around infant and young child feeding (IYCF) across the country, although our research suggests they often do not work as planned (see Section 4)

Ultimately, capacity building is being approached in a way that filters out the politics and dilutes the complexity of the task at hand. Interventions are designed to deal with the technicalities of improving nutrition rates, and the

Figure 3: A characterisation of the dominant approach to external capacity building in the Sierra Leone nutrition sector



Source: Denney et al. (2014)

theories of change underpinning programming – often implicit – appear to be guided by linear logics that make multiple assumptions. That is, the right outcomes are expected to emerge once the right formula of inputs is in place. This fails to take into account variations in geographic and seasonal conditions across the country vis-à-vis social norms within communities, the nature of local health systems, and the role of politics in mediating planning and implementation (see Denney and Mallett, 2014).

capacity building that favours the technical, tangible dimensions of individual and organisational capacity. As the following two sections illustrate, although this has helped to achieve progress in some areas, it has also neglected other aspects of the health system to its detriment.

External capacity support to the wider health sector over the last 13 years appears to have followed a broadly similar pattern, with emphasis placed on the restoration and rehabilitation of core organisations – in particular, PHUs together with specific administrative parts of the MoHS – as well as on the development of a stronger health workforce. A number of those we spoke with across government and local civil society raised big questions over the investments in these areas, particularly the staff training aspect. Their concerns were less to do with whether the approach itself was the right one – after all, the health sector's skills deficit problem is widely acknowledged – but rather whether the approach has been effective. For example, while one interviewee bemoaned the lack of post-training monitoring – 'Where I think we've been missing the point is on following up' – another felt that health worker trainings had generally been overly technical and insufficiently practical. Others took issue with the limits of the training approach, especially when wider aspects of the health system had been neglected. In the words of one training director, 'Our job is to train health professionals. And we do. So it is done. But the question actually lies in the rest of the system [as to whether this has been effective]'. His point was that current models of capacity building assume success is achieved once training has been delivered. However, as the latest World Development Report demonstrates (World Bank, 2015b), the behaviour of a health worker is subject to a range of biases, which operate regardless of how well trained she might be. Health workers can easily fall into 'sub-standard' ways of dealing with patients, irrespective of their technical competence (ibid.: 154). While evidence suggests that these can be effectively corrected through continued supervision or 'peer visits' (Jamtvedt et al., 2007, in World Bank, 2015b: 154), a sustained monitoring approach of this kind has been largely absent from capacity support to date.

Overall, then, the approach taken towards strengthening the capacity of Sierra Leone's health sector since 2002 has evolved from one characterised by an initial focus on restoration and rehabilitation of basic health infrastructure and staffing in the immediate aftermath of the civil war, to reforms that took a slightly more 'systemic' approach (such as the FHCI). Yet, the overarching picture remains consistent with what we have previously found in relation to the nutrition sector: it is an approach to

3 What has this approach achieved? A summary of progress since the end of civil war

From the shockingly low base at which Sierra Leone found itself in 2002, the approaches to health sector capacity building set out above have helped achieve some remarkable gains. Of course, this is not to say that all problems were ironed out, as the gaps highlighted by the Ebola outbreak clearly demonstrate. Nonetheless, despite ongoing challenges, clear progress was made in the post-war years, and it is important not to overlook this. While we do not have space to detail all areas of progress here, some of the key improvements are mentioned.

Since 2002, the country's health infrastructure and human resourcing have been strengthened considerably, both in terms of (re)building health facilities and training health personnel. Table 4 highlights how the health labour force tripled in six years from 2005 to 2011, with noticeable increases in the numbers of staff employed in most (but not all) occupations. This has helped to ensure greatly improved access to healthcare for much of the population. That said, many staff remain concentrated in the Western Area, as well as in district capitals, far removed from the country's primarily rural population.

Table 4: Changes in numbers of selected health professionals in Sierra Leone's health sector workforce, 2005-2011

Occupation	2005	2011
Medical Officers / Senior Medical Officers	62	100
Community Health Officers	120	248
Senior Registered Nurses	227	271
Community Health Nurses	274	1372
MCH Aides	471	1892
Lab Technicians	18	85
Endemic Disease Control Staff	250	189
Midwives	70	47
Pharmacy Technicians	250	211
Total (including other occupations not included here)	3017	9347

Source: Reproduced from Witter et al. (2015a)

The government's Free Health Care Initiative, launched in 2010 with considerable backing from the highest levels of politics and significant donor support, has perhaps been the country's most notable health achievement. It has been described as 'breathtaking' in terms of how well it was planned and how quickly it was achieved (Rob Yates, quoted in Donnelly, 2011). It also helped to respond to an urgent need: in 2009, Amnesty International released a report describing maternal

health in Sierra Leone as a ‘human rights emergency’, seven years after war was officially declared over. This highlights an important takeaway from the country’s post-conflict trajectory vis-à-vis recovery, rebuilding and reform: the introduction of the FHCI – a key moment and clear turning point in Sierra Leone’s health system – did not emerge until almost a decade on from the end of conflict. This illustrates that ‘windows of opportunity’ for major reforms or step changes do not necessarily occur in the immediate aftermath of a crisis, as is often assumed. Rather, finding the right spaces for reform often demands patience and longer-term engagement from development partners, who may find themselves able to help ripen the institutional context for change (Bertone et al., 2014).

While the FHCI has only been in place for four years, evidence suggests it has already led to greater uptake of formal health services. The policy has also helped to achieve impressive reductions in rates of maternal and infant mortality, attributable in large part to the increase in mothers’ giving birth at PHUs rather than at home. According to an early report by UNICEF (2011), for example, in the year following the introduction of the FHCI, there was a 150% increase in the number of maternal complications managed at health facilities, a 61% reduction in the maternal case fatality rate, and a 214% increase in the number of under-fives receiving medical care.

In relation to malnutrition, an initial worsening of the nutrition of children under five following the end of the civil war has been partially turned around, especially when we look at the shares of children who are underweight (too thin for their age) or wasted (too thin for their height). While levels of stunting (too short for their age) continued to increase according to the Multiple Indicator Cluster Survey (MICS) (see Table 5), the 2014 national nutrition survey using standardised monitoring and assessment in relief and transition (SMART) methods suggests numbers are in fact decreasing.

Table 5: Nutritional status over time of children under five in Sierra Leone

	2000	2005	2010
Underweight prevalence (moderate and severe)	27	30	22
Stunting prevalence (moderate and severe)	34	40	44
Wasting prevalence (moderate and severe)	10	9	8

Sources: Statistics Sierra Leone and UNICEF 2000; 2007; 2011.

At the same time, there have also been improvements in several other areas of health, with a steady decrease in mortality trends for malaria, AIDS, tuberculosis, diarrhoea and vaccine-preventable diseases (WHO, 2014). For example, drawing on a cross-sectional survey in four districts, Diaz et al. (2013) report high healthcare-seeking rates for children with diarrhoea, malaria and pneumonia soon after the introduction of the policy, and the case fatality rate for malaria in public hospitals fell by 90% just one year on from implementation (UNICEF, 2011).

In addition, Sierra Leone has made notable progress in neglected tropical disease (NTD) control, seeing, after just three rounds of mass drug administration: a 60% decline in river blindness (Koroma, 2012); an 89% decline in lymphatic filariasis (or elephantiasis) (Koroma, 2013); and an 84% decline in schistosomiasis (or snail fever) (Sesay, 2014). Rodriguez Pose with Rabinowitz (2014) argue that a series of activities linked to the FHCI, such as greater investments in health facility infrastructure and drug supplies, played an important role in accelerating progress against NTDs.

The capacity building approaches that have enabled these improvements have also prioritised technical skills training, infrastructure projects, and equipment and resource supply. That is, there has been a focus primarily on the ‘bricks and mortar’ of the health system. These are clearly indispensable, and the health system cannot function effectively without these basics. Yet, at the same time, it also cannot function effectively with these basics alone (Boozary et al., 2014). Such modes of capacity support assume that the problem with health access is overwhelmingly one of supply – and that if supply is improved, then citizens will access healthcare in a straightforward way. This overlooks a number of problems that limit healthcare access (discussed in the following section), and relate more to the interactions between health users and providers. Some attempts have been made more recently by DFID’s support to the FHCI and the World Bank’s Performance-Based Financing for Health to overcome some barriers to access, such as cost and poor performance, but, as will be seen below, obstacles remain.

4 What has this approach missed? Four blind spots of capacity support

While the dominant approaches to capacity development in Sierra Leone's health sector have achieved some notable gains, they have also had their weaknesses. These approaches have been formed and operationalised in a particular way, drawing on limited ideas of what 'capacity' is about and how it can be engaged with. Within international development, conventional definitions of capacity are incredibly broad. The OECD (2006), for instance, defines it as 'the ability of people, organisations and society as a whole to manage their affairs successfully.' What is slightly odd, then, is that the way in which the concept is often operationalised in practice is based on a highly constrained understanding of what capacity is about.

Far from being the force for 'emancipatory social change' that Clarke and Oswald (2010) have talked about, capacity development is typically conceived in the policy world as a technical fix to a technical problem (ibid.: 4). From a policy perspective, capacity development sees the world as apolitical and largely value-free; a neutral space in which some things simply work better than others. The task of capacity development – and capacity developers – is to look at the things that work less well, and propose a solution that fixes them (that is, bring them up to the standard so that they do work well). The technocratic approach to capacity development perpetually, and somewhat tautologically, identifies the problem as stemming from a 'lack of capacity'. The solution that follows, driven and animated in part by the 'tick-box nature of the "aid effectiveness agenda"' (Wild et al., 2015: 37), uses investments to quantitatively increase capacity in order 'fill the gap' that produced the problem in the first place.

Although somewhat crude, this characterisation of how dominant modes of capacity development 'see the world' captures the basic elements of mainstream policy and practice. We argue that this approach is problematic for several reasons. First, it represents a *deficit-based* way of thinking about development (see Clarke and Oswald, 2010), in which explanations for why problems exist are reduced to equations with missing symbols (that is, 'this problem exists because this factor is not in place'). This assumes that there is in fact a right way of doing things; that in order for malnutrition rates to fall, for example, a number of capacities (e.g. trained health staff, compliant communities, access to the right food) must first be present. This is both deterministic in the sense that causation is seen to automatically occur when the correct inputs are provided, as well as teleological in the sense that we already know what the final outcome will necessarily be. But more than this, deficit-based logics are rooted in deeply normative assumptions about how something – such as a health system – ought to look and work. The identification of (capacity) deficits or gaps is only made possible by comparing that health system with ones from another place or time, thereby privileging

particular forms and particular functions of development. And perhaps more than anything else, this represents a rather defeatist and fatalistic way of approaching a problem, focusing only on what is missing (and what should be there) rather than working more positively and proactively with what actually exists in the first place (see Boege et al., 2008; Booth and Cammack, 2013; Moore and Unsworth, 2010).

Second, a deficit-based way of thinking about capacity development in turn derives from a particular way of thinking about how change happens. More specifically, it sees change as a linear and relatively static process, which accounts for why the dominant capacity development model comes across as so deterministic. This narrow understanding of capacity – that if you fill in gap *x* with input *y* then consequence *z* follows – is at odds with contemporary thinking about dynamic, non-linear theories of change in international development (Valters, 2014) and the unpredictability of complex adaptive systems (Barder, 2012; Ramalingam, 2013), of which health systems are a perfect example (Mikkelsen-Lopez et al., 2011; Sturmberg et al., 2012). Centrally formulated plans, policies and programmes always work to a theory of change, whether explicitly articulated or implicitly acknowledged, which is necessarily contingent upon the realisation of multiple assumptions. In the real world, however, these assumptions may not hold 100% of the time (or even 10% or 1% of the time), and it is often difficult to know how policies will ‘mutate’ across space and time once they are actually being implemented (Peck, 2011).

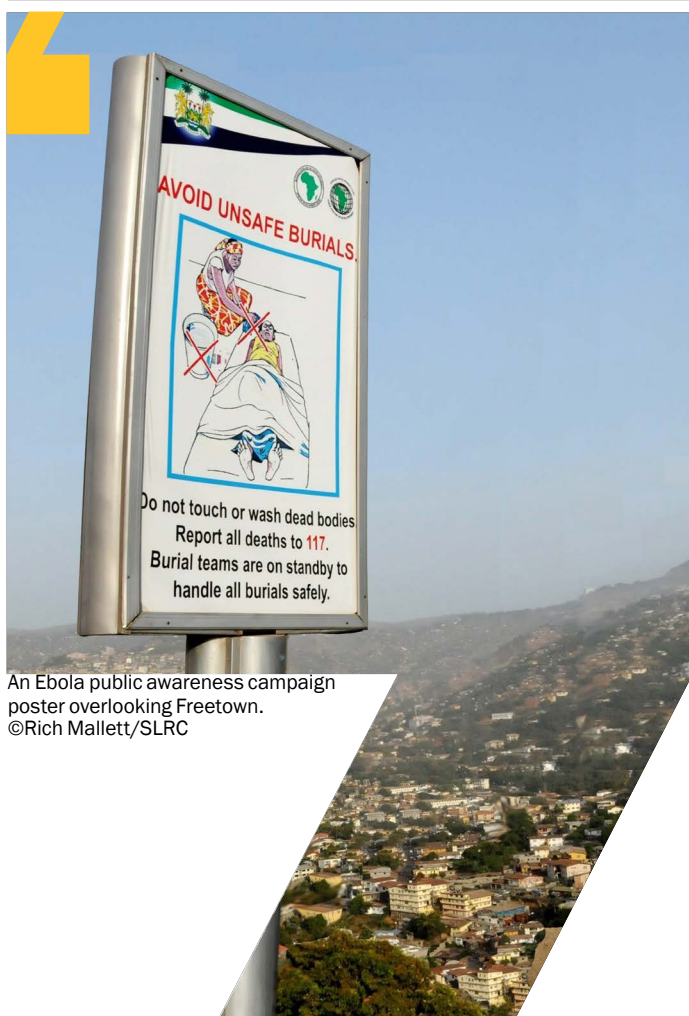
The third problem we see with the dominant conception of capacity development is to do with the way it understands systems. It is common for researchers to separate out the different ‘spaces’ in which capacity ‘exists’. Pritchett et al. (2012), for example, talk of agents/individuals, organisations, and systems, as do many of the conventional definitions of capacity. This is a perfectly acceptable heuristic technique that can help us get to grips, in a slightly abstract way, with what are some undeniably challenging questions. Using this heuristic can enhance the granularity of our analysis, which is important for getting to the detail of the problem. At the same time, however, it lends itself quite naturally to a particular way of thinking, in policy and practice terms, about how capacity can be built. While the literature deals quite carefully with the relationships between the three ‘levels’ (agent, organisation, system), often insisting that changes at one level do not automatically translate into changes at another, the principles of the heuristic seem to have been hijacked to exactly that end. That is, in practice there often appears to be an assumption that ‘if we build capacity at the individual level – train staff, give people equipment – then we will enhance the capacity of the overall system’. This approach means that systems are conceived as *modular* constructions, which

can indeed be constructed by building up the individual *units* within it. One of the main problems we see with this somewhat functionalist approach is that the focus of analysis and engagement is placed squarely on those units, rather than on the connections between them. As the discussion in this section shows, this is not helpful in attempting to strengthen a health system.

It is our argument that these approaches to building and developing capacity – which are invariably and unavoidably normative – have helped shape the present nature of the country’s health system, and have allowed certain weak points and vulnerabilities to persist despite years of investment (see Section 1). In this section we look at a number of specific features of the dominant approach to capacity support which in effect reproduce vulnerability within the system (or which at least fail to do much about it). We identify four ‘blind spots’. This terminology refers to the particular form and function that the dominant approach takes, and to the elements of the landscape that are rendered invisible by this particular set-up. In other words, the way in which ideas of ‘capacity’ and ‘capacity building’ are normalised prioritises certain issues, problems and subjects over others, in the process inevitably creating a series of ‘ontological limits’ that ultimately demarcate the scope and nature of policy and practice. Our ‘blind spots’ refer here to the spaces outside those parameters; elements of the landscape that go unnoticed, and which are therefore inadequately understood.

4.1 Blind spot I: Taking the complexity of (seemingly) basic interventions for granted

We now know that a great deal of capacity support has been channelled towards developing the technical know-how of individuals within the Sierra Leonean health system. However, capacity building efforts often assume a more straightforward relationship between knowledge and behaviour change than in fact exists. The result is that theories of change simplify what are quite complex processes, glossing over multiple assumptions and steps in complicated chains of causation. This disconnect between knowledge and behaviour change was apparent during the Ebola response in relation to people’s use of appropriate response avenues. Knowledge, Attitude and Practice surveys indicated a high level of citizen awareness, for instance, of protocols surrounding what to do if a family member develops Ebola-like symptoms, is found to have Ebola, or dies from suspected Ebola (including calling the Ebola hotline, isolating the person, not touching them, adhering to household quarantine, not touching dead bodies, and waiting for burial teams) (see Focus 1000, 2014a; 2014b). Yet, in practice, the spread of the disease has been largely attributed to a lack of adherence to such measures.



An Ebola public awareness campaign poster overlooking Freetown.
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While Ebola and the response protocols that followed are quite extreme examples of the knowledge-behaviour disconnect, we found a similar story in SLRC's malnutrition research, suggesting there are significantly more steps between 'providing technical knowledge' and 'desired behaviour change' than (implicit) capacity building theories of change often imply. For example, there are thousands of M2M support groups throughout Sierra Leone (see Section 2), and plans to scale up coverage by 50% were in the pipeline for 2014 prior to the Ebola outbreak. M2M groups typically consist of 10-15 members who, under the guidance and supervision of a 'lead mother', are supposed to meet regularly in order to learn about and discuss a broad range of nutrition-related issues and practices. The broad objectives of the model are to promote optimal IYCF practices within communities, and to encourage the uptake of routine preventive services at PHUs. Most of the time, the groups are formally established by either MoHS or NGO staff.

Our research found that, although the M2M groups are consistently mentioned by development partners and government as central to the country's effort to prevent malnutrition, in practice they operate unevenly and often not as planned. Within a single district, we saw variations

in the way different groups were implemented and run. While some groups comply fairly closely with the formal programme design, in other cases they operate in a less (or differently) structured way than one might expect. For example, in one chiefdom in Kambia, neither the PHU staff nor the lead mother of the M2M group knew each other personally, and it was clear that very little in the way of information sharing – let alone actual coordination – between the two was being done (Denney et al., 2014: 15). In another, the lead mother had no 'group' per se, but rather visited house-to-house in the community. And in a third chiefdom, we were told that the M2M group and the local FFS were one and the same thing, with little sign of a clear division of labour between the two groups (ibid.). What this means is that while those supporting M2M groups can claim that they have x number of groups operating across the country, and thus imply that improved IYCF practices are occurring in those locations, in reality it is not clear that many of the groups exist, especially as per the programme design, or that they provide accurate IYCF knowledge, or that this knowledge translates into changed behaviour. While a potentially useful structure has been set up and does in some cases appear to be operating as intended, based on the groups we visited this cannot be taken for granted everywhere. Given the central role of M2M groups in efforts to prevent malnutrition, understanding how these groups operate in practice is critical.

Observing the M2M groups and the goals they are intended to achieve, we noted a number of interim steps necessary in order to get from the establishment of the groups themselves and the provision of IYCF knowledge, to improved nutritional outcomes. At an absolute minimum, one would expect to see the following (from Denney et al., 2014):

- Demand within the community for the creation of such a group, and regular participation from members (dependent on willingness and time availability)
- Lead mothers who are properly trained and can communicate/teach effectively
- That information and messages are not only received but also grasped by group members
- That the group is effective at sensitising other members of the community, which is dependent on communication skills, good (enough) relationships between group members and non-members, and ability to move around the local area (sometimes into quite remote places)
- That non-members grasp information and messages and are able to put the knowledge into practice.

Without these steps, this aspect of capacity support makes multiple assumptions, reducing a complex behavioural change process into a neat intervention that has been uncritically replicated nationwide.⁷ But the messy realities of local context can present numerous barriers to the fulfilment of the final step outlined above: translation of knowledge into behaviour. These came out strongly through our second phase of research (see Denney and Mallett, 2014). Many aspects of social life within Sierra Leonean society are governed by a combination of patriarchal and gerontocratic institutions, which often place limits on the agency of young women and mothers (with some nuances and exceptions). So, in relation to IYCF behaviour, we might see: a skewed distribution of food within households, driven by the expectation that larger, better quality portions go first to either the father or his parents; an early cessation of breastfeeding due to the resumption of sexual activity by mothers living in polygamous arrangements, driven by the fear of falling out of favour with a husband if intercourse is abstained from for long periods; and a failure to practice exclusive breastfeeding in the first six months of a child's life, for example because pregnant and lactating mothers are still expected to participate in agricultural labour during the rainy season.

For these reasons, it is simply unrealistic to assume that behaviour automatically shifts when individuals are exposed to new knowledge; life processes and decisions can rarely be accounted for by individualistic rational-choice models, but are closely governed by group dynamics and social relationships (Pescosolido, 1992; World Bank, 2015b). This, in turn, raises an important question for how we think about capacity development. When it comes to a health system, it is service providers themselves who are typically seen as the 'targets' of capacity support interventions. But what about the capacities of the 'end user', especially when health outcomes are ultimately contingent upon their behaviour? These capacities, if we can call them that, are likely to be far more difficult to externally engage with.

It was not clear that staff at the national level knew about the full extent of variation between M2M groups, suggesting a system that monitors and feeds back inadequately. Capacity building programmes cannot be considered 'finished', or assumed to operate according to Freetown-based policies and plans at the moment at which they are implemented. These are complex interventions that seek to alter people's behaviour. While their creation can be logged quite easily in a project logframe, our research illustrates why a more extended period of monitoring, assessment and continued

supervision is essential if these new community organisations are to work according to plan. This seemed not to be happening in most of the sites we visited.⁸

There is a related, broader point here around the dangers of focusing on reach, which can mean less investment in depth – essentially, quantity over quality. This is not to suggest that the international community has not invested in strengthening the quality of health services. Clearly, many training programmes, as well as the World Bank's PBF, aim to do precisely that. However, the complexity of interventions to improve quality are often not sufficiently appreciated or engaged with, and there is often a tendency to fall back on programming that favours reach – an easily quantifiable objective, such as setting up x number of M2M groups, or training y number of PHU staff – rather than genuine behaviour change. The Deputy Minister for Health and Sanitation himself highlighted this issue during our interview in March, noting that in the post-Ebola recovery plan, 'There is a need to increase not only the quantity but also the quality of health clinics'. This means that future capacity building strategies must move away from simplistic theories of change that mask the complexity of the desired behaviour change.

4.2 Blind spot II: Taking 'what ought to be' as the starting point, rather than 'what actually is'

Gaining a better understanding of how to build state capacity to address a range of acute and chronic public health issues first means getting to grips with the nature of the health system itself, and asking how and why health seekers make decisions about which provider(s) to use. Sierra Leone is characterised by a plural health system: there is no single provider, but a multiplicity, cutting across both state and non-state forms of provision (as is the case the world over). In practice, a range of actors – including PHUs, traditional birth attendants, traditional healers, drug peddlers and community health workers – are all involved in delivering various forms of healthcare to their communities.

The importance of engaging with this plural set of health actors became apparent during the Ebola crisis. Community health workers emerged as critical to delivering sensitisation messages and assisting with community screening, while traditional healers were belatedly recognised by the formal authorities as key to encouraging changes in community behaviour. However, external capacity support to date has typically focused – as it did in the early stages of the Ebola response (until November 2014) – on formal, state-run healthcare structures. In doing so, it has tended to overlook and

⁷ We found similar problems regarding the assumptions embedded in cascade training models, which are also used more widely throughout the health sector. While these may be cost-effective ways to transmit information to large groups of people, in practice we found that the training operated like something akin to 'Chinese whispers', with the message arriving at the 'bottom' not reflecting the accurate, more nuanced information delivered at the 'top' (see Denney et al., 2014).

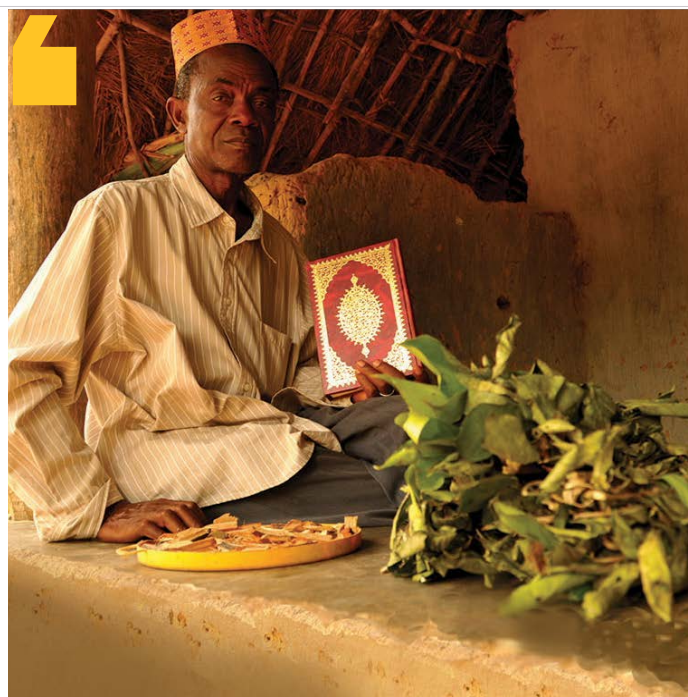
⁸ It is worth noting that some organisations are attempting to address this lack of ongoing supportive supervision. For example, Helen Keller International is introducing mobile technology to enable rapid reporting of supportive supervision by district level staff to the national level using set performance criteria (vis-à-vis integrated mother and child survival strategies) (pers. comm.)

bypass alternative providers.⁹ The problem is that this dominant approach does not connect with the reality of how large numbers of people in Sierra Leone access healthcare.

Our previous research highlighted the various actors that make up Sierra Leone's plural health system, as well as the interactions between them (Denney and Mallett, 2014: 20-29). These actors are not discrete, and do not necessarily operate in competition to attract patients (although some level of competition does exist from time to time). Rather, they constitute a plural system that is often highly cooperative, constituted by providers that many communities do not view as mutually exclusive. Tracing how people move through the various health providers available to them, we found that, in practice, people often use traditional healers as a first port of call if there is no PHU within the community, or if relations with the PHU staff are poor. In addition, people who can afford to do so will seek assistance from both the PHU and the traditional healer at the same time, in order to combat an illness from both biomedical and spiritual sides. Drug peddlers are also often seen as essential due to the 'drug stock-outs' – cases where the supply of medicines has apparently been exhausted – that are common in many PHUs. The decision-making process underpinning these choices and pathways are highly gendered; it is usually a father or his mother who decides where a sick child should be taken.

This highlights the difficulty of engaging with just one part of the health system given that it is so interconnected with other providers. Transforming the ways in which people access healthcare is not likely to be effective if these actors are assumed to belong to discrete units in which one provider seeks to 'win out' over another. This kind of zero sum logic fundamentally misunderstands how people themselves view and use the health system. Following people's own paths along the health system reveals a more interconnected picture that can help to shape how capacity building interventions can deliver improved health outcomes.

It is also important, however, that a focus on plural health systems does not lead to an over-reliance on 'traditional practices' to account for poor health outcomes. Cultural beliefs are just one of many factors that influence people's behaviour, and are thus important to engage with, but do not offer a full explanation in their own right. Culturally deterministic, essentialist accounts of public health issues or governance challenges have a tendency to set cultural beliefs up as the scapegoat, framing them as barriers to be overcome if positive change is to be achieved (Oosterhoff and Wilkinson, 2015). For instance, in addition to the treatment of traditional healers and traditional beliefs as inhibitors to behaviour change



A traditional healer in Kambia district.
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during the Ebola outbreak, we have similarly found an unsubstantiated emphasis placed on the role of food taboos as a cause of poor diet in efforts to combat malnutrition. Food taboos – where communities believe it is 'forbidden' to eat certain foods – are seen to prevent a balanced and nutritious diet. Indeed, in our community visits we heard of several food taboos, including not eating eggs or certain kinds of meat. However, further investigation revealed that these taboos are quite loosely enforced and that, again, they are just one factor among many in influencing people's diets. This was perhaps best demonstrated in one focus group discussion where a group of grandmothers explained how it was currently taboo to eat mangoes that had fallen from trees as they may be infected with the Ebola virus (this was in late-May 2014 on the Guinean border, when Ebola was just started to break in Sierra Leone). Yet, later in the discussion a mango fell from the tree under which we were sitting; the response of one grandmother present was to pull it apart and share it amongst the children and women present.

⁹ The one notable exception to this is the work that some NGOs have done to engage with traditional birth attendants in encouraging them to work alongside PHU staff in delivery.

The plurality of health providers in Sierra Leone is not surprising given the history of conflict and weak state structures. As Scott et al. (2014: 292) note:

Caregivers in Sierra Leone have endured in the absence of adequate health care for decades: their resourcefulness in devising multiple strategies for care must be recognised and integrated into the service delivery reforms that are making health care increasingly available.

What is more, the plural health system does not appear to have weakened since the introduction of the FHCI in 2010 (Scott et al., 2014)¹⁰. A plural reality endures and is likely to do so for some time to come. As such, there is a need for capacity building programmes to recognise and engage with the ways in which people actually use the system, rather than with the ways development partners believe the system ought to be used. This offers multiple entry points that have so far been largely neglected. Our interviews with the Traditional Healer's Union in Freetown this year suggested that traditional healers (healers, herbalists, TBAs and *soweis*¹¹) are eager to engage and see themselves as a major player in efforts to improve healthcare. Indeed, one example of this is the training of TBAs to act as part of Community Advocacy Groups (CAGs) tasked with sensitising pregnant women to health messages and accompanying them to the health facility for delivery. Other community leaders, such as chiefs and religious leaders are also critical elements of the wider health picture – as has been revealed throughout the Ebola response – and should be engaged with at all levels.

4.3 Blind spot III: Focusing on the units, not the connections

The tendency of capacity support interventions to target individuals and organisations has resulted in fragile, or in some cases even absent, connections between the system's multiplicity of units. This is true in both a 'horizontal' and a 'vertical' sense.

By *horizontal connections* we refer to the links between different actors occupying the same space at a particular scale. One example would be the nutrition community operating at the national level, consisting of certain parts of central government (notably the MoHS, but also the Ministry of Agriculture, Forestry and Food Security and the Ministry of Social Welfare, Gender and Children's Affairs) and a range of development partners, from multilateral and bilateral donors (such as UNICEF and Irish Aid) to major international NGOs more closely involved in implementation work (for instance, Helen Keller

International and Concern International), to advocacy and campaigning platforms (for example, the Scaling Up Nutrition Secretariat). It is clear that whatever each actor is doing vis-à-vis nutrition policy and programming needs to be coordinated with what everyone else is doing, and that some kind of division of labour needs to be agreed. To achieve this, a variety of meetings regularly take place in Freetown, the main purpose of which is to promote coordination. It was our sense, however, having talked to numerous people involved in these processes and attended a number of the meetings on our research visits, that there is confusion about the specific aims of the various meetings and working groups, and that the content of the discussions is therefore often not as useful as it could be. As one NGO interviewee explained, 'We don't know exactly who is doing what, who is part of what meeting'.

These are long-running problems within the wider health sector. Interviews with people involved in the sector during the 2000s, and certainly prior to implementation of the FHCI, suggest that communication breakdowns were a common feature at the national level, particularly between major donors and the Ministry. An advisor with the Africa Governance Initiative described the situation before the introduction of the FHCI: 'what struck me was how some donors would have their own meeting and talk among themselves and then come back and tell the ministry, "Why isn't it done?"' (quoted in Donnelly, 2011). We were also told by one MoHS worker that while the monthly health partners meetings, which were coordinated by the Ministry, were 'usually pretty well turned out', they were mainly designed for partners to share information and provide updates on their own work. In practice, relatively little in the way of actual coordination and joined-up planning seemed to be happening. This lack of coordination between different actors within the health sector has been described by Bertone and Witter (2013: 3) as 'an important feature of the policy context [in the post-war years]'.

The point here is not that coordination meetings and working groups are meaningless or irrelevant. In fact, the creation of a series of committees – staffed by the right people, co-chaired by both MoHS and donor personnel, and tasked with a very specific terms of reference – was considered instrumental for the successful roll-out of the FHCI in 2010 (Donnelly, 2011). Rather, the point is that – in a similar vein to behaviour change interventions at the community level (see above) – it cannot simply be assumed that coordination is something which simply emerges when you get a group of people together in the same room. Providing updates is one thing, but tackling collective problems or joint planning are considerably more demanding exercises, requiring the right mix of people and a sufficient allocation of time and resources. The challenges posed by these requirements are often taken for granted, but those working on organisational

¹⁰ It may even be plausible that certain providers, such as the traditional healers and drug peddlers, have been inadvertently 'strengthened' (at least financially) by the FHCI, as drugs and other supplies leaked outside of the formal system and into their hands (pers. comm.)

¹¹ *Soweis* are responsible for conducting clitoridectomy as part of girls' secret society initiations across Sierra Leone.

theory have shown time and again how processes such as seemingly simple as delegation are 'complex' and 'fragile', as well as inherently political (Ribes et al., 2013: 1). It is the failure to grasp the difficulties associated with such processes – cooperation and coordination included, both *within* as well as *between* organisations – that undermines a great deal of capacity development.

Weak points are also present within the system's *vertical connections*, by which we mean the mechanisms linking agents and organisations across different scales (that is: macro/national; meso/district; micro/community). Recent research by the Overseas Development Institute has shown why engaging at each of these three levels is important for health systems strengthening (Samuels et al., 2014). Our own research suggests that, with reference to the nutrition sector, clear improvements have been made at the national level in terms of building commitments and leadership. As one NGO staff told us, 'Five years ago you didn't want to be called a nutritionist. Ami [Aminata Shamit Koroma, Director of the Food and Nutrition Directorate] has done really well'. But this seems not to have been accompanied by the kinds of developments needed to ensure effective operation at the sub-national level, not least because responsibility there is shared by both DHMTs and District Councils, the latter of whom usually have little or no health expertise. We heard about this problem, and how it manifests, from multiple interviewees. One senior NGO representative described how weaknesses at the district level meant that there was a 'disconnect between the policies the MoHS wants to promote and the structures at the community level'. Another highlighted problems in data flows and reporting systems: 'We work a lot with the DHMT on the understanding that they report back to the national level. But a lot of information at the district level does not make its way up'.

This illustrates a related point: it is not enough to develop capacity at each level without working on the connections between them. These connections take a number of forms, but include things like reporting structures, referral processes between levels of the health system, surveillance systems (the weaknesses of which have been starkly exposed by the Ebola crisis), utilisation of technology and information systems, and funding channels. The referral system, in particular, appears to be one area in need of dramatic improvement, and many of those we interviewed identified this as a reason why so many patients fail to receive adequate care at the right level. This brings us back to the discussion at the beginning of this section: capacity building interventions are often based on a modular approach, which disaggregates various components of the wider system into discrete units (or, to borrow the phrasing of the ECDPM work, 'targets'). Investments focus on developing technical capacity within each of these units in what can often be quite a siloed manner. Less attention is paid to

the connections between the units, which then results in the kinds of problems described above (weak referral mechanisms, lacklustre coordination efforts, inequitable planning and budgeting processes). Getting beyond a modular approach to capacity building is part of what makes systems thinking and working so challenging, but there is clearly a need for progress in this area (see Pain and Levine, 2012 for a similar discussion in relation to resilience and 'resilience building').

4.4 Blind spot IV: Failing to see that systems are made up of people who relate to each other

Much of the preceding discussion builds towards an overarching point: the problem with the dominant approaches to capacity building is that they overlook the wider environment in which people – ministry staff, health workers, service 'users' – live and work. It is this wider environment which plays an influential role in how health workers are treated by the government, how the workers in turn treat their patients, and how 'users' perceive and navigate the health system. As such, renewed capacity building efforts need to take account of how the wider system impacts on the delivery of quality health services, and to reframe health systems as *people-centred processes* rather than technocratic constructions.

Even when we get beyond training individuals and equipping organisations to talk about health systems (and how to strengthen them), the emphasis is normally placed on a relatively technical set of systemic design features (which nonetheless have political dimensions to them). These include administrative systems, such as those concerning the staff payroll and attendance monitoring, as well as logistical things like procurement mechanisms and supply chains. While important, these are often weak or altogether absent in low-income, conflict-affected countries. Where engagement at the systems level did happen in Sierra Leone – not until the late-2000s – policies sought to develop these kinds of administrative systems. However, systems thinking (and working) is about more than just the formal processes and mechanisms that connect up the many components of a health system. Health systems are *socially embedded*, the product not only of technical expertise and 'hard' resources but also of social relationships at multiple scales (Bloom et al., 2008). This is as true for the constellation of actors within the health sector – from health workers to line ministries to donors – as it is for communities' uptake of health services. And it is why the idea of 'people-centred health systems' has gained much traction in recent years, despite limited operationalization in practice (Sheikh et al., 2014).

During the Ebola outbreak, more than at any other time, the lack of citizen trust in the healthcare system became strikingly apparent. Despite popular stories of people failing to seek medical care for Ebola due to 'traditional

cultural beliefs' (see Al Jazeera, 2014), more importantly it seems that people actively chose not to seek care at the PHUs because of their past experience with the formal health system (Shepler, 2014). For many communities, PHUs are distant and underequipped, healthcare staff can be unwelcoming, and informal fees are sometimes demanded for treatment (Denney and Mallett, 2014). These issues are, in turn, partially rooted in a post-conflict context in which citizens, especially those living in rural areas, have low expectations of state services. In light of this, it is not altogether surprising that many turned their back on the PHUs, even when they found themselves in need. Of course, people also relied on traditional healers, who not only play an important role in healthcare in many communities in Sierra Leone, but are often also influential, respected figures within local society. But culturally deterministic explanations overlook the fact that avoiding the formal health system is also a rational response to years of poor service.

Citizens' poor relationships with the health service came out very clearly during our research in Kambia over the last two years, where bad user experiences at the PHU or difficult interactions between users and PHU staff were clearly found to affect care-seeking behaviour (see also Scott et al., 2014). In 2014, we visited three communities at varying degrees of remoteness from health facilities. One of the factors we found to be critical in determining people's decisions as to whether to use the PHUs was past experience of treatment – both their own as well as that of others in the community. In two of the three communities, experiences with the PHU were, generally speaking, poor. We were told how women were treated badly by staff and made to wait in the sun without a drink of water after walking up to six kilometres to reach the clinic. Staff reportedly often looked down on patients, particularly if their appearance suggested a lack of material wealth, and many users complained of the rude attitudes they faced at the PHUs. This is mirrored by the recent comments of the director of a Kono-based NGO (in Hongoltz-Hetling, 2015) who explained:

Health care workers in Sierra Leone have been given this narrative that they are superior to local healers and that women are weaker if they go to local healers ... It takes a lot of mentoring to get to a place where our health care workers are not simply condemning patients.

For all their technical training, it seems as though the PHU staff lacked the necessary 'bedside manner' – that is, the softer communication and interpersonal skills necessary to encourage a population already unfamiliar with relying on state services to use them (even though such skills form a small part of the curriculum taught to health staff). These kinds of attitudes and practices in effect act as deterrents against future uptake of formal health services, especially, it seems, when they are combined with problems in the more tangible dimensions



Members of a Mother-to-Mother Support Group meet at a PHU in Kambia district.
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of treatment, such as drug stock-outs or unauthorised charging of informal fees for treatments that should be free under the FHCI (see Boozary et al., 2014).¹²

Such negative experiences invariably shape an individual's perception of the service, which as evidence shows matters when it comes to how people make choices about which providers to turn to in plural health systems. A recent survey of more than 1,400 respondents in Liberia, for example, found that people's confidence in their ability to secure needed care is driven more by their experiences with the healthcare system than by ostensibly more 'objective' or tangible aspects, such as proximity or quality of medical equipment in health clinics (Svoronos et al., 2014). Interestingly, the researchers' regression analysis found several demographic variables, including age and gender, to be insignificant. What their findings suggest is that while a well-stocked, capable health system is important, it is people's perceptions of the system that really matter – and this, in turn, appears dependent upon prior experiences.

¹² It should be pointed out that such stock-outs are not always actual stock-outs. There have been cases where health staff withhold supplies for their own personal use or sale as a way of dealing with delayed or unpaid salaries (pers. comm.).

Yet, it is not only patients who often fail to receive adequate care. During the Ebola outbreak, healthcare workers felt insufficiently protected from the virus, and were stigmatised by their communities as being a source of illness. Indeed, we heard stories of healthcare staff travelling to work in plain clothes with their uniforms in plastic bags for fear of being associated with the health system (and Ebola), and subsequently risking social stigmatisation from within their own communities.

Again, these problems are not new. PHU staff have little incentive to fulfil their substantial day-to-day responsibilities in a hospitable manner when there are chronic problems with their own remuneration and reward systems (Wurie and Witter, 2014). Staff salaries, rural area allowances and PBF payments are regularly delayed by up to several months – as has also reportedly been the case with a large portion of the \$23.7 million of Ebola-related hazard pay (Maxmen, 2015). A lack of government vehicles means that outreach and monitoring visits are difficult to conduct, requiring staff to catch rides with NGOs travelling in the same direction or pay for fuel themselves (Witter et al., 2015b). For staff working outside of Freetown – and especially for those working outside of district capitals – living conditions are poor, making it difficult to attract and retain qualified staff.

Such problems are evident not only at the very local levels or in particularly remote parts of the country. At the district level, health workers are 'disgruntled', in the words of one NGO interviewee, feelings borne out of their frustration with their isolation from the rest of the health system. The planning and budgeting processes that happen at the district level often take place with little support from the centre. Up until this year, for example, there has been just a single nutritionist per district responsible for the promotion and coordination of all nutrition work (since 2015 this has increased to two nutritionists per district). She – and it usually is a she – sits within the DHMT, where plans and priorities are first negotiated before then going through the District Council. The District Nutritionists typically do not have a particularly strong position when it comes to negotiating, something not helped by the fact that they are fairly recent additions to the DHMTs (since 2009), as well as by the wider framing of nutrition as a 'women's issue', rather than a broader social problem. As such, the nutritionist's weak capability to influence and negotiate then acts as a broader constraint on state capacity to prevent malnutrition, as nutrition gets squeezed out of health plans and budgets. This is not about nutritionist's technical capacity but rather their negotiating and communication skills, as well as their positioning in relation to others at the district level (Denney et al., 2014; see also Mallett, 2014). The broader yet related point to make here is that formal processes and mechanisms are usually (if not always) influenced, quite strongly in some cases, by informal dynamics (Barma et al., 2014).

At the central ministry level too, there are aspects of the working environment that are more disabling than enabling. Throughout the mid- to late-2000s, with the exception of a handful of key figures (see Donnelly, 2011), governance and leadership within the MoHS was reportedly very weak. One MoHS employee familiar with the situation around 2007-2008 described how, despite 'huge levels of commitment', so many ministry staff simply did not have the requisite skills to provide leadership across the health sector.¹³ And, in the instances where appropriately skilled staff were available, their surrounding environment appeared to have been more disabling than enabling:

The resources – human and otherwise – simply weren't there to take on what was needed. So many of the Directorates [within the Ministry] were just a one-man show. They didn't even have a Secretary. It was an impossible job. There was a lack of staff, systems, information.

When 'disabling environments' are present at multiple levels of the formal health system – from the central to the district to the local – day-to-day delivery suffers, as does user experience. What this means is that the environment in which health workers operate produces effects which are not limited to the workers themselves: they filter down the chain and ultimately impact on health service delivery. In the absence of a 'culture of care', promoted and provided by the state to its own agents, the conditions are created for the emergence of a more problematic set of relationships down the line (the latest World Development Report has much to say on this issue of how an individual's external environment shapes, often sub-consciously, their subsequent attitudes and behaviour (World Bank, 2015b)). In other words, when health staff feel undervalued and disrespected, we cannot realistically expect them – especially those working in remote, difficult regions – to provide passionate, empathetic and appropriate care for their patients. Staff are unlikely to look after their patients when the state does not look after them. As one interviewee in Freetown put it, 'They [the PHU staff] are humans after all!' This is not to suggest that this is the single, or even the primary, reason why good quality care is not being provided at the community level. We know, for instance, that the way in which health staff are trained also matters, as do the locally specific ways in which state authority is negotiated between communities and agents of the state (as well as other non-state or hybrid providers of public goods). But the nature of treatment by the state towards its own agents is in itself an important factor – perhaps even the starting point – in shaping the kind of culture that is built within the health system.

¹³ This situation is also linked to decades of a failing education sector, in which this has been little encouragement of students' initiative or critical thinking capacities. Across the GoSL, there has been a culture of promotion according to years of service rather than performance.

These kinds of relational issues are all the more important in a conflict-affected context where trust in state institutions remains weak. Efforts to strengthen capacity in the health sector must be embedded in an understanding of these trust deficits, and place relationship building, as much as technical skills training, at the centre of programming. This will be especially important in the wake of the Ebola outbreak, during which communities and health workers each feared the other as vectors of the disease.

The four blind spots highlighted in this section can be understood as the limits of the dominant approach to thinking about capacity – and about how to develop it. While these primarily emerged from our extended analysis of capacity support to Sierra Leone's nutrition sector, it is apparent that their value and relevance extend to the health system more generally. The Ebola crisis has sparked a much-needed discussion about the ongoing problems of the health sector in Sierra Leone, but this must also extend to a reflection on how capacity building efforts themselves must change. To recap, these blind spots are as follows:

- **Taking the complexity of (seemingly) basic interventions for granted.** Popular interventions that are widely assumed to work need to be unpacked. There are at least two steps to this: first, the multiplicity of quite complicated interim steps needs to be acknowledged and problematised; and second, the right kind of support needs to be provided by programming so that interventions have a better chance of achieving their desired aim. Improved monitoring, greater reflexivity and more finely tuned feedback loops will all help to provide those supporting capacity building with better knowledge of how things are unfolding on the ground, rather than assuming that their designs are being implemented consistently country-wide.
- **Taking 'what ought to be' as the starting point, rather than 'what actually is'.** Capacity building efforts must engage with the plurality of health providers that people actually use, rather than starting with a normative idea of how things are expected to work (or how they should work). Starting instead with an understanding of the interconnections between different providers, as well as the health seeking paths that people take, will help us move away from overly top-down capacity building efforts that focus overwhelmingly on state provided services.
- **Focusing on the units, not the connections.** Capacity building efforts have tended to take discrete individuals and organisations as their objects of analysis and engagement, without paying as much attention to the linkages between them. A greater focus on 'connecting up' the health system – both across 'levels' (for instance, between various government ministries and development partners) as well as between 'levels' (from community, to district,

to national) – will help shape a health system that has greater awareness of its various moving parts.

- **Failing to see that systems are made up of people who relate to each other.** Like organisations, systems themselves are fundamentally about human beings, and, as human beings, we respond to both the behaviour of others as well as the nature of our environment. In the Sierra Leonean health system, we see this when the poor treatment of patients at the local level deters uptake of government health services. But it can also be traced up the various levels of the system, through the poor conditions of PHU staff, the lack of support given to district level staff, and the generally weak leadership and management structures at the central level. This reflects the need for not just technical training, but also training in the softer skills required to deliver healthcare, such as communication, bedside manner, leadership and management. It also speaks to the wider need to build a culture of care within the health system. This goes beyond training to the way that staff are incentivised and rewarded.

These blind spots are indicative of an approach that treats capacity as an engineering problem. It is an approach that is overly technical, and which assumes capacity is merely a matter of 'stuff' – skills, equipment and resources – rather than also being about how that stuff works together within the (health) system. The key point is that capacity is, at its core, a relational concept. It is about far more than just the things we can see and touch, but also about people, culture and power. This is not to suggest that those working on improving the capacity of the health sector are not aware of these wider dynamics, or that frameworks for dealing with these relational aspects do not exist (for example, see Morgan, 2006). Rather, these ideas have not yet been built into programming, and have failed to dislodge the dominant approaches to capacity development. The final section turns to what might be done about this.

5 Recommendations: Five ideas for future capacity support to Sierra Leone's health sector

The Ebola crisis not only created acute public health needs, but also exposed underlying problems in the health systems of the three worst-affected countries. In the case of Sierra Leone, these problems have persisted despite more than a decade of external capacity support to the country's health sector. The long-term continuation of fragility within the health system has left millions of Sierra Leoneans vulnerable not only to major public health shocks, such as outbreaks of infectious disease, but also to slow-burning chronic conditions, such as malnutrition.

Recent papers by Save the Children (2015), Oxfam (2015) and Christian Aid (2015) have drawn attention to the need for donors and partner governments to invest more money in building health systems resilience, not just in Sierra Leone, Guinea and Liberia, but in low-income countries around the world. The question is: what will it take to produce and sustain health systems that look and act in ways we might consider to be 'resilient', and what role can external capacity support play?

In this concluding section, we argue that future capacity development efforts should be designed and implemented with five key messages in mind. In keeping with the recent shift towards focusing on 'the how of development' (see Campos et al., 2015), these should be seen as ideas for how governments, donors and implementing partners might think and behave differently (and hopefully better). As in the rest of the paper, while our discussion is grounded in and speaks most directly to the Sierra Leone experience, these recommendations are likely to be relevant to health systems strengthening more broadly.

5.1 Accept that a 'business-as-usual' approach to capacity building is insufficient. Future capacity support needs to be smarter.

While the GoSL and international partners are still largely preoccupied with the Ebola response, donors and NGOs are also starting to plan for their post-Ebola interventions. Our sense from interviews with donors and NGOs was that most planned to redouble their efforts in capacity building, but largely through more of the same – that is, through the same kinds of approaches that were being used before the outbreak. This was largely explained as being due to these approaches producing some good results. However, it also appears that few could envision what a different approach might actually look like. Everyone is, of course, calling for a 'resilient' health system, but relying on the same approaches that failed to address the blind spots set out in section 4 is unlikely to produce better outcomes this time around.

There is now an opportunity to make a step change in how capacity support is designed and delivered. This should not only involve strengthening the things that have previously been done well, but should also address

the four critical blind spots identified in the previous section. This is an opportunity to take advantage of the traction and solidarity that is already apparent in much of the Ebola response, to deliver a better health system that people can actually rely on. Maintaining this political momentum is absolutely key: evidence on the success (and failure) of past reforms in Sierra Leone's health sector clearly shows the importance of strong political vision and commitment (Bertone and Witter, 2013; Donnelly, 2011).

In particular, this will require:

- The **government** to create and sustain a clear vision for the future of the country's health system and to play a strong role in calling for new approaches; to be closely involved in their design, implementation and monitoring; and to be consistent across ministries and other agencies to ensure development partners receive a clear message. Political commitment from the highest levels will be required to build cross-sector coalitions within the GoSL and to generate buy-in from diverse parties (with diverse interests). This is important: donors cannot be expected to align with the state when the state is not aligned within itself.
- **NGOs** to invest time in reflecting on what their existing strategies overlook, and to consider what elements of their programming need to change as a result. This may be uncomfortable and will require pushing beyond received wisdom, but finding and testing new ways of working will be important in supporting a more people-centred, systemic approach to health sector reform. To this end, 'cultures of learning' must be further developed, and the results of well-run evaluations – as well as those of more iterative processes of everyday information gathering – need to be internalised and acted upon.
- **NGOs** must also revisit their theories of change for common interventions such as Mother-to-Mother Support Groups and cascade training to interrogate whether the assumptions being made hold in practice. This will help to ensure more realistic capacity support that connects with how interventions operate in practice.
- **Donors** to encourage and monitor their implementing partners to ensure that the programmes they support do not fall back into 'business-as-usual' approaches. As with NGOs, part of this is about reflecting upon what the dominant foci of donor investments miss or marginalise. New approaches must look beyond simply improving the reach (or quantity) of services, to sharpening the focus on effectiveness (or quality).
- **Technical** working groups to conduct joint discussions on what new ways of working are required, sharing internal lessons-learning exercises and supporting each other in developing new approaches.

5.2 Ensure that the emergency mindset does not distort programming

The Ebola response has seen the return of the emergency community to Sierra Leone in order to deal with the humanitarian crisis. While this has been necessary in the short term, there is a danger that this may extend into the post-Ebola context, realigning the focus of health policy and programming towards more immediate targets and objectives in an ahistorical manner and away from longer-term priorities.

It took Sierra Leone many years to emerge from the emergency mindset following the end of civil war. We saw this, for instance, in relation to the nutrition sector, where the ongoing focus of programming on treatment of malnutrition (rather than prevention) was connected more broadly to the experience of conflict and the emergency response this triggered. This response tends to focus on the immediate priority of saving lives through directly supporting treatment, rather than the additional priority of upstream prevention that would alleviate the need for treatment. This makes sense in the immediate post-conflict moment but in Sierra Leone, many in the nutrition community felt support of this kind dragged on for a decade after the formal end of the conflict. This was exacerbated by organisational features of aid programming, such as 'danger' and 'hardship' job statuses which attract particular skillsets, as well as the nature of the funding available, which can also incentivise an emergency focus. It has only really been in the last couple of years that the nutrition community has been able to make a genuine shift from treatment to prevention.

It is likely that concerns about the potential for heightened malnutrition rates in the wake of Ebola, which were predicted rather than verified at the time of our visit in late March 2015, will see a return to a focus on treatment. This may be appropriate if higher rates of malnutrition are found to exist and where those cases are found. However, it is very unlikely that the entire country will require a return to a focus on treatment of malnutrition, not least because the effects of Ebola, including its impact on food security, vary across the country.

What must be guarded against, therefore, is a scenario in which the emergency response unseats efforts to shift towards more sustainable, developmental and preventative health approaches. In particular, it will be important to ensure that staff with pre-Ebola country expertise are involved in programming, particularly in order to avoid ahistorical approaches to the health sector. It is important to remember that many of the challenges we see today were around long before the Ebola outbreak

It is therefore recommended that:

- **All actors** involved in the health sector in Sierra Leone ensure there is an evidence base for their post-Ebola programming. There are already several assumptions about what the effects of Ebola might have been, nurtured by the inability of many organisations to conduct country-wide assessments in the current environment. When the country is declared 'Ebola free', the priority should be on verifying the situation across the country, and ensuring that programming is based on evidence about the (probably diverse) effects, rather than based on assumptions about those effects.
- The **government** continue to focus on the detail of the post-Ebola health plan, specifically highlighting where emergency response is needed and where developmental approaches are more appropriate. The MoHS in particular must advocate against the return to an 'emergency mindset', using evidence to show the important health gains made in recent years when longer-term approaches took root.
- **NGOs** ensure that their programmes are informed both by emergency and development staff, particularly – and very importantly – ensuring some continuity with organisational knowledge of the pre-Ebola health situation.
- **Donors** balance available funding between emergency response facilities for those areas found to be in need of assistance, and non-emergency facilities that can support a renewed focus on non-Ebola (but nonetheless potentially Ebola-affected) health areas, such as malaria, malnutrition, HIV and AIDS, and NTDs. This should help guard against programming becoming skewed towards an Ebola lens, with other health needs deprived of funds.

5.3 Quality healthcare exists when people trust the health system. Capacity building should pay closer attention to state-society relations.

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 incorporate this into programming. As the Director-General of the World Health Organisation (WHO) noted in the midst of the Ebola outbreak (WHO, 2014):

I have never seen an infectious disease contribute so strongly to potential state failure. I have never seen a health event threaten the very survival of societies and governments in already very poor countries.

When patients do not trust their health system, the quality of care suffers (Boozary et al., 2014). As discussed previously, in many parts of Sierra Leone – as in the other

badly affected countries (Tsai et al., 2015) – there is a lack of public confidence in the formal health system. This was clearly illustrated by some people's refusal to attend health clinics or comply with official state guidance in the early stages of the Ebola outbreak. On top of this, government health staff have found it difficult to place their trust in the state to protect them from the disease, combined with a fear of patients bringing the disease into clinics. This speaks to a longer history of conflict and fragility in Sierra Leone. In rural Sierra Leone, the presence of the state and state-run services can be extremely limited. While the state's reach has certainly been extended in the years since the civil war, helped in part by development partners, people living 'off the tarmac road' continue to experience weak service delivery and have innovated their own coping strategies. As Lind and Ndebe (2015: 2) note, 'The remoteness of the state from the daily lives of most Sierra Leoneans ... is one of the most significant conflict legacies seen in the current Ebola epidemic.' (Re)building trust between state and society is necessary if the government health service is to become genuinely universal.

To get around this issue of state weakness, it has been suggested in post-Ebola plans that much more needs to be done to promote community involvement in the health system, so that a greater sense of ownership is felt by the people who use it. While the numbers of community health workers are set to rise (and, vitally, there is some discussion of actually paying them), there have also been calls for greater community ownership of public health issues. In terms of (re)building trust in the state, there is some logic to this. Recent survey evidence from five conflict-affected countries, for example, shows that when individuals are more engaged in community meetings about service delivery, they are also more likely to hold relatively positive perceptions of government (Mallett et al., 2015). The same is true when grievance mechanisms (or complaints procedures) are embedded within modes of service provision (ibid.): where these exist, people are also more likely to trust the government. Thus, the way in which a service provider relates to its users can influence not just the effectiveness of service delivery – indeed, enhancing the accountability of health services is considered key to improving their overall quality (Boozary et al., 2014) – but also people's perceptions about the state more generally. Against this backdrop, donors should pay as much attention to a state's 'capability to relate' as they should its 'capability to deliver' (Morgan, 2006).

At the same time, it is important that involving the community does not mean the state divests its responsibilities to provide health for its citizens. One strategy used to screen for malnutrition during the Ebola outbreak has been to provide mothers with individual mid-upper arm circumference measuring tapes to screen their own children without fear of contamination. This seems a good strategy under the circumstances, and

there are plans to continue this post-Ebola. While this is not in itself problematic, if there are wider moves to shift responsibility for health onto individuals, this could fundamentally alter the nature of the health system in Sierra Leone in a manner that decreases the role of the state and places additional burdens on citizens. As our prior discussion of the problems associated with behaviour change interventions demonstrates (see Section 4), there are good reasons to be concerned about this.

To (re)build people's trust in the health system, as well as the state more broadly, it is therefore recommended that:

- **All actors** pay attention not just to the objective, measurable dimensions of what a quality health service looks like, but also to public perceptions of the service. Evidence shows that what people think matters when it comes to service uptake. A health facility might be well-equipped, hygienic and properly staffed, but uptake will suffer if members of the catchment community do not trust the system. Building a health system that treats patients with dignity, in addition to providing safe, effective care, is a priority.
- The **government** should make explicit efforts to win the trust and confidence of communities by ensuring that people perceive the health system to be safe and welcoming. In the short term, this may be facilitated by activities such as a national cleaning day, in which health facilities – PHUs, hospitals, ambulances – are seen to be cleaned and sanitised. While it may be the case that these spaces are already technically or 'objectively' sanitary, what matters are people's perceptions. In order to amplify the visibility of such events, PHUs might consider holding 'open days' in which newly cleaned facilities are presented to the public as renewed and welcoming spaces. Similarly, holding a national day to honour healthcare workers could go some way to making staff feel valued by the government and the public. Such small-scale, almost banal activities could help signal a step change in the way the health system works for its staff and its citizens.
- In the longer term, the **government** should consider introducing and improving the quality of existing grievance mechanisms within the healthcare system, so that patients at least have the option to feed in complaints and feedback. In addition, they should strengthen mentoring, monitoring and supervision of PHU staff in a manner that supports them to deliver better care to patients.
- Finally, the **government** should fulfil its commitments to health spending as set out in the Abuja Declaration – that is, 15% of the national budget should be spent

on health, including to enable better conditions (be it pay, living arrangements, etc. for remote staff).

- **NGOs** should facilitate trust-building between citizens and the formal health system by focusing not only on the technical skills of health staff, but also on their interpersonal skills, which have been identified as a deterrent for some in using government health facilities. This should include supporting the design and delivery of curriculums which train health workers in the softer dimensions of capacity, such as bedside manner, communication skills and attitudes towards patients. Mechanisms should be implemented which monitor and support health worker compliance, such as peer visits. NGOs should also support the GoSL in activities designed to (re)build trust in the health system.
- **Donors**, and particularly the World Bank, should consider integrating citizen scorecards (or a variant of) into the PBF, which would create a financial incentive for facility staff to treat patients with dignity and respect. This needs to be done in a way that supports both patients and frontline healthcare workers. Donors should also support the GoSL in activities designed to (re)build trust in the health system.

5.4 It is not just governments that provide health services. Capacity building should engage with the health system as it actually works – and how people actually use it.

As we noted in Section 4, in an effort to strengthen health outcomes development partners have often engaged with the health system on the basis of how it ought to work, rather than how it does work. That is, they have focused overwhelmingly on state-run health facilities and neglected those other providers that people rely on for their health needs. The problem is that this does not connect with the ways in which people themselves navigate the plural health system. If the capacity of the health system is to be strengthened, it is important to ensure that government and development partners have a full view of that system and understand the interactions – both cooperative and competitive – between its elements. This will enable an approach to health systems strengthening that maps onto how people view and use the health system. It will also ensure that the health system is built in a people-centred manner which draws on the inputs and legitimacy of the diverse set of actors that constitute Sierra Leonean society. This means finding ways of including traditional healers, soweis and traditional birth attendants, as well as community health workers. In order to engage with the health system as it actually works:

- **All actors** need to recognise that people access healthcare through a diverse range of providers, who in many cases actually work with and support each other. In particular, they need to acknowledge the position and influence of traditional healers, who often perform multiple roles within the community outside their public health functions. Indeed, their status, together with questions of social obligation within the community, can often mean there are social consequences for people not using them. All actors should develop an improved understanding of how people access healthcare within the communities they work, as well as the factors that influence people's decisions, based on a recognition that health is not simply a biomedical issue but in fact a deeply social one. This will generate a range of entry points for programming to overcome blockages and constraints.
- **The government** should consider more fully and carefully the future role of community health workers – and more broadly the transfer of health responsibility to unpaid volunteers and citizens. While this transfer represents a potentially important step towards the realisation of a more people-centred health system, GoSL should proceed with an awareness of what the potential trade-offs and pitfalls of devolving further responsibility might entail. There are, for example, some concerns around the problems associated with popular training models and the factors that prohibit the effective translation of new knowledge into behaviour. Government can also play a role in bringing actors including traditional healers and chiefs into discussions about health systems strengthening. Ensuring such actors are on board with new health plans is critical in ensuring they do not become potential 'spoilors'.
- **Donors and NGOs** should examine whether their current support engages with the realities of how communities access health. Programmes that seek to reach out to traditional healers, soweis, religious leaders, drug peddlers and traditional birth attendants should be encouraged to bring together all those who are involved in health provision in various ways within communities. This does not necessarily mean validating their ways of working, but rather brokering discussions about how this group of actors can best work together to deliver improved access to quality health for communities.

5.5 Lose the modular approach to health systems strengthening. Capacity building should not only target the units within a health system, but also the connections between them.

As we talked about in Section 4, capacity building often takes a modular approach, attempting to improve the

performance of discrete organisations and individuals in the hope that this will somehow 'aggregate up' into stronger systems. This is optimistic thinking based on assumptions that typically do not hold in practice. Much less attention is paid to the connections, feedback loops and relationships between different individuals and organisations.

The bulk of investments go into strengthening the 'building blocks' of a system without providing or consolidating the 'glue' that holds them together. As others have argued in relation to the WHO's widely used 'building blocks' framework for health systems strengthening (see footnote 8),

The building blocks alone do not constitute a system, any more than a pile of bricks constitutes a functioning building. It is the multiple relationships and interactions among the blocks – how one affects and influences the others, and is in turn affected by them – that convert these blocks into a system (De Savigny and Adam, 2009: 31).

There is an urgent need to engage with these relationships and interactions, including in both a horizontal and a vertical sense. Most critically:

- **NGOs and donors** must move beyond capacity building that focuses solely on technical training and provision of equipment and supplies at the individual and organisational levels, to explore more comprehensive approaches to capacity that engages also at the systems level. This needs to begin with donors and NGOs have a clearer sense of what capacity is comprised of.

With regard to *horizontal* connections:

- The **government** needs to ensure consistently and clearly articulated health policies across ministries that donors and NGOs can align with. Coordination mechanisms for development partners should be clarified to alleviate confusion about whether and how this happens at the district and national levels. Government should proactively engage with development partners as they develop plans (that is, in the early stages of programming) to ensure that alignment is meaningful and goes beyond paying lip service to government policies and priorities and signing off on designs they have had little engagement with.
- **Donors** should support better cross-sector planning and budgeting, both between the health sector and other sectors (agriculture, social welfare and education) as well as within the health sector (where health issues can compete for limited funds).

- **NGOs** and donors should revisit the design of the coordination mechanisms in place that seek to promote knowledge sharing, joined-up planning and collective problem solving at the national level. Technical meetings, for example, do not appear to be meeting expectations, and more thought should be given to *who* attends, *what* the objectives of such meetings are, and *how* they are run, as well as what additional coordination happens outside of these meetings.
- NGOs should involve government representatives in their project planning at the earliest possible stage to build genuine ownership and alignment with plans and priorities. This will help to avoid a situation in which NGOs believe there is ownership but government disagrees.

With regard to *vertical* connections within the health system, actors need to focus not just on frontline delivery at the local level, but at each of the levels involved. In particular:

- **All actors** should seek to drastically improve reporting systems and information flows between the local, district and national levels. Accurate data is key to planning, budgeting and overall performance.
- The **government** should pay particular attention to performance at the district level. It should provide more support to and implement closer monitoring of planning processes within DHMTs, ensuring that important public health issues, such as malnutrition, do not get squeezed out. This might involve providing national-level representation during the negotiation of district health budgets to lend weight to critical issues. Additionally, a greater emphasis should be placed on sustained supervision of health staff at both the PHU and district levels. Allocating more towards regular 'peer visits', which have been found to improve staff performance, should be a priority.
- **Donors** should ensure that their support does not lead to a 'missing middle' in the health system, which emerges when funding gets concentrated at national and local levels. Some of our interviews suggested that such a 'missing middle' has already emerged, constraining policy implementation, undermining monitoring and learning, and fuelling geographical unevenness in terms of policy effectiveness. Donors should explicitly address this by: supporting the development of better data systems and data handling expertise at the district level; supporting human resource expansions at the district level; and better understanding the politics of decision making and relationships within and between the various district-level bodies (particularly the DHMTs and District Councils).

- **NGOs** should continue to explore mechanisms for improving information flows from PHU to district to national levels, for instance through the use of mobile technology. However, such technologies remain dependent on accurate data collection by individual health workers who may require additional training, mentoring and supervision.

The Ebola crisis has revealed not only weaknesses in the Sierra Leone health system, but also deficiencies in the dominant approaches to capacity building that have informed much development partner support over the last 13 years. In order to better strengthen capacities to provide improved healthcare to communities, development partners need to 'do capacity building differently'. We have set out here some recommendations for how this might be done. But these recommendations are not exhaustive, and peeling back dominant ways of working – and the kinds of assumptions that have become implicit in capacity building approaches – will take sustained commitment. It will also require development partners to think reflexively about their own capacities, and to seriously consider the ways in which these might need to be altered (indeed, reflexivity and internal adaptation are themselves important capacities in the world of international development).

We are aware that this is no mean feat. But attempting to doing so, and framing the Ebola outbreak as a serious wake-up call for this purpose, will help to not only reconfigure the ways in which we collectively think about this vague and fuzzy idea of 'capacity', but also help us see with far greater clarity the contribution that more people-centred and systemically aware forms of capacity building can make to genuine and sustained improvements in citizens' access to quality healthcare.

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Annex 1: Methodology

Research for this report draws on the last two years of research under the SLRC Sierra Leone country programme. This has involved qualitative and survey work in Kambia District, as well as interviews with government, donor and civil society representatives in Freetown (for more on the selection of Kambia as the research site, see SLRC, n.d.). More specifically the research has been split across three stages:

- **Stage 1.** To understand how development partners have been attempting to develop state capacity to prevent malnutrition, and to assess whether these approaches are fit-for-purpose, we conducted 62 semi-structured interviews in Freetown and Kambia in September 2013. These generated information on organisations' malnutrition and capacity building activities, barriers to effective prevention, areas for improvement, and experiences of malnutrition policy and capacity building activities on the ground. In Freetown, we conducted interviews with both the 'providers' and 'targets' of capacity support, with the aim of understanding what the nutrition community looks like at the national level and how it works. We identified those within the donor and NGO communities who had knowledge of their organisation's capacity building activities around malnutrition, as well as those within a range of GoSL ministries, including the Ministry of Health and Sanitation (MoHS), the Ministry of Agriculture, Forestry and Food Security (MAFFS), the Ministry of Education, Science and Technology and the Ministry of Social Welfare, Gender and Children's Affairs. In Kambia District, we focused on two sets of stakeholders: first, political figures, government and NGO staff in the district capital, including members of the District Council, the District Health Management Team (DHMT), NGO staff and the Paramount Chief; and second, those working on frontline service delivery in communities across Kambia's seven chiefdoms, including staff at the government-run Peripheral Health Units (PHUs), Mother-to-Mother (M2M) Support Groups and Farmer Field Schools (FFSs) (for more information see Denney et al., 2014).
- **Stage 2.** In the second phase of research we were interested in better understanding the underlying social drivers of malnutrition at the micro-level, as well as local communities' health seeking behaviour. To generate information that would help us answer the first question, a semi-quantitative evaluation of access and coverage (SQUEAC) survey was implemented in Kambia District in February/March 2014 by SLRC partners, Focus 1000 and Valid International. This survey shed light on the locally specific barriers to preventing malnutrition. It included three parts: a review of existing data and literature, which informed the design of a series of hypotheses about infant and young child feeding practices; random sampling of mothers/carers in five semi-purposely selected communities to test these hypotheses; and a case-control study, in which a questionnaire was administered to two matched pairs of stunted and non-stunted children across 10 sites (giving a total of 20 pairs of 'cases' and 'non-cases') (for more information see Binns et al., 2014).
- **Stage 3.** Following the SQUEAC, qualitative research was carried out as part of the second phase of the research programme digging deeper into the questions asked in the survey. In May/June 2014, we conducted 18 focus group discussions and 22 interviews across three communities in Kambia District, purposively selected to capture geographical variation in proximity to PHUs, sophistication of nearest PHU, and existence and formality of M2M groups. Through the focus groups, which were split by gender and age, we sought to understand feeding practices, food sources and taboos, household decision-making processes, as well as behaviour related to the uptake of health services. Semi-structured interviews were carried out with a range of respondents in each community, including individual mothers, the local chief, PHU staff, community health workers, traditional birth attendants, traditional healers, and lead mothers of the M2M groups (for further information see Denney and Mallett, 2014).¹⁴

¹⁴ A fourth stage of research – falling under the third phase of the programme – was originally scheduled to take place in October 2014. This was planned to focus on food security, local trade and access to markets. However, due to the Ebola outbreak and the difficult of conducting research in Kambia at this time, the decision was made to cancel this portion of the research.



Annex 2: List of interviewees and focus group attendees

Focus groups

Donor Focus Group: Representatives from Irish Aid, USAID, UNICEF and the World Food Programme

International NGO Focus Group 1: Representatives from World Vision, GOAL, Action Contre La Faim

International NGO Focus Group 2: Representatives from Save the Children, Helen Keller International

National NGO Focus Group: Representatives from Pikin-To-Pikin, Children Advocacy Forum Sierra Leone, Alliance for Women's Development, Heritage Sierra Leone, Youth Dream Centre

Focus 1000 Focus Group: Alhaji Jah, Board Chairman, Dr Samuel Pratt, Director of Programmes, Paul Sengh, Director of Research and Evaluation, Ramtu Jalloh, National Coordinator Health and Nutrition Sierra Leone Civil Society Platform, George Saquee, Programme Manager

Interviews

Theresa Bagrey, Senior Programme Officer (Community Health/HIV) and Jeanne Kamara, Country Manager, Christian Aid, Sierra Leone

Paramount Chief Charles Caulker, Chairman of the Council of Paramount Chiefs, Sierra Leone

Chukwu-Emeka Chikezie, Director, Up!-Africa

Yayah Conteh, Donor Liaison Officer, Ministry of Health and Sanitation

Dr Joseph Edem-Hotah, Dean, College of Medicine, Sierra Leone

Dr Mohammed Foh, National Coordinator and staff, Scaling Up Nutrition Secretariat

Sarah Fox, Senior Technical Officer with Family Planning High Impact Practices and former-ODI Fellow, Ministry of Health and Sanitation, Government of Sierra Leone

Sibida George, Acting Country Director, Sustainability Nutrition and Agriculture Promotion, Sierra Leone

Mary Hodges, Country Director, Helen Keller International, Sierra Leone

Mohammad B. Jalloh, CEO, Focus 1000

Freya Jephcott, PhD candidate in Emerging and Infectious Diseases, University of Cambridge

Abie Kamara, Deputy Director of Aid Coordination, Ministry of Finance, Sierra Leone

Ami Kandeh, Deputy Team Leader, Access to Security and Justice Programme, Sierra Leone

Dr Baillioh Lee, College of Medicine, Sierra Leone

Jason Lee, Health Advisor, UNDP

Paula Molloy, Deputy Head of Country, Irish Aid

Joanna Reid, current Head of Country, DFID Sudan and former-Health Advisor, DFID Sierra Leone

Mohamed Hashim Rogers, Health Specialist, World Bank, Sierra Leone

Foday Sawi, Deputy Minister of Health and Sanitation, Ministry of Health and Sanitation

Aminatta Shamin, Director, and Solade Pyne-Bailey, Nutrition Directorate, Ministry of Health and Sanitation

Abuja Sheriff, Deputy Director Planning, Evaluation, Monitoring, and Statistics Division, Ministry of Agriculture, Forestry and Food Security

Traditional Healer's Union, Sierra Leone

Chris Walker, DFID Advisor to the National Ebola Response Committee, Sierra Leone



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