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ABOUT THE FORUM ON HEALTH SECTOR REFORM

The Forum on Health Sector Reform is a group of experienced senior technical people with a common interest in health policy and health sector reform who meet regularly. Members are currently drawn from bilateral and international agencies, regional development banks, ministries of health and selected resource institutions.

Forum meetings serve to share information about the scope and nature of current and planned activities related to supporting health sector reform; identify priority issues in health sector reform; review discussion papers on priority topics commissioned and produced by the Forum; discuss relevant country experiences as well as different agencies’ approaches to supporting the reform process in countries.

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CAPACITY BUILDING FOR HEALTH SECTOR REFORM

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I. BACKGROUND

Investment in physical assets has dominated the development scene in the third world ever since foreign aid assumed special importance. The massive investments that countries have made in infrastructure, buildings, industry and public services have for the most part focused on the creation of assets such as roads, dams, hospitals and power plants. The assumption was that these assets would automatically result in outputs and services that people would benefit from and that growth and development would follow from the capacity thus generated. Development projects were often completed on a turnkey basis by donors and handed over to governments to manage. Technical assistance was built into many a project in the hope that it would enable governments to continue and expand the project activities and benefits.

By the 1970s, there was considerable evidence to show that the investment in infrastructure, facilities and services that was made in most developing countries had not produced commensurate outputs and benefits. Often projects and the assets that they created deteriorated and could not be sustained. When the expatriate experts and consultants who managed the projects and trained the local staff disappeared from the scene, project activities and benefits also ground to a halt. In some countries, the continued presence of consultants did little to improve matters. Governments and local staff seemed unable or unmotivated to maintain and expand the facilities and services satisfactorily. This pattern was by no means limited to donor projects and investments. It applied equally well to many development activities initiated by governments themselves, with or without external assistance.

Several hypotheses have been offered by development experts to shed light on the phenomenon described above. Many experts would now agree that the importance of capital investment as the dominant trigger for development was overrated. Some would argue that the paucity of resources (recurrent costs) for maintenance was the main problem. But then, many projects that had adequate resources also failed the sustainability test. Yet another explanation was that country commitment to the projects was weak and that technical assistance was ineffective. There is no doubt some truth in this view. It does not, however, explain why government initiated projects (without aid) met the same fate in many cases.

One hypothesis that has attracted much international attention in recent years is that development efforts have failed because of their lack of attention to the human and institutional capabilities of the countries involved. This view recognises the importance of capital investments, but notes that capital will not be productive unless matching human and institutional capabilities are available. World Bank experience of the 1970s amply demonstrated that their projects went on smoothly as long as special project implementation units supported them, but that they collapsed when governments took them over without the reinforcement of the Bank's implementation units. Further support to this view comes from East Asian countries whose developmental success has been attributed, among other things, to their higher levels of literacy and education and to the purposiveness and organisational
strengths of their governments. Education here reflects human capabilities and organisational strengths are a proxy for institutional capabilities.

The emergence of policy reform and structural adjustment in the 1980s provided further evidence on the importance of human and institutional capabilities. Multilateral lending agencies began by taking experts to developing countries to diagnose their policy environments and to propose or to assist in the design of policy reforms. In many cases, this approach resulted in competent studies and sensible recommendations, but was followed by poor implementation and low internalisation of the proposed reforms in the country. While lack of political commitment to reform was a contributory factor in most countries, it became increasingly evident that local counterparts and their institutions were often ill equipped to dialogue on policy issues, to undertake studies and to skilfully assess policy options. They did not have institutional mechanisms within or without government to initiate and sustain these processes and to effectively carry out the actions arising from the agreements with donors. For example, expertise in macro economic and related analysis or in the areas of trade, pricing, corporate finance and management was found to be scarce within the economic ministries of governments, universities and consulting firms. Visiting experts could no doubt design reforms, but were for the most part unequal to the task of transferring skills to their local counterparts in a short period of time or of implementing and sustaining the reform process.

Experience with conventional development projects as well as with recent policy reforms highlights an important lesson that donors and governments can ill afford to ignore. In brief, the lesson is that human and institutional capabilities in developing countries are critical to the success of their physical investments and policy reforms. External expertise and assistance can help initiate change, but to internalise and sustain change and reform, deliberate efforts are required to expand and upgrade human and institutional capabilities. Prescription of reforms and conditionalities imposed from outside are no substitute for this task. The rationale of "capacity building" rests squarely on the emerging consensus on the foregoing diagnosis.

II. THE CONCEPT OF CAPACITY BUILDING

It is useful to begin with a working definition of capacity building so that we can see what new perspectives it offers and where it overlaps with other concepts. In the world of technology, capacity has a precise meaning and content. The capacity of a machine, for example, can be measured and rated. A buyer then can be sure as to what s/he is getting for her/his money. Questions could be asked also about the life of the capacity and the efficiency with which it could be utilised. Capacity thus refers to the measure of a durable stock that yields a series of outputs over time in conjunction with other inputs/materials. Capacity here is measurable, visible and lends itself to being compared with other similar objects/measures.
The bundle of human and institutional capabilities referred to above is conceptually no different from that of machines or of other physical objects. But in practice, it is difficult to measure, see and compare them. A person with a set of skills, for example, can be thought of as a stock the capabilities of which can be drawn upon over a period of time. An organisation with a structure, systems and other capabilities is also a stock from which a series of services or outputs could flow over time. One possible difference worthy of note is that a person or organisation may improve in quality over time while a machine is generally supposed to deteriorate with use. The main point is that capacity building refers to the creation, expansion or upgrading of a stock of desired qualities and features called capabilities that could be continually drawn upon over time. Better management may not necessarily lead to improved results when the stock itself is weak or outdated. A good policy maker or manager will be able to achieve much more when the stock of human and institutional capabilities available to him/her is of requisite quality. The focus of capacity building therefore tends to be on improving the stock rather than on managing whatever is available.

In reality, many people seem to think of capacity building as a new label for training and development. Some may view capacity building as a component of institutional development or of good management. There are clearly overlaps between these concepts. Thus training no doubt tends to be an important part of capacity building efforts. But capacity building may go beyond training to incorporate many other elements which may also overlap with institutional development. Capacity building needs to be in place in reasonable measure before an activity or organisation can be effectively and efficiently managed. For the present, it is enough to note that institutional development and management are broader concepts than capacity building. Institutional development may require a proper legal framework to be in place. But that is not the same as capacity building. If, however, the design of a legal framework is held up for lack of certain capabilities, then capacity building may assume special significance. When the primary concern is about expanding or upgrading the stock of human and institutional capabilities in a specific context such as a sector, programme or organisation, capacity building is the most appropriate concept to deploy.

In the context of the health sector, it may be useful to elaborate on the concept of capacity building along four different dimensions:

- human vs. institutional dimension
- planning vs. implementation dimension
- micro vs. macro dimension
- cognitive vs. practice dimension

Human and Institutional Capabilities

As noted above, training and skill development are at the core of capacity building as far as most people are concerned. Whether it be for projects or for policy reforms, education and training of staff are normally accepted as an essential prerequisite. There is much less
recognition of the fact that trained personnel will be effectively utilised only in organisational settings with certain capabilities. People need to work together to achieve common goals. They need to be given the required resources and supervised and motivated. They tend to be productive in an enabling and supportive institutional framework. The capability to create and manage these institutional mechanisms and arrangements is distinctly different from the capability of a person to perform a specific task. Human (in the individual sense) and institutional capabilities are thus different, but complementary and mutually reinforcing. When the organisations in which people function have major weaknesses such as the lack of a clear mission, inadequate structures, weak internal systems and practices or suffer from a lack of adequate autonomy and incentives, it is quite likely that the staff, even if well trained and capable, will not be productive or motivated to perform. Not all these problems can be attributed to gaps in institutional capabilities, but there is clearly a vast area here that can be improved only through systematic capacity building over time. In a given context, it is important to diagnose the problem in terms of both human and institutional capabilities since the remedies will not be the same for these two types of gaps. Standard training courses for staff in policy analysis can be organised locally or abroad whereas institutional capabilities may require customised approaches.

**Planning and Implementation Capabilities**

While the planning-implementation dichotomy can sometimes be overdrawn, it is a useful distinction to make in a discussion of capacity building. Planning and implementation call for different skills and capabilities. The underlying disciplines and orientation, and the institutional arrangements required for these activities are not the same. Planning in the sense of analysing the environment, and generating and selecting policy options require specialist skills. But strong links between policies, plans and their implementation are essential to their success. Hence the need to interpret capacity building as encompassing both dimensions. Planning capabilities focus on analytical skills, breadth and depth of environmental (sectoral) understanding and interdisciplinary collaboration while implementation capabilities focus much more on organisational action, incentives, teamwork and results. Those engaged in capacity building need to note the interdependence between the two and should not be carried away by an overemphasis on one or the other unless in a given context a severe imbalance in capacity exists between the two.

**Micro and Macro Dimensions**

At the micro level (e.g., at the level of a specific programme, a district agency or a hospital), the relevance of capacity building is likely to be much more on the implementation or management front than on the policy or planning front. It is because broad policies and programme design tend to be given or influenced by a higher level. This is not to rule out the need for policy understanding or capabilities at the micro level, but to say that the scope for initiating policy work or for choosing policy options tends to be more limited at that level. Implementation capabilities, on the other hand assume special importance at the micro level. The capability to manage assets, deliver services, monitor and use feedback and to motivate performance at the ground level will be key to micro level effectiveness. At the macro or
sector level, much greater attention needs to be given to policy analysis and to the fine
tuning of the choice of policy options and mid-course corrections. While implementation is
of great concern at higher levels, the fact is that this function is being shared with micro level
agents in most cases. The macro level role in implementation is one of planning and
supervision rather than of direct action. On balance, therefore, policy and planning
capabilities need to receive greater attention at the macro level.

**Cognitive vs. Practice Dimensions**

The transfer of knowledge and development of analytical skills are basic to capacity
building. Consequently, education and training, both formal and informal, play a major role
in the development and upgrading of individual capabilities. The health sector is well known
for its emphasis on the cognitive dimension of capacity building. This is equally true of the
field of policy analysis.

It is unlikely, however, that investment in knowledge in the intellectual sense is all
that is required for capacity building. The ability to apply and adapt knowledge depends a
great deal on the opportunities one gets to practice over a period of time. This is even more
ture of institutional capabilities that invariably call for the orchestration of many parts, teams
and organisations. Understanding a context, establishing rapport, design of new systems and
practices, bargaining and negotiation, and other related capabilities take time to develop and
fine tune even for those who have excellent theoretical knowledge. Organisational teams
develop and internalise ways of working these processes by practice over time. Trial and
error and learning by doing are thus part of the process of capacity building. It explains why
a long term perspective is essential to the strategy for capacity building.

In brief, the different dimensions discussed above provide a useful starting point for
thinking about capacity building. The distinction between human and institutional
capabilities is useful because the approaches and specific steps required for development in
these two cases tend to be different. By drawing attention to both planning and
implementation capabilities, the importance of strengthening the capacity for action is being
highlighted. The micro and macro dimensions point to the need to diagnose capacity
building requirements with reference to the relevant level of the economy. The cognitive and
practice dimensions of capacity building explain why the process takes time, especially when
complex institutional capabilities are involved. Analysing and assessing capacity building
needs along these dimensions will hopefully provide a better understanding of the problem
and a sounder basis for evolving a strategy for capacity building in any sector of the
economy.

**Health Sector Reform**

Wide ranging reforms for the health sector are being discussed today in developing
countries. Their overall objective is to improve sector performance in terms of dimensions
such as efficiency, equity, public satisfaction and health outcome. Health financing, choice
and cost effectiveness of services, outreach and access to services, decentralisation,
intersectoral and legal issues are facets of reform that are presently receiving much attention. It is pertinent to explore how capacity building to facilitate these reforms could be conceptualised in light of the foregoing discussion.

Health financing entails multiple components of policy reform. A shift from the public sector to market orientation must be preceded by careful policy analysis and decisions concerning the scope for and limits to the shift and the design of guidelines for standards, quality and pricing where appropriate. Specification of the role of private practitioners and health insurance, for example, calls not only for good policy analysis, but also for organisational assessments and implementation analysis. New organisations, legislation and possibly networks for information and monitoring may be required. Though health financing reforms are sectoral in nature and entail major policy choices, the capacity to plan and implement them is not limited to the acquisition of analytical capabilities by a few good people. Institutional and implementation capabilities are also required, besides the fine tuning of the capacity through practice. Policy analytical skills are a starting point that needs to be coupled with some measure of institutional and implementation capabilities.

When we move to a reform like decentralisation, complex policy analytic capabilities are not at the core of the capacity required to see this reform through. Rather, it is the capabilities to assess and design organisational structures, systems and processes, to create and enforce a suitable legal and financial framework, and to motivate and manage people at different levels that will take centre stage. Practice and confidence creation rather than cognitive skills will assume greater importance in capacity building in this context. Knowledge of the law and finance, for example, will certainly be important and probably can be transferred from elsewhere. But the capability to apply and adapt this knowledge and to create the systems and incentives to support and make it work has to be built up locally over time. It may be useful to examine different elements of health reform along these lines to identify the nature and mix of capacity dimensions required in specific country contexts.

Irrespective of the sector, capacity building would seem to involve more than knowledge transfer. It is more appropriate, therefore, to think of capacity building in terms of knowledge, processes and practice. Knowledge focuses on the analytical and substantive understanding and skills to be built up. Processes refer to the institutional strengths and dimensions to be created. Practice is the means by which both knowledge and processes are internalised and reinforced. Several important implications of capacity building follow from this interpretation.

1. There is much merit in starting by dissecting each reform into distinct components and the sequence in which they are likely to follow. The kind of capacity that needs to be developed for each component can then be identified and assessed. The shift to market orientation, for example, will require some people with capabilities to undertake competent policy analysis and related empirical research. But it will also call for expertise in contracting out and monitoring services and in the
design of standards. Managerial and implementation skills are indispensable in making these systems work. Different disciplines, experience and orientation will thus be required for the different elements and tasks of reform. Some tasks will demand efficient institutional arrangements in addition to individual skills. A systematic delineation and assessment of the tasks of reform along these lines will help clarify the types and dimensions of capabilities that need to be in place. The resulting checklist can be used to see what capabilities already exist and what needs to be created, expanded or upgraded.

2. The pace of capacity building is accelerated through the repeated application of skills and the gaining of experience. Classroom training without opportunities to practice the new skills in the real world results in the erosion of capacity that exists in many institutions/sectors. Trained staff may then get labelled "theoretical" and "academic". Capabilities are strengthened and sustained only when practice is built into the process itself. This has been a major problem with technical assistance in some sectors. People are trained in the country or abroad in the hope that they will automatically get properly placed and utilised. New organisations are created and funded in the hope that their services will be appropriately utilised. In countries that are new to such skills and organisations, this may turn out to be an unrealistic assumption. In sectors like health, it is possible that those in authority are unfamiliar with or unconvinced about the nature of reform. Their professional backgrounds do not always equip them to initiate policy reform or undertake policy analysis. Deliberate efforts to encourage potential users (e.g., governments, sector agencies, etc) to draw upon the new capabilities will be in order under these conditions. In other words, capacity building should not be a purely "supply" oriented exercise. It should pay special attention to the task of creating or stimulating the "demand" to use the capabilities being created. This task may well call for a participative approach on the donor side so that host governments and agencies may internalise the new needs and ideas. Health sector experience is pertinent in this context. Given the importance people attach to curative care or as a result of their improved awareness, the training given to doctors tends to be well utilised in many places. The same cannot be said for policy analysts or managers. The "mind set" of health ministry policy makers may need to be influenced and changed as part of the strategy for capacity building.

3. Opportunities for "practice" and the creation of "demand" cannot be planned like training for which a period of time and a sequence can be set in advance. Opportunities for practice can be planned up to a point. But conditions may change and opportunities may evaporate. Demand may look real at one point only to disappear at the next. The Ford Foundation had in the 1950s and 1960s helped in the establishment of several new research and policy analytic institutions in Latin America. Despite a promising start, these institutions faced a hostile environment when authoritarian regimes took over in one country after another. There was hardly any demand for their training or advisory services. As a donor, Ford continued to
support them during this lean period in the belief that the valuable capabilities built up over time at great cost would be depleted in the absence of continued support. The important lesson here is that given the fragility of demand and the uncertainties in ensuring opportunities for practice, capacity building should be undertaken with a long term perspective and a commitment to deploy adequate resources over the long haul should the need arise. The typical short term "TA Project" mentality is inappropriate in the capacity building context in most developing countries.

III. STRATEGIC ISSUES

Five strategic issues in capacity building are discussed below as an aid to the formulation of strategies specific to the health sector. Options and examples from different sectors will be presented to stimulate thinking about their relevance to capacity building for health policy reform.

1. What are the barriers to the building and utilisation of capacity?

An invisible barrier to the creation and utilisation of capacity is the lack of information and awareness of important users who in the first place should be demanding such capacity. When potential users (e.g., policy makers, heads of ministries) are indifferent or even hostile to policy reform out of ignorance, support for capacity building is likely to remain weak and existing capacity may seldom be used. If, for example, doctors and other professionals are unaware of the need for policy analysis and reform or uncertain as to what it means, will they support building capacity for it?

A similar situation arose when the Indian Institute of Management (IIM) was established at Ahmedabad to train MBAs for industry. Many industry leaders were uncertain as to what the new graduates could do for them. A special campaign to inform and educate them on the "products" of IIM was then launched with positive results. To turn out graduates assuming that they would be automatically absorbed by business would have been unwise. How to prepare potential users to be positive towards policy reform and analysis prior to capacity building is a strategic issue.

A second barrier is the perverse incentives of users that may militate against capacity building. In this case, potential users may be well informed about what policy reform could do, but tend to resist reform because it might cause them to lose their power and patronage. When policymakers stand to gain from the status quo, they will have no incentive to support reform or capacity building for it. In general, it takes a major crisis to break the stranglehold of vested interests. It is why reforms such as privatisation occur only in countries facing a severe financial crunch.
Sometimes, exceptional leaders or a new regime uncommitted to the status quo may initiate reforms. They could then be allies in the capacity building exercise.

Finally, lack of financial resources tends to weaken capacity building efforts. Immediate and pressing problems always tend to win in the battle for scarce resources. When adequate resources are not allocated, the newly created capacities tend to be poorly maintained, a familiar phenomenon in the wake of project completion. Skilled professionals leave the new institutions or remain unmotivated to perform as their compensation is uncompetitive. Human and institutional capabilities thus remain underutilised.

Donor support can play a strategic role in dealing with this barrier. Malaysia undertook a massive training and development of its civil servants and modernisation of its government institutions soon after independence, an investment that paid handsome dividends. They modernised the civil service system and substantially raised the salary levels of public servants. Poorer countries might find it difficult to undertake capacity building efforts on this scale.

2. **How should capacity building needs be assessed?**

The traditional approach to capacity building tends to focus primarily on the supply side. An assessment is typically made of the kind of organisations, facilities and skills that are required. The foregoing discussion of barriers shows that other factors need to be considered even before the supply side is firmed up. The attitudes, preparedness and incentives of the potential users of capacity and the resources they might make available are clearly important factors to be assessed. Such exercises can help in the formulation of a strategy for capacity building and in planning the sequence of steps to be taken.

All the four dimensions of capacity discussed in Section II are pertinent to the assessment of capacity building needs. Capacity building needs for health financing must be assessed in terms of both human and institutional aspects. It is not only capacity for analysis of the issues, but also for planning and managing the pertinent organisations, systems and regulations required for health finance that needs to be created. An assessment exercise therefore should cover the entire spectrum. Finance is a sectoral issue and hence the assessment should focus at the macro rather than the micro level.

The mechanisms used for needs assessment will vary with the context of the country or sector. Consultants or task forces can be an aid to the process. A careful assessment of the sector context and consultations with potential users of the proposed capacity should be built into the exercise.
3. **When should the demand side of capacity be given special attention?**

First of all, when a needs assessment signals that awareness and incentives of users could create problems, it is imperative that demand is given special attention. Ways and means to deal with the lack of awareness and perverse incentives of users could then be built into the strategy for capacity building.

Secondly, whenever capacity results in new "products" in terms of capabilities, the demand side of capacity will require special emphasis. This is more than an awareness or incentive problem. Users may simply not be equipped to deal with a new capability. In the IIM case cited above, a special senior level management programme was created to orient chief executives of companies to new ways of solving business problems. This was an approach to create confidence in them about the use of the new graduates to be put on the market by IIM. IHPP’s strategy of involving senior MOH officials in the formulation of the research work to be undertaken by university teams is also an example of paying special attention to demand partly because of the newness of the subject of policy reform in health ministries.

Thirdly, when capacity is being created outside of the control of users, it is essential that special attention is given to the demand side. Although not universally true, there is a greater chance that when a government is actively involved in creating a unit in MOH or close to it, its output and advice will be sought or used by policymakers. The Korean Development Institute, a policy research body closely linked to the government, has been heavily used by the Korean Ministry of Finance and other agencies. This is also the case in Indonesia where the government has set up a policy implementation institute. But where there is no such close linkage or sponsorship, it is important that the organisations involved take the initiative in creating linkages with policy makers. Universities and autonomous bodies are likely to fall into this category. It is not only demand from government, but also links with the media and other publics that new institutions should seek to create.

4. **Should capacity building for policy reform be confined to government and its agencies?**

Most donors who work with governments assume that capacity building for policy reform should focus on government ministries and agencies. Policy is the concern of governments and it is the latter who should be equipped to generate policy analysis and to implement policy decisions.

On the other hand, captive policy research groups in government have certain disadvantages. Their autonomy and independence could be compromised. Leadership changes could cause instability of demand for their work. They could degenerate into
bureaucratic entities with little dynamism and creativity. Instead of anticipating and raising issues and challenging the leadership to look ahead, they may simply follow orders.

All these are reasons why in the field of policy reform, multiple sources of analysis and advice need to be created. Capacity building should therefore be encouraged both within and without government. Autonomous centres and institutes for policy analysis and implementation can be established as freestanding entities or as part of universities or even private sector organisations. A major advantage of this approach is that greater flexibility in terms of compensation and incentives can be built into autonomous centres more easily than in government agencies. It will make it easier then to attract and retain competent professionals. As noted above, this is a chronic problem for government. Developed countries have many such institutions. Increasingly, developing countries also have experimented with this concept. In Africa, the Africa Economic Research Consortium is an example of an effort by some donors to strengthen the capacity of economists in different universities to undertake research and provide policy advice to interested governments. It acts as a network of members who receive professional inputs from abroad through donor support. Both TDR and IHPP also seem to operate in the same mode in the health sector with respect to university groups.

If this approach is adopted, policy units in MOH should be planned to play the demand role rather than to be pure research and analysis agencies. They should be able to define policy issues, prepare terms of reference, subcontract research or assign tasks to competent bodies, evaluate the findings and other work of contractors, and make recommendations to policymakers. This set of capabilities is a missing link in many governments. The Korean example given above is probably an exception.

Independent sources of policy advice and analysis are essential to stimulate the interest of the private sector and the public at large in policy issues. This, of course, assumes a pluralistic society and a government that is open to public debates on policy matters. The private sector, media and professional groups are potential consumers of policy research. Capacity building in this area needs to pay special attention to issues such as long term funding, leadership and the creation of viable institutions with a critical mass of expertise in the relevant subjects. Government and industry could contribute funds to set up autonomous centres. A series of autonomous agro-economic research centres were set up at universities in India three decades ago with government support. Such autonomous groups are more likely to "speak truth to power" than the captive policy units within government.
5. **How can strategies for capacity building be tailored to meet country needs?**

Our discussion so far has been concerned with some of the generic issues that need to be addressed while thinking about capacity building. It does not, however, provide a basis for identifying the specific strategic interventions for capacity building appropriate to a given country context. To formulate a strategy, we need to get much closer to the country or sector features. When the focus is on capacity for health policy reform, what sector features merit special attention? How can an analysis of selected features be used to derive a strategy for capacity building?

It is proposed that we begin by assessing a country's health sector in terms of the factors that affect the supply of and demand for health policy capacity. For example, if the basic skills, institutions and systems required for policy analysis and implementation are well developed and available in a country, we might conclude that the supply side of capacity building in that country is strong. If they are spotty, the supply side is weak. If there is strong interest and commitment in government for the use of such skills and institutions, we would characterise the demand side of capacity building as strong. If the government is indifferent to them, the demand for policy reform capacity is weak. When countries/sectors are classified along both supply and demand dimensions in a 2 x 2 matrix format, we can get four different combinations of demand and supply in which real countries/sectors can be placed. In the following diagram, supply is depicted on the vertical axis and demand on the horizontal axis. Note that cell 1 represents countries that are weak on both supply and demand sides. Cell 3, on the other hand, will fit countries that are strong on both counts. Cells 2 and 4 fall in between. This is a simple, but useful way to categorise countries/sectors. It enables us to ask what strategic interventions for capacity building will be appropriate in a country, given a specific combination of supply and demand.

Take a cell 1 health sector, for example. Trained personnel such as health economists, management experts, social scientists, etc., are assumed to be in short supply here. Research centres that can nurture these skills are probably non-existent. Implementation capabilities are also weak. If we did not look at the demand side, we are likely to recommend heavy investment in new institutions and in training so as to strengthen the supply side. But the state of demand is also weak. It means that policymakers, officials, etc., are uninformed about or indifferent to policy reform capacity building. The interventions proposed for cell 1 do not refer to the creation of new centres/units for policy reform work in government or outside. Conditions are not yet ripe for this intervention. Instead, they focus on measures to improve demand such as study tours, demonstration work in this area by donors, and long term investment in training for improving local skills.

In a cell 2 health sector, it is in order to create capacity for policy reform through a government unit. This is because the demand side is strong. Autonomous
### DIAGRAM 1
**Strategic Interventions**

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<thead>
<tr>
<th>DEMAND</th>
<th></th>
<th>SUPPLY</th>
</tr>
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<tbody>
<tr>
<td>Weak</td>
<td>Weak</td>
<td>Strong</td>
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<tr>
<td>Invest in long-term training</td>
<td>Support government unit</td>
<td></td>
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<tr>
<td>Study tours for policymakers</td>
<td>Create autonomous capacity/centres</td>
<td></td>
</tr>
<tr>
<td>Donor dialogue with government to stimulate demand</td>
<td>Invest in consultant capacity</td>
<td></td>
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<td>Twinning arrangements</td>
<td></td>
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<tr>
<td>1</td>
<td>2</td>
<td></td>
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<tr>
<td>Strong</td>
<td>Use of capacity by donors</td>
<td>Top-up capabilities</td>
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<tr>
<td>Grants to MOH to use capacity</td>
<td>Promote regional use of capacity</td>
<td></td>
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<tr>
<td>Stimulate use of capacity by media and private sector</td>
<td>Support dissemination of work</td>
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<td>Upgrade skills</td>
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Centres and consultancy firms are to be strengthened. Twinning arrangements with foreign institutions to improve skills are proposed as the supply side is weak. When supply is strong, but demand is weak as in cell 4, donor use of capacity is recommended. Grants could be given to government to encourage the use of existing skills and capacity. Donor role is seen as facilitating the use of capabilities that already exist. Media, NGOs and industry could also be encouraged to use the available capacity. Twinning arrangements are proposed not merely to upgrade skills, but also to stimulate demand. The challenge in cell 3 is not one of conventional capacity building, but of facilitating the wider sharing of the skills and institutional capabilities of the health sector.

The strategic interventions proposed in the different cells are suggestive and not exhaustive. When different combinations of supply and demand exist, we can see how different strategies for capacity building suggest themselves. By bringing supply and demand assessments together, new and creative ways can be found to think about strategies for capacity building. More detailed insights into the sector context can help further refine or broaden the mix of interventions necessary for capacity building.

### IV. LESSONS AND IMPLICATIONS FOR DONORS

In this section, we present the major lessons that both donors and countries have learned over the years about capacity building. They draw upon the experiences with diverse
sectors and in different country settings. The implications of these lessons for international donors are also highlighted.

1. Conventional donor projects have often worked against the requirements of capacity building. Projects typically operate within tight budgets and deadlines and are managed by staff who may stay on the same job only for short periods. They tend to focus on project expenditures and completion deadlines, and on immediate and measurable outputs, if at all outputs are monitored. Given the pressure to complete certain project tasks, technical assistance might be used by them to bring expatriate consultants into the country to carry out these jobs, but not to worry about capacity building. Policy reform is particularly susceptible to this type of donor behaviour.

The implications of this tendency for donors are twofold. Firstly, at the project planning stage, hard questions need to be asked about the role of the proposed project in building local capabilities. Perhaps, more could be done for capacity building even under the prevailing constraints provided staff are forced to think about the issue of capacity building. Secondly, it could well be that some projects are not good vehicles for capacity building. It is because of these limitations in Africa that the World Bank along with other donors decided to launch the Africa Capacity Building Initiative (ACBI). A specially focused, long term programme rather than conventional projects was seen as the best way to address capacity building objectives in Africa. A similar logic can be seen behind the creation of CGIAR too. The basic support and leadership required to sustain complex agricultural research institutions could not have been provided on a long term basis through the standard project mode practised by most donors. Special funds and mechanisms for capacity building may provide the flexibility and autonomy project managers will require on the job and enable them to attract the kind of staff who are more in tune with capacity building objectives.

2. Capacity building efforts are likely to be more effective when designed and managed in a participative mode with national counterparts actively committed to the process. Assessment of capacity building needs must be informed by this approach. Smaller donors such as private foundations have been adept at this approach and their results clearly testify to its efficacy. The turnkey or highly technical projects of some large donors may not call for the same degree of participation and their staff are not always sensitive to capacity building needs. A major implication here is that a lot of time and effort need to be given upfront to analyse, understand and agree on what strategies are appropriate, in collaboration with local groups that have a clear stake in capacity building efforts. In setting up the IIM referred to earlier, much effort was put in to bring industry on board. IHPP held extensive consultations on the ground with clients before its strategy was designed.

3. There is no doubt that capacity building efforts tend to be dominated by a supply oriented approach. Technical experts generally assume that when capacity is
created, it will get automatically utilised in the country or sector. Under certain
conditions, this may be a valid assumption. If doctors or nurses are trained, they
probably will be put to good use. In some cases, supply may create its own demand.
When large numbers of scientists or economists are trained or research centres are set
up, demand for their services may increase. But since these investments use scarce
resources, it makes sense to pay attention to the demand side at the planning stage.
Otherwise, utilisation of capacity will remain a chronic problem. A participative
mode will naturally pay attention to the demand dimension. Most importantly, it will
alert planners to think about ways to influence the demand side, should there be
some problems with it. Important decisions like where to locate a policy analysis unit
(within government or a university) can be guided by a good assessment of the
strength of demand.

4. If demand is seen as a problem, as is clear from the diagram, donors can play
a useful "pump priming" role by directly using the capacity created. The World Bank
and other donors have given contracts to research and consultancy centres and to
individual consultants who otherwise might have remained underutilised by
government. This can also be overdone to the point that this expertise is not available
to the government when it is ready. But on the whole, such pump priming has a
positive demonstration effect and provides valuable experience to the local experts.
Donors can also encourage the use of capacity by government through the device of
small grants to ministries or agencies in order to motivate them to use the new
capabilities, especially when they operate under difficult financial conditions. In
countries that are turning liberal or democratic, support to the media and the private
sector to draw upon the newly created capacity can be productive. Encouraging
exchanges and communication between them and governments is essential not only
for the promotion of a more open society, but also for the optimal use and
productivity of the human and institutional capabilities being created.

5. Most of the interventions discussed above are not only time consuming, but
also skill intensive. Some measure of continuity will be required of those who wish to
support these efforts. Instead of donors managing such interventions directly, they
need to look for twinning arrangements for local institutions with foreign counterparts
that enjoy some credibility in the subjects involved. The Asian Institute of
Management in Manila and the Central American Institute of Business (INCAE) in
Costa Rica have had long term collaborations with the Harvard Business School. The
University of Dar in Tanzania has had a similar long term twinning arrangement in
economics with a Swedish University. Looking for and supporting such innovations
should be part of the role of donors.

6. Small countries face some special problems in the area of capacity building.
Given their lack of economies of scale and resources, creating viable institutions and
a critical mass of expertise in each country could be too costly for donors to
undertake. An important challenge here is to design acceptable arrangements to share common institutional infrastructure between countries. This will apply to training, research and advisory services though consultancy lends itself to a smaller scale operation. The Central American Institute referred to above operates in this mode in that region of small countries. The Asian Institute of Technology in Bangkok (a different subject altogether) does the same in Southeast Asia. Working out such collaborative arrangements in health policy capacity may be pertinent to some regions. One clear implication of this approach is that the institutions involved cannot be under any one government.

7. Donors vary in terms of their resources, project priorities, time horizon, and regional focus. They also vary in the degree of flexibility they can have in their project operations, funding and management. These features have important implications for the roles they can play in capacity building. For one thing, not everyone has a comparative advantage in capacity building. On the other hand, by pooling resources and working out a division of labour that makes the best use of the relative strengths of different members, donors can do a better job of supporting capacity building than if they were all to do their own thing. Thus, smaller and more flexible donors can plan and manage twinning arrangements and small grants better than their larger counterparts. The latter, on the other hand, may have greater clout in dialoguing with governments on the demand side and to pave the way for the ground level role of the smaller donors. Matching the relative competencies of different donors to specific sector contexts is also an important strategic issue.

V. IMPLICATIONS FOR DEVELOPING COUNTRY GOVERNMENTS

Most of the lessons and policy implications for donors discussed above are equally relevant to the governments of developing countries. The need to take a long term view of capacity building, the importance of planning ahead for the proper utilisation of the human and institutional capabilities being created, the role that twinning arrangements can play in the capacity building process, and the case for regional collaboration for capacity building in the case of small countries are strategic ideas that both developing country leaders as well as donors need to consider and adopt. There are, however, some other implications that are unique to developing country governments to which we turn below.

1. The creation and efficient use of human and institutional capabilities in a wide variety of fields including policy analysis is a basic challenge for all developing countries. In their preoccupation with numerous projects, mobilisation of funds and operational problems that require immediate attention, governments may sometimes get distracted from this fundamental function. In the final analysis, the pace of development and the ability to successfully respond to new problems in a society will depend on its indigenous human and institutional capabilities. A priority concern of
governments should therefore be to see how the capabilities of its civil servants can
be retained, strengthened and sustained over time. Politicisation of the civil service
that leads to the mass exodus of skilled civil servants with change of governments, as
happens in Latin American countries, can result in the inefficient use of the capacity
that already exists in the country. Broader civil service reforms need to seriously
address this issue in countries where this problem persists.

2. Policy reform capacity is a field in which governments stand to gain by
encouraging capacity building outside of government too. Multiple centres of policy
reform capacity in health, for example, will be an asset when a ministry is in need of
independent assessments and options. But to be able to draw upon such independent
centres of advice, ministries need to have in-house units with skills in formulation of
issues, identification of suitable experts/institutions, and interpretation and use of their
findings and advice. The Government of Indonesia, for example, has made extensive
use of external consultants and institutions as policy advisers. It appears that a few
senior level persons in government were adept not only in listening to the advice
from outside, but also in sifting out what was of value and rejecting the rest. Its
economic ministries did not have large internal policy units. The lesson here is that
government with limited internal policy analytic capabilities can nevertheless
generate good policy outcomes through the skilled use of advisers, both local and
foreign, who are located outside of government.

3. There is considerable scope for the use of twinning arrangements for the
development of capacity. A certain degree of dependence of one institution on
another is implied in the concept of twinning. But the process should be so planned
that dependence declines over time and a more equal relationship between
institutions becomes possible through the capacity building process. Twinning is
possible not only between foreign and developing country institutions, but also
between institutions in the same country. Thus the better developed institutions of
training, research or consultancy in a country can play a useful role in the
development and upgrading of other local institutions through long term collaborative
arrangements. Governments should facilitate this process and arrange for the
financing of such collaborations, if required. A major problem here is the lack of
information about the kinds of capabilities, both human and institutional, that exist in
a developing country. External donors often find it difficult to identify suitable
consultants and centres of expertise in different fields simply because information is
not readily available. Here again, governments as well as professional associations
can play an active role in assembling, updating and disseminating the relevant
information.

4. There is clearly a trade-off between the attention that a government needs to
give to specific policy reforms today and its willingness to invest in long term
capacity building for policy reform. When capacity building is neglected, the chances
are that its dependence on external advice to undertake policy reform will continue into the future. This is because policy reform is not a one-time task that becomes redundant once the problems of structural adjustment that many countries face today are satisfactorily resolved. The need for further reforms will emerge over time as new problems arise and as major changes occur in the national and global environments. Thus new problems could arise in the functioning of the market or of the regulatory systems in operation. Assessments of the way prices, subsidies, and new institutional mechanisms are affecting the poor may become necessary. A country needs to develop and sustain human and institutional capabilities in policy analysis, reform and implementation in order that it may effectively anticipate and respond to the new problems without having to seek external advice and support every time. Capacity building may not yield answers to the policy dilemmas and choices being faced by a government today because the process takes time to generate the needed skills and institutional strengths. It should be seen as an investment that society must make today to be more self-reliant in the future in policy analysis and reform.
REFERENCES


