

Knowledge gap nr 4. Capacity development in turbulent healthcare arenas

“Capacity development in fragile states is a highly political, and often politicized, undertaking, although the language of capacity development tends toward the technical, the bureaucratic, and the euphemistic” (Brinkerhoff, 2007).

The lack of capacity is constantly invoked to justify poor healthcare provision, as a self-explanatory statement not in need of demonstration. Arguably, the pervasive perception of a crushing capacity shortage may have its roots in searching for capacity in the wrong places, and in expecting that it manifests itself with familiar signals. The striking point is that many indigenous health initiatives have prospered without such capacity markers.

The record of interventions aimed at ‘building’ capacity is not bright. Recurrent failure says more about the intrinsic fallacy of the ‘building’ concept than the actual presence or absence of capacity in ungoverned or misgoverned contexts. The engineering image is at odds with empirical observations (Denney et al., 2015). Rarely if ever capacity is transferred or transplanted, as outsiders would desire. Rather, it emerges organically, mostly bottom-up, at several sites and thanks to the connected efforts of local actors concerned with actual problems.

State agencies, such as ministries of health, are encouraged by international partners to emulate the structure of their developed congeners (Woolcock, 2014). This model usually translates into larger, structured institutions composed of many departments interacting through hierarchical rules and procedures. Ministries recovering from decades of disarray may see their premises, working tools and employees to expand considerably. Their outputs, however, may not improve proportionally to their growth. Civil servants absorbed by internal activities or international events demonstrate in many cases a progressive loss of touch with reality. Inflated formal institutional structures may often manifest themselves in unenforceable or harmful provisions.

Given the high degree of informalisation and privatisation attained by healthcare provision, a problem-solving, task-oriented culture would be preferable to a rule-bound one. In light of the fluidity of the environment, alertness and responsiveness would be crucial assets. A broader perspective would encompass public and private actors, paying more attention to interfaces and transactions than to formal structures. Capacity-development support congruent with such a vision would take characteristics strikingly divergent from those being now mainstream.

Even in the least-promising environments, institutions are in place to respond to real problems: mid-sized hospitals, health training outlets, pharmaceutical importers and wholesalers, regional and district health authorities, professional networks, social security nets. A down-to-earth approach to capacity development would imply the review of the concrete institutions that already exist on the ground, their influence on events, and how they might be supported in their development. Such *capacity-tapping* might provide better returns than conventional approaches, while offering learning opportunities.

QUESTIONS

1. The flaws of conventional capacity-development interventions have been recognised since a long time. Why are they so resilient to correction?

2. What would capacity-tapping (as opposed to –building) interventions look like?

3. What signals would indicate real progress in capacity development?

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