Systemic capacity building: a hierarchy of needs

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'Capacity building' is the objective of many development programmes and a component of most others. However, satisfactory definitions continue to elude us, and it is widely suspected of being too broad a concept to be useful. Too often it becomes merely a euphemism referring to little more than training. This paper argues that it is more important to address systemic capacity building, identifying a pyramid of nine separate but interdependent components. These form a four-tier hierarchy of capacity building needs: (1) structures, systems and roles, (2) staff and facilities, (3) skills, and (4) tools. Emphasizing systemic capacity building would improve diagnosis of sectoral shortcomings in specific locations, improve project/programme design and monitoring, and lead to more effective use of resources. Based on extensive action research in 25 States, experience from India is presented to illustrate how the concept of the capacity building pyramid has been put to practical use.

Key words: capacity building, health sector reform, transfer of technology, India

Introduction

External international aid for development should not lead to perpetual dependency. The very concept of development implies independence. This is why effective capacity building in the health sectors of developing countries is essential. Some have even argued that capacity building is synonymous with development assistance, or that it should be the performance indicator of development projects and programmes s*ine qua non* (Berg 1993; Hawe et al. 1997; Schacter 2000; Godfrey et al. 2002). In the opening paragraph of a recent provocative and stimulating paper by Filmer et al. (2000), the authors state, 'First, institutional capacity is a vital ingredient in providing effective services. When this capacity is inadequate, health spending, even on the right services, may lead to little actual provision of services.' However, Maconick (1999) noted that the expression 'capacity building' had at the time 'no generally agreed definition . . . among the entities of the UN system' and that it 'had evolved from an earlier concept of institution building'.

So widely is the need for capacity building recognized that it has become a cliché, part of the jargon of health sector development to talk about a 'lack of capacity' or the need to develop 'more capacity', and specifically 'management capacity' or 'institutional capacity'. One of Maconick's conclusions was that 'there is a need to define more precisely or rather more operationally capacity building'. Land (1999) makes the point that 'a "systems" approach to understanding capacity development . . . can help to sort out inherent complexities, and in doing so provide a basis for strategic design'. This paper tries to provide a more useful operational understanding of the term by taking a systems perspective, and argues that a more rigorous systemic approach would lead to better problem diagnosis, better project and programme design and more effective monitoring and evaluation. The authors argue that capacity building consists of meeting a hierarchy of needs which all need to be considered in a logical order if investments in development are to pay off. This paper concentrates on this aspect, and uses as its context the Indian health and family welfare sector.

The context

In October 1998, the European Commission's (EC) largest health programme started, a sector investment programme (SIP) intended to assist the Government of India (GoI) in implementing a new policy framework for its family welfare sector. This new policy direction was the result of India's participation in the International Conference on Population & Development in Cairo in September 1994, and was described in *The Paradigm Shift* (Government of India, 1996). The SIP was a grant worth €200m, €190m given to the GoI over 5 years in tranches dependent on the achievement of various agreed performance indicators, €5m retained by the EC for monitoring and evaluation and similar support activities, and €5m for a Technical Assistance team of national and international consultants based in Delhi.[1]

One part of the Technical Assistance team's responsibilities was to work with the GoI to develop the original Financing Agreement into a practical programme of activities which would lead to the reforms outlined in *The Paradigm Shift*, taking cognisance of other emerging issues, such as the constitutional amendments giving greater emphasis to locally elected bodies (*panchyats*), and the need for better development partner (donor) co-operation. Inevitably, there was considerable demand from all quarters for the SIP to give adequate attention to 'capacity building'. However, there was considerable evidence that the many earlier efforts by GoI and external partners in previous decades had not led to significant changes, and the Technical Assistance team believed that most attempts had relied on a superficial analysis of the real organizational and systems problems within the health and family welfare sector in India. After detailed literature searches and observations of the way the

system worked at field, District, State and national levels, the authors concluded that providing training courses, buildings and equipment in the name of 'capacity building' was failing to address the real needs, was a waste of scarce resources, and at worst helped bolster systems which were corrupt and harmful to those they were supposed to assist. It also became clear that a more rigorous understanding of the concept of 'capacity building' was required.

One obvious reason for being more precise about what is meant by this expression is that currently, different stakeholders – let us say a national government and a development partner (donor agency) – may both agree that there is a lack of 'capacity' and agree that investment in 'capacity building' should take place, but they may have entirely different understandings of what is meant by the expression, about how the lack of capacity manifests itself (for example 'lack of time', 'not enough power' or 'insufficient know-how'), or about how it impacts the programme under consideration. Consequently, they may have totally different ideas about the remedial action to be taken or the investments that are needed to rectify the problem. Furthermore, proposed interventions may be further distorted by the demands of project management for measurable inputs and the exigencies of tight deadlines and pressures to disburse funds which may militate against getting to grips with longer term underlying issues. Beliefs about capacity will also influence what different stakeholders consider practicable in terms of programme performance or reforms, and the pace at which, for instance, decentralization can occur, or the extent to which 'solutions' have to be imposed from above in a predetermined way as opposed to permitting local approaches to problem solving.

Defining 'capacity building'

As things stand, it is as diagnostically useful to say 'there is a need for capacity building' as to say 'this patient is unwell'. Schacter (2000) cites authors who conclude that the phrase has become so 'all-encompassing a term as to be "useless" from an analytical and practical point of view'. For the present authors, the expression is merely a starting point for investigation and intervention. Everyone agrees that it is important, but in practice attempts to achieve it often lead to considerable wasted effort and resources, as well as frustration when investment does not lead to expected results. Land (1999) refers to the 'slipperiness of capacity building' and talks of it being 'a risky, murky business with unpredictable and unquantifiable outcomes, uncertain methodologies, contested objectives, many unintended consequences, little credit to its champions and long time lags.' Bossuyt (1994) says 'this lack of clarity on what capacity development actually means is a major obstacle to effective implementation'.

The problem is not trivial. Some would see it at the very heart of development assistance and its failure. Even in financial terms it is a significant element of aid. Yet it continues to be used superficially. A major new US$4bn fund for health is to have 5% 'earmarked for capacity building', according to a conference of African Ministers of Finance supported by

UNAIDS (UNAIDS 2001). An undated but recent document on the WHO website says, 'Governments considering taking on the procurement task must build capacity with support from technical experts to ensure a safe and reliable supply of vaccine at a fair price' (WHO undated). A UN Foundation website invites contributions on building capacity for conflict prevention strategies, but it seems to be little more than consultant-speak included in the title simply to attract attention, because the text offers no definition and instead goes into strengthening common country assessments (UN Foundation 2001).

Pielemeier and Salinas-Goytia (1999) openly admit that 'the concept of capacity-building is not necessarily different from concepts such as institution-building, institutional strengthening, development management and others'. They point out that in their view (and ours), 'capacity-building . . . emphasizes the creation or strengthening of capacity for programme execution independent of the permanence of an institution'. We would go further and say that it should enable programme execution independent of changes of personalities, technologies, social structures and resource crises, i.e. it implies developing sustainable, *and robust*, systems. In the same volume, the context of Maconick, Pielemeier and Salinas-Goytia's work was a UN review of the impact of capacity building in its various projects and programmes for its triennial review in 1998.

At worst, the expression has become an over-pompous synonym for training, even worse than the expressions 'staff/human resource development'. Under the title 'Putting the capacity into capacity building in South Sudan', an article in *The Lancet* stated that 'In the past many international training efforts have simply not gone far enough. This is not surprising, since achieving the right balance between providing crucial health services and teaching and supporting local people to provide them – i.e. "capacity building" – in such cases is difficult' (Bower 2000). This example, in which the author seems to equate capacity building with training/support, could be multiplied many times, but is somewhat surprising because it was written by one of WHO's information officers, and WHO itself has published a very useful paper which seeks to develop the concept of capacity building as a more subtle, analytical concept (Paul 1995). Paul takes as his starting point the meaning of 'capacity' in the technological sense, and his proposed definition 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 . . . The focus of capacity building therefore tends to be on improving the stock rather than on managing whatever is available.' Whether this definition is helpful in terms of practical application is questionable, but Paul makes many important points about the feasibility of assessing the real needs and suggesting various dimensions that might be used in such an analysis. In particular, he rightly lifts the concept beyond mere training: 'It is unlikely, however, that investment in knowledge in the intellectual sense is all that is required for capacity building'. Berg (1993) and Bossuyt (1994) have also made many practical suggestions to place capacity building more centre stage and increase its

effectiveness by focusing on better design of assistance, and the latter very rightly makes explicit links to governance issues.

Ballantyne (2000) pulled together a variety of quotations and definitions from various sources, but as he says, 'everyone probably has a "gut feeling" for what capacity building means' and he notes that if we compared the quotations, 'we would probably find a huge variation in interpretations'. Paul (1995) attempted a more detailed analysis and argues that capacity building is a sub-set of institutional management, which itself is a sub-set of something called good management. As we have seen, Filmer et al. (2000) talk about 'institutional capacity' and Maconick (1999) notes that 'capacity building. . .had evolved from an earlier concept of institution building'. Currently, capacity building and capacity development are being used interchangeably, and sometimes the terms are hyphenated, sometimes not. The present authors believe that it is better to think of 'systems capacity' and to recognize that there is a hierarchy of needs which must be considered, each requiring its own strategic response.

In everyday use, in dialogue between government officials, external consultants and others, the term is employed most frequently to imply that there is a lack of skills which needs to be solved by training, i.e. people simply do not know how to discharge their functions properly. At other times it is used as though there is a lack of time, money or authority to do all the things expected, and so the proposed solution is for more pairs of hands (extra staff, hiring consultants or setting up a discrete project implementation unit), or for a computer, vehicles, a bigger budget, or greater devolution of powers. Yet another use is as a synonym for lack of institutional capacity, so the proposal is to build more training schools or research institutions.[2]

Capacity building: the Indian experience

Some examples from the Indian health and family welfare sector can be used to illustrate these points. (A fuller historical descriptive account of the sector can be found in Ojha and Das (1999); Mosse and Cassels (1996) provide an incisive analysis of the problems and needs of the sector.) In the mid-1990s it was felt that there was 'insufficient capacity' among medical officers in districts and 'blocks' (a block is an Indian administrative unit consisting of approximately 100 000 people) to carry out 'micro-planning'. Suddenly, large numbers of doctors were being sent off to various institutions to learn how to micro-plan their services. Content and teaching materials were developed with assistance from development partners, and there were no doubt even components for training-of-trainers and for evaluation.

But the reality is that planning in the sector is strongly top down: from the National Planning Commission, through the Ministry of Health & Family Welfare and its three departments, through the State ministries and departments; and it often takes the form of explicit targets for vertical programmes. The doctors who were trained had almost no opportunity to use the skills taught, even if they were taught well. Similarly, supervisors were sent on courses to learn

about 'supportive supervision', but the employment practices in the sector are such that neither effective disciplinary powers nor incentives exist in the system to back up supervision (whether supportive or otherwise). There may have been a lack of capacity in terms of skills, but training alone was largely a waste of effort and resources because of a more serious lack of *systems* capacity to address the real problems.

As a third example, it was believed that the country had insufficient capacity to deliver high quality training in the sector. Consequently, a National Institute of Health & Family Welfare (NIHFW) was recognized as the apex institution, and under it, states would develop State Institutes of Health & Family Welfare (SIHFWs). The SIHFWs would provide advice and training to lower-level training institutions, monitor their performance, provide training-of-trainers courses, advise the state bureaus of H&FW (the actual arrangements differ from state to state), develop training materials, etc.

At considerable expense (usually loans from development partners who readily accepted the 'lack of capacity' mantra) many SIHFWs were constructed, with residences for staff, an auditorium, computer labs, and dormitories. But the staff they were allocated (if and when they were allocated any) were not matched to the intended objectives of the new institutions. Instead of experts in adult learning, for example, the same motley collection of demographers, medical officers and temporarily displaced bureaucrats typically found in the lower-level institutions were found at the SIHFWs. Training posts are often seen as punishment posts by medical officers, and little was done to enhance the status or desirability of such positions. The SIHFWs were generally not given responsibility by the state bureaus to monitor and advise them on the training programmes carried out by lower levels. The faculty were not appointed to the boards of lower level institutions to act as linking pins (Likert 1961). No proper mechanisms were built between the NIHFW and the SIHFWs.

Once they were built, the institutions became white elephants, delivering more of the same old courses based usually on learning by rote and lectures. Currently, the mood is towards making them independent institutions so they can only survive by providing what the market wants – but the money was borrowed and spent to create strategic centres which would do more than just sell courses. Their strategic potential has been lost. Yet the lessons have still not been learned, and the present authors recently had to resist a State Minister of Health who was trying to persuade them to fund a number of community teaching centres 'because there is no capacity. . .'. The sense of *déjà vu* is a common one in development work.

Investing large sums of money in new clinics, hospitals, or institutions such as SIHFWs is a complete waste of effort and money if their role and staffing are not carefully thought through, or the wider organizational context is not changed at the same time. Extra capacity in the sense of increasing *volume* (whether of beds or training places) will rarely have an impact unless there is obvious overcrowding already. But

it is a nice, easy response for governments and development partners alike.

In India, as in many other countries at a similar stage of development, there clearly are problems with 'volume capacity' in the sense that there are too few staff (or at least, too few of the right staff in the right place) and/or too few facilities. There are no doubt problems of intellectual or skills capacity which require training. These adversely affect the ability of programmes to deliver to their full potential. But the primary capacity problems (in the sense of what needs to be tackled first) in the Indian health and family welfare sector (and in most of the other dozen or so similar countries the authors have worked in) are to do with 'systems capacity'. An organizational *system* is composed of a network of *programmes* of services*, staff, facilities, structures (*forums for discussion and collective decision-making such as management boards, committees, etc.), and *processes* of supervision, decision-making, information passing, financial flows, and so forth. In India, there is usually a lack of capacity in terms of structures and processes which allow health workers/managers and facilities to fulfil their potential.

To give another specific example, it has been observed that performance at district or central department levels is closely linked to the quality of the person in the post, but in India the rate of change of key personnel can be very high, especially nodal officers drawn from the Indian Administrative Service (IAS). For example, in the 10 active states with which the European Commission-assisted Health & Family Welfare Sector Programme was working over the 18-month period to December 2000, three states were on their fourth Health Secretary or equivalent senior person responsible for the sector, and four states were on their third. However much one trains the staff around these key people, whatever increase in institutional volume may be made, their frequent change may prevent any performance improvement unless the management and decision-making processes are made largely independent of the individual. The issue is the *organizational capacity to cope with the frequent changes*. This, in turn, raises questions about the system's decision-making processes, reporting processes, resource allocation processes, etc.

Systemic capacity building: a hierarchy of capacity needs

Rather than attempt to develop one definition which covers all of the ways in which such complex socio-cultural situations lack capacity, the authors believe it is better to recognize that there is a hierarchy of capacity building needs. It is also possible to identify a superficial, sub-optimal approach to capacity building, and a more effective one.

The EC Technical Assistance team spent many months in action research at all levels exploring why doctors, managers and other staff failed to provide effective services. What became clear was that administrative and organizational arrangements systematically undermine individuals' attempts to make effective decisions, provide quality services or perform their work properly. However talented the person might be, however much training they received, however many buildings, drugs or items of equipment they were provided, the overall system inhibited effectiveness. Poor supervision, lack of accountability, fragmentation of too many vertical programmes imposed from above, slow disbursement of budgets, lack of authority, corruption and lack of attention to support systems, such as maintenance, laboratory and information systems, destroyed confidence and initiative.

Worse still, the way the administration system is designed means that there are not even the forums and monitoring systems which might reflect on the shortcomings in a meaningful manner. A mixture of vested interests, rapid transfer of senior officers and archaic file-based administrative systems prevents serious analysis or change from occurring. Development partners and observers have pointed out the difficulties time and time again, but as long as project funds keep flowing, the GoI has been under no pressure to take complaints seriously.

The EC Technical Assistance team began to collect evidence showing that capacity building can be approached systematically using the series of interconnected levels shown in Figure 1. As shown in Box 1, the authors differentiated nine separate but interdependent components of the unitary concept 'capacity building'.

These groups may then be organized in a logical hierarchy (as in Figure 2) to show how the effectiveness of one form of capacity depends on, and builds on, the effectiveness of other forms of capacity building. The pyramid can be thought of as a prism (see Figure 3).

By systematically applying the pyramid to the system and asking what the capacity shortfalls are in terms of each component, a better understanding of the organizational shortfalls can be assessed and a more logical approach taken regarding where action is needed most. For example, there is little point training staff if they are not going to be allowed to use the skills or techniques taught, or if lack of consumables or power means that it is impossible to treat patients.

Figure 4 shows how the levels in the hierarchy can be given summary labels and placed on a graph of complexity against time.[3] Superficially throwing money at 'worthy' schemes like additional buildings and training courses merely wastes resources, breeds cynicism and corruption, and ultimately undermines the very process it is designed to achieve: improved capacity and less dependency.

Although on paper the sequencing looks as if interventions to improve capacity may be planned logically, in practice, change is likely to be iterative. Attempts to improve personal capacities lead to recognition that better equipment services are needed or that better supervision and new sorts of meetings are needed. This leads to identification that budgetary arrangements are too centralized, but more budgeting responsibility means more training courses for the staff concerned. This matches the experience of the Tavistock Institute's action research on organizational transformation:
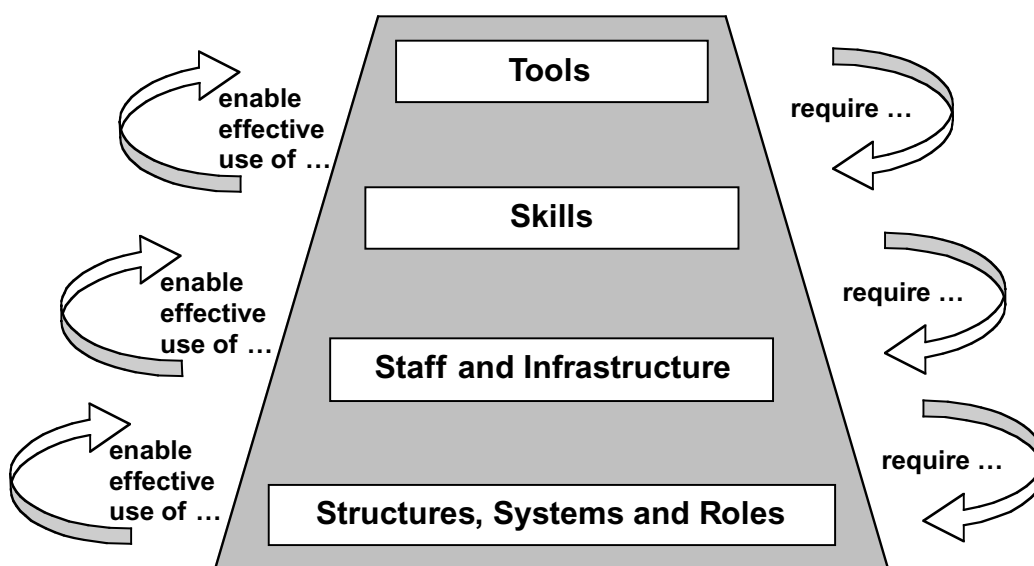
Figure 1.   Capacity pyramid

Box 1.   Nine component elements of systemic capacity building

- *Performance capacity*: Are the tools, money, equipment, consumables, etc. available to do the job? A doctor, however well trained, without diagnostic instruments, drugs or therapeutic consumables is of very limited use.

- *Personal capacity*: Are the staff sufficiently knowledgeable, skilled and confident to perform properly? Do they need training, experience, or motivation? Are they deficient in technical skills, managerial skills, interpersonal skills, gender-sensitivity skills, or specific role-related skills?

- *Workload capacity*: Are there enough staff with broad enough skills to cope with the workload? Are job descriptions practicable? Is skill mix appropriate?

- *Supervisory capacity*: Are there reporting and monitoring systems in place? Are there clear lines of accountability? Can supervisors physically monitor the staff under them? Are there effective incentives and sanctions available?

- *Facility capacity*: Are training centres big enough, with the right staff in sufficient numbers? Are clinics and hospitals of a size to cope with the patient workload? Are staff residences sufficiently large? Are there enough offices, workshops and warehouses to support the workload?

- *Support service capacity*: Are there laboratories, training institutions, bio-medical engineering services, supply organizations, building services, administrative staff, laundries, research facilities, quality control services? They may be provided by the private sector, but they are required.

- *Systems capacity*: Do the flows of information, money and managerial decisions function in a timely and effective manner? Can purchases be made without lengthy delays for authorization? Are proper filing and information systems in use? Are staff transferred without reference to local managers' wishes? Can private sector services be contracted as required? Is there good communication with the community? Are there sufficient links with NGOs?

- *Structural capacity*: Are there decision-making forums where inter-sectoral discussion may occur and corporate decisions made, records kept and individuals called to account for non-performance?

- *Role capacity*: This applies to individuals, to teams and to structure such as committees. Have they been given the authority and responsibility to make the decisions essential to effective performance, whether regarding schedules, money, staff appointments, etc?
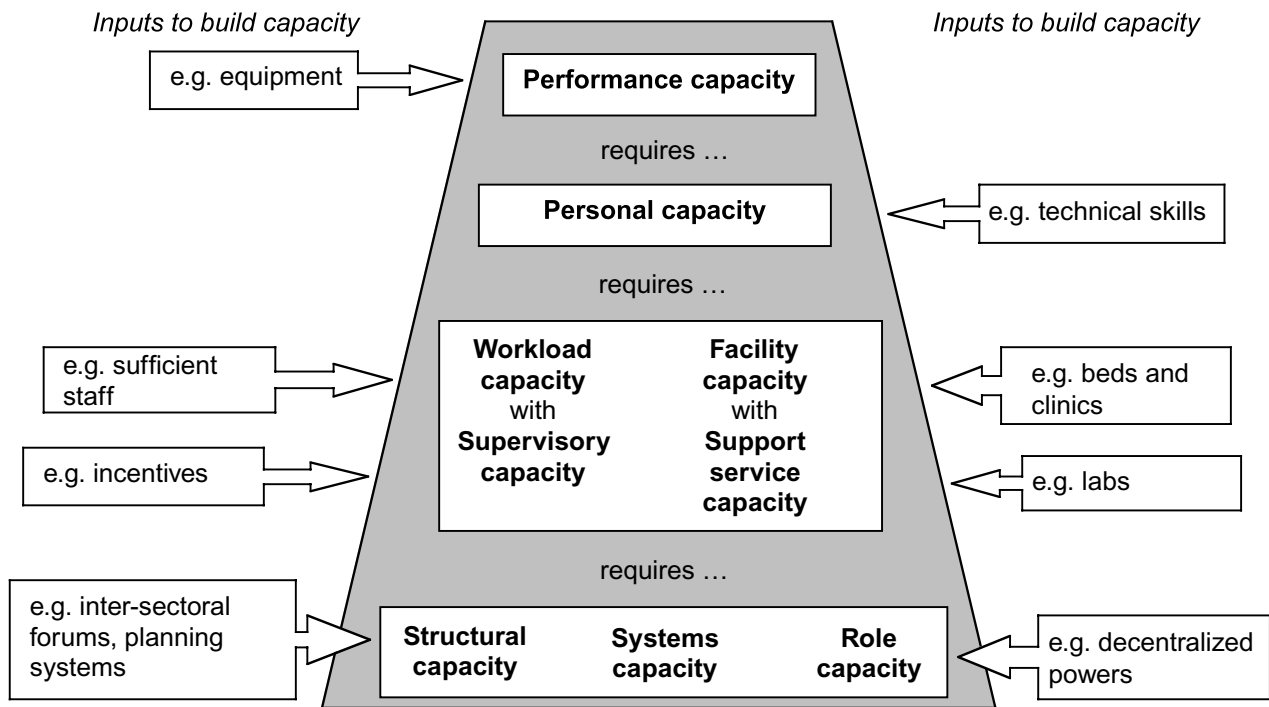
Inputs to build capacity   *Inputs to build capacity*

e.g. equipment → **Performance capacity**

requires …

Personal capacity ← e.g. technical skills

requires …

e.g. sufficient staff → **Workload capacity** with **Supervisory capacity**   **Facility capacity** with **Support service capacity** ← e.g. beds and clinics

e.g. incentives → ← e.g. labs

requires …

e.g. inter-sectoral forums, planning systems → **Structural capacity**   **Systems capacity**   **Role capacity** ← e.g. decentralized powers

Figure 2.   Pyramid of effective capacity building

Component elements of systemic capacity building

Tools   ➢ *Performance capacity*

Skills   ➢ *Personal capacity*

System to be strengthened →

Staff and Infrastructure

➢ *Workload capacity*
➢ *Supervisory capacity*
➢ *Facility capacity*
➢ *Support service capacity*

Structures, Systems and Roles

➢ *Systems capacity*
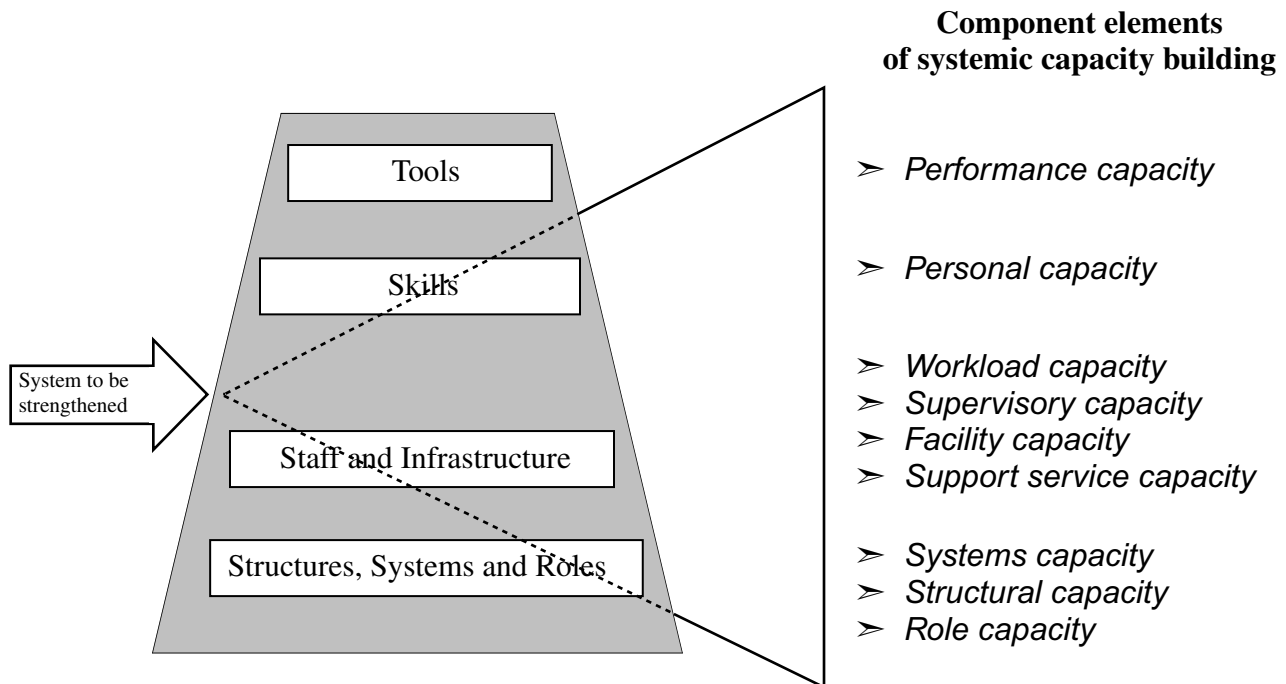➢ *Structural capacity*
➢ *Role capacity*

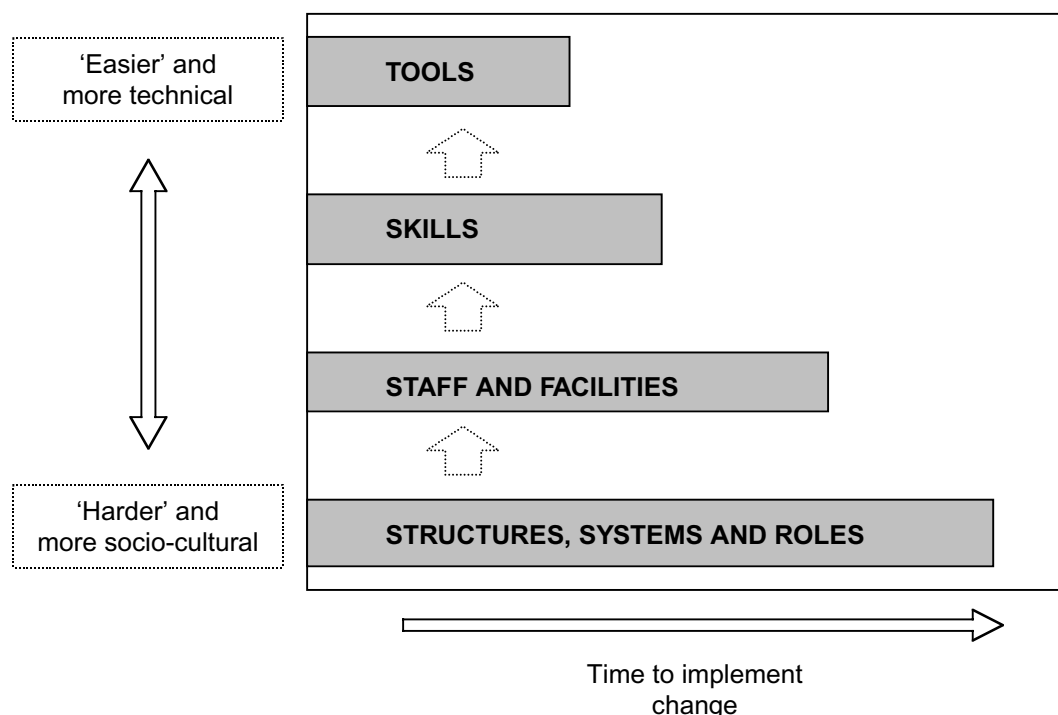**Figure 3.**   Capacity pyramid as prism

Figure 4. Complexity/time dimensions of capacity building

'the planning of change usually needs to be an iterative process. Many blocks to change and opportunities for development become visible only once the process has started' (Holt and Nuemann undated).

Without adherence to a rational structure, interventions aimed at building capacity are likely to achieve (the all too common) sub-optimal results, as in Figure 5.

Better diagnosis

To appreciate which capacity building initiatives are most likely to lead to better results requires what ethnologist Clifford Geertz famously called a 'thick description' of the contexts within which we work, with a much fuller appreciation of the realities of the way decisions are made, the way information and money flows around, the limitations on personal or team activity, and so on (Inglehart 2000). Paul (1995) proposed a two by two matrix to assist in developing appropriate strategies for capacity building in different countries. His matrix assessed both supply and demand sides as weak or strong, providing four different scenarios (Figure 6). This is very helpful, but the authors believe that such a strategic assessment must be given a finer focus by addressing each of the nine different interacting capacities identified here.

The EC Technical Assistance team and their GoI counterparts used a variety of techniques, including maturity matrices, 'fish-bone' analysis, semi-structured interviews and algorithms, to try to reach consensus on the systems problems that actually created bottlenecks and inefficiencies. They used these findings to build consensus about what

systemic reforms might bring about improvements congruent with GoI expressed policies.

Applying the model: the Indian experience

As a result of using this approach to systemic capacity building, the EC Technical Assistance team and the GoI identified some particularly disabling problems in the sector. The whole approach to community needs assessment and district planning described in *The Paradigm Shift* was actually the same old top-down target setting as before, interested not in the epidemiological needs or the expressed wishes of the community, but only in scheduling a handful of central priorities. These, along with vertical programmes being funded largely by external agencies, fragmented services rather than addressing the holistic primary health care needs of individuals, families and communities. At the district level, there was no effective mechanism for identifying needs, planning interventions or managing services. District chief medical officers currently have no compulsory management or public health training (except in Gujarat and Maharashtra). The decentralized bodies were left out of arrangements in most states (Kerala was a notable exception). At state level the central dysfunctional split into departments of health and departments of family welfare is replicated, with serious fragmentation of planning and decision making. Similarly, in most states there was little or no co-ordination of external development partners.

As part of the SIP, therefore, the EC Technical Assistance team and GoI initially introduced new organizational structures in 12 states and 20 districts. At district level, new Health

Technical training and equipment supplied, but relatively ineffective because staff overstretched, facilities are dilapidated, and powers to refurbish remain centralized.
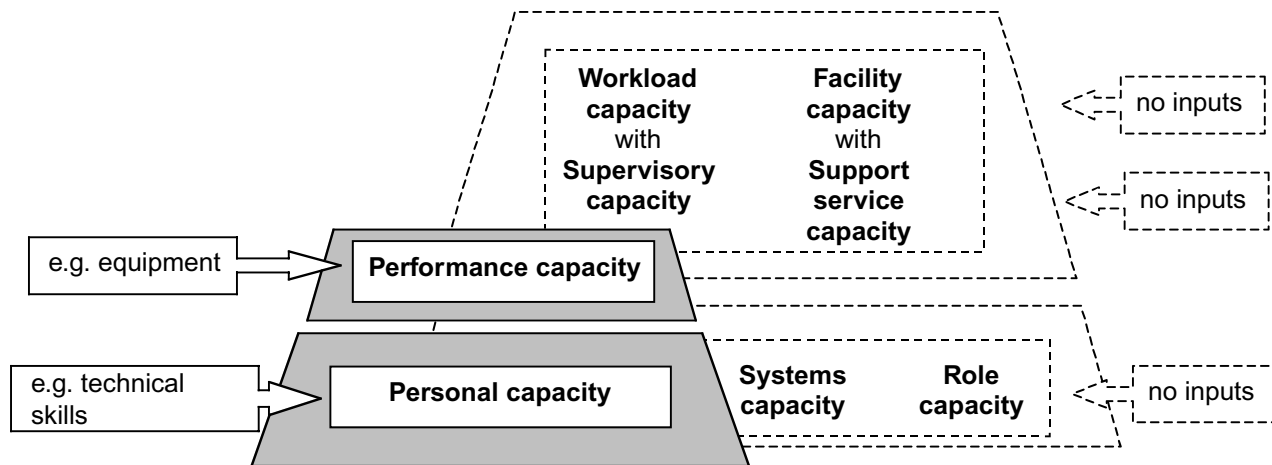

Figure 5. Sub-optimal capacity building

		Demand	
		Weak	Strong
Supply	Weak	➢ Invest in long-term training ➢ Study tours for policymakers ➢ Donor dialogue with government to stimulate demand **1**	➢ Support government unit ➢ Create autonomous capacity/centres ➢ Invest in consultant capacity ➢ Twinning arrangements **2**
	Strong	**3** ➢ Use of capacity by donors ➢ Grants to MOH to use capacity ➢ Stimulate use of capacity by media and private sector ➢ Upgrade skills	**4** ➢ Top-up capabilities ➢ Promote regional use of capacity ➢ Support dissemination of work

Figure 6. Strategic interventions

& Family Welfare Agencies were introduced which subsumed the rash of existing semi-autonomous groups that dealt mainly with disbursement of external aid money but had virtually no planning or management function. These bodies involved representatives of cognate government departments, NGOs and the wider civil society. They were given various degrees of authority within different states but were all expected to start addressing holistically the wider primary health care needs, up to and including first referral hospital services. Despite only starting with 20 of India's nearly 600 districts, within a short time several state governments passed orders facilitating setting up these bodies throughout their states. This process is underway and at the time of writing, the SIP directly supports these new organizational structures in over 50 districts and cities.

At state level, Sector Reform Cells were established, which again were intended to provide forums where a variety of stakeholders could sit together and analyze problems and construct corporate responses, including better co-ordination of external agencies. Starting with 12 states which showed initial interest, the SIP now works with 24 of the country's 35 States and Union territories. A new 12- to 13-week training programme in Public Health Management was introduced at the National Institute of Health & Family Welfare, which is being rolled out to regional centres with a view to training at least three people in every district in India in the basics of epidemiology and management. The course itself teaches participants to reflect on systems problems and how they can develop systemic capacity building. At national level, the emphasis has been on trying to stop centralized

'cookie-cutter' planning for change and to encourage decentralization of design with more emphasis at the centre on monitoring and facilitation.

The headlong rush to build peripheral primary health care buildings or hospitals without properly assessing why existing buildings are ineffective has been a particular focus of the EC SIP. At all levels the GoI has been encouraged to think through which of the nine capacity building components are priorities, and how this varies from state to state, location to location. In this way, National, State and District plans have increasingly begun to prioritize systems changes and reform – including greater use of third party providers – rather than traditional project components. Consequently, all concerned have more confidence that investments may actually begin to address the health care needs of communities, and not merely the vested interests of a few officials and politicians.

The approach also enabled the EC Technical Assistance team and GoI to address more systematically the problem of monitoring and evaluation. It is easy to count the number of training courses or participants, to report the numbers of syringes or refrigerators purchased, or the buildings constructed. But as anyone who has ever worked in the field knows, this often has no connection with the outcome indicators measuring the impact on people's health status. The reason is clear. Unless systemic capacity building is addressed, training courses and purchases leave the health workers and managers as ineffective as before. By demanding to know more precisely *how* an intervention is going to impact an agreed problem, it is possible to look for process and outcome improvements and not just input-related benchmarks and milestones. This was particularly important in the context of the SIP because the grant was performance-linked.

Conclusions

In India, as in most countries coping with large populations at a relatively low level of economic development, there is without question a 'lack of capacity' in the sector, but it is primarily a lack of *system capacity*, i.e. *organizational systems* and *processes*, linked to too few people being allocated *role capacity*, rather than a mere lack of training or institutions. Empowering people, whether communities, health support workers, doctors, or managers, means greatly increasing the system's 'capacity' by creating processes that continue through time and are more or less immune to changes of individual staff and outside interference, and setting up structures that 'institutionalize' those processes and involve a much wider range of stakeholders in 'management'. Issues such as transparency, giving responsibility for formulating options and proposals to others and setting up bodies that can act across sectors are all part of the considerations. Unfortunately, instead of being the last need to be addressed, *facility capacity* is too often the first straw to be grasped at, supported by *personal capacity*. But without addressing the more basic needs, newly constructed facilities inevitably fail to perform well, and the investment is soon wasted. Simply offering more training can be a cynical exercise in blaming the victims, and handing out ever more buildings and equipment enables vested interests to give the impression of addressing the needs of their people while actually continuing to exploit them.

It is surely time for governments of countries struggling to improve their health services, and for development partners ostensibly trying to support their efforts, to move beyond the mantra of 'lack of capacity' and the ineffective placebos of equipment, training and construction. By addressing systemic capacity building as a hierarchy of components in which the less tangible are the most important, the authors believe significant improvements could come about in the way development aid resources are used.

Endnotes

[1] A further grant of €40 million was added after the earthquake in Gujarat in January 2001, specifically to assist worth redevelopment in that state.

[2] The *Concise Oxford English Dictionary* offers several definitions for the word 'capacity', *inter alia*:

> 1.a the power of containing, receiving, experiencing, or producing
> 1.b the maximum amount that can be contained or produced, etc.
> 1.c the volume, e.g. of the cylinders of an internal-combustion engine.
> 2.a mental power
> 2.b a faculty or talent
> 3. a position or function (e.g. in my capacity as a critic)

These definitions indicate how and why the term might be applied in the context of development in different ways and thereby cause confusion. To take the first set of definitions to do with physical space to contain something, it is obvious that a training school or a hospital can be described as having insufficient capacity if the demand by students or patients is greater than, for example, the classroom size, dormitory accommodation, bed numbers, or number of key staff.

Definitions 2a and 2b may also be applied in the sense that 'the doctors (or managers, or technical staff) do not have sufficient capacity', meaning they do not have the skills for a particular medical or managerial function. Equally, to say that a system lacks capacity may mean that its various key workers collectively do not have the skills, but such a meaning is quite different than that in the previous paragraph.

The third use of the term refers to the role a person is called on to play, and it would be perfectly legitimate to say that the system does not have the managerial capacity in that there are no officers with the social or legal role as managers. Or that the system does not have the decision making capacity, because key managers or clinicians are not given the role of decision makers. The analysis that doctors 'do not have management capacity' may be used to mean they do not have decision making capacity. But does this mean they do not have management skills so they need to be trained in management techniques such as problem solving? Or that the organizational culture denies them the role of decision maker (formally or informally, explicitly or implicitly) so that no amount of training will make any difference, nor will any amount of investment in new schools or clinics?

So we may agree when we say a cadre of staff in a district, or an institution, or even a sector as a whole, does not have sufficient management capacity, but we can mean that the staff concerned:

> • do not have the knowledge or skills, so there is a need for training or help from consultants or institutions;
> • are insufficient to do all the work, so either they need to be supplemented with additional pairs of hands, or their workload and priorities need to be reconsidered;

- do not have the tools to do the job, such as computers, vehicles, support workers, etc.;
- do not have a clear role in the (formal or informal) system of decision making, resource allocation, supervision, etc., to have a managerial impact (and there is the related wider issue of the constraints of general government regulations on a particular sector);
- are not supported by appropriate organizational arrangements, such as clear lines of accountability or forums for formal decision-making.

It will be clear that any or all of these may be true, but that the most effective solution and investment will depend on the extent to which each is true, and how the factors interact.

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