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Four approaches to capacity building in health: consequences for measurement and accountability

BETH R. CRISP, HAL SWERISSEN and STEPHEN J. DUCKETT
Australian Institute for Primary Care, Faculty of Health Sciences, La Trobe University, Bundoora, Victoria 3083, Australia

SUMMARY

The term capacity building has been used in respect of a wide range of strategies and processes which have the ultimate aim of improved health practices which are sustainable. After defining capacity building, this paper explores the processes and strategies associated with four distinct approaches to capacity building, considers the role of funding bodies and begins to question how these factors impact on the evaluation of capacity building.

Key words: capacity building; health programs; funding; measurement

INTRODUCTION

Australian health policy developed at the close of the 20th century not uncommonly refers to 'capacity building' as either a strategy for achieving a healthy society or as an objective in its own right. Among other assumptions, this reflects a growing recognition of the importance of 'social capital' for the health outcomes of communities (Putnam, 1993). Individuals, organizations and societies can all gain through building social capital which involves developing high levels of co-operation, reciprocity and trust as members of the community work together for mutual social benefit (Gillies, 1998). Underpinning the achievement of these goals typically involves a process of capacity building (Pollard, 1999).

While one could be forgiven for thinking that the term 'capacity building', which in some quarters is associated with program maintenance after cessation of limited term funding, is a not unexpected consequence of 1990s-style economic rationalism, such assumptions are wrong. Rather, capacity building has its roots in a range of disciplines which in the 1970s flew the flag for empowerment, e.g. community development, international aid and development, public health and education. Although these traditions are somewhat inter-related and have, to varying degrees, been concerned with developing healthy communities, it is perhaps not surprising that 'capacity building' as a term has been conceptualized in a diverse range of ways and associated with a plethora of meanings (Selsky, 1991; Hawe *et al*., 1997). However, while there has been recognition for some time that capacity building is not a unitary term, much of both the academic literature and policy documents concerned with this topic are seemingly oblivious of this fact.

After defining capacity building, this paper explores the processes and strategies associated with four distinct approaches to capacity building, considers the role of funding bodies and begins to question how these factors impact on the evaluation of capacity building.

CAPACITY BUILDING

While capacity building has been applied to interventions aiming to produce sustained change at

levels ranging between the individual and entire nations (Sajiwandani, 1998), organizations are typically an integral component of health capacity building. Based on our reading of the literature, we believe that there are four main approaches and within each of these a range of strategies would appear to have potential for capacity building. The four approaches we have identified are: (i) a top-down organizational approach which might begin with changing agency policies or practices; (ii) a bottom-up organizational approach, e.g. provision of skills to staff; (iii) a partnerships approach which involves strengthening the relationships between organizations; and (iv) a community organizing approach in which individual community members are drawn into forming new organizations or joining existing ones to improve the health of community members. Although each of these approaches individually is sometimes referred to as being capacity building, changes in one domain (e.g. in the individuals who comprise the organization, the policies and practices of the organization, or the relationships between organizations), will often impact on other domains. Indeed it is sometimes argued that capacity building has not occurred unless more than one domain has been impacted upon (McLaughlin *et al.*, 1997).

Notwithstanding the belief that change is possible, it is often difficult for organizations to change or develop without external assistance or unless incentives exist. Thus, capacity building typically involves the provision of financial and/or other resources to organizations from external sources. Such resources are provided on the condition that they will produce future benefits in addition to immediate ones (Elmore, 1987; Hugo, 1996). However, the aim of such conditions is not to enable the external provider to control the projects it has resourced, but rather the aim is to 'increase the self-sustaining ability of people to recognize, analyse and solve their problems by more effectively controlling and using their own and external resources' [(de Graaf, 1986), p. 8].

When assisting organizations or communities to gain control over health issues which affect them, there is a need to ensure that dependence on a funding body, or other external sources, does not result. While it is accepted that capacity building is not a fast process and may take several years (Amodeo *et al.*, 1995; Chavis, 1995), an underlying principle is that external resources are provided for a time-limited and not indefinite period. Moreover, these external resources are provided with the recognition that communities, and the individuals and organizations which are a constituent part of them, can increase their capacity to tackle health problems by the 'nurturing of and building upon the strengths, resources and problem-solving abilities already present' [(Robertson and Minkler, 1994), p. 303; see also (Murray and Dunn, 1995) and (Bellin *et al.*, 1997)].

Although external resources are only provided for a limited period, the aim of capacity building projects is improved community health practices which are sustained. However, there is no agreement as to what is meant by sustainability (Shediac-Rizkallah and Bone, 1998). While planning for sustainability of programs has sometimes been interpreted as ensuring their adoption and maintenance by local organizations (Schwartz *et al.*, 1993; Bracht *et al.*, 1994), this aim is not necessarily consistent with the idea that capacity building is a dynamic process (Bellin *et al.*, 1997). Instead, although organizations or communities may initially be funded to tackle one health problem, capacity building will hopefully add new health targets or result in change of focus rather than ceasing health promotion work after a period of time (Wickizer *et al.*, 1998).

In summary, we would argue that irrespective of the processes and strategies used to achieve capacity building, this term can be applied to interventions which have changed an organization's or community's ability to address health issues by creating new structures, approaches and/or values. These will be ongoing without need for future funding. However, this approach which produces systemic change should not be equated with the provision of short-term pilot or demonstration funding which improves an organization's or community's ability to attract ongoing funding from other sources to address health issues.

PROCESSES FOR CAPACITY BUILDING

Having identified four distinct approaches which have been advocated as being capacity building, the processes and strategies which contribute to each will be examined separately.

Bottom-up organizational approach

The development of technical expertise is often considered to be essential for organizations so that they can plan, implement and evaluate appropriate health programs and measures (Meissner *et al*., 1992; Schwartz *et al*., 1993). Underpinning this approach is the premise that developing a core of well-trained individuals decreases reliance on external consultants and increases local capacity to sustain efforts when funding ceases (Herman and Bentley, 1992). The need to acquire expertise applies to both direct service providers as well as to health bureaucrats (Meissner *et al*., 1992). While capacity building may involve further training in a health specialization (Chalmers, 1997), broadening the skills of generalist health workers can also have strategic benefits (Poncelot and de Ville de Goyet, 1996).

This approach focuses on training members of the organization and providing them with skills and knowledge which is not only beneficial to the individuals concerned but more importantly to the organization and the wider community:

> …. development is in the end and in the final test, the development of people. However, this should not be understood in a narrow, individualistic sense: I am not talking about individual improvement, enrichment, education or influence. In fact such individualized changes are very often obstacles to sustained development as it leads to increased inequality, waste of social resources, conflict and competition [(de Graaf, 1986), p. 15].

For organizations to reap the benefits of what may be considerable investments in the training process, how trainees are selected, trained and provided with opportunities to utilize their newly acquired skills and knowledge is crucial (Rist, 1992; Godlee, 1995). In a report on fellowships funded by the World Health Organization, Godlee (1995) seriously questioned whether the program met its capacity building objective, given some recipients were awarded fellowships as a reward for long service within national health administrations rather than their ability to use the fellowship to contribute to the health of their constituency. Consequently, it was hardly surprising that many recipients were expected to return to their previous positions with no expectation that they may use any skills or knowledge obtained in their period of training.

Rather than sending staff to training outside the organization or bringing in external consultants to conduct training programs, it has been argued that a more effective means of building capacity is for organizations to become committed to continuous learning and improvement. Thus, rather than teaching new skills and knowledge, staff are encouraged to become 'reflective practitioners' both individually and collectively with the expectation that this will lead to health programs which are more responsive to community needs (Hall and Best, 1997).

Top-down organizational approach

Building and sustaining capacity requires organizational capacity as well as the expertise of individuals (Grisso *et al*., 1995; Rist, 1995). Training programs must be facilitated within organizations through decision-making processes which ensure that staff are able to participate. Organizational infrastructure typically also includes non-personnel resources which in their presence or absence contribute to capacity. However, co-ordination and planning are often necessary to ensure resources, e.g. personnel, equipment and facilities can be mobilized when required (Poncelot and de Ville de Goyet, 1996), and quality assurance systems may be necessary to determine whether an organization is performing optimally or to assist it to learn and improve (Muller, 1996).

In some cases, increased capacity may be acquired through organizational restructuring. For example, the Ghana Leprosy Service became a more responsive and effective health agency by devolving the planning and implementation of programs from a single central agency to a regional or district level at which programs could be developed taking into account the varying needs and health issues within regions by becoming integrated into the primary health care programs at a district level (Bainson, 1994).

Capacity building efforts focused only on changing the institutional headquarters and not at the local level will have limited impact (Babu and Mthindi, 1995). Again, some form of restructuring which enables organizations to be more responsive to existing and emerging health issues may result in enhanced capacity. Such thinking resulted in the activities required for certification of local health departments in Illinois changing to focus on practices and processes rather than functions. Prior to these changes occurring in 1993, these were specified as program areas, e.g. 'Food sanitation' and 'Chronic disease'. By way of contrast, the revised standards

were concerned with the processes to identify and address health issues, e.g. 'Assess the health needs of the community' and 'Evaluate and provide quality assurance'.

Sometimes it is the policies and practices rather than the structure that restrict organizational capacity. Having identified women's health issues as not being a current research priority, the University of Pennsylvania Medical Center recognized that it was important to facilitate training initiatives related to women's health and remove some of the structural impediments which prevented such research being undertaken. This resulted in changes to the curriculum for medical students and the provision of research grants in this priority area (Grisso *et al*., 1995).

Partnerships

The development of partnerships between organizations or groups of people who might otherwise have little or no working relationship is another approach to building capacity (Chavis, 1995; Marty *et al*., 1996). This approach is based on the assumption that providing possibilities for the two-way flow of knowledge can lead to partnerships through which the resources required to plan and implement health programs may emerge. This is especially so if prominent members of the community, including community leaders, community advocates and representatives, as well as health professionals who can facilitate health promotion efforts, are involved (Wickizer *et al*., 1998). In rural Pennsylvania, a coalition of 56 agencies concerned with servicing the health needs of women and their families has developed in response to a range of substance use issues in a local community. Representatives of these agencies meet monthly, and this has resulted in several jointly sponsored activities and products including a local human service directory, programs and forums. Most (83%) members of the interagency coalition who participated in one study reported increased interactions with other agencies, with 87% noting that involvement in the coalition had resulted in new collaborations for their agency (Vicary *et al*., 1996). However, the question of whether these relationships can be sustained in the long term without funding still remains to be answered.

Rather than developing a strong coalition, capacity building may also occur in a more organic way in which a series of partnerships is developed within communities. For example, when it was discovered in Seattle that the African–American population had a high rate of cardiac arrests but that bystanders initiated cardiopulmonary resuscitation less than half as often as within the white population, it was hypothesized that increasing African–American awareness of the technique would lead to better survival and recovery rates within that community. A member of the target community who worked as a paramedic agreed to teach a series of classes which were sponsored by a community organization involved in health promotion. When this organization unexpectedly closed, a number of other community groups became involved by offering spaces to run classes and promoting them to their constituencies (Bellin *et al*., 1997).

In some instances, partnerships may be formed between organizations which are very different in respect of factors, e.g. power and influence, mandates and interests, but which may be crucial to achieving the aims of all parties. This was recognized in Canada when developing a national strategy for the prevention of cardiovascular disease. By drawing together the resources of Health Canada, the 10 provincial health departments and over 1000 voluntary, professional and community organizations across Canada, a range of initiatives was developed in local communities. While initially focused on cardiovascular diseases, in many areas this has resulted in increased capacity for health promotion and disease prevention more generally (Stachenko, 1996).

A variation of a partnerships approach to capacity building which could happen within organizations, but which could involve overcoming barriers as permeable as the boundaries of organizations would involve partnerships between different professional groups who may previously have had little interaction. Such interactions can lead to individuals gaining familiarity with new approaches and concepts and result in changed understandings, attitudes and practices (Kengeya-Kayondo, 1994; Stephenson and McCreery, 1994) as well as learning the limitations of one's own professional discipline (Kamara, 1997).

Community organizing approach

Perhaps the most ambitious approach to capacity building involves working with communities,

especially with the most disenfranchised members of a community, to solve health issues:

> Capacity building can be characterized as the approach to community development that raises people's knowledge, awareness and skills to use their own capacity and that from available support systems, to resolve the more underlying causes of maldevelopment; capacity building helps them better understand the decision-making process; to communicate more effectively at different levels; and to take decisions, eventually instilling in them a sense of confidence to manage their own destinies [(Schuftan, 1996), p. 261].

Thus, capacity building aims to transform individuals from passive recipients of services to active participants in a process of community change (Finn and Checkoway, 1998). Underpinning this approach is the notion that the most successful programs are those which are initiated and run by the members of the local community (de Graaf, 1986; Eisen, 1994). Nevertheless, the approach to capacity building is most likely to be effective in communities with existing resources, e.g. health and welfare professionals, who become involved with health promotion (Goodman *et al*., 1993). Indeed:

> It may be unrealistic to assume that lay-people are willing and/or able to take the initiative and lead a community health promotion effort. Such an effort requires passion for the issues, expertise in planning and program development, an appreciation for existing community networks, leadership skills, and, most of all, time. Without accounting for such factors, even the best models are not likely to produce the desired outcomes [(Goodman *et al*., 1993), p. 216].

Forming new organizations is rarely a straightforward process, and it is probably unrealistic to expect community members to form workable organizations without providing the opportunities for them to gain skills in leadership, decision-making and conflict resolution, developing norms and procedures and articulating shared visions (Murray and Dunn, 1995; Poole, 1997).

One successful program which utilized a community organizing approach was the Minnesota Heart Health Program. This involved the development of local community boards to advise in the development and implementation of programs in their area. Members were invited to join these boards after having been identified as being significant leaders and decision-makers in their sector of the community. The sponsoring body gradually withdrew its involvement resulting in the local boards gaining more control over the projects and in the most place making plans for the long-term maintenance of the programs. Some years after the sponsoring body had withdrawn completely, a high percentage of the programs continued (Bracht *et al*., 1994).

A potential shortcoming of a community organizing approach to capacity building is that community expectations may be built up unrealistically. The Prevention of Maternal Mortality Network in one part of West Africa conducted what initially seemed to be a very successful program of community mobilizing and health education resulting in many women coming forward to use the available facilities for obstetric care. However, because there were insufficient facilities to cope with this increased demand, community members were soon discouraged and utilization of health facilities soon dropped to below pre-intervention levels (Kamara, 1997).

INVESTING IN CAPACITY BUILDING

Alongside each of these approaches to capacity building in many cases is the relationship between the providers and recipients of program funding. This relationship may be a crucial factor in the achievement or failure of capacity building efforts, and therefore it would be imprudent not to explore this further.

For funding bodies, capacity building has more recently been seen as a holy grail. As greater pressure has been placed on public funding and voluntary organizations it holds out the possibility of sustainable long-term improvements in health outcomes for short-term effort. If capacity building is successful it produces fundamental and lasting changes in how organizations and communities address health issues without the need for ongoing funding. But this has often proved elusive in practice.

Often funders find they have difficulties withdrawing their support without the risk that programs which appear to be producing worthwhile results may close. This can lead to either funders being captured by program providers, or ultimately a reduction in the commitment and trust between funders and providers when funding is phased out. Capacity building is therefore difficult for funders to promote because it embodies a paradox. Because funding for capacity building is intended to produce sustainable

change, successful funding recipients will not be funded in the future.

It is therefore important that funding bodies which adopt a capacity building approach are clear about their role and the strategies and outcomes they are prepared to fund. Currently there is a dearth of information on what funding strategies work for which types of capacity building across different settings and health issues.

Often, funding bodies interested in capacity building have been relatively passive and reactive. As evaluations of funding agencies are often based on how rapidly and efficiently they can allocate funds to projects (Trostle and Simon, 1992), a not uncommon consequence is that 'accountants and auditors increasingly dominate donor administrations, leaving less space for policy and programme development' [(Freedman, 1994), p. 51]. Furthermore, the pressure to move large amounts of money can result in poor decision-making processes and neglect of small and/or creative initiatives (Trostle and Simon, 1992). In a worst case scenario, it is the needs of the funding body and not the health needs of communities which are driving funding decisions (Shediac-Rizkillah and Bone, 1998). Even if it is considered desirable for funding bodies to move beyond being merely administrators of money to providing expert consultancy at the stage of project development and beyond (Trostle and Simon, 1992; Godlee, 1995), structural constraints may render this impossible.

How a funding body considers its outlays may be an indicator of its attitude to capacity building. It is not implausible for a funder which considers itself to be investing in communities to have a much greater commitment to capacity building than one that is primarily concerned with the rapid and efficient divestment of funds. Although investments have the potential to reap great rewards, the risk of failure is ever present, and it is likely that some investments will fail. Not all risks can be eliminated, but with appropriate processes for decision-making based on a set of principles, rather than a detailed prescription, investment risks can be minimized. For example, programs that receive insufficient funding will yield at most a modest impact which can stifle future funding opportunities and render sustainability unlikely (Shediac-Rizkillah and Bone, 1998). And even if the funding is sufficient, the conditions of funding and the levels of reporting required by a funding body may result in recipients being unable to spend grant funds effectively (Trostle and Simon, 1992).

If funding bodies expect capacity building to occur, they must also be realistic as to the extent this is achievable. For example, it is not unheard of for funding bodies to envisage capacity building as community organizing but fund only existing organizations rather than key individuals who may be able to facilitate this process. Similarly, one might ask whether it is realistic to expect the building of networks between agencies to occur if funds are provided only to one organization.

Our analysis has suggested four different but inter-related approaches to capacity building, and associated with each of these is a range of strategies that might be funded. Therefore, funding and accountability agreements for capacity building programs should be clear about the organizational context, the strategies to be employed and the structural changes expected to produce sustainable improvements in health practices. The resource quantum, time lines, contractual obligations and support provided for agencies that are funded should also be specified to facilitate the aim of capacity building being realized.

MEASURING CAPACITY BUILDING

As each of the four approaches outlined in this paper incorporates a range of strategies, a range of evaluation approaches will be necessary to establish whether capacity building does in fact occur. Quantitative measures of network density or involvement (e.g. the number of people or organizations) are appropriate for evaluating partnerships and community organizing approaches to capacity building, but arguably unsuitable for bottom-up and top-down organizational approaches which may be more suited to more subjective qualitative evaluations, although some quantitative measures may be applicable. One of the difficulties in evaluating capacity building is that each project may use a unique set of approaches and strategies (Poole, 1997), and therefore require different specific indicators. However, irrespective of the approach, the ultimate question which emerges when evaluating attempts at capacity building is whether sustainable changes to the health of the organization or community can be attributed to an intervention. Therefore, it may be more appropriate to evaluate whether capacity building

Table 1: Capacity building approaches and measurement areas

Approach	Measurement areas
Top-down organizational	Policy development Resource allocation (leverage) Organizational implementation Sanctions/incentives for compliance
Bottom-up organizational	Workforce/professional development program Staff skills, understanding, participation and commitment Ideas generated and implemented
Partnerships	Community activation Collaborations and information sharing between organizations Network density Reorienting of services and programs provided by individual organizations
Community organizing	Involvement of key community leaders Involvement of persons from disadvantaged groups Community ownership

processes have been implemented, and the impacts which have resulted from these. Table 1 provides examples of measurement areas for each of the four approaches.

Establishing the links between, and measures of, capacity building and social capital, and how they relate to health outcomes is an ongoing task in which new complexities continue to be revealed (Gillies, 1998). However, a number of principles have already emerged which can guide the evaluation of capacity building in health. Firstly, the actual strategies for building capacity need to be specified and impact measures developed which relate to these. As capacity building is a process, the outcome measures adopted must take account of this. Thus, the measures of capacity building presented in Table 1 were primarily those in which new or changed processes are the outcomes (Gillies, 1998).

Secondly, it is imperative that if we are concerned with capacity building within organizations and communities, then the measures adopted need to be measures of organizational and community processes, which are not the same as summing the impact measures for the individual members of these groupings (Shiell and Hawe, 1996). This may necessitate the use of a qualitative case study approach to evaluation (Gillies, 1998). Thirdly, because capacity building tends to be an evolving process, different measures may be required at different stages of the intervention (Hawe *et al*., 1997). Fourthly, notwithstanding the necessity to establish whether the agreed aims and objectives for a capacity building intervention have been achieved (Hawe, 1994), capacity may develop in areas other than that which was originally anticipated. Thus, additional measures of capacity may need to be developed as the intervention evolves.

CONCLUSION

It is not difficult to understand why the promise of long-term gain for short-term investment is so appealing to those who oversee finite budgets but must continually address new health issues. However, noble goals, e.g. capacity building, are rarely achieved by merely giving assent to sentiments. Yet all too often the implications of embarking on a capacity building process have not been considered in dimensions other than the financial. The processes required to achieve capacity building and the measurable outcomes which may be obtained are not necessarily the same as for other paradigms, but there has been all too little recognition of these issues. Our identification of four distinct approaches to capacity building has major implications for the necessary further work in this area.

If funding bodies are serious about capacity building, there are steps that can be taken to facilitate moving beyond mere rhetoric. Firstly, capacity building should be specified as a target in funding agreements. Given the multitude of meanings which have been ascribed to this term, an explicit statement of what is expected should be included. Secondly, funding agreements should specify what steps are being taken to facilitate capacity building. Not only will this involve being explicit about which of the four approaches is to be taken, but also what, if any,

the involvement of the funding body will be above and beyond the provision of funds. These specified outcomes should guide the basis of outcome measures adopted. Finally, there must be commitment to ensuring that projects initially funded with a target of capacity building are not subsequently treated as pilot projects and refunded on a recurrent basis. Such action will do nothing to convince future grant recipients that the funding body really means what it says in respect of being committed to capacity building.

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Address for correspondence:
Beth Crisp
Australian Institute for Primary Care
Faculty of Health Sciences
La Trobe University
Bundoora
Victoria 3083, Australia

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