Capacity Building Strategy

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1   Introduction

1.1   Opportunity for impact

The ReBUILD consortium has a real opportunity for impact on capacity development in health systems research within all partner institutions and country contexts. This strategy focuses on 1) ensuring that we have the capacity to deliver the project effectively and 2) leaving a legacy of improved capacity amongst project partners and wider groups to sustain the development and use of research findings in health systems in policy making.

1.2   What is capacity development?

Much of the literature on capacity development focuses on individual and micro level activities such as the choice of research trainees (e.g., Nchinda, 2003) with limited consideration of how such activities can be integrated into the wider research system. Ghaffar et al (2008) argue that the focus on individuals is not surprising given the historic preference for funding studentships as a means of building capacity. In recent years there has been an increasing interest in capacity development in health in resource poor contexts from donors, practitioners, policy makers and academics alike.

Prioritising the need for the international community to make a "quantum leap in capacity building", as suggested in 1998 by the Director General of the World Health Organization (WHO), would improve health and reduce poverty in developing countries (Nchinda, 2002). This increasing interest has also brought changes to how capacity development is conceptualised and in particular recognition of focusing beyond the individual level. The importance of also focusing on broader organisations and systems is captured in this widely cited definition of capacity development as supporting "an ability of individuals, organisations or systems to perform appropriate functions effectively, efficiently and sustainably" (Milen 2001 p1).

The Department of International Development (DFID)'s focus on capacity building also goes beyond the individual. In the DFID Research Strategy (DFID, 2009) capacity development is defined as *enhancing the abilities of individuals, organisations and systems to undertake and disseminate high quality research efficiently and effectively*, as follows:

> **Individual:** involving the development of researchers and teams via training and scholarships, to design and undertake research, write up and publish research findings, influence policy makers etc
> **Organisational:** developing the capacity of research departments in universities, think tanks and so on, to fund, manage and sustain themselves
> **Institutional:** changing the 'rules of the game' and addressing the incentive structures, the political and the regulatory context and the resource base in which research is undertaken and used by policy makers.

The goal of capacity building, for DFID, is "to facilitate individual and organisational learning which builds social capital and trust, develops knowledge, skills and attitudes and when successful creates an organisational culture which enables organisations to set objectives, achieve results, solve problems, and create adaptive procedures which enable them to survive in the long run". (DFID, 2009 guidance on capacity building)

Potter and Brough (2004) also argue for the need for a systematic and holistic approach to capacity development which goes beyond focusing on the individual and is embedded within the realities of structures and systems and roles in different contexts (see appendix 1 for their capacity pyramid reflecting these multiple levels).

In ReBUILD we adopt the holistic approach to capacity development that is embedded within the structures, systems and processed in post conflict contexts and our strategy focuses on the following levels: organisational, institutional.

2   Situating the strategy within the literature/evidence base

ReBUILD has an excellent opportunity to develop capacity for health systems research amongst partners and contribute to the evidence base on capacity development in post conflict states. Through reviewing the literature on 'capacity development in health research' and 'capacity development in fragile states' it appears there is a very limited knowledge base that bring these two bodies of work together.

In a forthcoming review of evaluating capacity development in health research 593 articles were identified and only 4 were in resource poor contexts (with only 1 paper focusing on a fragile state - Pakistan1), (Bates et al, 2011).

Given the limited literature on capacity development in health in post conflict states, we first outline learning from research on capacity development in health research and capacity development in post conflict states.

2.1   Capacity development in health research – focus on resource poor contexts

There are three key principles that have evolved from literature reviews, development of tools and research experience on capacity development in health research resource poor contexts (Bates et al 2006 and Bates et al 2011and these are confirmed by ESSENCE (2011) an interagency group on capacity development in health. These principles, which guide our capacity development strategy, are outlined in Fig 1 below.

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[1] This article by Hyder et al 2003 focused on a retrospective survey of Pakistani post-doctoral researchers who received their PhDs outside Pakistan. Participants identified through key individuals in public and private sector organizations

Fig 1 Principles for capacity development

> **Principle 1:** start small and use a "phased approach"; this requires the sequential involvement of all stakeholders in assessing capacity gaps, developing strategies to fill these gaps, and evaluating outcomes
>
> **Principle 2:** "strengthening of existing processes"; this is an iterative and flexible process that focuses on enhancing local ability to solve problems, define and achieve development needs, and then incrementally incorporate expanding circles of individuals, institutions, and systems
>
> **Principle 3:** "partnerships"; for effective or sustained capacity building, the various partners involved must have similar concepts and share responsibilities and obligations, with local partners taking ownership and leadership (adapted from Bates, 2006, 2009 a&b)

These three principles need to be taken forward against an in depth knowledge of context including health, political, social and cultural norms and practices and with buy in from all partners. As the ESSENCE (2011) initiative argues: 'Only a deep consideration of ... context will help with the understanding of underlying barriers to and detect specific opportunities for capacity building efforts'.

Our strategy builds on learning from post conflict literature (considered next) as this is the context for ReBUILD and also learning and experience from partners working in these settings, and key themes emerging from Country Situational Analysis reports.

2.2   Particular areas of concern

There is very limited literature on the experiences and processes of capacity development for research (including health research) in post conflict states. In this strategy we learn from the broader literature on capacity development in post-conflict settings. Post conflict health sectors are likely to face considerable challenges as a result of limited government capacity, weakened management systems, deficient human resources, damaged infrastructure and the proliferation of fragmented humanitarian and recovery initiatives (Pavignani & Colombo, 2005).

These influence the broad capacity development needs in the health sector, the post conflict literature highlights the following inter-related challenges (for further detail and references on these challenges see Appendix 2):

- Enabling provider co-operation: the state, donors and NGOs (multiple players)
- Juggling technical and political barriers
- Attracting back the diaspora versus working positively with current HR
- Priorities in capacity building: services now *or* institutional strengthening.

3   Implementation

3.1   ReBUILD legacy, long term view

The literature clearly highlights the time it takes to develop capacity and the six year DFID RPC model provides an exciting opportunity here. Drawing on discussions from our first partner meeting in Edinburgh in March 2011 (see Appendix 3) and our meeting in Kampala (Nov 2011) we start this section by looking forward to the anticipated legacy of ReBUILD as a whole and by partner institution. We then provide baseline information on capacity at both individual and organisational levels.

The ReBUILD legacy will include:
- Redressing the history of neglect of health systems research in post conflict states and building the evidence base here
- Increased engagement with the role of research and evidence based practice on health systems and post conflict frameworks through building researcher, policy maker and practitioner led partnerships for change
- Capacity building for multidisciplinary health systems research that is close to policy and practice and research communications
- Further embedding all partners in regional and international networks.

The legacy goal for each partner is included in Table 1 below.

Table 1 Legacy goal for each ReBUILD partner

BRTI	Fully functional and sustainable unit for research and training in healthy systems, health economics and/or human resources research (HRR). A unit capable of completely applying and securing grants in those disciplines. Relationships with regional and international academic institutions consolidated.
CDRI	Reputation for excellent poverty research extended to include health systems research and better understanding and research record in health financing and human resources for health. Trusting links with policy makers strengthened.
COMAHS	Functional Ethics Committee in both COMAHS and University of Sierra Leone. Research and Development office established within COMAHS. Trained researchers/staff members particularly on qualitative research, grant management, and opportunities to participate in post graduate training. Research portfolio on health systems research developed, and regional and international support networks put in place.
IIHD	Consolidate human resource and gender mainstreaming focus areas. Complement and expand repertoire on fragile states beyond psycho-social. Develop a legacy of greater expertise in post conflict research. Support development of young researchers in this field.
LSTM	Expanded network of researchers working on human resources and health financing. Enhanced knowledge of working in fragile states and health financing. Stronger research networks and experience of developing demand for research in post conflict states.
Makerere	Becoming a center of research excellence in post-conflict health and health systems; strengthening project management skills – financial and administrative; creating a sustained and valued culture of multidisciplinary and cross department research. Strengthening links with Gulu University. Contributing to a policy environment that values and uses health systems research.

3.2   Baseline and priorities for action

An exercise with all partners has been completed along with qualitative interviews, comments and feedback. This work has identified the baseline and priorities for action in year one of the ReBUILD project.

This is included in Table 2 below.

Table 2 Baseline priorities for action in year one, all ReBUILD partners

	Individual level		Organisational		Institutional level	
	Current capacity	Focus for action	Current capacity	Focus for action	Current capacity	Focus for action
BRTI	Biomedical research and training Large long term cohort studies in rural and urban settings Research ethics Running a diversity of training courses	Health systems research, health economics and human resources for health. Particular interest and need in health economics (currently no health economists in Zimbabwe).	Organisational capability for supporting post graduates studies in biomedical research. Organisational ability to run (and disburse funds for) multi-country studies	Through ReBUILD can focus on postgraduate training in HSR, HE and HRH. Need external support in terms of technical expertise to drive the programme, Trainer of trainers, mentorship and supervision of programmes in those disciplines.	Good links with organisations working on health systems (researcher, donor, government, policy and practice)	Further develop skills and experience in research uptake and intensify relationships with organisations working on health systems.
CDRI	Strong multidisciplinary and multi-sectoral poverty research. ReBUILD team have complementary skills in health economics, quantitative and qualitative methods	Developing skills and knowledge gaps in econometric analysis models, methods and concepts (including approaches in qualitative research and human resources). Additional support needed in developing	Strong support and administration at CDRI, with library and variety of research support staff.	Developing further skills and experience in research uptake.	Some links with policy makers within and beyond the health sector	Strengthening opportunities for partnership with (very busy) policy makers and practitioners within the health sector.

	quality research outputs.					
COM AHS	Strengths in biomedical research. Before the war, research was very actively conducted in the university. The research culture in Sierra Leone is yet in the embryonic stage. There are three researchers employed in ReBUILD working under the guidance of Edem- Hotah and Samai.	Need to build skills, a culture and resources for health systems research, including methods, disciplines and contexts. There is a real opportunity to do so with sustained funding. The 3 researchers need support in research methods (particularly qualitative, including NVIVO training), also in proposal writing and access to academic resources.	There is a ReBUILD office housing the researchers and supported by an administrator. There was a research ethics committee in the university but that committee is not functioning at the moment.	To support the administrator in their ability to sustain and support research. To develop skills and experience in research uptake activities.	The team has limited experience with research engagement but are strategically placed here with good links at policy and practice levels. The Ministry of Health now has a scientific and research committee.	To develop an ethics committee with COHMAS and support capacity of all SL ethics committee to appropriately appraise health systems research. To further consolidate partnerships within and beyond the MoH.
IIHD	Social research with a focus on health economics Strong critical mass of health economists, established capacity in post conflict psycho-	Develop expertise in health systems research in post conflict health systems.	Research administration infrastructure in place, ethics committee in place.	Gain more experience and exposure in research in post conflict settings. Establish greater capacity in research	Good links with international health systems key influential bodies including, WHO, Alliance HPSR, GHWA. The Asia Pacific Alliance for HRH, the World	Strengthen links with key influential bodies at international and national levels.

	social research.			support functions in QMU to manage multi-country partnerships.	Bank UNICEF and other academic institutions contributing to health systems development.	
LSTM	Skills and experience in human resources, and qualitative research and gender equity analysis.	Stronger research skills in health financing and experience of research in post conflict settings.	COO, research uptake and administrative support housed in LSTM. Active research culture and training. Research administration in place, ethics committee.	Enhance our capacity and human resources to undertake research uptake activities.	Good links with international health systems key influential bodies (e.g. health workforce xxx)	Strengthen links with key influential bodies at international and national levels.
MUS PH	Very strong established departments, with skills in Health systems research & policy analysis (Public Health) and gender and equity analysis and health (Gender studies). Both departments have Skills in quantitative and qualitative research. Working	Alongside established researchers are younger research team members to develop into experts (through on the job training in different methods and disciplines, and seeking opportunities and funding for relevant courses). Additional skills required in network	Young but active communication unit MUSPH, MakCHS with good networks with health media.	Strengthen and build the communication unit. Consolidate inter-departmental links within MU and across universities (with Gulu)	Strong working relationships with policy makers and practitioners through ongoing engagement.	Intensify interactions with policy makers to increase demand for health systems research with a post conflict analysis.

	links between different departments. Links with Gulu University	analysis for Project 5, and can be accessed though MU. Focus on partnership and capacity building activities with Gulu University.				

3.3   Immediate priorities for capacity building

These priorities were identified following:

- Review by partners of earlier drafts of the capacity building strategy and development of the baseline and priorities for action
- Consultation and feedback from all partners and the CAG
- Review of the capacity building needs identified in the 15 country specific research protocols developed for the five ReBUILD research themes
- Interviews conducted with partner representatives in Kampala, Nov, 2011.

3.3.1   Embedding cost effective approaches to capacity building within core business

There is no 'core' ReBUILD budget line for capacity building and hence a need to both ensure capacity building activities are included in ReBUILD core business (research, research uptake and management) in a cost effective manner and to simultaneously seek opportunities for additional funds for capacity building. Approaches to embed capacity building within ReBUILD's core business include:

Technical support and mentoring are built in to the development of protocols and the running of the projects. We need to ensure a coordinated and responsive approach to technical support that responds to partners needs and the evolving experience of the delivering the different projects. This will be coordinated by the COO in collaboration with Sally Theobald (lead on capacity building) and project leads. We will also put in place structures for multi-disciplinary mentoring within the consortium to ensure support for the different methodological skills and disciplines needed to deliver ReBUILD.

Enabling sharing of learning from running projects in different country contexts: all projects with the exception of project five (aid architecture Uganda only) are taking place in multiple settings. Projects one (Health financing) and two (Incentives) are taking place in Uganda, Sierra Leone, Zimbabwe and Cambodia.

Project three (Contracting) in Cambodia and Sierra Leone and project four (rural posting) is in Uganda and Zimbabwe. Project leads will take responsibility to ensure opportunities for learning and experience sharing between and across contexts are seized and discussed. The use of annual workshops which will allow for reflective learning from the project and this will be complemented by Skype discussions.

Strategic choice of courses/concrete capacity development activities: we need to balance skills development through formal courses and ability to deliver ReBUILD's core business. We will explore undertaking a range of short course (such as modules in human resources), online

courses where people stay in country and dedicate some time to learning (such as the World Bank health economics course and Queen Margaret University's course in proposal writing).

Off site PhDs linked to ReBUILD core projects (where the candidate stays in country) also offer good potential here. For example Neath is pursuing his PhD (which is closely linked to project one) offsite with Prof McPake at QMU, and QMU has agreed to waive fees in this instance. Opportunities for study are also being explored in LSTM.

Use of SharePoint as a capacity building resource: we will make resources and materials available in SharePoint to support the capacity building agenda, this will include materials relating to disciplines (health economics), specific methods (life histories) and topics or concepts (the post conflict trajectory).

We will increasingly use SharePoint throughout ReBUILD so that it becomes a useful and responsive resource. We are also mindful of current constraints on good internet access in Sierra Leone and are trying to use other approaches as well such as providing resources on memory sticks.

3.3.2   Leveraging additional funds for capacity building

We will explore opportunities to leverage additional funding to support ReBUILD's capacity building priorities. This will include:
- Further negotiations within institutions to access training activities for free (fee waiver) or at cost.
- Dialogue with the British Council and other organisations who have an interest in capacity building
- Scoping the funding landscape for funding opportunities or cost sharing for capacity building activities
- Support from CAG members in identifying opportunities.

3.3.3   Strengthening skills and experience in post conflict health systems

This is in specific concepts/topic areas in health systems research in post conflict settings. Some partners are newer than others to health systems research. However all partners said they would welcome further skill development in the concepts, models and frameworks to better situate research in the post conflict trajectory. Within the inception period/year one we will:
- Develop resources on concepts, models and papers which specifically focus on post conflict and make these available through SharePoint
- Foster stronger links and experience sharing with relevant initiatives and organisations including:

- o The Stockholm International Peace Initiative (SIPRI) meetings, discussions and papers on health in conflict and post conflict settings (Sally Theobald a taskforce member)
- o The Fragile Health Networks (which will be facilitated by our CAG member, Dr. Egbert Sondorp)
- o The Sustainable Livelihoods Research Consortia which has a focus on fragile states
- o NGOs and institutions in our partner countries which have a specific post conflict remit
- Have explicit discussions about the meaning of research findings within the post conflict trajectory at partner meetings and in project specific research groups.

Some partners also expressed desire to improve their exposure to key skills and concepts in human resources for health. We are exploring possibilities for team members to attend the short 2 week intensive module on human resources for health at LSTM (which focuses on motivation, staff distribution and performance).

3.3.4 Strengthening skills and experience in methods and disciplines

There was an interest from some partners (BRTI and COHMAS) to develop stronger skills in health economics. Zimbabwean colleagues explained there are no health economists in the whole country at present. Again we will work to identify key resources (with a focus on health financing) and support materials here as a priority for year one. A key opportunity here which comes highly recommended is the online World Bank course on Basics of Health Economics with courses available in Jan – Feb 2012 and March - April 2012.

All partners have some skills and experience in qualitative research, but the focus on life histories (also sometimes referred to as case histories) in order to analyse perceptions and experiences through time are new to most. Projects one and two will use this approach.

Life histories are used in project one in order to understand community views on changes in patterns of household expenditure and experience through time; whereas in project two life histories are used to explore health professionals' experience of the broader incentive environment. We organised a mini training on life histories in response to demand in Kampala (Nov, 2011) and have made ReBUILD specific resources available on SharePoint.

We have also agreed that researchers using these methods will meet every three months through Skype (we can ring in colleagues from Sierra Leone if internet remains problematic) to share experiences of what worked well and less well in using life histories, and early analytical

frameworks. This shared learning will hopefully form the basis of a co-authored paper on the experiences of using life histories in this way.

3.3.5   Building skills and experience in research uptake

This is key to ReBUILD's approach and both Makerere and LSTM have strengths in this area. As laid out in the Research Uptake Strategy, a number of activities will take place to support research uptake in the first years of implementation. Establishing a community of practice to support learning and exchange on research uptake is key priority for year one.

3.4   Embedding our approach and immediate priorities for action in literature

Table 3 below shows how the capacity development activities we will pursue in ReBUILD (year one and beyond) are embedded in the literature on building health research capacity in resource poor contexts.

They are also informed by the literature on capacity development in post conflict contexts and include, for example, activities which foster partnership between government policy players and NGOs, support and offer opportunities to researchers to try and sustain them in contexts which are often fluid with high levels of out migration.

Table 3: Embedding our approach within the 3 key principles for building health research capacity in resource poor contexts

Levels	P1: phased approach (start small)	P2: build on what exists	P3: partnerships
Individual	Training workshops – face to face/online	Multi-disciplinary mentoring Supporting consultancies in core areas Off site PhD model	Ensure partnerships and learning across different countries undertaking same projects
Organisational	Developing and monitoring a research uptake strategy Developing and evaluating a capacity development strategy	Developing a shared resource of materials (concepts, methods and disciplines in SharePoint)	Cross university and departmental relationships strengthened Strengthening partnerships with groups working in fragile states Developing research protocols in collaboration with key policy players to reflect demand.
Institutional	Working with policy makers from an early stage, to develop receptivity to research and ability to interpret research findings.	Working with and strengthening research networks in country and in regions.	Supporting partnerships with ethics committees. Fostering relationships with policy champions.

4 Approach, aim and objectives

4.1 Approach

Throughout ReBUILD capacity development will not be limited to education: individuals' needs will always be considered in the broader context of creating an enabling organisational and institutional environment for research and research uptake, including improving local availability of resources, and strengthening institutional and national systems to ensure that research is supported and used.

4.2 Aim

To develop partner, affiliate and key stakeholders' capacity to conduct and/or use quality ethical research on health systems (especially health financing and HR) in post conflict contexts.

Table 4 Partner information

Partner	6 core partners
Affiliate	ReBUILD has 20 affiliates confirmed so far who are able to bid for monies to take forward research activities against ReBUILD's key priority areas (which may include capacity building activities).
CAG member	Including representation from MoH and international agencies
Key stakeholder	Key policy players including, for example, Ministries of Health, trade unions, professional groups, donors, NGOs and ethics committees

We have 4 capacity development objectives in ReBUILD. The activities we will undertake to meet these objectives are included (including the priority activities for year one as discussed above). The following table highlights objectives and activities.

4.3 Objectives

Our capacity building objectives for ReBUILD are:
- To embed capacity building within the core functioning of the consortium
- To consolidate skills in research processes, techniques and topics
- To engage others in research uptake and to build influence
- To develop a supportive environment for ReBUILD at the institutional level.

Table 5 Activities to support successfully meeting all objectives

Activities	Indicators
Objective one	
1. Responsive and coordinated technical support for project delivery	Number of technical support visits
2. Ensuring sharing of learning (methods and analytical frameworks) across the different contexts	Number of discussions across different projects (Skype, face to face)
3. Strategic choice of short courses and training opportunities	Number of formal trainings undertaken (face to face and on-line)
4. Encouraging use of SharePoint as a resource for capacity building through developing responsive resources	Number of finance and admin staff supported through COO
5. Identifying opportunities for further funding to undertake ReBUILD capacity building activities	Additional monies generated (or saved through waivers) for capacity building activities
6. Mentoring of admin and finance staff by ReBUILD COO.	
7. On-site support through annual or ad hoc visits by COO including review of project management and financial systems and support for development of these where necessary.	Number of specific capacity building resources available on SharePoint

Number of bibliographies available through SharePoint |
Objective two	
Foster partnerships with groups working on health in conflict/post-conflict situations	Meetings held with groups working on health in conflict/post conflict situations
Developing skills in particular disciplines and methods (through courses and mentoring) – e.g. health economics, life histories	Number of support products (e.g. briefing papers) produced to support work in this area
Developing skills in topics and concepts (through courses and mentoring) – e.g. in post conflict settings and human resources	Number of co-authored peer review papers
Developing skills in proposal writing and academic paper writing	Number of peer review papers which are co-authored with policy makers and practitioners

Number of and £x of additional resources, |

Encourage and support young promising researchers to undertake consultancies that complement ReBUILD core areas	research grants generated Number of relevant consultancies undertaken
Objective three	
1. Develop a cross consortium strategy and national communications strategies and activity plans with partners to identify potential barriers to research uptake in target stakeholders and mechanisms to overcome information gaps and improve research literacy 2. Skills development on research uptake as part of annual meeting to improve all partners understanding of research communications techniques and emerging communications theory and technologies 3. Resources and toolkits on research communications made available through SharePoint 4. Network with other RPC communications staff (virtually) to share learning across the large DFID financed multi-country research projects 5. Identify potential communications partners in Sierra Leone, Cambodia, Zimbabwe and Uganda to support the research uptake process 6. Identify training opportunities in communications and support partner's involvement 7. Instigate a communications community of practice within the Consortium to aid mutual learning 8. Support the communications and research uptake elements of affiliate's proposals and subsequent work	Number of meetings of the community of practice Communications strategies developed for the partners and the Consortium and updated each year Communications skills development sessions held in annual meetings Number of research communications resources shared per year Number of contacts with communications professionals (for example, journalists)

9. Document examples of communications and research uptake work and share with partners and affiliates	
Objective four	
1. Identify and support key champions who foster evidence based policy in health systems research. Support could include funding to attend high profile events and joint paper writing 2. Exploring possibilities of linking with the diaspora to champion ReBUILD work 3. Organise ReBUILD seminars and policy forums to discuss findings. 4. Support ethics committees with tools and guidelines to appropriately assess health systems research in post conflict states 5. Develop ethics guidelines and mini case studies 6. Share guidelines with different ethics committees for comments and adjust accordingly	Number of health systems seminars Numbers of participants Numbers of parliamentary debates with health systems content Number of ethics committees who review and respond to guidelines

5   Monitoring and evaluation

Given that we are working in fluid fragile states we will revisit the capacity building strategy annually as part of our M&E approach to see if it needs adaptation to reflect new emerging concerns and issues. At each annual meeting we will review the strategy against our indicators and adapt our objectives and activities accordingly.

The quantitative indicators above will be collated every three months as part of the quarterly report process and discussed and reported on an annual basis. In addition we will collect qualitative reflections on the successes, opportunities and challenges in capacity development activities (individual, organisational and institutional) with all six partners on an annual basis (at each of the partner annual meetings), enabling a long term perspective.

It takes five to ten years to ensure that research capacity is sustainable (Ghaffar et al, 2008) but Bates et al struggled to identify articles that took a long term view.

The ReBUILD platform provides an interesting opportunity to track progress through time. Bates et al (2011) refer to four stages of capacity building:

- Awareness
- Planning/experiential
- Expansion
- Consolidation/sustainability

See Appendix 4 for details of suggested generic indicators for each stage. We will use the qualitative interviews to explore the depth and detail of the experience and challenges of capacity building, and context and processes.

The first interviews have taken place and we will analyse these to develop qualitative indicators to track progress through time. The process of qualitative interviewing and reflection will form the basis of internal learning for ReBUILD, as well as academic papers to respond to the gaps in knowledge about capacity development for health research in post conflict contexts.

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7   Appendix 1: Capacity Pyramid

Capacity Pyramid

Christopher Potter and Richard Brough
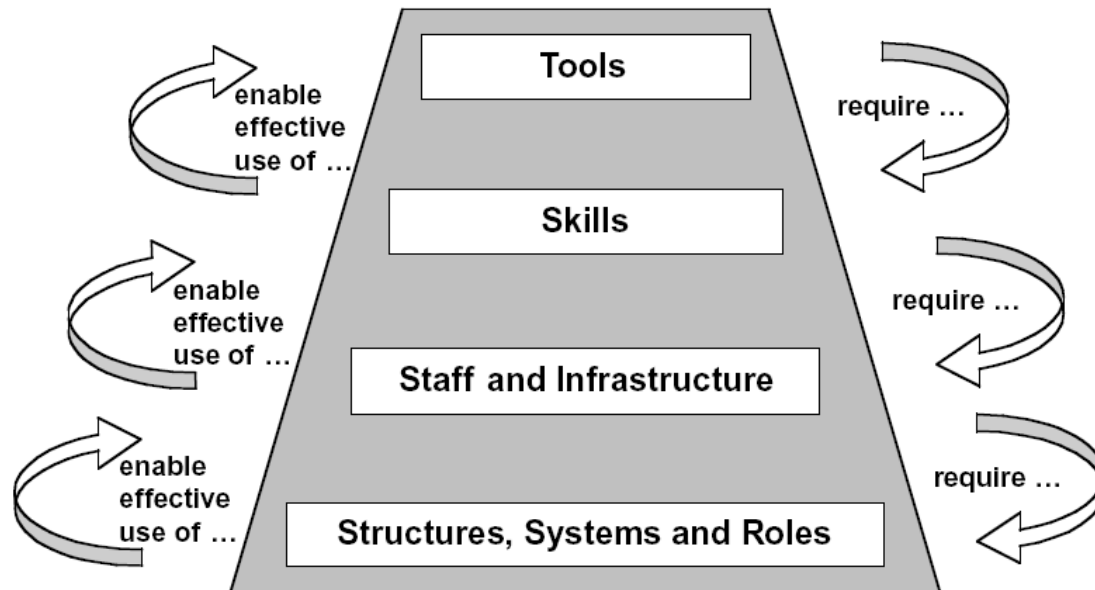
8   Appendix 2: Capacity development in post conflict states: What are the particular areas for concern?

Provider co-operation: the state, donors and NGOs

Post conflict states often lack important elements for ReBUILDing the health sector and may be dependent on external support for financial input and expertise and to bolster new governments which themselves may be considered politically contentious (Macrae et al., 1996). The vital coordination and collaboration between donors, NGOs and local authorities is not straight forward, but consistent support for new authorities can substantially aid their credibility and scope (Varpilah et al., 2011, World Health Organization, 2005).

Cooperation and commitment will be required to establish effective methods in delivering core functions of government;   developing capacity to govern and legitimacy; and recognition that the state may no longer be the principal provider of health services (Newbrander et al., 2007). These sensitive relationships between stakeholders may have an influence on capacity building for research of governments' dependency on donors to fund priority health systems research while donors, because of their financial and technical positioning, frequently become the primary users and gatekeepers of the findings (Hill, 2004). The immediate post-conflict period

can create a window of opportunity for the 'policy entrepreneurs', local or international, to re-shape policy direction, with the support of donor investment (Reich M, 1995, MDGs, 2005, Smith and Kolehmainen-Aitken, 2006, High-Level Forum on the Health MDGs, 2005).

Priorities in capacity building: services now or institutional strengthening.

There may be a post-conflict tension between urgent imperatives for action that over-ride the longer term need to develop local capacity, as well as a need to support compromised structures of governance; lack of familiarity from international stakeholders with the local political and cultural complexities that underpin these structures may also be an impediment (Hill); (Newbrander et al., 2007).In the immediate post-conflict period quick results and emergency delivery of services– in which international NGOs have considerable expertise – may take precedence over long term programmes and building state capacity with disagreement between stakeholders on how to strengthen weak governments (Vergeer P et al., 2009). Kosovo is an example of where the WHO led a health policy framework for the emergency period that included elements of health sector reform but where there was tension between the need to have a policy in place rapidly and the desire to be participatory (Shuey et al., 2003).

Early investment however, to develop a functioning, equitable health system can have important health and state building benefits (Kruk et al., 2010). There is an opportunity for long-term strategies for organizational and individual capacity strengthening, such as the establishment of a human resources management unit in the health authority to take responsibility for incentives to improve performance and attraction and retention of health professionals, particularly if there has been substantial displacement of health personnel (Varpilah et al., 2011, World Health Organization, 2005).

Post conflict situations necessitate rapid capacity building in key areas such as planning and management, clinical skills and education which will have long-term implications, and which should be taken advantage of in the limited period where high-level donor funding is available (World Health Organization, 2005). Short-term solutions for building capacity may create long term problems, for example developing accelerated training programmes for a large quantity of lesser skilled health workers who subsequently have insufficient capacity to further their careers.

A focus on equity may get lost with the immediate need to deliver services, this may be exacerbated by inequity left over from the conflict period, whereby the poor and rural populations have poor access to health care, particularly secondary and curative services. Issues of equity may be influenced by the nature of the conflict, for example, displaced and sexually abused women have conspicuously failed to benefit from post conflict health interventions in various post-conflict settings (Carballo et al., 2010).

Technical and political barriers

Health systems researchers are likely to face specific problems in post-conflict settings which affect their ability to initiate their research (for example, the body which authorizes research may be unclear) or carry out their work due to limited access to parts of the health system, security concerns, incomplete data or deficient information systems (Hill, 2004).

In many countries post conflict strategies have created a triple burden on the health system and failed to provide a platform for long-term development: the new policies exacerbate the problem on top of those inherited from the health system of the pre-conflict era, and the long-term effects of conflict on health and health services. In Uganda the capacity of civil servants to support positive policy development was threatened by the limited knowledge base and technical skills within the service (Macrae et al., 1996).

Attracting back the diaspora versus working positively with current HR: The displacement and diaspora of health workers during conflict may be compounded by a brain drain of professional staff to NGOs and beyond (World Health Organisation, 2005). There are challenges in attracting back the trained personnel from the Diaspora. The longer they remain out the more difficult to woo them back as they also settle in their new environment. Back home the working environment might not have adequate resources to support their work. Strategies for attracting back personnel may include increasing and standardizing salaries; funding incentive packages in order to retain staff in hard to reach areas; the use of donor funds to fill priority posts in the health sector and retention of staff improved by stipulating a commitment of service required from beneficiaries of scholarships (Varpilah et al., 2011).

> **Diaspora and health research in Zimbabwe:**
> We are saying that obviously over the years we have lost a lot of our skills in terms of the researchers and scientists and so forth. The key issues would obviously be to try and attract specialists from the Diaspora and that expertise we have lost over the years, so obviously the longer they remain out there the more difficult it is to get them back and also settle in the new environment. I think there is a lot of people that would come back but mainly for the research not the environment. The research environment is very conducive, but the resources and facilities might not be there and there may be issues to do with mentorship, supervision and so forth, so sometimes researchers come back but maybe because they don't have that backup they get very frustrated and then might leave because some of the equipment is not there for conducting the research. Those are the issues we have to consider to make the environment more conducive and more sustainable so we can attract researchers, and retain them to be able to push the agenda forward for ReBUILD Zimbabwe.

9   Appendix 3: Needs assessment Edinburgh, March, 2011

Partner needs assessment and vision exercise. Edinburgh, March 2011

- From your experience what are key issues to consider in capacity building in fragile / post crisis / post conflict states? Do you have access or ideas for resources here?
- What is your capacity building legacy 'ideal' from ReBUILD?
- What is your current capacity re:
  - o Individual – training needs, skills and knowledge gaps and quality of research outputs
  - o Organisational
  - o Systems and resources
  - o Core capabilities (see ECDPM, DFID note on sticks)
- What are your capacity building priorities – short term and long term (within the ReBUILD timeframe).

10   Appendix 4: Monitoring indicators for capacity building

Source: Bates, I. Taegtmeyer, M. Squire SB. Ansong, D. Nhlema-Simwaka, B. Baba, A. Theobald, S. (2011) Indicators of sustainable capacity building for health research: analysis of four African case studies. Health Research Policy and Systems, 9:14.

Table 2 Generic monitoring indicators for capacity building programmes derived from commonalities in case studies

Phase	Common activities	Generic indicators derived from activities	Examples of sources of evidence for indicators used in case studies
Awareness	Lack of local capacity recognised early in project Stakeholders agree to support activities to address capacity gaps Need for uptake of research outputs identified	List of capacity gaps to be filled List of stakeholders who will be critical for implementing project outputs Evidence of engagement of stakeholders (beyond core project team) able to facilitate capacity building activities	Written assessment of gaps in capacity Notes of meetings with stakeholders beyond research team (e.g. government or institutional directors)
Experiential	Capacity building activities focused primarily on individuals directly involved in project Formal and informal routes for using project outputs to influence policy/guidelines are explored Formal plans for addressing capacity gaps are gradually defined Preliminary models for capacity building are tested and adapted for scale up Strategies for ensuring that the relevant policies were in place or updated	Written plan and timescale for addressing gaps agreed with stakeholders Documented strategy for using project outputs to rectify mismatches/gaps between evidence and policy/practice Results of testing of pilot projects/models for capacity building	Annual plans with targets, timescale and details for rectifying policy gaps Review of comparison of different models and report of testing of models
Expansion	Concerted effort to influence policies and practice Focus broadens from individuals to strengthening institutions and systems Capacity building activities and individuals expand and begin to be integrated in existing structures Researchers inputs down-scaled to provide light touch guidance Sustainable funding actively sought Peer-reviewed publications from research and capacity building published	Expanded relevant skills and workforce Reduction of inputs by northern partners Regular review process instigated for updating/developing relevant policies Evidence of strengthening of systems (e.g. new committees or reporting structures) Diversification of funding sources independent of original funders Publications and/or presentations at national/international meetings	Training records indicating number of individuals trained, topics covered, skills audit and evidence of use of new skills Individual student assessments to demonstrate knowledge, skills and competencies Institutional annual budgets showing earmarked research funds Workplan showing phase out of northern partners, policy review and set up of new structures Documentation of number, type and success rates of publications and funding applications
Consolidation	Expansion beyond initial project objectives and original institution/region/country Southern partners lead bids for alternative sources of funding independent of original project funds Southern partners responsible for project and budget management	Evidence that long-term funding has been secured Project management and key decisions, such as commissioning of further external inputs, led by southern partners	Financial statements showing diverse sources of funds and that southern institution is responsible for budgeting Minutes of meetings showing key decision-making by southern partners