When training is insufficient: reflections on capacity development in health promotion in Peru

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SUMMARY
The international development community has lately recognized the programatic importance of capacity development. Despite growing attention, a consensus is still lacking on appropriate strategies and interventions to strengthen local capacity for development programs. The CHANGE Project designed and implemented a program to contribute to capacity development in health promotion in Peru between 2002 and 2005. This article discusses key lessons learned in the program. Successful capacity development requires the strengthening of institutional networks. Training activities alone are insufficient. Educational opportunities need to be integrated into strategies that aim to institutionalize competencies in specific work contexts and promote the inter-institutional linkages.

The experience suggests that capacity development programs need to start by assessing challenges to make competencies effective in job performance. Projects should neither be donor-driven nor depend on individuals. Instead, they should focus on institution building, find creative ways to promote long-term sustainability of capacity development, and require long-term commitment to promote ownership and sustainability. What is needed is an approach that maximizes the impact of programs through collaboration among institutions committed to supporting and absorbing capacity, and to having mechanisms to monitor and change job performance according to the needs of staff, supervisors and other stakeholders.

Key words: capacity development; health promotion; Peru

INTRODUCTION
This article discusses an intervention to develop capacity in health promotion in Peru between 2002 and 2005. The underlying premise was that strengthening the health promotion competencies of professionals and institutions will support the improvement of health behaviors and conditions in the country. The intervention was designed and conducted by the CHANGE Project in partnership with a consortium of Peruvian universities and two local NGOs. (Between 1998 and 2005, the CHANGE Project was a cooperative agreement between the United States Agency for International Development and the Academy for Educational Development.) Because the activities have not been formally evaluated, no evidence-based assessment about impact is offered. Despite the lack of formal data, it is possible to draw lessons to inform future planning of capacity development interventions, particularly on health promotion.

The article is organized as follows. A brief context is given to understand the origin of the activities in Peru as well as the institutional mechanisms that were used to design and implement the activities. Key lessons learned are summarized in a section about promoting local ownership of capacity projects. Conclusions and recommendations are offered in the final section.

Background
In recent years, capacity development has been at the forefront of the agenda of donors, governments and development agencies. Here, ‘capacity
development’ to denominate the process by which individuals and institutions develop and strengthen competencies to perform tasks that facilitate the accomplishment of development objectives (United Nations Development Program, 1997).

Current interest in capacity development is based on the realization that development efforts cannot deliver sustainable results without institutions and professionals adequately prepared to meet technical responsibilities (Eade, 1997; Milen, 2001). Pouring resources into programs that lack well-trained personnel is unlikely to deliver successful, long-term results, particularly given the redefinition of job responsibilities amidst the decentralization of health services (Homedes and Ugalde, 2005). Too many development efforts have failed because insufficient attention and funding had been devoted to strengthening human and institutional capacity (Kwapong and Lesser, 1990; Dobie, 2005; Hawe et al., 1997). Fortunately, increasing attention has been paid to this issue in recent years.

Conventional strategies used in the past seem insufficient to deal with capacity challenges in international development (Cracknell, 2000). Training professionals from Southern countries in Northern institutions is no longer seen as a preferred strategy to strengthen local capacity. It certainly has merits, namely, offering opportunities to South-based professionals to acquire skills and develop personal networks. Such an approach, however, is limited to remedy fundamental institutional problems underlying capacity problems. Because the focus is on training individuals, it does not necessarily deliver sustainable results in terms of institution building. Training alone does not solve well-known problems affecting the performance of the health workforce such as ‘brain drain’, job attrition and rotation, and institutional lethargy.

Given the limited impact of capacity programs exclusively oriented to training individuals, there have been calls for a ‘paradigm shift’ (Kaplan, 1999). The new mindset needs to understand capacity development as a task that should aim to build and strengthen local institutions and promote local participation that incorporates a variety of institutions involved in the provision and promotion of health services (e.g. educational/training, policy-making and service delivery). Capacity efforts are still hampered by many problems such as poor planning, insufficient commitment from donors and partners, and conventional approaches to training. A key problem is the lack of coordination among donors and agencies. It is not unusual for the same group of individuals to receive similar training from programs funded from different sources, or for a small number of professionals to get the lion’s share of opportunities to receive further training.

Another challenge is the general lack of coordination between training curricula and workplace performance. Training is not always adjusted to job expectations and demands in the workplace. A focus on building skills prevents capacity programs from paying serious consideration to institutional expectations and incentives to encourage health promotion officers to use newly learned competencies. The lack of coordination is also manifested in the weakness of linkages between capacity programs directed at in-service staff and students. Some programs prioritize the training of students based on the assumption that changing the performance of in-service staff is less likely to be successful than teaching skills to the next generation of professionals. Other programs, instead, prefer to focus on in-service staff based on the assumption that the training of working professionals has better chances of having an immediate impact on job performance. Recently, a number of articles have stressed the need for strengthening health promotion capacity in developing countries (Atkinson et al., 2005; Tang et al., 2005). The literature, however, has not reached a consensus about viable models to guide future interventions.

To contribute to this debate, this article presents and discusses the results from the CHANGE intervention in Peru. It proposes that capacity development fundamentally requires institution-building strategies to support health promotion offices in Ministries of Health as well as civic institutions. In the context of decentralization of health services, and given the perennial difficulties of health promotion offices in many developing countries, capacity strategies need to have an inclusive perspective that maximizes the talent and participation of governments and civil society.

**Intervention**

Between 2001 and 2004, the CHANGE Project received funding from USAID/Peru’s Office of Health to contribute to strengthening capacity in health promotion in the country through...
universities and the regional health roundtables in eight regions. (As part of the process of the decentralization of health services, roundtables have been formed in Peru’s regions. The Roundtables bring together representatives from government and civil society to discuss and identify health needs and priorities, and design and execute plans.) To carry out these tasks, the project partnered with two actors: universities and non-government organizations. CHANGE partnered with the Consorcio de Universidades, an institution formed by four of Peru’s most prestigious private universities (Pontificia Universidad Católica, Universidad Cayetano Heredia, Universidad de Lima and Universidad del Pacífico) to conduct social outreach programs, and with substantial human resources and expertise in public health and communication. To support the work of the local communication roundtables, CHANGE partnered with APROPO and PRISMA, two Peruvian NGOs with vast expertise in health communication and a solid track record in the regions where they were selected to work. Activities included workshops on health promotion issues for faculty, NGOs and MOH personnel; training in health news coverage for students and journalists; a research grant program focused on health promotion and communication; and internship program for undergraduate students.

The activities intended to build upon previous interventions that had been developed by the Ministry of Health’s Office of Health Promotion and various NGOs in the past years. Although Peru has built-in health promotion resources, particularly related to family planning interventions, the bulk of the capacity has been centralized in Lima (Consorcio de Universidades, 2005). Therefore, the project aimed to strengthen human resources in the regions that bear the highest burden of disease and levels of poverty (UNICEF, 2001). In a country of almost 28 million inhabitants, the highest rates of mortality and morbidity, particularly for both child and maternal health, are unequally distributed (Ministerio de Salud, 2000). The central and eastern regions bear a disproportionate proportion of morbidity and mortality rates. With the goal of contributing to the decentralization of health services, the project worked in eight regions of the country and partnered with regional universities and NGOs to discuss, design and implement activities. (The universities that participated in the Project were the Universidad Nacional San Cristóbal de Huamanga, Universidad Nacional San Antonio Abad del Cusco, Universidad Nacional del Centro, Universidad Nacional de Trujillo, Universidad Nacional Hermilio Valdizán, Universidad Nacional Daniel Alcides Carrión, Universidad Nacional de San Martín and Universidad Nacional de Ucayali.)

Strategic approach

One of the basic premises of the strategic approach was that successful capacity development requires strengthening institutional networks. The intervention deliberately tried to avoid common pitfalls of capacity development projects that reduce activities to training individuals and producing learning materials divorced from actual contexts of professional practice. The activities were conceived as mechanisms to encourage the formation and maintenance of coalitions. For example, internships were opportunities not only for undergraduate students to gain hands-on experience in health promotion, but also for faculty who supervised interns as well as for institutions (universities, NGO, MOH and the media) to collaborate. Workshops were opportunities not only for defining and learning competencies but also to develop ideas for collaboration across local and regional health promotion actors. These and other activities effectively contributed to bringing a diversity of public and private actors together in eight provinces. Subsequently, faculty and health promotion officers collaborated in common projects beyond the duration of the project.

Another key component of the strategic approach was a participatory process to identify opportunities and obstacles for strengthening the health promotion capacity of regional universities. The initial needs assessment revealed the following challenges:

- Unequal capacity among partners. While Lima-based universities had substantial experience and human resources in health promotion, capacity in regional universities was minimal.
- Absence of previous collaboration in similar programs between Lima-based and regional universities as well as among regional universities. Peru’s higher education system has been characterized by weak interuniversity ties and outreach plans.
• Logistical and planning difficulties. The majority of the regional universities continued to experience political situations (strikes, frequent changes of authorities, government intervention and academic reorganization) that presented a variety of challenges such as delay and cancellation of activities; changes in staff responsible for managing activities.

• Cliques in universities limited opportunities for faculty and students to participate in development projects. (These challenges were the result of several factors: the historical centralization of the educational system in Lima; the political violence that engulfed campuses during the 1980s and early 1990s that drove regional universities to sever ties with civil society; and university politics closely dependent on larger politics in regional governments.)

Based on these findings, the intervention was premised on the notion that coalition building is central to capacity strengthening through network building and widening opportunities for faculty and students (Crisp et al., 2000). A partnership with a consortium of universities offered significant advantages to facilitate the formation of a coalition of academic institutions committed to health promotion. First, the Consortium had academic depth and quality to staff the various needs of the project. Its members have solid credentials and national prestige. Second, it offered institutional resources to launch the project in the short term. Given logistical difficulties, time delays and the expenses of setting up a new mechanism, the Consortium’s built-in structure made it possible to start activities in a short period of time. Third, the Consortium offered better chances for long-term ownership and sustainability given that it was not dependent on external donors or multilateral agreements. The fact that the Consortium continues to lead health promotion strengthening activities after the CHANGE Project formally ended suggests the merits of the strategic choice. More time is needed to assess the long-term impact, but as of the time of this writing, the continuation of activities suggests that sustainable mechanisms and institutions are needed for capacity strengthening project to endure beyond the duration of one project or donor’s support.

Another important strategic element was the need to promote institution-building and linkages across organizations. Efforts to develop the health promotion capacity of regional roundtables also presented institution-building challenges. To contribute to the development of participatory health promotion plans and activities, the intervention was charged with the mission of coordinating activities, providing technical capacity, and leading the development and implementation of health promotion interventions. As a consequence of the decentralization of health services in Peru, local institutions are responsible for identifying priorities and designing promotion programs, among other tasks. To make health systems responsive to regional and local needs, the devolution of responsibilities requires adequate capacity to perform tasks that, traditionally, were in the hands of central authorities and officials (Iwami and Petchey, 2002).

The initial assessment showed that regional expertise in strategic health promotion interventions was generally scarce. With the exception of some MOH staff, the majority had limited experience. Equally significant was the fact that only half of the people who had received training said that they had opportunities to apply what they have learned. These findings confirmed that capacity activities needed to be sensitive to conditions and expectations in the workplace, and that training programs need to define competencies based on the conditions in which professionals perform. Assessing opportunities to implement competencies in the workplace, then became central. Another challenge was to promote collaboration across sectors and institutions in the region which, despite geographical proximity, have had few opportunities to participate in common projects among sectors or between regional and district levels.

The main tasks of the roundtables included appointing executive committees; identifying capacity resources and needs; and determining the content of capacity development activities. Sorting out management and coordination issues was not free of difficulties, and the assignment of roles and responsibilities was particularly challenging. The track record and reputation of the two national NGOs in each region was decisive. Working with local NGOs accelerated the launch of the project (e.g. offices were functional, local staff was already working, personal networks and local knowledge existed). Because skepticism and controversy around ‘NGOs’ was tangible in some regions, the fact that the partners brought an excellent reputation was fundamental to
move the project forward. (Both organizations were respected not only because of having technical competencies in health promotion but also because they were competent leaders in bringing various parties and interests together.) During the early part of the project, it was decided that the project needed to strengthen key competencies of regional institutions that participate in local roundtables. One of the most tangible gaps was the absence of evidence-based analysis in health promotion plans. Strategies and messages had been frequently selected without a careful diagnosis of the problems. This was not the result of the lack of adequate epidemiological and social studies, but rather the absence of sufficient human capacity in strategic communication.

The lack of a broad training in health promotion planning was remarkable. Staff had generally received training in specific professions (from nursing to journalism), but they lacked a deeper understanding and nuanced perspective of health promotion approaches and methodologies. Our interest was to strengthen key competencies including health promotion planning, quantitative and qualitative research skills, and message design and testing. The project also aimed to promote ‘learning by doing’. The premise was that capacity development could be more effective if participants had opportunities to apply skills. After an initial series of training sessions, the groups designed and implemented interventions to address health issues that the regional roundtables had prioritized.

Although it is difficult to assess the long-term impact of the project at this point, there are indications that it has contributed to sparking interest in strategic health promotion and served as a catalyst for hands-on experiences for roundtables and communities.

**COMMITMENT TO CAPACITY DEVELOPMENT PROJECTS**

A central issue in the activities with universities and the regional roundtables has been local commitment to capacity development projects. What strategies are appropriate to promote local ownership? How to articulate project goals with the objectives of institutions? What role should donors and agencies play?

To answer these questions, five important lessons can be drawn from the intervention. First, the ultimate goal should be strengthening institutional capacity. It is necessary to go beyond the idea that capacity equals training individuals, particularly in the context of developing countries with weak health promotion institutions. Health promotion professionals typically do not work independently or in private practices. Instead, they work in organizations with specific job expectations, rules and cultures. Also, while individuals typically come and go (particularly when government departments experience frequent staff rotation), institutions remain. In order to affect job performance, it is necessary to define learning competencies based on a nuanced knowledge of how institutions work, how they make decisions, how they incorporate innovations, how they promote staff and the like. If those contextual factors are ignored, capacity development projects could effectively equip individuals with necessary competencies but fail to have an immediate and tangible impact on actual performance. In discussions with supervisors and participants, capacity development activities need to address how competencies can be effectively incorporated in the workplace. If training curricula do not address the specific contexts of practice, capacity activities might unintentionally contribute to promoting a sense of frustration among participants who work in organizations that provide little support to change job performance. The incorporation of health promotion competencies does not mainly depend on whether individuals had effectively learned, but rather on the opportunities, incentives and motivation they receive from their organizations to apply them. Understanding how organizations functions is fundamental to design the content of activities. Only when institutions believe that a set of competencies is needed to improve performance and are committed to encourage their staff to learn and apply skills, local ownership is possible.

Second, if capacity initiatives are (or are perceived to be) donor-driven, then building local ownership is extremely challenging. Sustainability can only occur when local institutions are strongly committed to the project. Chances for sustainability are higher when external actors basically act as catalysts in support of local initiatives; that is, when they support local institutions to resolve challenges that they have already identified or contribute to ongoing projects. If donors and agencies want to spearhead new projects, then existing plans and needs of potential...
partnering institutions need to be assessed to define common plans of action. The reason is that they may obtain short-term buy-in from institutions, but they will not necessarily promote the 'institutionalization of health promotion programs' (Goodman and Steckler, 1987–88).

Third, projects need to find ways to strengthen institutional commitment. If capacity projects depend on support from individuals, personnel changes may disrupt the work and undo what has been accomplished. This issue is of paramount importance considering that staff changes are not unusual in health promotion offices in Ministries of Health. Political volatility, tenure rules and personal circumstances often cause changes in key personnel. Projects might find individuals in key positions who may support a given project and even take an active role. If they bring appropriate management and leadership skills, and have institutional backing, basic conditions are in place for the project to move forward. What happens when the continuity of ‘the project’s champion is unlikely? How to promote institutional ownership?

Projects that involve new institutions are more likely to run into sustainability and ownership challenges. Because the processes were completely new, long-term ownership was unknown. However, it would be a mistake to assume that ownership is guaranteed when working with well-established organizations. Plenty of experiences demonstrate that even in these cases it is hard to guarantee a long-lasting institutional commitment.

There are no proven strategies to increase institutional commitment. One lesson learned is that it is necessary to widen the basis for support within the organizations and identify courses of action to ensure commitment and continuity in spite of changes in individuals. Working closely with ‘project’s champions’ to increase and solidify institutional support may be necessary such as written commitments from academic boards and other institutional bodies that have long-term existence. Signed agreements may be valuable as long as they stipulate roles and responsibilities and can be enforced.

Fourth, there has been some discussion about the comparative advantages of different organizations (NGOs, universities and private voluntary organizations) to lead capacity development initiatives, particularly in terms of strengthening health promotion capacity in MOHs. Our experience suggests the difficulty of settling this debate. Just as important as the central mission of local institutions are their technical strengths, presence, and human and financial resources to determine their capacity to participate in the process. From our experience, the following conclusions can be drawn. First, NGOs and PVOs typically have more field experience than universities, but are not always designed to be long-term, capacity development institutions. Universities are expected to offer training opportunities, but generally are not sufficiently involved in applied work. Second, NGOs are more likely to have expertise working with donors and international organizations (partially because their finances are closely dependent on development projects), but they may lack sufficient time and resources to conduct specific tasks. In contrast, universities might have a cadre of experts, but institutional mandates tend to restrict their participation in development work and social outreach. Third, NGOs tend to have a wealth of hands-on experience, but they lack time to reflect upon and impart lessons learned. The presence of universities does make a difference in terms of the quality and expertise of local professionals. However, universities are generally not designed to plan and conduct training programs in a short amount of time for key audiences (e.g. MOH staff). Fourth, despite their size and number of staff, NGOs generally have a structure that is better suited to implement capacity projects on the ground in a relative short amount of time than universities, which have a more complex and slow-moving decision-making process. Lastly, capacity development should not be reduced to a series of isolated, haphazardly programmed workshops and other activities. Just because workshops are offered and materials are produced year after year, a stronger capacity would not be the final result.

In Peru, for example, there is no shortage of opportunities for health promotion training. The résumés of hundreds of participants clearly demonstrated the wide availability of health promotion courses. Some health issues have been exhaustively studied. Nor has there been a massive ‘brain drain’ that could have undone the impact of previous capacity development efforts. (‘Brain drain’ is more likely to happen among health staff than health promotion personnel owing to the rotation system in the MOH.) However, institutionalized capacity in health promotion is lacking. Although NGOs and
Lima-based universities have valuable experience and critical mass, the availability of these resources did not translate into a continuous application of strategic health promotion.

To maximize linkages between existing capacity in NGOs and universities with the vast and far-reaching network of the MOH, a different approach is needed. Institutional strengthening can hardly be developed without two conditions: a medium-term time horizon (a minimum of 3–5 years) and a perspective that focuses simultaneously on annual activities and the institutionalization of capacity development. If such perspective is missing, then it is not surprising that institutions and individuals only offer short-term commitment to the projects. Without long-term planning, local ownership of capacity development projects is unlikely. While institutions (governments, universities, NGOs and other civil society organizations) might approach such projects mainly as temporary injections of funds and technical assistance, individuals might only see them as consulting opportunities to complement meager salaries. Who might devote full time to projects that only have a short-term commitment? Without a broad perspective and a reasonable time horizon, capacity activities are likely to produce more certificates of training and publications without necessarily churning out professionals and institutions adequately prepared to meet responsibilities and programmatic goals.

CONCLUSIONS AND RECOMMENDATIONS

A long-term commitment from donors and agencies alone is insufficient to successfully address all problems that account for weak commitment to capacity development projects. Strengthening capacity among central and regional governments is likely to confront perennial problems such as bureaucratic red tape, constant personnel changes, overworked and underpaid staff, and political pressures to scrap plans designed by previous administrations. Partnerships with universities, NGOs and PVOs may confront fewer obstacles, but they are not exempt from those challenges.

Capacity projects cannot ignore these conditions. They need to be taken into account in the planning of activities and content, particularly in projects in developing countries such as Peru where government health systems, despite substantial shortcomings, manage to reach and deliver services to the majority of the population. Capacity projects might decide to contribute to enhancing the capacity of civil society organizations, but if they do not also promote capacity in government levels, they might have limited impact on health programs and, ultimately, on citizens.

Creative thinking is needed to re-conceptualize training programs, a staple activity of capacity development projects. Their appeal is obvious: they meet institutional demand and quotas for training. However, they may not have a long-term impact on health promotion and public health effectiveness. Capacity development is not synonymous with training, particularly in context where health systems suffer from continuous brain drain, low morale among staff and lack of institutional incentives to improve workplace performance.

Capacity strengthening entails building institutional partnerships. To be successful, partnerships need to clearly stipulate the terms of collaboration and ensure that all parties are similarly committed to achieving the same results. If these conditions are missing, then shared ownership would be fragile, and partnerships and goals might be short-lived. What is needed is an approach that maximizes the impact of programs through collaboration among institutions committed to supporting and absorbing capacity, to encourage staff and their supervisors to apply newly learned competencies, and to identify mechanisms for monitoring and changing job performance.

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