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KATANGA

USAID'S INTEGRATED HEALTH PROGRAM

Capacity Development Approach

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DISCLAIMER

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USAID'S INTEGRATED HEALTH PROGRAM

Capacity Development Approach

Contract No.: 72066018C00001

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ACRONYMS AND ABBREVIATIONS

BCZ	Bureau Centrale de la Zone de Santé (Central Health Zone Office)
CA	Conseil d'Administration
CAC	Cellule d'Animation Communautaire
CBO	Community-Based Organization
CDR	Centre de Distribution Régional
CLA	Collaboration, Learning, and Adaptation
CNP-SS	Comité National de Pilotage-Secteur Santé
CODESA	Comité de Développement de l'Aire de Santé (Health Area Development Committee)
COGE	Comités de Gestion
CPP-SS	Comité Provincial de Pilotage-Secteur Santé
DEP	Directorate of Planning and Studies
DGOGSS	Direction Générale d'Organisation et de Gestion des Services et Soins de Santé
DHIS2	District Health Information Software 2
DPS	Division Provincial de Santé (Provincial Health Division)
DRC	Democratic Republic of the Congo
ECZS	Equipe Cadre de la Zone de Santé
EEI	Equipe d'Encadrement Integré
EPP	Encadreur Polyvalent Provincial (Responsible for strengthening health zones)
FP/RH	Family Planning and Reproductive Health
GBV	Gender-Based Violence
GHSC-TA	Global Health Supply Chain-Technical Assistance
HF	Health Facility
HFG	Health Financing and Governance (USAID project)
HMIS	Health Management Information System
ICB	Institutional Capacity Building
IGA	Integrated Governance Activity (USAID implementing partner)
IGS	Inspection Générale de la Santé
IHRIS	Integrated Human Resource Information System
IPS	Inspection Provinciale de la Santé
IRC	International Rescue Committee
KAP	Knowledge, Attitudes, and Practices
LMIS	Logistics Management and Information System
M&E	Monitoring and Evaluation
MEL	Monitoring, Evaluation, and Learning
MNCH	Maternal, Newborn, and Child Health
MOH	Ministry of Health
PEPFAR	President's Emergency Plan for AIDS Relief
PICAL	Participatory Institutional Capacity Assessment and Learning Index
PNAM	Programme Nationale d'Approvisionnement en Medicaments
PNDS	Plan National de Développement Sanitaire
PNLP	Programme Nationale de Lutte Contre le Paludisme
PNSR	Programme Nationale de la Santé de la Reproduction
RBF	Results-Based Financing
SBC	Social and Behavior Change
SCM	Supply Chain Management
SIGL	Système d'information de gestion logistique
TB	Tuberculosis
TRG	Training Resources Group
UNDP	United Nations Development Program
USAID	United States Agency for International Development
USAID IHP	USAID's Integrated Health Program
WASH	Water, Sanitation, and Hygiene
ZdS	Zone de Santé (Health Zone)

EXECUTIVE SUMMARY

BACKGROUND

The Capacity Development Approach report provides USAID's Integrated Health Program (USAID IHP) team and its client, the United States Agency for International Development (USAID), with a description of the capacity-development approach that will be employed over the course of the seven-year program. This report informs program partners of the guiding principles, methodology, strategy, and expected results that will frame the design and implementation of effective capacity-building interventions.

USAID IHP is being implemented by Abt Associates, International Rescue Committee, Inc. (IRC), and Pathfinder International, with a base period of January 31, 2018 through May 30, 2022 and one three-year option period from May 31, 2022 through May 29, 2025[1] in the regions of Eastern Congo (provinces of Tanganyika and South Kivu), Kasai (Kasai-Oriental, Lomami, Sankuru, and Kasai-Central), and Katanga (provinces of Haut-Lomami, Lualaba, and Haut-Katanga). The purpose of USAID IHP is to strengthen the capacity of Congolese institutions and communities to deliver quality, integrated health services to sustainably improve the health status of the Congolese population.

- Objective 1 is to strengthen health systems, governance, and leadership at provincial, health zone, and facility levels in target health zones.
- Objective 2 is to increase access to quality, integrated health services in target health zones.
- Objective 3 is to increase adoption of healthy behaviors, including use of health services, in target health zones.

The strengthening of institutional capacity cuts across all components of USAID IHP and is an essential element of the program's sustainability strategy.

CONTEXT FOR CAPACITY BUILDING

Institutional reforms in the Democratic Republic of the Congo (DRC) have increased the number of provinces or units (including Kinshasa) from 11 to 26 and increased the number of authorities within these entities. In line with this, the Ministry of Health (MOH) has established 26 new health provincial and Kinshasa health divisions (Division Provincial de Santé [Provincial Health Division] or DPS); consolidated the number of central directorates from 13 to nine; and restructured specialized programs. USAID IHP will support the reform process through institutional strengthening at the provincial, Zone de Santé (Health Zone) or ZdS, and health facility levels of the health system along with their community and private sector partners. However, USAID IHP will work with and through the MOH to ensure coordination with national level systems and procedures. Based on USAID IHP's experience, it will also share lessons learned to shape and influence national policies that directly affect the functioning of the DPS and ZdSs (especially focusing on empowered health zones).

[1] Period of performance based on Modification1 to the Contract, which is in the process of finalization with USAID.

OBJECTIVES OF CAPACITY BUILDING

USAID IHP will implement an institutional capacity-building approach that will:

- Strengthen the DPSs in the nine focal provinces so they can function effectively as strong and effective organizations. To do so, they will use core MOH management systems and procedures in planning, reporting, coordinating, oversight, and financial management.
- Strengthen the institutional capacity of the 178 ZdSs and health facilities (HFs) so they can carry out their core functions, which are managerial, service delivery-oriented, or community development-oriented. This includes collaboration with Comité de Développement de l'Aire de Santé (Health Area Development Committee) or CODESAs and health committees, and coordination of the activities of key stakeholders, including private sector providers.
- Build the capacity of organizations that are part of the health system or partners to the health system. This includes community structures such as the CODESAs, other community-based organizations (CBOs) and private sector health care providers. For community structures, USAID IHP will also reinforce their ability to interact with MOH institutions and to foster accountability of the MOH institutions to carry out their functions effectively.
- Develop and strengthen individuals' technical knowledge, service delivery and management skills to enable the systems and organizations to provide improved health services.

DEFINITION AND GUIDING PRINCIPLES

USAID IHP proposes a broad framework for the institutional capacity building (ICB) approach in which capacity building is defined as the process through which individuals, organizations, and societies obtain, strengthen, and maintain the capabilities to set and achieve their own development objectives over time (United Nations Development Program (UNDP)). Our institutional strengthening work is grounded in the premise that capacity building and institutional development are tools and means to an end, and therefore a shared vision is the primary goal that leads service delivery achievements and other beneficial outcomes.

Our capacity building approach will be:

- **Grounded in organizational development.** Together with stakeholders, we will jointly develop a comprehensive view of what it takes to be a functioning organization and create capacity strengthening plans based on institutional assessments.
- **Aligned with MOH's priorities and processes.** In all program activities, USAID IHP will work through and reinforce MOH systems, thereby supporting the ongoing reform process.
- **Part of an integrated system including CODESAs, ZdSs, and DPSs.** Interventions, while geared towards meeting the needs at each level within the MOH, must be implemented in an integrated manner and coordinated with other projects and donor activities.
- **Assessment- and data-driven.** Prior to conducting interventions, USAID IHP guides the MOH entity to conduct a self-assessment and to plan organizational development activities. The outcomes of the self-assessments inform the design of tailored capacity-building interventions.
- **Outcome-driven.** The emphasis of our capacity building is on moving institutions to focus on performance to achieve desired outcomes and proper implementation of core functions.

- **Inclusive of intangible factors.** USAID IHP will work with the MOH to reinforce all aspects of a well-functioning organization, including ensuring attention to intangible areas that typically receive less attention (such as working on organizational culture, social skills, experience, creativity, social cohesion, social capital, values, motivation, habits, traditions, institutional culture). Leadership is an essential element of establishing a "corporate culture" and we will work with managers at various levels to diagnose the particular cultures existing in their current organizations, analyzing the impact that these cultures have on their ability to provide services, and attract and retain repeat clients, and recognize the various factors that influence such cultures in an organization and coach on how to change them. These activities are also partially informed by the Conflict Sensitivity report and the Gender Sensitivity report.

METHODOLOGICAL APPROACH

A four-stage methodology describes the overall flow of the USAID IHP institutional capacity-building:

- Organizational assessment, using the Participatory Institutional Capacity Assessment and Learning Index (PICAL) tool, identifies management and performance gaps, allowing us to develop a customized capacity-building plan for each institution.
- Strengthening of the institution is based upon this capacity-building plan, which identifies performance gaps and interventions to overcome them.
- Application of newly acquired skills and competencies requires real-time, frequent application of new skills that embeds them in behaviors for sustained impact.
- Achievement of outcomes requires constant reinforcement and buy-in from management, as well as a critical mass (tipping point) of individuals adopting the behaviors.

The **PICAL** Index is an assessment tool to evaluate and monitor four themes of institutional capacity development: Demand for Institutional Performance, Organizational Learning Capacity, Administrative Capacity, and Institutional Strengthening Capacity. The PICAL tool is part of USAID/DRC's evolving assessment framework.

STRATEGY

USAID IHP will build on the Health, Finance, and Governance (HFG) capacity building strategy successfully applied in Haut-Katanga and Lualaba provinces, and in the Ministry of Health, to expand coverage to the provincial, health zone, and community levels. A key element of this strategy is continuous staff development within USAID IHP to promote the mindset and skills needed to achieve program goals by working within the organizational frame and systems of the MOH. The USAID IHP approach to capacity development will be implemented at the individual, organizational, and system levels.2

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[2] Using the President's Emergency Pan for AIDS Relief (PEPFAR) framework

Individual. We will develop the public health competencies and management skills of individuals, increasing staff knowledge and implementation of organizational systems at the DPS, ZdS, and community levels to support the MOH's organizational capacity to perform its service delivery functions.

Organizational. Working with MOH organizational entities, we will identify, prioritize, and detail areas needing the most attention to build their organizational capacity.

- *At the national level*, while we will not be doing direct organizational capacity building, but we will coordinate with central MOH directorates and the Comité National de Pilotage-Secteur Santé (CNP-SS) to share experience and help transmit, shape policies and procedures based on the work at the provincial and health zone levels. Our national-level interactions, mostly consisting of 1) constant information sharing and 2) involving them in periodic visits to provinces to participate in provincial-level dialogues, will promote consistency and a common vision, aiming at ensuring that the MOH policies and procedures are informed by and supportive of USAID IHP's work, strengthening cross-sectoral collaboration and enhancing the sustainability of the health system.
- *At the provincial level*, we will work with the DPSs to address needs related to the capacity to use core MOH systems; basic organizational strengthening; and capacity to strengthen their ZdS staff and organizations. Provinces will then work with USAID IHP to prioritize specific health zones where coaching will be provided to ensure application of skills learned and to apply MOH systems.
- *At the health zone level*, we will train management teams to strengthen the CODESAs and other key community organizations to fulfill their roles as partners in the health system representing community interests and holding ZdSs and their facilities accountable for the quality and extent of their service delivery.

System. USAID IHP will build the capacity of institutions and communities to use existing systems, including the human resources management and supply chain systems. Through intra-sector and inter-level collaboration, we will identify and address implementation challenges to ensure positive outcomes.

At the provincial and zone levels,, the USAID IHP team will develop the skills to enable and support capacity development at the next level down, in a cascading approach to building capacity. Processes at each level must work in tandem if USAID IHP is to successfully strengthen the health systems of the DRC's MOH. For this to happen, USAID IHP will need engagement at each level and recognition that capacity development is one of the linchpins of long term success.

We anticipate that focusing on empowered health zones is key to building a solid process that can be a model for success elsewhere. This is part of the cluster plan described in our work plan, where we identify better-performing health zones and health facilities and work with them to establish them as role models for other facilities near-by. While many factors limit the rate of uptake and success of USAID IHP's program, such as security, financial situation of the ZdS or health facilities, cultural systems that affect the speed of behavior change, USAID IHP will use a cluster approach to help change the norms from within the society, with models owned and spread by the facilities and local populations themselves. The cluster approach identifies better performing health zones and facilities and helps them to extend themselves further to become models in their region, exemplifying well-run, accountable, and patient/client service delivery successes. These model facilities then become active participants and leaders in the strengthening of other facilities in their region or "cluster."

EXPECTED CAPACITY-BUILDING RESULTS

The goal of USAID IHP is to successfully build the capacity of MOH institutions, service delivery personnel, and community organizations to understand, embrace, and effectively carry out their roles and responsibilities, using MOH systems, structures, and evolving MOH strategies. The ultimate metric for success will be the extent to which the nine DPSs and 178 ZdSs become stronger institutions, and service delivery becomes more efficient and effective.

Some highlights of capacity development success that we will achieve include:

- Ability of DPSs and ZdSs to use standardized MOH procedures to develop operational plans and budgets, account for financial resources, and establish effective quarterly coordination meetings with stakeholders.
- Capacity of DPSs, ZdSs, HFs, and CODESAs to identify and advocate for resource needs from the MOH, development partners, and the private sector.
- Strengthened internal management of the DPSs, ZdSs and HFs on better knowledge and implementation of appropriate financial and administrative roles.
- Strengthened role of the Inspection Provinciale de la Santé (IPS) in reinforcing and supporting compliance and implementation especially in relation to the DPS which has potentially overlapping mandates.
- integration of specialized programs, such as the immunization program or the family planning program, into the DPS structure, without compromising the operational efficiency they acquired as stand alone programs.
- Strengthened DPS capacity to develop the ZdSs, train them in and supervise their operations, and ensure that the ZdSs and their facilities are providing quality service delivery.
- Strengthened ZdS management capacity, in particular by helping DPS to strengthen Comités de Gestion (COGE) and the Conseil d'Administration (CA), and helping ZdSs to strengthen CODESAs, so that the expectations and roles of each are clear and are carried out effectively. The choice of counterpart organization(s) will be a case-by-case basis, prioritizing those organizations that are most functional in a given ZdS, and moving over time to address less functional organizations as time/budget permit.

IMPLEMENTATION

As the responsibility for capacity building is widely shared across USAID IHP, all program staff must have an understanding of this approach. Allowing adequate time for ICB efforts is key to success. USAID IHP therefore proposes a multi-year time horizon to enable meaningful organizational change to take hold, recognizing the need for sustained effort and the range of factors influencing the implementation time frame. As a dynamic process, ICB needs ongoing monitoring that assesses progress, identifies issues, and learnings, and makes mid-course corrections and adaptations. We will use a robust approach to monitoring, evaluation and learning (MEL), using annual PICAL-based assessments to track progress and Collaboration, Learning and Adaptation (CLA) approaches to capture and disseminate learning.

1. BACKGROUND AND CONTEXT

1.1 INTRODUCTION

The goal of USAID's Integrated Health Program (USAID IHP) is to strengthen Congolese institutional and community-level capacity to deliver high-quality, integrated health services that sustainably improve the health status of the Congolese population. The program builds on previous health investments in the Democratic Republic of the Congo (DRC), USAID's Country Development Cooperation Strategy, and related Government of the DRC strategies and policies.

USAID IHP will provide support to provinces to empower Zones de Santé (Health Zones) or ZdSs to sustainably improve their ability to deliver quality services in family planning and reproductive health (FP/RH); maternal, newborn, and child health (MNCH); nutrition; tuberculosis (TB); malaria; water, sanitation, and hygiene (WASH); and supply chain services. Cross-sector areas of program focus include gender, gender-based violence (GBV), climate change, social and behavior change (SBC), innovation, urban health, the youth bulge, and the private sector. Targeted institutions include province directorates, ZdSs, health facilities, health committees, and civil society organizations. The capacity-building interventions target both facility-level and community-level primary health care platforms. USAID IHP will operate in nine provinces, operationally grouped in three regions of the DRC: Eastern Congo (South Kivu and Tanganyika); Kasai (Kasai Central, Lomami, Sankuru and Kasai Oriental); and Katanga (Haut Katanga, Haut Lomami, and Lualaba).

1.2 INSTITUTIONAL CAPACITY DEVELOPMENT CONTEXT: MINISTRY OF HEALTH

The DRC's February 18, 2006 constitution made several profound institutional reforms, including an administrative and territorial reform based on decentralization principles. This reform increased the number of provinces or units from 11 to 26 (including the city of Kinshasa) and increased the number of authorities within these entities. Despite limited progress decentralizing other sectors, the Ministry of Health (MOH) has moved forward in establishing the 26 new health provincial and Kinshasa Divisions Provincial de Santé (health divisions) or DPSs, consolidating the number of central directorates from 13 to nine, and restructuring the specialized programs. The DPSs, which are a focus of USAID IHP, were established in 2015-2016 and have been functioning for several years.

The MOH realizes that investments in the health sector that do not take into account institutional capacity building (ICB)—and governance more broadly—will not have much impact on the provision of and access to quality health care. It recognizes that support for the reform process must include institutional strengthening to enable all levels of the health system to carry out their roles effectively.

Equally, USAID/DRC's Country Development Cooperation Strategy 2014-2019 recognizes that transformational change in the DRC will require long-term investment and focus. USAID's 20-year vision for the DRC features a strengthened democracy and governance system, where the Congolese take ownership of their future to sustain and manage growth with their own resources[3]. The development hypothesis underlying this new strategy is that if "USAID and the international community invest in

[3] Country Development Cooperation Strategy 2015-2019. USAID DRC

institutional capacity to create a foundation upon which Congolese reforms can build, then the Congolese will be equipped to take greater ownership of the country's future, ensuring that basic needs are met, more equitable growth occurs, and stability increases." ICB is an essential investment and is a tool for enhancing good governance and integrity.[4]

Since 2015, USAID has been actively implementing this vision in the health sector. It supported[5] the restructuring and establishment of two central directorates, the Directorate of Organization and Management of Health Services and the Directorate of Human Resources. It also supported strengthening and decentralized capacity building in two provinces—Lualaba and Haut-Katanga—and provided limited institutional-strengthening assistance to other central directorates and programs. This provincial experience directly informs USAID IHP's institutional capacity development approach, especially for MOH provinces and ZdSs. USAID seeks to enhance synergies between its health and democracy-and-governance programs as the MOH reform process feeds into a larger governmental reform in a number of other key sectors that USAID also supports.

The new decentralization mandate requires work at the DPS and ZdS levels to ensure they have the training, resources, and other assets necessary to meet challenges accompanying this structural change. DPSs and ZdSs typically do not use best practices in planning, budgeting, and monitoring and are not always aware of the norms and systems set by the national-level Ministry. Provincial and ZdS staff often lack management skills. A lack of strong internal accountability; the limited capacity and use of accountability mechanisms (such as Comités de Développement de l'Aire de Santé [Health Area Development Committees] or CODESAs) and reporting functions; and either insufficient leadership attention or corruption lead to waste and fraud. There are also inconsistent (and sometimes absent) incentives to motivate staff to improve their performance. Health personnel supervision is infrequent and inadequate; many positions are often unfilled. Additionally, not all DPSs are equipped to use existing MOH management systems. Thus, a large part of USAID IHP's capacity building approach aims to develop provincial and ZdS-level MOH institutional ability to carry out core functions of planning, program implementation, coordination, supervision, and monitoring and evaluation (M&E). These components will enable improvement to programs and service delivery, leading to better health outcomes.

USAID IHP will work with the governmental structures at the DPS and ZdS levels, as well as with other governmental and nongovernmental actors, to strengthen their capacity to interact with systems, inform them, and promote accountability. These actors will include those at the community level, within the supply chain, within private sector delivery services, and with MOH service-delivery mechanisms.

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[4] The Concept of Institutional Capacity Building and Review of Road Sector Projects, MD Langaas, J. Odeck, and K. Bjorvig, Norwegian Public Roads Administration, Norway. p. 12.

[5] Abt-led Health Finance and Governance Project

1.3 INSTITUTIONAL DEVELOPMENT AND IMPACT RESULTS

Some studies have shown that when institutional development is the main objective, impact results are not impressive nor sustainable.[6] Capacity building and institutional development are tools and means to an end, not an end in themselves, and therefore a shared and owned future vision for the institution is the primary goal that, with the right coaching and other capacity development methods, can lead service delivery achievements and other beneficial outcomes. This shared vision can be a tool in itself, reducing resistance to change and creating excitement around improvements and desire for individual development, which will fuel the organization's maturing over time and achievement of its service delivery mandate. This shared vision of a functional organization is the foundation of all the institutional-strengthening work that USAID IHP will undertake. The strengthening of institutional capacity cuts across all components of USAID IHP and is an essential element of the program's sustainability strategy.

USAID IHP's ultimate metric for success will be the extent to which the nine DPSs and 178 ZdSs become stronger institutions, and service delivery becomes more efficient and effective. Obvious signs of such increased strength are the ability to carry out core functions in line with their mandate and the extent to which health system pillars (over which they have implementation responsibility) perform better. We will use the Participatory Institutional Capacity Assessment and Learning (PICAL) Index to measure the baseline and changes during project implementation.

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[6] The Concept of Institutional Capacity Building and Review of Road Sector Projects, MD Langaas, J. Odeck, and K. Bjorvig, Norwegian Public Roads Administration, Norway. p. 12.

2. BACKGROUND AND APPROACH

2.1 DEFINITION OF CAPACITY BUILDING

Among the many definitions of capacity building, we adopt a definition used by the President's Emergency Plan for AIDS Relief (PEPFAR) that considers three levels of intervention7. This aligns closely with the ecological model, one of the modern conceptual models for behavior change. USAID IHP's capacity-building approach includes all three levels:

1. **Individual:** develops the competencies of individuals in technical and in managerial domains to strengthen the knowledge and skills individuals need to fulfill certain roles.
2. **Organization**[8]**:** builds the capacity of a single organization or operating unit of a larger entity, such as a DPS, in management and organization, or a CODESA in its role as stakeholder representative and with its accountability function. Includes the ability of an organization or unit to finance, plan, manage, implement and monitor its activities and services.
3. **System**: manages multi-organizational structures and strengthens institutional arrangements and coordination mechanisms required for both public and private organizations to work together toward a common end. Comprises structures, standards, guidelines, supportive policies, legal frameworks, budgets, and even attitudes and behaviors and how they operate together.

The text box at right contains a definition of institutional/organizational capacity building that USAID IHP is using as a broad framework for ICB in the program.

Definition of Institutional/ Organizational Capacity Building

The process through which individuals, organizations and societies obtain, strengthen and maintain the capabilities to set and achieve their own development objectives over time.

Source: United Nations Development Programme

2.2 USAID IHP'S OVERALL OBJECTIVES OF CAPACITY BUILDING

- To strengthen the DPSs in the nine focal provinces so they can function effectively as strong and effective organizations. To do so, they will use core MOH management systems and procedures in planning, reporting, coordinating, oversight, and financial management.
- To strengthen the institutional capacity of the 178 ZdSs and facilities so they can carry out their core functions, which are managerial, service delivery-oriented, or community development-oriented. This includes health zone management teams and administrative councils, CODESAs, and coordination of the activities of key stakeholders, including private sector providers.
- To build the capacity of organizations that are part of the health system or partners to the health system. This includes community structures such as the CODESAs, other community-based organizations (CBOs) and private sector health care providers. For community structures, USAID

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[7] PEPFAR, Capacity Building and Strengthening Framework. 2011

[8] We use "institutional" capacity building (ICB) and "organizational" capacity building throughout this document, where "institutional" is typically referring mostly to government organizations, and the term "organization" is used more generically and also to cover community-based and other non-governmental structures.

IHP will also reinforce their ability to interact with MOH institutions and to foster accountability of the MOH institutions to carry out their functions effectively.

- To develop and strengthen individual's technical knowledge, service delivery, and management skills to enable the systems and organizations to provide improved health services.

2.3 GUIDING PRINCIPLES

We will adhere to the following guiding principles in our capacity-building approach:

- **Grounded in the details of organizational development**. We will apply a systematic approach to institutional assessments and share and use the findings to develop capacity-strengthening plans together with the stakeholders. We will engage regularly with client organizations from the outset, and jointly develop a comprehensive view of what it takes to be a functioning organization consisting of a defined mandate, strategy, clear organizational structure, clearly defined roles and responsibilities, sound internal leadership and management, and skills for working in teams.
- **Aligned with MOH's priorities and processes.** The reform process is well underway, especially at the provincial level. Different partners support the MOH in developing systems, guidelines, and procedures for new decentralized responsibilities. National-level planning, information, human resources, and management systems are also developed or being developed to ensure consistency across DPSs. In all program activities, the actor through which work is conducted is thus the MOH.
- **Working with CODESAs, ZdSs, and DPSs as an integrated system whose capacities to succeed are interdependent**. While each level within the MOH organizational structure has its own capacity-building needs, interventions must be implemented in an integrated manner, such as the bottom-up planning processes that the MOH promoted in Lualaba and Haut Katanga. For the planning process to work, the DPSs, ZdSs and CODESAs must work in a coordinated way. We will also coordinate with other projects and donor activities to promote consistency, reduce redundancy, ensure collaboration, and share learnings.
- **Assessment- and data-driven.** Prior to conducting interventions, USAID IHP will guide the MOH entities (DPSs in this case) to conduct self-assessments using the PICAL tool. MOH officials and staff are both participants and leaders in the assessment and planning of subsequent organizational development activities. The outcomes of the self-assessments inform the design of the capacity-building interventions, which will be tailored to the needs of each DPS and ZdS. While many needs will be generic, province- and zone-specific needs will emerge and require tailored interventions.
- **Outcome-driven.** The emphasis of our capacity building does not lie on provided inputs (e.g. training, coaching, or facilitation) but on moving institutions to focus on desired outcomes and the end state when core functions are properly implemented. This vision translates into a focus on performance rather than on inputs, such as numbers trained. For instance, strengthening capacities of each Equipe Cadre de la Zone de Santé (ECZS) should lead to more effective supervision with focus on health outcomes.
- **Inclusive of intangible factors.** Organizational improvement is often dependent on several intangible factors that can be addressed through leadership and management training and team building. These include the development of organizational values and the behaviors to make them come alive, motivation of staff in ways other than financial, and building social cohesion in the work

team through team building. USAID IHP will work with the MOH to reinforce these aspects of a well-functioning organization.

A simple but powerful example of how USAID IHP can help the MOH in addressing intangible factors is by promoting the guiding principles that underly the implementation of the Plan National de Développement Sanitaire (National Health Development Plan) or PNDS. These could include: accountability, customer satisfaction, ownership, partnerships with communities. Such factors are often written in strategic plans, and then forgotten. Such intangibles, e.g. attitude of service delivery staff, their interactions with the public, will be tested through the Knowledge, Attitudes, and Practices (KAP) surveys that we conduct, and through the Geopoll social media inquiries that we put in place, as well as the VIAMO complaint hotlines. More importantly, the intangibles that are part of the organizational culture will be tested by the yearly PICAL assessments that are part of the PICAL process, which encompasses not only the assessments, but the action planning and skills strengthening resulting from the PICAL assessment.

To succeed, the MOH and USAID IHP will include activities designed to implement the available MOH-provided incentives or work through dialogue with the national level to develop and institute them through the DPS and ZdS levels to appropriately reward or sanction behaviors, create environments that encourage effective communication and information sharing, develop MOH institutions and their staff's capacity to engage with stakeholders, assess situations and define a vision that helps move from analysis to action, including evaluation and monitoring of performance.

We will build **collaboration, learning, and adaptation (CLA)** into the organizational development process. Mature organizations use CLA to shift management practices towards planning and reflection that recognize systemic problems in an organized manner rather than as "exceptions." Our organizational development strategy will include building the institutions' capabilities to analyze and reflect on behaviors and successes and use this feedback to refine processes and provide input to management at the national level, especially where such information should inform systems and policies.

We will promote a **cascading approach** to building capacity. The MOH's new system tasks the national level with the task of "encadrement" of the provincial level, the DPS with the "encadrement" of the ZdS, and the ZdS with the "encadrement" of the CODESAs, Comités de Gestion (COGEs), and Cellules d'Animation Communautaire (CACs). This means that the USAID IHP team will at each level build the skills to develop the next level down.

USAID IHP has a multi-year time horizon to allow time to make noticeable and sustainable improvements. We realize there is no quick fix and that improved institutional performance will require sustained effort over time.

USAID IHP will use a range of **interventions that include and go beyond training**. Not only does training require follow-up to be effective, but ICB also requires a much broader array of interventions than training. Key to these activities is accompanying the institutions and organizations as they carry out their functions in a learning-by-doing model of capacity building, assigning roles and tasks, and helping managers build the skills to assess, oversee, support and hold staff accountable for the effective implementation of assignments.

Finally, we will use a robust approach to monitoring, evaluation, and learning (MEL), using annual PICAL-based assessments to track progress and CLA approaches to capture and disseminate learning.

2.4 METHODOLOGICAL APPROACH

Our overall methodological approach has four stages, which can be repeated in a cyclical fashion.

FIGURE 1: Theory of Change

- Assessment and planning during stage one identifies management and performance gaps. It allows us to develop a customized capacity-building plan for each institution.
- Strengthening of institutional capacity during stage two is based upon this capacity-building plan, which identifies performance gaps and interventions to overcome them.
- Application of new skills in real time in stage three is not a one-time intervention. Real-time, frequent application of new skills embeds them in behaviors for sustained impact.
- Achievement of program outcomes in stage four requires constant reinforcement and buy-in from management, as well as a critical mass (tipping point) of individuals adopting the behaviors. Although some changes can induce sudden impact, newly acquired capacities must be sustained over time before the organization can claim sustained impact of program outcomes.

The above theory of change mirrors the overall flow of our institutional capacity-building methodology.

2.5 STRATEGY

We build on the foundations, experiences and lessons learned of the Health Financing and Governance (HFG) capacity-building strategy that was successfully tested and applied in Haut-Katanga and Lualaba provinces and in a few institutions of the MOH (see https://www.hfgproject.org/essential-package-of-health-services-country-snapshot-the-democratic-republic-of-the-congo/). We will make use of its existing materials, of the institutional self-assessment tool PICAL, and of a web of contacts who are champions of the process. The HFG DRC Final Report (2018) (see https://www.hfgproject.org/hfg-democratic-republic-of-the-congo-final-country-report/) describes evidence upon which the current strategy will build to strengthen institutions.

USAID IHP will expand coverage and apply the strategy at the provincial, health zone, and community levels, and adapt it to the needs of each. All technical staff will, in some way, effect capacity development as part of their daily work, and will thus contribute to the increased capacity to plan, implement and monitor programs and services by using proven ICB methodologies.

We also build on the central role of the health zone in DRC health system, the pivot around which the whole health system and its subsystems gravitates and the entity from within which the lives of 150,000 to 200,000 people can be directly affected through the delivery of services, information or products. Dependent on its leadership, its resource environment, its own culture and tradition a health zone can be anywhere on the continuum that ranges from being dependent, weak and disempowered to being confident, forward looking and in control. If a metric would exist that captures the degree of empowerment it would be normally distributed with some variation around a mean. We envision that the capacity building skills that we intend to entrust the provinces with would move such distribution to

the right, i.e. increasing the average degree of empowerement, while also narrowing the variation around its mean, i.e. having more health zones evolving towards that state of consistently greater empowerment. Given the structure of the PICAL, which has many subsets under its four major categories, the disaggregated measures will be more meaningful in terms of assessing progress than the overall score, which will be helpful from both a measurement point of view, as well as a "next steps" point of view.

For decentralization to succeed, USAID IHP commits to working with and through the MOH to reinforce and build its capacity to implement its envisioned decentralized ***organization***, ***systems, and personnel.***

A mindset change needs to take place, as USAID IHP achieves its program goals by working within the organizational frame and systems of the MOH, rather than doing work in place of the MOH. It is a mind-set change not only for MOH employees, but also for program staff. Indeed, to achieve results, projects often deliver services or are the purveyors of services to fill perceived gaps in government services.

Such a strategy requires adjustment of attitudes and perspectives of program staff and needs continuous skills building around consultation techniques and organizational development strategies. Continuous staff development within USAID IHP is therefore also a pillar of this capacity-development approach.

To further follow the rubric mentioned in Section 2.1—individual, organization, and system-wide—USAID IHP will emphasize organization-level capacity development, but also include systems and individual capacity development both as functions of building an organization's capacity, and in recognition of their unique contributions to an institution's overall well-being and functionality and their personal ability to deliver quality services. Accountability, for example, is approached through systems that the MOH puts in place and which their organizational units implement. Employees/individuals need the right incentives (such as professional development, recognition by their peers or supervisors; these are not always financial) to do their jobs well. They also need professional development in terms of their technical knowledge in USAID IHP target areas such as MNCH, FP/RH, malaria, TB, nutrition, and WASH to provide the appropriate treatment and services to clientele.

All processes must work in tandem for USAID IHP to successfully strengthen the health systems of DRC's MOH. The following sections detail our approach to strengthening each of these elements of a well-functioning institution. The following chart shows USAID IHP's capacity-development approach. Although designed for PEPFAR, it is a broadly relevant capacity-development framework that can be applied in the government or the community context.

Table 1. Capacity Building and Strengthening Framework

<table>
<tr><th colspan="2" rowspan="2">POTENTIAL EFFECT OF CAPACITY BUILDING BY COMPONENT</th><th colspan="2">ILLUSTRATIVE EXAMPLES OF ACTIVITIES FOR BUILDING CAPACITY</th></tr>
<tr><th>GOVERNANCE/MANAGEMENT</th><th>TECHNICAL</th></tr>
<tr><td>Systems/Policy</td><td>Activities <u>improve external environment where organizations and individuals function,</u> including structures supporting how organizations interact, and/or policies and standards. May be at national level or below.</td><td>Governance and stewardship
Policies and regulations
Decentralization frameworks
Human resource management systems
Financing policies and systems
Resource mobilization or resource allocation
Operating guidelines or operating systems
Stakeholders coordination systems and networks
Knowledge management systems
M&E systems</td><td>Technical leadership
Accreditation systems
Technical councils, task forces
Technical guidelines and standards
Infrastructure works
Continued education and professional development
Technical exchange forums</td></tr>
<tr><td>Organizations</td><td>Activities <u>improve performance of internal organizational systems and processes,</u> leading to stronger organizations with ability to adapt and continue to develop over time.</td><td>Governance procedures
Strategic planning and change management
Organizational management
Human resource management
Financial management procedures
Standard operating systems
Information technology systems
Project management
CLA</td><td>Organizational technical leadership
Program approach
Technical guidelines
Standard operating procedures
Results monitoring and reporting
Technical infrastructure (laboratories, curriculum development) & equipment
Organizational training systems
Strategic technical partnerships</td></tr>
<tr><td>Individual/ Workforce</td><td>Activities improve performance of staff per specific, defined competencies and job requirements. Incentivizes professional development and facilitates behavior change.</td><td>Coaching, competency based training and/or degrees in the following areas:
• Leadership (including intangibles)
• Strategic thinking
• Organizational management
• Performance management
• Project management
• Financial management
• Supervision
• Partnerships /collaboration
• Professional networking
• Access to information resources
• Use of data for decision-making
• Advocacy and mobilization</td><td>Skills, training and/or degrees in the following areas:
• Clinical and non-clinical
• Program strategic information
• Epidemiology and surveillance
• Evaluation, monitoring and research
• Laboratory
• Technical training and mentoring</td></tr>
</table>

Freely adapted from "Capacity Building and Strengthening Framework, FY 2012, V 2.0, President's Emergency Plan for AIDS Relief (PEPFAR).

2.6 CHALLENGES OF CAPACITY DEVELOPMENT

Resistance to change, lack of leadership, protection of the status quo, a sense of insecurity about the consequences of change can challenge skills transfer or capacity building. Often, managers and organizations lack effective processes to introduce, encourage, facilitate, and enforce the change.

While one person can make a difference, establishing a critical mass of convinced adopters is even more important when pushing for adoption of new technologies, systems or behaviors. Getting to this tipping point is a key in all behavior change (along with enforcement and accountability), but each situation must be analyzed to determine which factors will potentially cause (or are causing) the resistance to change and how to overcome it.

Our supply chain subcontractor, i+Solutions, shared an experience in Rwanda where a champion led adoption of new reporting requirements that provided good data for decision-making at his level, which his staff adopted and used. But when he left, the new manager, responding to a few complaints, made it optional. Soon, no one was reporting this data. We want to get to a state in these institutions where staff recognize the importance of the change and see value in conducting the new activities or behaviors.

Challenges that stall this process can be minimized when MOH leadership at each level is clear about and owns the desired outcomes. Inspiring the MOH to address these changes and accompanying challenges has multiple advantages and ensures organizational improvements and systems adoption.

- The MOH has established the reform goals and designed systems for change, so the mandate is led by the head of the organization and its leaders.
- Recognizing well-performing organizations within the framework of MOH performance criteria is a motivating incentive. These could include employee-of-the-month events, professional development opportunities, supervisor feedback and goals achievement.
- Procedures that foster accountability and sanction non-performance are often not applied. With the Inspection Générale de la Santé (IGS) and Inspection Provinciale de la Santé (IPS) in place, there is an accountability mechanism that managers can use judiciously to improve MOH's move towards organizational maturity.
- Even more critical are the management skills at the DPSs and ZdSs, where organizational success should be recognized as the success of the department as a whole.

3. CAPACITY DEVELOPMENT AT SYSTEMS, ORGANIZATION, AND INDIVIDUAL LEVELS

3.1 SYSTEMS CAPACITY DEVELOPMENT

The DRC Health System Strengthening Strategy has inspired MOH and its partners to develop a wide range of systems in support of the ministry's key mandate. These systems undergo upgrades and periodic updates, and some are still being developed. It is not in USAID IHP's mandate to create new systems, but to build the capacity of institutions and communities to implement these systems. (See Section 4.0). For example, human resources information systems (such as the Integrated Human Resource Information System or IHRIS) and the logistics management systems (such as the Logistics Management Information System or LMIS) have been under continuous development over the past few years, and we will continue that systems development trajectory as part of USAID IHP via subcontractor BlueSquare. The level of development of the IHRIS tools and LMIS tools are different. A description of existing systems from our analytical work provides a description of HR and LMIS systems.

- HR information systems: The government - with the help of Intrahealth - has setup an IHRIS data platform that has been deployed in four DPS, including one DPS in the USAID IHP program area (Lualaba). Subcontractor BlueSquare has not assessed the accuracy of the data (we will do that in upcoming work), but we anticipate that the data may be outdated since the Intrahealth efforts took place a couple of years ago (~2015). In terms of maturity, the main issue with the HR system is that there is not a clear policy direction from the MOH on how HR data is managed. Will the HR data be supported by a specific HR system for the health sector or by the civil servant data system? Will that system be IHRIS? There isn't a clear direction from the Ministry on these issues. We see the role of USAID IHP as 1) to gain the best possible understanding of the HR situation in the three USAID IHP regions based on the existing data (and baselines); 2) to support IHRIS (and it's possible integration with the HMIS) in its deployment; and 3) support the MOH in defining a direction with regards to HR data systems.
- LMIS systems. On this, the MOH has taken a clear direction (with the support of the Global Health Supply Chain-Technical Assistance project): the Health Management Information System (HMIS)/ District Health Information Software 2 (DHIS2) is the data warehouse for LMIS data. USAID IHP will build dashboards on this data base to provide LMIS monitoring to MOH stakeholders. This choice of using the HMIS/DHIS2 as LMIS system is not without contraints and problems, but we believe that it is the good choice given the complexity in deploying systems in DRC, and at least the direction is clear and basic building blocks are in place and have been used if not systematically, at least in the beginning stages. We believe that the role of USAID IHP is to support data completeness, but also build better LMIS metrics in the HMIS.

The role of USAID IHP is to work at the DPS and ZdS levels to help their management understand and implement these systems, not to create new or parallel systems. On the other hand, operationalizing such systems may reveal shortcomings in their design or administrative challenges. USAID IHP should then use existing forums for intra-sector and inter-level collaboration to bring those implementation challenges to the fore and contribute to the design of the next generation of solutions. This functionality is also part of the CLA approach mentioned above.

There are a few exceptions to USAID IHP's role in systems development. For example, through program subcontractor BlueSquare, we will support continued development and implementation of the

integrated HMIS and will invest continuously to improve the capacity of provincial, zonal and facility-based experts to manage these systems.

HMIS Systems: BlueSquare will support the MOH to evolve an integrated data architecture centered around a strong HMIS. We envision multiple interventions:

- Help the MOH to improve HMIS data structure: e.g., support the continuous improvement of the health facility registry and its data structure.
- Strengthen the HMIS as a reliable source of data that accompanies the shift from parallel data management of different programs to HMIS-centered data management. This support includes building interoperability across data systems and technical support in change management.
- Support deployment of other MOH data systems (e.g., Results-Based Financing (RBF) data system, WASH data system) and align these systems with the HMIS.
- Support the MOH in their OpenData policy dialogue through deployment of public-facing dashboards that display routine MOH data.
- Help the MOH gain a better understanding of health system problems and how to use combinations of different data sources for decision-making.

Supply Chain Systems: i+Solutions will work with the Global Health Supply Chain-Technical Assistance (GHSC-TA) project's contractor to construct "last mile" reporting and management systems implemented from the DPS and ZdS level on down, which feed into each other for inventory management and reporting. Still under discussion with GHSC-TA, as part of our systems cooperation work we may introduce a dedicated stock management system (also known as a logistics management and information system, or e-LMIS), in addition to DHIS2, to provide data visibility up to the last mile. We will work with the ECZS to introduce these new systems and conduct training at the HF and ZdS levels. An important part of this training will focus on transitioning where possible from a paper-based process to an electronic stock management system at the ZdS level and possibly at some health facility levels, and on related behavior change to ensure successful implementation–building the capacity of organizations to use systems to achieve positive outcomes.

3.2 ORGANIZATIONAL CAPACITY DEVELOPMENT

Organizational capacity development improves "the performance of internal organizational systems and processes leading to stronger organizations with the ability to adapt and continue to develop over time."[9] An organization may have some functions that work well and others that do not. USAID IHP will work with MOH organizational entities to identify, prioritize and detail areas needing the most attention to build their organizational capacity to carry out their functions at the DPS and ZdS levels.

[9] Capacity Building and Strengthening Framework, FY 2012, V 2.0, PEPFAR.

PROVINCIAL

USAID IHP proposes the MOH use an assessment-driven approach based on the PICAL tool to identify strengths and weaknesses of each DPS, establish a baseline against which to measure progress, and develop a capacity-strengthening plan. In the first phase, USAID IHP will facilitate the assessment in all the DPSs (except for Lualaba and Haut Katanga).[10] Beginning at the end of Y1 and beginning of Y2, USAID IHP will train selected DPS staff to conduct the assessments and develop capacity strengthening plans.

Based on HFG's experience in 2016-2017, capacity-strengthening needs should fall into three categories:

1. Capacity to use core MOH systems (e.g. annual operating plans, financial management, results-based management);
2. Core organizational strengthening (e.g. roles and responsibilities, team-building, leadership and management, internal management practices); and
3. Capacity to strengthen their health zones' staff and organizations (e.g. coaching, supervision, monitoring and evaluation).

We will also support provinces to strengthen their coordination. This requires direct support to the Provincial Steering Committee for the Health Sector (CPP-SS), clarification of the roles and responsibilities of the DPS vis-à-vis the IPS, and development of DPS capacity to regularly engage stakeholders through quarterly coordination meetings and other mechanisms such as the "contrat unique.". Through the capacity development planning process, we will encourage the DPS to engage inor even organize stakeholder and multi-partner discussions if they do not already occur. USAID IHP will support the "contrat unique" or other coordination mechanisms as they evolve or as the DPSs introduces them in the province.

Lualaba and Haut-Katanga are likely to be more advanced than the other seven provinces, as both have experienced two PICAL assessments and benefited from two-plus years of institutional strengthening. A final PICAL was conducted at the end of HFG to update their most recent results, and this information will be used as a starting point, unless many changes have occurred in the interim (such as a large number of new staff), in which case the PICAL may need to be redone. If it does not need to be redone, those two provinces' staff can spend less time on developing an intervention plan, and implementation can start more quickly. This should focus on strengthening institutional competencies shown to need more work in the last PICAL conducted at the end of the HFG project.

The following table shows illustrative province-level interventions for USAID IHP. Also for illustrative purposes, Annex A lists interventions that HFG carried out in the Lualaba DPS.

The program will develop materials for these interventions, adapting those developed under HFG as a starting point. These cover leadership and management; team building; coaching; supervision; financial management; results-based management; training of trainers; and information technology.

Illustrative Interventions at the DPS Level
In Haut-Katanga and Lualaba

Core MOH systems

- Support development of provincial Development Health Plan
- Support development of annual Operations Plan
- Provide financial management training
- Hold results-based management workshop
- Support functioning of CPP-SS and its thematic groups
- Integrate specialized programs into the DPS structure

Basic organizational strengthening

- Establish Encadreurs Polyvalent Provincial (EPPs)
- Strengthen institutional systems
- Improve stakeholder engagement
- Offer leadership and management training
- Provide team-building
- Provide information technology equipment

ZdS strengthening

- Offer supervision training
- Monitor performance indicators
- Provide coaching skills

HEALTH ZONE

The Integrated Governance Activity (IGA) is a USAID implementing partner that has developed an easy-to-use, short version of PICAL for the zonal level. USAID IHP will collaborate with IGA to learn from its experience and adapt its methods to our health zone PICAL needs. We will adapt the PICAL tool for use at ZdS and possibly at the facility level, and train Encadreur Polyvalent Provincial (EPPs) in each DPS to use the tool. EPPs are DPS staff such as is the case in Haut Katanga and Lualaba.

A PICAL-based assessment typically takes two people two weeks. Because health zones are significantly smaller entities, the tool can be simplified to be implemented by one person in a week. EPPs can then lead assessments in six to eight zones in a sequenced fashion and use those results to develop capacity-strengthening plans. At 178, there are too many ZdSs to assess each one immediately. Provinces will work with USAID IHP to prioritize ZdSs and determine a schedule and work plan to continue this work over the life of the program.

Illustrative Interventions for CODESAs and CBOs

- Clarify roles and responsibilities of CODESAs
- Provide training in planning, implementation, and monitoring of activities, possibly including use of a scorecard approach to obtain community feedback and assess gender and social inclusion
- Set up mentoring programs between stronger CODESAs and weaker ones

Illustrative Interventions at the ZdS Level

Core organizational strengthening

- Provide leadership and management training
- Support development of stakeholder engagement strategies
- Develop advocacy strategy to mobilize resources
- Strengthen coaching skills
- Provide training in results-based management
- Provide training and follow-up in financial management
- Institute accountability structures that also accommodate learning and adaptation

Strengthening community structures

- Support health committees
- Provide technical, financial, and management support to CODESAs so they engage in planning, implementation, and follow-up of activities
- Offer coaching and planning capacity building relating to their organizational mandates

Achieving effects of scale in the large set of health zones requires implementers to adapt small group strategies to much larger ensembles of operational units.

The EPPs will provide follow-up coaching in ZdSs to ensure the application of learned skills and apply the MOH systems for accountability, coaching, and performance management. So, for example, if the DPS intends to organize a workshop to build capacity in stakeholder engagement, two to three members of the health zone management team from each of five to eight health zones will be invited. We will work with the DPS staff to follow up individually with each participating ZdS.

CODESAS AND OTHER CBOS

Just as EPPs in the DPSs will be trained to strengthen the health zones, the health zone management team will be trained to strengthen the CODESAs and other key community organizations that we identify in the ZdSs. We will adapt the PICAL tool to assess the capacity of a limited set of CODESAs (due to their large numbers) and assist the health zone management teams to develop and implement capacity-strengthening interventions.

PRIVATE SECTOR

The private sector is an important player in the DRC's health sector. Private sector health providers—including pharmacies, clinics, and private hospitals—are becoming more numerous. However, oversight of the private sector remains weak. While many of them are competent and offer services not available in the public sector, especially in more remote areas, public sector referral systems do not always include them. The private sector can also play a role beyond service provision, including as an advocate for MOH resources to be applied in infrastructure at the local level, and for the private sector themselves as a provider of resources through public-private partnerships that include private sector contributions to local health sector infrastructure or costs. Other options for working with and developing responsible management of private sector resources are described in a recent report prepared by Abt Associates (in draft[11] and not yet available for public dissemination) financed by the World Bank and the International Finance Corporation, and supported by USAID, the Bill and Melinda Gates Foundation and others.

USAID IHP's capacity development role within the private sector is limited and is to support the MOH institutions to understand and implement their oversight and certification roles within the private sector as defined by the MOH strategies and policies. No support would be directly provided to the private sector other than working with the MOH to include them in community dialogue opportunities and begin to develop an understanding of the important role of the private sector in the health sector. We will work with a limited set of private sector providers through DPS and ZdS institutions and CODESAs to include them in stakeholder and technical forums, where appropriate. If other programs begin to emerge (especially as a result of the mentioned report), we would collaborate with them, as the private sector is a part of the health sector landscape.

NATIONAL CAPACITY DEVELOPMENT

The Congolese system is newly based on a decentralized model, where provinces are extensions of the central government with a significant level of autonomy, where the provinces must follow standardized MOH systems and procedures in such areas as planning and reporting, but are responsible for their own management, staffing, budgeting, and planning, quality control, and supervision of their zones, and service delivery. USAID IHP will work closely with central MOH directorates and participate in the Comité National de Pilotage-Secteur Santé (CNP-SS) to share experience and shape policies and procedures that directly affect the program's work in the provinces. Our national-level interactions with the MOH will promote consistency and a common vision across the ministry, conveying successful models, and ensuring that the MOH and USAID IHP are aligned.

We will develop strong linkages at the central level by holding regular one-on-one meetings with the key central directorates, notably the Direction Générale d'Organisation et de Gestion des Services et Soins

[11] The Role of the Private Sector in Improving the Performance of the Health Sector in the DRC, prepared by Abt Associates Inc., financed by The World Bank and the International Finance Corporation, draft May 17, 2018.

de Santé (DGOGSS), and especially the Directorate of Planning and Studies (DEP) in its lead role in the reform process. We will participate actively in or request briefings regarding the CNP-SS and its six committees to better understand MOH priorities, share USAID IHP experience, and coordinate with other development partners working on the same issues. We will also work with the Bureau Centrale de la Zone de Santé (BCZ) and the Comité de Gestion to facilitate collaboration between the central and provincial levels by funding quarterly meetings to share lessons learned on systems strengthening. These activities will strengthen cross-sectoral collaboration among central and provincial stakeholders and enhance the sustainability of the health system as best practices are disseminated.

3.3 INDIVIDUAL/WORKFORCE CAPACITY BUILDING

MINISTRY OF HEALTH AND ITS WORKFORCE

Individual capacity building is part of the overall capacity-building program at the DPS, ZdS, and community levels. To strengthen these organizations and their systems' effectiveness and efficiency, we will increase staff knowledge and implementation of organizational systems. There are, however, other aspects to capacity development that require attention to individuals' competencies.

Technical Competencies: USAID IHP has a dual responsibility to increase skills in certain areas of public health (including MNCH, FP/RH, infectious diseases, WASH, nutrition, malaria, and TB) and in MOH's organizational capacity to perform its service delivery functions. USAID IHP, as part of its service delivery activities, will work with the MOH and the DPS organizations to provide training and opportunities for technical skill development and provide opportunities in the MOH for skills enhancement. In developing the technical competencies of health workers, we will include the Kinshasa School of Public Health and other relevant schools in programs that lead to their curriculum enhancement. Our work with the ECZSs and EPPs will include extending systems for professional development and skills upgrading of health staff in zones and facilities. We will also strengthen the systems for human resources upgrading within the Ministry structure. Personal skills upgrading is a vital motivator, with implications for hiring and personnel management structures.

Management Skills: Per one study that specifically describes health systems dynamics and capacity building in developing countries, individual professional skills can be divided into competencies and impact variables.[12] Zwanikken *et al.* conducted a study across six countries in four continents on public health competencies and impact variables and the validation of their prioritization and importance in public health degree programs in lower-middle class countries compared to high-income countries. Subsets of the competencies (public health science skills as mentioned in the prior paragraph on technical competencies) and impact variables (context-sensitive competencies) received the highest rankings from both experts and academia.

[12] Validation of public health competencies and impact variables for low- and middle-income countries. Zwanikken et al, BMC Public Health 2014, 14:55. http://www.biomedcentral.com/1471-2458/14/55.

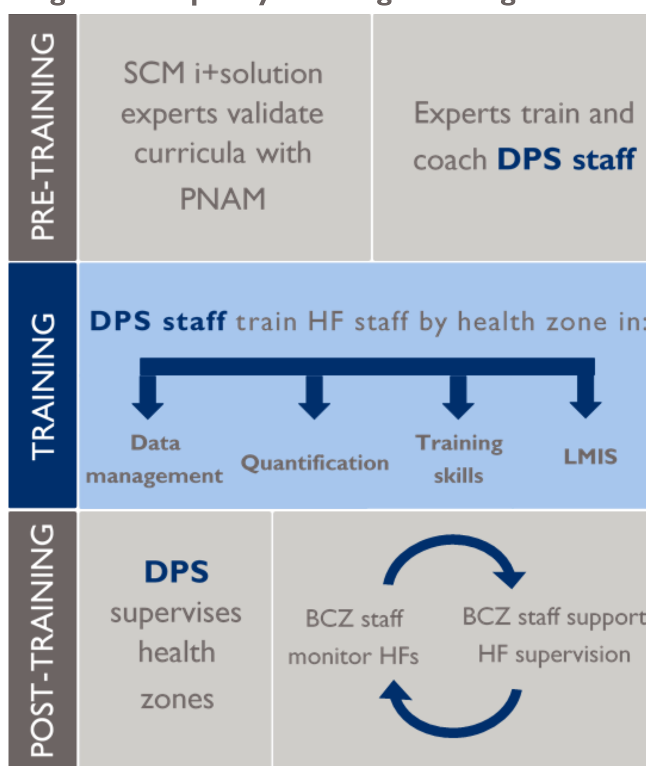
We have selected a brief set of bullets from the study to better explain impact variables and their distinctions before describing how they inform our capacity/workforce development approach under USAID IHP:

- High-scoring impact variables were "planning and management," "communication" as well as "leadership" and "systems thinking."
- Slightly lower but still high ratings were assigned to "policy development" and "community and inter-sectoral competencies."

Impact variables that scored the highest were: "Created evidence for decision-making," "Developed a study or research proposal," "Reported and made recommendations on populations' health status or needs," and "Implemented performance improvement strategies in response to monitoring and evaluation findings."

The main point of citing this study and its findings is to show individual competencies and skills that practitioners find have an effect on the performance of an organization, are highly correlated with advanced management skills. Impact variables are especially interesting as they describe the capacity to use information for decision-making, conduct considered evaluation of performance, and then adjust their strategies. This aspect is relevant for USAID IHP in many of our activities. For example, we will work extensively with the MOH's data collection and utilization systems. Collecting and analyzing data is insufficient for organizational capacity building if it is not used for—nor results in—improved decision-making. If solid decision-making behaviors and processes are rewarded in an organization, this should incentivize individuals to improve their performance as they seek promotions and other recognition, while raising the functioning of the organization.[13]

Figure 2. Capacity Building Training Process



As a further example, the organizational capacity building that i+Solutions will conduct on supply chain systems will contribute to improved availability at service delivery points of essential medicines and other commodities, including malaria, TB, FP/RH, and MNCH commodities. The training approach reinforces ownership and leadership of DPS, ZdS, and health facility (HF) staff in supply chain

[13] This may make a good research agenda topic.

management (SCM), execution of related processes, and the use of SCM tools and systems, from systems, organizational, and individual (technical and managerial) perspectives.

As the graphic above shows, SCM experts at i+Solutions will validate all levels of curricula with the Programme Nationale d'Approvisionnement en Medicaments (PNAM) and train/coach DPS staff. i+Solution SCM advisors will train and coach the DPS staff jointly with PNAM experts. At the provincial level training of trainers will be targeted at staff of DPS who are engaged in the supply chain, such as staff of the Programme Nationale de la Santé de la Reproduction (PNSR), Programme Nationale de Lutte Contre le Paludisme (PNLP), Bureau d'Inspection de la Pharmacie, IPS, and the Centre de Distribution Régional (CDR), on a differentiated basis, depending on their role in the system. Quality of trainings provided by DPS staff and BCZ staff at the respective lower levels is proposed to be maintained as follows:

1. Training of health zone staff by DPS level supportive supervision by i+solutions and PNAM experts.
2. Training of health facility staff performed by health zone staff, supportive supervision by DPS staff already trained and USAID IHP regional/provincial supply chain officers.

DPS staff will then train health facility staff by ZdS and accompany them in facilitating their cascading training activities for several events in a training-of-trainers approach. These interventions will be based on assigned objectives in terms of improving previously identified weak areas of knowledge, skills and attitudes of HF staff in quantifying, managing the supply chain, maintaining optimal stock availability and reporting correctly.

For DPSs and ZdSs, the training would cover the entire spectrum of SCM with more in-depth focus on data management, quantification and training of trainers. HF staff will be trained on the LMIS according to the current "Manuel Descriptif de SIGL (système d'information de gestion logistique)." This training, combined with available SCM transaction and reporting tools at health facilities, will allow the project to stimulate lower-level data generation through DHIS2, thereby assisting in decision making.

Following the training, the DPSs will supervise MOH SCMs at the ZdSs. The staff of the BCZs will start post-training monitoring of HFs to ensure that trained staff are implementing procedures and using tools correctly. Subsequently, BCZ staff will conduct supportive supervision of HFs and IPS staff will have a role in reviews and audits. Priority will be given to those HFs and ZdSs with poor reporting track records and high stock-out indicators to emphasize and reinforce the management of their systems.

Table 2. Expected Results

TARGETED GROUP/LEVEL	RESULT
DPS and ZdS staff	Ability to use standardized MOH procedures to develop operational plans and budgets and account for financial resources Establishment and effective use of quarterly coordination meetings with stakeholders Ability to manage roles and responsibilities in decentralized framework of new MOH systems, applying and enforcing national-level systems, guidance, policies and procedures
DPS, ZdS, HF, CODESA	Capacity to identify and advocate for resource needs from the MOH, development partners, and the private sector

	Strengthened internal management; i.e., holding regular staff meetings, ability to work in teams, timely information-sharing, effective implementation of performance management processes
DPS, ZdS, HF	Strengthened internal management based on better knowledge and implementation of appropriate financial and administrative roles
DPS	Better integration of specialized programs, such as the immunization program or the family planning program Strengthened capacity to develop health zones, train them in and supervise their operations, and ensure ZdSs and their facilities are providing quality service delivery
ZdS	Strengthened role of the IPS in reinforcing and supporting compliance and implementation Strengthened health zone management's capacity to collaborate with and strengthen CODESAs, so that expectations and roles of each are clear and are carried out effectively.
MOH	Motivated and well-trained staff at all target MOH levels

4. IMPLEMENTATION

4.1 ROLES AND RESPONSIBILITIES

The focal points for the MOH ICB component are the Kinshasa-based Capacity Building Advisor and the nine provincial DPS Capacity Building Advisors. The focal point for the community development and capacity-building activities is the (proposed) Kinshasa-based Community Engagement Advisor, the three Community Engagement Advisors, one for each region (Eastern Congo, Kasai, Katanga), and the Equipes d'Encadrement Integré (EEIs).

- The role of the Kinshasa-based Advisor will be to provide overall direction to the program's capacity building activities, liaise with the central MOH on capacity-building activities and strategy, train and support the regional and provincial advisors, develop the capacity of program staff to work through the DPS and ZdS staff and structures, develop materials for interventions common to each province, carry out selected interventions, identify consultants to carry out specific interventions, provide quality assurance, and determine and disseminate lessons learned across the program.
- The role of the provincial DPS Capacity Building Advisors will be to have primary responsibility for collaboration with the MOH ICB staff and help them coordinate and implement activities at the provincial and health zone levels. These advisors will facilitate the DPS and ZdS annual organizational self-assessments using the PICAL tool to identify needs, develop capacity building plans, and measure progress; and develop annual provincial and health zone capacity building plans in which USAID IHP contributions should feed. These plans will become part of USAID IHP annual work plans and inform budgets for implementation of program-supported interventions. The DPS Capacity Building Advisors, always working with the DPS and ZdS counterparts, will facilitate implementation of agreed-upon plans, and regularly assess and report on progress.
- The role of the EEI staff (consisting of a Health Systems Strengthing team lead, a Community Engagement Specialist, and a Service Delivery Specialist on each team) is to coach and help health facilities and ZdS staff apply new behaviors to their own systems and facilities, help problem solve, and work with the DPS Capacity Advisors to highlight problem areas, identify patterns of weakness that may require special attention, and to help the ZdS and health facilities exercise their new processes and leadership/management skills. They act as on-the-ground coaches and trouble-shooters.

The USAID IHP approach is that responsibility for capacity building is widely shared across the program. While the USAID IHP Kinshasa-based and provincial Capacity Building Advisors have lead responsibility for capacity building, all staff must have a basic understanding of this approach. Relevant staff will participate in trainings and learn the basic principles of ICB and be internally certified before allowing to practice those skills.

4.2 TIMING

Systems- and organization-level capacity-building activities have much greater impact if they are designed and implemented over a multi-year period. Meaningful organizational change takes time and dedicated effort, and there are multiple areas of strengthening and new systems, processes and skills that need to be introduced. The change process inherent in ICB can be complex within a single institution, requiring,

in general, three to five years. When introducing a new national policy that spans multiple institutions or levels of government, even a five-year time frame may not be adequate. [14]

Recent HFG experience in Lualaba and Haut-Katanga strongly supports the importance of allowing adequate time for ICB efforts. Once implementation of a capacity-strengthening plan begins at a DPS, a three-year timeframe is a reasonable expectation for a new behavior to be learned, take hold, and become the norm. Similarly, we expect a three-year timeframe for a ZdS, based on our experience in a limited number of locations. It may take longer in some provinces due to a range of factors, including security, changes in leadership, disease outbreaks or other crises, or where staff are barely in place.

The timing and needs for organizations such as CODESAs and other CBOs will require more experience to adequately judge the span needed. However, we do know that the range of CODESA and CBO organizational capacity is extremely wide, and goes from 1) complete non-functionality to 2) functionality with overwhelming entrenched interests through to 3) relatively functional. Our plan is to address community organizations that are locational stakeholders at the same time as we begin work with their specific ZdS organizations. This will simultaneously reinforce consistent, respective learnings about roles and responsibilities while strengthening the accountability that is part of the role of the community organizations. The overall sequence of USAID IHP capacity-building activities over a potential seven-year life-of-program timetable might unfold as described in Table 3.

Table 3. Overall Timeframe for Building an Institution's Capacity

YEAR	STAGE
Year 1	Assessment, planning, and initiation of implementation
Years 2-4	Implementation
Years 5-6	Ongoing monitoring and targeted assistance based on performance gaps
Year 7	Monitoring for sustained performance

Under this scenario, some DPSs might achieve sustainable institutional performance after four years. Others might have remaining gaps in specific areas that USAID IHP would work to address.

For the two provinces with which HFG already worked (we are calling them P1 [Lualaba] and P2 [Haut-Katanga]), we will use the recently finalized PICAL assessment to identify future focus topics for ICB. While some gaps remain, much of our work at the DPS level will be monitoring and working on such gap areas rather than full-blown capacity-building implementation. In these two provinces, our work will help them move implementation of these tools and capacity-building processes down to the ZdS and community-level organizations. It will be important to fully engage provincial staff in these activities as they are the ones charged with the dissemination, management and monitoring of the ZdS. This is the actual testing and "on-the-job" training that will build their skills.

In year 1, we will help those seven provinces not assessed under HFG conduct their self-assessments under PICAL and support them to develop and prioritize their capacity-development action plans. To the extent the planning evolves in this manner with the DPSs, we will also begin working with them on pushing these assessment activities (in modified form as described previously) to the ZdSs. This will be

[14] Excerpted from "Lessons Learned in Institutional Capacity Building" HFG, 2018

in a sequenced manner as it is important for the DPS staff to be knowledgeable and comfortable with the content of the assessments and the capacity-building interventions before the programming moves down to the ZdS level. With the DPSs, we will construct a calendar and decision criteria for selecting the sequencing of ZdSs to target. We will ccordinate with IGA to avoid duplication of effort for those DPS that IGA has assessed using PICAL. As long as those reports have the information needed, we will engage the DPS to use the findings to develop a capacity strengthening plan. Simiilarly we will review the simplified PICAL tool developed by IGA to avoid unnecessary duplication.

Simultaneously with the ZdS programming and action planning, USAID IHP's Community Engagement staff will work with the Capacity Building Advisor and DPS Capacity Building staff to identify appropriate community organization(s), including CODESAs and other strong CBOs; these should include strong representation from the private sector health providers and similar stakeholders. Working in tandem and collaboratively with USAID IHP staff that are focused on the MOH ZdS organizations, we will also build the capacity of local CBOs to gain expertise and experience in carrying out their functions more productively and effectively. We will emphasize their roles in ensuring ZdS accountability to the community, information sharing of technical health and service delivery issues, and their own accountability to their communities and contributions to health outcomes in their zones.

Development of the actual sequenced capacity-development calendar is part of the first year's activities at each provincial level. Table 4 contains a high-level—and very illustrative—view of the phases of activity for best results in adoption of new behaviors and systems and the sequencing we will apply to the programming. We will modify and update this table by province, ZdS and community during year 1 and in subsequent work plans.

Table 4. Illustrative Timeframe for Building Institutional Capacity

TARGET ORGANIZATIONS	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7
Provinces							
Lualaba and Haut-Katanga* (P1 and P2)	• Review last PICAL assessment, identify implementation priorities • Begin implementation	Implement and monitor	Implement and monitor	Ongoing monitoring and targeted assistance based on performance gaps	Ongoing monitoring and targeted assistance based on performance gaps	Monitoring for sustained performance	Monitoring for sustained performance
Other 7 provinces (P3 through P9)	Conduct PICAL assessment, identify gaps and develop action plans with province MOH staff	Implement and monitor	Implement and monitor	Implement	Ongoing monitoring and targeted assistance based on performance gaps	Ongoing monitoring and targeted assistance based on performance gaps	Monitoring for sustained performance
Health Zones							
P1 and P2: Provinces #1 & 2's Selected ZdSs ***Group #1:*** approximately 5-8 ZdSs each, of any previously assisted under HFG (P1G1 and P2G1)	• P1 and P2 should be ready to conduct or follow up on some of the ZdS PICALS given their prior training • Coach province staff to facilitate modified PICAL self-assessment in selected 5-8 ZdSs in each province • Identify gaps, develop action plans with province and ZdS staff	Implement and monitor	Implement and monitor	Ongoing monitoring and targeted assistance based on performance gaps	Ongoing monitoring and targeted assistance based on performance gaps	Monitoring for sustained performance	Monitoring for sustained performance

TARGET ORGANIZATIONS	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7
P3-P9: Province #3-9's Selected ZdS ***Group #1:*** approximately 5-8 ZDSs in one province (P3G1-P9G1)		(1st half of year) Coach province staff to facilitate modified PICAL self-assessment in selected 5-8 ZdSs in each province Identify gaps and develop action plans with province and ZdS staff	Implement and monitor	Implement and monitor	Implement and monitor	Ongoing monitoring and targeted assistance based on performance gaps	Ongoing monitoring and targeted assistance based on performance gaps Monitoring for sustained performance
P1G1 and P2G1: Provinces #1 & 2's Selected ZdS ***Groups #2:*** approximately 5-8 ZdSs each, of any previously assisted under HFG (P1G2 and P2G2)		(2nd half of year) Coach province staff to facilitate modified PICAL self-assessment in selected 5-8 ZdSs in each province Identify gaps and develop action plans with province and ZdS staff	Implement and monitor	Implement and monitor	Implement and monitor	Ongoing monitoring and targeted assistance based on performance gaps	Ongoing monitoring and targeted assistance based on performance gaps
P3-P9: Province #3-9's Selected ZdS ***Group #2:*** approximately 5-8 ZdSs in one province			Coach province staff to facilitate modified PICAL self-assessment in selected 5-8 ZdSs in each province	Implement and monitor	Implement and monitor	Ongoing monitoring and targeted assistance based on performance gaps	Ongoing monitoring and targeted assistance based on performance gaps

TARGET ORGANIZATIONS	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7
(P3G2 – P9G2)			Identify gaps and develop action plans with province and ZdS staff				
Continue to add ZdSs until all are addressed							

CODESAs, CBOs (simultaneously or shortly following work with corresponding ZdS)

TARGET ORGANIZATIONS	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7
P1and P2: Province #1 and 2's Selected ***Community Group#1:*** Work with at least one community-based organization per ZdS (CODESAs, CBOs), 5-8 (P1CG1 and P2CG1)	Under guidance of Community Engagement Advisor and Cap Bldg Adv, conduct modified PICAL self-assessment of CODESAs and CBOs Identify gaps and develop action plans with community engagement staff and CBOs/CODESAs	Implement and monitor	Implement and monitor	Implement and monitor	Ongoing monitoring and targeted assistance based on performance gaps	Ongoing monitoring and targeted assistance based on performance gaps	Monitoring for sustained performance
P3-P9: Selected ***Community Group #1:*** Work with at least one community-based organization per ZdS (CODESAs, CBOs), 5-8 (P3CG1 thru P9CG1)		(1st half of year) Under guidance of Community Engagement Advisor and Cap Bldg Adv, conduct modified PICAL self-assessment of CODESAs and CBOs	Implement and monitor	Implement and monitor	Implement and monitor	Ongoing monitoring and targeted assistance based on performance gaps	Ongoing monitoring and targeted assistance based on performance gaps

TARGET ORGANIZATIONS	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7
		Identify gaps and develop action plans with community engagement staff and CBOs/CODESAs					
P1 and P2: Selected ***Community Group #2*** Work with at least one community-based organization per ZdS (CODESAs, CBOs), 5-8 (P1CG2 and P2CG2)		(2nd half of year) Under guidance of Community Engagement Advisor and Cap Bldg Adv, conduct modified PICAL self-assessment of CODESAs and CBOs Identify gaps and develop action plans with community engagement staff and CBOs/CODESAs	Implement and monitor	Implement and monitor	Implement and monitor	Ongoing monitoring and targeted assistance based on performance gaps	Ongoing monitoring and targeted assistance based on performance gaps
Continue to add CODESAs and CBOs in out years							

*These two DPSs and some of their ZdS have already received 2+ years of capacity building support, so would start from a different place than the other seven provinces.

4.3 BUILDING USAID IHP STAFF CAPACITY

As previously mentioned, a cornerstone of USAID IHP's approach is to build the core capacity of all program staff in ICB and other forms of capacity building. Specific activities that we will undertake in FY19 to achieve this include:

- Train all USAID IHP managers and selected staff in the basic principles of ICB
- Train all USAID IHP managers and selected staff in capacity-building skills
- Regularly share information, lessons learned, and materials with all staff
- Develop provincial USAID IHP DPS Capacity Building Advisors in:
  - Organizational assessment based on PICAL tool and use of assessment results to develop a capacity-building plan
  - Broad range of ICB interventions, including workshop design and facilitation, coaching, and organizational development
- Co-facilitate action planning, financial planning events, coaching skills, data for decision-making, meeting preparation and management, and other organizational and community development tools to enhance knowledge on how to build capacity beyond "training"; role play briefings and feedback activities with DPS and ZdS counterparts; introduce other capacity building techniques to staff
- Develop Equipe d'Encadrement Integré staff and related specialists in consultation skills for working with government counterparts

4.4 USE OF MOH STAFF

Under HFG, Abt project staff successfully partnered with MOH staff as consultants, trainers, and facilitators on all activities involving use of standard MOH systems. These included:

- Development of annual operational plans;
- Results-based management;
- Financial management;
- Supervision; and
- Management of primary health care.

The benefits of continuing this approach include aligning MOH priorities, building MOH capacity that will expand throughout non-IHP provinces, building working relationships with central MOH staff, and providing professional development opportunities. USAID IHP will only pay travel and per diem to MOH staff.

4.5 BUILDING A ROSTER OF STAFF AND CONSULTANTS

The HFG project found a lack of organizational development experts in the DRC, and began selecting and building a small cadre during their implementation period. We will continue to build a roster of local partner staff and consultants with the capacity to carry out specific capacity-building interventions. Once all nine provinces are fully operational, we expect to need significant capacity to address these needs.

5. MONITORING, EVALUATION AND LEARNING

Our approach to MEL of the capacity-building component aligns with USAID's CLA approach, and will feed directly into the overall program Activity M&E Plan. We describe its three main components below.

5.1 INSTITUTIONAL ASSESSMENT USING PICAL

PICAL offers a tested tool for establishing a baseline against which progress can be measured. It is a diagnostic institutional assessment participatory assessment, conducted collaboratively by representatives of the recipient organization and one or two outside facilitators who guide the process. There are at least three representatives of the organization, named by the most senior person who is also a participants. One of the two (or more) others serves as the leader of the assessment (not the most senior person). In addition, one or more outsiders who know the organization intimately also join the assessment team. They conduct interviews and focus groups using a list of questions related to the sub-dimensions under each of the four PICAL categories or main dimensions. When they return for an initial analysis, each assessor assigns a score ranging from 0 (Deficient) to 5 (Continuously Improving) for each sub-dimension. They then work under the guidance of the facilitators to discuss the rationale for their respective scores. After this discussion there is a second round of scoring, after which the leader makes the final call. The facilitators do not contribute to the scoring, but help the assessors think through the reasons for their scores.

For the full list of dimensions and related questions, see Annex B - PICAL: Dimensions, Sub-dimensions, and Questions.

HFG used the PICAL tool 13 times over a three-year period. Three assessments were repeat iterations to measure progress, including the DPSs in Lualaba and Haut Katanga. We provide illustrative results from the two assessments for the Lualaba DPS in below. Scores are measured on a scale from 0-5 with 5 the highest score. These results also show the effectiveness of the approach described in this document.

Table 5. Results of Institutional Analysis in Lualaba in 2016 and 2017

DIMENSION	2016	2017
Administrative Capacity		
Leadership	2	3
Roles and responsibilities	2	3
Communications and reporting	2	3
Physical space and equipment	1	2
Organizational Learning		
Leadership in capacity building	2	3
Organization planning	2	3
Evaluation and learning	2	3
System Strengthening		
Resource mobilization	2	2
Logistical systems	1	3
Information sharing	2	3

Demand for Organizational Performance		
Internal accountability	2	3
Inclusion	2	3
Transparency	2	2
Understanding the mandate	3	4

From an organizational development perspective, an organizational assessment is more than a way to measure progress: It is the beginning of the process of organizational strengthening. The questions asked, the feedback on results, and discussions with the organization's staff on how to address the gaps all contribute to raising awareness of what it will take to strengthen their organization. Capacity-development staff introduce a framework for talking about organizational effectiveness as a starting point.

5.2 ONGOING M&E

As a dynamic process, ICB needs ongoing monitoring that assesses progress, identifies issues and learnings, and makes mid-course corrections and adaptations. We will formalize several processes for ongoing M&E.

- After each intervention (e.g. workshop), the DPS Capacity Building Advisor will debrief the team that carried out the intervention. The questions they ask will be similar to those they will also ask in an after-action review: What worked, what didn't work and why, what did you learn, and what follow-up is needed? The key points will be captured in a one- to two-page memo and shared with the Kinshasa-based Capacity Building Advisor.
- On a quarterly basis, the Kinshasa-based Capacity Building Advisor will convene a virtual meeting of the DPS Capacity Building Advisors to share progress, discuss common concerns, and identify ways to address them. We will also hold an annual internal meeting of the DPS Capacity Building Advisors leading up to the development of the annual work plan.
- On an annual basis, we will convene a meeting with DPS staff and other development partners to assess progress in building institutional capacity, identify what has worked and what hasn't. Based on these discussions, we will agree on adjustments to the capacity-building plan. This collaborative learning process will be a feature of our CLA approach.
- For the community organizations, the process will be similar and the Capacity Building Advisor and Community Engagement Advisor will work together—probably on a province-by-province basis since the teams are so large—to ensure community-based staff are supported, understand the topics, and have the training and tools to discuss challenges, find solutions, and effectively carry out their capacity-building activities.

5.3 LEARNING QUESTIONS

USAID IHP is committed to an ongoing process of learning, guided by the following questions, which may be revisited and revised over the course of the program.

- Which DPS are achieving the greatest success and why?
- What factors contribute most to strengthened institutional capacity at the provincial level?
- What factors contribute most to strengthened institutional capacity at the health zone level?
- What are the optimal relationships between national, provincial, and health zone levels under the decentralized system?
- What are the best practices for strengthening the CODESAs and other community structures?
- Which capacity-building interventions have the greatest impact and why?

The M&E process will provide evidence and insights to these questions. However, we will actively discuss these questions during quarterly and annual capacity-building meetings, as well as during program-wide work planning and review meetings.

ANNEX A: HFG INSTITUTIONAL CAPACITY-BUILDING ACTIVITIES FOR LUALABA DPS

EXAMPLE OF ACTIVITIES FOLLOWING PICAL ASSESSMENT	DELIVERABLES
Development of Operational Action Plans (May 2015)	PAO
Situation Analysis of Health Zones and DPS (September 2015)	Report
Development of Provincial Health Development Plan (February 2016)	Report
Development of Operational Action Plan (PAO) (February 2016)	Report on validation of PAO 2016
Support to meeting of CPP-SS (March 2016)	Report
Training in Team Building and Leadership and Management (July 2016)	Report Participant Manual
Procurement of IT equipment (computers, printer, scanner) August 2016	Document to hand over equipment
Training in Results-based Management (September 2016)	Report Participant Manual
Training in Financial Management (September 2016)	Report Participant Manual
Training in Supervision of ZdSs (December 2016)	Report Participant Manual
Training of EPPs in coaching and systems thinking (November 2016)	Report Participant Manual
Development of Operational Action Plan (March 2017)	Report
Support to the CPP-SS meeting to validate the PAO 2017 (May 2017)	Report
Training in Management of Primary Health Care (June 2017)	Report Participant Manual
Development of HRH Provincial Plan 2017-2020 (July 2017)	Report
Establishment of Human Resources for Health database (August 2017)	Report
Development of Operational Action Plan 2018 (November 2017) March 2017)	Report
Support to the CPP-SS meeting (December 2017)	Report
Workshop to integrate specialized programs into DPS (March 2018)	Report

ANNEX B - PICAL[15]: DIMENSIONS, SUB-DIMENSIONS AND QUESTIONS

1. Institutional Capacity Development Dimensions and Sub-Dimensions

Administrative Capacity

- Leadership
- Organizational Roles and Responsibilities
- Human Resources (Planning)
- Human Resources (Salaries)
- Information Management
- Financial Management
- Reporting
- Physical Space & Equipment
- Compliance / Auditing

Organizational Learning Capacity

- Capacity-Building Leadership
- Organizational Planning
- Assessment and Learning
- Knowledge Management
- Research

Systems Strengthening Capacity

- Policy Development
- Oversight
- Capacity Building
- Resource Mobilization
- Resource Allocation
- Decentralization
- System Logistics
- Information Sharing
- System Coordination

Demand for Organizational Performance

- Stakeholder Perceptions
- Accountability (Internal)
- Accountability (External)
- Inclusiveness
- Participation
- Transparency
- Corruption Controls
- Staff Understanding of Mandate
- Performance Incentives

[15] Participatory Institutional Capacity Assessment and Learning index

2. Questions Asked for Each Institutional Capacity Development Sub-Dimension

a) Administrative Capacity – Does the organization have adequate capacity to manage all general administrative and operational functions?

- Leadership: Does the organization develop the leadership capacity of senior staff and to prepare other staff to serve in leadership roles?
- Roles and Responsibilities: Are the roles and responsibilities of sub-units of the organization and staff of the organization clearly defined?
- Human Resources (Staffing): Does the organization have adequate capacity for ensuring high-quality staffing?
- Human Resources (Salaries): Does the organization have adequate capacity for managing staff salaries (with all salaries represented in official budgets)?
- Information Management: Does the organization maintain records in a manner that allows them to be effectively accessed and used by staff?
- Financial Management: Does the organization appropriately manage financial resources (with all finances represented in official budgets)?
- Communications and Reporting: Does the organization document and disseminate useful information at periodic intervals to provide regular feedback informing stakeholders about the organization's operations.
- Physical Space & Equipment: Does the organization have adequate physical space and equipment for it to operate?
- Compliance / Auditing: Does the organization have in place practices for ensuring compliance with laws, regulations and codes of conduct?

b) Organizational Learning Capacity – Does the organization have adequate capacity to improve the effectiveness of its operations?

- Capacity-Building Leadership: Are senior staff clearly designated for identifying and leading efforts to build the capacity of the organization?
- Organizational Planning: Does the organization plan its strategy and operations based on theory and evidence?
- Assessment and Learning: Does the organization measure and improve the effectiveness of its operations and its service to its constituents?
- Knowledge Management: Is the knowledge of staff members captured and distributed in order to foster staff learning and preserve institutional memory?
- Research: Are practices in place for intentionally generating and/or acquiring new understanding regarding its work?
- Constituent Perceptions: Does the organization solicit feedback from its constituents on its services?

c) Systems Strengthening Capacity – Does the broader institutional system of which the organization is part have adequate capacity?

- Policy Development: Is there adequate capacity for developing policy, including legal and regulatory frameworks, in the institutional system?
- Oversight: Is there adequate oversight, provided by legal or regulatory actors, in the institutional system?
- Capacity Building: Is there adequate capacity for building the capacity throughout the broad institutional system?
- Resource Mobilization: Is there adequate capacity for mobilizing resources throughout the broad institutional system?
- Resource Allocation: Is revenue appropriately distributed to actors throughout the institutional system, whether horizontally to specific functional units within the institution or to subsidiary units, such as provinces/localities?
- Decentralization: Is there adequate transfer of authority, responsibility and resources to sub-national governments within the institutional system?
- System Logistics: Is there adequate capacity for moving supplies and equipment to stakeholders throughout the institutional system?
- Information Sharing: Is information shared among stakeholders throughout the institutional system?
- System Coordination: Are activities of stakeholders coordinated throughout the institutional system?
- Stakeholder Feedback: Is there solicitation of feedback from stakeholders about the performance of the institutional system?

d) Demand for Organizational Performance – Does the organization have adequate capacity to foster demand for its high-quality performance?

- Stakeholder Perceptions: Does the organization solicit feedback from stakeholders about its performance?
- Accountability (Internal): Does the organization have monitor for and remedy improprieties in the organization’s operations?
- Accountability (External): Are there other organizations that monitor and assess the propriety of the organization’s operations?
- Inclusiveness: Are all stakeholders represented in the operations and services of the organization?
- Participation: Are all stakeholders involved as appropriate in informing its operations?
- Transparency: Does the organization disclose clear and accurate information on its operations?
- Corruption Controls: Does the organization monitor and remedy improper conduct of staff members?
- Staff Understanding of Mandate: Does the organization ensure that staff members have a clear understanding of the mandate of the organization?
- Performance Incentives: Are incentives in place for staff to improve the performance of the organization?