



MEASURING AND ASSESSING CAPACITY

A Landscape Review

MOMENTUM Knowledge Accelerator



SEPTEMBER 2021

MOMENTUM works alongside governments, local and international private and civil society organizations, and other stakeholders to accelerate improvements in maternal, newborn, and child health services. Building on existing evidence and experience implementing global health programs and interventions, we help foster new ideas, partnerships, and approaches and strengthen the resiliency of health systems.

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ABBREVIATIONS

ADB	African Development Bank
CLA	Collaborating, Learning, and Adapting
DOSA	Discussion-Oriented Self-Assessment
ECDPM	European Centre for Development Policy Management
FAO	Food and Agriculture Organisation
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH or, in English, the German Corporation for International Cooperation
MEL	Monitoring, evaluation, and learning
NGO	Nongovernmental organization
OECD	Organisation for Economic Co-operational and Development
PIRS	Performance indicator reference sheet
SWOT	Strengths, Weaknesses, Opportunities and Threats
UNDRR	United Nations Office for Disaster Risk Reduction
USAID	United States Agency for International Development
WBI	World Bank Institute

EXECUTIVE SUMMARY

The present landscape review is intended to support MOMENTUM partners' efforts to introduce, deliver, scale up, and sustain high-quality maternal, newborn, and child health services through sound capacity measurement.

Many capacity measurement tools have significant limitations. They tend to focus on organizations to the exclusion of other units of analysis (e.g., a system or a network) that exert significant influence on health outcomes. They often rely on self-assessment and make little use of evidence. They also tend to focus on latent capacity rather than performance and seldom yield information on the underlying determinants of performance. Another limitation of most capacity measurement tools is that they are frequently ill-suited for environments characterized by a high degree of complexity.

This study is based on a conceptual framework that views capacity development activities as *inputs* designed to generate additional capacity, a key *output*. The “owners” of the expanded capacity may operate at any one of four different levels: individual, community, organization, and system. Regardless of level, the outcome of capacity development is performance improvement, along with greater resilience and enhanced social capital. These gains, which occur in an environment characterized by complexity, lead to the achievement of significant results in the form of improved health outcomes for mothers, newborns, and children.

Although *capacity* is a term with contested meanings, there is consensus around several key ideas. Among these are the notion that capacity involves doing and achieving. *Capacity development* is also widely understood as a set of highly contextualized and localized processes; *best fit* is more important than *best practice*. Capacity development occurs through goal-oriented processes that identify and address areas of needed performance improvement.

An important dimension of capacity strengthening work is the development of resilience. Three specific capacities lie at the heart of resilience: absorptive, adaptive, and transformative. Actors with all three resilience-related capacities can thrive in environments characterized by high complexity. They can cope with adversity and, over time, address root causes of vulnerability. Social capital, which is demonstrably linked to health outcomes, can be another significant dimension of capacity development, especially if the capacity strengthening activities include extensive dialogue.

Capacity assessment and measurement tools are typically used for one of four different purposes: (1) to assess risk; (2) to diagnose capacity challenges; (3) to strengthen capacity by promoting learning and adapting; and (4) to fulfill accountability requirements to stakeholders (including, but not limited to, donors). Most tool types do not perform well in situations of high complexity or for more than one of these purposes.

Measuring capacity in a complex environment poses special challenges. Yesterday's metric may be obsolete tomorrow. Yet, changing metrics to remain relevant may limit the user's ability to detect longitudinal trends and performance patterns. Emergent learning, a critical practice in complex settings, entails evolving understandings of what capacities should be measured. In the early stages of capacity assessment, it may not be clear what should be measured.

Several important lessons about capacity assessment are discussed. Capacity assessment must be integrated into broader transformational processes and should shed light on key performance determinants. Capacity assessment tools should help users identify interrelationships among capacities so they can optimize change processes. Tools should also be grounded in theories of change. Finally, capacity assessment findings are optimized when the assessment process is dialogue-rich.

The study's final chapter presents a five-step methodology that was applied to generate indicators to measure capacity development across the MOMENTUM award suite. This methodology yielded 11 potential indicators, which were assessed through five different lenses. Ideas that informed the indicator development and assessment process include the following: (1) meeting the challenge of complexity requires resilience, (2) capacity development entails improvements in performance, and (3) capacity exists at multiple levels: individual, community, organization, and system;

The indicator-generation process culminated in the selection of two indicators for further development:

- % targeted actors using client or constituent feedback to improve program reach, coverage, or effectiveness.
- % of targeted actors who routinely modify programs to better reflect locally prevailing social norms, values, beliefs, and practices.

A third indicator (% of targeted actors using data generated through their monitoring systems to fine-tune activities or strategies) was also deemed especially promising for further exploration.

Details about how these indicators can be used are provided in four Performance Indicator Reference Sheets.

CHAPTER 1: INTRODUCTION TO THIS STUDY

Purpose of this study

This study's purpose is to support the efforts of MOMENTUM partners to introduce, deliver, scale up, and sustain high quality maternal, newborn, and child health service through sound capacity measurement.

This entails:

- Defining the different levels and types of capacity relevant to MOMENTUM that can be measured.
- Clarifying the distinction between capacity and performance.
- Identifying key capacity measurement tool types and assessing their general suitability for capturing different capacities relevant to MOMENTUM.
- Proposing promising approaches for capacity measurement, capacity indicators, and capacity measurement tool selection that reflect the operational realities of MOMENTUM partners.

THE NEED ADDRESSED BY THIS STUDY: MOST CAPACITY MEASUREMENT TOOLS HAVE SIGNIFICANT LIMITATIONS

- They don't measure the many kinds of capacity that are critical to a full understanding of how actors—both those within and beyond the health sector—can reduce maternal, newborn, and child death or disability.
- They shed little light on resilience (including absorptive, adaptive, and transformative capacity) at various health sector levels.
- They tend to focus on organizations to the exclusion of other sector levels (system, community, and individual).
- They often rely on self-assessment with little use of evidence, thus biasing results.
- They tend to focus on *latent capacity* rather than *performance*.
- They seldom yield information on the underlying causes of capacity and performance gains.
- They are ill-suited for environments characterized by a high degree of complexity.

THE STUDY'S METHODS COMBINED INTERVIEWS WITH A REVIEW OF PUBLISHED AND GRAY LITERATURE

- Interviews, jointly conducted with MOMENTUM Knowledge Accelerator consultant Meg Kinghorn, focused on current capacity measurement practices, the conceptual underpinnings of those practices, and perceptions of capacity measurement needs.
 - Interviewees included six USAID representatives and eight MOMENTUM staff.
 - Representatives from all MOMENTUM awardees were interviewed.
- Literature reviewed included practitioner publications, scholarly journals, selected books, and practitioner-focused websites.
 - Literature was drawn from multiple fields, including disaster response and recovery; food security; evaluation; organizational development, management, and leadership; health systems management; complexity theory; and social capital theory.
 - Special emphasis was given to the identification and review of capacity measurement tools and techniques.

THE PRIMARY INTENDED USERS OF THE STUDY INCLUDE THE ENTIRE SUITE OF MOMENTUM AWARDEES AND THEIR PARTNERS

Other potential users include:

- Capacity development and measurement professionals regardless of sectoral focus.
- Donors who support capacity development work.
- Organizations that wish to begin or build on their capacity development efforts.
- Evaluators who wish to consider alternative practices for linking capacity development activities to performance improvement.

THE STUDY'S MAIN LIMITATIONS ARE CIRCUMSCRIBED PARAMETERS AND LIMITED FIELD INPUT

- Despite the fact that the full suite of MOMENTUM awards transcends the health sector, the study focuses on the health sector rather than on all actors who influence health outcomes for mothers, newborns, and children (e.g., insurance providers, pharmaceutical companies, local community governance structures). The decision to circumscribe the study's parameters was made in consultation with several stakeholders and reflects resource constraints as well as the need to avoid the “glittering generalities” that sometimes emerge when study parameters are overly broad.
- MOMENTUM field-based partner organizations were not interviewed due to resource constraints.
- Ideas were not subject to field testing.
- The literature review was not confined to the fields of reproductive, maternal, newborn, and child health (MOMENTUM's focus); therefore, inferences drawn from disparate disciplines may not be as applicable to MOMENTUM as expected or intended.

CHAPTER 2: A FRAMEWORK FOR CAPACITY STRENGTHENING, ASSESSMENT, AND MEASUREMENT

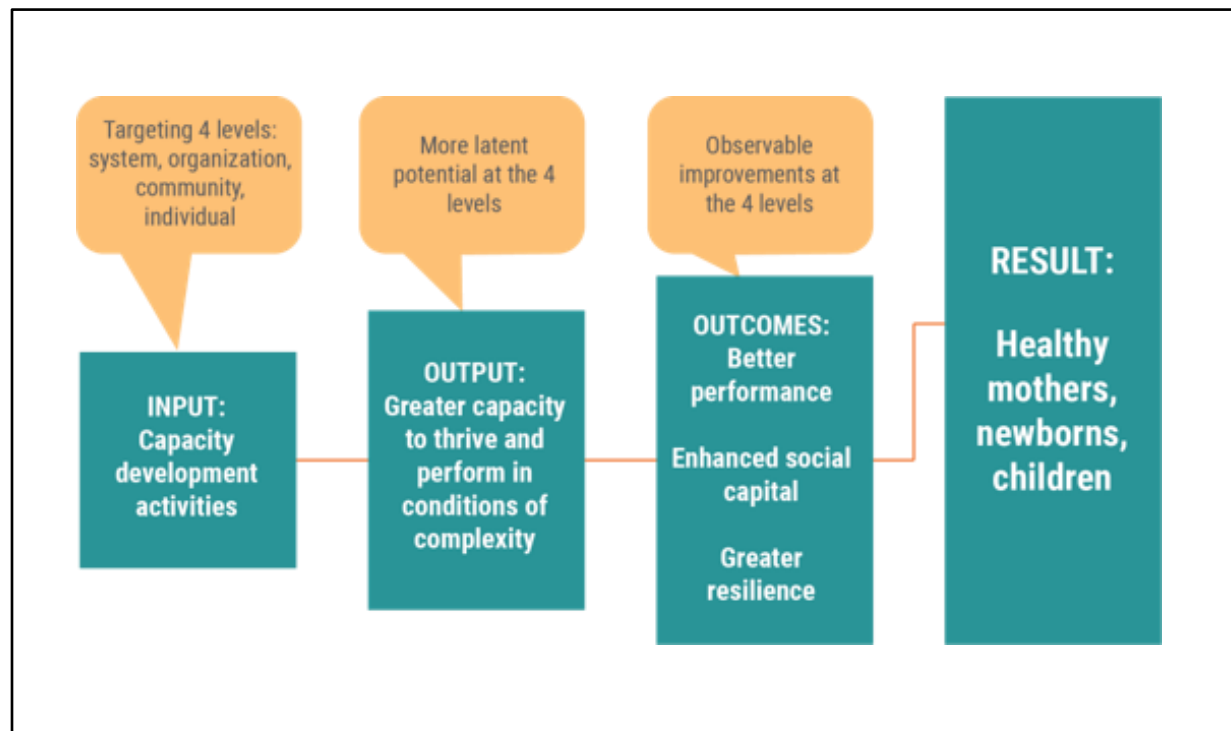
FRAMEWORKS INVOLVE IDENTIFYING INPUTS, OUTPUTS, AND OUTCOMES BY TARGET GROUP

In the realm of capacity strengthening, this entails specifying what is meant by:

- Capacity development (inputs).
- Capacity (a key output).
- Capacity “owners” (four levels of actors who have expanded capacity).
- Performance improvement (an outcome).
- Resilience (an outcome).
- Social capital (an outcome).
- Results.
- Complexity (a key characteristic of the MOMENTUM context).

Figure 1 illustrates the transformational process that capacity development is intended to unleash. A capacity development program may incorporate a broad array of activities, including enhanced supervision; creation of communities of practice; upgraded equipment; new protocols for patient care and reporting; improved documentation practices; new systems to support epidemiological tracking and information-sharing; managerial restructuring; team-building; and, of course, training. If well-designed and delivered, these activities should enable actors throughout the health care system to meet the challenges of complexity while delivering products and services that contribute to the well-being of mothers, newborns, and children.

FIGURE 1. CAPACITY DEVELOPMENT: A CAUSAL PATHWAY PERSPECTIVE



CAPACITY IS A TERM WITH CONTESTED MEANINGS

- The ability of an actor to perform, sustain itself, and self-renew.¹
- The emergent combination of attributes that enables a human system to create developmental value.²
- The ability of individuals, institutions, and societies to perform functions, solve problems, and set and achieve objectives in a sustainable manner.³
- The ability of people, organizations, and society as a whole to manage their affairs successfully (OECD).⁴
- The ability to achieve something in a wider environment.⁵

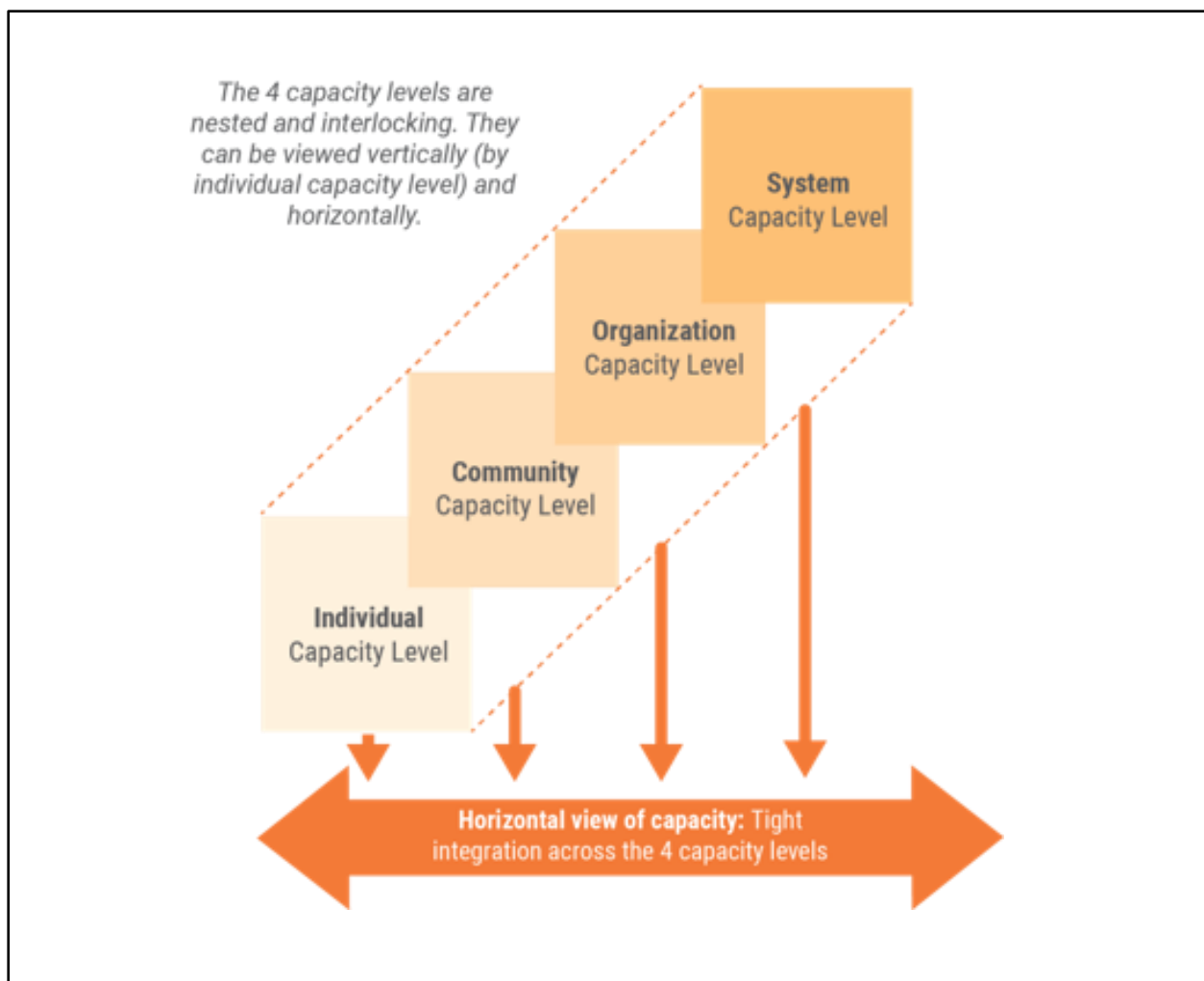
CAPACITY DEFINITIONS VARY, BUT FOUR CRITICAL IMPLICATIONS EMERGE

- Capacity exists at multiple levels: individual, community, organizational, systemic.
- The multiple levels of capacity are nested and interconnected; capacity entails tight coordination across multiple capacity levels (the horizontal view) as well as performance at each operational level (the vertical view).
- Capacity involves doing and achieving.
- Capacity is highly contextualized and localized: best fit is more important than best practice.

CAPACITY LEVELS CAN BE VIEWED BOTH HORIZONTALLY AND VERTICALLY

Capacity can be viewed from multiple perspectives, as illustrated in Figure 2. A vertical perspective is concerned with the question of whose capacity is under discussion. Do we wish to focus on the performance of individuals, communities, organizations, or the system as a whole.? In contrast, a horizontal perspective is concerned with connections across levels. When tight integration is present, resources, policies, and practices at each level are well-aligned to optimize outcomes. Information flows in a free and timely manner to support evidence-based decision-making and synergistic practice. In contrast, when integration is loose, resources are duplicative, policies at one level may compete or contradict those at another, bonds of trust (social capital) are weak among health care actors, and inefficiency is rampant. An important capacity development outcome is often strong integration across levels, which contributes to resilience and a stronger overall response to complexity.

FIGURE 2. HORIZONTAL AND VERTICAL VIEWS OF CAPACITY



CAPACITY DEVELOPMENT IS ANOTHER CONTESTED TERM

Capacity development has been defined in multiple ways.⁶

- “The **processes** whereby people, organizations, and society as a whole unleash, **strengthen**, create, adapt, and maintain capacity over time” (used by OECD, EuropeAid GIZ, ADB, FAO and others).
- “Approaches, strategies, or methodologies...to change, transform, and **improve performance** at the individual, organizational, sector, or broader system level” (USAID).
- “The **process** through which individuals, organizations, and societies obtain, **strengthen**, and maintain the capabilities to set and achieve their own development objectives over time” (UNDP). “The **process** of enhancing, **improving**, and unleashing capacity; it is a form of change which focuses on improvements” (ECDPM).
- “A locally driven **process** of learning by leaders, coalitions, and other agents of change that brings about changes in sociopolitical, policy-related, and organizational factors to **enhance** local ownership for and the **effectiveness** and **efficiency** of efforts to achieve a development goal” (WBI).
- The **process** by which people, organizations, and society systematically stimulate and develop their capability over time to achieve social and economic goals, including through **improvement** of knowledge, skills, systems, and institutions—within a wider social and cultural enabling environment (UNDRR).⁷

DESPITE THE MULTIPLICITY OF DEFINITIONS, KEY CAPACITY DEVELOPMENT THEMES EMERGE

FIGURE 3. KEY TERMS ASSOCIATED WITH CAPACITY DEVELOPMENT

FOUR CRITICAL IDEAS WITH IMPORTANT IMPLICATIONS COME OUT OF THE VARIED UNDERSTANDINGS OF CAPACITY DEVELOPMENT

- Capacity development contributes to performance improvement over time (usually in relation to a specific goal or objective).

Implication: Capacity measurement is needed to determine the direction and magnitude of performance changes.

- Capacity development often entails working at multiple levels.

Implication: Capacity development approaches and measurement strategies must vary by level; generic approaches are unlikely to be effective.

- Capacity development relies on dynamic processes.

Implication: Uncertainty and complexity are key features of dynamic processes. Measurement strategies must be adaptive and context-aware.

- Capacity development involves highly contextualized and localized processes.

Implication: Capacity measurement techniques should accommodate the localization of capacity measurement approaches and indicators.

CAPACITY DEVELOPMENT FOR IMPROVED HEALTH OUTCOMES INVOLVES ATTENTION TO FOUR LEVELS OF PERFORMANCE

- System-level: “All organizations, people, and actions whose primary intent is to promote, restore, or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities” .⁸
- Organization-level: the individual institutions that carry out activities, which affect health outcomes .⁹
- Community-level: The local actors (including community members) who work to achieve and sustain coverage, access, and quality over time along with those who hold service providers accountable for the quality of services provided.¹⁰
- Individual-level: the human resources who work in the health system at any level to carry out technical, managerial, and support functions .¹¹

HEALTH SECTOR SYSTEM-LEVEL CAPACITY DEVELOPMENT OUTCOMES ARE FAR-REACHING AND INTERDEPENDENT

Illustratively, capacity development outcomes at this level include:

- Improved availability of health services that are aligned with latest evidence.
- A well-performing health workforce.
- A well-functioning health information system.
- Equitable access to essential medical products (e.g., vaccines, medicines).
- A sound health financing system.
- Strong leadership and governance.¹²

CAPACITY DEVELOPMENT OUTCOMES FOR HEALTH-RELATED ORGANIZATIONS ENCOMPASS STRUCTURES, PROCESSES, MANAGEMENT SYSTEMS, AND TECHNICAL KNOWLEDGE

Illustratively, capacity development outcomes at this level include:

- Ability to adapt to changing circumstances.
- Ability to efficiently transform human, physical, and knowledge resources into services or products that contribute to sustainable health.
- Ability to prepare and execute a sound strategic planning process.
- Ability to manage financial resources, information, logistics (for contraceptives or medicines), communication networks, human resources, and work flows.
- Ability, through stakeholder engagement, to deliver products or services that meet (or exceed) user expectations and requirements.¹³

COMMUNITY-LEVEL CAPACITY DEVELOPMENT OUTCOMES CONNECT END-USERS AND HOUSEHOLDS TO HEALTH CARE PROVIDERS

Illustrative capacity development outcomes at this level include:

- Health center management and oversight by community committees.
- Linkages between community health workers and other local actors who influence household-level health outcomes.
- Promotion of healthy practices (e.g., breastfeeding).
- Health-seeking behaviors among community members.
- Capacity of community members to advocate for quality services.

INDIVIDUAL-LEVEL CAPACITY DEVELOPMENT OUTCOMES ARE OFTEN NECESSARY BUT SELDOM SUFFICIENT TO SUSTAIN CHANGES AT THE SYSTEM, ORGANIZATIONAL, COMMUNITY OR INDIVIDUAL LEVELS*

Illustratively, capacity development outcomes at the individual level include:

- Clinical judgments and techniques (including diagnosis, treatment, and hygiene practices).
- Management practices (e.g., record-keeping, supervision, reporting).
- “Soft skills” such as:
 - Problem-solving.
 - Communication.
 - Teamwork and collaboration.
 - Stakeholder engagement.¹⁴

PERFORMANCE IMPROVEMENT IS THE EXPECTED OUTCOME OF CAPACITY DEVELOPMENT

- Capacity is *latent*; it represents a *potential* state.
- **Performance improvement** is generally seen as a **project outcome** while **capacity development** activities are usually represented as **inputs** in a results framework or theory of change.
- **Performance** includes technical and logistical functions related to service delivery (e.g., identifying sources of funding, recruiting and retaining appropriate staff, harnessing knowledge to meet technical challenges).
- **Performance improvements** typically represent gains in relation to a set of specified development objectives, outcomes, or standards.^{15, 16}
- **Performance** involves adding value for those served.^{17, 18}

* As noted earlier in the discussion of the study’s limitations, this landscape review focuses on the health sector rather than on all actors who influence health outcomes for mothers, newborns, and children (including caregivers and patients). MOMENTUM awards may wish to adapt this discussion to include additional actors, if desired. The skills of individual community health workers fall, in part, at this level; when these workers join with others to offer services to the community, their actions correspond to the “community” capacity level.

AT ALL FOUR HEALTH-RELATED CAPACITY LEVELS—SYSTEM, ORGANIZATION, COMMUNITY, INDIVIDUAL—PERFORMANCE OCCURS AMID COMPLEXITY

Complex environments generally share these traits:

- The whole is larger than the sum of its parts (nonlinearity).
- Many interdependent actors engage in many interactions.
- Interactions among system elements are mostly uncoordinated; total order is not achievable.
- Interactions are dynamic and often unpredictable: “How system actor one interacts with system actor two at a later time depends on how system actor one interacts with system actor two at an earlier time.”
- Order, organization, and control are distributed rather than centralized.
- Technical and social complications abound; adaptive management and emergent learning are crucial skills as there is often inadequate expertise and agreement about what needs to be done.^{19, 20}

COMPLEXITY MANIFESTS ITSELF DIFFERENTLY AT EACH HEALTH SECTOR CAPACITY LEVEL

- System-level: Often, linkages, behaviors, and dynamics are decentralized, not well understood, and difficult to control; there is pressure to impose control (an effort doomed to failure).
- Organization-level: There is pressure to “lock down” the problem definition (i.e., to limit its scope and make the problem appear more “manageable”); actors may rely on formulas that have limited application to the challenges at hand; actors may give up trying to find a good solution.
- Community-level: Attempts to improve health center oversight or deliver quality services are thwarted by an unresponsive system, competing priorities, gender dynamics, socioeconomic factors, and community-level shocks.
- Individual-level: Poor match between technical skills and needs.

The opposite of complexity: “There is a straightforward task to perform, a stable context and operating environment, identical, duplicable products, and compliant, predictable, and reliable human ‘components’...”²¹

MEETING THE CHALLENGE OF COMPLEXITY REQUIRES RESILIENCE

A USAID definition of resilience

“The ability of people, households, communities, systems, & countries to mitigate, adapt to, & recover from shocks & stresses, in a manner that reduces acute and chronic vulnerabilities, and facilitates equitable health outcomes.”

(The MOMENTUM Integrated Health Resilience Approach)

Resilience means that communities and households living within complex systems can **anticipate** and **adapt** to risks, and can **absorb**, **respond**, and **recover** from shocks and stresses **in a timely and effective manner without compromising their long-term prospects**, ultimately improving their well-being”.²²

...that actors who face stresses and shocks can **bounce back quickly** and perhaps even **better**.²³

...the degree of change that can be tolerated while the **system maintains** its structure, basic functioning, and organization .²⁴

...that stressors and shocks have no long-lasting adverse development consequences.^{25, 26}

Common elements across definitions: effective, timely recovery from unexpected changes (a feature of complex environments) without long-term, adverse consequences.

USAID views resilience as a set of capacities

ABSORPTIVE: The ability to minimize exposure and sensitivity to shocks and stresses through preventative measures and appropriate coping strategies to avoid permanent, negative impacts. For example, disaster risk reduction, financial services, and health insurance.

ADAPTIVE: The ability to make informed choices and changes in livelihood and other strategies in response to longer-term social, economic, and environmental change. For example, income diversification, market information, and trade networks.

TRANSFORMATIVE: The governance mechanics, policies and regulations, cultural and gender norms, community networks and formal and informal social protection mechanisms that constitute the enabling environment for systemic change. For example, infrastructure, good governance, and formal safety nets (adapted from Bené et al.).

ACHIEVING ABSORPTIVE CAPACITY, A KEY COMPONENT OF RESILIENCE, ENTAILS SUCCESSFULLY COPING WITH ADVERSITY

Some proposed definitions of absorptive capacity are:

- The ability to take **intentional protective** action and to cope with known shocks and stress.²⁷
- The ability to minimize exposure and sensitivity to shocks and stresses through **preventative measures** and **appropriate coping strategies** to avoid permanent, negative impacts.²⁸

Common elements across definitions: minimized exposure to shocks through protective measures and quick recovery from shocks without permanent negative effects.

ACHIEVING RESILIENCE THROUGH ADAPTIVE CAPACITY REQUIRES INCREMENTAL CHANGES TO SKILLS AND STRATEGIES

Some proposed definitions of adaptive capacity are:

- The **social** and **technical skills** and **strategies** that can be harnessed to **respond to** changes in well-being, socioeconomic conditions, or the environment (adapted from InTeGrate).²⁹
- The ability to make **intentional, incremental, ongoing adjustments** in anticipation of, or **in response to, change** so that there is greater flexibility, more learning, and innovation in the face of an unpredictable future (adapted from Jeans et al. 2017).³⁰

Common elements across definitions: fine-tuned, continually modified skills and strategies that foster effective responses to unexpected change (a feature of complex environments).

ACHIEVING RESILIENCE THROUGH TRANSFORMATIVE CAPACITY INVOLVES ADDRESSING THE ROOT CAUSES OF VULNERABILITY

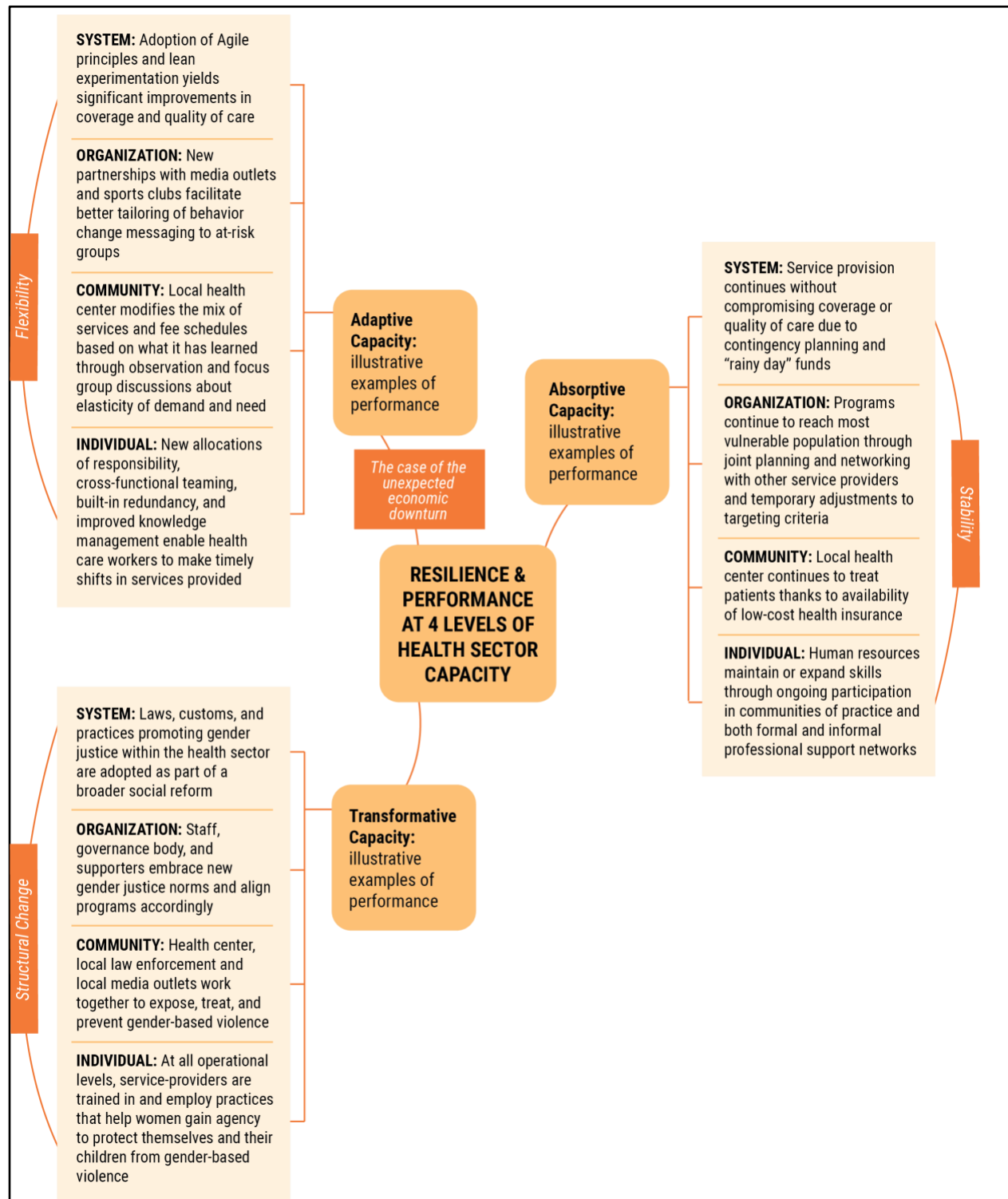
Some proposed definitions of transformative capacity are:

- The ability to create an **enabling environment** through investment in good **governance, infrastructure**, formal and informal **social protection** mechanisms, basic service delivery, and policies/regulations that constitute the conditions necessary for **systemic change**.³¹
- The ability to make intentional change to stop or reduce the **causes of risk, vulnerability**, poverty, ill health, marginalization, and inequality (adapted from Jeans et al. 2017).³²
- The **governance** mechanisms, **policies** and **regulations**, cultural and gender **norms**, community **networks**, and formal and informal **social protection mechanisms** that constitute the **enabling environment** for **systemic change**.³³

Common elements across definitions: The enabling environment—including governance, infrastructure, policies, rules, and regulations—that contributes to a reduction in vulnerability, marginalization, systemic inequity, and poor health outcomes for mothers, newborns, and children.

THE THREE RESILIENCE CAPACITIES CONTRIBUTE TO IMPROVED PERFORMANCE AT EACH CAPACITY LEVEL: OVERVIEW

When all three resilience capacities are well-developed, actors respond effectively to shocks (Figure 4).



ABSORPTIVE CAPACITY CONTRIBUTES TO PERFORMANCE GAINS AND IS DEVELOPED THROUGH THE CULTIVATION OF SUPPORTING CAPACITIES

TABLE 1. ABSORPTIVE CAPACITY AND PERFORMANCE GAINS LINK TO SUPPORTING CAPACITIES: AN ILLUSTRATIVE EXAMPLE

Stability achieved through absorptive capacity: the case of the unexpected economic downturn

Capacity level	Performance	Supporting Capacities
System	Service provision continues without compromising coverage or quality of care due to contingency planning and "rainy day" funds.	To prepare financial forecasts and contingency budgets.
Organization	Programs continue to reach most vulnerable population through joint planning and networking with other service providers and temporary adjustments to targeting criteria.	To collaborate and network; capacity to use epidemiologic data to inform decisions.
Community	Local health center continues to treat patients thanks to availability of low-cost health insurance.	To code, invoice, and collect payments from local insurance provider.
Individual	Human resources maintain or expand skills through ongoing participation in communities of practice and both formal and informal professional support networks.	To create and deliver effective staff development through multiple channels.

ADAPTIVE CAPACITY CONTRIBUTES TO PERFORMANCE GAINS AND IS DEVELOPED THROUGH THE CULTIVATION OF SUPPORTING CAPACITIES

TABLE 1. ADAPTIVE CAPACITY AND PERFORMANCE GAINS LINK TO SUPPORTING CAPACITIES: AN ILLUSTRATIVE EXAMPLE

Flexibility achieved through adaptive capacity: the case of the unexpected economic downturn

Capacity Level	Performance	Supporting Capacities
System	Earlier adoption of Agile principles leads to lean experimentation; now making a pivot that results in significant improvements to coverage and quality of care.	To create sound metrics; capacity to gather and interpret data in a timely way.
Organization	Draws on existing partnerships with media outlets and sports clubs to facilitate better tailoring of behavior-change messaging to at-risk groups.	To engage productively with partners.
Community	Local health center modifies the mix of services and fee schedules based on what it has learned through observation and focus group discussions about elasticity of demand and need.	To use human-centered design or constituent voice mechanisms to understand user preferences, expectations, and needs.
Individual	New allocations of responsibility, cross-functional teaming, built-in redundancy, and improved knowledge management enable health care workers to make timely shifts in the services they provide.	To attract talented individuals and manage them effectively.

TRANSFORMATIVE CAPACITY CONTRIBUTES TO PERFORMANCE GAINS AND IS DEVELOPED THROUGH THE CULTIVATION OF SUPPORTING CAPACITIES

TABLE 2. TRANSFORMATIVE CAPACITY AND PERFORMANCE GAINS LINK TO SUPPORTING CAPACITIES: AN ILLUSTRATIVE EXAMPLE

Structural change achieved through transformative capacity: the case of the unexpected economic downturn

Capacity level	Performance	Supporting Capacities
System	Laws, customs, and practices promoting gender justice within the health sector are adopted as part of a broader social reform.	To engage in policy advocacy; to formulate policies that address root causes of ill-health; to translate policies into operational procedures.
Organization	Staff, governance body, and supporters embrace new gender-justice norms and align programs accordingly.	To communicate effectively with internal and external stakeholders.
Community	Health center, local law enforcement, and local media outlets work together to expose, treat, and prevent gender-based violence.	To create and sustain productive relationships with “unlike” actors.
Individual	At all operational levels, service providers are trained in and employ practices that help women gain agency to protect themselves and their children from gender-based violence.	To hold sensitive conversations with vulnerable individuals; capacity to follow protocols regarding referrals, confidentiality, protection, and documentation.

SOCIAL CAPITAL—IN ADDITION TO GREATER RESILIENCE AND BETTER PERFORMANCE IN COMPLEX ENVIRONMENTS—CAN BE ANOTHER KEY PRODUCT OF CAPACITY STRENGTHENING WORK

Social capital, as defined by many scholars, comprises social networks, norms of reciprocity or social support, and social trust.³⁴ It is a source of vitality, growth, and effectiveness for health-promoting entities and is built through mission-driven motivation, a can-do culture, data-driven decision-making, purposeful innovation, and people-focused management. Social capital can also be built across communities, constituencies, and entities (both public and private). As social capital grows, networks expand.

Strategies that have been used to build social capital across institutional actors (including organizations and systems) include widening the circle of those who participate in governance functions; creating strong linkages to policymakers in adjacent sectors; using credible, results-focused communications; active outreach; purposeful networking; and adopting transparency practices. Improved performance is both a *product* and a *generator* of social capital (adapted from Sagawa and Jospin).³⁵

Important implication: *Where possible, capacity strengthening and measurement should seek to build social capital.*

HEALTH SECTOR SOCIAL CAPITAL CONTRIBUTES TO GOOD OUTCOMES FOR MOTHERS, NEWBORNS, AND CHILDREN

The importance of social connectedness to health outcomes is well established (Putnam).³⁶ The major components of social networks—norms of reciprocity, social support, and social trust—are highly relevant to maternal, newborn, and child health outcomes.³⁷

Social capital can be both an individual *and* a collective asset.³⁸ Thus, social capital can (and should) be purposefully enhanced at all four health sector capacity levels: system, organization, community, and individual. Forms of social support are varied and may also include information-sharing and appraisal support, which allows all actors to adapt, absorb, and transform.

CHAPTER 3: MEASURING AND ASSESSING CAPACITY— DIFFERENT TOOLS FOR DIFFERENT TASKS

Key Definitions For the Purpose of This Discussion

CAPACITY: The constellation of attributes that enables an actor working at any level of a sector—system, organization, community, or individual—to thrive and perform in conditions of high complexity.

CAPACITY MEASUREMENT: The use of quantitative data to determine the extent to which selected dimensions of capacity are present at a given point in time. In order to bolster data validity and objectivity, performance data is often used (as opposed to indicators of latent capacity).

CAPACITY ASSESSMENT: The process of gathering and analyzing information (including data generated through capacity measurement tools as well as qualitative insights gleaned from feedback loops and other mechanisms) to inform decisions about capacity development plans or activities.

CAPACITY DEVELOPMENT TOOL SELECTION DEPENDS ON PURPOSE: ONE SIZE DOESN'T FIT ALL

The first step in choosing a tool is to define the purpose of a tool's use. What do tool users hope to accomplish? Tools can be used to measure or assess capacity at any level: system, organization, community, or individual.

Capacity assessment and measurement tools are typically used for one of four different purposes:

- **To assess risk:** to support the development of risk mitigation strategies; to determine award eligibility.
- **To diagnose:** to develop a capacity strengthening plan based on capacity assets and needs.
- **To strengthen capacity:** to promote learning, adapting, and awareness (but not the development of a capacity strengthening plan; the tool's use and the conversation it generates is understood as a capacity development intervention).
- **To fulfill accountability requirements:** to prepare reports that satisfy stakeholder or donor expectations ("upward accountability"); to ensure that constituent expectations are met ("downward accountability").

Generally, each tool's purpose has a unique set of technical requirements; users must match tool selection to tool purpose to generate helpful and valid information. A given tool is usually suitable for only one capacity level: system, organization, community, or individual.

RISK ASSESSMENT TOOLS CAN ANSWER THE QUESTION “IS AN INVESTMENT IN THIS PARTNER SAFE AND PRUDENT?”

“Safe and prudent” means that the partner will comply with:

- Financial management requirements.
- Financial reporting requirements.
- All contractual obligations.
- All legal and operational requirements.

“Safe and prudent” also means that the partner will:

- Prove to be reliable (as evidenced by prior achievements).
- Influence the wider ecosystem through its connections.
- Leverage its experience, knowledge, and resources.

When risk assessment is undertaken to determine award eligibility (prequalification), it is often performed on a one-time basis.

RISK ASSESSMENT TOOLS CAN ALSO ANSWER THE QUESTION “WHAT MUST WE DO TO MITIGATE THE RISKS WE FACE?”

“Mitigating the risks” is often concerned with organizational sustainability. Typical concerns addressed by such tools include risks related to:

- Income flows.
- Reputation.
- Legal compliance.
- Ongoing or future humanitarian and natural disasters.
- Liabilities.

Risk assessment for the purpose of risk mitigation planning is often done annually.

DIAGNOSTIC TOOLS ANSWER THE QUESTION “WHAT ARE THIS PARTNER’S CAPACITY ASSETS AND NEEDS?”

“Capacity assets and needs” is understood in relation to a partner’s desired outcomes and results. Partners ask:

- What must we be able to do to achieve a set of proposed outcomes (critical competencies)?
- How are we performing in each of these critical areas?
- What strengths can we leverage to address our needs?

Generally, diagnostic tools are used to plan capacity strengthening activities. In this context, such tools do not need to make fine-grain distinctions as they are not designed to measure progress or the impact of a capacity strengthening program. Instead, they should be used to set capacity strengthening priorities.

CAPACITY-STRENGTHENING TOOLS THAT PROMOTE LEARNING AND ADAPTING ANSWER THE QUESTION “WHAT IMPORTANT CONVERSATIONS SHOULD WE BE HOLDING?”

“Important conversations” refers to the themes and learning agenda items partners need to explore in order to thrive in environments of high complexity. Partners:

- Recognize capacity-strengthening efforts as inputs connected to a Theory of Change (TOC).
- Believe that complexity requires ongoing testing and refinement of the TOC; new performance challenges may arise that render current plans obsolete.
- Are keenly aware that they operate in an environment marked by complexity; the system in which they function does not behave in a repeatable, predetermined manner.

Generally, tools that promote learning and adapting around capacity strengthening efforts are conversation-rich, make extensive use of evidence, and are capable of tracking fine-grained changes in performance over time. Such tools shed light on how changes in capacity are linked to performance improvement and higher-level outcomes (e.g., healthy newborns, mothers, and children)

ACCOUNTABILITY-REPORTING TOOLS ANSWER THE QUESTION “TO WHAT EXTENT ARE CONTRACTUAL OBLIGATIONS BEING MET?”

“Contractual obligations” are spelled out in signed agreements and are often connected to funding. These tools take many forms including:

- Financial reporting templates.
- Templates for reporting on inputs and outputs (e.g., timing, quantity).
- Program audit procedures.

ACCOUNTABILITY TOOLS CAN ALSO ANSWER THE QUESTION “ARE CONSTITUENT AND CLIENT EXPECTATIONS MET?”

“Meeting constituent and client expectations” means that an actor:

- Creates processes for gathering constituent and client feedback.
- Uses constituent and client feedback to address areas of concern.
- Engages in dialogue to understand and, as necessary, negotiate constituent and client expectations.
- Maintains ongoing, multidirectional feedback loops.
- Generally, tools for accountability can uncover performance problems. However, they don’t reveal underlying causes of shortfalls. Thus, when performance problems are uncovered, accountability tools will need to be augmented with insights gathered from diagnostic tools.

THE UTILITY OF A GIVEN TOOL TYPE DEPENDS ON THE HEALTH SECTOR CAPACITY LEVEL BEING ASSESSED

TABLE 4: UTILITY OF CAPACITY TOOLS BY HEALTH SECTOR CAPACITY LEVEL

Tool type	System	Organization	Community	Individual
Risk assessment	✓	✓	✓	✓
Diagnostic	✓	✓	✓	✓
Capacity strengthening		✓	✓	✓
Accountability		✓		

Note: These ratings reflect the author’s views and the technical references cited in the bibliography.

Tool selection must reflect a strong understanding of the use case, including the types of decisions that will be informed by tool findings.

MOST TOOL TYPES DO NOT PERFORM WELL IN SITUATIONS OF HIGH COMPLEXITY

TABLE 5: UTILITY OF CAPACITY TOOLS BY PERCEIVED LEVEL OF COMPLEXITY

Tool type	Low	Medium	High
Risk assessment		✓	
Diagnostic		✓	
Capacity strengthening			✓
Accountability	✓		

Tools best suited for environments of complexity focus on theory-building, conversation, and learning.

NEARLY ALL TOOL TYPES ARE POORLY SUITED TO THE MEASUREMENT OF TRANSFORMATIVE CAPACITY

TABLE 6: UTILITY OF CAPACITY TOOLS BY RESILIENCE CAPACITY

Tool type	Absorptive	Adaptive	Transformative
Risk assessment	✓		
Diagnostic	✓	✓	
Capacity strengthening		✓	✓
Accountability	✓		

Transformative capacity involves longitudinal change. Most tools take a short view of capacity and don't attempt to capture how performance improvements translate into far-reaching impacts.

MEASURING CAPACITY IN A COMPLEX ENVIRONMENT POSES SPECIAL CHALLENGES

- **Metrics:** Yesterday's metric may be obsolete tomorrow. Yet, changing metrics to remain relevant may limit the user's ability to detect longitudinal trends and performance patterns.
- **Focus:** Emergent learning, a critical practice in complex settings, entails evolving understandings of what capacities should be measured. In the early stages of capacity assessment, it may not be clear what should be measured.
- **Integration:** It is much easier to measure capacity by level (e.g., system, organization, community, individual) and ignore the ways in which the connections across levels are either fragmented or coherent. Yet, these cross-level connections (horizontal view) are important in complex environments. A level-by-level (vertical view) approach to capacity measurement is an example of "trying to tame the problem," a poor response to complexity.

CHAPTER 4: CHOOSING A CAPACITY ASSESSMENT TOOL

CHOOSING THE RIGHT CAPACITY MEASUREMENT TOOL REQUIRES ROBUST SELECTION CRITERIA

Utility for MOMENTUM:

- Alignment with MOMENTUM's theory of change.
- Alignment with MOMENTUM's learning agenda.
- Question(s) the tool can answer.

Construct validity:

- Use of evidence.
- Underlying paradigms and assumptions regarding what is measured and the use of evidence:
 - **Face validity.**
 - **Reliability.**
 - **Ease of use.**
 - **Complexity-awareness.**
 - **Resilience sensitivity (adaptive, absorptive, transformative).**
 - **Actionability.**

A STRONG CAPACITY MEASUREMENT TOOL MUST BE ALIGNED WITH MOMENTUM'S LEARNING AGENDA

Selected tools should be able to shed light on:

- Capacity changes at the individual, organization, community, and system level.
- Performance changes at the individual, organization, community, and system level.
- The pathways that produced these changes.

CONSTRUCT VALIDITY IS A CRITICAL CONSIDERATION IN TOOL SELECTION

Construct validity: how closely the results generated by a given capacity assessment tool capture reality, as opposed to some distorted view of how well an actor performs in relation to a set of performance expectations.

Most construct validity threats stem from false beliefs about performance improvement.

Examples of capacity measurement **construct validity threats** include:

- Failure to distinguish between *latent capacity* and *performance*.
- Limited or improper use of evidence to support scoring.
- Use of documentation as the only acceptable evidence for scoring support.
- Over-emphasis on attributes that have little or no bearing on performance.
- Assumption that individuals will actually apply training they've received.
- Assumption that Western models of capacity have universal applicability.

RESEARCH DEMONSTRATES THAT CONVENTIONAL WISDOM ABOUT CAPACITY IS SOMETIMES WRONG

As McLeod and Crutchfield (2007) report, many commonly held beliefs about what makes social-purpose organizations successful are not supported by research data.³⁹ In fact, the vast majority of the literature focuses on issues that, although important, don't appear to determine whether an organization has significant impact. Examples of conventional wisdom that were not confirmed by research:

- **Perfect Management.** Some of the successful organizations studied were not exemplary models of generally accepted management principles. Although adequate management is necessary, it is not sufficient for creating significant social impact.
- **Innovation.** Although some groups came up with radical innovations, others took old ideas and tweaked them until they achieved success (adaptive learning).
- **Mission Statements.** Only a few of the highly successful organizations studied spent time fine-tuning their mission statement on paper; most of them were too busy living it.
- **High Ratings on Conventional Metrics.** "When we looked at traditional measures of nonprofit efficiency, many of these groups didn't score well, because they don't adhere to misleading metrics" (adapted from McLeod and Crutchfield, 2007).⁴⁰

CONSTRUCT VALIDITY CAN BE ENHANCED THROUGH A CORE SET OF PRACTICES

- Use multiple forms of evidence including, illustratively, constituent feedback interviews, observation guides, records; don't rely solely on documentation from a single source.
- Triangulate data; draw upon multiple perspectives and multiple sources of information.
- Connect indicators to research-validated models of capacity that establish clear linkages between what is being measured and performance.
- Align capacity measurement tools to a carefully constructed theory of change when no research-validated model is available.
- Focus on measuring what matters most; it's better to measure a few capacities that matter reasonably well than to measure relatively unimportant capacities brilliantly, which may deflect attention from more critical areas.

FACE VALIDITY BUILDS CONFIDENCE IN FINDINGS AMONG CAPACITY MEASUREMENT TOOL USERS

Face validity means that capacity measurement tool users view the tool as:

- Relevant.
- Useful.
- Capable of producing new information and insights.

Face validity can be enhanced by:

- Providing users with a rationale for what is being measured.
- Communicating to users how findings generated by the tool are useful.

CAPACITY ASSESSMENT TOOLS MUST BE RELIABLE

RELIABILITY IN CAPACITY DEVELOPMENT MEASUREMENT IS ACHIEVED WHEN:

- Use of the tool by a single assessment team on two separate (but proximal) occasions yields similar results.
- Use of the tool by two different assessment teams on proximal occasions yields consistent results (inter-rater reliability).

Note: Reliability deals with how closely the measures agree with each other, as opposed to how closely they agree with reality. It is possible to have high reliability and a large sample size and still lack construct validity.

Reliability can be enhanced through:

- Good training and technical support for tool users.
- Strong documentation, including a clearly written users' manual.
- Choosing tools that combine ease of use with construct validity.
- Selection of well-constructed assessment rubrics that use mutually exclusive, clearly written, highly focused descriptions of practice.

CAPACITY MEASUREMENT TOOLS SHOULD BE EASY TO USE

Ease-of-use considerations include:

- Time to administer (typically no more than half a day).
- Level of effort (the required number of person-days should not cause major operational disruption).
- Results reporting turnaround time (ideally, results are reported the same day or within 24 hours).
- Technical requirements (needed hardware and software are readily available).
- Cost (which can include the cost of bringing people together from disparate locations; external facilitation or evidence gathering).

CAPACITY MEASUREMENT TOOLS MUST PRODUCE ACTIONABLE INFORMATION

- Tool documentation should provide clear information on how results can be used to guide decisions related to capacity development and performance improvement; ideally, the toolkit includes resources that help users translate findings into action plans.
- The decision to use a capacity assessment tool should include a plan for how and with whom results will be shared, the types of decisions that will be influenced by tool results, and who will be responsible for follow-up activities that involve the utilization of findings.

SOME CAPACITY MEASUREMENT TOOLS CAN HELP BUILD SOCIAL CAPITAL

- Tools that rely upon deep, open dialogue and appreciative inquiry build social capital.
- Tools that build social capital exemplify the principle that capacity measurement is, in itself, a capacity strengthening initiative.
- Tools that build social capital through deep dialogue help generate consensus around needed changes, foster adaptive learning, are more complexity-sensitive than static processes, and help foster a learning-rich organizational culture.

CHAPTER 5: CAPACITY ASSESSMENT TOOLS CAN—BUT DON'T NECESSARILY—CONTRIBUTE TO IMPROVED PERFORMANCE

Introduction

This chapter highlights five important lessons about the role of tool use in supporting capacity strengthening work. For tools to reach their full potential as capacity strengthening catalysts, they must be integrated into a broader process of reflection and learning.

This chapter draws on lessons gleaned from a study that examined the four-year application of one capacity assessment tool, the Discussion-Oriented Self-Assessment (DOSA), which was developed with USAID funding.⁴¹ Twenty nongovernmental organizations (NGOs), all USAID grantees, participated in the study. As a condition of support, these NGOs were required to use DOSA annually.

Although DOSA was designed to capture changes in organizations, it was subsequently adapted for use by an NGO network addressing maternal and child health challenges. Given the study's longitudinal nature and its multilevel focus, the findings and supporting data seem particularly relevant to a discussion of how capacity assessment can contribute to greater capacity at different capacity levels (i.e., system, organization, community, and individual).

LESSON ONE: CAPACITY ASSESSMENT MUST BE INTEGRATED INTO A BROADER PROCESS OF TRANSFORMATION

- Ideally, assessment tools are part of a tool *suite* that includes guidance for interpreting results, setting capacity development priorities, planning capacity development activities, and establishing metrics to gauge progress in addressing capacity development priorities.
- Capacity assessment tools and supporting processes must closely align with a shared vision of how the *actor being assessed* (that is, a system, an organization, a community-based entity, or an individual) ought to function.

Implications: The capacity assessment process must be intimately linked to the identification of activities that will contribute to enhanced capacity. In other words, the purpose of the assessment is to inform decisions about *what* capacities should be strengthened, *who* must be engaged in any capacity strengthening activities, *how* capacities will be strengthened, and *how* the new capacities—once converted into performance—will support achievement of key results.

LESSON TWO: CAPACITY ASSESSMENT SHOULD SHED LIGHT ON IMPORTANT DETERMINANTS OF CAPACITY

- Capacity assessment tools are not silver bullets. They do not *automatically* generate a will to change or agreement on who or what must change.
- It is important to assess the extent to which an environment *enables* the development and deployment of key capacities. Many capacity assessment tools do not help users identify root causes of high (or low) capacity. Features of an enabling environment might include appropriate incentives, leadership commitment to capacity strengthening, adequate resourcing, strong social capital, and a culture that supports experimentation.⁴²
- Capacity assessment tool users should be careful of falling into the “training trap.” Lack of knowledge or skill may indeed explain some suboptimal manifestations of capacity. However, low motivation, insufficient resources, or limited supervisory support—rather than inadequate knowledge—often explain disappointing performance. Ideally, a capacity assessment tool should shed light on these and other potential causes of under-performance.

Implications: A strong capacity assessment process should help users create an enabling environment for consistent and sustainable demonstrations of capacity. Capacity assessment tools should generate both a snapshot (the state of capacity at a given point in time) as well as an X-ray (the underlying causes of capacity). Well-designed capacity assessment tools can (and should) help users excel in thinking critically about the *what* as well as the *why* of performance.

LESSON THREE: CAPACITY ASSESSMENT TOOLS SHOULD HELP USERS IDENTIFY INTERRELATIONSHIPS AMONG CAPACITIES TO LEVERAGE CHANGE PROCESSES

- Capacities are often interrelated and form “clusters of change,” sets of connected, thematically linked, causally connected dimensions of organizational performance that vary together over time.
- Clusters of change vary by context. Capacity assessments can help users identify how capacities cluster in their operating environment.
- Plans to improve clusters of capacity greatly leverage capacity development resources and results.

EXAMPLE

DOSA generated an array of subscores drawn from multiple capacity domains. This enabled users to understand how seemingly disparate capacities connected to one another. Illustratively, the “stakeholder cluster of change” drew on scored items from three capacity domains: service delivery (programs), external relations, and strategic management. Users were able to identify common patterns of interaction across three very different stakeholder groups: donors, local partners, and internal colleagues.

Implications: Capacity assessment tools and processes should support the development of multifaceted change strategies that harness the power of clusters to accelerate performance improvement.

LESSON FOUR: CAPACITY ASSESSMENT TOOLS SHOULD BE GROUNDED IN THEORIES OF CHANGE

- Not all capacities are equally influential in determining results. Some capacities are definitely more important than others.
- The Pareto Principle can be used to formulate a useful rule of thumb: of the many capacities that can be measured, only 20 percent of them are likely to explain 80 percent of observed performance levels.
- Assessment tools should focus on capacities that deeply influence performance. Determining what matters most is a multifaceted process that entails literature reviews, interviews, and close observation of the local system.^{43, 44}
- Theories of change can help users identify the 20 percent of capacities that are truly critical.

Implications: “We treasure what we measure” is an oft-heard aphorism among evaluators. Assessing relatively unimportant capacities carries significant opportunity costs for both the capacity development supporter and the local partner; the practice diverts attention from what matters most. Capacity assessment tools that are grounded in well-developed theories of change are likely to help users avoid the trap of “doing the wrong [or unimportant] thing right.”

LESSON FIVE: CAPACITY ASSESSMENT FINDINGS ARE OPTIMIZED WHEN THE ASSESSMENT PROCESS IS DIALOGUE-RICH

- Dialogue-rich capacity assessment builds social capital (trust, cohesion, and a shared sense of purpose) as well as a more robust analysis of capacity and performance.
- Dialogue also strengthens the capacity of participants to strengthen capacity and set their own development path. In short, dialogue has the potential to launch a powerful virtuous cycle.
- An adequate stock of social capital is essential for any capacity strengthening plan of action to succeed.
- Capacity assessment processes that incorporate diverse participants, experiences, and vantage points often yield unexplored but promising pathways to higher levels of performance.

Implications: An important outcome of capacity assessment is learning, which is a cornerstone of resilience and, more specifically, adaptive capacity. Rich dialogue is a powerful means to foster learning, build resilience, enhance social capital stocks, and create a shared vision to guide future decisions. Such dialogue also sheds light on how knowledge, information, resources, and social capital flows into and through a system. These insights, in turn, inform and strengthen capacity development initiatives.

APPLYING THESE FIVE LESSONS TO CAPACITY ASSESSMENT TOOLS

- The main tools that are used to measure performance or assess capacity within the MOMENTUM suite of awards are the Organizational Performance Index Measurement Tool (OPI); the Non-U.S. Organization Pre-award Survey (NUPAS); the Organizational Capacity Assessment Tool for Organizations Funded by USAID (OCA/USAID); and the Integrated Technical Organizational Capacity Assessment (ITOCA).

- Several of these tools are dialogue-rich.
- Most are not designed to shed light on the determinants of capacity or how capacities cluster.
- In general, these tools give equal weight to the capacities they measure.
- For the most part, these tools are not linked to an explicit theory of change.
- Nevertheless, capacity development supporters feel that the tools generate useful data.

Implications: If many—if not all—of the five lessons presented in this chapter were incorporated into these commonly used tools through a process of revision, capacity development initiatives would become more effective.

CHAPTER 6: INDICATORS TO MEASURE CAPACITY DEVELOPMENT ACROSS THE MOMENTUM AWARD SUITE

Introduction

This section provides a brief description of the process used to assess and select potential indicators for the systemic analysis, synthesis, translation, and dissemination of capacity development results across the entire suite of MOMENTUM awards.

STEP 1

All MOMENTUM Monitoring, Evaluation, and Learning (MEL) plans were reviewed, particularly with respect to Results 2 and 3, which closely align with capacity development considerations.

STEP 2

USAID's Collaborating, Learning, and Adapting (CLA) guidance was reviewed.^{45, 46}

STEP 3

A list of common themes was created that integrated the collective MEL agendas and CLA considerations. The following 10 themes emerged:

- Accountability to other actors.
- Adaptive learning and management.
- Client-centeredness (an orientation toward meeting or exceeding expectations held by product—or service—users).
- Complexity awareness (actions that demonstrate a recognition of the fact that the operating context is not stable and that the human components of the system will not always behave in compliant, predictable ways).
- Context awareness (a prerequisite for adaptiveness and resilience).
- Gender-equity promotion.
- Innovation (largely through the application of Agile principles and lean experimentation).^{47, 48}
- Localization (MOMENTUM's focal areas—maternal, newborn, and child health services; voluntary family planning; and reproductive health care—are locally owned, locally led, and locally sustained).⁴⁹
- Perceived respect (refers to the extent to which clients, partners, or service users perceive that they are respected by other actors).
- Use of data, information, and evidence (for the purpose of learning, improving, reporting, meeting accountability or transparency expectations).

STEP 4

Based on this list, a set of 10 potential cross-MOMENTUM indicators was created:

- % of targeted actors that routinely modify programs to better reflect locally prevailing social norms, values, beliefs and practices.
- % of targeted actors making systematic use of data to achieve greater gender equity.
- % of targeted actors using client or constituent feedback to improve program reach, coverage, or effectiveness.
- % of targeted actors working collaboratively with local governance structure on determining how resources are allocated.
- % of targeted actors using data generated through their monitoring systems to fine-tune activities or strategies.
- % of targeted actors routinely sharing data on defined performance metrics with an “accountability body.”
- % of targeted actors who conduct experiments* that enable them to refine strategies or activities.
- % of targeted actors that routinely use Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis or comparable environmental scanning methods to determine whether adjustments to activities or strategies are needed.
- % of policies promoted by key actors that move up at least one stage on the “policy value chain” (e.g., research/analysis, consultation, drafting, agency or legislative review, adoption, implementation, review/research/evaluation).
- % of partners/clients who report that they feel respected in their interactions with “actors of interest.”

STEP 5

Each potential indicator was assessed through five different lenses:

- The degree to which each potential indicator connected to the ten common themes present in the MOMENTUM awards (Table 7).
- The extent to which potential indicators could shed light on the three capacities associated with resilience (Table 8).
- The extent to which potential indicators could create a “through-line” narrative by being applicable—with adjustments—to the four health sector levels: system, organization, community, individual (Table 9).
- The extent to which the potential indicator met eight selection criteria (Table 10 and shown below):
 - Ease of use.
 - Utility for sound decision making.
 - Potential contribution to complexity awareness.
 - Expression of performance or behavior (rather than latent capacity).

* *Experiments* is used here to denote activities that reflect such Agile principles as rapid iteration, well-defined metrics, and the use of “minimum viable products” (prototypes) that culminate in “pivot” or “persevere” decisions.

- Degree of “observability” or “verifiability.”
- Sensitivity (ability to fluctuate bi-directionally).
- Utility for enhancing resilience.
- Degree of applicability across the MOMENTUM suite of awards.

The extent to which the indicators performed well on the full set of measures and considerations (Table 11).

Based on this five-step analysis, two indicators were identified for further development:

- **% of targeted actors that routinely modify programs to better reflect locally prevailing social norms, values, beliefs, and practices**
- **% of targeted actors using client or constituent feedback to improve program reach, coverage, or effectiveness**

Partially completed PIRS sheets for these two indicators are provided in Annex 1. The first is presented for the organization and systems levels of the health sector, while the second is explored at the individual and community levels.

Another five indicators worthy of additional consideration were identified using the process described earlier:

- % of targeted actors making systematic use of data to achieve greater gender equity.
- % of targeted actors working collaboratively with local governance structure on determining how resources are allocated.
- % of targeted actors using data generated through their monitoring systems to fine-tune activities or strategies.
- % of targeted actors routinely sharing data on defined performance metrics with an “accountability body.”
- % of targeted actors who conduct experiments that enable them to refine strategies or activities.

A RATIONALE FOR THE APPROACH USED TO GENERATE AND SELECT THIS LIST OF INDICATORS

The methodology used to generate and select recommended indicators draws heavily from the discussion of capacity, complexity, and resilience in Chapter 2. Ideas that particularly informed the indicator development and assessment process include the following:

- Capacity is the ability of an actor to perform, sustain itself, and self-renew.
- Capacity involves doing and achieving.
- Capacity development entails improvements in performance.

- Capacity exists at multiple levels: system, organization, community, and individual.
- Uncertainty, unpredictability, and complexity are key features of the health sector.
- Given the dynamic nature of the health sector, measurement strategies must be adaptive and context-aware.
- Technical and social complications abound; adaptive management and emergent learning are crucial skills for actors at all levels.
- Meeting the challenge of complexity requires resilience.

Specific ways in which these concepts were applied include the following:

- Potential indicators were assessed to determine whether they could be adapted for use at multiple levels of the health sector.
- Indicators were assessed to determine the extent to which they were likely to contribute to performance improvement, quality programs, sound decision-making (critical for adaptive learning and management), resilience, and complexity awareness.

As noted earlier, two indicators performed especially well on the four tests that were used for indicator selection (see Tables 7–11). They both appear to be “fit for purpose.” A brief justification for the two recommended indicators follows.

Proposed indicator: % of targeted actors that routinely modify programs to better reflect locally prevailing social norms, values, beliefs, and practices

Justification: The proposed indicator focuses on a practice that, when performed regularly, is directly linked to improvements in program quality, coverage, and effectiveness. Implicit in the ability to routinely localize programs are skills related to adaptive learning, adaptive management, and complexity-aware monitoring. Furthermore, this indicator, with appropriate adjustments, can be used at varying levels of the health sector. The purpose of the modifications would be tied to achievement of results (e.g., increased access, acceptability, or use of health services and products).

Proposed indicator: % of targeted actors using client or constituent feedback to improve program reach, coverage, or effectiveness

Justification: The proposed indicator focuses on a practice that, when performed regularly, fosters greater localization along with a sense of program ownership. Those two variables, in turn, influence social-capital formation and sustainable improvements. Constituent feedback is also foundational for adaptive management and complexity-aware monitoring. Furthermore, this indicator, with appropriate adjustments, can be used at varying health sector levels.

TABLE 7. THE EXTENT TO WHICH 10 POSSIBLE CAPACITY DEVELOPMENT INDICATORS CONNECT TO THEMES REFLECTED IN MOMENTUM MEL PLANS

KEY	ACC: accountability ALM: adaptive learning & mgt CAW: context awareness	CCE: client-centeredness COM: complexity awareness GEP: gender-equity promotion	INN: innovation LOC: localization PER: perceived respect UDI: use of data, info & evidence
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Possible Indicator (numbers in parentheses refer to the number of themes that are related to each indicator presented)	Common themes across most MOMENTUM awards									
	ACC	ALM	CAW	CCE	COM	GEP	INN	LOC	PER	UDI
1. % of targeted actors making systematic use of data to achieve greater gender equity (5)		✓	✓		✓	✓				✓
2. % of targeted actors using client or constituent feedback to improve program reach, coverage, or effectiveness (8)	✓	✓	✓	✓	✓			✓	✓	✓
3. % of targeted actors working collaboratively with local governance structure on determining how resources are allocated (5)	✓		✓	✓				✓	✓	✓
4. % of targeted actors that routinely use SWOT analysis or comparable environmental scanning methods to determine whether adjustments to activities or strategies are needed (5)		✓	✓		✓			✓		✓
5. % of targeted actors using data generated through their monitoring systems to fine-tune activities or strategies (6)		✓	✓	✓	✓			✓		✓
6. % of targeted actors routinely sharing data on defined performance metrics with an “accountability body” (4)	✓			✓				✓		✓
7. % of targeted actors that routinely modify programs to better reflect locally prevailing social norms, values, beliefs, and practices (8)		✓	✓	✓	✓		✓	✓	✓	✓
8. % of targeted actors who conduct experiments that		✓	✓	✓	✓		✓	✓		✓

	Common themes across most MOMENTUM awards									
Possible Indicator (numbers in parentheses refer to the number of themes that are related to each indicator presented)	ACC	ALM	CAW	CCE	COM	GEP	INN	LOC	PER	UDI
enable them to refine strategies or activities (7)										
9. % of policies promoted by key actors that move up at least one stage on the “policy value chain” (e.g., research/analysis, consultation, drafting, agency or legislative review, adoption, implementation, review/research/evaluation) (3)			✓		✓					✓
10. % of partners/clients who report that they feel respected in their interactions with “actors of interest” (4)	✓			✓				✓	✓	
Total mentions across indicators	4	6	8	7	7	1	2	8	4	9

TABLE 8. THE EXTENT TO WHICH 10 POSSIBLE CAPACITY DEVELOPMENT INDICATORS ARE CONCEPTUALLY RELATED TO ABSORPTIVE, ADAPTIVE, AND TRANSFORMATIVE CAPACITIES

Possible Indicator	Relevance to the 3 resilience capacities		
	Absorptive (5)	Adaptive (9)	Transformative (5)
1. % of targeted actors making systematic use of data to achieve greater gender equity		✓	✓
2. % of targeted actors using client or constituent feedback to improve program reach, coverage, or effectiveness	✓	✓	
3. % of targeted actors working collaboratively with local governance structure on determining how resources are allocated	✓	✓	✓
4. % of targeted actors that routinely use SWOT analysis or comparable environmental scanning methods to determine whether adjustments to activities or strategies are needed	✓	✓	
5. % of targeted actors using data generated through their monitoring systems to fine-tune activities or strategies	✓	✓	
6. % of targeted actors routinely sharing data on defined performance metrics with an “accountability body”		✓	✓
7. % of targeted actors that routinely modify programs to better reflect locally prevailing social norms, values, beliefs, and practices		✓	✓
8. % of targeted actors who conduct experiments that enable them to refine strategies or activities		✓	
9. % of policies promoted by key actors that move up at least one stage on the “policy value chain” (e.g., research/analysis, consultation, drafting, agency or legislative review, adoption, implementation, review/research/evaluation)			✓
10. % of partners/clients who report that they feel respected in their interactions with “actors of interest”	✓	✓	

TABLE 9. THE EXTENT TO WHICH 10 POSSIBLE CAPACITY DEVELOPMENT INDICATORS CAN BE ADAPTED FOR USE AT FOUR DIFFERENT HEALTH SECTOR LEVELS: INDIVIDUAL, COMMUNITY, ORGANIZATION, AND SYSTEM

Possible Indicator	Utility for each health sector level (with appropriate adjustments made to the PIRS to account for differences in units of analysis; instrumentation; and operational definitions)			
	Individual/HR	Community	Organization	System
1. % of targeted actors making systematic use of data to achieve greater gender-equity		✓	✓	✓
2. % of targeted actors using client or constituent feedback to improve program reach, coverage, or effectiveness	✓	✓	✓	✓
3. % of targeted actors working collaboratively with local governance structure on determining how resources are allocated		✓	✓	✓
4. % of targeted actors that routinely use SWOT analysis or comparable environmental scanning methods to determine whether adjustments to activities or strategies are needed		✓	✓	
5. % of targeted actors using data generated through their monitoring systems to fine-tune activities or strategies	✓	✓	✓	
6. % of targeted actors routinely sharing data on defined performance metrics with an "accountability body"	✓	✓	✓	
7. % of targeted actors that routinely modify programs to better reflect locally prevailing social norms, values, beliefs, and practices	✓	✓	✓	✓
8. % of targeted actors who conduct experiments that enable them to refine strategies or activities		✓	✓	✓
9. % of policies promoted by key actors that move up at least one stage on the "policy value chain" (e.g., research/analysis; consultation; drafting; agency or legislative review; adoption; implementation; review/research/evaluation)			✓	✓
10. % of partners/clients who report that they feel respected in their interactions with "actors of interest"	✓	✓	✓	

TABLE 10. THE EXTENT TO WHICH 10 POSSIBLE CAPACITY DEVELOPMENT INDICATORS MEET SELECTION CRITERIA

KEY:	EoU: ease of use UTI: utility for sound decision making	COA: Potential contribution to complexity awareness PorB: Represents a performance or behavior	OoV: Observable or verifiable SEN: Sensitive (i.e., it fluctuates and can move bi-directionally)
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Possible Indicator	Suitability of indicator in relation to each selection criterion					
	EoU	UTI	COA	PorB	OoV	SEN
% of targeted actors making systematic use of data to achieve greater gender equity		✓	✓	✓	✓	✓
% of targeted actors using client or constituent feedback to improve program reach, coverage, or effectiveness		✓	✓	✓	✓	✓
% of targeted actors working collaboratively with local governance structure on determining how resources are allocated	✓	✓	✓	✓	✓	✓
% of targeted actors that routinely use SWOT analysis or comparable environmental scanning methods to determine whether adjustments to activities or strategies are needed	✓	✓	✓	✓	✓	
% of targeted actors using data generated through their monitoring systems to fine-tune activities or strategies	✓	✓	✓	✓	✓	✓
% of targeted actors routinely sharing data on defined performance metrics with an "accountability body"	✓	✓		✓	✓	✓
% of targeted actors that routinely modify programs to better reflect locally prevailing social norms, values, beliefs, and practices	✓	✓	✓	✓	✓	✓
% of targeted actors who conduct experiments that enable them to refine strategies or activities	✓	✓	✓	✓	✓	✓
% of policies promoted by key actors that move up at least one stage on the "policy value chain" (e.g., research/analysis; consultation; drafting; agency or legislative review; adoption; implementation; review/research/evaluation)	✓	✓			✓	
% of partners/clients who report that they feel respected in their interactions with "actors of interest"		✓			✓	✓

Note: Two other selection criteria—applicability to MOMENTUM awards and potential contribution to resilience—are deliberately omitted from Table 10. Table 7 addresses applicability across MOMENTUM awards; Table 8 addresses capacities linked to resilience.

HOW 10 POSSIBLE CAPACITY DEVELOPMENT INDICATORS PERFORM ON FOUR TESTS OF SUITABILITY FOR CROSS-MOMENTUM USE

<p>Test 1</p> <p>Indicator is related to at least seven of 10 themes that are reflected in MEL plans</p>	<p>Test 2</p> <p>Indicator is related to at least two capacities that underlie resilience</p>
<p>Test 3</p> <p>Indicator has the potential to be adapted for use with at least three of the four health sector levels</p>	<p>Test 4</p> <p>Indicator meets at least five of six established selection criteria</p>

Based on this five-step analysis, two indicators (highlighted in teal) passed all four tests and, thus, were identified for further development and potential use on a cross-MOMENTUM basis:

- % of targeted actors using client or constituent feedback to improve program reach, coverage effectiveness
- % of targeted actors that routinely modify programs to better reflect locally prevailing social norms, values, beliefs, and practices

Of the six indicators that passed three tests (highlighted in orange), Indicator #5 (% of targeted actors using data generated through their monitoring systems to fine-tune activities or strategies) is especially promising; it has very broad applicability across capacity levels and MOMENTUM award foci.

TABLE 11. HOW INDICATORS PERFORMED ON FOUR TESTS OF SUITABILITY

Possible Indicator	Test 1	Test 2	Test 3	Test 4
1. % of targeted actors making systematic use of data to achieve greater gender equity	✓		✓	✓
2. % of targeted actors using client or constituent feedback to improve program reach, coverage, or effectiveness	✓	✓	✓	✓
3. % of targeted actors working collaboratively with local governance structure on determining how resources are allocated		✓	✓	✓
4. % of targeted actors that routinely use SWOT analysis or comparable environmental scanning methods to determine whether adjustments to activities or strategies are needed		✓		✓
5. % of targeted actors using data generated through their monitoring systems to fine-tune activities or strategies		✓	✓	✓
6. % of targeted actors routinely sharing data on defined performance metrics with an "accountability body"		✓	✓	✓
7. % of targeted actors that routinely modify programs to better reflect locally prevailing social norms, values, beliefs, and practices	✓	✓	✓	✓
8. % of targeted actors who conduct experiments that enable them to refine strategies or activities	✓		✓	✓
9. % of policies promoted by key actors that move up at least one stage on the "policy value chain" (e.g., research/analysis; consultation; drafting; agency or legislative review; adoption; implementation; review/research/evaluation)				
10. % of partners/clients who report that they feel respected in their interactions with "actors of interest"		✓	✓	

CONCLUSIONS

Two indicators were selected, based on their ranking, for further development. Partially completed performance indicator reference sheets (PIRS) for these indicators are provided in Annex 1. The first of these indicators—% of targeted actors that routinely modify programs to better reflect locally prevailing social norms, values, beliefs, and practices—is presented for the **organization** and **system** levels.

The second indicator—% of targeted actors using client or constituent feedback to improve program reach, coverage, or effectiveness—is explored at the **individual** and **community** levels.

A third indicator—% of targeted actors using data generated through their monitoring systems to fine-tune activities or strategies—may also be appropriate for cross-MOMENTUM use. The PIRS in Annex 1 could easily be adapted to accommodate this additional indicator.

ANNEX 1: FOUR MODIFIED USAID PERFORMANCE INDICATOR REFERENCE SHEETS (PIRS)

PIRS #1

CAPACITY 1: % of targeted actors that routinely modify programs to better reflect locally prevailing social norms, values, beliefs, and practices that influence health outcomes

HEALTH SECTOR LEVEL: Organization

PRECISE DEFINITIONS:

Targeted actors: A local partner organization that receives direct financial or technical support through MOMENTUM for the delivery of products or services related to the achievement of a result (as specified in the MOMENTUM awardee's Results Framework or the partner organization's strategic plan).

Routinely: At least once per 12 months.

Modify: Make at least one adjustment to the products or services being offered. Adjustments can include changes to product or service content, the way in which the product or service is delivered (e.g., method, timing, or place), payment or pricing practices, target audience, or practices related to product or service promotion (e.g., media channels, messaging, explanation of benefits associated with the product or service).

Programs: The full constellation of products or services offered by the organization that are related to the achievement of results (as specified in the MOMENTUM awardee's Results Framework or the partner organization's strategic plan).

Reflect locally prevailing social norms, values, beliefs, and practices: Preferences that influence demand for and use of products or services being offered, as identified through focus groups, human-centered design methods, data analysis, key informant reports, or other feedback mechanisms.

UNIT OF MEASURE: Organizations. Numerator: Number of organizations that identify specific modifications made to better accommodate social norms, values, beliefs, and practices that contribute to improved health outcomes. Denominator: Number of organizations that receive MOMENTUM financial or technical support for their programs.

DATA TYPE: Written or visual descriptions (prepared by partners) of changes made to products or services with a supporting justification that reflects an accommodation to local norms, values, beliefs, or practices as operationally defined above.

DISAGGREGATED BY: Geographic region; ethnic, linguistic, or socioeconomic target group(s) served by the organization.

RATIONALE FOR INDICATOR: This indicator is directly linked to improvements in program quality, coverage (demand), and effectiveness.

PIRS #2

CAPACITY 2: % of targeted actors that routinely modify programs to better reflect locally prevailing social norms, values, beliefs, and practices that influence health outcomes

HEALTH SECTOR LEVEL: System

PRECISE DEFINITIONS:

Targeted actors: A cohort of eight to 15 institutions (per country) that has been created as a reference group for the purpose of monitoring, evaluating, and learning about how a country's health system is performing. The cohort may include one or more of the following actor types that operate within a given country: private health care providers; public primary-, secondary-, and tertiary-care facilities; institutions that provide prelicensure training to doctors and nurses; medical associations; local NGOs engaged in health promotion or service delivery; local health posts; health insurance providers; family planning service providers; pharmacies and/or pharmaceutical companies.

Routinely: At least once per 12 months per cohort member.

Modify: Make at least one adjustment to the products or services being offered. Adjustments can include changes to product or service content, the way in which the product or service is delivered (e.g., method, timing, or place), payment or pricing practices, target audience, or, practices related to product or service promotion (e.g., media channels, messaging, explanation of benefits associated with the product or service)

Programs: Products or services offered by individual cohort members who are materially linked to the MOMENTUM Results Framework

Reflect locally prevailing social norms, values, beliefs, and practices: Preferences that influence demand for and use of products or services being offered, as identified through focus groups, human-centered design methods, data analysis, key informant reports, or other feedback mechanisms.

UNIT OF MEASURE: Cohort of relevant health care institutions. Numerator: Number of cohort institutions that identify specific modifications made to better accommodate social norms, values, beliefs, and practices that contribute to improved health outcomes. Denominator: Total number of cohort members.

DATA TYPE: Written or visual descriptions (prepared by partners) of changes made to products or services with a supporting justification that reflects an accommodation to local norms, values, beliefs, or practices as operationally defined above.

DISAGGREGATED BY: Cohort member type (e.g., public vs private, audiences served by cohort member); geographic locale.

RATIONALE FOR INDICATOR: This indicator is directly linked to improvements in program quality, coverage (demand), and effectiveness.

PIRS #3

CAPACITY 3: % of targeted actors using client or constituent feedback to improve program reach, coverage, or effectiveness

HEALTH SECTOR LEVEL: Individual

PRECISE DEFINITIONS:

Targeted actors: A cohort of 25 to 50 individuals (per region or country) that has been created as a reference group for the purpose of monitoring, evaluating, and learning about how a paid health care worker is performing in areas related to the achievement of one or more MOMENTUM results (as shown in the MOMENTUM Results Framework). Cohort members have job descriptions that involve making clinical judgments related to one of the following areas: diagnosis, treatment, prevention, or hygiene.

Client or constituent feedback: Information and opinions about the cohort member's performance that is gathered through a formal, ongoing, institutionalized process (e.g., surveys completed from individuals who have directly interacted with the cohort member in a professional capacity).

Feedback use: Cohort member, together with a supervisor, reviews information and opinions on the cohort member's performance at least once per 12-month period. The cohort member and supervisor identify any performance modifications that should be made based on this feedback and develop a plan for introducing (and assessing) needed changes.

Improved program reach: An increase in the number of eligible people served by a program.

Improved coverage: An increase in the ratio of eligible people served by a program to the total number of people eligible for the program.

Improved effectiveness: An improvement in scores on key metrics used by the program to determine its effectiveness. Metrics will vary by program.

UNIT OF MEASURE: Cohort of relevant health care individuals. Numerator: Number of cohort individuals who report having met with a supervisor to review client feedback and, where needed, introducing changes reflective of the feedback received. Denominator: Total number of cohort individuals.

DATA TYPE: Brief annual reports (submitted as a questionnaire response) that describe the feedback mechanisms used, meeting(s) with supervisor, and any changes introduced in response to the feedback received.

DISAGGREGATED BY: Locale, cohort member's sex, institutional type, institutional size, socioeconomic/ethnic/linguistic community characteristics.

RATIONALE FOR INDICATOR: This indicator is directly linked to improvements in program quality, coverage (demand), and effectiveness.

PIRS #4

CAPACITY 4: % of targeted actors using client or constituent feedback to improve program reach, coverage, or effectiveness

HEALTH SECTOR LEVEL: Community (with a focus on community-based service provision facilities)

PRECISE DEFINITIONS:

Targeted actors: A cohort of 10 to 20 institutions (per region or country) that has been created as a reference group for the purpose of monitoring, evaluating, and learning about how well community-based facilities (e.g., health posts, local clinics, or satellite service providers) generate and use client or constituent feedback to improve performance.

Client or constituent feedback: Information and opinions about the cohort member's performance that is gathered through a formal, ongoing, institutionalized process (e.g., meetings with members of local governance or advisory bodies; user surveys sponsored by local governance or advisory bodies)

Feedback use: Cohort member representatives, together with local governance or advisory bodies, review information and opinions on the cohort member's performance at least once per 12-month period. The cohort member and governance or advisory body identify any performance modifications that should be made based on this feedback and develop a plan for introducing (and assessing) needed changes.

Improved program reach: An increase in the number of eligible people served by a program.

Improved coverage: An increase in the ratio of eligible people served by a program to the total number of people eligible for the program.

Improved effectiveness: An improvement in scores on key metrics used by the program to determine its effectiveness. Metrics will vary by program.

Cohort. Numerator: Number of cohort members who report having met with an advisory or governance body to review client feedback and, where needed, introduce changes reflective of the feedback received. **Denominator:** Total number of cohort members.

UNIT OF MEASURE: Cohort of community-based facilities. **Numerator:** Number of cohort facilities that report that they have using client or constituent feedback to improve program reach, coverage, or effectiveness. **Denominator:** Total number of cohort members.

DATA TYPE: Brief annual reports (submitted as a questionnaire response) that describe the feedback provided; plans created with the governance or advisory body to address that feedback; details of the changes introduced in response to the feedback received; and details regarding improvements in reach, coverage, and effectiveness.

DISAGGREGATED BY: Institutional type (e.g., health post, clinic or satellite facility), socioeconomic/ethnic/linguistic characteristics of community, feedback provider type (governance or advisory body)

RATIONALE FOR INDICATOR: This indicator is directly linked to improvements in program quality, coverage (demand), and effectiveness.

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