



USAID
FROM THE AMERICAN PEOPLE



LEADERSHIP, MANAGEMENT AND GOVERNANCE PROJECT: END OF PROJECT EVALUATION

March 2016

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Betsy H. Brown, Patricia David, Jennifer K. Katekaine and Christian L. Brewer.

**A leader is best
When people barely know he exists,
Not so good when people
Obey and acclaim him.**

**Fail to honor people and
They fail to honor you.**

**But of a good leader
Who talks little,
When his work is done and
His aim fulfilled,**

**They will say,
“We did this ourselves”**

Lao Tzu (6TH Century BC Philosopher)
“Tao Te Ching”

LEADERSHIP, MANAGEMENT AND GOVERNANCE PROJECT: END OF PROJECT EVALUATION

March 2016

Betsy H. Brown (Team Leader)

Patricia David (Evaluation Specialist)

Jennifer K. Katekaine (Health Systems Strengthening Specialist)

Christian L. Brewer, MPH (Team Member, USAID/GH/PRH/SDI)

This document (Report No. 142) is available online. Online documents can be located in the GH Pro website at <http://ghpro.dexisonline.com/reports-publications>. Documents are also made available through the Development Experience Clearinghouse (<http://dec.usaid.gov>). Additional information can be obtained from:

Global Health Performance Cycle Improvement Project

1331 Pennsylvania Avenue NW, Suite 300

Washington, DC 20004

Phone: (202) 625-9444

Fax: (202) 517-9181

ghpro.dexisonline.com

This document was submitted by The Global Health Program Cycle Improvement Project (GH Pro) to the United States Agency for International Development under USAID Contract No. AID-OAA-C-14-00067.

DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

ACKNOWLEDGMENTS

The evaluation team would like to extend its sincere thanks to the USAID Health Offices in Uganda and Ethiopia who hosted our team and shared their observations and views. A special thanks goes out to the GH Pro STAFF in Ethiopia, Dinsry Berhanu, and Uganda, Caroline Asiimwe, who organized the field visits while the team was in Africa. Appreciation and Special Thanks to the LMG teams in Washington, Ethiopia, and Uganda for the well-organized set of documents, meetings, and scheduling for the team in both in the U.S. and with field staff. Special recognition goes to Mackenzie Allen from the LMG/Washington Team and Christian Brewer from USAID who assisted with arranging the evaluation team's schedule of interviews and briefings across the many LMG-assisted countries over the course of three months.

CONTENTS

ACKNOWLEDGMENTS..... ii

ACRONYMS v

EXECUTIVE SUMMARYvii

I. Introduction I

II. Evaluation methods & limitations 7

III. Findings..... 9

IV. Conclusions 50

V. Recommendations..... 51

Annex I. Scope of Work 53

Annex II. Evaluation Methods and Limitations 76

Annex III. Persons Interviewed..... 85

Annex IV. Sources of Information 93

Annex V. Data Collection Instruments..... 102

Annex VII. List of LMG Tools and Their Use 121

Annex VIII: LMG Cost Share Report PY4 Q5 126

Annex IX: LMG Performance Management Report Summary..... 127

Annex X: Response from the Leadership, Management and Governance Project 130

FIGURES

Figure 1. LMG core funding sources..... 4

Figure 2. LMG conceptual model 6

Figure 3. EMP pre- and post-test results of ICRC training..... 13

Figure 4. USAID field mission responses: Increased self-reliance among participant organizations and host governments..... 22

Figure 5. Family planning services provided, RHU..... 30

Figure 6. Long-acting contraceptives provided by RHU, 2014 and 2015, first 6 months..... 31

Figure 7. Strategy and technical approach: The evidence continuum 40

Figure 8. Percentage of postpartum clients receiving family planning/sexual and reproductive health counseling at pre- and post-intervention by study arm..... 43

Figure 9. Post-partum family planning service delivery outcomes 43

Figure 10. Composition of LeaderNet registered members, by type of organization..... 45

TABLES

Table 1. Sample PMP indicators, cumulative total and PY5 target..... 2

Table 2. Number and type of key informant interviews 7

ACRONYMS

ACHEST	African Centre for Global Health and Social Transformation
AIDS	Acquired immune deficiency syndrome
AHLMN	African Health Leaders and Managers Network
ALERT	All African Ethiopian Research and Training Institute
Amref	Amref Health Africa (formerly African Medical Relief and Education Fund)
CA	Cooperative Agreement
CCM	Country Coordinating Mechanism
CSO	Civil society organization
CVT	Center for Victims of Torture
DCHA	Bureau for Democracy, Conflict, and Humanitarian Assistance (USAID)
DFID	Department for International Development
DG	Democracy and Governance
DRC	Democratic Republic of the Congo
DRG	Center of Excellence on Democracy, Human Rights, and Governance (USAID)
E2A	Evidence to Action Project
ECOWAS	Economic Community of West African States
EMP	Essential Management Package
FMOH	Federal Ministry of Health
FP2020	Family Planning 2020
GH	Bureau for Global Health (USAID)
HAPCO	HIV/AIDS Prevention and Control Office (Ethiopia)
HIV	Human immunodeficiency virus
HMIS	Health management information system
HR	Human resources
HRH	Human resources for health
HSS	Health systems strengthening
ICRC	International Committee of the Red Cross
ICT	Information and communication technology
IPPF	International Planned Parenthood Federation
IPPFAR	International Planned Parenthood Federation Africa
IR	Intermediate result
JCRC	Joint Clinical Research Centre
JHSPH	Johns Hopkins University Bloomberg School of Public Health
LDP	Leadership Development Program
LDP+	Leadership Development Program Plus
LMG	Project Leadership, Management, and Governance Project
LMS	Leadership, Management and Sustainability Project
M&E	Monitoring and evaluation

MDR	Multidrug-resistant
MEPI	Medical Education Partnership Initiative
MER	Monitoring, evaluation and research
MIUSA	Mobility International USA
MOH	Ministry of Health
MOST	Management and Organizational Sustainability Tool
MSH	Management Sciences for Health
MSPP	Ministère de la Santé Publique et de la Population
NCC	National Children’s Commission
NGO	Nongovernmental organization
NMCP	National Malaria Control Program
NUPAS	Non-U.S. Organization Pre-Award Survey
OCAT	Organizational Capacity Assessment Tool
OHA	Office of HIV/AIDS (USAID)
PATH	Partners Aligned in Trauma Healing Project
PEPFAR	President’s Emergency Plan for AIDS Relief
PMI	President’s Malaria Initiative
PMP	Performance management plan
PRC	Physical rehabilitation center
PRH	Office of Population and Reproductive Health (USAID)
PY	Project year
RBF	Results-based financing
RHB	Regional Health Bureau
RHU	Reproductive Health Uganda
SDG	Strategic Development Goals
SFD	Special Fund for the Disabled
SIDA	Swedish International Development Cooperation Agency
SLP	Senior Leadership Program
STTA	Short-term technical assistance
TB	Tuberculosis
TOT	Training of trainers
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
VLDP	Virtual Leadership Development Program
WAHO	West African Health Organization
WHO	World Health Organization
WILD	Women’s Institute on Leadership and Disability
WISN	Workload Indicator of Staffing Needs
Yale/GHLI	Yale University Global Health Leadership Institute

EXECUTIVE SUMMARY

EVALUATION PURPOSE

This end-of-project technical performance evaluation of the Leadership, Management and Governance (LMG) Project was commissioned by USAID's Bureau for Global Health (GH), Office of Population and Reproductive Health (PRH) to provide feedback to USAID in two main areas: effectiveness and sustainability of leadership, management and governance interventions and inform future programming of the GH and the Democracy, Conflict and Humanitarian Assistance (DCHA) bureaus.

PROJECT BACKGROUND

LMG is a five-year, \$198 million USAID/GH cooperative agreement for health systems service delivery strengthening, host country and civil society organizational capacity development and training, to improve service access and availability, institutionalized leadership programs and better quality of care at lower costs. Since its launch in 2011, the project has reached 89 countries and currently works in 23 countries under multiyear agreements. At the time of the evaluation, the project was scheduled to run until September 2016 and is the second in a succession of GH Bureau cross-sectoral projects, starting in 2005, that focus specifically on sustainable leadership and management interventions using tested approaches, tools and targeted technical assistance. LMG is the culmination of 30 years of USAID investment in leadership, management and training programs. Both LMG and its predecessor, Leadership, Management and Sustainability (LMS) are managed by Management Sciences for Health (MSH). The project is implemented by a consortium of five U.S. universities, Africa-based non-governmental organizations (NGOs) and a U.S. private sector health information and technology company. The project received 68 percent of its funding from USAID field missions, with the balance provided by GH and DCHA funding across multiple offices.

EVALUATION QUESTIONS, DESIGN, METHODS AND LIMITATIONS

A three-person external team and a GH/PRH team member conducted the evaluation between November 2015 and February 2016. The evaluation addressed three questions:

1. How effectively did LMG's leadership development approach respond to organizations' needs?
2. To what extent have LMG interventions benefited the target population of AIDS-Free Generation, Ending Preventable Child and Maternal Deaths, and Family Planning 2020 (FP2020)?
3. Based on experiences with LMS and LMG over the past 10 years, what lessons can be learned about sustaining global support for leadership, management and governance work?

The evaluation was primarily qualitative and designed to include several methods of data collection, including: review of nearly 300 documents to inform evaluation planning and the development of interview guides and questionnaire, and to confirm findings and data; a self-administered online questionnaire for USAID mission staff in 14 countries where LMG was implemented (where the team did not visit); review of select project data and reports from LMG and its beneficiary organizations; site visits to Uganda and Ethiopia, where face-to-face interviews and direct observations of some project activities took place; and face-to-face and virtual in-depth interviews with five categories of target key informants: respondents from USAID/Washington, USAID missions where LMG is implemented, LMG teams at headquarters and field offices, consortium partners, other donors of interest, and representatives of beneficiary organizations. A total of 208 key informants were interviewed for this evaluation, of which 61 percent came from in-country beneficiary organizations and ministries.

Limitations include potential bias in the evaluation findings, due to the small number of countries visited (only two out of 23 countries where the project operated) and the purposive, non-random selection of respondent organizations and respondents interviewed.

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

Findings: Question 1

- LMG directly strengthened the Global Fund Programming of malaria and HIV and TB grants through technical assistance to country coordinating mechanisms in Africa, Latin America and the Caribbean.
- LMG supported health sector grantees and regional organizations to make strategic organizational development and system-wide improvements in their operations through the use of tailored technical assistance and tools, resulting in organizational turnarounds that led to better resource mobilization and use and improved health outcomes. Examples are Uganda's National HIV Laboratory and Research Network, the Joint Clinic Research Center (JCRC), IPPF affiliates in Africa, the West Africa Health Organization (WAHO) and National Malaria Control Programs (NMCPs) across West and Central Africa and in Lao PDR.
- DCHA partner organizations reviewed focusing on disability rights, physical rehabilitation, torture and trauma rehabilitation, and child protection became more results-focused and served more clients after using LMG-tailored tools and technical assistance. Leadership and management tools were rolled out in 66 countries. More work needs to be done to embed the Essential Management Package (EMP) approach across country programs of the large International Committee of the Red Cross (ICRC)'s Physical Rehabilitation Program (PRP) and the ICRC Special Fund for the Disabled, but there is evidence of positive results and organizational buy-in.
- The project exceeded its service delivery and organizational capacity performance objectives, intermediate results (IR) 1 and 3, but fell short of meeting the full range of learning and evidence generation targets in IR 2 due to lack of USAID core funding and the complexity and cost of fielding complex research designs that might provide quantitative evidence of the effects of project interventions on the functioning of the health system and, ultimately, on health outcomes.

Findings: Question 2

- In family planning, through its consortium partnership with LMG, the International Planned Parenthood Federation has strengthened its Africa Regional Office (IPPFARO) and its network of 42 affiliates. IPPF credits its participation in LMG with leading to an increased number of new family planning acceptors, from 481,000 to 725,000.
- IPPF affiliates increased their revenue generation and non-USAID donor contributions.
- LMG's embedded long-term technical assistance helped to invigorate seven NMCPs in high-burden, politically sensitive countries to lead national malaria control programs in just one year. Continued assistance is needed to sustain and firmly implant these improvements. (Questions 1 and 2)

Findings: Question 3

- LMG supported and advised government-wide scale-up of leadership, management and governance curricula and programs in universities and ministries of health (MOH) in Ethiopia, Afghanistan, and Côte d'Ivoire.
- LMG produced the first quantitative evidence of the Leadership Development Program Plus (LDP+) tool, showing that LDP+ increased family planning counseling services by nearly 60 percent in a 2015 controlled study in Cameroon and also positively increased couple years of protection.

- Fifty-two technical papers and reports documenting elements of LMG technical assistance and results were produced and disseminated through LeaderNet, an online learning community including a resources section with select MSH tools. LeaderNet proves to be a rich resource for live and online information, reaching more than 2,000 registered members; 46 percent are from NGOs, and 17 percent are students. Research organizations, international organizations and independent consultants are other major users.
- Multiple LMG tools, including the LDP+, the Senior Leadership Program (SLP), and the Governance Guides, unleashed the power of beneficiary organizations to solve problems in the context of limited resources and often in post-conflict countries. The participatory approach to training led to changes in mindset across most country settings and organizations, and built team cohesion and manager confidence.
- The LMG participatory leadership model promoted equity, especially for those in subordinate positions, including women, and more overall team involvement in organizations' management decisions, yielding new resources for these organizations. The project expanded access to gender sensitivity tools in Afghanistan and Ethiopia, but this did not result in any demonstrable changes in gender equity for women within organizations. (Questions 1 and 3)

Project Strengths

- As of the time of the evaluation, LMG exceeded the 20 percent cost-share expectations, reaching \$29.1 million or 26 percent of total project expenditures.
- LMG is a highly responsive and flexible mechanism for USAID field missions; 63 percent of total financing came from the field.
- The excellent cooperative agreement consortium offers complementary technical assistance resources and built-in legacy mechanisms. Two of the five consortium members (Amref and IPPF) have field implementation programs in Africa with substantial external, non-LMG financing.
- Programs benefited from MSH's bilateral footprint and organizational capacity in many LMG countries (Burundi, Cameroon, Côte d'Ivoire, Ethiopia, Uganda, Haiti, Afghanistan, Rwanda, Honduras, and Vietnam).
- LMG technical assistance received praise and high marks. Multiple host-country respondents perceive USAID to be highly responsive to their organizational and national needs for leadership, management and governance. LMG succeeded in elevating a positive image for USAID in Afghanistan, Burundi, West Africa and Haiti.
- LMG proves to be a useful tool for USAID to support organizations and governments in achieving important health reform measures, such as decentralization, performance-based contracting by host countries for health services, increased resource mobilization and advocacy by regional organizations for work on building blocks of health systems strengthening (e.g., health governance), and meeting standards of care and certification requirements.
- The project collaborates extensively with other USAID and donor partners. Its approach relies on local leadership, consultants and teams.
- Tools and approaches are proven and tested in all types of low-income settings, including post-conflict, post-natural disasters and public health emergencies.

Project Limitations

- Less than expected USAID funding for evidence generation and research limited the project's ability to prove efficacy through scientific means.

- The effectiveness of the East African Women’s Mentoring Network was limited, due to technology issues and the distance coaching and mentoring model selected.
- Despite a rapid launch of the project, there was an overall back-loading of activities, and much work remains on youth leadership as well as strengthening the African Health Leadership and Management Network (AHLMN), a legacy institution. The evaluation noted the value and potential multiplier effect of continued support to AHLMN. Other countries may require more time to complete organization-wide strengthening, such as the NMCPs in West Africa, Ethiopia’s training of master trainers, local coaches and facilitators, and LMG’s work with WAHO.

Conclusions

LMG was built on a successful track record and 30-year legacy of USAID/GH investments in strengthening management and leadership skills, first for family planning programs then expanding these programs health sector-wide and to DCHA partners. LMG is a unique cross-sectoral training and technical agreement that has produced important organizational and health systems strengthening results for host countries and important civil society organizations (CSOs) and networks. The technical assistance linked to the Global Fund (e.g., technical assistance to CCMs, NMCP Advisors, and/or Interim Global Fund Liaisons) has helped countries leverage \$270 million in Global Fund malaria grants in Africa and \$27 million in HIV/AIDS funding in Latin America. The project has proved to be a useful vehicle to help organizations such as those working with DCHA, e.g., ICRC and The Center for Victims of Torture (CVT), and multiple African universities reach institutional strengthening goals, including expansion of leadership programs, greater ownership of results and institutional challenges, and financial solvency. The governance work has wide applicability for other USAID sectors and is the first of its kind to produce a set of simple governance tools and approaches that can be taken to scale for USAID-financed health sector work. The leadership and management tools and approaches also proved to be transferable to DCHA partners in other social sectors. Finally, at least four governments have chosen to scale up health systems strengthening measures supported by LMG, mobilizing other resources to achieve these goals (Afghanistan, Ethiopia, Côte d’Ivoire, and Cameroon). Some of the host country governments and regional organizations intend to finance LMG work from their own budgets, demonstrating their commitment and belief in the efficacy of leadership, management and governance work. LMG has also made extensive human resource (HR) management contributions in the areas of employee relations, staffing, reorganization, organizational design, personnel management, teamwork and appreciation of individual contributions to the ultimate organizational goal; these have improved work climate across ministries of health and CSOs and improved advocacy for better HR staffing.

Recommendations

- USAID needs to plan a detailed country-by-country hand-over of leadership, management and governance work to governments or legacy institutions. This will require GH field support teams to work with missions and regional bureaus to identify assistance mechanisms, if needed beyond 2016.
- During Year 5, LMG should accelerate work to strengthen institutions, including WAHO, AHLMN, and African Centre for Global Health and Social Transformation (ACHEST). MSH should accelerate strengthening IPPFAR and AMREF Health Africa as its consortium partners.
- USAID should consider extending for up to a year programs that will not complete by September 2016 due to external factors (elections, terrorism, Ebola), as well as the ICRC DCHA LMG work.
- USAID may want to consider expanding and promoting MSH board governance tools used by LMG partners across other sectors of USAID, such as the Center of Excellence on Democracy, Human Rights and Governance (DRG) office.

- LMG, in consultation with USAID, may want to certify the largest host country NGOs, training institutes and facilitators to carry on leadership, management and governance training and coaching, such as the Amref Leadership Institute in Nairobi.
- USAID/GH and DG may wish to consider expanding the use of LMG tools by identifying ESF, supplemental and DG funding for them in current and post-conflict areas. USAID can use these tools more broadly to improve future development leaders' management skills and build their commitment to strong governance.
- The LMG team should map the large alumni network of LMS and LMG for further work with USAID and other donor programs.
- USAID should encourage inclusion of private training institutions in projects that plan leadership, management and/or governance training, in order to help meet the demand for training of trainers and increase sustainability of training interventions in this technical area.
- PRH should ensure that the LMG tools housed on the LEADERNET on-line platform continue to be accessible at the end of the project. PRH should share with USAID/M/HR/Learning Office the LMG Senior Leadership Tools for multisectoral team planning for USAID mission team-building programs.
- PRH should work with GH/AMS to identify further LMG tools that can be used by USAID health officers in state-of-the-art courses or for online certification.

I. INTRODUCTION

EVALUATION PURPOSE

This end-of-project external evaluation of the five-year Leadership, Management and Governance (LMG) Project (2011–2016) was commissioned by USAID’s Office for Population and Reproductive Health (PRH) to document the project’s technical performance, including the value and contributions of the tools and approaches supported and lessons learned from this project and its predecessor, the Leadership, Management and Sustainability (LMS) Project. The Office of HIV/AIDS (OHA) and the Bureau for Democracy, Conflict and Humanitarian Assistance (DCHA) also contributed to this review. The evaluation specifically addresses sustainability and effectiveness of tools and approaches as the project nears its completion date of September 2016. The evaluation is designed to inform the Global Health and DCHA bureaus and field missions for future programming.

EVALUATION QUESTIONS

For this evaluation, LMG is the focus and LMS is used as a reference point.

1. How effectively did LMG’s leadership development approach respond to organizations’ needs?
 - a. Results of LMG’s organizational development approach on the capacity of civil society organizations (CSOs) and institutions that serve vulnerable populations through DCHA funding
 - b. Results in the areas of advocacy, service delivery, quality and accessibility
 - c. Elements of LMG’s organizational development approach that enabled or limited regional professional health bodies, such as Amref Health Africa (Amref), African Health Leadership and Management Network (AHLMN), African Centre for Global Health and Social Transformation (ACHEST) and IPPF, to meet their midterm and long-term goals
 - d. LMG’s leadership development to cultivate accountability and steward resources at subnational and national levels, particularly with ministries of health
2. To what extent have LMG interventions benefited the target populations of AIDS-Free Generation, Ending Preventable Child and Maternal Deaths, and Family Planning 2020 (FP2020)?
 - a. LMG’s approved work plans and their contribution to AIDS-Free Generation and President’s Emergency Plan for AIDS Relief (PEPFAR) 3.0 goal of epidemic control
 - b. LMG’s approaches to improve technical and organizational capacity of family planning/reproductive health service delivery organizations
 - c. Approaches that demonstrate potential for sustainability after the project ends
3. Based on LMS and LMG experiences over the past 10 years, what lessons can be learned about sustaining global support for leadership, management and governance work?
 - a. LMG and LMS components that are replicable by a variety of countries and institutions
 - b. LMG and LMS components that are difficult to replicate by a variety of countries and institutions
 - c. LMG and LMS contributions to the global knowledge base around investments in organizational development, health management and governance
 - d. LMG and LMS activities that have increased global and local advocacy and support for future investments in strengthening health leadership, management and governance practices
4. In addition to the above questions, what unforeseen challenges and opportunities have LMG and LMS encountered, and how were they managed?

LMG DEVELOPMENT HYPOTHESIS, GOAL AND RESULTS FRAMEWORK

The project’s development hypothesis is that by strengthening health systems through sustainable leadership, management and governance programs and trained providers, managers and policy makers, quality health services will be delivered at all levels of the health system. The project’s goal is to strengthen health systems to deliver more responsive services to more people by developing inspired

leaders, sound management systems and transparent governance practices among individuals, networks, organizations and governments. A primary anticipated outcome is to demonstrate that good leadership, management and governance are the key enabling factors to achieve sustainable health outcomes.

The project aims to achieve three intermediate results (IRs):

IR1: Strengthen global support, commitment and utilization of state-of-the-art leadership, management and governance tools, models and approaches for priority health programs.

IR2: Advance and validate the knowledge and understanding of sustainable leadership, management and governance tools, models and approaches.

IR3: Implement and scale up innovative, effective and sustainable leadership, management and governance programs.

The project’s performance management plan (PMP) was approved in April 2012 and modified in the following year, reviewing all core and field support work plans and program descriptions and prioritizing indicators. The Monitoring, Evaluation and Research (MER) team developed logic models for activities and aligned in-country PMPs with the project’s global PMP. At USAID’s request, the PMP was modified in early 2014. MER’s responsibilities included support to LMG field teams, data analysis, visualization and data quality analysis. PMP indicators track to the LMG Results Framework. The project’s Indicator Reference Sheet precisely defines each indicator and describes how it is measured.

The team created a dashboard for reporting against PMP indicator targets that included indicator trend visualizations. A sample of PMP indicators is shown in Table I, below.¹ The evaluation team found that the project is on its way to meeting or exceeding its targets for IRs 1 and 3;² however, in terms of IR2 (knowledge generation), the project was less successful (see Findings section). A detailed table of results against PMP targets by September 2015 from the LMG PY4 Annual Report appears in Annex IX.

Table I. Sample PMP indicators, cumulative total and PY5 target

Indicator	Cumulative total	PY5 target
Number of organizations that report increased demonstrated capacity to perform a key function for which it has received LMG technical assistance	6	15
Number of global health agencies, private sector partners and professional networks or associations that have actively partnered with LMG	23	10
Total resources in USD booked as cost share for LMG global activities and implementation of country-level LMG strategies, tools, models and/or approaches	\$26,135,376	\$40 million
Total number of LMG advocacy materials developed and disseminated with USAID, global practitioners and other key stakeholders	47	35
Total number of web site visits on LMG web portal	45,624	6,655
Number of global panels or working groups that LMG staff participate in as technical resource or expert on LMG	35	13
Number of new LMG tools, models and/or approaches created and field-tested	30	5
Number of teams trained by LMG staff using LMG tools, models, approaches and/or in-service curricula	2,291	150
Number of local facilitators or faculty trained by LMG staff to deliver tools, models, approaches and/or in-service curricula	659	70
Number of institutions that have integrated LMG pre-service training programs	9	5
Number of students enrolled in integrated LMG pre-service training program	430	750

A key indicator is “increased number of organizations with demonstrated capacity to perform a key function,” defined as follows: “A host-country organization to which LMG has provided long-term TA

¹ See complete table in LMG’s PY4 Annual Report.

² PMP dashboard in PY4 Annual Report.

[technical assistance] provides evidence of increased capacity to independently carry out identified L+M+G [leadership, management and governance] skills and/or practices that directly improve one or more components of the organization's operations." LMG demonstrates key capacity-building results by tracking "Desired Measurable Results," the outcomes of the Leadership Development Program (LDP+) training with teams across countries. These are now being compiled in a Desired Measurable Results database. Results include the number of teams participating in LDP+ workshops, the definition of a challenge to work on by topic area, and a measure of teams' increased capacity, indicated by whether the team achieved its goal (pre- and post-training difference in an indicator).

PROJECT BACKGROUND

LMG is a five-year, \$198 million, follow-on cooperative agreement (number AID-OAA-A-11-00015) between USAID/Washington and a consortium led by Management Sciences for Health (MSH), signed on September 25, 2011 and running until September 24, 2016³. Consortium partners include Amref Health Africa, the International Planned Parenthood Federation (IPPF), the Johns Hopkins University Bloomberg School of Public Health (JHSPH), Medic Mobile and Yale University Global Health Leadership Institute. LMG has worked closely with ministries of health (MOH), CSOs, international organizations such as the Global Fund, World Health Organization (WHO), and ICRC, and networks and host-country health training facilities in 89 countries. These include host-country government, civil society and non-governmental organization (NGO) partners in 66 countries where DCHA projects operate, and 23 countries receiving support from USAID missions.

In 2012, the LMG project estimated the numbers of clinical professionals benefiting from LMS training. Based on an LMG survey, the project estimates that 7,000 medical, nursing and public health professionals are being taught key leadership and management skills through pre-service training originally supported by either LMS or LMG.

—LMG 2012 LMS Assessment

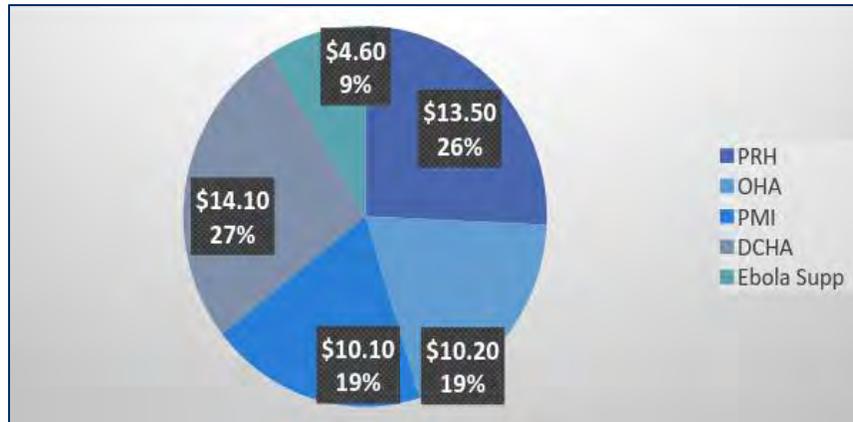
A total of \$140.9 million in funding has been provided through core investments by the Global Health and DCHA bureaus (Figure 1) and directly from USAID field missions, leaving a ceiling of \$58 million remaining if the Agency chooses to extend the project. Of the \$140.9 million awarded, USAID field missions financed \$88.2 million (63 percent) in field support directly to LMG. Additionally, the PRH office has concurrently managed an extension of the LMS project, which includes nine multiyear associate awards, totaling \$294 million, with missions in Southern Africa, Egypt, Peru, Haiti, Afghanistan, Nigeria, West Africa, Egypt and Kenya; the two largest are \$92 million for Afghanistan and \$15 million for Haiti. The combined total of USAID funding to date for both the LMS associate awards and LMG is \$435 million. At the time of this evaluation, all of the LMS awards, with the exception Nigeria, were completed or nearing completion. The LMS awards ran from 2006 through 2016 and were managed by in-country teams with MSH headquarters oversight. Afghanistan and Haiti provided the largest field support buy-ins to LMG: \$57.6 million (65 percent of all field support over the life of the project); they were awarded following the successful completion of LMS associate awards. The project has been highly subscribed by USAID missions since its launch.

Cost share, i.e., matching in-kind or cash funding, has also been generated: \$29.077 million over the life of the project from beneficiary organizations, host governments, CSOs and the private sector. At the time of review, LMG has surpassed the agreement's targets of 20 percent of total expenditures generated through a defined and mutually agreed cost share, reaching a 26 percent cost share against expenditures by December 2015.⁴ Matching funds have been used to leverage additional resources for training. For example, IPPFAR-leveraged cost share with the Swedish International Development

⁴ Information was obtained through USAID cooperative agreement modifications and MSH financial reports. Cost share sources include the Global Fund, MIUSA, Ponseti, World Bank, Sida, Inter-American Development Bank, Cordaid, Anadach Group, Skoll Foundation and Pan American Health Organization. See Ros/Brown report on cost share by December 2016: February 10, 2016.

Cooperation Agency (SIDA) supported LDP+ training for five additional member associations (See Annex VIII. Cost Share Report.)

Figure 1. LMG core funding sources



Legacy: LMG continues USAID global health investments in leadership and management that started in 1985 in the Office of Population in the Science and Technology Bureau and spanned 30 years of continuous support. Early projects pioneered approaches and tools for strengthening family planning program management⁵ and demonstrated that health systems strengthening (HSS) and management skills are necessary prerequisites for successful family planning and health programs. USAID investments in leadership, management and sustainability first focused on strengthening the capacity of workers in family planning and reproductive health and then expanded to other health areas, such as HIV/AIDS, malaria prevention and control, infectious diseases and support to some non-health programs.⁶ Sustainability was achieved by integrating leadership and management programs and curricula into pre-service medical and nursing education program in six countries (Kenya, Uganda, Egypt, Nicaragua, Guatemala and Ghana).⁷ This work continued under LMG, with Ethiopia adopting leadership and management curricula inspired by their work with the project. Since 2011, LMG has been working to disseminate best practices from the field of organizational development to empower health leaders, managers and teams at various levels (global, regional, national, subnational and individual) from a diverse range of health-related organizations worldwide. LMG has applied a range of tools to address participants’ most pressing priorities. Its work was intended to build upon that of its predecessor to advance the application, knowledge and dissemination of leadership and management tools and practices, while adding an increased focus on governance of public and private organizations, scale-up and technology (including information and communication technology (ICT)) applications and the integration of gender transformative approaches. Three of the nine missions that responded to the online survey for this evaluation had prior agreements with LMS, while four were new to LMG (two did not know). The project was also designed to advance a broader research and learning agenda on the role of enhanced leadership, management and governance practices on health services delivery, better health outcomes and HSS. Many field support grants complemented MSH-led USAID bilateral and regional

⁵ *Leadership, Management and Sustainability Final Report: 2005–2010*, pp 14-15.

⁶ Projects included the Family Planning Management and Training Project (1985–1990), the Family Planning Management Development Programs I and II (1990–1995) and (1995–2000), the Management and Leadership Program (2000–2005), and LMS (2005–2010). All of these projects have followed the principle of the importance of leadership and management to building strong health systems and local health services organizations.

⁷ Grenier and Trasi. 2013. *Sustainable Integration of Leadership, and Management Content in Medical Education, An LMG Report*.

health projects or other MSH agreements (Uganda, Rwanda, Southern Africa, Nigeria, Côte d'Ivoire, Liberia and Burundi).

Global Health Context: LMG was designed to support the larger objectives of the Global Health Bureau to promote an AIDS-Free Generation, Ending Preventable Maternal and Child Deaths, and FP2020,⁸ as well as the UN's newly issued Sustainable Development Goals (SDGs) for health, with a focus on women's, children's and adolescents' special needs.⁹ The LMG mechanism was also viewed as a tool for USAID field missions to contract with an evidence-based consortium for a set of tested tools and approaches to health management training, governance and organizational and system-wide capacity building. The idea is that by strengthening health services management at all levels, countries are better able to address and respond to these critical priorities to ensure a country-led response.

The LMG project was designed within a global health context of advances and overall better health trends around the world, especially in Africa. Over the past five years, and accelerating since 2000, sub-Saharan Africa has made encouraging improvements in child health, although it lags behind other regions in the rate of change. Countries and regions emerging from conflict and emergencies, including Libya, Afghanistan, Haiti, Liberia, Sierra Leone and regions in Ethiopia, have also begun to rebuild their primary care and overall health delivery systems, mental health services and physical rehabilitation centers (PRCs). LMG has played a role in this work. Positive gains have been seen in Africa in malaria control, for people living with HIV/AIDS, in the slowing of the HIV epidemic, and in increasing contraceptive prevalence from 12 percent in 1990 to 27 percent during 2006–2012.¹⁰ There has also been an increase in the number of private sector leadership and management programs springing up in Africa and the Caribbean in some LMG-assisted countries (Ethiopia, Uganda, and Haiti).

Since 2012, USAID, through initiatives such as the Global Health Initiative and PEPFAR, has strongly emphasized sustainability and country ownership within an HSS framework. Development practitioners have noted that leadership, management and governance are key building blocks of HSS and that improving this capacity among policy makers, health care providers and managers allows them to better implement quality health services and meet local health needs.¹¹ Use of organizational and self-assessment tools enables health leaders and policy makers to address their own challenges and achieve results. Despite the large increase in global health aid in past decades and governments' efforts to improve their citizens' health, progress toward meeting the Millennium Development Goals, and now the SDGs, is slow in many countries and is not sustained over time. Difficulties persist in scaling up successful interventions across larger geographical areas within countries and across regions. Poor health sector governance was also recognized as a contributing factor in poor health outcomes, and health governance was seen as a necessary competency. The Global Fund, from the outset, placed a high level of accountability on its country coordination mechanisms (CCMs) and local fund agents. WHO also defined leadership and governance as one of the six key building blocks of a health system.¹² In line with these initiatives, USAID, through LMG, invested significant resources to improve health governance through simple, feasible, cost-effective tools.

⁸ Led by the United Nations Foundation, FP2020 is a global initiative to step up family planning commitments by countries and the private nonprofit and for-profit sectors. Its goal is to reach 225 million women who have an unmet need for family planning by 2020. By 2015, FP2020 had reached more than 2.4 million women and girls with modern methods of contraception.

⁹ The SDGs propose to avert preventable maternal and child deaths by strengthening health system enablers such as human resources for health systems, health system responsiveness and health governance. See *Every Woman, Every Child: the United Nations Global Strategy for Women's Children's and Adolescents' Health (2016–2030)*, p. 60.

¹⁰ WHO/AFRO. 2014. *Health Statistics: African Regional Report*, pp. 12 and 4.

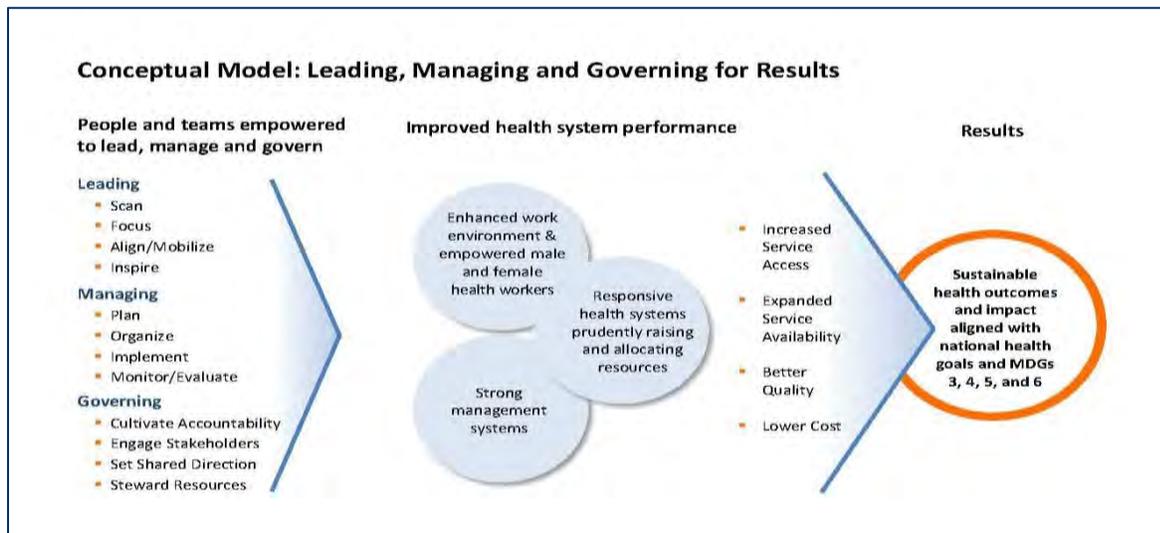
¹¹ WHO. 2007. *Strengthening Health Systems to improve Health Outcomes: WHO's Framework for Action*. Geneva: WHO Press.

¹² WHO. 2007.

In its 2015 health systems strategy, “A Vision for Action,” USAID has clearly articulated the importance of governance, including accountability and patient-centered care, and the prominent role that HSS must play in all disease-specific interventions.¹³ A strong health system is the best insurance developing countries can have against a rapidly shifting disease burden, as seen in the West African Ebola outbreak, where inadequate facilities, staff and investments led to a weak regional epidemic response. HSS is an essential ingredient for achieving many USAID global health objectives.¹⁴ This vision is also well aligned with national strategies that are moving toward less financial dependence on foreign aid and more local and regional solutions and enhanced domestic resource mobilization to address health sector problems. The LMG Project is one important USAID instrument to scale up manager- and provider-led HSS.

At LMG’s core is a results-oriented, participatory leadership development process that enables teams to address their self-identified challenges and move toward results through developed action plans and experiential learning. The tools rely on real workplace challenges and were primarily used to strengthen public sector and NGO regional and central health service delivery management structures. In some countries, the approach has been used to strengthen facilities and community-based care. The tools and approaches aim to improve health system performance by improving the work environment and designing responsive health systems. This should lead to better service access and quality of care and lower costs, and ultimately, it should contribute to better health outcomes (Figure 2).

Figure 2. LMG conceptual model



¹³ USAID. 2015. *USAID’s Vision and Health Systems Strategy (2015-2019)*.

¹⁴ *Ending Preventable Maternal Mortality—USAID Maternal Health Vision for Action* (June 2014), *USAID Multi-Sectoral Nutrition Strategy (2014–2025)*, and the country plans announced in *USAID’s Acting on the Call—Ending Preventable Child and Maternal Deaths* (June 2014), as well as the *PEPFAR Blueprint—Creating an AIDS-Free Generation* (2012).

II. EVALUATION METHODS & LIMITATIONS

TEAM COMPOSITION AND TIMING OF THE WORK

The evaluation team was composed of a team leader (an organizational development specialist), HSS specialist and evaluation specialist, as well as a representative from the USAID team managing the LMG Project in Washington, DC. Team members met via SKYPE during the first two weeks of November, carried out preliminary document reviews and developed draft questionnaires to use during the in-briefings and DC and field visits. On November 16-17, the team was briefed¹⁵ by the USAID Agreement Officer's Representative and other members of USAID project management team staff (see Annex III. Persons Interviewed).

The three external team members traveled to Uganda to conduct interviews and visits and were joined by the USAID team member for the Ethiopia visit. Additional interviews were conducted in person and by telephone with USAID informants during November (Annex II). The field visits were made to Uganda from November 30 to December 12 and to Ethiopia December 8-18, 2015. Additional interviews by telephone and SKYPE were conducted between December 18, 2015 and February 12, 2016.

EVALUATION DESIGN AND DATA COLLECTION

The evaluation was primarily qualitative and designed to include several methods of data collection:

1. Document review to inform evaluation planning and development of interview guides and questionnaire;
2. Review of selected project data and reports from LMG and its beneficiary organizations;
3. An online survey of USAID mission staff in countries not visited by the evaluation team;
4. Face-to-face and virtual in-depth interviews with five categories of target key informants: respondents from USAID/Washington, USAID missions where LMG is implemented, LMG teams at headquarters and field offices, consortium partners, other donors of interest, and representatives of beneficiary organizations. Eighteen of these latter interviews consisted of small groups of individuals (2-11) convened by the target organizations.
5. Site visits to Uganda and Ethiopia, where face-to-face interviews were conducted and some project activities observed.

Five different interview guides were developed for the target respondent categories, and two others for USAID/Washington interviews. A structured, self-administered questionnaire was also developed to survey USAID staff in 14 field missions where LMG was implemented; it was completed by nine respondents. (See Annex V. Data Collection Instruments.)

Table 2. Number and type of key informant interviews

Category	Number
USAID/DC	13
USAID/Field	10
MSH/HQ	11
MSH/Field	23
Consortium Members	16
Other Donors	3
Beneficiary Organizations/individuals	127
TOTAL	203

¹⁵ One member of the evaluation team based in Uganda and Tanzania joined these meetings via conference call.

The document review informed the planning of the evaluation, including selection of interviewees in key countries where LMG operated. The team made every effort to include all interviewees suggested by the USAID/Washington team as well as some of those suggested by the LMG team.

Ethical considerations. Data collection and analysis adhered to international standards for the protection of the privacy of respondents and confidentiality of data. All interviews included a consent process to ensure that all interviewees participated voluntarily and principles of data confidentiality were observed.

LIMITATIONS

There is potential bias in the evaluation findings due to the small number of countries visited—only two out of 23 countries where the project had field support buy-ins and the purposive, non-random selection of respondent organizations and respondents interviewed.

The countries to be visited were selected by the USAID LMG management team. One country, Haiti, was dropped from the visit schedule due to security concerns, but interviews with eight respondents in Haiti were successfully conducted via telephone. The team aimed to alleviate possible bias from this source by conducting remote (telephone/SKYPE) interviews in eight other countries. Informants in Haiti, Afghanistan, Vietnam, Côte d'Ivoire, Nigeria, Cameroon (and other West Africa), Liberia, and Burundi were interviewed virtually. All interviews with beneficiary organizations and their representatives were conducted without any USAID or project staff present. The onsite interviews in Uganda and Ethiopia, by their nature, provided a more complete picture of the LMG interventions and results in those countries than was possible to obtain from virtual interviews. Nevertheless, five interviews were conducted virtually with respondents in Afghanistan and eight respondents in Haiti, two LMG countries that received the largest field support buy-ins to the LMG agreement.

III. FINDINGS

QUESTION 1: HOW EFFECTIVELY DID LMG'S LEADERSHIP DEVELOPMENT APPROACH RESPOND TO ORGANIZATIONS' IDENTIFIED NEEDS?

Results of LMG's organizational development approach on the capacity of CSOs/ institutions that serve vulnerable populations through DCHA funding

Background: LMG was identified by DCHA as a centrally funded mechanism that could develop management capacity in seven program areas focusing on disability rights, physical rehabilitation, appropriate wheelchair service provision, torture and trauma rehabilitation, and child protection, each requiring different types of management technical assistance. In some cases, the partners requested assistance; however, the majority were offered the assistance by DCHA as a tangible means for USAID to support strengthening the host-country recipients and the home-office management systems. The evaluation surveyed representatives in four of the seven program areas—including LMG's work with the International Committee of the Red Cross (ICRC) and the ICRC Special Fund for the Disabled (SFD), Mobility International USA (MIUSA), Rwanda's National Commission for Children (NCC) and The Center for Victims of Torture (CVT)—and reviewed materials on the other two. The intent of LMG assistance was to provide tailored organizational management support and leadership development to strengthen partners carrying out work in disability rights and inclusion, psychosocial services, physical rehabilitation, and/or child protection in 66 countries. The DCHA partners represented an entirely new technical sector and audience outside of the health sector for LMG.

LMG's work with the ICRC SFD and ICRC's Physical Rehabilitation Program (PRP) began in 2012. The partnership started with consultation meetings, needs assessments, and review of external evaluations of SFD and PRP that recommended more management capacity development. In response, LMG developed some tailored tools with ICRC's assistance for service delivery organizations that are referred to as the Essential Management Package for Physical Rehabilitation (EMP). The EMP consists of: the Essential Management Systems Assessment Tool (EMSAT), a tailored leadership development program (LDP); the Essential Management Systems Manual, and the Work-Related Stress Intervention (WRS). For sector level actors, LMG and ICRC delivered senior leadership programs (SLPs) in 15 countries to strengthen the enabling environment. The SLP was largely developed by the LMG/Yale Global Health Leadership Institute (Yale/GHLI).

"The disability community lacked public health planning approaches."

– Senior LMG Advisor

Overall findings: The evaluation team found that DCHA's adoption of LMG was a good use of an extensive existing archive of tools and approaches developed over many years for a broader group of health sector partners. Both MSH and Yale/GHLI offered the DCHA partners a high level of tested approaches tailored for use in their organizations both by their recipients and internally within their own operations. The LMG mechanism also provided DCHA with a tangible set of tailored tools for organizational management and leadership capacity development expertise. A variety of technical approaches included cascade training; in-service training; training over a series of workshops; virtual coaching and mentoring; stakeholder alignment and mobilization workshops; strategic planning; financial management capacity building; team-based problem solving; and other methods to partners in 66 countries. The assistance was highly appreciated by the recipients, as all the partners interviewed stated, and the adaptation of these tools showed that they have broader use for other USAID sectors. With the exception of one key informant out of those surveyed, respondents reported considerable success in applying the LMG tools and approaches and high praise for the tailored materials and short-term technical assistance offered by LMG.

DCHA LMG funding: \$14.1 million (10 percent of overall USAID LMG funding)

Target populations: NGOs Partner organizations and individual leaders reaching survivors of torture and trauma, civilian victims of conflict, persons with disabilities and vulnerable children. The program's portfolio's overall goal is to strengthen the leadership, management, and governance capacities of these organizations and individuals to contribute to greater inclusion of and improve better services for vulnerable populations.

Number of DCHA organizations served: 74 organizations across 66 countries, six umbrella CSOs spanning victims of torture and disability rights, and 15 country delegations

ICRC: ICRC is a large independent international humanitarian aid organization created in 1863 to ensure protection and assistance for victims of armed conflict and war. Within the ICRC, LMG works with the Physical Rehabilitation Program (PRP) unit which is a global leader in supporting physical rehabilitation services worldwide through expertise, technology, and financial resources. In most countries where the ICRC has provided physical rehabilitation support, such services were previously either minimal or non-existent. In addition to working with ICRC/PRP, LMG also works with the ICRC Special Fund for the Disabled (SFD), which is an independent NGO that was created by the ICRC in 1983 to ensure the continuity of former ICRC programs for populations affected by conflict, and support other physical rehabilitation centers in low income countries.

In 2012, LMG's work with ICRC focused primarily on countries in Africa, but it has evolved to roll out new leadership and management approaches in Africa and Asia.

ICRC Senior Leadership Development: ICRC carried out three rounds of the SLP, reaching a total of 15 countries, which led to strengthened networks between government and civil society. The DRC, Togo and Madagascar multi-sectoral senior leadership delegations who joined together for six months of action planning and implementation reported impressive, tangible results from their senior leadership training. The results led to expanding disability access and improving disability services and outreach to hard-to-reach populations, advocating for the rights of the disabled and vulnerable children and securing domestic resources for their work. Following SLP formation and training, the Togolese delegation reported that they obtained a budget line item for disability supplies and equipment and a five percent reduction in the purchase price of disability equipment and supplies from the leading national supplier. The Madagascar delegation designed and implemented a national strategy to communicate availability of services to hard-to-reach disabled populations, resulting in a 42 percent increase in disability service use in 14 remote rural provinces and a first-ever donation from a major mobile phone company in Madagascar to the disability community. This donation served to raise awareness through SMS messages as part of their SLP field project. A disability human rights advocate, who was an SLP facilitator, noted that his advocacy skills were sharpened by the program, and that it "gave him the confidence as someone with a disability to help draft disability access platforms with the African Union (AU) at its 2015 regional meeting on the rights of the disabled." In Tanzania, the SLP delegation continues to work to improve the enabling environment for physical rehabilitation: ICRC reports a five percent increase in the number of disabled people in need of services at their centers, and the Government of Tanzania is now paying directly for more program line items, such as disability supplies, housing and food, that were previously funded by the ICRC. Tanzania has also put in place a monitoring and evaluation (M&E) system that interviews 10 percent of beneficiaries to solicit patient feedback. In terms of performance, Tanzania was cited by ICRC as the

Senior leadership delegations from Togo and Madagascar working on disability access and physical rehabilitation reported that the single biggest factor contributing to their success in meeting challenges was learning how to work in multidisciplinary teams and empowering the entire group to achieve an objective.

–SLP Training, Addis Ababa, December 2015

country that delivered the best SLP results of beneficiaries in Africa, despite not having entirely completed all of the modules due to staff turnover.

ICRC Management and Leadership Development for Service Delivery Organizations: LMG adapted existing tested approaches in partnership with ICRC to develop the EMP materials. In 2013, these materials were initially piloted with one center in Ethiopia and then further refined. To begin scaling up the EMP to impact more of ICRC assisted physical rehabilitation partners, ICRC requested to pilot the EMP in five countries (Togo, Tanzania, Myanmar, DRC, and Ethiopia) and then roll it out to an additional five countries (Vietnam, Cambodia, Pakistan, Tajikistan, and Madagascar in early 2016.

An ICRC supervisor noted that the EMP allowed them “to take a snapshot of where your organization stands and to assign scores.” The SLP supported the five countries to form multi-sectoral planning teams for disabilities and physical rehabilitation. In Tanzania, the government’s SLP team is now a recognized committee and meets every 60 days to review their progress on their challenges. Other ICRC supervisors noted the EMP process “had changed their personal management style.”

Developing EMP materials took three years and roll-out took place in 2014 and 2015. Despite these positive early results, it is still too early to tell if the EMP is successfully established in the first-phase countries, but there are some signs that it is taking hold. Among ICRC supervisors that oversee ICRC assistance to physical rehabilitation partner organizations, all but one believed that LMG management made unique contributions to their operations and that they were lacking management approaches prior to LMG assistance. None of these supervisors had received prior ICRC management training, and most believed that the LMG tools, meetings, coaching and follow-up on action-planning, and having partners set their own expectations were delivering concrete results. Moreover, they reported seeing results even in post-conflict situations such as the DRC, where much of the physical rehabilitation work takes place. ICRC staff noted, “The Essential Management Package (EMP) tool had given both the ICRC supervisors and the physical rehabilitations center staff the ability and confidence as managers and supervisors to work with their host country government counterparts to address problems and key challenges.”

An ICRC regional supervisor participated in the SLP and then attended the EMP Coaching and Communication Workshop in Uganda with partners from LMG’s Global Health-funded work. During this workshop, he informally discussed the LDP+ roll-out that LMG was supporting with Reproductive Health Uganda (RHU) staff who were further along with LDP+ training and organizational development. This further influenced his interest in rolling out the EMP across ICRC programs. After the experience in Uganda, LMG adapted the Coaching and Communication Workshop and delivered it to 21 ICRC/PRP and SFD senior managers. These coaching trainees now are using more mentoring and coaching work styles, rather than moving to get the work done themselves as they would have done before, as noted by one coach. Several coaches noted that the latter approach did not result in sustained host-country capacity building.

Myanmar was noted as having completed the full EMP training, analysis, planning and execution process. Togo completed the 10 EMP modules and has made good progress, according to ICRC.

The ICRC supervisor noted that the EMP “has snowballed in our organization (ICRC). It is beginning to get traction at the top.” In terms of lessons learned, the supervisor noted that they should have started the process by training coaches and then moved to the SLP and EMP roll-out. For Togo, another coach noted there is no plan yet to incorporate EMP into MOH protocols, and it is still not a priority for the physiotherapy department. The next step to move toward sustainability of the Togo leadership training is to integrate the approach into the university’s physiotherapy curriculum and build sustainable governing boards for the PRCs. ICRC key informants

“The collegial technical support by the LMG team for the CEOs of these small mental health organizations and CVT’s organizational development was the most helpful input.”

–CVT staff

noted that the EMP process takes time and forces PRC managers to “own the problem” and accept that they are the leaders.

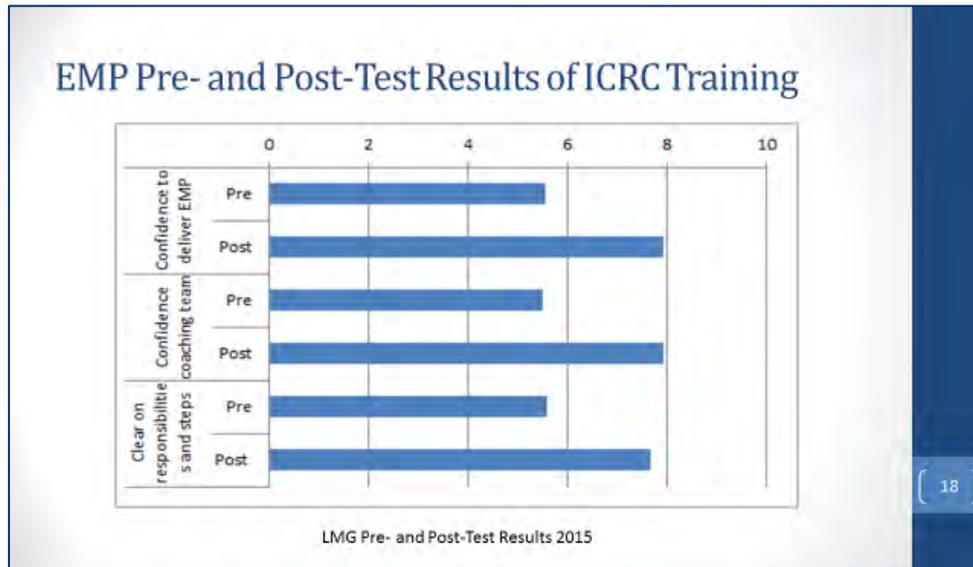
In the DRC, ICRC indicated that the PRC managers appreciated the EMP tools, because they had been assigned their job with no management training. The PRC in Kinshasa reported that it now has clear job descriptions and for the first time understands its scope of work. ICRC observed that a memorandum of understanding is now in place with the MOH on the PRC teams’ expected results. On average, the DRC center was seeing seven people per month before the EMP implementation. After seven months of implementing the EMP and coaching by ICRC following LMG training, ICRC reported that one DRC PRC run by the MOH was able to reach on average 15 people per month. The medium-term team goal following the EMP process is 20 clients per month. Other results reported by ICRC in DRC include better resource mobilization and strategic planning. This support by LMG has helped the MOH to look for a more diverse range of funded partnerships. An example cited of new resource mobilization following LMG training is that Handicap International, which had pulled out of DRC, is set to reenter the country after a hiatus in funding. A key lesson learned during this pilot was the need to work at multiple levels of the PRC system simultaneously so that central PRC supervisors and managers are working in sync with PRC facility managers.

Institutionalizing Leadership and Management Development: The ICRC’s SFD integrated LMG into its strategic plan work at the pilot PRCs. Consensus among the Africa ICRC EMP coaches is that more coaching and time are needed for the program to be fully implanted, as providers and center managers are drawn from highly hierarchical organizations that have little exposure to the type of transformational change that LMG espouses. ICRC’s SFD work covers both public sector and NGO PRCs. More work, ideally two more years, is needed to fully roll out the program and obtain high-level ICRC buy-in, but there is great enthusiasm for the results achieved thus far on the part of most (except one) of the country representatives interviewed.

Ultimately, the formal adoption and broader roll-out of LMG-supported management and leadership approaches across the SFD and physical rehabilitation country programs will rely on higher-level ICRC headquarters’ acknowledgement, endorsement and funding to continue the leadership process. USAID’s ongoing donor contributions to the SFD and participation in ICRC board meetings might be another opportunity and source of funding for strengthening and standardizing PRC management improvements. In mid-March 2016, ICRC Headquarters initiated a high-level discussion with LMG to outline strategic direction for how ICRC/PRP would integrate management and leadership development into their ongoing programming beyond the LMG end-of-project timeframe.

ICRC intends to institutionalize LMG training, tools and approaches, but this needs to be clearly spelled out in the scope of work for its supervisors. As part of the LMG’s fifth-year work plan, in March 2016, LMG staff will hold an integration meeting with ICRC/Geneva to officially integrate the leadership and management capacity development including the EMP into ICRC standard operations and programs. The meeting agenda also includes a discussion of next steps, ongoing technical assistance, if needed, and the timeline for ICRC/PRP and SFD to create a core staff group to champion and coordinate leadership and management activities, complete the first delivery of the EMP process in phase one countries and roll it out in phase two countries. Data from an LMG pre- and post-training assessment from the early November 2015 EMP training in Ethiopia indicate that ICRC’s EMP coaches and facilitators are becoming more confident and committed (see Figure 3 below). ICRC/PRP and SFD should be encouraged to incorporate EMP participation into host-country agreements.

Figure 3. EMP pre- and post-test results of ICRC training



CVT, MIUSA and NCC: LMG’s technical assistance and tools were also found to be a good fit for CVT, MIUSA and NCC. Each organization adopted and adapted different tools and assistance. For example, LMG worked with CVT in CVT’s USAID-funded Partners in Trauma Health project (PATH). The PATH project was mandated to provide capacity building for ten independent NGOs providing services and support to victims of torture in countries emerging from conflict (e.g., Liberia and Sierra Leone). In partnership with CVT, LMG used strategic planning, financial management, resource mobilization approaches, among others to support organizational development capacity building for the CVT/PATH partners. Six of the ten CVT grantees are women-led organizations. Because these organizations had limited exposure to management approaches, working with volunteer boards and medium- to longer-term planning, LMG provided tools for planning and organizational analysis. “LMG gave our grantees a safe space to explore how to be better managers.” Other tools used in partnership with CVT and the PATH partners included: MSH’s Program for Organizational Growth, Resilience, and Sustainability (PROGRES), the LMG capacity development road-mapping process, some human resources (HR) templates, and cost-recovery planning tools. For CVT, having access to a range of management tools was important, and prior to LMG it did not have financing to offer PATH partners this type of assistance. CVT reported organization-wide use of strategic planning and road-mapping tools with seven partners; the resource mobilization module, cost-recovery module and several HR templates with three grantees; and the financial management tool with two partners. Centrally, CVT has used the LMS/LMG Challenge Model to modify its approach to fundraising, allocating more staff to it.

Rwanda’s National Commission for Children (NCC) was given embedded LMG long-term technical assistance in 2014 to advance its child rights policy agenda through coaching and to strengthen staff performance through better teamwork and cross-office collaboration. The LMG advisor also provided coaching to NCC leadership on the planning for recruitment and deployment of 68 social workers to carry out its child protection work and with the issuance of child rights guidelines.

MIUSA Women’s Institute on Leadership and Disability (WILD) is a small, highly focused leadership program to develop advocacy plans for disabled women in developing countries. Women from 17 countries participated in WILD’s training of trainers in 2015, and in-country training will be held in these same countries in 2016. LMG supported MIUSA to develop a facilitator’s guide and an approach to systematically measure the impact of these replicated WILD training sessions. Previously WILD had

anecdotal evidence, but LMG helped it modify its M&E approach and carry out and document follow-up at three and six months after training.

As reported by MIUSA, “The Women’s Institute on Leadership and Disability (WILD) got technical assistance and tools to document existing program performance, resource mobilization brochure to attract new donors and a training manual for its women leaders.”

WILD documented 100 women becoming advocates for disability rights as a result of their DCHA-funded training. Other USAID/DCHA implementing partners, including World Vision, have attended the Gender and Disability Development Institute (a part of the WILD training) and learned about inclusive development from WILD participants. “LMG was an excellent fit for us,” MIUSA’s senior leadership reported. A new tool, the facilitator’s guide, was created to improve leadership training and is used organization-wide. LMG supported WILD’s development of a communications plan, brochure and video to market its services and grow its donor base. Respondents reported, “The organization now has more opportunities. LMG has taken our M&E program to the next level”; “We now have quantifiable results”; and “The entire staff has benefited from the leadership manual.” The revised edition of the LMG text, *Managers who Lead*, was given to all MIUSA staff. The women leaders trained under WILD are also being educated about family planning services. WILD will network and seek new partners in this area, including attendance at this year’s international family planning conference in Indonesia, as disabled women are at risk for sexual abuse and violence and lack family planning services.

Conclusions on DCHA tools: The evaluation found the LMG tools applicable to a very diverse range of educational levels and skill areas that extend beyond the traditional health sector, where the tools were originally developed. The tools are readily applied to the DCHA partners. DCHA partners noted that MSH’s LMG technical assistance was tailored to their needs.

Specific to LMG’s work with ICRC at the service delivery level, the parts of the 10-module EMP that coaches found to be the most useful were group self-assessments of organizational capacity (EMSAT) and self-scoring, scanning problems, laying out a common vision and consensus on feasible problems to be tackled (challenges) and action planning. Among those interviewed from the ICRC/SFD Africa team, Tanzania was described as the most successful SLP experience in Africa, followed by DRC, despite both experiencing staff turn-over. ICRC coaches were enthusiastic champions for the EMP.

In December 2015, evaluators learned that LMG worked with ICRC to begin a process to intentionally coordinate the SLP with the EMP so that countries with a large ICRC physical rehabilitation programs have both trained EMP coaches at the service delivery level supported by high-level SLP trained delegations that champion policy reform and resource mobilization needed to carry out sustained improvement of PRC services. ICRC hopes that having trained EMP coaches and high-level delegations to support policy reform and resource mobilization will yield greater gains from both of the separate programs. The timing and sequencing of the EMP start-up and SLP may not have been as coordinated as it could have been, due to challenges related to availability of participants, LMG funding cycles, USAID priority countries, ICRC planning processes, and other circumstances in the local context (for example, elections). This appears to be on track now and should be coordinated going forward so that they are mutually reinforcing. Trained senior leaders, mid-level and technical managers and PRCs are needed to create the enabling environment necessary to reach disability access and service improvement goals. A key recommendation for the final year of EMP work is to make sure that the EMP and existing SLP participants work closely together and are well coordinated in the next group of EMP countries scheduled for 2016. Although no further SLPs are planned by LMG at this time, ICRC should consider directly funding SLPs as there are major service delivery implications of weak management of PRCs. In Ethiopia for example, a key informant noted that the ICRC estimates that the PRCs only reach 10 percent of the country’s disability needs. In order to meet higher service delivery targets, all levels of the

system must be engaged in communicating to the public the availability of services and ensuring that supplies and materials are available at PRCs to meet increased demand.

A problem noted by ICRC EMP coaches was the time needed to complete all of the modules and the homework requirements for participants. Given the nature of physical rehabilitation work and the time pressure on staff in these centers, it may be possible to consolidate the delivery of the modules and accelerate action planning and results. Several countries, such as Myanmar, already made adaptations with LMG coaching. In Myanmar, rather than delivering the modules every week or every two weeks, the EMP team delivered the first 4 modules in a two-day workshop and then delivered the other modules over several other one-day sessions. A related problem for EMP roll-out and sustainability is the limited time remaining in the project to complete all of the sequential EMP steps to ensure that work will continue beyond 2016. For Ethiopia, one possible solution is to use LMG legacy institutions, such as Haramaya University and Harar Health Sciences College or Amref/Ethiopia, with support from the LMG/Ethiopia health team, to provide technical assistance beyond that offered by ICRC to accelerate the pace of EMP implementation.

SLP Francophone participants from government ministries were equally satisfied with the training and tools. Perhaps most importantly, the multi-sectoral senior leadership delegations, including leaders of disabled people's organizations (DPOs) from civil society, pointed out to evaluators that the LMG tools gave them the confidence to have a voice at a national level, to communicate with their peers and to gain much-needed visibility for their issues. They said that persons with disabilities are usually the most seriously vulnerable, stigmatized and culturally invisible populations in many African countries, where abandonment or exploitation of the disabled is common.

This vulnerability was underscored in LMG's work with MIUSA, a blind woman who participated in a DCHA-funded WILD program noted, "There are no role models for the disabled, limited services, abysmally poor access to buildings and specialized adapted equipment and few jobs. I am the role model and I have learned how to assume this role. This is not easy. I am now networked with many other disabled citizens in my country."

Recommendations:

- LMG must accelerate work during PY5 to complete EMP roll-out in the first five pilot countries and strengthen legacy institutions there, such as local universities or an ICRC regional coaching unit and trainers. In countries where other recognized capacity exists, such as Amref/Nairobi or Ethiopia, these local institutions might be positioned to work beyond 2017 with ICRC if needed. The process of moving from an LMG financed mode of technical assistance to ICRC post-LMG financing has not yet taken place but must be urgently addressed by ICRC headquarters to avoid a hiatus in EMP roll-out and formal adoption process by host countries and local NGOs.
- LMG and ICRC should consider collapsing the modules from 10 to five, as Myanmar has done, to allow completion in a more intensive, compressed timeframe.
- In setting priorities for PY5, USAID and ICRC need to consider whether there is sufficient time remaining for ICRC and LMG to embark on EMP roll-out to a second group of EMP countries as now planned. As part of this discussion, USAID and ICRC should agree upon funding for leadership, management and governance work beyond July 2016.
- DCHA should consider what further assistance could be offered to CVT to strengthen its capacity building to partner independent NGOs, such as the PATH project which concluded in 2015. One possibility could be to link the NGOs to LMG legacy institutions. For example, the Liberia Association of Psychological Services (LAPS) in Liberia might be able to link with LMG/Liberia's training organizations. A country-by-country analysis should be done to identify ways CVT partners and LMG health recipients can reinforce each other.

- LMG, with PRH assistance, needs to promote the full range of leadership, management, and governance tools and LeaderNet use and find ways to further embed these tools into other USAID archives, including those that reach the DRG Center and DCHA.
- The board governance tools have broad applicability for DCHA organizations. For example, there is tremendous scope for the work on board governance with DCHA NGO recipients in the field (CVT) that operate with independent boards.
- Given the strategic importance of ICRC and CVT partners in current and post-conflict areas, GH and DCHA should consider extending up to a year (possibly even 18 months) ICRC programs that will not complete by September 2016 due to external factors (elections, terrorism or other compelling reasons).
- GH and DCHA senior leadership might consider the use of ESF and DG funding for LMG tools in current and post-conflict areas.

Elements of LMG's organizational development approach that enabled or limited regional professional health bodies to meet their mid- and long-term goals

Overview: The evaluation team reviewed results from six African regional health professional and advocacy organizations that received LMG project assistance or were an LMG Consortium partner. ACHEST in Uganda is a policy think tank led by international leaders in health and development. It supports the development of technically sound regional health policies and strategies. The All Africa Leprosy and Epidemic Control Training Center (ALERT), based in Ethiopia, is a Pan-African training center used by the Ethiopian Federal Ministry of Health (FMOH) for training purposes and a WHO regional center of excellence for HIV training. The AHLMN is a regional membership organization and health information dissemination platform that links African universities, schools of public health and management training institutes. It channels and disseminates information and educational knowledge and materials through a network of 26 African universities and NGOs. These three regional health professional organizations face similar challenges, including staffing and financing.

The West African Health Organization (WAHO), based in Burkina Faso, is a specialized institution of the Economic Community of West African States (ECOWAS) responsible for health issues.

LMG Consortium partner the International Planned Parenthood Federation Regional Office (IPPFARO) in Nairobi is part of the global IPPF family planning and reproductive health federation. LMG Consortium partner, Amref, is one of Africa's largest international health nonprofit organizations; it offers regional training and education programs in family planning and reproductive health, maternal and child health and newborn care, and child survival, and chairs the AHLMN network. IPPFARO is the only one that has service delivery branches.

LMG tools and approaches: With the exception of IPPFARO and WAHO, management and staff of these organizations are largely composed of health professionals such as doctors, nurses and pharmacists who, in general, have not received formal training in leadership, management and governance, because these competencies are still not viewed as central to their professional training. All of these organizations, however, have recognized that these skills are essential in advancing their missions of public health training, policy, advocacy, networking and, ultimately, improving service delivery and health outcomes. They were highly appreciative of the tailored support that LMG offered to further their missions. LMG built or restructured management systems for ACHEST to enhance their organizational and individual staff capacity in finance, communications, planning, work climate, performance management, advocacy and resource mobilization. LMG also offered tailored short-term technical assistance (STTA) to AHLMN to strengthen its network, and developed a new leadership, management and governance certification program for midwives that is housed with consortium partner

Amref. An IPPF affiliate (the RHU) used LMG tools and training to build or restructure their management systems such as the internal audit system in the RHU.

LMG Consortium partner IPPFARO oversees 42 affiliates and seven learning centers and their branches, including 2,800 service delivery points across sub-Saharan Africa. The affiliates all receive direct support from IPPF for their operations, are expected to generate a portion of their budget from patient fees and services, and also receive direct support from international donors, including USAID missions and PRH, UNFPA and private donations. IPPFARO affiliates received direct LMG support to strengthen financial management

“The most useful intervention was to get the Governance right. The local board has enabled us to engage with the EU and the Dutch Government in a stronger position. Together with the Strategic plan, this has worked very well.” Another manager said, “Training on board governance has strengthened ACHEST’s systems of governance including accountability, transparency, improve donor relations, financial management and reporting.”

– ACHEST senior staff member

systems, improve business planning and resource mobilization, and training in the LDP+ program. At the time of the evaluation, LMG was planning a training course for IPPF affiliates in board governance. The LDP+ was packaged by LMG for use by IPPF Learning Centers.¹⁶ Based on its review of the RHU in Uganda and interviews with IPPFARO in Nairobi, the evaluation found that the LMG work supported and complemented the work of its members to retain their own federation certification requirements. (IPPF’s requirements are tantamount to a licensing procedure.) An important factor leading to successful uptake of assistance by the IPPFARO Learning Centers is that these centers were set up expressly to carry out fee-for-service training for NGOs in their countries, as a structured part of the federation’s revenue stream. IPPFARO informants reported to evaluators that LMG supported the Learning Centers to roll out new courses, thus contributing to their ability to generate training revenue. In 2014, Cameroon and Mozambique had 77 percent and 8 percent income growth, respectively. “Member Associations benefited from LMG and their financial health is partly attributed to improved systems, leadership, management and governance which is the core thrust of LMG project,” said a senior official at IPPF Nairobi. LMG also strengthened the capacity of the affiliates to offer in-service training and empower youth and women in leadership, management and governance. LMG applied tools such as the LDP+, Non-U.S. Organization Pre-Award Survey (NUPAS), board governance training, the youth peer coaching, business planning, and women’s empowerment and strengthening. The affiliate in Uganda, RHU, conducted 10 step-down training sessions on multiple tools for staff in its six branches and some training included board members. The RHU Learning Center now has a well-developed set of leadership, management and governance courses that they offer to other organizations on a fee-for-service basis.

ACHEST: According to USAID, ACHEST was identified as a valuable African advocacy and policy NGO that required organizational management strengthening to achieve its mission and grow. The LMG organizational capacity self-assessment tool, MOST, was used in assessing and responding to ACHEST’s perceived organizational development gaps. LMG carried out organization-wide STTA to strengthen the financial management system, board governance, resource mobilization and grant writing. As the African Coordinating Center for the Medical Education Partnership Initiative (MEPI) Program led by George Washington University and financed by the Office of the Global AIDS Coordination (OGAC) through the Fogarty Center of the National Institutes for Health (NIH), improving these systems was also a prerequisite for further USG (HSS HRSA and NIH) assistance. As a result, ACHEST revised its strategic plan and its HR manual, including the development of a well-defined organogram, reporting structures, performance management system, salary survey, staff salary grades and position standardization. It also recruited a chief operations officer to manage finance and administration. ACHEST formed a local

¹⁶ The LMG assistance, as noted in the RHU Case Study, Question 2, page 42, was determined by evaluators to be highly effective in accomplishing all of these objectives.

advisory board, in addition to the international advisory board, and developed a board manual. On the local board, ACHEST set up committees focusing on different governance areas, including approval of policies. According to the ACHEST senior leadership team, expertise on the new board has added to ACHEST's strategic and technical programming capacity. Following these interventions, ACHEST was reassessed using a post-intervention "Mini-Management and Organizational Sustainability Tool (MOST)" assessment, and their organizational capacity score improved by from two to four out of four. LMG helped ACHEST build a Ministerial Health Leadership Support Program for ministers of health and supported dissemination of a Handbook for Ministers of Health launched in 2015 at the World Health Assembly.

LMG Assistance Leads to Greater ACHEST Resource Mobilization

The evaluation found that LMG was instrumental in building ACHEST's capacity in business planning and financial management, which has led to greater financial sustainability and diversification of funding partners. ACHEST needed to adopt U.S. Government financial management procedures in order to participate in the Medical Education Partnership Initiative (MEPI). "ACHEST got tailored LMG STTA to strengthen its financial management capacity," noted a senior ACHEST official. As a result of strengthened financial management capacity, ACHEST qualified for new donor grants and received a new five-year, € 8 million health project from the EU/Dutch and WHO, in partnership with Amref. This supports civil society activities in maternal and child health across Africa. ACHEST's new resource mobilization team now meets weekly and has a strategy. The organization is more proactive in its applications for donor funding; LMG trained it to look for opportunities, and this has become routine.

LMG trained ACHEST's communication officer in the development of a comprehensive communication strategy and built organizational capacity in communications to guide the generation and dissemination of health evidence. According to ACHEST's senior management, this has been very effective in strengthening donor relations and improved communication messaging and packaging through publications and the African Health Systems Governance Network (ASHGOVNET), of which ACHEST is the secretariat. As a result of these improvements, an ACHEST senior manager reports the organization was able to provide data to a coalition of CSOs and lawyers who took the Ugandan government to court over a case on high maternal mortality.

ALERT: LMG undertook a MOST assessment of the ALERT training center and subsequently trained the team in grant writing and grant management and developed a grant development training manual. ALERT now offers this training to health managers and clinical service providers for a fee and has become a lead facilitator for the leadership, management and governance national in-service training for health providers. Thus far, ALERT has trained Oromia Regional and Adama Zonal Health Bureaus using the Ethiopian leadership, management and governance curriculum, and carried out two rounds of training with 16 participants from the FMOH and 12 private sector participants from outside Ethiopia. ALERT was identified as an FMOH training center of excellence and incorporated leadership, management and governance training in its annual training calendar. It also received funding from WHO for this training.

LMG consortium partner Amref: The LMG project designed the LMG for Midwifery Managers Certificate Course, which is being implemented by Amref-supported teams in Ethiopia, Kenya, Lesotho, Malawi, Rwanda, Sudan, Tanzania, Uganda, Zambia and Zimbabwe. The LMG for Midwifery Managers Course consists of a five-day workshop focused on six areas prioritized by a skills gap assessment: teamwork and communication, advocacy, coaching and mentoring, database management, change management and strategic problem-solving. An external evaluation found that the LMG for midwifery managers stimulated multiple improvements at service delivery facilities that improved maternal and

neonatal services in some clinics in South Sudan and Tanzania.¹⁷ As of December 2014, the evaluation found that 13 out of 48 midwives had achieved or surpassed their action plan targets, with many still implementing their projects and reporting M&E data. Midwives who participated in the training and were interviewed by the external evaluation found the training to be relevant and useful. Survey respondents reported that the skills obtained have strengthened the nurse-midwives' effectiveness in their work settings. However, it is reported that in many countries, the governments were not ready to fund follow-up to the training and that not enough advocacy was done by LMG in each country for this to happen. In Ethiopia, the Amref representative for LMG contributed to the development of the FMOH in-service curriculum. A second wave of a similar follow-up study of trained nurse-midwives is planned for March 2016. The evaluation team did not see evidence that Amref alone was in a position to influence major changes in the nurse midwife curriculum before the end of the LMG project. LMG-trained midwives continue to exchange ideas and best management practices through an online community of practice and mobile phone applications (Whatsapp and Viber), without external financial support and the LMG midwifery course curriculum. Is being offered and available virtually on Amref's website. In Ethiopia, the Amref LMG staff also trained 43 participants from 14 hospitals, including four teaching hospitals, using the Ethiopian LMG curriculum. Participants included midwives, clinical nurses and health information officers. As a result of the training, an Amref informant reported that participants have been able to prioritize their needs. LMG has also trained 13 Deans of Health Science Colleges, who in turn trained health extension workers using the health facility curriculum.

AHLMN: LMG conducted a Virtual Leadership Development Program (VLDP) with five teams from members of the AHLMN network including the University of Zambia, University of Witswatersrand in Johannesburg, South Africa, the Moi University of Kenya and the Institute of Development Management at Mananga's Executive Leadership Center in Swaziland. The focus of the VLDP was to develop a plan for how L+M+G could be integrated into pre-service health workforce curricula at the team's university. However, only two of the many trained network member institutions, Makerere University and Botswana Institute of Management, were able to train their own faculties, because there was no LMG funding to do so. The current AHLMN chair noted that it is also not clear whether the VLDP training was incorporated into the curriculum of the health professionals in these institutions, and if so, whether it is examinable. The work done with AHLMN has not yet created a critical mass of trained members in the application of the VLDP who can carry on the legacy of LMG tools in their institutions. The one common issue noted by key informants was the limited funding for AHLMN from Amref and USAID core support to fully complete this work by the time of this evaluation. Another informant noted that, "Working through digital networks is proving difficult." The evaluators believe that, on balance, this network platform has great promise to disseminate materials (e.g., those produced by LMG and others supported by USAID) in the future.

WAHO: LMG made substantial contributions to WAHO's governance strengthening plan by supporting the organization in the articulation of a plan and its initial execution. LMG provided governance training to WAHO's entire 80-person staff, including the Director General, and informants indicated that the training strengthened its internal governance. LMG carried out "Governance Academies" for Togo, Mali, and Nigeria's MoH senior leaders. WAHO extended this governance training to its 15 member countries to develop their governance bodies. A WAHO informant noted that it now has a governance strategy and is planning to roll out governance training to the 15 member countries of the Economic Community of West African States (ECOWAS). WAHO reported and a USAID informant confirmed that the training assisted WAHO officials to meaningfully engage with ministries of health in the member countries and discuss improving governance. LMG prepared governance guides, a facilitation handbook and the eManager on governance. WAHO has organized similar workshops in Nigeria, Togo and Mali. Member countries committed their own resources to

¹⁷ Amref and LMG External Evaluation of the LMG Midwives Certification Program, pages 20-25.

support this training. WAHO views governance as a tool for health systems strengthening (HSS) in West Africa and will continue to use it. WAHO credits LMG LDP+ training as helping improve its work climate and teamwork. Developing performance targets and action plans and holding host country technical teams accountable for results were areas reinforced by LMG training. LMG supported the development of WAHO's new organizational structure. A WAHO respondent observed that team morale at headquarters had improved, and there was greater cohesion of staff toward common goals with clearly articulated targets. A USAID respondent noted that, "WAHO's effectiveness in carrying out its policy agenda had improved with LMG technical assistance." The ability to follow through on health policy adoption was also noted by a USAID informant.

Other LMG/West Africa project achievements reported by LMG include:

- Completing a series of four Leadership Development Program Plus (LDP+) workshops and coaching sessions with WAHO State Focal Points from Benin, Côte d'Ivoire, Guinea, Nigeria, and Togo;
- Assisting WAHO in planning and conducting the first Regional Forum on Good Practices in Reproductive, Maternal and Child Health from July 28-31, 2015;
- Promoting the development of national strategies for integrated health services for adolescents and youth in the ECOWAS region;
- Developing and training for WAHO's Professional Officers on targeted tools for improved L+M+G within WAHO.

LMG's leadership development cultivates accountability and helps steward resources at sub-regional and national levels, particularly with ministries of health.

Cultivating accountability (financial management and governance): LMG defines accountability as spanning personal, organizational, social and internal accountability, as well as measuring performance with transparency, sharing information and providing effective oversight.¹⁸ Adding the governance skill set to leadership and management was very important to the global health sector: As multiple informants noted in the course of this evaluation, "Lack of good governance is the biggest stumbling block to good development in Africa." Evaluators found many examples of improved accountability leading to better financial management. Using tools such as FinMAT and tailored STTA for improved financial management and reporting, ministries of health in Côte d'Ivoire, Ethiopia and Afghanistan were able to adopt new standard operating procedures and work with new software that led to improved resource management, internal and external reporting, and absorptive capacity.

As an example, an informant from Afghanistan described the success of the semi-autonomous hospitals in using their state budgets. The Kabul blood bank and transfusion center reported that in 2015, it was able to spend 100 percent of its budget due to better budgeting, planning and timely procurements. With LMG support, the senior leadership of Côte d'Ivoire's National Malaria Control Program (NMCP) learned how to set goals and transparent budgets with inputs from across its teams. This has led to better sharing of resources and proved to be an excellent morale boost as reported to evaluators: "It was not the usual practice for managers to reveal their budgets to one another. Everyone kept their budgets secret. No one questions their boss." The LMG advisors in country worked on team building at multiple levels, resulting in team members knowing their scope of work, expectations and resources they can expect from the NMCP to get the job done. Several USAID informants noted that this clarity and transparency has

"LMG trained the directorate which then took this issue as their challenge, and took the contractors to court to hold them accountable."

—Senior official at the Ethiopian FMOH

¹⁸ *The implementation and use of LMG's governance tools, models, approaches, practices, applications, publications, guides and handbooks and technical assistance.* June 2014.

energized staff and improved performance, which in less than 18 months has led to improved NMCP malaria prevention and control in some countries and leveraged successful awards of Global Fund Malaria Grants.

Another example was LMG's introduction of a new financial management software platform at the Harar Regional Health Bureau (RHB) in Ethiopia. According to that bureau, the new system has improved timeliness and accuracy of financial reporting and led to increased resource mobilization. The bureau's budget has increased by 13 percent since putting in the system which our informant credits the greater confidence by the FMOH and donors in their financial system.

A very different example from Ethiopia's central MOH was highlighted after its entire central senior leadership team received SLP training. The FMOH Legal Affairs Directorate set as one of its challenges holding private sector construction contractors accountable for their work on health facilities, which resulted in repairs at no further cost to the FMOH. The LMG training gave the legal team the time to work together to plot out a course of action to resolve a longstanding problem.

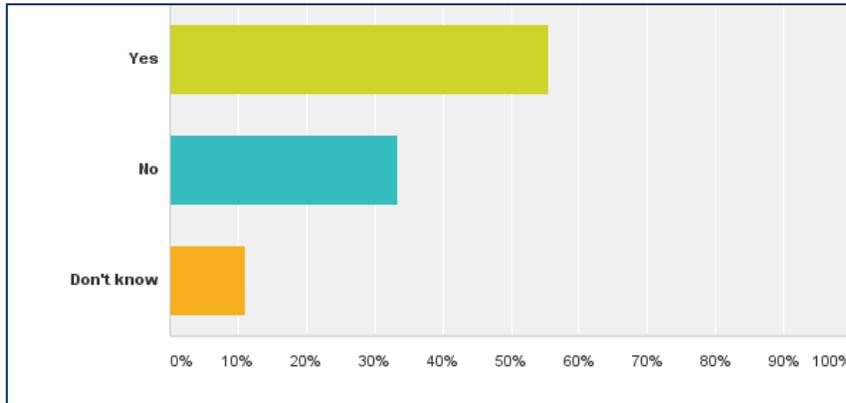
Another way that LMG supported good governance is by working with teams, even in remote areas, on provider attendance problems. As the main partner for Ethiopia's Health Systems Strengthening Special Support Unit (HSS SSU) in four "emerging" regions (less developed in all ways than the other regions), LMG is not funded to work directly in the regions, but it trained the HSS SSU supervisors to roll out leadership training. The HSS SSU reported to evaluators that this work has resulted in reductions in employee absenteeism and better and more equitable distribution of medical equipment and drugs from the regions to the districts. LMG training in some woredas (districts) of Afar, one of the emerging regions, has improved team spirit, created a conducive work environment: "Professionals were usually absent from their work but this has changed; they are showing up for work in the woredas," said a senior official at Afar RHB. Several respondents reported that LMG training increased respect for every position in the Oromia region. It increases the sense of ownership in working and coordinating with other staff. They also said that most other training offered by the MOH is technical, while the SLP addressed the leadership and governance skills gap.

In West Africa, after LDP+ training, NMCP staff became more accountable to their work teams for their overall productivity and its impact on others in the organization. This helped to better define and set staff and team priorities and obtain team consensus about the timelines required to meet NMCP objectives and team and personal expectations. "Before LDP we did not share a common vision and without it everyone was working with blinders on in their own fragmented areas. Not having a shared vision was a big obstacle," said an official in Côte d'Ivoire.

The project was instrumental in setting up a MOH grants and contracts unit in Haiti and providing technical support to such units in Afghanistan and Haiti to award contracts using international best practices and to implement results-based financing (RBF). The structure and smooth operation of these important MOH units, which included embedded LMG staff for a time, made it possible for these ministries to obtain other partner host-country agreements. In both Afghanistan and Haiti, the units were a prerequisite to World Bank and USAID support for a sector-wide loan. In Haiti, LMG also helped the Ministère de la Santé Publique et de la Population (MSPP) to create an independent oversight contract review board to assess results of contracted service providers against performance targets.

More than 50 percent of the USAID field missions that responded to the evaluation's online survey reported that financial self-reliance had increased among local organizations and host governments participating in the LMG project (Figure 4).

Figure 4. USAID field mission responses: Increased self-reliance among participant organizations and host governments



Stewarding resources: LMG’s work on resource management included better resource mobilization, allocation and management of financial and human resources. Examples of better stewardship include work with Global Fund CCMs in multiple countries, HR management and gender-inclusive approaches.

CCM strengthening: LMG conducted Global Fund Eligibility Performance Assessments (EPAs) in Ghana, Sierra Leone, Mali Morocco, Mozambique, and Senegal.

As a result of the LMG NMCP timely embedded long-term technical assistance in NMCPs in West Africa, \$270 million for malaria has been leveraged from the Global Fund for PMI (President’s Malaria Initiative) non-focus countries.

This technical assistance has helped countries meet CCM eligibility and Global Fund grant reporting requirements. There were numerous testimonials about LMG’s effect on CCMs. The Global Fund noted that as a result of the technical assistance, there has been a significant improvement in report quality. For example, Côte d’Ivoire’s Global Fund grant received a B rating in 2014, and this permitted the NMCP team to qualify for a performance-based stipend. Several respondents from host countries and USAID noted that because of LMG assistance, CCMs have been able to access and better manage Global Fund malaria and HIV funds. LMG technical assistance also includes support for CCM members in their oversight role. CCM members and ministries of health report improved coordination and communication among themselves, the principal recipients and local fund agents. The MSPP in Haiti noted that LMG technical assistance strengthened systems in HIV and health.

Improved human resource management: Through the leadership, management and governance training, the Harar RHB reports collaboration with the civil service, which deploys workers in the health system, to successfully advocate for additional staff positions, resulting in an increase from one midwife and one health officer per health facility to three midwives and three health officers per facility. While it is hard to directly attribute changes in death rates to better staffing, this team highlights the reduction in the institutional maternal death rate in their hospitals, which went from an annual rate of 122 deaths to four (per 100,00 births). Another challenge that this RHB team took on during training was a need to better identify the poor and vulnerable, i.e., the population eligible for free health services. RHB funds allocated to provide services to this group used to be returned to the Treasury or used for other unexpected expenses, but one RHB informant noted, “Now we can use them here in our region.”

Pre-service training in Ethiopia: LMG strengthened HR for health in a number of ways. TA was provided to integrate L+M+G into pre-service training in Ethiopia and is still being used and incorporated into the curriculum in six countries: Kenya, Rwanda, Swaziland, South Africa, Uganda and Zambia, and in eight universities in Ethiopia. With LMG in-country technical assistance to Ethiopia's In-Service Technical Working Group, chaired by ALERT, the leadership curriculum was adopted in universities. This was particularly significant and required multiple ministries' approval, obtained through collaboration between the FMOH and Ministry of Education, according to local LMG staff. This curriculum contributed to the creation of a future cadre of health management professionals with leadership skills. In other countries, those who want to revise the university or other higher education curriculum to include such training should note these issues and plan ahead to gain the approval of other relevant officials and ministries.

Pre-service training for health service management students in Ethiopia

Viewed as a major breakthrough and done in a relatively short timeframe, leadership, management and governance training began in Addis Ababa, Jimma, Bahir Dar, Gondar, Mekele, Wollo, and Hawas universities and is being piloted in Hawassa and Mekele universities. At Bahir Dar University, it is a required course for all health science students, including medical students.

Haramaya University has been running the training for public health officers, medical students, midwives, nurses and pharmacy students for one year. It is also using community engagement and team training to build staff capacity in the health facilities where the students go for practicum. This training requires coaching, but the university lacks transport and other resources. So far it has trained 33 health workers. The university also created a pool of nine staff (four trainers from the RHB and five university faculty) responsible for health worker training. The FMOH mandated that the RHB contract pre-service training institutions to conduct training. The RHB and universities have a shortage of trainers and do not have a budget for training, despite the huge need and demand. This concern was cited by many interviewees, including the Amhara and Oromia RHBs. RHB leaders are committed and understand how important LMG is to health facilities, but this commitment is threatened by high RHB staff turnover. The RHBs prepared a proposal and asked partners to support further training. The Global Fund allocated a budget for country-wide training, and Columbia University supported senior-level training.

There is a need to increase the pool of trainers (master trainers and training of trainers) to ensure sustainability and scale-up of the training. The Government of Ethiopia is encouraging private training institutions that offer such training to register with a government body that regulates professional training institutions, which will greatly assist in meeting the high demand. The Ethiopia LMG Project's PMP added an IR on institutional capacity building of training institutions, to provide much-needed support in experiential learning methods to these institutions. ALERT, which has been identified as an FMOH training center, has been one of the beneficiaries of this training.

Following LDP+ training, Haramaya University introduced staff recognition, education, promotion, career development (in the form of further training opportunities) and improved communication channels. In Hiwot Fana Hospital, the senior health team noted a change in the mindset of the hospital team as a result of in-service training in leadership, management and governance: Staff is motivated to do better, facility management has improved, the staff has clear objectives and work plans, the hospital is cleaner and infection control has improved, and the staff developed standard operating procedures and guidelines. They also want to access more leadership, management and governance resources.

Pre-service training and HR staffing in Afghanistan and Ethiopia: In Afghanistan, LMG helped develop the curriculum for community health workers used by the school of public health. "They helped to advance our community health program from nothing to a nationwide program. They helped move us out of isolation after 30 years of war. We needed to see other countries and their advances," said a senior MOH official. LMG embedded 10 people in the Community Health Department which oversees

the 30,000 citizen village health worker program that has become a model for the government's rural outreach National Citizen Charter program. This department, according to key informants, is known as one of the strongest in the MOH. MSH provided 80 percent of the technical assistance for the community health worker program.

In Ethiopia, the HR Directorate participated in LDP+ training and also receives support from Tulane University, which was funded by USAID to revamp the health management information system (HMIS). This HR team set as a challenge transferring HR records for 60,000 health workers nationwide from paper to an electronic personnel database and decentralizing the data to the regional level. Currently, 90 percent of RHB paper-based HR data are in the electronic human resources information system. This reduced the FMOH workload, unnecessary travel to headquarters and HR costs. Now HR staff at the FMOH and RHBs are able to obtain staff profiles, check vacant positions by a click of a button and use data for HR decision-making. The Haramaya College of Health Sciences had the same intervention, which reduced turnaround time and increased customer satisfaction, as reported by a senior college manager who is now putting to use computers and HR software furnished by another USAID-funded project. The College of Health Sciences is now a model for better HR management, and the FMOH has sent other institutions there to learn from it.

Following SLP training, the Oromia RHB set a target of 20 percent for integration of HIV prevention programs in all levels of the region's multisector services. The actual increase was from 9 percent to 27 percent in just two years by both government and private sector organizations. This result energized the RHB and motivated the team to set another round of challenges to advance its HIV work.

Gender responsiveness: LMG/Afghanistan worked in partnership with the MOH on a gender integration tool and a revision of its gender strategy. LMG also trained MOH staff in LDP+ (in Ethiopia called the LMG). As result of this training, female staff were empowered to play a role in committees. "In Afghanistan, very few women at first wanted to join our team as we need to go out to the field and women can't travel easily. Thanks to LMG the facility was able to create an environment of caring," said a senior MOH official. Women also benefited from training opportunities out of the country.

In Ethiopia, LMG assisted the Gender Directorate within the MOH to develop a gender manual and guides for facilitators and participants. The manual will be used in the gender directorates of all 42 government ministries to train their own staff. Since this manual uses health examples, it will raise awareness about better health outcomes and gender as a determinant of health. The assistant director personally learned how to facilitate this training, use fishbone analysis and prepare manuals.

Gender effects from training were not acknowledged by respondents in Ethiopia, but the evaluators heard many comments about how participation in the LMG resulted in more equitable functioning of teams. Amhara RHB HR staff said that the training particularly benefited staff from lower levels not usually involved in such advanced training: They develop confidence and even start to challenge their leaders. A female janitor in a local hospital who participated in the training when employed at the RHB said, "I am important equally as the bureau head." When someone asked her what she did, she answered, "I am trying to explode the rocket to the moon," meaning that she paves the way. She knows how important janitorial work is: "Without sanitation there is not normal work in the hospital." This anecdote is an example of how participants perceive the effects of the training, even on the lowest workers in the hierarchy. Another HR employee remarked, "Everyone in the sector understands that leadership is important for ALL individuals—at all levels—not just the top. Starting with guards and janitors and the top leaders in one room at the same time. Every individual is a leader for himself." In Uganda, an RHU LDP+ facilitator said, "Once you get to the root cause, you understand how to solve it. It helps the team to continuously reflect on the team's abilities and their contributions. You can see how each one is making a contribution to the work." This informant went on to say that this builds the team and

enhances compliance among all levels of staff as the work progresses. Overall, the evaluators did not hear from any field respondents that the project had improved gender equity in their organization.

Conclusions on organizational capacity building: The evaluation team found strong global evidence across regions that the LMG leadership development approach—grounded in the principles of team-based self-assessments, an organization-wide assessment (OCAT), root cause analysis, setting challenges and measurable benchmarks, coaching and measuring results—was highly responsive to the 23 country programs and organizations with which the project worked over the 4.5 years reviewed.

The evaluation team learned that LMG approaches and tools work best when supervisors, managers and whole teams adopt them and commit time and resources toward meeting action-planning goals. The evaluators observed that the process works in small, medium and large organizations, but as several informants noted, it takes more time in larger organizations to reach consensus on vision and goals and to move toward action planning and results. Building national government and institutional consensus around leadership, management and governance practices, guidelines and approaches also takes time but can yield enormous benefits. Having internal champions, coaches and facilitators within organizations was also an important factor for success highlighted by key informants. Of all USAID staff contacted for this evaluation, 95 percent were satisfied or highly satisfied with LMG’s organizational capacity-development work. This report highlights LMG’s work with RHU, ACHEST, JCRC and ICRC.

QUESTION 2: LMG’S CONTRIBUTIONS TO THE AIDS-FREE GENERATION, EPMCD AND FP2020

This section describes interventions LMG provided to service delivery organizations, using examples from a range of countries, and reports on the results of this work in terms of changes in service quality and accessibility. In addition, suggestions are made for linking these organizational improvements to increased use of services and the potential for sustainability. It should be noted that the target population for LMG interventions is not the end-user or clinic client, but rather facility service providers and their managers in districts, ministries and other organizations.



RHU Kampala Training Center

The project took three approaches to strengthen service delivery organizations:

1. Training through experiential learning—using the LDP+¹⁹ and all its variants
2. Broad technical assistance by organizational development consultants
3. Long-term technical advisors embedded in the organization

Leadership, management and governance training: The main LMG capacity-building interventions for service delivery organizations (including government health services) is the LDP+. There are different adaptations of the LDP+, such as

“By its nature health centers are teamwork. [LMG training] increases the teamwork for the group to solve different problems... Training practically identifies those [bottlenecks] using the challenge model, focus on those that hinder the performance.”

—Amhara RHB staff

¹⁹ See *Developing Managers Who Lead: A Handbook*

the modular self-directed version in the EMP, Ethiopia's LMG, and the IPPF LDP+ adapted for IPPF affiliate needs. Much of LMG's work with service delivery units or organizations was to train trainers in the LDP+ process. The evaluators found that in some cases, organizations were first exposed to this approach through participation in a VLDP, which stimulated their interest, before engaging with LMG. One informant (an experienced LDP+ specialist and LMG staff trainer) noted that the LDP+ process is best suited to the facility level, where teams are formed to address a self-identified challenge that hinders success of their work. Indeed, the evaluators heard repeatedly of the improvements brought about by LDP+ participation: in teamwork, motivation and confidence in problem solving.

The training approach is learning by doing, i.e., experiential learning. Trainers go through the LDP+ workshop as they are trained, and many of those we interviewed said that this process not only improved teamwork and made them realize that they had the ability to solve their own problems, but also had ramifications for their personal as well as professional lives. This was true across countries, participant organizations and trainee levels.

Example: Creating a cadre of leadership, management and governance trainers to reach all levels of the health system: In Ethiopia, LMG is helping the FMOH develop a cadre of LMG trainers

(In Ethiopia this program is called LMG). LMG in-service training materials are being used to train trainers to deliver the LMG to senior health service leaders (RHB directors and staff) and mid-level health staff in district health management teams, and will be used to train health facility staff, although the training has not fully cascaded down to that level, because the TOT cadre thus far developed is not sufficient yet to meet demand. LMG has done in-service roll-out training with 1,382 health managers to build that cadre. These numbers are not easily translated into improvements in the services delivered by the health system until looking at examples of how this work is progressing and what the recipients say about their experience and new skills.

"[We found that] almost 75% of solutions are in our hands."

—Amhara RHB

Informants in key stakeholder organizations reported how successful the process was and how necessary it is to build a larger cadre of trainers in order to bring the training to the facility level. Forty-three percent of the LMG teams involved in the in-service rollout training organized by LMG chose to work on challenges to health service delivery, while other teams worked on improvements they felt were needed in their support services work, such as HR, finance and HMIS.²⁰

For example, the TB manager from a team in the Amhara RHB that was trained in the LMG process using the new Ethiopian curriculum reported that he selected as the first challenge for his LMG team how to better serve resistant TB patients. As he described it, this meant improving health promotion work to communicate better with colleagues in hospitals who had a fear of multidrug-resistant (MDR) TB patients. They needed to change provider attitudes, which they did by developing materials and promoting them more effectively. Hospitals were not designed to treat these patients, and there were only MDR treatment units in three hospitals, caring for only 54 patients. Because MDR TB is a big problem in the region, they needed to establish another five treatment units, so that they could go into the community and collect more of these patients, who should be hospitalized. As a result of their LMG action plan, the hospitals in the region are now serving 137 inpatients in eight hospitals.

A senior official in Ethiopia's HIV/AIDS Prevention and Control Office (HAPCO) reported that TB case identification increased, the treatment success rate improved, and the country increased the number of centers treating MDR-TBw from 13 to 26. Referring to the leadership, management and governance training plan, he said, "If they participate, they see how useful it is." This is corroborated by interviews in Harar and Amhara RHBs, which observed the training approach, met with participants who were very

²⁰ LMG/Ethiopia presentation to evaluators, December 2015.

happy, and wanted to expand this training. However, demand for this training exceeds the current supply of trainers.

A Special Support Unit (SSU) in the Health Systems Strengthening Directorate of the FMOH supports the four emerging regions. The evaluators learned from the SSU that teams going through the leadership, management and governance training took on challenges in many government priority areas, including service delivery (immunization, institutional delivery) as well as other support services. After nine months, they have seen good results in Afar. One team increased institutional delivery from 22 percent to 30 percent, identifying the root cause of the problem as lack of community awareness. They worked on social mobilization to improve community awareness of the need for a safe delivery in a facility, the main challenge being low uptake.

The SSU has tried to evaluate the districts that received LMG training and those that did not, and reported a big difference in team spirit and coordination, planning system and use of services like skilled delivery, family planning users and child immunization. For example, Penta3 coverage was 48 percent in one woreda prior to training and 72 percent afterward. According to the reporting checklist used at the region's quarterly review meetings, services have improved. This team reported improvements in managerial skills and in transparency and accountability, with medical equipment and drugs more fairly distributed to facilities, health posts and their staff. In some woredas in Afar, as mentioned earlier, the senior-level training is credited with creating a more conducive working environment and reduction in staff absenteeism. Health professionals began showing up for work, and facilities were open regularly, thus directly contributing to improved availability of services.

Other LMG partners in Ethiopia attested to the popularity and success of the training curriculum. Amref, an LMG Consortium partner, does facility-level training and provided an example of how facility teams can change their work practices and improve services. One team chose as their key challenge procurement of critical medical supplies and equipment. As a result of the LMG training, the facility started to prioritize what they needed to procure and were able to improve their stock of the most important supplies. Quality of services improved, because the facility had the most important material, a functioning supply chain and logistics system, and they were also able to procure a much-needed ambulance.

Amref also reports that it can carry on leadership training beyond LMG, and that being a partner in LMG helped Amref to enhance its visibility in this technical area. Last year Johnson & Johnson increased funding to Amref to further develop the practices of its training institute's alumni. Their one-week intensive management courses have trained 100 new leaders. With the Johnson & Johnson funding, Amref will do more, including setting up special events to bring the alumni together.

The LMG approach, with its key practices, has been adopted by the government for regions to use in implementing their work plans. The problem for Ethiopia is that this work has just begun; developing a national leadership, management and governance curriculum with a large technical working group and pilot testing it took almost two years. Demand for the training far exceeds the number of trainers thus far trained. More time needs to be built into the work plans for countries who want to institutionalize the modules into their formal educational structures.

Broad organizational development technical assistance to improve

organizational capacities: The evaluation

team saw examples of the broad range of technical assistance through short-term consultants that LMG provided to key service provision organizations in Uganda, for example LMG's assistance to the Joint Clinical Research Center (JCRC).

"The assessment tools MSH used produced a good diagnosis of the problems the organization faced. It was flexible and they were able to tailor the tools to the mission's needs with JCRC. JCRC was too big and important to fail." "[LMG] helped JCRC to become more mission driven rather than donor driven."

– USAID

The USAID mission thinks that LMG assistance helped JCRC ask some fundamental questions about its organization and to take effective corrective action. The technical assistance focused on sustainability and diversification of resources. One informant from USAID reported that it made JCRC think about resource mobilization, become more proactive and speak with more confidence about a clearer set of needs for other donors and for their board. The evaluation team that reviewed JCRC's work with LMG found that the LMG interventions made JCRC a more sustainable service provider and research organization.

JCRC: Increases in Service Quality and Service Provision to Support an AIDS-Free Generation

LMG provided broad technical assistance to JCRC in Uganda, the largest laboratory network for HIV testing and research in the country, and a key PEPFAR partner. JCRC trains health workers from across the country in laboratory systems strengthening, especially for HIV testing. Their hospital is also the country's only provider of advanced treatment for HIV/AIDS treatment failures. This organization is too important to fail. JCRC got an organizational makeover, including changing the organizational structure, hiring new staff and realigning tasks.

Staff participated in LMG's finance training, which introduced management skills that they in turn incorporated into their laboratory mentorship and "Strengthening lab management towards accreditation" training. JCRC received a revamped ICT platform; board training on management and risk assessment; governance tools; board manual; one-to-one consultant technical assistance; and developing or upgrading manuals for HR, finance, audit, procurement and inventory. Their systems for finance, laboratory and clinical services needed to be connected and made to work harmoniously. To build sustainability, it received assistance with its business plan, resource mobilization strategy and proposal writing.

One result of the assistance is that their systems for billing, lab and clinical services are working together. The links through the new ICT platform are improving performance: Doctors can find patient histories more quickly, records are linked to alert the lab to required tests, and results come back more quickly, resulting in better quality of care. The improvements have led to a 30 percent shorter waiting time for patients, improving satisfaction. The new ICT system enables them to give appointments to patients for future visits, which has improved the providers' own daily planning. In addition, each department now has better data and can show achievements against targets in business plans and annual reports.

Coaching of hospital department heads was said to be particularly useful; informants said it improved communication and supportive supervision. JCRC also says that since introducing the online system, there have been improvements in the quality of their internal controls. They have better financial management, with increased procurement efficiency and stringent inventory controls, all of which have increased savings. For example, expenditure on stationery has gone down by 50 percent, due to the new electronic record linkages.

Partly as a result of the business planning assistance, JCRC has introduced new services, including an advanced center for treating HIV failures under standard treatment from facilities across the country. In addition, JCRC has established new income-generating services that at the same time increased the number and types of services offered: a dental clinic, cardiac clinic, private pharmacy and private outpatient clinic.

Finally, JCRC developed a sustainability plan, and diversified not only service provision but also research, expanding from HIV to other diseases and conditions. This year JCRC has written 10 research applications and diversified its donor pool. Both prongs of income-generation activities have increased revenue, contributing to JCRC's sustainability as a key organization in nationwide provision of HIV testing and treatment services.

Another organization receiving significant LMG technical assistance is RHU, an IPPF affiliate. The following case study of this organization exemplifies how LMG's systems-strengthening interventions lead to improvements not only in increased organizational capacity and sustainability, but also in increased access to and use of family planning and reproductive health services, contributing to the FP2020 vision.

RHU is one of 42 IPPF affiliates in Africa and has 18 branches and an international Learning Center based at its headquarters in Kampala. The Learning Center conducts courses to strengthen family planning and reproductive health services and management, nationally and in neighboring countries. Since 2012, RHU has received a broad range of technical assistance from LMG consultants: LDP+ training of trainers, board governance training, strategic planning, HR strengthening, resource mobilization and advocacy for local and other funding. The evaluators found that LMG has been a catalyst for RHU growth, expanded services, and a move toward greater financial sustainability under stronger board leadership. According to a senior RHU official, “LMG reshaped our thinking. The most impact was at the branch/grass root level. LMG assisted us in helping us to articulate a common vision across the affiliate, set goals, focus on challenges and come up with solutions.”



Outdoor Display for the RHU, Uganda Learning Center

Since it began work with LMG, RHU has grown from tenth largest to third largest IPPF service provider in Africa. In Uganda, it is the second largest family planning and reproductive health service provider and operates in static clinics and outreach networks. During this period, RHU’s annual operating budget grew from \$3.0 to \$5.0 million per year. Local revenue increased by 35 percent between the first half of 2014 and first half of 2015 due to better fee collection and longer service hours.

In 2005, prior to LMG, an RHU staff member participated in a VLDP, and in 2010, 10 members of the senior management team participated in a VLDP focused on M&E. In 2013, RHU staff were trained as trainers in LDP+ and did 10 step-down trainings to six branch teams and their boards. RHU participants reported that the challenge model and root cause analysis were especially useful for analyzing problems and bottlenecks and plotting a way forward. Multiple staff described the LDP+ training as having “changed our organizational mindset and given us a shared vision.”

RHU informants attribute the following results to LMG’s technical assistance, tools and approaches:

- **Strengthened HR management systems** in the branches, fewer complaints to headquarters, less troubleshooting required from headquarters, and improved responsiveness from headquarters to resolve challenges and promote multitasking. For example, RHU driver duties have expanded; now they also carry out condom distribution and are champions of family planning in their communities. The headquarters receptionist in Kampala at the flagship clinic is also trained now to respond to some client questions with more in-depth information. The entire organization is now aware that educating clients and promoting services is everyone’s job, not just the job of providers.
- **Improved teamwork, work climate and staff attitudes and confidence.** A cleaner reported, “I have been in RHU for many years. I had never had an opportunity to be in the same training with my manager until the LDP+ training.” The LDP+ introduced innovation, enabling participants to identify challenges and their root causes. RHU headquarters staff report that branches now look for multiple ways to solve their challenges and engage the entire staff to come up with solutions.

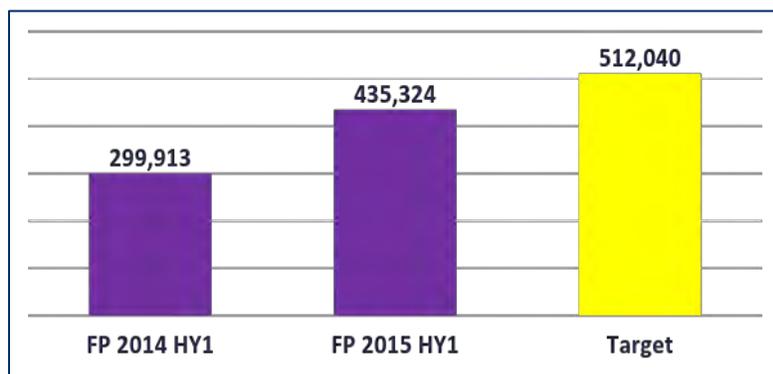
- **Increased stakeholder ownership and networking skills, better board participation, and interaction with staff.** An informant from RHU’s national board noted, “For years we had struggled with ways to advance the affiliate. The LMG training and subsequent work helped point us in the right direction.”
- **Improved service quality and increased access to and use of family planning services.** Specific challenges that LDP+ training teams addressed include drug stock-outs in Gulu, lack of coordination and teamwork in Luwero, low numbers of clients at static clinics and low demand for cervical cancer screening across the country. LDP+ is now used as a continuous improvement tool.

In Luwero District, visited by the evaluation team, over a six-month period in 2015, the clinic increased family planning clients from 256 to 1,756 per month. This branch also now offers daily outreach visits to neighboring and more remote communities in the afternoons, when their branch clinic sees fewer clients and agricultural workers in remote areas have returned home after work and can receive services closer to home. Other factors noted by branch staff as contributing to better service delivery outcomes were more effective use of volunteers to mobilize the population, more intensive and systematic supervision using checklists, holding weekly staff meetings to review workload and set expectations, and assuring that there is adequate staff coverage during scheduled staff absences.

Overall, an IPPFARO report states that RHU achieved a 250.5 percent increase in their service delivery results by developing new community partnerships and engaging vulnerable populations in decision-making regarding when and where they wanted to receive services. This led to an additional 50,608 family planning/reproductive health clients being served in all six RHU clinics where teams had participated in the LDP+ over the period of implementation.²¹

Figure 5 displays RHU’s data documenting the increase in family planning services provided across all branches between the first half of 2014 and first six months of 2015. Figure 6 shows a doubling of IUD insertions and more than doubling in use of injectables over the period.

Figure 5. Family planning services provided, RHU

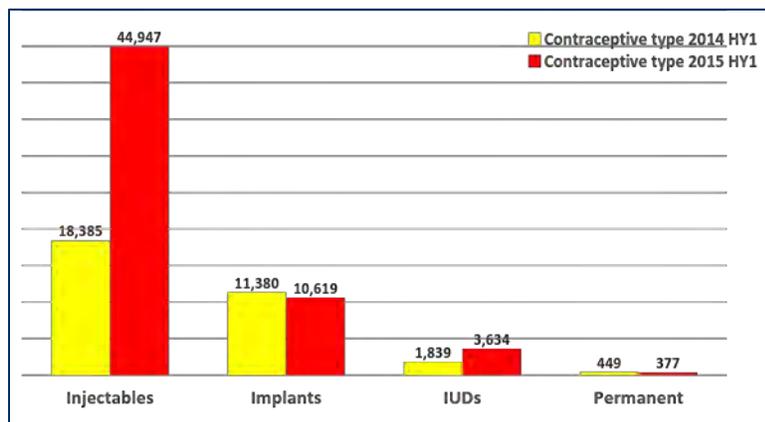


HY=half year

Source: Reproductive Health Uganda

²¹ IPPF/AFR. n.d. *LMG Qualitative Learning Centre Report: Developing capacity among IPPF Learning Centers, evaluative report.* p. 6.

Figure 6. Long-acting contraceptives provided by RHU, 2014 and 2015, first 6 months



HY=half year

Source: Reproductive Health Uganda

The senior management team reported changes in other aspects of RHU’s functioning:

- The RHU finance team credits scoring well on the NUPAS with **improving the organization’s reputation, making it easier to receive funding from other donors**, such as PATH and UNFPA. An initial assessment, action planning and a post-action assessment increased compliance with USAID regulations. RHU is using the NUPAS assessment as a fundraising and marketing tool, and says that it helped it win two awards from the Uganda Institute of Certified Public Accountants. IPPFAR noted, “RHU has set the bar for IPPFAR affiliates on improvements in its financial management and internal controls for other IPPF affiliates.”
- **Business planning technical assistance** has helped RHU’s Learning Center to package training courses for income generation beginning in 2016. RHU will develop an institution-wide business plan for 2016, coinciding with development of its strategic plan. This includes a costed strategy to scale up its model for outreach camps in order to offer services to more hard-to-reach communities, increasing access and efficiency, while reducing costs and building partnerships with districts.
- **Strategic work plan development**, another result of the LMG intervention, is ongoing and includes upgrading of clinics to make them more viable through infrastructure development and purchase of equipment. This strategy for improving the quality of service delivery is intended to attract more clients who can pay higher fees. Through this strategic plan, RHU also intends to introduce new services, such as ultrasound, that can generate more revenue.
- Regarding **board governance**, LMG built on the existing strong IPPF governance guidelines and revised the governance manual. The LMG tools and LDP+ training led to the affiliate’s adoption of more rigorous guidelines. These included LDP+ trained team members taking the initiative to reinforce the organization focus on risk management, which is now integrated into the reporting system. There is also clear segregation of duties between the board and the CEO. After the board training carried out by LDP+ trained RHU staff, RHU staff and some board members trained all branch executive councils and recruited an internal auditor, helping RHU prepare for the next round of IPPF accreditation in 2016.
- Other activities undertaken with LMG support are youth leadership peer coaching, which aims to build a society of leaders as part of the IPPF International Youth Action Movement, and a women’s

mentorship network. This new effort will build on the experience of the LMG East Africans Women’s Mentoring network, which used an online platform to share knowledge, skills and competencies.

The future for RHU: “Aim high.” RHU senior managers’ long-term vision is to be fully sustainable, with a mix of internally generated, local development and IPPF funds and less dependency on external donors. They are focused on improving efficiency, effectiveness, cost containment and increased revenue generation from service provision. They have seen UNFPA funding increase from \$200,000 per year to \$1 million per year for the next three years. Local income increased by 35 percent, from 296,304,454 Uganda shillings in the first half of 2014 to 400,353,729 in the first six months of 2015 (\$20,000 to \$200,000).²² This was made possible by major improvements in branch fee collections. In Luwero branch, for example, staff reported that in just one year, collected fees for services went from 9.6 million shillings to 16.1 million shillings.

Scaling up the RHU model in IPPF affiliates: This work with RHU is having a multiplier effect in IPPF affiliates in Africa. IPPF reports that RHU trained Tanzania and Malawi affiliates in the LDP+ process using IPPFARO’s own funds (\$375,000). IPPF leveraged Swedish AID resources to scale up leadership, management and governance work with Learning Centers in Kenya, Ethiopia, Togo, Swaziland and Côte d’Ivoire. Business planning orientations have been conducted for the IPPFARO Learning Centers. Two have developed business plans. Further business planning took place in 2015 in 10 other member associations. Like RHU, the IPPF Learning Center in Ghana identified business planning as a product it can offer to organizations as a means of contributing to improved health, service delivery and income generation. IPPFAR’s plan for 2015–2019 is to roll out LDP+ and business planning to its entire network of member associations; larger ones will receive both LDP+ and business planning workshops, while smaller ones will receive one of these types of training.

Other affiliates report the numbers of family planning acceptors are increasing, but precise figures were not available at the time of this evaluation. More work with IPPF could profitably be done to improve the data. At the moment, the only national figures the evaluators have seen for member associations come from RHU.

In addition to RHU, IPPF organizations in Kenya, Mozambique, Cameroon and Ghana have been assessed using the NUPAS tool, and their financial systems found to be robust.

Expanded use of tools, especially LDP+, continues and attracts new training capacity: The LDP tool developed by MSH and updated into the LDP+ in LMG, has gained wide acceptance in some countries through use in other MSH projects. A good example that demonstrates how the process affects service quality and increases use of key reproductive health services happened under the STRIDES project in Uganda, which used the LDP to train providers in key district facilities. ACODEV, a local training organization headed by an LDP alumna, participated in the LDP training of trainers to become STRIDES trainers, liked it and incorporated it into its own training program. Since then ACODEV has applied the LMS/STRIDES leadership model to projects in agriculture, youth and education. This local organization has expanded its portfolio to provide leadership, management and governance training, writing a national curriculum for in-service leadership training. As one informant told us, “Leadership is a living thing and you need to build it at the facility level.” In 2013, ACODEV spun off the African Center for Leadership, a leadership center of excellence that now has 42 staff and an annual

“Previously they thought it was the work of managers, now they have realized they need to take charge. All employees have job descriptions. LDP has brought in big changes. Health workers only learn clinical skills so the training is very helpful in equipping them with leadership skills.”

–Nurse and trainer, Kagondo

²² Data provided to evaluators from presentation to RHU’s Advisory Board.

budget of \$1.0 million, working in Tanzania, eastern Congo and Rwanda. Some of the funding comes from PEPFAR through Ugandan HIV/AIDS organizations. Among other clients, the Ugandan ministries of education and gender are now using these ACODEV services, and local organizations now exist to provide leadership, management and governance training.

In Kagondo Hospital, staff teams, including heads of departments, participated in rollout LDP training. Maternal and child health staff were concerned about the low uptake of family planning services and the many women coming to deliver who had unwanted pregnancies. The LDP training led staff to use village health workers and take a community approach to mobilize women to come to outreach services. New family planning methods were introduced (implants), and sterilizations and IUD insertions increased. According to a nursing sister at the hospital, uptake of family planning increased by 30 percent and has been maintained. Most departments improved quality of care and increased their client load after the LDP training. This experience led to interest from the local district health team, which saw how the village health team (volunteers) encouraged male involvement in accessing health services such as antenatal care, delivery and Option B+. A supervisor from a regional hospital where these interventions took place noted, “Staff feel that their work is not only a salary, but is also about saving a life.”

District Health Management Teams (DHMTs) are at the forefront on policy issues. As an MSH consultant close to the project told us that prior to the LDP training in Kagando Hospital, in which DHMT members participated, the team did not meet unless the district health officer was present. After participating in the LDP, DHMT members realized the need for delegation and improved communication, especially the importance of village health teams attending facility meetings. This has provided further impetus to ongoing discussions in the MOH about integrating village health teams in the MOH as a paid cadre. The DHMT requested MSH to come and participate in the training again, but there was no funding for that.

“STRIDES has come and gone but at district level people have taken on the LDP messages and internalized the lessons of LDP.”

–MSH consultant, Uganda

Embedded technical assistance: System-strengthening technical assistance indirectly contributes to better results of malaria treatment and prevention. In addition to training and technical assistance, another method LMG adopted to provide support was to embed technical advisors in government units.²³ LMG supports LMG/PMI advisors embedded in seven NMCPs in non-focus PMI countries and one focus country (Liberia) that have Global Fund malaria grants. The goal of the assistance is to strengthen each country’s grant performance.

The NMCPs receive Global Fund grants, but no USAID PMI money (because they are PMI non-focus countries). Starting in 2012, the advisors’ role has been to help the units manage their grants, assist with writing concept notes, and develop budgets. They also help the NMCPs construct resource mobilization plans with other donors and stakeholders. Interviews from the evaluation contain numerous testimonials to their abilities and work methods: A USAID mission staff member reported, “I have gotten good verbal feedback from the NMCP about LMG. LMG’s technical assistance is most appreciated. When the [government] sees LMG at work they see USAID...LMG has made a difference in my work.”

The Global Fund noted that as a result of the technical assistance, there was significant improvement in the quality of countries’ quarterly reports. NMCPs were helped to restructure and reach Global Fund milestones. Technical assistance was provided to help NMCPs work together to create strong organizational capacity. In Sierra Leone, the LMG advisor helped the NMCPs retrain all the government accountants. In Burundi, NMCP reported that it needed help in strengthening its finance system and accountability to qualify for the Global Fund grant, and the LMG advisor gave them these skills: “We

²³ Besides the NMCP example that follows, others include with HAPCO in Ethiopia and in Afghanistan.

asked for a financial expert and got one. LMG trained a core group of MOH staff to facilitate and do more LDP training. These TOTs will be funded by the [Global Fund].”

An LMG employee in one country reports: “The NMCP loved the LDP+ and those tools and the challenge model are now routinely used in their work for problem solving. The NMCP organized a TOT group so that they could carry on without MSH.” Another says, “When I got to [country X], the NMCP had no communication across departments and no mass media strategy for their malaria campaigns. Now they do. This was part of their action plan and challenges [in the LDP+ workshops].”

“Co-locating TA [technical assistance] is important because you need to sit side by side with coworkers and live their reality. Flying in consultants doesn’t work. TA needs to be flexible and practical. The NMCP we found had tons of resources, they just were using them poorly.”

–LMG staff member, West Africa

As a result of LMG technical assistance to the Ministry of Health by LMG/Cote D’Ivoire, a high-level official in Côte d’Ivoire close to the MOH’s Director General participated in all six modules of the LDP+, and the Director General himself participated in one module. This respondent reports that the LDP+ was seen as so important that Côte d’Ivoire advocated for the Global Fund and the EU to provide further funding to increase training.

Among reported NMCP results, the Côte d’Ivoire advisor said: “We deepened our outreach to remote rural areas and did better case management. We also brought the private sector onboard. [NMCP] is mapping locations of all private sector companies and clinics so they can count on them to help during campaigns and routine IPTP. There are 60 private companies.”

“LDP+ has been a great tool. LMG helped us to improve employee governance at all levels. The DG [Director General] lobbied other donors including the GF and the EU to fund through a line item in their budgets for more LDP+ assistance across the ministry and the new decentralized regions.”

–MOH official, Côte d’Ivoire

The challenge model is a key part of the LDP+ process, and the LDP+ training for NMCP staff in Côte d’Ivoire provides examples of the service delivery challenges chosen by the teams: “The proportion of pregnant women who visit health facilities and receive the three doses of SP [sulfadoxine-pyrimethamine] increases from 17% to 22% in one region, and from 25% to 30% in the second region.” These teams succeeded in reaching at least 80 percent of their challenge goal. Between March and September 2015, the first team reached 27 percent coverage, exceeding their goal of 22 percent, and the second team reached 27 percent.²⁴ These examples show how improvements in teamwork and problem solving built into an action plan contribute to improvements in service delivery.

In Côte d’Ivoire’s 2014 annual malaria report, the government reports that intermittent preventive treatment for pregnant women has increased from 46 percent in 2013 to 57 percent in 2014. MSH is cited in the report, credited with having helped to develop job descriptions, resulting in an increase in management staff. The NMCP feels so confident that it says it will not need an advisor after LMG ends.

In Haiti, LMG demonstrated other ways the embedded technical assistance works to improve service delivery results. LMG has been a key partner with the World Bank, Global Fund and other USAID projects to co-finance the MSPP-led RBF, which uses common indicators and methods to pay provider organizations based on performance results in different regions of the country. LMG’s long-term technical assistance helped the MSPP revise the essential package of services for districts and health facilities at different levels and a dashboard for the MSPP Director General to track all health service performance. (At the time of writing, neither of these initiatives has yet been finalized.) The advisor helped draft the national RBF guidelines, now found on MSPP’s website. An MSPP informant said, “The RBF approach will have an impact on the population as each department and unit have targets and agree

²⁴ LMG. “National Malaria Control Program Capacity Building Project, Côte d’Ivoire.” Presentation. January 2016.

how they can spend their scarce funding to achieve results. If some facilities don't come up with targets they get cut off."

LMG's work on the Global Fund grant in Haiti improved coordination of HIV/TB and malaria services. An external verification agency was set up to oversee results. The advisor works with both the contracting unit and the health operations unit, resulting in better reporting, more joint supervision by HIV/TB and malaria teams, more testing for TB at HIV sites, and, for the first time, a joint HIV and TB plan for treating HIV/TB co-infection. USAID/Haiti reports, "All of the work with the central MSPP has an indirect impact on health service and overall MOH performance."

QUESTION 3: LESSONS LEARNED ABOUT HOST-COUNTRY OWNERSHIP, SUSTAINABILITY AND REPLICABILITY OF TOOLS AND APPROACHES AND SUSTAINING GLOBAL SUPPORT FOR LEADERSHIP, MANAGEMENT AND GOVERNANCE

Overview: Numerous lessons can be drawn from the LMG and LMS experiences over the past 10 years about host-country ownership, scale-up and sustainability, replicability of LMG tools and sustaining global support for leadership, management and governance. Both projects demonstrate the feasibility of integrating leadership, management and governance curriculum and practicum into pre-service and in-service medical, nursing, pharmacy and public health schools in six countries, thereby contributing to the next generation of providers and leaders who can manage. LMG research in selected countries, 36 papers, the rich LeaderNet platform, publications and 82 tools all offer the health field the materials and evidence needed to continue leadership and management work. LMG, through its successful cost-share agreements, has generated \$22 million to match USAID's impressive investments in this important area. Equally impressive have been other donor commitments to future training, scale-up, and incorporation into: Global Fund grants (the Global Fund and EU in Côte d'Ivoire); MOH central and regional and local budgets in Ethiopia; IPPFAR affiliates' budgets; the roll-out of IPPF Learning Center leadership, management and governance courses; ALERT's Africa Research and Training Center management courses; and Amref's Leadership Institute, which draws on private sector financing from Johnson & Johnson and private contributions and fees. AHLMN disseminates leadership, management and governance modules and tools to 26 African universities, which has the potential for a large outreach and continuous updates once fully operational. Finally, while private sector training institutes were not a key target for LMG, the evaluation team met with a private sector training organization in Uganda, ACODEV, whose founder was originally trained years before by LMS through a VLDP and who is now offering regional courses within Uganda and to neighboring countries through its five Learning Centers. USAID complementary bilateral and field support investments have taken the LDP+ model of challenges, root causes and work planning to scale in the Hospital Autonomy Project in Afghanistan, the STRIDES Project in Uganda and the Decentralization Project in two regions of Côte d'Ivoire. Côte d'Ivoire's MOH Director General's Office reports that he lobbied to get more funding from the Global Fund to incorporate LDP+ training in the TB Global Fund grant and plans to include it in future decentralization work. Evaluators also learned that MSH had signed a direct technical services contract with the MOH financed independently by the government.

Host-country ownership and sustainability

A good test of sustainability is when countries and organizations take to scale the tools and approaches they have received. The LMG Project has numerous examples of host-country and CSO ownership and use of their own funding for LMG tools and approaches.

The most striking example of country ownership evaluators encountered is the development and use of an Ethiopian version of the LMG (LDP and SLP) training curriculum. Ethiopia's Health Sector Transformation Plan (the current five-year health strategy) identifies leadership and management as a

critical gap in the HR plan for the health sector.²⁵ The Ethiopian FMOH identified the need for leadership, management and governance training and decreed that there would be one curriculum, not many different training courses delivered in hotel venues by different contracting organizations. The FMOH established and led a technical working group, which LMG participated in, to develop the curriculum. The training materials, including facilitator and participant manuals, were then developed by the technical working group under FMOH leadership and supported by LMG. The full set of materials developed by the government-led technical working group was endorsed by the FMOH as a country resource. These materials are being used to train trainers to deliver the LMG to senior health service leaders (RHB directors and their staffs), mid-level health staff in DHMTs, and eventually will be used to train health staff at the facility level.

The Ethiopia FMOH implemented a nationwide roll-out of senior leadership training for all RHBs, and LMG for other public managers. The former and current ministers of health participated in this process. The FMOH put in place mechanisms to ensure the roll out of in-service training to the facility level, and provide pre-service training to students in training to become health professionals at various levels. While the pool of master trainers is still not enough, leadership, management and governance training is in high demand and requires more time to help the FMOH, RHB and university trainers to fully consolidate their skills. This is especially the case in the four emerging regions in Ethiopia under the HSS SSU, which have the weakest health indicators, lower overall education levels and other cultural and religious barriers to health care access. These regions have 169 districts but only 20 LMG trainers.

LMG assisted the FMOH Medical Services Directorate in improving guidelines for implementing hospital reform in nine clinical areas. The hospitals revised and added some missed components in management areas, now increased to about 18 components. Previous implementation of these guidelines was poor, but LMG helped draft revisions and trained hospital teams to understand their work and environment. According to an informant from this sector of the FMOH, between nine and 13 hospital teams identified and addressed gaps in the guidelines and communication barriers between clinical and non-clinical teams and the senior hospital leadership. These interventions increased the speed of implementation of the hospital reform guidelines, he said. The graduate team in Mekele–Ayder University Hospital increased the implementation of reform guidelines from 31 percent to 72 percent of the new standards; the hospital established a new governing board and has a plan to train it.

Other examples of country ownership and potential for sustainability:

- The Côte d'Ivoire MOH adopted the LDP+ across all Global Fund grants, including in the new malaria and TB grants, and is contracting MSH for services to have the LDP+ program rolled out in the country's next phase to scale up decentralization of health services.
- The Director General for Health in Côte d'Ivoire is using leadership skills and improved outcomes of the NMCP to lobby for more staff for NMCP. The government has also allocated funds within its own budget for technical assistance to scale up LMG tools and training and is in the process of directly contracting for services.
- In Afghanistan, LMG trained and helped establish the MOH Community Health Department, which oversees the 30,000 citizen village health worker program that has become a model for the government's rural outreach National Citizen Charter program.

²⁵ Federal Democratic Republic of Ethiopia. Ministry of Health. 2015. *Health Sector Transformation Plan (2015/16–2019/20)*. Leadership, management and governance section. pp. 51-53.

- ICRC will begin discussions with LMG about rolling out the EMP leadership program to the next phase of countries in South and Central Asia and formally adopting the package, including creating a core group of EMP trainers.
- The disability senior leadership committee of Togo, who participated in the SLP, secured a line item in the national budget for disability program implementation, including supplies, and negotiated with a leading disability device supplier for a five percent reduction in the purchase price of supplies.
- Haiti is scaling up the RBF and contracting that LMG set up and piloted. The World Bank and the EU will contribute and partner with the MSPP and USAID for the scale-up.
- The contracts and grants units set up with support of LMG in Haiti and Honduras, and supported in Afghanistan²⁶ are now processing health sector grants to NGOs the ministries of health in these countries.
- IPPFARO raised other donor financing to spread leadership, management and governance work and tools to additional affiliates in Africa. Four of their seven Learning Centers were trained in the LDP+ and received LMG's business-planning technical assistance.
- LMG supported the Public Health Officer Association in Ethiopia to establish public health officer training in higher learning institutions in six regions. LMG strengthened the governance capacity of the board and supported an annual conference that will bring together 500 health officers from across the country. The association has about 1,500 members and depends on membership fees. It expects to raise \$200,000 from the annual conference, around 90 percent of its annual budget. It has now graduated from LMG assistance and is fully operational.
- While LMG has worked with AHLMN, which has as its mission channeling educational materials and state-of-the-art approaches through its membership network of 26 African universities and NGOs, more technical assistance and funding channeled through Amref, the AHLMN chair, is needed to fully sustain and nurture this network to fully operationalize the platform.

Replicability of tools and approaches

The LMG and LMS projects produced 82 tools (Annex VII). Several assessments of the efficacy and replicability of specific tools were made during the two projects, including the LDP, SLP and pre-service university-level leadership and management training rolled out in six countries. The evaluation team reviewed these assessments and confirmed their conclusions through site visits to training centers in Ethiopia and the Uganda Learning Centers, meetings with coaches and trainers gathered at the DCHA-financed francophone SLP course, and both virtual and direct feedback received during key informant interviews with providers, public health managers, MOH officials who had participated in the training and NGOs. Ninety percent of the host-country respondents reported their use. The LeaderNet platform captures the number of hits for specific tools. LeaderNet is a global resource used in 142 countries that has 2,322 individual members who are accessing tools on their own, and 601 members have “friended” one or more other members.²⁷ All of the regional professional organizations contacted for this evaluation were using LeaderNet and saw it as a resource for their work. Of these, the group that has the most potential to spread and replicate the LMG archive and learning tools is the AHLMN.

A September 2015 qualitative assessment of the LDP and the LMG tool for strategic planning reviewed performance of the tools in Nepal and South Africa. The assessment found that beneficiaries in both countries reported a “wide range of individual, organizational and health delivery outcomes.” They also

²⁶ In Afghanistan the grants unit was supported by LMG but was set up by MSH prior to LMG.

²⁷ LMG LeaderNet data as of December 14, 2015.

noted that the LDP+ “achieved time savings,” and that organizations reported an increase in their service-generated revenue.²⁸

USAID field missions were also asked which tools they perceived to be the most useful and replicable in their country and regional programs. Twenty-seven percent of the USAID field missions queried among the LMG countries indicated that they have witnessed a scale-up of the LMG models. Of the tools used in USAID country programs, the field respondents indicated that the governance guides and the OCAT were the most useful tools, used by 50 percent of USAID-funded grantees, while LDP+ was used by nearly 30 percent.

LMG created a tailored EMP toolkit for the ICRC PRP and SFD to use and roll out to partner physical rehabilitation centers in the countries where they work. The first set of EMP training teams were from Ethiopia, Myanmar, Tanzania, Togo, and DRC. A senior leadership program, also tailored to the ICRC, was developed and has been done three times for a total of 15 ICRC country teams (4 in the first program, 5 in the second, and 6 in the third). Within the PRCs rolling out the EMP, the EMP will serve as a strategic planning, work-planning and problem-solving tool to advance service delivery and quality improvements for persons with disabilities to regain their mobility. Discussions with ICRC are underway to roll out this EMP framework throughout its PRC global network of partners. The second EMP training of trainers is set for early 2016 for teams from Cambodia, Madagascar, Pakistan, Tajikistan and Vietnam.

“The LMG training (LDP+) made it possible for my team to work together on a shared vision and set of actions and to better share the workload. As a result of LMG we are now expanding the number of FP services offered.”

–Family planning provider/ supervisor,
Luwero, Uganda

The IPPF Learning Centers are phasing in the roll-out of the resource mobilization tools and the NUPAS vulnerability assessments, based on their successful pilot in RHU’s Learning Center. Other organizations, including ACHEST and JCRC (Uganda), ALERT (Ethiopia), the MOH in Côte d’Ivoire, MIUSA and CVT, commented on the useful training they received in resource mobilization and its effects on their own ability to mobilize new resources.

There was near unanimous consensus from host-country users of the LMG tools that the participatory adult learning approach was new for many countries and was essential to break down communication barriers across teams. Over the life of the project, LMG trained more than 2,700 adult teams. Respondents said, “The training was life altering,” and it “changed the whole dynamic of our organization.” In some cases, the participatory approach used in the LDP+ made it possible for women managers and providers to speak up and contribute to their organization. Three examples observed by the team during sites visits included women managers taking charge of their teams’ successful attainment of objectives (Harar and Oromia RHBs). The women reported greater confidence after the LDP+ training. A common thread through all country interviews is that LDP+ and SLP unleashes the power within each individual participant to think through how to change their work situation to reach common goals. While in the U.S. and Europe many workplaces give employees the opportunity to do team building and team-based strategic planning, none of the countries surveyed for this evaluation used these techniques or had these opportunities prior to LMS or LMG. Moreover, as several respondents noted, many organizational cultures where USAID-funded projects operate frown on subordinates making decisions or questioning a supervisor. A respondent from Ethiopia’s pan-African training center (ALERT) who chaired the technical working group on in-service training for medical doctors, nurses and pharmacists noted that in general, management and governance were not part of the core curriculum for health professionals, and that the five principles of governance covered in the

“LMG gave me the opportunity to see my boss’s face for the first time. Before LMG I had not done so.”

–East African respondent (female)

²⁸ LMG Assessment of LDP+ and IST. September 2015. p.2.

LMG governance manual were not addressed at all and were identified as gaps in the national training programs. Therefore, the LMG assistance in creating governance tools met a great need in Ethiopia's health training program.

Other widely used tools were the governance manual adopted by the Government of Afghanistan. The manual and its approaches were also used in the 11 autonomous hospitals and nationwide for provincial health authorities. The gender manual developed by LMG with the FMOH in Ethiopia is also being used nationwide as the national gender-training tool. The LMG RBF tool developed in Haiti and successfully piloted in several regions is now being taken to scale across Haiti with funding from multiple donors, including the World Bank and the European Union. As one respondent familiar with LMS and LMG tools who worked with the LMG consortium said, "The tools for LMG were developed and tested by health providers and managers across the globe and therefore are highly replicable." In terms of senior leadership training modules, the entire senior leadership team of Ethiopia's FMOH, including the former Minister of Health and all RHB teams across the country have been trained in SLP and LMG.

The quality and the simplicity of the tools also made them highly adaptable to all country situations and easily translatable into local languages. In Ethiopia, the LMG tools have been translated into Amharic and other regional languages.

Of all the tools mentioned by respondents, the two found to be the most difficult to replicate or sustain were the HIV/AIDS dashboard tested by RHU and the HIV/AIDS Provincial Planning Simulator used in Vietnam (see text box). Once PEPFAR funding ended, the RHU team determined that the dashboard needed to be modified to take into account family planning and other indicators. The RHU liked the dashboard approach so much that one of their logistics staff created a stock inventory dashboard. Similarly, in Vietnam, the scale-up of an HIV staffing forecasting tool is taking place (see text box).

A key challenge the Government of Ethiopia (where the LMG curriculum is widely used) is facing is the limited number of trained facilitators and coaches to support the high number of trained teams. ICRC coaches for the EMP also noted that the EMP process requires considerable time and coaching but is worthwhile because it builds the team commitment and ownership needed to get PRCs' work done on a sustainable basis. Some countries, e.g., Myanmar, decided to collapse the introduction of the 10 EMP modules so that they could complete them sooner.

The applicability of the governance tools, particularly in post-conflict settings, was noted as a plus by a DCHA liaison for GH. He noted the applicability and utility of the LMG tools, particularly those linked

Transition to Sustainability for Vietnam's HIV/AIDS Program

Multiple informants noted that Vietnam has recently been classified as a middle-income country. As a result, the national HIV/AIDS program embarked on a transition toward greater self-financing. This implies shifting from an emergency response approach to one that is less reliant on external donor financing and locally sustainable, with a focus on continued effectiveness, increased efficiency and decreased dependence on external assistance (LMG Transition Support Project End of Project Report. Oct 1, 2012–Sept 30, 2014). LMG used the Workload Indicator Staffing Needs (WISN) tool to determine how many workers per cadre are required to deliver the HIV/AIDS services currently delivered in Hai Phong, a PEPFAR priority province. This followed a review and discussion of the workload analysis in HIV service delivery facilities in HCMC to identify next steps for HR transition planning. LMG also developed a stakeholder engagement planning tool to support provincial planning of HIV/AIDS services. The results of the tool's implementation were accepted and approved at the highest level of government and disseminated to all stakeholders. Government capacity improved, because it collected the data itself and now knows how to use the WISN and HIV planning tools. However, the implementation period was very short, so sustaining and scaling up use of these tools nationwide might be a challenge.

to transparent management practices and good governance, as relevant to other areas of USAID democracy work.

LMG and LMS project contributions to the global knowledge base related to investments in organizational development, health, management and governance

LMG plan for producing evidence to contribute to the knowledge base: The LMG MER strategy was developed in PY2. It was not a deliverable, but was used by the team to think through its approach to answering research questions. LMG aimed to be able to generate, synthesize and use information and data about the value of leadership, management and governance interventions for health system performance and health outcomes. The strategy to achieve IR2, “Advance and validate the knowledge and understanding of sustainable leadership, management and governance tools, models and approaches,” listed the steps the team would take:

- Articulate a theory of change or logic model for the field support projects, linked to the overall PMP.
- Look for opportunities to conduct operations or other research studies. (Engage with missions and technical team for support.)
- Disseminate and incorporate findings into technical strategies in other field support and core-funded activities.

The strategy articulated several key principles to guide the work, important for tracing a causal pathway between LMG interventions and service delivery outcomes:

- Identify and refine common indicators.
- Make measurement rigorous, using appropriate methods to answer questions.
- Shift from retrospective to prospective measurement, evaluation and research.
- Work with academic partners and local partners to answer questions of interest.
- Use evidence to shape LMG’s advocacy and communication.

With Johns Hopkins University, LMG developed a research agenda, based on the project’s conceptual framework and a systematic review of the evidence. LMG/MER documents demonstrate that the team and their partners took IR2 very seriously and designed a plan for research studies, applying findings from the systematic review, which was quite complex.

Figure 7. Strategy and technical approach: The evidence continuum



How has the program affected you as a health leader, manager or service provider?

How does implementation of the program lead to effects on health behavior, services or status? What describes the context in which implementation occurs?

Are indicators (at the facility and beneficiary level) of a program that is being implemented changing?

Has health service delivery or performance improved due to implementation of the program rather than other causes?

As the “evidence continuum” in Figure 7 demonstrates, LMG and their research partners started off with idea that the project could do randomized controlled trials to produce solid evidence of intervention effectiveness.

LMG’s Evidence-Generation Continuum:

How has the program affected you as a health leader, manager or service provider? What describes the context in which implementation occurs? *Anecdotes, testimonials, case studies*

How does implementation of the program lead to effects on health behavior, services or status? *Post-intervention measures, pre/post measures in intervention sites*

Are indicators in facilities and beneficiaries of a program that is being implemented changing? *Pre/post and intermediate service delivery (and health) outcomes in intervention sites; longitudinal, mixed-method research in intervention and comparison sites*

Is improved health service delivery or performance due to implementation of the program rather than other causes? *Pre/post and intermediate service delivery (and health) outcomes in intervention and comparison sites*

Early in the project, a lot of time was devoted to trying to get such studies off the ground, one MER team member reported. The MER team paired these research questions with projects where studies could be implemented, developed concept papers, and proposed studies (to be done with Johns Hopkins University) to missions in Ethiopia, Kenya and Afghanistan, among others, but the complex designs and need for large sample sizes led the missions to respond that the budgets proposed—e.g. \$550,000 per year for two years—were “too much for research,” and, “Can’t you do this cheaper?” As an MER team member reported, “[There was] a lot of sticker shock about implementation research from the missions.” Ideas were of interest to missions, but they were not interested in funding them. As a project partner reported, implementation of research had to rely on mission interest, so in the end Johns Hopkins University did not do any of the research it had expected to do.

Rethinking the research agenda: By the end of PY3, the project still did not have research to demonstrate the added value of leadership, management and governance. The team went back to the drawing board, revisiting what is defined as “effective.” The project wanted to see service delivery improvements, but interventions were more distal. Trying to connect to service delivery is difficult. A USAID field informant said, “Some elements, like logistics, are very clear on how they impact health outcomes (e.g., “no product, no service”). It is harder to see the LMG contribution.”

The project recrafted several research ideas, and four were approved for funding:

1. A database to generate evidence of LDP implementation (LDP, LDP+, VLDP, SLP)—Desired Measurable Results: As mentioned earlier, the Desired Measurable Results database is the way the project decided to measure improvements in what LDP+ teams identified as their challenges. The database is underway, and LMG agreed to provide some preliminary results by HSS building blocks to give an idea of the results of the exercises across the hundreds of teams trained to date. One example is that among the total teams reporting Desired Measurable Results in PY4, 125 (51 percent) specifically identified their challenge as related to family planning or maternal and child health. However, many other teams reported indicators that have an effect on delivery of services, such as patient satisfaction, quality of care, or HR management, which would also affect family planning service delivery. LMG is cumulating these measurable indicators from all their country teams now and will review the quality of the data before releasing a comprehensive report.
2. A survey of youth leadership (programmatic review mid-term report, 2015)—a survey of two youth networks (International Youth Alliance for Family Planning and YHRC): The purpose of this study is

to identify promising models of youth leadership development. Key findings describe how the programs in youth leadership operate, and how youth who “age out” continue to be involved. Due to a low response rate, LMG will relaunch the survey and share further findings in PY5.

3. A formative study of influence of gender among the family planning workforce: Key informant interviews and a literature review of gender norms and supportive supervision led to the development of a paper describing a theoretical framework meant to shape implementation research and provide guidance for future gender-sensitive and transformative family planning HR management interventions.
4. A core-funded study of the added value of LDP+ to postpartum family planning service delivery in Cameroon: The purpose of this study, just reporting preliminary results now, is to evaluate the added value of a leadership, management and governance capacity-building intervention to postpartum family planning service delivery within maternal, newborn and child health departments of tertiary hospitals in Yaoundé. In a sample of six hospitals, it uses mixed methods to address the following questions:
 - What are the content, contextual and process barriers or facilitators to postpartum family planning service delivery?
 - How does LDP+ training influence hospital leaders’/managers’ attitude and practice toward postpartum family planning provision?
 - How does leadership, management and governance capacity building influence hospital work-related stress in the context of postpartum family planning integrated service delivery?
 - What influence does leadership, management and governance capacity building have on postpartum family planning service delivery outcomes?

The sample consists of three arms: two hospitals that received clinical family planning training and commodities only, two that received those interventions plus the LDP+ training, and two that received commodities only as control sites.

The study’s underlying premise is that LDP+ in all adaptations or versions, including LDP+, SLP and EMP, institutionalize certain behaviors, practices and strategic thinking in health sector. People gain skills that translate to behaviors/practices, and in turn will transmit them to service delivery through a series of pathways. The study uses a behavioral assessment tool, which the MER team feels has been a contribution to the field. (To develop the instrument, the team held a workshop with LDP+ practitioners, asking what kind of changes they have seen, clustered the changes by practices/behaviors, and from these, a scale was created to measure them.²⁹) The team noted that LDP+ is also effective in creating other results, such as team coordination, but it is harder to measure such effects.

By end of project, LMG had started to gain evidence, and the following two figures show just a few preliminary quantitative results that indicate that that the LDP+ process does add value to service delivery outcomes.

²⁹ See Trasi, et al. n.d. “Unpacking the LDP Conceptual Model.” Unpublished paper. LMG.

Figure 8. Percentage of postpartum clients receiving family planning/sexual and reproductive health counseling at pre- and post-intervention by study arm

LDP+ hospitals had greater increases in the % of PP clients receiving FP/SRH counseling

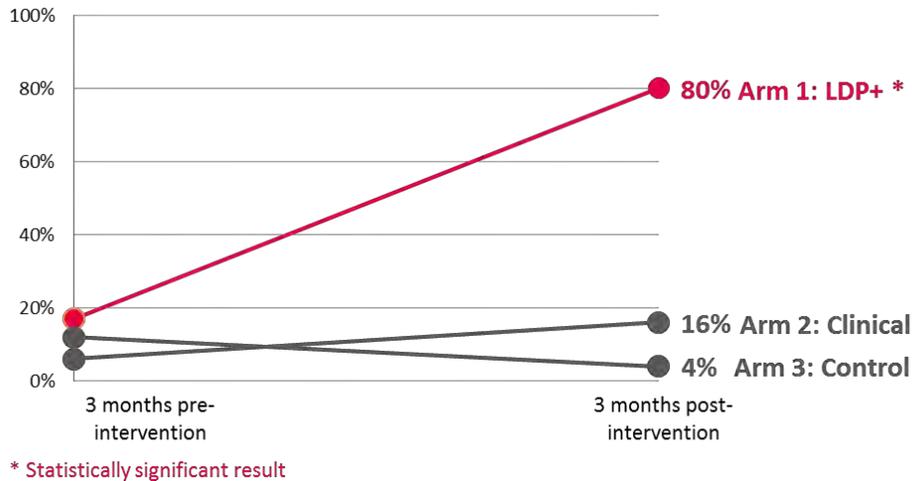


Figure 8 shows that hospitals receiving LDP+ training had a significantly greater increase in the percentage of postpartum clients receiving family planning counseling than either the hospitals receiving clinical training only or the control sites.”

Figure 9. Post-partum family planning service delivery outcomes

Both **LDP+ hospitals** and **Clinical hospitals** had increases in CYP from baseline to endline

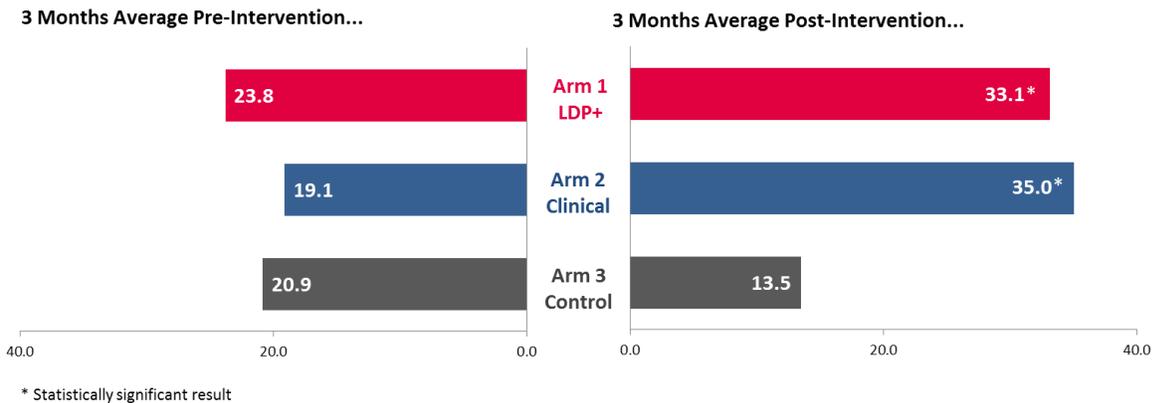


Figure 9 shows that couple-years of protection increased in both the LDP+ and Hospitals with Clinical Training alone hospitals while declining in the control sites. The MER team said that when these results were reported to Cameroon’s Director of the MOH Division of Family Health., he was impressed with the study’s findings and has said that the ministry wants to scale up the LDP approach beyond the capital city.

Key conclusions on LMG contributions to knowledge: The MER team’s evidence generation “felt like trying to fit square peg into round hole,” i.e., “trying to implement epidemiological methods to something that is by design customizable, up to teams.” The MER team was able to bring many disciplinary insights to this problem from management and organizational behavior theory about to how

to measure motivation and empowerment, but it found it could not use what had been used conventionally for other topics (e.g., women's empowerment). "This was a different beast." It is difficult to conceive how to measure improvements in interdepartmental functioning, a common type of challenge defined by an LDP+ team. In addition, the concept of exploring pathways, for example, of how LDP+ teams go from one step to the next in achieving their results, is still unexplored.

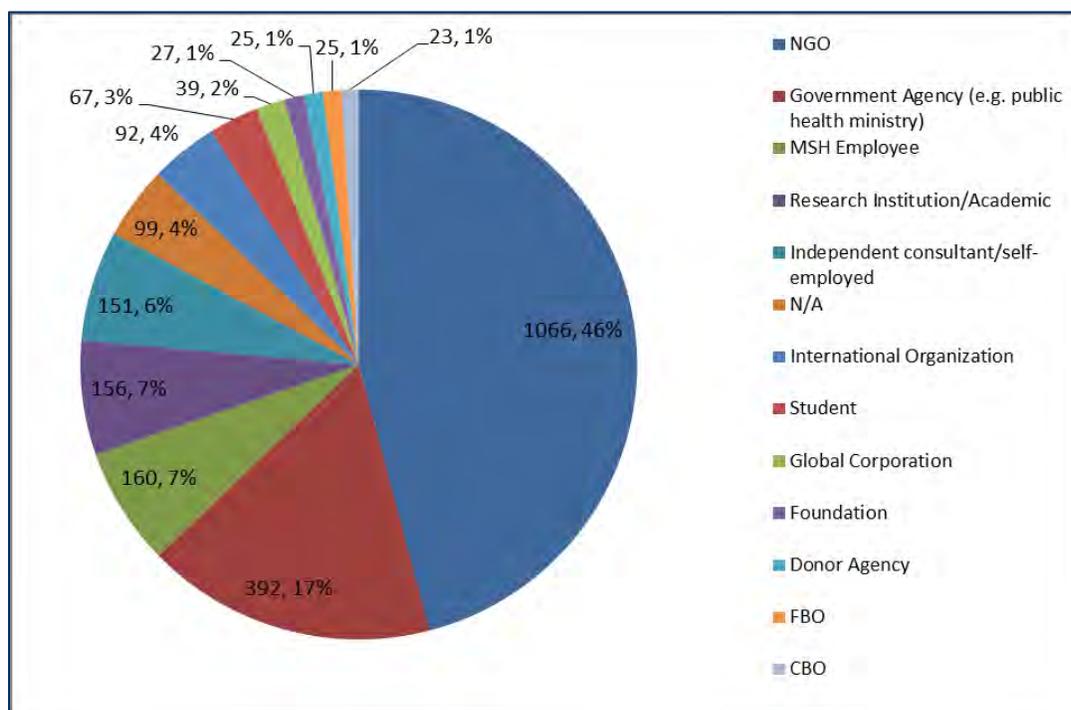
The LMG Project did not accomplish all that was expected of it in terms of evidence generation, although it does have promising results from the one complex study funded. However, the project has contributed tools and concepts toward developing an evidence base founded on rigorous research. As one MER informant concluded, this field warrants study, and the implication for public health is immense. The field is so new, in terms of evidence generation, that almost any solid evidence would constitute progress.³⁰

There is now an opportunity take this forward and build on what LMG did accomplish, by using the conceptual models, causal pathways, instruments and study designs the MER team developed, and building on the papers and reports produced. It is also a learning opportunity for others in USAID and the global health community to understand LMG's experience of which research methods are appropriate to generate evidence and the costs associated with doing that.

Dissemination of evidence, project results and tools: Another LMG contribution to the knowledge base is LeaderNet. LeaderNet uses a multimedia platform to share information with its users. It is an important legacy resource for USAID and the global health community. The LMG Project reports that as of January 2016, LeaderNet has more than 2,300 registered members on the site. As seen in Figure 10, 46 percent are from NGOs, and 17 percent are students. Research organizations, international organizations and independent consultants are other major users. Careful thought should be given to how to market, transfer, store and retain the portions of this knowledge base that USAID funded.

³⁰ Please note that the evaluation team believes that its interviews and findings provide a huge amount of evidence, albeit anecdotal, from the people on the ground who are using these approaches and who, the evaluators found, are asking for more project assistance. Some places, like the conflict-affected countries where LMG worked, are the most unlikely ones where we might think such interventions would work.

Figure 10. Composition of LeaderNet registered members, by type of organization



Examples of LMG and LMS activities that have strengthened advocacy and commitment for future investments in leadership, management and governance

The team found that LMG proposed and built a strong, complementary technical consortium. All five members (Yale, Amref, IPPFAR and Medic Mobile, and Johns Hopkins University in Afghanistan) contributed beneficial institutional technical assistance. Yale and Amref developed materials and tools for use across LMG countries, while Medic Mobile worked on new communications applications and tools for governance and is a subcontractor on other USAID bilateral projects in Africa. Amref and IPPF both serve as technical assistance providers and have field implementation programs. Both are active on the ground, with substantial external non-LMG financing to carry on leadership, management and governance work beyond the life of LMG for their own organizations and for others in Africa.

Amref played an important role in the LMG project, providing technical assistance in Ethiopia while also running its own privately funded leadership training institute with support from Johnson & Johnson for classroom and virtual leadership courses. Amref is also a member of USAID’s Human Resources for Health (HRH) 2030 consortium and has multiple mechanisms to carry on leadership, management and governance training beyond LMG. Amref’s work in this area also enhanced its ability to mobilize other donor funding for its private leadership program. According to Amref’s business development director, last year Johnson & Johnson increased its funding to Amref to further develop the practices of its training institute’s alumni. Amref’s one-week intensive management course has trained 100 new leaders. With Johnson & Johnson funding, Amref will do more with leadership, management and governance tools and approaches. Amref is also setting up special events to bring its leadership alumni together and is looking to deepen its Virtual Management Development Institute, run out of its Nairobi technical headquarters.

The LMG Project served to strengthen the capacity of IPPFAR Learning Centers to carry out leadership, management and governance training for other institutions and its own network of 42 affiliates in sub-

Saharan Africa. Thus far, IPPFARO contributed \$375,000 of its own funds for leadership development and is committed to strengthening leadership, management and governance among all its affiliates by 2020. IPPF leveraged Swedish AID resources to scale up this work with Learning Centers in Kenya, Ethiopia, Togo, Swaziland and Côte d'Ivoire. For example, the RHU Learning Center team trained Tanzania and Malawi affiliates in the LDP+ process and has begun offering training to other NGOs in Uganda and neighboring countries for a fee.

During PY4, there were numerous examples of foundations and other organizations, including RHBs, willing to buy assistance directly from the LMG consortium or scale up the LDP+ modules using LMG master trainers. These include the World Bank in Afghanistan, UNFPA in Uganda, ministries of health in Côte d'Ivoire and Cameroon, the Oromia RHB in Ethiopia, and the Global Fund and EU in Côte d'Ivoire. MSH has recently signed a host country agreement with Côte d'Ivoire for continued LDP+ work even before LMG ends,³¹ and WAHO encouraged the 15 ECOWAS countries to roll out governance training with their own resources. Ethiopia has made a national commitment to leadership, management and governance by incorporating the modules into its pre- and in-service medical, nursing and pharmacy education programs.

The regional government is asking for continuation of LMG and said, "We don't want anything else. LMG is special. Is there a possibility of a follow on?" The USAID mission is also exploring the next steps for future of this work.

LMG worked alongside many USAID bilateral health projects. Many of these, such as STRIDES or the TB project in Uganda, SIAPS in Burundi, E2A (family planning, reproductive health, maternal and child health) in Cameroon, the Integrated Health Program (IHP) in the DRC and the Liberia sector-wide health project, have adopted and incorporated MSH tools and are taking them to scale. As noted above, LMG also had extensive collaboration with other USAID partners and donors, such as the Global Fund, which incorporated LDP+ training into its malaria and TB grants to Côte d'Ivoire.

Another very tangible legacy for LMS and LMG is the network of alumni trained by these two projects, who are spread across the globe and have adopted and applied leadership, management and governance approaches and tools over the past 30 years. They include ministers of health and director generals in some countries and in WAHO, multiple directors in Afghanistan's MOH and the entire FMOH and all of its RHB teams in Ethiopia, and seven NMCPs in Africa and Laos. Many of these leaders have gone on to form important national leadership bodies. For example, in Afghanistan, the Head of Community Health started a union of public health professionals, who lobby Parliament on behalf of community health. He now sits on an important and visible national working group in the new government, the Citizen Charter, which looks for ways to bring multi-sectoral rural development programs to citizens in remote areas of the country. The health sector work has become a model upon which the government hopes to extend more services to communities in need.

The evaluation found that graduates of LMS and LMG also launched their own private leadership technical assistance. ACODEV, a local training institution in Uganda, was started by an LDP alumni. He established the leadership excellence center and incorporated LDP into the institute's technical assistance program. ALERT, a Pan-African institute in Ethiopia, is now marketing a grant writing and management course to other NGOs after receiving training from LMG in this area.

QUESTION 4: UNFORESEEN CHALLENGES, OPPORTUNITIES AND WEAKNESSES FOR LMG AND LMS AND WAYS THEY WERE ADDRESSED

The LMS and LMG projects span a decade that witnessed momentous and unforeseen challenges in many of the projects' designated countries. During this period, there was armed conflict or civil war in

³¹ Personal communication. February, 2016. Jason Wright, LMG COP, to evaluation team.

the DRC, Afghanistan, Côte d'Ivoire, Liberia and Libya, all LMG countries. There was also ethnic conflict in Nigeria, as well as periods of deep and severe civil unrest in Burundi, Kenya and Haiti and cross-border conflicts affecting Ethiopia and Uganda. Many people in these countries were displaced, became refugees, and/or suffered trauma and/or physical impairments as a result of these conflicts. The scale of the challenges strained these nations' already weak health systems, physical rehabilitation infrastructure, and mental health services—creating additional burdens for service providers including many of LMG's partners in the DCHA activities.

In 2010, during the LMS Project, Haiti witnessed one of the most destructive earthquakes in its history, which destroyed the country's infrastructure for the central and regional governments, and resulted in a large death toll and a related deadly outbreak of cholera. The Ebola outbreak in 2014, the largest and most-deadly recorded public health pandemic in West Africa's history, shut down normal government and private sector operations in Liberia for nearly a year, and all of its neighboring countries, extending as far as Nigeria and Côte d'Ivoire, were directly affected by the outbreak. Finally, in 2014 and 2015, many Francophone countries previously not affected by major armed conflict, like Cameroon (an LMG country), Mali and Burkina Faso, have been confronted with the rise of internationally financed terrorist operations. Terrorism has also been a key issue for northern Nigeria, also an LMG country. These terrorist events have strained internal security and created logistics and public health service delivery problems for national health leaders.

Against these dramatic and unforeseen tests of leadership and management, it is the assessment of the evaluation team that the LMS and LMG projects have creatively and systematically helped these nations in crisis both deal with immediate post-conflict situations and find ways to feasibly address organizational issues within their existing resource levels. The project also addressed rebuilding and strengthening health systems by embedding leadership training in pre-service and in-service training for doctors, nurses, midwives, pharmacists and public health managers who were assigned to those functions without prior management training. In Afghanistan, for example, an LMG study found that only 40 percent of health professionals had the skills and felt prepared to manage the full scope of their existing work.

Despite major obstacles, due to often courageous technical assistance and commitment by the LMG consortium, the evaluation team found that national health leaders from countries as different as Afghanistan, Côte d'Ivoire and Liberia reported good results and success in addressing both day-to-day and medium- to long-term problems in organizing their work and making fundamental changes in their health systems. Not surprisingly, countries such as Ethiopia, which have strong national public health infrastructure and leadership and relatively few nationwide political or economic disruptions, made the most progress in meeting their LMG objectives. An evaluation of the Afghanistan Hospital Autonomy Project that ended in 2015, for which MSH was the prime contractor, found that while the 14 national and specialty hospitals in the project had been delegated authority for all financial and procurement actions, more work was needed to decentralize their HR hiring and firing authorities. LMG staff continued to work with the hospital leaders who had benefited from USAID hospital bilateral funding.³²

The LMG evaluation team interviewed two senior health officials leading the MOH in Haiti and Côte d'Ivoire, countries emerging from civil unrest or dislocations. Both key informants indicated that LMG tools and technical assistance in areas such as strategic planning, resource mobilization and priority setting, as well as the LDP+ process (including the root cause analysis and action planning) all advanced their government's public health work. Feedback from NMCP leaders in Liberia, Côte d'Ivoire and Burundi also indicated that despite the massive disruptions they faced in their programs, LMG support was invaluable and was delivering impressive results. Nevertheless, NMCPs will likely need more embedded technical assistance for up to two additional years to assist in the smooth launch and

³² *Hospital Management Review in Afghanistan: Hospital management systems at 16 national institutions*. May 2015.

operation of the newly awarded Global Fund malaria grants. As a note of caution, two of the USAID field respondents in large country programs³³ indicated that they are concerned that MSH technical assistance was so good and effective that the country might be overly dependent on this technical assistance and may stumble once it is removed.

At the project level, another challenge the project has faced is turnover in staff of assisted organizations, necessitating the need to train high numbers for purposes of retention. The evaluation team also found that in many countries, field missions and the LMG team and partners were not aware that the project was ending in September 2016, and believed that they would not be able to finish their LMG work in the remaining nine months. ICRC, MOH partners in Haiti, Ethiopia, Côte d'Ivoire and Burundi and USAID/West Africa, all expressed a concern about how to hand off and complete planned work in the time remaining. Other donors in Haiti working with USAID also noted their concern about having LMG exit in 2016, just as positive momentum was building to move the country from a pilot phase for some HSS work to national roll-out.

A USAID official overseeing malaria control work in Africa noted, “The LMG in-country technical assistance (the NMCP advisor) was exactly what we needed, someone with financial management, public health malaria and diplomatic skills,” and “The Technical Assistance helps to improve USAID’s image in the country. When the Government sees LMG they see USAID.” Another USAID field manager in an important South Asian country noted, “The quality and commitment of the MSH/LMG technical team contributed to major service delivery and organizational changes. The teams made this possible.” This point was also underscored in the electronic survey responses sent out to USAID field missions.

A final challenge the project faced was insufficient core funds to carry out the project’s intended scope for evaluative research. The project faces a methodological problem of addressing how to cost-effectively measure leadership, management and governance interventions in public health programs. Robust indicators, as well as cost-effective methods for measuring the success and contribution of leadership and management, required more core funding. However, through the early years of the project, core funds for research were scarce and are now financing studies whose results will be completed by the end of PY5.

Some of the project’s key success factors are team-building training, leading by example and motivational pacing. In Afghanistan, the senior leadership training was cited by two leaders of major national health programs as having been their “lifeline” to keep staff on track. They consulted the LMS and LMG editions of *Managers who Lead* as a reference when faced with insurmountable problems. Central and clinic-based RHU staff spoke of using the LDP+ training, strategic planning, root cause analysis and challenge models to set goals and improve productivity. Transparent leadership and mutual cooperation were two factors LMG trainees and participants credited with helping them to change their mindset about solving their own problems in a sustainable manner. In Ethiopia, the central FMOH approved of the LMG training and encouraged all of the RHBs to use the approach to meet their accreditation and certification requirements. Results of the training in Ethiopia were compelling, and some took place in the most remote and insecure part of the country.

To achieve these results, the LMG consortium employed all forms of long- and short-term technical assistance, embedded advisors and co-located technical teams, as well as periodic off-shore technical advisors and in-country short-term consultants. The evaluation team found that the caliber of technical assistance recruited by the consortium was impressive, responsive and enthusiastically embraced and received by participants. Of the 128 beneficiary organizations and participants interviewed, none raised or questioned the caliber of the technical assistance provided, and the majority praised LMG for offering exactly the assistance needed.

³³ Please note that these countries are also outliers in terms of their need for support.

The evaluators found that the LMG team was able to turn challenges into opportunities. In Burundi, civil unrest necessitated bringing the in-country teams working on developing the Global Fund Malaria Concept Note to a working meeting site outside the capital city and to other countries. This approach, necessitated by violence in the capital, allowed them to complete the document much more quickly than originally planned. The Ebola pandemic necessitated malaria outreach teams working with LMG to adopt rigorous hygiene and handwashing practices, which have benefited overall infection control practices across all MSH/Africa bilateral and regional service delivery projects. Malaria messaging developed by the NMCPs incorporated practices to prevent Ebola, using the existing modes of communication to promote expanded messages. Ebola funding of \$4.6 million, or 3 percent of the LMG life-of-project obligations, was added to the project in 2014 and 2015 for West Africa missions for advocacy, communications, health information and HSS measures.

LMG weaknesses: The LMG project included elements that did not appear to be effective: (1) The East African Women's Mentoring Network paired mentors with women from other countries, and the virtual and distance communication technology available to the mentor and mentee (including Skype and WhatsApp), suggested by teams to work around poor internet connections, also proved to be difficult to sustain. Although there may be examples where this mentoring network was effective evaluators only observed an example where it was not working. (2) There is little evidence that the LMG activities improved gender equity within organizations during the five years. This may have been an overly ambitious result, given the employment laws in the LMG-assisted countries and the relatively short timeframe to see results. (3) A key weakness of several project initiatives, including ICRC EMP/SFD work, the youth network survey and the WAHO governance work, is that many important activities were done in PYs 3 and 4 and therefore have minimal time remaining to complete the actual work and capture the results. (4) A design flaw in an otherwise well-designed global health project, which might have been corrected by PY 3 or 4 but is apparent in hindsight, is that the project primarily focused on strengthening public sector training organizations and was unable to reach out to private sector leadership, management and governance programs that are appearing across Africa. As noted, the project's scope of work with NGOs and the public sector was very ambitious, and this is likely the reason that the private sector was not incorporated into the scopes of work of either LMG or LMS agreements.

Beyond these technical weaknesses, an overall implementation lesson learned was observed by the team: In certain countries, field support activities and core-funded work were managed separately by the MSH home and country offices. This led to some missed opportunities. In the ICRC activity in Ethiopia, for example, the local LMG team in Addis and the RHB team in Harar could have accelerated the timeline for EMP completion and thought through creative ways to overcome staffing challenges faster than the MSH home office team. The Ethiopia team had tackled similar types of challenges in neighboring public health facilities. Côte d'Ivoire's malaria work was the best contrasting example of MSH headquarters effectively supporting a local team's work.

IV. CONCLUSIONS

The evaluation team's main conclusion is that the LMG Project unleashed the power of recipients through its participatory tools and high-caliber technical assistance to solve problems in the context of limited resources. The LDP+ and SLP tools were directly observed to have changed workplace mindset and work climate and built team and manager confidence across all types of programs and country settings, including post-conflict countries and remote areas. The project offered ministries of health and CSOs a practical set of core management training that these organizations would not otherwise have accessed. This first exposure, in many instances, led to the teams' funding of their own broader roll-out and cascading of leadership, management and governance through existing pre-service and in-service training infrastructure.

What is clear from the LMS and LMG experiences is that there is a great need and high demand for leadership, management and governance training and outside assistance. It is highly beneficial that the U.S. Government can offer these proven approaches to strengthen individual and team-based leadership. All of the USAID field respondents praised LMG's technical assistance, and 13 out of 14 USAID field key informants noted that the MSH footprint and complementary work with USAID bilateral projects was positive. The LMG consortium was strong and provided complementary technical inputs and direction. Within that consortium, IPPFARO and Amref are institutions that can carry forward this work and should be encouraged by USAID to do so.

LMG was highly effective in guiding organizations through the process of organizational change. This led to some key partners of the U.S. Government, such as the IPPFARO affiliates, ministries of health in Ethiopia, Haiti, Afghanistan and Côte d'Ivoire, and the laboratory network in Uganda, adopting and practicing state-of-the-art leadership and improved management and governance. This was true across these organizations, including at the regional and district levels. The LMG approach is a necessary complement to other quality improvement and service delivery programs supported by the U.S. Government, which strengthen health facilities and work more directly with service clients.

LMG has been instrumental in supporting countries seeking Global Fund grants for HIV/AIDS and malaria funding. The \$270 million in Global Fund malaria grants leveraged in West and East Africa and \$26.7 million in Global Fund HIV grants in seven Latin American and Caribbean countries have been instrumental to USAID successfully advancing its PMI and PEPFAR goals. CCM strengthening assistance through LMG has been highly praised by recipient countries.

As one African leadership expert from a CSO noted, "Lack of L, M and G is a big disease. It is a big gap and it is big work. [It's] not like medicine you can inject, it's a system. You can't just train some and leave the others. L, M and G is one of our priorities, so the country needs more." A key question for USAID going forward is how the Agency will continue to deliver leadership, management and governance assistance (which had an aggregate demand of \$435 million) and where this work should be housed within the Bureau for Global Health.

V. RECOMMENDATIONS

- GH/PRH and LMG should immediately begin to develop a country-by-country hand-over plan that includes a cross-walk strategy for technical assistance from LMG to new and existing GH and USAID bilateral mechanisms.
- The GH Bureau should identify for USAID field missions which continuing GH mechanism(s) will support missions that require tailored and specialized organizational capacity strengthening.
- The GH Bureau, working closely with PMI and OHA, should identify a hand-over plan for every CCM and NMCP where LMG is playing a key role.
- LMG must accelerate work during PY5 to strengthen institutions, such as WAHO, AHLMN, and prepare them to take on the future demand for technical assistance and training in leadership, management and governance. This has not yet taken place. This same type of discussion about local institution work beyond LMG should take place with ICRC and other DCHA partners, such as CVT and the NCC in Rwanda.
- With PRH assistance, LMG needs to promote the full range of leadership, management and governance tools and LeaderNet use and find ways to further embed these tools into other USAID archives, including those that reach the Center of Excellence on Democracy, Human Rights and Governance (DRG) and DCHA.
- MSH board governance tools adopted and used by LMG partners have broad applicability for other family planning, PEPFAR-funded and DCHA organizations. There is tremendous scope for board governance work with DCHA NGO recipients in the field (CVT) with independent boards. For example, autonomous hospital boards in Afghanistan and decentralized RHBs and district hospitals need more board oversight training.
- USAID should consider certifying the largest U.S. child survival and family planning NGOs and private sector training institutes to carry on training and coaching after LMG ends. Root cause analysis, setting and monitoring challenges with action plans (both part of LDP+), financial management and board governance are all transferable to the private sector.
- USAID should encourage inclusion of private training institutions in projects that plan leadership, management and/or governance training, to help meet the demand for training of trainers and increase sustainability of training interventions in this technical area.
- GH should consider extending up to a year programs that will not complete by September 2016 due to external or compelling factors, such as elections, public health emergencies or terrorism. Some countries, such as Ethiopia, may require more time to be able to train more master trainers, particularly in remote regions.
- The GH Bureau's senior leadership team should consider ESF and DRG Funding for LMG tools in current and post-conflict areas.
- In PY5, LMG should map the LMS and LMG Alumni Network and make this information available to USAID field missions for use in country programming. It is clear that LMG participatory tools and training are well received, even in remote and politically sensitive regions, and that participants who have gone through the program are open to applying the practices more broadly to their work.
- LMG should include in its PY5 work plan a review of key PEPFAR, EPMCD and FP2020 priority countries' private sector institutions to continue organizational and individual training in leadership, management and governance.

ANNEX I. SCOPE OF WORK

Global Health Program Cycle Improvement Project -- GH Pro
Contract No. AID-OAA-C-14-00067
10-06-15

TITLE: Leadership, Management and Governance (LMG) Project End of Project Evaluation

Requester / Client

USAID/Washington

Office/Division: _____ GH _____ / _____ PRH _____

Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)

- | | | |
|--|--|---|
| <input type="checkbox"/> 3.1.1 HIV | <input type="checkbox"/> 3.1.4 PIOET | <input type="checkbox"/> 3.1.7 FP/RH |
| <input type="checkbox"/> 3.1.2 TB | <input type="checkbox"/> 3.1.5 Other public health | <input type="checkbox"/> 3.1.8 WSSH |
| <input type="checkbox"/> 3.1.3 Malaria threats | <input type="checkbox"/> 3.1.6 MCH | <input type="checkbox"/> 3.1.9 Nutrition |
| | | <input type="checkbox"/> 3.2.0 Other (specify):
DCHA |

Cost Estimate: \$465,550: DCHA contributed \$50,000 to this evaluation and the remaining funds were split between PRH and OHA

Performance Period

Expected Start Date (on or about): _____ November 2, 2015 _____
Anticipated End Date (on or about): _____ end April 2016 _____

Location(s) of Assignment: (Indicate where work will be performed)

Washington, DC
Medford, Massachusetts (possibly)
Four countries where LMG has field-based programs: tentatively, Haiti, Guatemala, Uganda and Côte d'Ivoire.

Type of Analytic Activity (Check the box to indicate the type of analytic activity)

EVALUATION:

Performance Evaluation (Check timing of data collection)

Midterm Endline Other (specify):

Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.

Impact Evaluation (Check timing(s) of data collection)

Baseline Midterm Endline Other (specify):

Impact evaluations measure the change in a development outcome that is attributable to a defined intervention; impact evaluations are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are

made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.

OTHER ANALYTIC ACTIVITIES

Assessment

Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

Costing and/or Economic Analysis

Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

Other Analytic Activity (Specify)

PEPFAR EVALUATIONS (PEPFAR Evaluation Standards of Practice 2014)

Note: If PEPFAR funded, check the box for type of evaluation

Process Evaluation (Check timing of data collection)

Midterm Endline Other (specify): _____

Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)

Outcome Evaluation

Outcome Evaluation determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)

Impact Evaluation (Check timing(s) of data collection)

Baseline Midterm Endline Other (specify): _____

Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.

Economic Evaluation (PEPFAR)

Economic Evaluations identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?

BACKGROUND

If an evaluation, Project/Program being evaluated:

Project/Activity Title:	Sustainable, Leadership, Management and Governance (LMG)
Award/Contract Number:	AID-OAA-A-11-00015
Award/Contract Dates:	September 25, 2011–September 24, 2016
Project/Activity Funding:	As of May 15, 2015: \$119,857,585 (total): PRH core funds \$11,450,000; OHA core funds \$15,889,938; DCHA core fund \$8,961,310; field support buy-in \$83,556,337 <u>Project ceiling: \$198 million</u>
Implementing Organization(s):	<u>Lead:</u> Management Sciences of Health (MSH)

	<u>Sub-partners:</u> African Medical Research Foundation (Amref), Frontline SMS: Medic; International Planned Parenthood Federation (IPPF), Johns Hopkins University Bloomberg School of Public Health (JHSPH), Yale University Global Health Leadership Institute (Yale GHLI)
Project AOR:	Reena Shukla; Technical Advisors: Temitayo Ifafore (PRH), Sandy Jenkins (DCHA), Matthew Schneider (OHA); Bhavna Patel (PMI); Project Assistant: Michael Leavell (PRH)

Background of project/program/intervention:

The LMG project is a follow-on cooperative agreement between USAID/Washington and MSH, signed on September 25, 2011 for a five-year period ending on September 24, 2016. LMG is a continuation of a series of USAID global health investments in leadership and management that started in 1985. USAID investments first focused on strengthening the capacity of workers in reproductive health and then expanded to include other health areas, such as HIV/AIDS, infectious diseases and now DCHA activities. These projects included the Family Planning Management and Training Project (1985–1990), the Family Planning Management Development Programs I and II (1990–1995) and (1995–2000), the Management and Leadership Program (M&L) (2000–2005), and the Leadership, Management and Sustainability Program (LMS) (2005–2010). All of these projects have followed the principle of the importance of leadership and management to building strong health systems and local health services organizations. This evaluation will look retrospectively at the timeframe from 2005–2015 to review work under the LMS project and current LMG project.

Since 2011, the LMG project has been working to disseminate best practices from the field of organizational development to empower health leaders, managers and teams at various levels (global, regional, national, subnational and individual). These participants represent a diverse range of health-related organizations throughout the world. LMG has applied a range of tools to meet and address participants' most pressing priorities. LMG's work was intended to build upon the predecessor LMS's work to advance the application, knowledge and dissemination of leadership and management tools and practices, while adding an increased focus on governance of public and private organizations and the integration of gender transformative approaches. The project also has also embedded a broader research and learning agenda in order to contribute to the scant evidence base on the role of enhanced leadership, management and governance practices on health outcomes.

LMG works in close coordination with ministries of health (MOH), civil society organizations (CSOs), international organizations, networks and health training facilities to design, implement and monitor a wide range of activities focusing on improving the leadership, management and governance capacities of health systems. More than 20 countries have received support through LMG through either core investments or field support buy-ins since 2011. One of the primary outcomes of the project is to demonstrate that good leadership, management and governance are the key enabling factors to achieve sustainable health outcomes.

LMG's work is intended to incorporate lessons learned from LMS and to support the larger objectives of the Global Health Bureau, which are to promote an AIDS-Free Generation, End Preventable Child and Maternal Deaths, and Family Planning 2020 (FP2020). The idea is that by strengthening health services management at all levels, countries are better able to address and respond to these critical priorities to ensure a country-led response.

LMG's current work focuses on three main objectives, which are to:

- 1) **Strengthen global support, commitment and use of state-of-the-art leadership, management and governance tools, models and approaches for priority health programs.**

Since 2011, LMG has partnered with 13 global or regional organizations to disseminate the importance of leadership, management and governance (L+M+G) concepts in the global health agenda. These organizations include global agencies like the World Health Organization (WHO)

and the Global Fund for AIDS, Tuberculosis, and Malaria, international non-governmental organizations (INGOs), private sector partners and public-private partnerships. LMG has been successful in leveraging global support, which has been reflected through high levels of financial and matching contributions in LMG's cost share. The LMG project's tools, models and approaches have been updated, modified and used across the PRH, DCHA and OHA portfolios of work as well as with field support funds. To date, nine organizations in six countries have formally incorporated LMG's leadership, management and governance tools, models or approaches into their work including curriculum, business plans and national policies. This includes academic institutions, CSOs, government agencies and public and private health facilities. The project will organize a series of high-profile events in the coming year to generate increased visibility on the role of leadership, management and governance for advancing the objectives of health and DCHA-supported organizations. The project's causal pathway is demonstrated below on the hypothesis that leadership, management and governance are key enablers for sustained health outcomes.

2) **Advance and validate the knowledge and understanding of sustainable leadership, management and governance tools, models and approaches.**

To date, LMG has globally trained and provided technical assistance to more than 13,000 women and 1,200 men across 23 countries to promote the use of leadership, management and governance tools within the health and DCHA sectors. There is a need to understand the validity of these tools and how these broader approaches have contributed to specific service-delivery factors in family planning, HIV and DCHA programming. LMG has employed the train-the-trainer model to establish a community of facilitators trained in LMG's tools, models and approaches across eight countries. Based on early feedback from participants, LMG updated its suite of leadership tools in 2012 and 2013 and developed new governance and gender tools in 2013 and 2014. LMG's goal in this area is for organizations and participants to be able to use these tools to identify, define and implement solutions that are appropriate to their type of organization, setting and needs with minimal external assistance.

From April–August 2015, LMG will be conducting an external assessment of their suite of leadership and management (L+M) tools that have been used by the LMG and the LMS projects. The assessment will ascertain the continued use of selected tools, benefits of these tools and results for various stakeholders, and opportunities for sustained use and institutionalization of these approaches. This assessment will also look at the commitment and use of LMG tools, as identified in LMG's objective 1 above. It is expected that this assessment will serve as a key document for this end-of-project evaluation and be used to inform activities in the final year of the LMG project. Further, this evaluation will build off this assessment and contribute to developing a stronger understanding regarding whether and how these tools supporting advancing public health objectives of the organizations that received training and technical assistance.

3) **Implement and scale up innovative, effective and sustainable leadership, management and governance programs.**

To accomplish this objective, LMG worked with individuals and organizations to develop their ability and capacity to better govern and manage their health programs. LMG has used funding from the Office of HIV/AIDS (OHA) to develop management tools for CSOs to better reach key populations: those disproportionately infected with HIV compared to the general population, such as those that inject drugs, gay men and other men who have sex with men, transgender persons and sex workers. LMG has also used OHA funding to enhance the resources available to leaders and decision makers to design, monitor and implement programs. For example, these tools include the LMG PEPFAR dashboard and performance improvement process that help NGO managers set and track program goals and adjust their work if they are not achieving these goals, and the resources and information available to policymakers and service providers on the OVCsupport.net website.

For family planning, LMG has worked with the Implementing Best Practices Initiative to promote use of the *Guide for fostering change to scale up effective health services*, a guide that helps countries reach their FP2020 goals. With International Planned Parenthood Federation (IPPF) in the Africa Regional Office, LMG has worked to improve the leadership and management skills of IPPF member associations so they may increase access to quality family planning services, thereby contributing to higher family planning uptake. Further, LMG is working to strengthen youth leadership to advocate for increased access to quality youth-friendly family planning and reproductive health services. For DCHA, LMG has worked in support of its Vulnerable Populations Programs, whose goal is protecting the human rights of and developing the capacities of vulnerable populations. Over the life of the project, LMG worked with partners in 37 countries with DCHA funding for a variety of vulnerable populations. DCHA's vulnerable population programming covers displaced children and orphans, war-wounded victims of torture, wheelchair users, and people living with disabilities. They worked in specific countries to improve wheelchair providers' skills and strengthen management of wheelchair programs. They also worked with the International Committee of the Red Cross to strengthen program management and leadership skills programs, and with Ponseti International Association to scale up effective clubfoot treatment within a few target countries. DCHA office will contribute resources to conduct this evaluation.

Strategic or Results Framework for the project/program/intervention (*paste framework below*)

If project/program does not have a Strategic/Results Framework, describe the theory of change of the project/program/intervention.

What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

SCOPE OF WORK

A. **Purpose:** Why is this evaluation or analysis being conducted (purpose of analytic activity)? Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

This performance evaluation comes toward the end of LMG project. The overall purpose is to provide information that will be used by the Global Health and DCHA bureaus to inform future programming and that can provide specific feedback and recommendations regarding the effectiveness and sustainability of the range of interventions implemented by the LMG project.

B. **Audience:** Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

The primary users of the evaluation findings are the Office of Population and Reproductive Health (PRH), the Office of HIV/AIDS (OHA), the Office of Health Systems Strengthening (OHS), the DCHA Bureau and the respective missions that bought into the LMG mechanism via field support.

C. **Applications and use:** How will the findings be used? What future decisions will be made based on these findings?

Inform future programming and provide specific feedback and recommendations regarding the effectiveness and sustainability of the range of interventions implemented by the LMG project.

D. **Evaluation/Analytic Questions & Matrix:**

- a) Questions should be: (a) aligned with the evaluation/analytic purpose and the expected use of findings; (b) clearly defined to produce needed evidence and results; and (c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.); they must be incorporated into the evaluation/analytic questions. **USAID policy suggests 3 to 5 evaluation/analytic questions.**
- b) List the recommended methods that will be used to collect data to be used to answer each question.
- c) State the application or use of the data elements toward answering the evaluation questions; for example, (i) ratings of quality of services, (ii) magnitude of a problem, (iii) number of events/occurrences, (iv) gender differentiation, (v) etc.

Evaluation Questions:
 There are two broad themes that should be explored for this evaluation, which are effectiveness and sustainability.
 Effectiveness for the purpose of this SOW is defined as: the extent to which LMG is achieving its intermediate objectives and serving the needs of the organizations (CSOs, universities and public sector entities, namely Ministries of Health, private sector partners, and professional health networks or associations) with whom it works. Excluded from the scope of this evaluation is a review of LMG’s work with technical working groups and other global donor agencies.
 Sustainability for the purpose of this SOW is defined as: the extent to which LMG is providing quality technical assistance to organizations (as listed above), so that they are institutionalizing key tools, practices and models within their operations, as well as increasing or maintaining demand for services, generating income, decreasing dependence on funds from external donors, and increasing organizations’ skills for advocacy, provision of quality services to constituents and/ or increased service accessibility.
 Based on the findings to these evaluation questions, the team should also **articulate specific, actionable, and feasible recommendations** with regards to effectiveness and sustainability.
 Consultants are asked to use data generated from the performance monitoring plan (PMP) as a baseline for quantitative data (where possible) and to identify approaches that worked or did not work.
 Consultant should also use the PMP and other reports as evidence of the extent to which LMG altered activities to incorporate feedback and lessons learned.

	Evaluation/Analytic Question	Research Methods	Application or Data Use
I	<p>How effectively did LMG’s leadership development approach respond to organizations’ identified needs?</p> <p><u>Things to consider:</u></p> <ul style="list-style-type: none"> a. Results of LMG’s organizational development approach on the capacity of CSO/institutions that serve vulnerable populations through DCHA funding b. Results in the areas of advocacy, service delivery, quality and accessibility c. Elements of LMG’s organizational development approach that enabled or limited regional professional health bodies, such as Amref, AHLMN and ACHEST, to meet their mid- and long-term goals d. LMG’s leadership development to cultivate accountability and steward resources at subnational and national 	<ul style="list-style-type: none"> ● Key informant interviews (semi-structured) ● Review of institutional data of participating organizations (IPPF, Amref, AHLMN, JCRC, university pre-service institutions, ICRC, ACHEST) ● LMG document review (progress reports, management reviews) ● Self-assessment internet survey 	

	levels, particularly with Ministries of Health		
2	<p>To what extent have LMG interventions benefited the target populations of AIDS-Free Generation, Ending Preventable Maternal and Child Deaths and FP2020?</p> <p><u>Things to consider:</u></p> <p>a. LMG’s approved work plans and their contribution to the to an AIDS Free Generation and PEPFAR 3.0 goal of epidemic control</p> <p>b. LMG’s approaches to improve technical and organizational capacity of family planning/reproductive health service delivery institutions</p> <p>c. Approaches that demonstrate potential for sustainability after this project ends</p>	<ul style="list-style-type: none"> ● In-depth case study ● Key informant interviews ● Review of project data and reports ● Self-assessment questionnaire 	
3	<p>Based on experiences with LMS and LMG over the past 10 years, what lessons can be learned about sustaining global support for leadership, management and governance work from this project? (Note: LMG is the focus of this evaluation, and LMS is used as a reference point.)</p> <p><u>Things to consider:</u></p> <p>a. Components of the LMG and LMS projects that are replicable by a variety of countries and institutions</p> <p>b. Components of the LMG and LMS projects that are difficult to replicate by a variety of countries and institutions</p> <p>c. LMG and LMS project contribution to the global knowledge base around investments in organizational development, health management and governance</p> <p>d. LMG and LMS activities that have increased global and local advocacy and support for future investments in strengthening health leadership, management and governance practices</p>	<ul style="list-style-type: none"> ● Self-assessment questionnaire ● Key informant interviews ● Document reviews ● Archives 	
4	<p>In addition to the above questions, what unforeseen challenges and opportunities has LMG and LMS encountered, and how were they managed? (Note: LMG is the focus of this evaluation, and LMS is used as a reference point.)</p>	<ul style="list-style-type: none"> ● Document review ● Key informant and group interviews ● Survey 	

Other Questions [OPTIONAL]

(Note: Use this space only if necessary. Too many questions leads to an ineffective evaluation or analysis.)

E. **Methods:** Check and describe the recommended methods for this analytic activity. Selection of methods should be aligned with the evaluation/analytic questions and fit within the time and resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.

General Comments related to Methods: The evaluation will use pre and post comparisons of available institutional data to make comparisons before and after the intervention. As a performance evaluation, no counterfactuals have been established, and therefore, the results will not address a cause-and-effect relationship through rigorous methods. However, the LMG project has collected significant baseline information and has tracked progress throughout various interventions. There are also data from the LMS project to inform the evaluation. Comparisons between project baseline data will be compared to end of project to assess changes in institutional capacity and outcomes. As much as possible, the influence of the LMG's over these changes will be explored in the context of other factors which may have contributed to such changes.

Document and Data Review (*list of documents and data recommended for review*)

This desk review will be used to provide background information on the project/program, and will also provide data for analysis for this evaluation. Documents and data to be reviewed include:

- LMG and LMS project documents, including:
 - RFA (LMG and LMS)
 - Cooperative Agreement (LMG and LMS)
 - Annual work plans (LMG and LMS)
 - PMP and indicator data (LMG and LMS)
 - Semiannual and annual progress reports (LMG and LMS)
 - Financial reports (LMG and LMS)
 - Annual management review reports (LMG and LMS)
 - Scopes of work for field-funded activities, as applicable (LMG and LMS)
 - Self-assessment question responses (LMG)
 - MSH internal review (January 2015) (LMG and LMS)
 - Baseline, midpoint and end-line data from organizations that received LMG training or technical assistance (LMG)
 - Resource materials and technical documents developed under LMG and LMS
 - Past internal and external evaluation reports related to LMG and LMS
 - LMS closeout documents
- Institutional data of participating organizations (IPPF, Amref, AHLMN, JCRC, University pre-service institutions, ICRC, ACHEST)
- Other useful documents
 - USAID Forward Reform Agenda (sections on building capacity of local partners, evaluation)
 - USAID Global Health Initiative Strategy (sections outlining focus on capacity building, sustainability, country ownership, evidence-based programming, M&E)
 - PEPFAR strategy (sections outlining focus on capacity building, sustainability, country ownership), AIDS- free generation blueprint.

USAID and MSH staff will provide the evaluation team with access to a broad range of background documents.

Secondary Analysis of Existing Data (*This is a re-analysis of existing data, beyond a review of data reports. List the data source and recommended analyses*)

Data Source (existing dataset)	Description of data	Recommended analysis

Key Informant Interviews (list categories of key informants, and purpose of inquiry)

Qualitative, in-depth interviews will be conducted with key stakeholders and partners. Whenever possible, the evaluation team should conduct face-to-face interviews with informants. When it is not possible to meet with stakeholders in person, telephone interviews should be conducted. The evaluation team will have interviews with the following (not exhaustive):

- Relevant USAID offices at USAID/Washington and other U.S. Government offices
- MSH representatives (Ballston and Medford offices)
- Sub-partners of the LMG consortium
- Relevant USAID offices at the country level (USAID/Ethiopia, Kenya and Uganda, USAID/Haiti, USAID/Central America)
- Graduates of the VLDP/SLP/LDP+/Leadership Academy/Governance Academy; (via teleconference, web-based questionnaires or face to face)
- Current representatives from CSOs, professional networks, public sector and academic institutions receiving technical assistance from the LMG project at the different countries specified above (in-depth interviews, web-based questionnaires or face to face)

A list of suggested key informants will be provided to the evaluation team prior to the team planning meeting.

Focus Group Discussions (list categories of groups, and purpose of inquiry)

--

Group Interviews (list categories of groups, and purpose of inquiry)

Optional: Some of the key informant interviews can be clustered, as long as there are no power differentials, and all respondents feel comfortable in voicing their opinions within the group. (See list and description above under Key Informant Interviews.)

Client/Participant Satisfaction or Exit Interviews (list who is to be interviewed, and purpose of inquiry)

--

Facility or Service Assessment/Survey (list type of facility or service of interest, and purpose of inquiry)

--

Cost Analysis (list costing factors of interest, and type of costing assessment, if known)

--

Survey (describe content of the survey and target responders, and purpose of inquiry)

A self-assessment questionnaire will be utilized to obtain data about LMG and LMS on their effective approaches, lessons learned, best practices, etc. When possible, this survey will be administered via the internet (e.g., SurveyMonkey), but when this is not feasible, respondents will be asked to complete a hard copy of the questionnaire, or it will be administered in person by an evaluation team member. LMG has employed a self-assessment. As appropriate, the evaluation team can use and/or adapt this tool for this evaluation.

Observations (list types of sites or activities to be observed, and purpose of inquiry)

Evaluation team members, as appropriate, will visit three countries (tentatively, Uganda, Guatemala, Haiti, Côte d'Ivoire), where LMG has worked with ministries of health and local teams. Work during these site visits will include key informant and group interviews. Where possible, the evaluation team will observe LMG field intervention activities, such as trainings, workshops, governing board work, mentorship, training of trainers, etc.

Data Abstraction (list and describe files or documents that contain information of interest, and purpose of inquiry)

Case Study (describe the case, and issue of interest to be explored)

The case study will highlight factors that have contributed to successful programs, as well as factors that may have contributed to weak results.

Verbal Autopsy (list the type of mortality being investigated (i.e., maternal deaths), any cause of death and the target population)

Rapid Appraisal Methods (ethnographic / participatory) (list and describe methods, target participants, and purpose of inquiry)

Other (list and describe other methods recommended for this evaluation/analytic, and purpose of inquiry)

If impact evaluation –

Is technical assistance needed to develop full protocol and/or IRB submission?

Yes No

List or describe case and counterfactual”

Case	Counterfactual

HUMAN SUBJECT PROTECTION

The analytic team must develop protocols to insure privacy and confidentiality prior to any data collection. Primary data collection must include a consent process that contains the purpose of the evaluation, the risk and benefits to the respondents and community, the right to refuse to answer any question, and the right to refuse participation in the evaluation at any time without consequences. Only adults can consent as part of this evaluation. Minors cannot be respondents to any interview or survey, and cannot participate in a focus group discussion without going through an IRB. The only time minors can be observed as part of this evaluation is as part of a large community-wide public event, when they are part of family and community attendance. During the process of this evaluation, if data are abstracted from existing documents that include unique identifiers, data can only be abstracted without this identifying information.

ANALYTIC PLAN

Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data are to be triangulated (if appropriate). For example, a thematic analysis of qualitative interview data, or a descriptive analysis of quantitative survey data.

All analyses will be geared to answer the evaluation questions. Additionally, the evaluation will review both qualitative and quantitative data related to the project/program's achievements against its objectives and/or targets.

Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age and location, whenever feasible. Other statistical tests of association (i.e., odds ratio) and correlations will be run as appropriate.

Thematic review of qualitative data will be performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances and homogeneity and outliers to better explain what is happening and the perception of those involved. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data do not exist.

Use of multiple methods that are quantitative and qualitative, as well as existing data (e.g., project/program performance indicator data, and applicable country-specific data available through DHS, SPA, MICS, &/or HMIS data, etc.) will allow the team to triangulate findings to produce more robust evaluation results.

The evaluation report will describe analytic methods and statistical tests employed in this evaluation.

ACTIVITIES

List the expected activities, such as the team planning meeting (TPM), briefings, verification workshop with implementing partners and stakeholders, etc. Activities and Deliverables may overlap. Give as much detail as possible.

Background reading—Several documents are available for review for this analytic activity. These include LMG and LMS proposals, annual work plans, M&E plans, quarterly progress reports, and routine reports of project performance indicator data, as well as applicable country-specific survey data reports (i.e., DHS, SPA and MICS). This desk review will provide background information for the evaluation team, and will also be used as data input and evidence for the evaluation.

Team planning meeting (TPM)—A four-day team planning meeting (TPM) will be held at the initiation of this assignment and before the data collection begins. The TPM will:

- Review and clarify any questions on the evaluation SOW
- Clarify team members' roles and responsibilities

- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion
- Review and finalize evaluation questions
- Review and finalize the assignment timeline
- Develop data collection methods, instruments, tools and guidelines
- Review and clarify any logistical and administrative procedures for the assignment
- Develop a data collection plan
- Draft the evaluation work plan for USAID's approval
- Develop a preliminary draft outline of the team's report
- Assign drafting/writing responsibilities for the final report

Briefing and Debriefing Meetings—Throughout the evaluation, the team leader will provide briefings to USAID. The in-briefing and debriefing are likely to include the all evaluation team experts, but will be determined in consultation with the mission. These briefings are:

- **Evaluation launch**, a call/meeting among the USAID, GH Pro and the team leader to initiate the evaluation activity and review expectations. USAID will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the team leader and review the initial schedule and other management issues.
- **In-briefing with USAID**, as part of the TPM. This briefing may be broken into two meetings: (a) at the beginning of the TPM, so the evaluation team and USAID can discuss expectations and intended plans; and (b) at the end of the TPM, when the evaluation team will present an outline and explanation of the design and tools of the evaluation. Also discussed at the in-briefing will be the format and content of the evaluation report(s). The time and place for this in-briefing will be determined between the team leader and USAID prior to the TPM.
- **In-briefing with project** to review the evaluation plans and timeline, and for the project to give an overview of the project to the evaluation team.
- The team leader will brief USAID **weekly** to discuss progress on the evaluation. As preliminary findings arise, the team leader will share these during the routine briefing, and in an email.
- A **final debriefing** between the evaluation team and USAID will be held at the end of the evaluation to present preliminary findings to USAID. During this meeting, a summary of the data will be presented, along with high-level findings and draft recommendations. For the debriefing, the evaluation team will prepare a **PowerPoint Presentation** of the key findings, issues and recommendations. The evaluation team shall incorporate comments received from USAID during the debriefing in the evaluation report. (*Note: preliminary findings are not final, and as more data sources are developed and analyzed these findings may change.*)
- **Stakeholders' debrief/workshop** will be held with the project staff and other stakeholders identified by USAID. This will occur following the final debriefing with the mission, and will not include any information that may be deemed sensitive by USAID.

Fieldwork, Site Visits and Data Collection—The evaluation team will conduct site visits for data collection. Selection of sites to be visited will be finalized during the TPM in consultation with USAID. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field.

Evaluation/Analytic Report—The evaluation/analytic team, under the leadership of the team leader, will develop a report with findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:

1. Team leader will submit the draft evaluation report to GH Pro for review and formatting.
2. GH Pro will submit the draft report to USAID.
3. USAID will review the draft report in a timely manner, and send their comments and edits back to GH Pro.
4. GH Pro will share USAID's comments and edits with the team leader, who will then do final edits, as needed, and resubmit to GH Pro.

5. GH Pro will review and reformat the final evaluation/analytic report, as needed, and resubmit to USAID for approval.
6. Once the evaluation report is approved, GH Pro will reformat it for 508 compliance and post it to the DEC.

The evaluation report **excludes** any **procurement-sensitive** and other sensitive but unclassified (**SBU**) information. This information will be submitted in a memo to USAID separately from the evaluation report.

DELIVERABLES AND PRODUCTS

Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under “Other” in the table below. Provide timelines and deliverable deadlines for each.

Deliverable / Product	Timelines & Deadlines (estimated)
<input type="checkbox"/> Launch briefing	November 2, 2015
<input type="checkbox"/> Work plan with timeline	November 18, 2015
<input type="checkbox"/> Analytic protocol with data collection tools	November 18, 2015
<input type="checkbox"/> In-briefing with USAID/GH/PRH	November 11-18, 2015
<input type="checkbox"/> In-briefing with LMG	November 19, 2015
<input type="checkbox"/> Routine briefings	Weekly
<input type="checkbox"/> In-briefing with missions (country site visits)	Upon arrival in each country
<input type="checkbox"/> Out-briefing with mission (country site visits)	Just prior to departure from each country
<input type="checkbox"/> Out-briefing with USAID/GH/PRH with PowerPoint presentation	February 3, 2016
<input type="checkbox"/> Findings review workshop with stakeholders with PowerPoint presentation	February 4, 2016
<input type="checkbox"/> Draft report	February 26, 2016
<input type="checkbox"/> Final report	March 17, 2016
<input type="checkbox"/> Raw data	March 17, 2016
<input type="checkbox"/> Dissemination activity	
<input type="checkbox"/> Report posted to the DEC	April 25, 2019
<input type="checkbox"/> Other (specify):	

* **Note:** Expected blackout dates December 20 to January 18, due to holidays and consultants' availability.

Estimated USAID review time

Average number of business days USAID will need to review deliverables requiring USAID review and/or approval? _____ Business days

TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)

Evaluation/Analytic team: When planning this analytic activity, consider:

- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leaders for evaluations/analytics must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.

- Evaluations require an evaluation specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with methodological expertise related to the
- Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest, or describing the conflict of interest if applicable.

Team Qualifications: Please list technical areas of expertise required for this activities

List the key staff needed for this analytic activity and their roles. You may wish to list desired qualifications for the team as a whole, as well as for the individual team members.

The evaluation team will be a mixed team consisting of evaluators external to USAID and a team member internal to USAID. The evaluation team should have five members that have collective knowledge, experience, and context in evaluation methods, HRH, health system strengthening, and local context.

It is desirable that a member of the team have knowledge of evaluation of DCHA programs.

Edit as needed to the team leader's position description.

Team Leader: This person will be selected from among the key staff and will meet the requirements of both this and the other position. The team leader should have significant experience conducting project evaluations/analytics.

Roles and Responsibilities: The team leader will be responsible for (1) providing team leadership; (2) managing the team's activities, (3) ensuring that all deliverables are met in a timely manner, (4) serving as a liaison between the USAID and the evaluation/analytic team, and (5) leading briefings and presentations.

Qualifications:

- Minimum of 10 years of experience in public health, which includes experience in implementation of health activities in developing countries
- Demonstrated experience leading health sector project/program evaluation/analytics, utilizing both quantitative and qualitative methods
- Excellent skills in planning, facilitation and consensus building
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners and other stakeholders
- Excellent skills in project management
- Excellent organizational skills and ability to keep to a timeline
- Good writing skills, with extensive report writing experience
- Familiarity with USAID
- Familiarity with USAID policies and practices
 - Evaluation policy
 - Results frameworks
 - Performance monitoring plans

Key Staff I Title: Health Systems Strengthening Specialist

Roles and Responsibilities: Serve as a member of the evaluation team, providing technical expertise on HSS, covering the six building blocks to HSS. S/He will participate in evaluation planning, data collection, data analysis and report writing.

Qualifications:

- Expertise working with health system strengthening in developing countries, with a firm understanding of the six building blocks for HSS
 - i. leadership/governance
 - ii. health care financing
 - iii. health workforce
 - iv. medical products and technologies
 - v. information and research
 - vi. service delivery
- Experience in individual and organizational capacity development related to health system strengthening
- Experience in stakeholder engagement
- Experience in conducting USAID evaluations of health programs/activities
- An advanced degree in public health, or related field
- At least five years' experience in USAID health program management, oversight, planning and/or implementation (family planning and HIV projects is desirable)
- Able to work well on a team
- Good interpersonal communication skills
- Good writing skills, specifically technical and evaluation report writing experience
- Proficient in written and spoken English; additionally, French is desirable.
- Experience in conducting USAID evaluations of health programs/activities

Key Staff 2 Title: Evaluation Specialist

Roles and Responsibilities: Serve as a member of the evaluation team, providing quality assurance on evaluation issues, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. S/He will oversee the training of all engaged in data collection, insuring highest level of reliability and validity of data being collected. S/He is the lead analyst, responsible for all data analysis, and will coordinate the analysis of all data, assuring all quantitative and qualitative data analyses are done to meet the needs for this evaluation. S/He will participate in all aspects of the evaluation, from planning, data collection, and data analysis to report writing.

Qualifications:

- At least 10 years of experience in USAID M&E procedures and implementation
- At least five years managing M&E, including evaluations
- Experience in design and implementation of evaluations
- Strong knowledge, skills, and experience in qualitative and quantitative evaluation tools
- Experience implementing and coordinating other to implements surveys, key informant interviews, focus groups, observations and other evaluation methods that assure reliability and validity of the data
- Experience in data management
- Able to analyze quantitative data, which will be primarily descriptive statistics
- Able to analyze qualitative data
- Experience using analytic software
- Demonstrated experience using qualitative evaluation methodologies, and triangulating with quantitative data
- Able to review, interpret and reanalyze as needed existing data pertinent to the evaluation
- Strong data interpretation and presentation skills
- An advanced degree in public health, evaluation or research or related field
- Proficient in written and spoken English; additionally, French is desirable.

- Good writing skills, including extensive report writing experience
- Familiarity with USAID health programs/projects (family planning and HIV projects are desirable)
- Familiarity with USAID and PEPFAR M&E policies and practices
 - Evaluation policies
 - Results frameworks
 - Performance monitoring plans

Key Staff 3 Title: Capacity and Organizational Development Specialist

Roles and Responsibilities: Serve as a member of the evaluation team, providing technical expertise to evaluate capacity and organizational strengthening activities, with focus on leadership, management and governance at a global level, as well in-country interventions and approaches, including human resources for health (i.e., human resources management, education and training, and performance support systems). This individual will bring the lens of his/her subject matter expertise and experience to bear on all aspects of the scope of work. S/He will participate in all aspects of the evaluation, including planning, data collection, data analysis and report writing.

Qualifications:

- Background and at least five years' experience in organizational capacity development/strengthening
- Expertise in approaches to strengthen leadership, management and governance of health programs.
- Knowledgeable in HRH, including human resource management, training and education, performance support systems, etc.)
- Knowledgeable in organizational development and capacity-building assessment (e.g., OCATs), as well as evaluation methodologies
- Experience working in organizational development/strengthening among governmental and non-governmental entities in developing country settings to strengthen health programs/activities
- Experience in implementing and/or evaluating programs/projects (family planning and HIV projects is desirable)
- Proficient in English; additionally, French is desirable.
- Good writing skills, specifically technical and evaluation report writing experience
- Experience in conducting USAID evaluations of health programs/activities

Other Staff: Titles with Roles and Responsibilities (include number of individuals needed):

DC-based Program Assistant, under the direction of the team leader, will support the evaluation team as needed, to assist with planning, logistics, arranging appointments, taking notes, etc.

Local Evaluation Logistics/Program Assistant will support the evaluation team when on site visit to countries where LMG is implemented. The Logistics/Program Assistant support the team with all logistics and administration to allow them to carry out this evaluation. The Logistics/Program Assistant will have a good command of English and local language(s). S/He will have knowledge of key actors in the health sector and their locations, including MOH, donors and other stakeholders. To support the team, s/he will be able to efficiently liaise with hotel staff, arrange in-country transportation (ground and air), arrange meeting and workspace as needed, and insure business center support, e.g. copying, internet, and printing. S/he will work under the guidance of the team leader to make preparations, arrange meetings and appointments. S/he will conduct programmatic administrative and support tasks as assigned and ensure the processes moves forward smoothly. S/He may also be asked to assist with note

taking at interviews and meetings, as well as with translation of data collection tools and transcripts. (1 per country visited)

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or analytic activity.

Yes – If yes, specify who: Nandita Thatte

No

Staffing Level of Effort (LOE) Matrix (Optional):

This optional LOE Matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

- For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.
- Immediately below each staff title enter the anticipated number of people for each titled position.
- Enter row labels for each activity, task and deliverable needed to implement this analytic activity.
- Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.
- At the bottom of the table total the LOE days for each consultant title in the 'Subtotal' cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

Level of Effort in **days** for each evaluation/analytic team member

Activity / Deliverable		Evaluation Team				
		Team Lead/Key Staff 1	Key Staff 2	Key Staff 3	Program Assistant (DC)	In-Country Logistics/Program Assistant
Number of persons →		1	1	1	1	4
1	Pre-assignment planning	2				
2	Launch briefing	1	0.5	0.5		
3	Document review	5	5	5		
4	Team planning meeting	3	3	3	3	
5	In-briefing with USAID/GH/PRH	1	1	1	1	
6	Briefing with LMG	1	1	1	1	
7	Data collection and data quality assurance workshop (protocol orientation for all involved in data collection)	1	1	1	1	
8	Preparation/logistics for data collection	1	1	1	2	
9	Data collection (U.S.-based)	10	10	10	4	
10	Preparation for field visits (4 countries TBD)	1	1	1	.5	2
11	Travel to 4 countries for field visit	8	8	8		
12	Field visits to 4 countries—activities include: in- and de-briefing with mission staff, data collection and preliminary analysis	20	20	20		5
13	Data cleaning and analysis (U.S. and field)	7	7	7	.5	1
14	Debriefing with presentation with USAID/GH/PRH to present preliminary findings (U.S. and field), with preparation	1	1	1	1	
15	Stakeholder presentation on preliminary findings (U.S. and field), with preparation	1	1	1	1	

16	Draft report	7	6	6	1	
17	GH Pro report quality control review and formatting					
18	Submission of draft report to USAID/PRH					
19	USAID report review					
20	Revise report(s) per USAID comments	3	2	2		
21	Finalization and submission of report					
25	508 compliance review					
26	Upload evaluation report(s) to the DEC					
	Subtotal LOE	73	68.5	68.5	16	8
	Total LOE	73	68.5	68.5	16	32

If overseas, is a 6-day workweek permitted Yes No

Travel anticipated: List international and local travel anticipated by what team members.

Haiti, Uganda, Guatemala, potentially Côte d'Ivoire

LOGISTICS

Note: Most evaluation/analytic teams arrange their own work space, often in their hotels. However, if Facility Access is preferred GH Pro can request it. GH Pro does not provide Security Clearances. Our consultants can obtain **Facility Access** only.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

USAID Facility Access

Specify who will require Facility Access: _____

Electronic County Clearance (ECC) (International travelers only)–Depending on the countries visited

GH Pro workspace

Specify who will require workspace at GH Pro: Team planning meeting and workspace while in DC

Travel–other than posting (specify): _____

Other (specify): _____

GH PRO ROLES AND RESPONSIBILITIES

GH Pro will coordinate and manage the evaluation/analytic team and provide quality assurance oversight, including:

- Review scope of work and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for analytic activity
- Recruit and hire the evaluation/analytic team, with USAID point of contact's approval
- Arrange international travel and lodging for international consultants
- Request for country clearance and/or facility access (if needed)

- Review methods, work plan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
- Report production—If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for internal distribution.

USAID ROLES AND RESPONSIBILITIES

Below is the standard list of USAID’s roles and responsibilities. Add other roles and responsibilities as appropriate.

USAID Roles and Responsibilities
<p>USAID will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:</p> <p>Before Field Work</p> <ul style="list-style-type: none"> ● <u>Scope of work</u>: <ul style="list-style-type: none"> ○ Develop scope of work. ○ Peer review scope of work ○ Respond to queries about the scope of work and/or the assignment at large. ● <u>Consultant conflict of interest (COI)</u>: To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CVs for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates. ● <u>Documents</u>: Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment. ● <u>Local consultants</u>: Assist with identification of potential local consultants, including contact information. ● <u>Site visit preparations</u>: Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs. ● <u>Lodgings and travel</u>: Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation). <p>During Field Work</p> <ul style="list-style-type: none"> ● <u>Mission point of contact</u>: Throughout the in-country work, ensure constant availability of the point of contact person and provide technical leadership and direction for the team’s work. ● <u>Meeting space</u>: Provide guidance on the team’s selection of a meeting space for interviews and/or focus group discussions (i.e., USAID space if available, or other known office/hotel meeting space). ● <u>Meeting arrangements</u>: Assist the team in arranging and coordinating meetings with stakeholders. ● <u>Facilitate contact with implementing partners</u>: Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team’s arrival and/or anticipated meetings. <p>After Field Work</p> <ul style="list-style-type: none"> ● <u>Timely reviews</u>: Provide timely review of draft/final reports and approval of deliverables.

ANALYTIC REPORT

Provide any desired guidance or specifications for the final report. (See [How-To Note: Preparing Evaluation Reports](#))

<p>The evaluation/analytic final report must follow USAID’s Criteria to Ensure the Quality of the Evaluation Report (found in Appendix I of the <u>USAID Evaluation Policy</u>).</p> <ol style="list-style-type: none"> a. The report must not exceed XX pages (excluding executive summary, table of contents, acronym list and annexes). b. The structure of the report should follow the evaluation report template, including branding found <u>here</u> or <u>here</u>. c. Draft reports must be provided electronically, in English, to GH Pro who will then submit it to USAID.
--

- d. For additional guidance, please see the Evaluation Reports to the How-To Note on preparing Evaluation Draft Reports found [here](#).

Reporting Guidelines: The draft report should be a comprehensive analytical evidence-based evaluation/analytic report. It should detail and describe results, effects, constraints, and lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. **The report will be edited, formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.**

The findings from the evaluation/analysis will be presented in a draft report at a full briefing with USAID and at a follow-up meeting with key stakeholders. The report should use the following format:

- Executive Summary: concisely state the most salient findings, conclusions, and recommendations (not more than 4 pages)
- Table of Contents (1 page)
- Acronyms
- Evaluation/Analytic Purpose and Evaluation/Analytic Questions (1-2 pages)
- Project [or Program] Background (1-3 pages)
- Evaluation/Analytic Methods and Limitations (1-3 pages)
- Findings
- Conclusions
- Recommendations
- Annexes
 - Annex I: Evaluation/Analytic Statement of Work
 - Annex II: Evaluation/Analytic Methods and Limitations
 - Annex III: Data Collection Instruments
 - Annex IV: Sources of Information
 - List of Persons Interviews
 - Bibliography of Documents Reviewed
 - Databases
 - [etc.]
 - Annex V: Disclosure of Any Conflicts of Interest
 - Annex VI: Statement of Differences (if applicable)

The evaluation methodology and report will be compliant with the USAID Evaluation Policy and Checklist for Assessing USAID Evaluation

Reportshttp://usaidealarninglab.org/sites/default/files/resource/files/mod11_summary_checklist_for_assessing_usaid_evaluation_reports.pdf

The evaluation report should **exclude** any **potentially procurement-sensitive information**. As needed, any procurement-sensitive information or other sensitive but unclassified (SBU) information will be submitted in a memo to USAID separately from the evaluation report. All data instruments, data sets (if appropriate), presentations, meeting notes and report for this evaluation/analysis will be provided to GH Pro and presented to USAID electronically to the Program Manager. All data will be in an unlocked, editable format.

USAID CONTACTS

	Primary Contact	Alternate Contact 1	Alternate Contact 2	Alternate Contact 3
Name:	Reena Shukla	Temitayo Ifafore	Kenneth Sklaw	Sandy Jenkins
Title:	Health Officer	Technical Advisor	Technical Advisor	
USAID Office	GH/PRH/SDI	GH/PRH/SDI	GH/OHA	DCHA
Email:	rshukla@usaid.gov mailto:rshukla@usaid.gov	tifafore@usaid.gov mailto:tifafore@usaid.gov	ksklaw@usaid.gov mailto:ksklaw@usaid.gov	Sjenkins@usaid.gov mailto:Sjenkins@usaid.gov
Telephone:	571-551-7048	571-551-7345	571-551-7282	202-789-1500 x 238
Cell Phone (optional)	(202) 802-0565	571-214-2162		

List other contacts who will be supporting the requesting team with technical support, such as reviewing the scope of work and report (such as USAID/W GH Pro management team staff)

	Technical Support Contact 1	Technical Support Contact 2
Name:	Amani Selim	
Title:	Evaluation Technical Adviser	
USAID Office/Mission	USAID, Bureau for Global Health, Office of Population and Reproductive Health	
Email:	aselim@usaid.gov	mailto:aselim@usaid.gov
Telephone:	571-551-7528	
Cell Phone (optional)	571-721-9577	

REFERENCE MATERIALS

Documents and materials needed and/or useful for consultant assignment, that are not listed above

--

TABLE OF ACRONYMS

ACHEST	African Centre for Global Health and Social Transformation
ADS	Automated Directives System
AFG	AIDS-Free Generation
AHLMN	African Health Leadership and Management Network
AIDS	Acquired Immune Deficiency Syndrome
Amref	Amref Health Africa (formerly the African Medical and Research Foundation)
CDC	Center for Disease Control
CSO	Civil society organizations
DCHA	Democracy, Conflict and Humanitarian Assistance
EPCMD	Ending Preventable Child and Maternal Deaths
FP	Family Planning
FP2020	Family Planning 2020
FY	Fiscal Year
GFATM	Global Fund for AIDS, Tuberculosis, and Malaria
GH	Global Health Bureau
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HSS	Health Systems Strengthening
IPPF	International Planned Parenthood Federation
LMG	The Leadership, Management and Governance Project
L+M+G	Leadership, management and governance
LMS	The Leadership, Management and Sustainability Project
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MOH	Ministry of Health
NGO	Non-governmental organization
OHA	Office of HIV and AIDS
OHS	Office of Health Systems

PEPFAR	President's Emergency Plan for AIDS Relief
PIA	Ponseti International Association
PMI	President's Malaria Initiative
PRH	Office of Population and Reproductive Health
RFA	Request for Applications
RH	Reproductive Health
RNMCH	Reproductive, Maternal, Newborn and Child Health
USAID	United States Agency for International Development

List of Data Sources LMG Project End of Project Evaluation

General Background

- USAID Forward Reform Agenda
 - USAID Forward Progress Report 2013
- USAID Global Health Initiative Strategy
 - GHI Strategy
- PEPFAR Strategy
 - PEPFAR Strategy
 - Annex–Global Context of HIV
 - Annex–Global Health Initiative
 - Annex–Prevention, Care, and Treatment

Project-Specific Context

- RFA
 - SLMG RFA Final 2011
- Cooperative Agreement
 - LMG Cooperative Agreement
 - LMG Cooperative Agreement–Attachment B Basic Program Description
 - Modification 1–Modification 17 (5.14.15)
- Annual work plans
 - LMG Year 1 Work plan Final
 - LMG Year 2 Work plan Final
 - LMG Year 3 Work plan Final
 - LMG Year 4 Work plan Final
- PMP
 - LMG PMP Final
 - LMG PMP Progress Update
 - LMG PMP Updated
 - LMG Indicator Definitions
 - PMP Reports
- Semiannual progress reports
 - LMG Year 1 Annual Progress Report
 - LMG Year 2 Semiannual Progress Report
 - LMG Year 2 Annual Progress Report
 - LMG Year 3 Semiannual Progress Report
 - LMG Year 3 Annual Progress Report
 - LMG Year 4 Semiannual Progress Report
- Financial reports
 - LMG Annual Baseline (9.30.11) Submitted

- o LMG Annual Baseline (9.30.12) Submitted
- o LMG Annual Baseline (9.30.13) Submitted
- o LMG Annual Baseline (9.30.14) Submitted
- Annual management review reports
 - o LMG Year 1 Management Review Questions
 - o LMG Year 1 Management Review Memo Final
 - o LMG Year 2 Management Review Responses
 - o LMG Year 2 Management Review Memo Final
 - o LMG Year 3 Management Review Presentation
 - o LMG Year 3 Management Review Responses
 - o LMG Year 3 Management Review Memo Final
- Scopes of work for field-funded activities, as applicable
 - o LMG Afghanistan Work Plan March 2013-June 2014
 - o LMG Latin America and the Caribbean Scope of Work March
- Self-assessment question responses
 - o LMG self-assessment 2013
 - o LMG self-assessment 2014

Technical Data Sources

- Pre-service education (PSE)

Useful Websites

- LMG www.lmgforhealth.org<http://www.lmgforhealth.org/>
- MSH www.msh.org/<http://www.msh.org/>
- LeaderNet

ANNEX II. EVALUATION METHODS AND LIMITATIONS

Design

The scope of work for this end-line performance evaluation specified the methods to be used. These were primarily data and document review, semi-structured interviews with key informants, supplemented by document and data review. Primary data collection methods were therefore primarily qualitative in-depth interviews with a small closed-ended questionnaire administered online. The team reviewed project data, including the project dashboard for reporting on PMP indicators and a preliminary analysis of a project database still under construction, and reviewed more than 300 project documents.

These project documents and data were used to understand the scope of the project, help to develop the interview guides and corroborate certain statements made by interviewees. The team was also able to triangulate data regarding evaluation questions from multiple perspectives, since it interviewed a number of different target groups. The team also observed a branch clinic in one district in Uganda and conducted interviews there, and it observed another project activity, a Senior Leadership Program (SLP) training in Ethiopia for (francophone) ICRC staff, and conducted interviews with the participants.

The following sections describe major components of the evaluation: (1) fieldwork preparation, (2) description of data collection tools, (3) categories of key evaluation respondents, and (4) evaluation calendar.

Preparation for field work

The evaluation team spent three weeks doing extensive work in Uganda and Ethiopia, including site visits mentioned above. Prior to these visits, the team undertook the following preparation activities:

- During November, the team reviewed project documents provided by MSH via a 'drop-box' and by USAID/DC via Google Docs.
- During the week of November 16-20, the team conducted in-briefings with the USAID/Washington team managing the LMG project and interviews with other USAID/Washington staff knowledgeable about the project.
- During the same week, an in-depth introduction to the project was given by LMG staff at MSH Arlington headquarters (in person) and via virtual conferencing with LMG staff in Medford, MA and in various countries where LMG staff and former LMS and LMG staff who served as informants were located.

Development of data collection tools

The evaluation team developed data collection instruments for key informant interviews (described below) prior to arrival in Uganda, minimally pre-testing them with informants interviewed by SKYPE prior to the team's leaving the U.S. Due to changes in the travel itinerary and the need to schedule interviews in Uganda almost immediately upon arrival, this is the only formal pre-test that could be done. At the time these tools were developed, however, the team also identified the key themes to be used to code the interviews, and the evaluation advisor produced a final set of interview guides and coding sheets so that interviews could be coded soon after they took place.

Scheduling of field team visits with implementing partners

Key informant interviews were scheduled in close coordination with the LMG team at headquarters in Arlington, VA and Medford, MA, as well as the LMG team in Ethiopia and MSH staff in Uganda. LMG headquarters provided a staff member to assist with scheduling virtual interviews with LMG staff. USAID/Washington proposed certain individuals to interview in countries visited and to be interviewed virtually. MSH/LMG staff also proposed a large number of interviewees, both LMG staff and from beneficiary organizations. The evaluation team tried to interview all those suggested by USAID, as well as a selection of those proposed by the LMG team whose programs corresponded to the questions raised by USAID. An attempt was made to have geographic distribution, to focus on larger field support and regional programs and to balance respondents from the various core funding streams (family planning/reproductive health, HIV/AIDS, DCHA and PMI).

Data collection tools

The evaluation field team gathered data in the field and virtually using the following instruments:

Individual key informant interview guides: Individual interviews were conducted in a semi-structured format in which all relevant questions were asked in an order appropriate for the specific interview, and interviewers were able to choose to omit questions irrelevant for a specific interviewee, but the format also contained appropriate probes to obtain further information if needed. Five guides were developed:

1. For leaders, board members, managers of public and private organizations, and service delivery organizations, including government units, which participated in LMG interventions
2. For key persons in Amref, AHLMN, ACHEST, ICRC, IPPF and local affiliates and universities and other institutions of higher learning that have directly participated as beneficiaries in LMG activities/interventions
3. For key MSH staff in each priority country visited (or by phone), and implementing partner organizations (consortium members as implementers, including Yale University Global Health Institute, and Johns Hopkins University Bloomberg School of Public Health, Amref, IPPFAR, Medic Mobile)
4. For interviews with other donors, as relevant (e.g., World Bank, Global Fund)
5. For in-depth interviews with USAID field mission staff (in countries visited or interviewed in-depth: e.g., Haiti, Côte d'Ivoire, Kenya, Ukraine, Nigeria, Afghanistan, LMS-West Africa, Burundi, Liberia, Cameroon, Vietnam, Southern Africa).

As appropriate, several people from the same organization or agency at times participated together in an interview. In total 18 such group interviews were conducted, ranging in size from 2 to 11 participants, as convened by various agencies or government units.

Online survey: The evaluation team developed a short closed-ended questionnaire, supplemented by open-ended questions, which the USAID/Washington LMG management team sent to USAID missions via an email link to an online survey to obtain information from most USAID missions where the evaluation team would not visit. These were supplemented by virtual interviews with mission staff in eight countries. The USAID team sent the email to 14 missions just prior to the Thanksgiving holiday, and promised to send follow up reminders in December to improve the response rate.

Ethical considerations. Data collection and analysis adhered to international standards for the protection of respondents' privacy and confidentiality of data. All interviews included a consent process to ensure that all interviewees participated voluntarily and principles of data confidentiality were observed.

DCHA interviews and site visits

In order to respond to the questions raised by DCHA on effectiveness of the LMG tools and approaches with its grantees, the team surveyed two country delegations consisting of 12 key informants who were in Ethiopia for the LMG francophone Senior Leadership Training. A total of 13 other key informant interviews were held with DCHA grantees, including two with the DCHA Bureau and four with the MSH/LMG and Yale/LMG technical assistance teams. (Yale's GHFI has developed the SLP curriculum that has been used in 15 ICRC countries.)

The evaluation team visited a PRC in Ethiopia in Dire Dawa, close to the Somali border, where injured refugees are being sent as well as patients with congenital disabilities and other serious and disabling injuries, and met with its staff. The staff provided an overview of the PRC's work and described in general how the EMP training was progressing in their center. A member of the evaluation team also spent a full day in Addis Ababa observing the SLP training held in Addis for 60 francophone participants from six multi-disciplinary national delegations and various CSOs. Individual participants and group interviews with SLP participants and ICRC EMP-trained coaches were also interviewed.

The DCHA portion of the evaluation also benefited from the assessment of the LMG EMP, which was developed for ICRC's work in nine countries in Africa and Southeast Asia, carried out by DCHA in 2015.³⁴ Five of the DCHA key informants were with the ICRC, and the site visited is a non-governmental PRC supported in part by ICRC. In-depth group interviews of 4-7 key informants were conducted with country delegations from Togo and Madagascar.

Site visits to organizations in Ethiopia and Uganda, including observation of training and services, allowed the team to directly assess the effects of the LMG approach. Virtual key informant interviews produced information from key beneficiary organizations, including from ministries of health in Ethiopia, Afghanistan, Haiti, Nigeria, Burundi, Vietnam and other donors including the World Bank, the International AIDS Alliance and the Global Fund.

Some organizations were reviewed in-depth, including JCRC and RHU in Uganda, Ethiopian Public Health Officers Association, three RHBs in Ethiopia and numerous departments and units in the FMOH in Ethiopia, the contracting and grants units in Haiti and Afghanistan, the community development department and blood bank in Afghanistan. We also interviewed four of the seven grantees receiving LMG assistance from the DCHA component of the project and the DCHA-funded senior leadership host country delegations. The LMG project also contracted for independent evaluations of the LDP+ and SLP modules in 2015 and conducted a study of the impact of LDP training in Cameroon. These reports were available to the team. The team also did a selective review of the LMG M&E tracking system that monitors completion of LDP team targets (challenges) and written reports on country programs.

Analysis

A simple descriptive analysis of the frequencies of each response was carried out for the online survey responses (nine of 14 were completed).

For the qualitative, in-depth interviews, an initial list of key themes was developed to address the four primary evaluation questions. Each team member coded data from their initial interviews, and the team met to review their results and agree on a final list of themes. A matrix of themes was developed in MS Word to use when coding interviews, allowing a residual ("other") category for relevant statements that might emerge from individual interviews that did not fit into any of the pre-identified thematic areas. Team members then coded their interviews, and finally, reviewed their code sheets to identify and

³⁴ Susan Eitel. 2015. Trip Report, DCHA.

summarize recurrent and important themes and associated notes and quotes, which team members aligned with either the evaluation questions or the six WHO health system strengthening “building blocks.”

The team then met to triangulate the results of its qualitative data analyses and to incorporate data from the other sources. (See list of data sources in Annex IV.) Findings reported summarize responses to the online questionnaire and in-depth interviews with key informants, supplemented by program data where relevant.

A case study was developed to provide an example of the methods used by LMG and to highlight the factors underlying its results, with a focus on one reproductive health organization that received multiple types of technical assistance from LMG.

Matrix of evaluation questions and key themes

Evaluation questions and elements to consider:	Key themes for coding interviews
<p>1. How effectively did LMG’s leadership development approach respond to organizations’ identified needs?</p> <p><u>Things to consider:</u></p> <p>a. Results of LMG’s organizational development approach on the capacity of CSO/institutions that serve vulnerable populations through DCHA funding</p> <p>b. Results in the areas of advocacy, service delivery, quality and accessibility</p> <p>c. Elements of LMG’s organizational development approach that enabled or limited regional professional health bodies, such as Amref, AHLMN and ACHEST, to meet their mid- and long-term goals</p> <p>d. LMG’s leadership development to cultivate accountability and steward resources at subnational and national levels, particularly with Ministries of Health</p>	<p>Tools and their uses</p> <p>Helped with focus challenges</p> <p>Capacities built</p> <p>New funding opportunities created and/or secured</p> <p>Employee performance, satisfaction improved</p> <p>Other</p>
<p>2. To what extent have LMG interventions benefited the target populations of AIDS-Free Generation, Ending Preventable Maternal and Child Deaths, and FP2020?</p> <p><u>Things to consider:</u></p> <p>a. LMG’s approved work plans and their contribution to the to an AIDS Free Generation and PEPFAR 3.0 goal of epidemic control</p> <p>b. LMG’s approaches to improve technical and organizational capacity of family planning/reproductive health service delivery institutions</p> <p>c. Approaches that demonstrate potential for sustainability after this project ends</p>	<p>Improved service delivery</p> <p>Changes in organizational performance</p> <p>Benefits for women/women leaders</p> <p>Other</p>
<p>3. Based on experiences with LMS and LMG over the past 10 years, what lessons can be learned about sustaining global support for leadership, management and governance work from this project? (Note: LMG is the focus of this evaluation, and LMS is used as a reference point.)</p> <p><u>Things to consider:</u></p> <p>a. Components of the LMG and LMS projects that are replicable by a variety of countries and institutions</p> <p>b. Components of the LMG and LMS projects that are difficult to replicate by a variety of countries and institutions</p> <p>c. LMG and LMS project contribution to the global knowledge base around investments in organizational development, health management and governance</p>	<p>Tools adopted or adapted</p> <p>Still using tool(s)</p> <p>Scaling up, replication</p> <p>Evidence produced, disseminated</p> <p>Institutionalization</p> <p>Host country ownership</p> <p>Belief in sustainability of L+M+G models/approaches</p> <p>Other donors support L+M+G</p> <p>Evidence of collaboration with other entities/projects</p> <p>Other</p>

d. LMG and LMS activities that have increased global and local advocacy and support for future investments in strengthening health leadership, management and governance practices	
4. In addition to the above questions, what unforeseen challenges and opportunities has LMG and LMS encountered, and how were they managed? (Note: LMG is the focus of this evaluation, and LMS is used as a reference point.)	Funding shifts Other priority issues emerged Project timeline Other

Limitations

There is potential bias in the evaluation findings due to the small number of countries visited, only two out of 20 countries where the project operated, and the purposive, non-random selection of respondent organizations and respondents interviewed.

The countries to be visited were selected by the USAID LMG management team. One country, Haiti, was dropped from the visit schedule due to security concerns, but interviews with eight respondents in Haiti were successfully conducted via telephone. The team aimed to alleviate possible bias from this source by also conducting interviews in eight other countries via virtual means (telephone and SKYPE calls). Informants in Haiti, Afghanistan, Vietnam, Côte d'Ivoire, Nigeria, Cameroon (and other West Africa), Liberia and Burundi were interviewed virtually. All interviews with beneficiary organizations and their representatives were conducted without any USAID or project staff present.

Other limitations stem from the effect of interviewing project staff and participants, who may have exaggerated the positive effects of the intervention in which they participated, or from “courtesy bias” by respondents who did not wish to say things that might offend the project funder (USAID) or project staff, although neither were present at interviews. The team tried to avoid such effects by limiting the use of LMG staff interviews in reporting results and by triangulating data from different types of respondents and from documentary evidence. Interviews with LMG staff were used primarily to ensure evaluators had sufficient background to conduct interviews with beneficiary organizations.

LMG EVALUATION CALENDAR

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1-Nov	2-Nov	3-Nov	4-Nov	5-Nov	6-Nov	7-Nov
	Launch call	Document review	Document review	TPM	Document review	
8-Nov	9-Nov	10-Nov	11-Nov	12-Nov	13-Nov	14-Nov
	Document review	Document review	VETERANS DAY TPM	Document review	Document review	
15-Nov	16-Nov	17-Nov	18-Nov	19-Nov	20-Nov	21-Nov
	TPM In-brief	TPM In-brief	In-brief and interviews in DC	LMG briefing Prep for site visits	Tools development Prep for site Visits	
22-Nov	23-Nov	24-Nov	25-Nov	26-Nov	27-Nov	28-Nov
	Prep for site visits U.S. data collection	U.S. data collection	U.S. data collection and tools development	THANKSGIVING	U.S. data collection and tools development	
29-Nov	30-Nov	1-Dec	2-Dec	3-Dec	4-Dec	5-Dec
BB and PD depart for Uganda	Team arrives Uganda	Team meeting and finalizing instruments	Interviews in Uganda	Interviews in Uganda	Interviews in Uganda	Interviews in Uganda
6-Dec	7-Dec	8-Dec	9-Dec	10-Dec	11-Dec	12-Dec
	Interviews in Uganda	BB travels to Ethiopia Uganda interviews continue	JK and PD travel to Ethiopia BB interviews ICRC	Ethiopia interviews	Ethiopia interviews	Ethiopia interviews
13-Dec	14-Dec	15-Dec	16-Dec	17-Dec	18-Dec	19-Dec
Travel to site visits in Dire Dawa and Bahir Dar	Site visits and interviews PD returns to Addis Ababa	BB and JK return to Addis Ababa Interviews continue	Interviews continue	PD travels to home Interviews continue	BB and JK Travel PD Interviews in U.S.	Travel
20-Dec	21-Dec	22-Dec	23-Dec	24-Dec	25-Dec	26-Dec
Blackout	Blackout	Blackout	Interview	Blackout	Blackout	Background Sections Plan DC Interviews
27-Dec	28-Dec	29-Dec	30-Dec	31-Dec	1-Jan	2-Jan
Blackout	Interview scheduling and coding	Drafting background and coding	Drafting background and review online survey results	Completion of KI tables and coding	Blackout	Blackout

3-Jan	4-Jan	5-Jan	6-Jan	7-Jan	8-Jan	9-Jan
Interviews and coding	Interviews and coding	Interviews, coding	Interviews, coding	Coding	Interviews	Interviews
10-Jan	11-Jan	12-Jan	13-Jan	14-Jan	15-Jan	16-Jan
Draft Section 4	Complete DCHA interviews and draft findings	Interviews	Interviews West Africa	Interviews	Review new materials and complete source tables	
17-Jan	18-Jan	19-Jan	20-Jan	21-Jan	22-Jan	23-Jan
Blackout	Interviews in Haiti and NMCPs in Africa	Final interviews; prepare for team meeting in DC	Final interviews; prepare for team meeting in DC	Travel to DC	Preliminary analyses	
24-Jan	25-Jan	26-Jan	27-Jan	28-Jan	29-Jan	30-Jan
	Preliminary analyses	Preliminary analyses	Preliminary analyses	Preliminary analyses	Preliminary analyses	
31-Jan	1-Feb	2-Feb	3-Feb	4-Feb	5-Feb	6-Feb
	Preliminary analysis	Preliminary analysis	Preliminary analysis Prepare PPT	Preliminary analysis Prepare PPT	Preliminary analysis Prepare PPT	
7-Feb	8-Feb	9-Feb	10-Feb	11-Feb	12-Feb	13-Feb
	Data analysis Draft evaluation report	Data analysis; meet with USAID	Debrief with LMG/MSH	Debrief with USAID	Travel home	
14-Feb	15-Feb	16-Feb	17-Feb	18-Feb	19-Feb	20-Feb
	Data analysis Draft evaluation report	Data analysis Draft evaluation report	Data analysis Draft evaluation report	Data analysis Draft evaluation report	Finalize first draft of key findings and executive summary	
21-Feb	22-Feb	23-Feb	24-Feb	25-Feb	26-Feb	27-Feb
	Team comments on draft	Team comments on draft	Consolidating final draft	Team reviews consolidated final draft	Submit draft evaluation report to GH Pro	
28-Feb	29-Feb	1-Mar	2-Mar	3-Mar	4-Mar	5-Mar
	GH Pro review starts	GH Pro review and editing	GH Pro submits draft to USAID	USAID reviews draft evaluation report	USAID reviews draft evaluation report	

6-Mar	7-Mar	8-Mar	9-Mar	10-Mar	11-Mar	12-Mar
	USAID reviews draft evaluation report	USAID reviews draft evaluation report				
13-Mar	14-Mar	15-Mar	16-Mar	17-Mar	18-Mar	19-Mar
	USAID reviews draft evaluation report	USAID reviews draft evaluation report	USAID reviews draft evaluation report	USAID sends comments/edits on draft evaluation report	Team finalizes draft/edits technical	
20-Mar	21-Mar	22-Mar	23-Mar	24-Mar	25-Mar	26-Mar
	Team finalizes draft/edits technical	Team finalizes draft/edits technical	Team finalizes draft/edits technical	Team submits final tech draft to GH Pro	Tech draft sent to USAID	
27-Mar	28-Mar	29-Mar	30-Mar	31-Mar	1-Apr	2-Apr
	USAID final tech review					

Details of evaluation team

Betsy Brown, MALD, Team Leader and Organizational Development Specialist

International public health manager with experience building, leading and mentoring multinational, child and maternal health, HIV/AIDS, tuberculosis, infectious and chronic disease, vector control and multi-disciplinary health teams. Expertise designing, implementing, evaluating and crafting strategic plans for PEPFAR programs for USAID and PEPFAR Country Teams in Mozambique, Russia, Ukraine and Georgia. Ending Preventable Maternal and Child Morbidity and Mortality Program (EPMCD) design experience in Senegal. Served as the U.S. Government representative to the Global Fund's Country Coordinating Committee in Russia from 2004–2007. Designed and implemented the first generation of USAID-funded HIV/AIDS social marketing and STI programs in Jamaica and Haiti. Recognized manager, policy advisor and negotiator for USAID and the Millennium Challenge Corporation. Served as a recurrent short-term senior advisor over a three-year period to the Government of Mongolia on the MCC financed non-communicable disease project, which included serving as a direct report to a Mongolian medical director inside the Mongolian Ministry of Health. Expertise in program design, problem solving, resource allocation, strategizing, teaming, innovating, designing, monitoring and evaluating international health and education programs and organizational management and staffing. Nonprofit CEO expertise gained through over two years managing a NYS Planned Parenthood affiliate (PPNCNY) with an annual budget of \$5.2 million and a staff of 80 covering six counties with eight health centers. Secured funding for HIV/AIDS and STI testing, diagnosis and counseling from three counties for PPNCNY over two consecutive years, led the affiliate through both NYS Department of Health and Planned Parenthood accreditation processes.

Jennifer Katekaine, MSc, MBA, Health Systems Strengthening Specialist

Ms. Katekaine is a Health Systems Specialist with strong skills in research policy, strategic planning programming, and over 14 years' experience in health programming, management, research, evaluation and training. Recently, Ms. Katekaine served as a Principal Recipient Management consultant in Nigeria providing technical support for the Nigeria HIV/TB Global Fund grant-making to four Principle Recipients. She served as an evaluator (Health Systems Strengthening Specialist) for Support for Service Delivery-Integration (SSDI) project. She was also a Short-Term Systems Strengthening and Capacity

Development Advisor for USAID/Namibia. Her other consulting assignments include development of a curriculum for health systems strengthening in Africa and training ministries of health in East, Central and Southern Africa on the same. She is an Associate Consultant at East and Southern African Management Institute, facilitating in several management courses, including human resource management, public policy, project management, strategic management and governance. She has worked in more than 12 countries throughout the eastern and southern region of Africa. Ms. Katekaine possesses extensive experience with a variety of donors, including PEPFAR, USAID, the Bill and Melinda Gates Foundation and HIVOS Netherlands, among others.

Patricia H. David, PhD, Evaluation Specialist

A medical demographer with training in epidemiology and sociology, Dr. David has more than 25 years of experience in international public health research, focusing on the practical application of research methods to program evaluation, and building capacity of program staff to collect and use meaningful data. She has worked in more than 15 countries for a range of clients, including both multilateral and bilateral donors and foundations. For nine years, she taught at the Centre for Population Studies, London School of Hygiene and Tropical Medicine. She also served as Senior Evaluation Advisor, John Snow, Inc. for seven years and as Director of Research and Metrics at Pathfinder International for six years. Her specialties include data collection methods for household and facility surveys, presentation and use of data for decision-makers, and evaluation of health and population program effectiveness.

ANNEX III. PERSONS INTERVIEWED

Name	Group/Affiliation	Title/Role	Location
Nandita Thatte	USAID, PRH Research, Technology and Utilization Division	Technical Advisor GH Bureau	Washington, DC
Maggie Farrell	USAID/GH/PRH	Former AOR LMS/AOR SHOPS	Washington, DC
Andrea Harris	USAID/GH	Public Private Partnerships Advisor	Washington, DC
Karen Cavanaugh	Director Office Health Systems, GH	Office Director	Washington, DC
Jodi Charles	USAID/Office of Health Systems	Sr. Health Systems Advisor	Washington, DC
Lois Schaefer	USAID/GH/PRH	Senior Technical Advisor HR for Health	Washington, DC
Ellen Starbird	Director, PRH	GH/PRH, USAID	Washington, DC
Anne Hirshey	Division Chief, Family Planning Service Delivery	GH/PRH, USAID	Washington, DC
Ken Sklaw	GH/OHA	Capacity Building Team Lead and Act Adv	OHA
Sandy Jenkins	BHR/DCHA	Senior Program Liaison, LMG Activity	DCHA
Cate Lane	PRH	USAID PRH point of contact for youth activities	Core-funded
Kristi Rendahl	DCHA		Core-funded
Cindy Lewis	DCHA	Director of Programs at MIUSA	Core-funded
Susan Dunn	DCHA	WILD Project Director at MIUSA	Core-funded
Bhavna Patel	GH/Office of Health, Infectious Diseases, and Nutrition/Malaria	PMI Advisor and LMG Activity Liaison	Core-funded
David Jacobstein	Center of Excellence on Democracy, Human Rights and Governance (DRG)	DCHA/DRG Cross-Sectoral Programs Team, DRG Center, Washington, DC	Core-funded
Seyoum Dejene	USAID/Uganda	LMG Activity Manager	Uganda
Sylvia Tagaba	USAID/Uganda	Finance Advisor (involved in overseeing LMG activities)	Uganda
Jackie Calnan	USAID/Uganda	LMG Activity Manager (alternate)	Uganda
Elsy Salnave	USAID/Haiti	Health Program Manager/LMG	Haiti
Alfred Amoatwo	USAID/West Africa	HIV/AIDS Program Management, USAID/WA, LMG Activity Mgr	West Africa
Aisatou Ngong	USAID Cameroon		Cameroon
Christie Reed	USAID/Liberia	CDC PMI Resident Advisor	Liberia
Lievin Nsabiyumva	USAID/Burundi	Program Development Specialist (Malaria)	Burundi
Lisa Childs	USAID/Liberia Health Office	Office Director	Afghanistan
Dr. Eshete Yilma	USAID/Ethiopia HAPN Office	Deputy Head, Health office and HSS Advisor	Ethiopia
Jemal Mohammed	MSH Senior Staff/LMG Ethiopia	LMG Project Director	Ethiopia

Getine Kaba	MSH Senior Staff/LMG Ethiopia	Pre-Service Education Advisor	Ethiopia
Frehivot Getahun	MSH Senior Staff/LMG Ethiopia	LMG Institutional Development Advisor	Ethiopia
Sualna Alkadev	MSH Senior Staff/LMG Ethiopia	Training Advisor	Ethiopia
Yared Ketema	MSH Senior Staff/LMG Ethiopia	Project Finance Manager	Ethiopia
Sasima Girma	MSH Senior Staff/LMG Ethiopia	Program Assistant	Ethiopia
Temesgen Workayew	MSH Senior Staff/LMG Ethiopia	M&E Director	Ethiopia
Jackie Lemlin	MSH/Headquarters Ethiopia	Support LMG Ethiopia, SLDP and AMENA	Ethiopia
Lourdes de La Preza	MSH/Headquarters Ethiopia	LDP and LDP+ Training and Technical Advisor	Ethiopia
Joe Dwyer	MSH/Headquarters Ethiopia	DCHA Program Advisor	Ethiopia
Kate Wilson	MSH/Headquarters Ethiopia	Program Advisor LMG/DCHA	Ethiopia
Tadeo Atuhura	MSH/Uganda	MSH/Uganda Country Communications Officer	Uganda
Martin Owero	MSH/Uganda	LMG Finance Consultant	Uganda
Sara Wilhelsen	MSH Headquarters Uganda Programs		Uganda
Karen Johnson Lassner	MSH/LMG	LMG Activity Manager for all work with the Global Fund	Core-funded
Antoine Ndiaye	LMG/Côte d'Ivoire	Project Director	Côte d'Ivoire
Emmanuel Le Perru	LMG/West Africa	LMG/West Africa Principal Technical Advisor	West Africa
Pepin Miyigbena	LMG/NMCP Côte d'Ivoire	Senior Technical Advisor	Côte d'Ivoire
Maurice N'Djore	LMG/NMCP Cameroon	Senior Technical Advisor	Cameroon
Kwabena Larbi	LMG/NMCP Liberia	Senior Technical Advisor	Liberia
Oliver James Pratt	LMG/NMCP Liberia	Director	Liberia
Cheikh Gassama	LMG/NMCP Burundi	Senior Technical Advisor	Burundi
Dr. Dionis Nizigiyimana	LMG/NMCP Burundi	NMCP Project Director	Burundi
Dr. Saleh	LMG/Afghanistan	Project Director	Afghanistan
Nga Then Nguyen	LMG/Vietnam	Technical Advisor/Acting Project Director	Vietnam
Cam Anh Nguyen	LMG/Vietnam		Vietnam
Jim Rice	LMG/MSH	Former LMG/MSH Project Director	Core-funded
Reshma Trasi	MSH/LMG	Director, Monitoring, Evaluation, Research	Arlington, VA
Catherine Taylor	MSH	Vice President for Health Services Center	Arlington, VA
Megan Kearns	MSH/LMG	Assistant Project Director LMG	Arlington, VA
Susan Balera	LMG/Rwanda	NCC Advisor/Rwanda	DCHA
Martin Oiko		LMG Technical Advisor (consultant)	Uganda
Manjit Kaur	Independent Health Consultant	MSH/Uganda consultant LMG Tools	Uganda

Gwen Morgan	MSH/E2A Family Planning Advisor Cameroon		Core-funded
Christine Butegwa	LMG's East Africa Women's Mentoring Network	Mentor	Uganda
Grace Odeke	LMG's East Africa Women's Mentoring Network	Mentor	Uganda
Lynette Awor	Women's Mentoring Network	RHU National Advocacy Advisor and mentor	Uganda
Emmanuel Were	Women's Mentoring Network	Information Management Coordinator	Uganda
Kidest Lulu Hagos	East Africa Women's Mentoring Network (PRH core-funded)	Mentor	Ethiopia
Rene-Frederic Plain	Global Fund/CCM Director	Global Fund counterpart in Geneva for OHA core-funded work with CCMs	Core-funded
Maria Cecilia Boada de Tapia	Global Fund/CCM Directorate	Global Fund counterpart in Geneva for OHA core-funded work with CCMs	Core-funded
Jo Nagels	ICRC	Regional Lead for Africa	Ethiopia
Yvan Sidler	ICRC	Officer in Charge of Special ICRC Funds for the Disabled	Ethiopia
Leslie Angama Mueller	ICRC	Chief of ICRC DRC	Ethiopia
Miguel Fernandes Endalkachew Getachew	ICRC ICRC	ICRC/Ethiopia Manager, Physical Rehab Program, Head of LMG Project Program Officer, ICRC Ethiopia	Ethiopia Ethiopia
Solenne Chupin	ICRC	ICRC Physiotherapist East Africa, EMP Coach	Ethiopia
Eden Gebre Mariam	ICRC	Program Officer, ICRC Ethiopia	Ethiopia
Hannan Endale	MYUSA/WILD Participant	World Vision, Inclusion Officer Ethiopia	Ethiopia
Heather Fosburgh	MYUSA/WILD Participant	NGO Finance Specialist, Yala Program Manager for SLP	Ethiopia
Dr. Geremew Tsegaye	All African Lep, TB Training Center (Alert)	Dir Training/Natl HIV/AIDS CTR Exc	Ethiopia
Yatma Fall	Expert Human Rights Consultant	Expert for the African Union on Human Rights for the Disabled and LMG Trainer	Ethiopia
Robert Odedo	ACHEST	Chief Operating Officer	Uganda
Dr. Patrick Kadama	ACHEST	Director, Policy and Strategy	Uganda
Dr.E. Kiguli-Malwadde	ACHEST	Medical Doctor and Technical Director	Uganda
Josephine Amuron	ACHEST	Accounts Assistant	Uganda
Okoine Abraham	ACHEST	IT Technician	Uganda
Peter Mugwany	JCRC	JCRC Executive Director	Uganda
Micheal Kabugo	JCRC	THALAS COP, LMG focal point	Uganda
Fred Byaruhanga	JCRC		Uganda
Michael Kabugo	JCRC	Chief of Party for LMG award	Uganda
Collin Makanga	JCRC	JCRC Finance Mgr	Uganda

Godfrey Kubor	JCRC	JCRC ICT Chief Programmer	Uganda
Amelia Natukensha	JCRC	JCRC HR Mgr	Uganda
Cissy Kityo	JCRC	Deputy Executive Director	Uganda
Charles Munafu	JCRC	JCRC Coordinator, Laboratory Systems Strengthening	Uganda
Dr. Samuael Kirya	JCRC	Deputy COP JCRC	Uganda
Andrew Kigozi	EDES & Associates	LMG Finance Consultant and volunteer JCRC board advisor	Uganda
Jackson Chekweko	RHU/Uganda Senior Leadership Team	Executive Director, RHU	Uganda
Emmanuel Were	RHU/Uganda Senior Leadership Team	Dashboard champion	Uganda
Peter Muganga	RHU/Uganda Senior Leadership Team LDP+ Facilitator	Internal Auditor	Uganda
Peter Ibembe	RHU/Uganda Senior Leadership Team	DD Programs	Uganda
David Serehin	RHU/Uganda Senior Leadership Team	Logistics Coordinator	Uganda
Wilberforce Ojiambo	RHU/Uganda Senior Leadership Team		Uganda
Peter Simon Lugliobi	RHU/Uganda Senior Leadership Team		Uganda
Robirah Namboore	RHU/Uganda Senior Leadership Team		Uganda
Doreen Kansiiime	RHU/Uganda Senior Leadership Team	LMG Project Coordinator LDP+ Facilitator	Uganda
Raymond Ruyoka	RHU Youth Coaches (TOTs)	Project Coordinator	Uganda
Shafiz Busano	RHU Youth Coaches (TOTs)	RHU Youth volunteer	Uganda
Rachel Babinye	RHU Youth Coaches (TOTs)	RHU Youth volunteer	Uganda
James Kato	RHU Youth Coaches (TOTs)	RHU Youth volunteer	Uganda
Daphynne Olgah Namukuza	RHU Youth Coaches (TOTs)	RHU Youth volunteer	Uganda
Annet Kyarimpa	RHU LDP+ Facilitators	Special Project's Coordinator	Uganda
Anicia Filda	RHU LDP+ Facilitators	Branch In charge	Uganda
Julius Yeko Mukwanya	RHU Board Member	RHU Board Chair /Board Governance Participant	Uganda
Sherina Kyesula	RHU/Lawero Branch Center	Lawero Branch Manager/Nurse Midwife	Uganda
Rosetter Nakitto	RHU/Lawero Branch Center	Program Operations Lawero Center	Uganda
Agath Nanfuka	RHU/Lawero Branch Center	Advocacy Advisor	Uganda
Kabanda Obed	ACODEV	Executive Director	Uganda
Esther Atolere	Kagonda Hospital	Principal Nursing Officer	Uganda
Dr. Agasha Doreen Birungi	PREFA	M&E Officer	Uganda
Elly Mugumya	IPPF	LMG Director	Core-funded

KoKou Djagadou	IPPF	Youth focal point at ARO	Core-funded
Faida Nsensele	IPPF	Youth focal point at ARO	Core-funded
Lucien Kouakou	IPPF	Africa Regional Director	Core-funded
John Good	IPPF London	Finance Director	Core-funded
Caroline Mpele	IPPF Cameroon (CAMNAFAW)	Trainer trained to deliver the LDP+	Core-funded
Aline Mekone	IPPF Cameroon (CAMNAFAW)		Core-funded
Zahirah McNatt	Yale	LMG Activity Manager	Core-funded
Anbrasi Edwards	Johns Hopkins University Bloomberg School of Public Health Dept. of International Health	Associate Scientist, Dept of Hlth Sciences	Core-funded
Isaac Holeman	Medic Mobile	Regional Africa Director	Core-funded
Regina Mutuku	MM	Director of Capacity building	Core-funded
Peter Ngatia	Amref Kenya	LMG for Midwives project manager	Core-funded
Priscillah Ngunju	Amref Kenya	LMG for Midwives consultant	Core-funded
David Chase	Amref NY	Director, Business & Resource Development at Amref USA	Core-funded
Jillian Gideon	International Youth Alliance for Family Planning	Vice Chair of Administration	Core-funded
Ces Millado	IHAA		Core-funded
Kate Killberg	IHAA		Core-funded
Mr. Edner Noucicaut	CCM	President of the CCM	Haiti
Dr. Paul Brunel Delonnay	Unité de Coordination des Programmes Nationaux	Director	Haiti
Dr. Georges DuBuche	MSPP	Director General	Haiti
Johnny Calonges	l'Unite de Contractualisation	Director	Haiti
Dr. Mongbo Mèdessi Yves Armand	WAHO	Child Adolescent and Youth Health Professional Officer	West Africa
Tome CA	WAHO	Health Systems Manager	West Africa
Mrs. Nafisatu Adamu	Planned Parenthood Federation of Nigeria		West Africa
Jeannie Mantopolu	Yale		Partners
Andrew Sunil Rajkumar	World Bank/Haiti	Technical Team Leader/Health Project	Haiti
Prof. Adesegun Fatusi	Obafemi Awolowo Medical School, Ile-Ife University	Provost	Nigeria
Kedist Nadew	Yale University in Addis	Country Director	Ethiopia
Tedlla Mulatu	Amref Ethiopia	Partnership Director	Ethiopia
Dr. Ashambel	Bahir Dar University	School of Public Health, Health Services Management Unit	Ethiopia
Almaw Dessie	The Health Sciences College	Lecturer in the Bahir Dar Health Sciences College, IST TOT,	Ethiopia
Bekalu Tesfa	Ethiopian Public Health Officers Association	Association President	Ethiopia
Dr. Desalegn Admassu	Haramaya University	Dean of the School of Medicine	Ethiopia

Dr. Kama Klonsewosen	HFSUH	Medical Doctor	Ethiopia
Dr. Mosisa Fufa	HFSISH	Medical Doctor	Ethiopia
Abdullbasif Musa	Haramaya University	Director of the College of Health Medical Sciences	Ethiopia
Dr. Yadefi	College of MSH	Chief Medical Director	Ethiopia
Mohammedi Abdo	HFSUH		Ethiopia
Dr. Jiregna Fayera	HFSUH	General Director	Ethiopia
Selam Dagnergbye	HFSUH	Pharmacist	Ethiopia
Meire Aroyo Modash	HFSUH	Pharmacist	Ethiopia
Ammanuel Fissehaye	HFSUH	Pharmacist	Ethiopia
Jermeal Abdeh	HFSUH	Pharmacist	Ethiopia
Lemma Negesa	Haramaya University	Pharmacist	Ethiopia
Adehogwru Miyeyim	HFSUH	Consortium Coordinator	Ethiopia
Fitsum Gebreal	HFSUH	Human Resources Director	Ethiopia
Alemmayehu Ashalew	HFSUH	Environmental Health Sciences	Ethiopia
Akuwa Pinda	Francophone Senior Leadership Training Participants, Addis-Togolese Delegation	Director CNAO	Ethiopia
Djaou Bowess	Francophone Senior Leadership Training Participants, Addis-Togolese Delegation	Finance Administrator	Ethiopia
Wasiou Karimou	Francophone Senior Leadership Training Participants, Addis-Togolese Delegation	Director of Disabilities, Ministry of Social Action, Women and Literacy	Ethiopia
Dr. Kuami Battach	Francophone Senior Leadership Training Participants, Addis-Togolese Delegation	Chief of the Health Branch of the Togolese Red Cross	Ethiopia
Abollatse Koussade	Francophone Senior Leadership Training Participants, Addis-Togolese Delegation	Ministry of Health	Ethiopia
Esse Celestin	Francophone Senior Leadership Training Participants, Addis-Togolese Delegation	Officer FSH/CICR for the disabled	Ethiopia
Palaebawy Katatchom	Francophone Senior Leadership Training Participants, Addis-Togolese Delegation	FETAPH Special Funds of CICR for the Disabled	Ethiopia
Essokizza Anankpa	Francophone Senior Leadership Training Participants, Addis-Togolese Delegation	Finance Administration, Ministry of Finance	Ethiopia
Faizatou Affo-Alidow	Francophone Senior Leadership Training Participants, Addis-Togolese Delegation	Assistant Inclusion Officer, FSH/CICR	

Dr. Ranaivoarimiandry	Francophone Senior Leadership Training Participants, Addis-Madagascar Delegation	Chief of the Protection of Vulnerable Groups, Ministry of Health and Social Affairs	Ethiopia
Dr. Andrianaly	Francophone Senior Leadership Training Participants, Addis-Madagascar Delegation	Director of the Handicaps Devices Branch of the Ministry of Public Health	Ethiopia
Dr. Rakotonandrasana	Francophone Senior Leadership Training Participants, Addis-Madagascar Delegation	Director of the Reeducation Center of Madagascar	Ethiopia
Ms. Lydia, Rabendrisiny Seviro-Horissea	Francophone Senior Leadership Training Participants, Addis-Madagascar Delegation	Executive Secretary for the Federation of Handicap Persons of Madagascar	Ethiopia
Dr. Rakotomotrima	Francophone Senior Leadership Training Participants, Addis-Madagascar Delegation	Officer in charge of the Program for the Struggle Against Physical Challenges of the Ministry of Public Health	Ethiopia
Dr. Odilet Lesperance	RéseauHaïtien des Journalistes en Santé (RHJS)	Secretary General	Haiti
Dr. Ahmad Masoon Rahmani	Afghanistan Ministry of Health	Director, National Blood Bank	Afghanistan
Dr. Arwal	Afghanistan Ministry of Health	Director, Community-Based Health Care	Afghanistan
Dr. Massoud Mehrzad	Afghanistan Ministry of Health	Project Manager, Partnership Contractors for Health Services, Grants and Contracts Management Unit	Afghanistan
Dr. Kouassi Armand Noel	Direction General de Sante	Charge d'Etudes at the Direction General de Sante	Côte d'Ivoire
Dr. Koulou Alla Edmond	Indénié-Djuablin	Regional Health Director	Côte d'Ivoire
Dr. Koffi Brindou, JB	N'zi-Iffou-Moronou	Regional Health Director	Côte d'Ivoire
Dr. Jean Denis Pierre	Departement Sanitaire du Nord-Est	Director	Haiti
Dr. Darline Carre Theodore	Direction de l'Organisation des Services de Santé (DOSS)	Director	Haiti
Sayed Amin Hamed, MD	Ministry of Public Health, Afghanistan		Core-funded
Bambera Shemsdin	FMOH/HSS Unit Special SU	LMG focal person for four regional states within FMOH Health Systems Str. Unit	Ethiopia
Yordanos Demesen	FMOH/HSS Unit Special SU	Maternal Health HSS SSU 4 emerging reg.	Ethiopia
Miraf Walelern	FMOH/HSS Unit Special SU	Assistant Officer HSS SSU 4 emerging reg.	Ethiopia
Behibe Sbagadis	FMOH/HSS Unit Special SU	Team Coordinator HSS SSU (for AFAR)	Ethiopia
Dr. Markos	FMOH	Assistant Director for Medical Services and LMG focal person	Ethiopia

Alemayehu Bogale	FMOH	Director of Gender/Youth Affairs Directorate	Ethiopia
Ato Dagnew Hagezom Kabsay	FMOH	Deputy Director of Health Systems Strengthening Department	Ethiopia
Rahima Shikur	FMOH	Case Team Manager IST	Ethiopia
Berhanu Feyara Tilla	Federal HIV/AIDS Prevention and Control Office	Director General, HAPCO	Ethiopia
Dr. Tsegaye Legwesse	Federal HIV/AIDS Prevention and Control Office	Global Fund Manager	Ethiopia
Dr. Dereje	Oromia Regional Health Bureau	Deputy Bureau Head	Ethiopia
Dr. Fatuma Abafita	Oromia Regional Health Bureau	HIV/AIDS sub-process	Ethiopia
Dr. Mengistu	Amhara Regional Health Bureau	Head of Human Resources, Amhara Region	Ethiopia
Solomon Assefa Akinam	Amhara Regional Health Bureau	Training Officer	Ethiopia
Cronetu Alen	Amhara Regional Health Bureau	TB Officer	Ethiopia
Meseret Addisu	Amhara Regional Health Bureau	Project Coordinator	Ethiopia
ShasheTakele	Amhara Regional Health Bureau	HRH and Registration Officer	Ethiopia
Dr. Rania Mohammed	Harar Regional Health Bureau	Head of Health Bureau M&E	Ethiopia
Dr. Afendi Balha	Harar Regional Health Bureau	Assistant Director	Ethiopia
Constance Nishimwe			Core-funded
Dr. Morsy Mansour			Core-funded

ANNEX IV. SOURCES OF INFORMATION

LMG AND LMS PROJECT DOCUMENTS

1. Management Sciences for Health Technical Application: RFA SOL-0AA-11-000009 and Technical Annexes A-H (Partnering, Staffing, Performance Monitoring Plan, Past Performance, Environmental Compliance and Tools, Models and Approaches). Submitted to USAID January 21, 2011.
2. Leadership Management and Sustainability Project Associate Awards. November 2015.
3. LMG Field Support and OHA Activities: AMENA Portfolio (Afghanistan, Ethiopia, Uganda, Libya, Zambia. November 2015.
4. USAID/PEPFAR-funded Nigeria PLAN-Health Key Results (June 2010–September 2015).
5. Leadership, Management and Sustainability Program Final Report (2005–2010), Cooperative Agreement GPO-A-00-05-00024-00.
6. MSH/LMG Cooperative Agreement Baseline Reports, September 2012–November 2015.
7. LMG Annual Report, Project Year One: (September 25, 2011– June 30, 2012). August 2012.
8. LMG Semi-Annual Report Project Year Two: July 1, 2012–December 31, 2013. February 15, 2013.
9. LMG Annual Report Project Year Three: July 1, 2013–June 30, 2014.
10. LMG Project Year 4 Semi-Annual Report: July 1, 2014–December 31, 2014.
11. LMG Annual Report Project Year Four: July 1, 2014–September 30, 2015.
12. LMG Performance Monitoring Plans Project Year 1-3, Revised March 12, 2014.
13. LMG Monitoring Evaluation and Research Team Report: Refocusing Evidence Generation for Leadership, Management and Governance, PYs 2013 and 2014.
14. LMG Individual Sheet for PMP. 2012.
15. LMG Project Year 1 Work Plan September 25, 2011–June 30, 2012.
16. LMG Project Year 2 Work Plan July 1, 2012–June 30, 2013.
17. Project Years 3, 4 and 5 Appendices on Activity and Deliverables Planned.
18. LMG Cooperative Agreement Modification Tracker dated May 6, 2014.
19. Introduction to the LMG PMP: Indicator Reference Sheets. April 2014.

LMG TECHNICAL REPORTS, PUBLICATIONS AND PRESENTATIONS

1. Mohammed, Jemal (MSH/LMG Country Project Director), Temesgen Workayehu (Monitoring and Evaluation Advisor, LMG/Ethiopia) and Ummuro Adano, Human Resources. 2015. *Development, Institutionalization and Scale-up of Leadership, Management and Governance in the Health Sector: Lessons and Results from Ethiopia*. USA: MSH.
2. *Joint Clinical and Research Centre: Organization Capacity Assessment Final Report*. April 20, 2015.
3. *More HIV/AIDS in Patients on ART Got Nutritional and Counseling Support at Ayder Hospital*. LMG/PEPFAR, USAID/Ethiopia Success Story. November, 2015.
4. *Improving Human Resource Management in Amhara Region Health Bureau through Leadership, Management and Governance Training, LMG/Ethiopia*. PEPFAR, USAID/Ethiopia Success Story. n.d.

5. *Leadership, Management and Governance Training Improved Provider-Initiated HIV Testing and Counseling Services in South West SHOA Zone of Oromia Region*. October, 2015.
6. *One Step towards Standardized Leadership, Management and Governance Training in Ethiopia*. LMG/Ethiopia, PEPFAR, USAID/Ethiopia Success Story. n.d.
7. *Harmonized and Aligned Plans for Better Health Outcomes in Ethiopia*. LMG/Ethiopia, PEPFAR, USAID/Ethiopia. n.d.
8. *Improving HIV/AIDS Diagnostic Services in Ethiopia*. LMG/Ethiopia, PEPFAR, USAID/Ethiopia Success Story. n.d.
9. *Leadership, Management and Governance Project: LMG/Ethiopia Project Activities and Achievements in Pre-Service and In-service Training, LM&G Capacity of FHAPCO FMOH, RHBs, Zonal, District Facilities and PLHA*. December 10, 2015.
10. Anwari, Shukla, Maseed, Warak, Sardar, Matin, Rashed, Hamedi, Sahak, Aziz, Boffa and Trasi. 2015. Implementing People-Centered Health Systems Governance in 3 Provinces and 11 Districts of Afghanistan: A Case Study. *Conflict and Health* 9:2.
11. Peer Coaching in Uganda Step-Down-Reproductive Health Unit (RHU).
12. *The Implementation and Use of LMG's Governance Tools, Models, Approaches, Practices, Applications, Publications, Guides and Handbooks and Technical Assistance*. November 2015.
13. Giorgis, Mugumya, Lindsay. 2013. *An Open Mind and a Hard Back: Conversations with African Women Leaders*. LMG.
14. Golden. *Profiles in Courage: Stories of Impact for LMG/Afghanistan Program (2012–2015)*.
15. Grenier, Martin. 2014. *Summary Report: Equipping Future Health Professionals with L, M and G Competencies*.
16. LMG Health Governance Guides (multiple for facilitators and trainers). June 2014.
17. Grenier and Trasi. 2013. Sustainable Interventions of Leadership and Management Content in Medical Education.
18. Yale GHI and MSH. 2013. *Rwanda Senior Leadership Program (SLP) Report*.
19. Amref and MSH Training Curriculum for Certificates in Management for Midwives. Amref Virtual Training School Faculty. Nairobi Kenya.
20. *Leadership and Management Internal Assessment Report*. September 2015.
21. Proceedings from the Third Governance Roundtable for Health Conference held September 29-30, 2014 in Cape Town, South Africa: Summary Report. September 2015.
22. Deshpande, Levy, Hasting and Trasi. *Gender Transformative Supportive Supervision: A theoretical framework*. September 2015.
23. Grenier, Martin and Koval. 2015. *Virtual Leadership Development Program for African Health Leaders and Management Network (AHLMN)*.
24. *Emanager: Professional Leadership and Management in Health Care*. June 2012.
25. *LMG Report: The Implementation and Use of LMG's Governance Tools, Models, Approaches, Practices, Applications, Publications, Guides and Handbooks and Technical Assistance*. 2015.
26. Capacity Building in LM&G of the African Center for Global Health and Social Transformation (ACHEST): Scope of Work for LMG Assistance. February 28, 2013.

27. Activity Report: Joint Work Visit with ACHEST by HRSA/USAID/GWU/MSH-LMG, Kampala Uganda. August 13-15, 2012.
28. LMG. Youth Leaders, Setting Priorities for Adolescent Health. LMG Advocacy Report. Session at the World Health Assembly May 18-21, 2015.
29. *LMG Report: Success Stories from the LMS Project: (2005-2010)*. June 22, 2012.
30. Allen, Woldehetnel, Sicar, Mantopoulous and Bradley. 2015. *Evaluation Report: East Africa Regional Senior Leadership Program for Physical Rehabilitation Centers and Disability Rights*. Yale University Global Health Leadership Institute (GHLI).
31. LMG. 2015. Empowering communities: Community Based Health Care in Afghanistan. Brochure.
32. Rasekh and Pappas. 2014. *Kabul National Hospital Autonomy Evaluation (KNHAE), Management Sciences for Health, Final Report*.
33. LMG/Afghanistan. *Rebuilding the Health Sector in Afghanistan: Professionalizing Leadership and Management as a Pillar of the Health System*. 2014.
34. Holeman, Coolison, and Pagliari. 2015. *Digital Technology for Health Sector Governance: Key Findings from a Scoping Review*.
35. RHU/Uganda. n.d. *LMG Qualitative Learning Center's Evaluation Report: Developing Capacity among the IPPF Learning Centers*.
36. RHU/Uganda Learning Center Data Table on LDP+ training and Step-Down Action Plan Completion, Women's Mentorship, Youth Leadership in Ghana, Uganda, Cameroon, Mozambique, Tanzania, Malawi. n.d.
37. Martin and Allen. 2016. *LMG/MSH Report: Utilizing Mobile Peer Support Networks to Improve Midwifery Service Delivery: Integrating Use of What's App*. Draft Report.
38. Trasi, R. 2012. *The Importance of Evidence: Does a Program Work? How? Why?* USAID and LMG.
39. Trasi, R., M. Boyd-Boffa, L. Seims, and S. Greiner. 2013. *Unpacking the LDP Conceptual Model: A decade of experience informs measure and results*. MSH.
40. Trasi, R. 2012. *LMG Strategy Paper: Evidence for Action*. USAID and LMG.
41. LMG. 2012. *Refocusing Evidence Generation for Leadership, Management and Governance*. Unpublished.
42. LMG. 2012. *Do L(eadership) + M(angement) + G(overnance) interventions result in improved service delivery outcomes (and therefore health outcomes)?* Unpublished.
43. *Operations Research on Evidence of Leadership Management and Governance: MSH LMG Concept Note*. 2012.
44. USAID and MSH. 2014. *The Added-Value of a Leadership Development Program on Postpartum Family Planning Service Delivery: Study Protocol*.
45. Baba-Djara, M., R. Trasi, M. Conlin, M. Boyd-Boffa, A. Deshpande, M. Guida, and Lee. 2015. *A Baseline Study Report: the Added-Value of a Leadership Development Program on Postpartum Family Planning Service Delivery*. USAID and LMG.
46. Anwan, Z., M. Shukla, B. Maseed, G. Wardak, S. Sardar, et al. 2015. Implementing people-centred health systems in governance in 3 provinces and 11 districts of Afghanistan: a case study. *Conflict and Health* 9:2.
47. *Youth Leadership Programmatic Review Midterm Report*. October 2015.

47. Rauscher, M., M. Boyd-Boffa, A. Lee, and R. Trasi. 2014. *Analyzing the Virtual Leadership Development Program: Results and Recommendations*. USAID and LMG.

LMG-ASSISTED PLANS, GUIDES AND PRODUCTS

1. HIV/AIDS Prevention and Control Office. 2014. *HIV/AIDS Strategic Plan: 2015–2020 in an Investment Case Approach*. Addis Ababa, Ethiopia.
2. Federal Democratic Republic of Ethiopia Ministry of Health. 2014. *Health Sector Gender Training Manual: Participants' Guide and Participants' Note*.
3. Ministry of Public Health of Afghanistan. Provincial Public Health Coordination Committee (PPHCC). 2014. *Governance Guide, Rahanamud-I-IHokomatdari*.
4. UNFPA, WHO, USAID, and LMG. 2014. *The State of Afghanistan's Midwifery*.
5. Afghanistan's Governance Institute. 2014. *Assessment of Decentralization Feasibility Options for the Health System*.
6. USAID/Afghanistan. 2014. *LMG Success Story: Successful Closeout of the Community Health Nursing Education Program*.
7. USAID LMG Success Story, LMG: USAID Helps to Improve the Quality of Health Management Information Systems data in Afghanistan's Health Sector. December 2013.
8. *Empowering Communities: Communities Based Health Care in Afghanistan*. January 2015.
9. *LMG/Afghanistan Status Report: Leadership, Management and Governance in Afghanistan: Strengthening the capacity of the Ministry of Public Health (September 1, 2012–June 30, 2015)*.
10. *Hospital Management Review in Afghanistan: Hospital Management Systems at 16 National Institutions*. May 2015.
11. USAID Afghanistan. 2013. *LMG Success Story: USAID Support Health Systems Strengthening in Afghanistan*.
12. LMG/Afghanistan Web Portal: *Rebuilding the Health System in Afghanistan*. December 2014.
13. LMG/Afghanistan Closeout Conference: *Success Stories from Across Afghanistan*. December 2015.
14. *L, M and G Competencies Assessment in the Ministry of Health in Afghanistan: A survey based on a Self-Assessment by Managers across the Ministry of Public Health*. 2014.
15. Amref and MSH. 2014. *Leadership Management and Governance Project Report: Evaluation for Midwifery Leadership, Management, and Governance*.
16. Djara/David. 2016. *Memorandum of Preliminary Findings from Cameroon Study: The Added Value of a Leadership Development Program on Post-Partum Family Planning Service Delivery*.

LMG AND LMS EVALUATION REPORTS, TOOLS, GUIDES AND INSTRUMENTS FOUND ON THE LMG AND LMS LEADERNET

17. eLearning Certificate Track at USAID's Global Health eLearning Center: *Governance and Health, Practices of Good Governance, Infrastructure for Good Governance*
18. *A Guide to Develop and Implement Strategies to Achieve an Effective and Sustainable Health Workforce (HRH Guidelines)*. MSH Tool.
19. *A Guide to Fostering Change to Scale up Effective Health Services*. MSH Tool.
20. *Human Resource for Health Action Framework*. MSH Tool.

21. Functional Analysis for Global Fund Country Coordinating Mechanisms. MSH Tool.
22. Governing Board and CEO Evaluation Tools. Yale GHLI Tool.
23. LM by Design Chapter Tool. MSH Tool.
24. Senior Alignment Meeting. MSH Tool.
25. Yale's Global Health Leadership Institute Annual or Bi-annual Conference and Certificate Programs. Yale GHLI Tool.
26. Amref International Training Center: Short courses. Amref Tool.
27. Amref Online Resource Centre. Amref Tool.
28. Cluster Randomized Trials and Quasi-experimental Methods (with comparison groups, before and after measurements and randomized assignment of interventions). JHSPH Tool.
29. Code of Good Governance. IPPF Tool.
30. Distance Learning for Health Care Professionals. Amref Tool.
31. Employee Satisfaction Survey. MSH Tool.
32. Executive Dashboard Tool. MSH Tool.
33. The Global Exchange Network for Reproductive Health. MSH Tool.
34. Grounded Theory. JHSPH Tool.
35. The Health Manager's Toolkit. MSH Tool.
36. Indicator Guide for Developing and Implementing a National Plan for HRH (included in the six-tool compilation developed by WHO and MSH).
37. Tools for Planning and Developing Human Resources for HIV/AIDS and Other Health Services. IPPF Tool.
38. IPPF's Membership Accreditation System. IPPF Tool.
39. IPPF's Web-based Portal for Learning. IPPF Tool.
40. LeaderNet: Electronic Archive and LM&G Portal. MSH Tool.
41. Leading and Managing at All Levels: A Handbook for Improving Health Services. MSH Tool.
42. Liberia Accreditation Standards. Yale GHLI Tool.
43. Logic Models. JHSPH Tool.
44. The Manager and the eManager. MSH Tool.
45. The Manager's Electronic Resource Center. MSH Tool.
46. Monitoring & Evaluation Participatory Self-Assessment Tool for Civil Society Organizations. MSH Tool.
47. Patient Experience Survey Tool. Yale GHLI Tool.
48. Pattern Matching and Explanation Building. JHSPH Tool.
49. Poverty Analysis and Institutional Analysis: JHSPH combines detailed case studies with the use of secondary data and household surveys. JHSPH Tool.
50. Putting the IPPF Monitoring and Evaluation Policy into Practice. IPPF Tool.

51. Qualitative Research Methods. JHSPH Tool.
52. The Rapid Assessment of Country Coordinating Mechanism Oversight Capacity Tool. MSH Tool.
53. Time-Series Analysis. JHSPH Tool.
54. Virtual Business Planning for Health Program. MSH Tool.
55. Virtual Fostering Change Program. MSH Tool.
56. Virtual Human Resource Management Program. MSH Tool.
57. Virtual Leadership Development Program. MSH Tool.
58. The Virtual Manager as Coach Program. MSH Tool.
59. Virtual NGO Board Governance Program. MSH Tool.
60. Virtual Strategic Planning Program. MSH Tool.
61. Welcome on Board: A handbook to help IPPF Member Associations improve their governance. IPPF Tool.
62. Work Group Climate Assessment. MSH Tool.
63. Yale's Master of Hospital and Healthcare Administration Program. Yale GHLI Tool.
64. A Facilitator's Guide for Integrating Leadership and Management Curriculum into Preservice Health Institutions. MSH Tool.
65. Business Planning for Health Program. MSH Tool.
66. Civil Society Organization Board Governance Workshop. MSH Tool.
67. CORE Plus: Helps managers and planners estimate the costs of individual services and packages of services in primary health care facilities as well as total costs for the facilities. MSH Tool.
68. Delegation Mini-Workshop. MSH Tool.
69. Ethiopia Hospital Reform Implementation Guidelines.
70. Financial Management Assessment Tool (FinMAT). MSH Tool.
71. Frontline Forms: Frontline SMS. Medic Tool.
72. Frontline SMS: This is an SMS platform that allows anyone with a laptop, mobile phone and GSM signal to manage contacts and coordinate large amounts of incoming and outgoing text messages. Users can manage groups and subgroups of contacts, create keyword triggers (e.g., auto-replies, auto-forwarding, external commands, forwarding via email, etc.). Frontline SMS. Medic Tool.
73. Guide for Training Community Leaders to Improve Leadership and Management Practices: The community leadership and management program is a tool used to strengthen leadership capacity in rural communities. "Walking Together to Grow Together," as the program became known in Spanish, focuses on values-based leadership and improved community management. MSH Tool.
74. HealthMap and Ushahidi integration: Both Ushahidi and HealthMap offer free and open source mapping software that can be harnessed to visualize SMS and forms-based data overtime and space. Viewing critical information geographically can help identify trends and provides an intuitive portal for resource managers. Both applications are web-based; data on these maps can be securely accessed over the Internet by users across tiers of the health system who have been assigned a username and password. Frontline SMS. Medic Tool.
75. Human Resources for Health Rapid Assessment Tool. MSH Tool.

76. HRH Planning and Budgeting Framework. MSH Tool.
77. Inventory Management Assessment Tool. IPPF Tool.
78. IPPF's Accreditation System. IPPF Tool.
79. Leadership Development Program (LDP). MSH Tool.
80. Management and Organizational Sustainability Tool (MOST). MSH Tool.
81. OpenMRS. Frontline SMS. Medic Tool.
82. PatientView: Frontline SMS. Medic Tool.
83. The Performance and Assessment Improvement Process (PAI): PAI is a process by which district and NGO teams can assess their current service performance, plan interventions for dramatically improving performance, and monitor the resulting health and service trends overtime, while learning how to better use their routine and survey data. Such team processes generally focus on priority health problems and related essential public health services and functions in support of national health policy and strategy. MSH Tool.
84. Rapid Funding Envelope (RFE) is a grant-making mechanism that pools donor funding and responds to the need for a more rapid process to fund CSOs while bigger, longer-term projects are organized and funded. The RFE responds rapidly and flexibly and focuses on filling gaps in technical and geographical support, funding innovations, testing replication and supporting institutional strengthening. MSH Tool.
85. Responsibility and Authority Mapping Tool (RAMP): The RAMP is a practical tool for managers in countries where the health system has been decentralized or is undergoing decentralization. The RAMP "maps" the perceptions and opinions about the distribution of responsibility and authority among management levels or stakeholder groups of managers at every level of a health system and displays where disparities exist. MSH Tool.
86. The Strategic Planning Course. MSH Tool.
87. TextForms and Resource Finder: TextForms was developed to efficiently and accurately send structured information via plain text SMS available on lowest-common-denominator handsets in low-resource settings. It provides a simple syntax and enables structured data collection with the robustness and scalability of SMS through plain text, boolean, multiple choice and checklist responses. Use cases include dynamic stock reporting and resource mapping, landmine victim care tracking, and maternal health vital event reporting. Frontline SMS is collaborating with Google to enable TextForms to update information about health facilities in Resource Finder, a tool Google has developed to help disseminate updated information about which services various health facilities offer. Frontline SMS. Medic Tool.
88. GovScore Tool: LMG On-Line Governance Score Card and Survey Tool to Allow Independent Self-Assessment on Governance Parameters. October 2015.
89. Essential Management Package in English: 10-Step LDP Adapted from LDP Facilitators Guide. Developed for the International Committee of the Red Cross. March 2014.
90. Modular Leadership for Development Program for Physical Rehabilitation Centers, Board Results and Board Alignment (multiple documents). Adapted for the ICRC Physical Rehabilitation Centers, March 2014.
91. Country Global Pathways Advocacy Program. IPPF tool.
92. Health Manager's e-Handbook: Effective Practices for Leading and Managing in Health. MSH tool.

93. *Leadership, Management and Sustainability Evaluation Report: Kenya Leadership Development Program: A Programmatic Assessment Linking Changes in Management and Leadership with Service Delivery Outcomes on the Context of Human Resource Constraints*. January 2011.
94. Amref and MS. n.d. *Evaluation for Midwifery Leadership, Management and Governance*.

USAID LMG PROJECT DOCUMENTS

1. USAID. Request for Applications (RFA) No. SOL-OAA-11. Issued January 21, 2011.
2. USAID. Cooperative Agreement AID-OAA-A-11-00015 to MSH. September 25, 2011.
3. USAID. Cooperative Agreement Modifications (19) dated September 25, 2011–September 25, 2015.

USAID PRESENTATIONS AND BRIEFING MATERIALS SUPPORTED BY LMG

1. Professionalization of Leadership, Management and Governance. PowerPoint presentation. November 18, 2015.
2. Equity, Efficiency and Enterprise: New Directions in Family Planning. Johannesburg, South Africa. June 2013.
3. USAID Technical Brief: Use of Technology in the Ebola Response in West Africa. November 2014.
4. New Technologies, New Opportunities and New Vision for Health Care Financing: Health Care Financing Capacity Building Workshop. Tanzania. June 9-13, 2014.
5. Mobile Technology: Bringing the Community and the Health System Together: 2013 International Family Planning Conference. Addis Ababa, Ethiopia.
6. Scaling up Mobile Technology: Applications for Accelerating Progress on Ending Preventable Maternal and Child Deaths. USAID mHealth Meeting. Addis Ababa, Ethiopia. 2013.
7. Africa on the Move: Health as a Driver of Sustained and Accelerated Trade and Investments, AGOA 2013. Addis Ababa, Ethiopia. August 9-13, 2013.
8. USAID Health Briefer Series: Rwanda Health Briefer. Updated June 16, 2015.

USAID POPULATION AND REPRODUCTIVE HEALTH AND OFFICE OF HEALTH SYSTEMS DOCUMENTS

1. USAID. Office of Population and Reproductive Health. Service Delivery Improvement. 2014. *LMG Project Management Review*.
2. USAID Office of Population and Reproductive Health. 2015. *LMG Project Management Review*.
3. USAID Office of Population and Reproductive Health. 2013. *LMG Project Management Review, July 1, 2012–June 30, 2013*.
4. USAID. 2015. *USAID's Vision and Health Systems Strategy (2015-2019)*.
5. Dr. Ariel Pablos-Mendez. 2016. Press Release: 2015 in Review: A Year of Key Global Health Achievements. Huffington Post web site.

OTHER SOURCES

1. Bertrand, Manani, and Knowles. 2000. *The Evaluation Project: Handbook, Contract Number DPE-3060-C-00-1054-00, Indicators for Family Planning Program Evaluation*.
2. Ulin, Robinson, and Tolley. 2005. *Qualitative Methods in Public Health: A Field Guide for Applied Research*. Chapters 4-7 pp. 71-175. Family Health International, Robinson/Toljey Bass.

3. HIV/AIDS Prevention and Control Office. 2014. Investment Case Approach. *HIV/AIDS Strategic Plan: 2015-2020*. Addis Ababa.
4. Federal Democratic Republic of Ethiopia. Ministry of Health. 2015. Leadership, Management and Governance Section. *Health Sector Transformation Plan (2015/16-2019/20)*. pp. 51-53.
5. RHU. *Youth Action Movement Magazine* 2 (3).
6. Muyonjo, Maria Alice. *A Report for the Peer Coaching Training Carried out at the RHU/Uganda Learning Center September 23-25, 2015*.
7. WHO. 2013. *Guide to Fostering Change to Scale-up Effective Health Systems*. Geneva: WHO Press.
8. The Global Fund. 2014. Country Coordinating Committee Member Eligibility and Performance Assessment. PowerPoint presentation.
9. The Global Fund. Technical Assistance and List of Providers. *CCM Guidance Note: 2015*. p. 4.
10. The Global Fund. 2015. *CCM Eligibility in the New Funding Model*.
11. Family Planning 2020. 2014. *Partnership in Progress 2013-2014*.
12. WHO/AFRO. 2014. *Health Statistics African Regional Report*.
13. UN Director General. 2015. *Every Woman, Every Child: Global Strategy for Women's Children's and Adolescents' Health: Sustainable Development Goals (2016–2030)*.
14. RHU Secretariat. 2015. *Reproductive Health Unit Uganda Strategic Plan (2016-2022)*.
15. RHU Monitoring and Evaluation Department. 2015. *HYI 2015 Performance Review*.
16. RHU. 2015. *Scaling up the Comprehensive Family Planning Surgical Camp Model: Phase I Strategy*.
17. Ethiopian Public Health Officers Association. 2015. Proposal for its Fifth Annual Conference and Exhibition.
18. Government of the Islamic Republic of Afghanistan. Ministry of Public Health. General Directorate for Human Resources Capacity-building, Management and Leadership Department. 2015. *Strategy for Institutionalizing LM and G in the Health System (2015–2020)*.
19. Newman and Feldman-Jacobs. 2015. *Family Planning and Human Rights—What's the Connection and Why is it Important*. Population Reference Bureau Policy Brief.
20. Republic of Ivory Coast. *National Strategic Plan to Combat Malaria (2014–2017)*.
21. Republic of Ivory Coast. 2014. *National Plan to Scale-up Malaria Activities*.
22. Holeman, Evans, Kane, Grant, Pagliari and Weller. 2014. Mobile Health for Cancer Care in Low to Middle Income Countries: Priorities for research and development. *European Journal of Cancer Care*.
23. Medic Mobile and University of Edinburgh Global Health Academy. Announcement of an On-line mHealth course in high and low income settings.
24. Masood/Brown e-mail dated January 26, 2016 with National Blood Banking Supply Data from 2015 published at the end of the LMG/Afghanistan in December 2015.
25. *USAID Afghanistan Briefing Report: The Project Management Unit Team Experience at the Ministry of Public Health Related to USAID Funding*. March 28, 2012.
26. World Health Organization. 2007. *Strengthening Health Systems to Improve Health Outcomes, WHO's Framework for Action*. Geneva: WHO Press.

ANNEX V. DATA COLLECTION INSTRUMENTS

INTERVIEW GUIDE: #1

General Interview Guide for USAID/Washington Staff

Person Interviewed:

USAID/W Organization:

Title:

Date:

Relationship to the LMG Project:

Relationship to the LMS Project:

GENERAL USAID QUESTIONS:

1. Please tell us about your work and your collaboration with the Leadership, Management, Governance (LMG) project and its predecessor, the Leadership, Management and Sustainability (LMS) project.
2. From your perspective, does the LMG project respond well to the Agency's current priority health and population problems and needs?
3. What have been some of the pivotal global health issues, challenges and changes over the past four years which have shaped the public health landscape since LMG was designed?
4. Has the LMG mechanism been responsive to these changes?
5. What is the comparative advantage of having a global leadership, management and governance project relative to other global or country projects?
6. What health priorities in Africa, Latin America and the Caribbean, or Asia has the LMG project addressed?
7. The project's three intermediate objectives are: strengthening global support, commitment and utilization of LMG tools models and approaches for priority health programs; advancing and validating the knowledge and evidence on the effectiveness of these tools; and scaling up innovation and sustained leadership management and governance programs. Do the goals and intermediate results outlined in 2011 align with USAID current programmatic realities and changing landscape?
8. Please describe how and where the LMG project has collaborated with other USAID (DC and missions) projects or other donor projects working in the area of health systems strengthening.
9. What role does LMG play in the PRH and GH portfolio?
10. What overarching changes do you see taking place in the PRH program in terms of USAID's role in family planning/reproductive health, funding trends and host country or private sector domestic resource mobilization?
11. [In your view, is there evidence that the project has had an impact on strengthening health systems and health outcomes?]

12. What was missing from LMG that you wish it had tackled? What prevented this activity or activities from being carried out?

13. What in your view have been the most attractive features/products of the LMG project? At the following levels:

- Missions
- Africa, Latin America and the Caribbean, and Asia bureaus
- Other USAID/Washington offices
- USAID/Africa and Latin America and the Caribbean regional missions
- Participants
- Stakeholders
- Users of LMG products

INTERVIEW GUIDE: #2

General Interview Guide for USAID/Washington LMG Core Team and PRH Staff

Person Interviewed:

USAID/W Organization:

Title:

Date:

Relationship to the LMG Project:

Relationship to the LMS Project:

SPECIFIC QUESTIONS FOR USAID AFR/TR COR AND USAID/W LMG CORE TEAM:

1. In your view, is the project as currently designed responsive to the political and economic development landscape and realities which the GH team faces today? If so, why; if not, why not? What's missing and what are the bureau's chief technical assistance and support needs?
2. In your view, what are the key family planning and reproductive health services delivery results you can highlight linked to LMG work on leadership development, harnessing new resources for this approach and host country adoption and use of tools? Have these approaches and tools strengthened the USAID assisted health workforce in family planning/reproductive health programs?
3. Has the project deviated from the original design? If so, please explain.
4. Do you think the LMG framework is still relevant? If so, why? If not, Why? What in your view are the big differences between LMS and LMG?
5. Have the field support buy-ins contributed to Global Learning objectives? Have lessons learned in one country been shared well with others? Have the leadership and associate awards addressed the global health agenda for Leadership, Governance and Management originally envisioned in the LMG project?
6. Has the MSH footprint and extensive presence in bilateral country offices lead to a more rapid response to requests by the Agency for technical support and technical assistance?
7. What have been the specific contributions of other consortium members such as Yale University and IPPF/AFRO?

8. What are the key institution-strengthening actions and interventions the project has completed to date? Please describe the specific ways country-level and regional institutions have changed as a result of LMG work.
9. Is the LMG project moving toward reaching its organizational capacity-building plans? Are there organizations which have demonstrated their capacity to independently carry out L, M and G skills? If so, what were the key factors contributing to these results?
10. The 2014 PMP indicates that the project has attained a cost share of \$25 million. In your view, is the project on track to meet the \$45 million cost share by the end of year five?
11. To what extent has the project been a useful mechanism for generating knowledge and building the evidence on this important subject? Have these approaches been incorporated into U.S. and host country schools of public health programs?
12. The project was designed to move from training and directing building the capacity of health providers to sustaining country ownership and professionalize cadres of health managers. From your perspective how has the project contributed to these ambitious objectives?
13. LMG's design included a minimum cost share of 20 percent. To what extent has the project advanced the cause of leveraging additional resources for LMG health work? From your perspective, is there greater country ownership of these approaches today?
14. Can you cite some of the best examples of LMG work in your field?
15. What have been some of the more challenging assignments for the LMG project where the approach adopted by the project may not have worked well?
16. What is the optimal LMG staffing mix given funding?
17. If you were designing the next phase of a global LMG program, what elements would you add or omit from to those in the current LMG project? Is there still a compelling need for this type of program?
18. Can you name the three top achievements of LMG and the key outputs and products?
 - By health areas
 - In the areas of governance, leadership and management development
19. What was missing from the LMG project that you wish it had tackled? What prevented this activity or area of emphasis from being carried out?

KEY INFORMANT INTERVIEW GUIDE #1

For interviews with: leaders, board members, managers of public and private organizations, service delivery organizations (including family planning/reproductive health, HIV/AIDS and vulnerable groups), which participated in LMG training (For example, directors of health services, heads of departments at MOH, permanent secretaries, health planners, HMIS officers, district and regional health management teams, NGOs, etc.)

Introduction and informed consent

Hello. My name is _____, and I work with GH Pro, an organization that USAID has commissioned to evaluate the Leadership, Management and Governance project (LMG). Since you/your organization has worked with the LMG project, I would like to ask you some questions about the assistance it has provided to your organization. This information will help USAID's Global Health Bureau improve its support in this area. The interview usually takes about thirty or so minutes.

Your individual responses will be treated confidentially. Your participation is completely voluntary, and you are free to withdraw at any time and can choose not to answer specific questions. However, we hope that you will participate in this evaluation, since your answers are very useful to us. Before we begin do you have any questions or concerns? Are you ready to begin?

Signature of interviewer _____ (indicates that informed consent has been received).

Name of respondent:

Title:

Organization:

Date of interview:

Interviewer:

1. How long has your organization worked with LMG?
2. Did your organization work with any of LMG's predecessor projects? If so, which ones?
3. Which LMG interventions or activities did you or your organization participate in?
4. Why was the intervention introduced (Probe: what challenge did your organization face)? How are you using it?
5. Have you adapted or modified the tool or training course or workshop? How?
6. Did the participation in the activities or interventions address your needs or challenges? (Probe: has it made a difference to your organization?) If so, how? If not, why not?
7. Is your organization still using this approach/continuing to apply model introduced by LMG? Which ones are you still using, if any? If so, why are you still using it? If not, why not?
8. In your view, what tools or approaches were most helpful?
9. Do you see any changes in your organization's performance that you think is a result of the leadership, management or governance (L+M+G) intervention? Have your organization's capacities increased? If so, which ones?

GOTO CHECKLIST: *use the following checklist to note which changes are mentioned.*

Checklist of capacities built or changes or new competencies adopted		
Has your organization:	✓	Short explanation or clarification
Established a unit, dept. or integrated L+M+G issues into an existing program		
Has LMG supported changes in your board composition, materials, etc.		
Accountability to stakeholders has improved e.g., stakeholder engagement, community forums		
Composition of workforce more balanced in terms of gender, age, tribe and skills		
Professionalized managers and reinforced management skills		

Increased women's participation in organization's work		
Improved the work climate, e.g., HR systems, policies, procedure and practices		
Improved HR practices in place, such as performance appraisals		
All employees have job descriptions with roles and responsibilities clearly delineated		
Salary structure, incentives, hiring and firing procedures in place		
Updated organogram		
Procedures have been reengineered (such as reduction in waiting time)		
Business plan in place?		
Advocacy plan in place?		
Able to champion organization's cause and gained recognition and visibility about your work		
Increased support for organization's work		
Improved your fundraising, planned for resource mobilization		
Has your engagement in fundraising increased/improved since you implemented LMG interventions		
Become more financially independent		
Percentage of donor funding as a percent of total budget decreased		
Percentage of local funding increased		
Found new opportunities for funding		
Organization's dependence on donor funding changed		
Able to utilize the available funding within the funding period		
Resources are spent in response to need		
Asset inventory control in place		
Commodity management systems improved		
Improved knowledge management e.g., web site, an intranet, repository of documents		
Introduced new services or expanded the number of service delivery points		

Improved client satisfaction		
Developed a new strategy, guideline, standard oOperating procedures or protocol, manuals for service delivery		
Adopted or adapted the training course(s) into your existing curriculum		
Improved monitoring, evaluation		
Information and communications technology improved		
Add others mentioned here:		

10. Do you have any data or evidence related to or showing those changes that you can share? Please explain or cite the evidence.

11. How have women managers benefited from these changes? Please explain.

12. Has your organization expanded the use of LMG tools or training to other parts of the organization or to other geographic regions where you work?

13. Have you talked about these interventions or recommended them to any colleagues from other organizations? Please give examples.

14. Have you engaged in any advocacy activities regarding L+M+G interventions?

KEY INFORMANT INTERVIEW GUIDE #2

For interviews with key persons in Amref, AHLMN, ACHEST, ICRC, IPPF and local affiliates, and universities and other institutions of higher learning that have directly participated as beneficiaries in LMG activities/interventions.

Introduction and informed consent

Hello. My name is _____, and I work with GH Pro, an organization that USAID has commissioned to evaluate the Leadership, Management and Governance project (LMG). Since you/your organization has worked with the LMG project, I would like to ask you some questions about the assistance it has provided to your organization [add if needed: that is, apart from how you worked with it as a member of the consortium]. This information will help USAID's Global Health Bureau improve its support in this area. The interview usually takes about thirty or so minutes.

Your individual responses will be treated confidentially. Your participation is completely voluntary, and you are free to withdraw at any time and can choose not to answer specific questions. However, we hope that you will participate in this evaluation, since your answers are very useful to us. Before we begin do you have any questions or concerns? Are you ready to begin?

Signature of interviewer _____ (indicates that informed consent has been received).

Name:

Title:

Organization:

Date of interview:

Interviewer:

1. How long has your organization worked with LMG?
2. Did your organization work with any of LMG's predecessor projects? If so, which ones?
3. Which LMG intervention or activities did you or your organization participate in?
4. Why was the intervention introduced (what challenge did your organization face)?
5. Have you adapted or modified the tool or training course or workshop? How? (Probe: pre-service training curricula; training for your organization's staff, etc.)
6. In your view, what tools or approaches were most helpful?
7. Did the participation in these activities address your needs or challenges? If not, why not?
8. Is your organization still using this approach/continuing to apply model introduced by the LMG project? Which ones are you still using, if any? If so, why are you still using it? If not, why not? (i.e., pre-service curricula or modified curricula?)
9. Do you see any changes in your organization's performance that you think are a result of the leadership, management, and/or governance (L+M+G) intervention? Have your organization's capacities increased? If so, which ones? (Probe: Did the LMG project make a difference to your organization? Have you established any new partnerships? M&E improved, etc.?)
10. Do you have any data or evidence related to or showing those changes that you can share? Please explain or cite the evidence.
11. Have women managers benefited from these activities? Please explain.
12. Has women's participation in your organization's work increased?
13. Has your organization expanded the use of LMG tools or training to other parts of the organization or to other geographic regions where you work? If so, how?
14. Have you talked about these interventions or recommended them to any colleagues from other organizations?
15. Have you engaged in any advocacy activities regarding L+M+G interventions?

KEY INFORMANT INTERVIEW GUIDE #3

For interviews with key MSH staff in each priority country, visited or by phone; implementing partner organizations (consortium members as implementers, including Yale University Global Health Institute, and Johns Hopkins Bloomberg School of Public Health, Amref, ICRC, IPPF-London, IPPF-Afro, Medic Mobile)

Name:

Title:

Organization:

Date of interview:

Interviewer:

Introduction and informed consent

Hello. My name is _____, and I work with GH Pro, an organization that USAID has commissioned to evaluate the Leadership, Management and Governance project (LMG). I would like to ask you some questions about your involvement in the project. This information will help USAID's Global Health Bureau understand its contribution to the field. The interview usually takes about thirty or so minutes.

Your individual responses will be treated confidentially. Your participation is completely voluntary, and you are free to withdraw at any time and can choose not to answer specific questions. However, we hope that you will participate in this evaluation, since your answers are very useful to us. Before we begin do you have any questions or concerns? Are you ready to begin?

Signature of interviewer _____ (indicates that informed consent has been received).

Questions only for the other members of the consortium (not MSH):

1. What role does your organization play in the LMG consortium?
2. Have you/your organization adopted any of the LMG interventions for use in other venues or with other projects? (Probe: scaled any up?) Please explain.

Questions for all respondents (MSH + other consortium members):

3. In your opinion, what aspects of these LMG capacity-building interventions show the strongest evidence that they are effective in strengthening organizations? (Probe: What tools and approaches LMG uses are, in your view, the most helpful? Probe: evidence about improved use of resources, financial decisions, human resources management?)
4. What in your opinion are the most replicable components of the LMG interventions? How do you know this? (Probe: what is your evidence)
5. Which are more difficult to replicate? Why? (Probe: what are the constraints to replication?)
6. Can you provide examples of best practices in replication? Please cite them.
7. Has LMG collaborated with other in-country projects (MSH or other) and if so, how? What were the funding sources for that collaboration?
8. Have you supported in any way work to build country ownership? If so, how? Please share with us how you documented it. (Obtain the document(s) if possible.)
9. Do you have evidence that you can share that MOH or local government budgets have supported these approaches? Please explain.
10. To your knowledge, have any LMG-assisted institutions become eligible for USAID or other donor funding after participating in leadership, management, and/or governance training?
11. Have any institutions supported by LMG graduated to host country or private sector financing? Which ones?

12. Have you encountered any unforeseen challenges during the course of implementing the project? Please explain. (Probe: lack of USAID field support for research or other activities? Public health crises? Other changes affecting funding? Staffing changes?)

KEY INTERVIEW GUIDE #4

For interviews with: Other donors (e.g. UNFPA, World Bank, IPPF, Global Fund, Ponseti),

Introduction and informed consent

Hello. My name is _____, and I work with GH Pro, an organization that USAID has commissioned to evaluate the Leadership, Management and Governance project (LMG). I would like to ask you some questions about the assistance it has provided from your perspective. [add if needed: as another donor to global health initiatives]. This information will help USAID's Global Health Bureau improve its support in this area. The interview usually takes about thirty or so minutes.

Your individual responses will be treated confidentially. Your participation is completely voluntary, and you are free to withdraw at any time and can choose not to answer specific questions. However, we hope that you will participate in this evaluation, since your answers are very useful to us. Before we begin do you have any questions or concerns? Are you ready to begin?

Signature of interviewer _____ (indicates that informed consent has been received).

Name:

Title:

Organization:

Date of interview:

Interviewer:

1. Are you familiar with the LMG project?
2. Have you ever collaborated with the project? If so, how have you collaborated? What tools or training, etc., if any, were part of this collaboration?
3. What do you think is the value of leadership, management and governance (L+M+G) interventions? Please explain.
4. What tools or approaches are the most helpful, of those with which you are familiar? Has your organization expanded use of any of these tools?
5. Do you think this/these models are sustainable? Why or why not?
6. Which ones do you think are easiest to replicate widely? Why?
7. Which ones more difficult to replicate? Why?
8. Has your organization provided funding (or allocated budget) for L+M+G training? To whom?
9. Are you satisfied with the partnerships formed between your organization, the LMG project, and the local institution(s) you supported?

KEY INTERVIEW GUIDE #5

For in-depth interviews with USAID field mission staff (in countries visited or interviewed in-depth: Haiti, Côte d'Ivoire, Kenya, Ukraine, Nigeria, Guatemala, Afghanistan, LMS-West Africa, Southern Africa). If the respondent mission has not filled out the SurveyMonkey, bring that form to the interview and add those questions at the end of the following questions:

Hello. My name is _____, and I work with GH Pro, an organization that USAID has commissioned to evaluate the Leadership, Management and Governance project (LMG). Since your mission has worked with the LMG project, I would like to ask you some questions about the assistance it has provided in your country. [This information will help the Global Health Bureau improve its support in this area.] The interview usually takes about thirty or so minutes.

Your individual responses will be treated confidentially. Your participation is completely voluntary, and you are free to withdraw at any time and can choose not to answer specific questions. However, we hope that you will participate in this evaluation, since your answers are very useful to us. Before we begin do you have any questions or concerns? Are you ready to begin?

Signature of interviewer _____ (indicates that informed consent has been received).

Name:

Title:

Organization:

Date of interview:

Interviewer:

1. Did your mission have any involvement with LMS, the predecessor project? If so, did the LMG project differ from LMS in terms of its focus? If so, how did it differ?
2. What interventions did LMG implement in your country?
3. What results has LMG delivered?
4. What tools or approaches were most helpful, in your view?
5. In each funding stream, are you satisfied with the project's results (OHA, POP, DCHA, Malaria/PMI)? Please explain.
6. Have you seen any evidence of country adoption of the models? (Probe: country ownership?)
7. Have you had any feedback from government or civil society organizations about the LMG project or these interventions?
8. Have you encountered any unforeseen challenges during the course of funding the project? Please explain. (Probe: for example, were there unexpected public health crises that affected your country's needs and funding? Other unexpected changes in funding? Staffing changes?)
9. Have you seen any unexpected dividends or opportunities that arose from the project?
10. Do you think the LMG project has made a difference in your country?

SURVEYMONKEY QUESTIONS FOR USAID FIELD MISSIONS:

Your mission has been involved with the LMG project that is now being externally evaluated. The project is in the fourth year of its five-year cooperative agreement. The external evaluation

commissioned by USAID is being carried out through GHPro. We ask that the member of your team most familiar with LMG complete the following short survey to inform the evaluation. This survey should take no more than 20 minutes to complete. Your responses will be anonymous, and there will be no individual-level analyses done using your responses or attribution of statements to individual respondents. We greatly appreciate your contribution to this evaluation.

1. Did your mission have any involvement with LMS, the predecessor project?
Yes No Don't know
2. If the mission used both projects, did LMG differ from LMS in terms of its focus?
Yes No →SKIP TO Q. 4 Don't know→SKIP TO Q. 4
3. In what way(s) did LMG differ from LMS?
4. What are the key institutions in your country that the LMG project has worked with? Choose all that apply.
 1. Local NGOs
 2. International NGOs
 3. National government institutions
 4. Local government institutions
 5. Private sector organizations
 6. Other (please specify) _____
5. What have been the key interventions that LMG has carried out with these institutions? Choose all that apply.
 1. Training
 2. Short-term technical assistance
 3. Long-term technical assistance (embedded technical assistance)
 4. Technology transfer
 5. Other (please specify) _____
6. Which of the following tools has LMG implemented in your country? Choose all that apply.

1. LDP+	2. FinMAT
3. SLDP	4. Governance Guide
5. OCAT	6. VLDP
7. Fostering Change	8. Youth Leadership
9. Governance eLearning	10. Midwifery Management course
11. Other (specify) _____	12. None of these

7. Which of these, if any, did you find useful in meeting the needs of your organization? Choose all that apply.

1. LDP+	2. FinMAT
3. SLDP	4. Governance Guide
5. OCAT	6. VLDP
7. Fostering Change	8. Youth Leadership
9. Governance eLearning	10. Midwifery Management course
11. Other (specify) _____	12. None of these

8. Have you seen any evidence of local adoption of the models, tools, or products that LMG promotes?
 Yes No →SKIP TO Q. 10 Don't know→SKIP TO Q. 10

9. (If yes) Please cite examples.

10. Have you seen evidence of host country or local organization contributions to taking any of the LMG models, approaches or tools to scale?
 Yes No →SKIP TO Q. 12 Don't know→SKIP TO Q. 12

11. (If yes) Please cite examples.

12. In your view, what have been the major contributions of the LMG project?

13. Which member(s) of the LMG consortium have provided the technical assistance in your country? Choose all that apply.

1. MSH	2. ICRC
3. Johns Hopkins University	4. IPPF-Afro
5. Yale University	6. Frontline SMS Medic
7. Amref	9. Don't know

14. In your view, has LMG partnered with other donors or the private sector to leverage the LMG work?
 Yes No →SKIP TO Q. 16 Don't know → SKIP TO Q. 16

15. Which other donors or private sector organizations?

1. UNFPA	2. Bilateral donors
3. UNICEF	4. Foundations
5. WHO	6. Private for-profit organizations
7. World Bank	8. Private nonprofit organizations
9. United Nations Development Programme	10. Other (specify)_____

16. In your view, what have been the most attractive features of the LMG project for USAID, if any?

1. Training
2. Products
3. Short-term TA
4. Long-term TA (embedded TA)
5. Use of technology
6. Leadernet archive
7. Other (specify)_____

17. What, if any, are some of the unforeseen challenges that the LMG project or USAID encountered in the course of implementing LMG work?

18. Have any local national organizations become centers of excellence or started providing leadership, management and/or governance technical assistance without LMG assistance?
 Yes No →SKIP TO Q. 20 Don't know→SKIP TO Q. 20

19. (If yes) Please name the organizations_____
20. Have you seen any evidence of increasing financial self-reliance among the local organizations or host government entities that LMG has assisted?
Yes No →SKIP TO Q. 22 Don't know→SKIP TO Q. 22
21. (If yes) Please give examples_____
22. To your knowledge, have any LMG-assisted institutions become eligible for USAID or other donor funding?
Yes No Don't know
23. Have any institutions supported by LMG graduated to host country or private sector financing?
Yes No Don't know
24. Do you have any other comments you would like to share with the evaluation team?

ANNEX VI: DISCLOSURE OF ANY CONFLICTS OF INTEREST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

USAID Non-Disclosure and Conflicts Agreement- Global Health Program Cycle Improvement Project

As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, "sensitive but unclassified information," procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID's mission.

Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:

1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.
2. Before disclosing Sensitive Data, I must determine the recipient's "need to know" or "need to access" Sensitive Data for USAID purposes.
3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.
4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.
5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.
6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.
7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to \$5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).
8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

CAsimwe

Signature

Date 09-05th 2015

Name CAROLINE ASIMWE (Ms)

Title LOGISTICS COORDINATOR

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature	<u><i>Dinsry Berhanu</i></u>	Date	11/03/2015
Name	<u>DINSRY BERHANU</u>	Title	Logistics Coordinator

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Betsy H. Brown
Signature

9/19/2015
Date

Betsy H. Brown
Name

Public Health Consultant
Title

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature Patricia H. David

Date 9/21/15

Patricia H. David

Name

Title Dr.

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that:
- (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me;
 - (ii) becomes available to me in a manner that is not in contravention of applicable law; or
 - (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.



Signature

Date 21/09/2015

JENNIFER KAAHWA KATELAINE

Name

Title MRS

ANNEX VII. LIST OF LMG TOOLS AND THEIR USE

	Tool used	Country	New LMG tool?	FS, core or split
Midwives	LMG for Midwifery Managers	Kenya	Y	Core
Midwives	LMG for Midwifery Managers	Tanzania	Y	Core
Midwives	LMG for Midwifery Managers	Ethiopia	Y	Core
Midwives	LMG for Midwifery Managers	Malawi	Y	Core
Midwives	LMG for Midwifery Managers	Uganda	Y	Core
Midwives	LMG for Midwifery Managers	South Sudan	Y	Core
Midwives	LMG for Midwifery Managers	Zimbabwe	Y	Core
Midwives	LMG for Midwifery Managers	Zambia	Y	Core
Midwives	LMG for Midwifery Managers	Lesotho	Y	Core
Midwives	LMG for Midwifery Managers	Rwanda	Y	Core
Leadership and management sustainability	Communication and Coaching Program	Uganda	Y	Core
NSP	NSP Facilitator's Guide	Malawi	Y	Core
CVT	FinMAT	Sierra Leone	N	Core
CVT	FinMAT	Liberia	N	Core
CVT	PROGRESS	South Africa	N	Core
CVT	Supervisor's HR Handbook	Moldova	Y	Core
CVT	Challenge Model	Kenya	N	Core
CVT	Challenge Model	Georgia	N	Core
Pre-service training	Faculty Facilitator's Guide	Rwanda	Y	Core
Governance	Governance guides and handbooks	Afghanistan	Y	Split
Governance	Governance guides and handbooks	Nigeria	Y	Split
Governance	Governance guides and handbooks	Togo	Y	Split
Governance	Governance guides and handbooks	Mali	Y	Split
Governance	Governance guides and handbooks	WAHO	Y	Split
Governance	Governance guides and handbooks	Ethiopia	Y	Split

Governance	Practices of good governance integrated in pre-service and in-service training curricula	Ethiopia	Y	Split
Governance	Governance guides and handbooks	Côte d'Ivoire	Y	Field
Governance	Practices of good governance in CCM member orientation program	Zambia	Y	Core
Governance	eCourses on USAID Global Health eLearning Center: Governance and Health	Global	Y	Core
Governance	eCourses on USAID Global Health eLearning Center: Key Practices of Good Governance	Global	Y	Core
Governance	eCourses on USAID Global Health eLearning Center: Infrastructure for Good Governance	Global	Y	Core
Governance	HIV/AIDS Provincial Planning Simulator	Vietnam	Y	Split
Cameroon postpartum family planning study	LDP+	Cameroon	N	Core
Cameroon postpartum family planning study	L&M Behavioral Self-Assessment	Cameroon	Y	Core
Cameroon postpartum family planning study	Work-Related Stress Survey	Cameroon	Y	Core
Youth	Youth Leadership eCourse	Global	Y	Core
Women's Mentoring	East Africa Women's Mentoring Network	Benin	Y	Core
Women's Mentoring	East Africa Women's Mentoring Network	Botswana	Y	Core
Women's Mentoring	East Africa Women's Mentoring Network	Burundi	Y	Core
Women's Mentoring	East Africa Women's Mentoring Network	DRC	Y	Core
Women's Mentoring	East Africa Women's Mentoring Network	Ethiopia	Y	Core
Women's Mentoring	East Africa Women's Mentoring Network	Ghana	Y	Core
Women's Mentoring	East Africa Women's Mentoring Network	Kenya	Y	Core
Women's Mentoring	East Africa Women's Mentoring Network	Malawi	Y	Core
Women's Mentoring	East Africa Women's Mentoring Network	Mozambique	Y	Core

Women's Mentoring	East Africa Women's Mentoring Network	Rwanda	Y	Core
Women's Mentoring	East Africa Women's Mentoring Network	Tanzania	Y	Core
Women's Mentoring	East Africa Women's Mentoring Network	Somalia	Y	Core
Women's Mentoring	East Africa Women's Mentoring Network	Uganda	Y	Core
Women's Mentoring	East Africa Women's Mentoring Network	Zambia	Y	Core
Wheelchairs	Basic Level Knowledge and Skills Test	Global	Y	Core
	SLP	Rwanda	Y	Core
OHA Dashboard	PEPFAR dashboard	Uganda	Y	Core
OHA Dashboard	PEPFAR dashboard	Kenya	Y	Core
Learning Centers	NUPAS	Kenya	N	Core
Learning Centers	NUPAS	Uganda	N	Core
Learning Centers	NUPAS	Mozambique	N	Core
Learning Centers	NUPAS	Ghana	N	Core
Learning Centers	NUPAS	Cameroon	N	Core
Learning Centers	LDP+	Uganda	Y	Core
Learning Centers	LDP+	Mozambique	Y	Core
Learning Centers	LDP+	Ghana	Y	Core
Learning Centers	LDP+	Cameroon	Y	Core
Pre-service	VLDP on pre-service L+M+G integration	AHLMN members	N	Core
Learning Centers	Business planning tool	Uganda	N	Core
Learning Centers	Business planning tool	Mozambique	N	Core
Learning Centers	Business planning tool	Ghana	N	Core
Learning Centers	Business planning tool	Cameroon	N	Core
Implementing Best Practices	Guide to Fostering Change to Scale Up Effective Health Services	Uganda	N	Core
Implementing Best Practices	Guide to Fostering Change to Scale Up Effective Health Services	Burkina Faso	N	Core
ACHEST	MOST	Uganda	N	Core
ICRC	SLP	East Africa: Sudan, Zambia, Tanzania, Ethiopia	Y	Core
ICRC	SLP	South East Asia: Myanmar, Vietnam, Cambodia, Philippines, Lao PDR	Y	Core
ICRC	SLP	Francophone Africa: Burundi, Madagascar, Chad, Niger, DRC, Togo	Y	Core

ICRC	Communication and Coaching Program	Held in Bangkok, but participants were based in Burundi, DRC, Colombia, Togo, Vietnam, Cambodia, Lebanon, Tanzania, Thailand, Myanmar, Algeria	Y	Core
ICRC	Essential Management Package	Ethiopia	Y	Core
ICRC	Essential Management Package	Held in Bangkok, but participating countries were: Pakistan, Madagascar, Vietnam, Cambodia, Tajikistan	Y	Core
Wheelchair	Wheelchair Service Training Package-Basic	Ethiopia, Zimbabwe, Philippines, Cambodia, Albania, Mongolia, Vietnam, Peru, El Salvador, Ukraine, Guatemala, Madagascar, Brazil, Pakistan, Malaysia	N	Core
Wheelchair	Wheelchair Service Training Package-Intermediate	Albania, Philippines, DRC, Cambodia, Fiji	N	Core
Wheelchair	Wheelchair Service Training Package-Managers and Stakeholders	Philippines, Mongolia, Vietnam, Peru, Ukraine, Guatemala, Madagascar, Brazil, Fiji, Cambodia, DRC	Y	Core
Wheelchair	TOT Flash Cards	Virtual/Global	Y	Core
NCC	Challenge Model	Rwanda	N	Core
Ponseti International Association	The Guide to Fostering Change	Nigeria, Pakistan, Peru	N	Core
Independent Living	Challenge Model	Conducted in USA but participating countries were Albania, Paraguay, Haiti, Kazakhstan, Georgia, South Africa	N	Core
	Eligibility and Performance Assessment Tool	Côte d'Ivoire, Ghana, Senegal, Mali, Morocco, Mozambique, Sierra Leone	N	Split
LMG/Haiti	RBF tools (manual, costing tool, contract templates)	Haiti	Y	Field support
LMG/Haiti	Management and Organizational Sustainability Tool (MOST)	Haiti	N	Field support

LMG/Haiti	Dashboard for the Director General and dashboards for the three priority programs (malaria, TB, HIV)	Haiti	Y	Field support
LMG/Haiti	Referral and counter-referral tools	Haiti	Y	Field support
LMG/Haiti	Integrated HIV/TB supervision tools	Haiti	Y	Field support
LMG/Cote d'Ivoire	LDP+	Côte d'Ivoire (4 cycles to date)	N	Field support
LMG/Cote d'Ivoire	CCM Executive Dashboard	Côte d'Ivoire	N	Field support
LMG/NMCP Project	Organizational Capacity Assessment Tool (OCAT)	Burundi, Côte d'Ivoire, Sierra Leone, Cameroon, Guinea, Liberia	N (Developed by Fanikisha)	Field support
LMG/NMCP Project	LDP+	Côte d'Ivoire, Cameroon, Guinea, Liberia	N	Field support
LMG/West Africa Regional	Organizational Capacity Assessment Tool (OCAT)	Burkina Faso	N (Developed by Fanikisha)	Field support
LMG/West Africa Regional	LDP+	Burkina Faso	N	Field support
LMG/NMCP Project	FinMAT training	Sierra Leone	N	Field support

ANNEX VIII: LMG COST SHARE REPORT PY4 Q5

LMG Quarterly Cost Share Report: PY4 Q5, July-September, 2015

Cost Share Requirement	Cost Share Requirement Based on Total Obligation to Date	Total Obligation to Date	Percentage of Cost Share Booked (goal: 20%)	Percentage of Cost Share Pipeline (goal: 20%)	Total Cost Share Booked to Date		
20%	\$27,241,898	\$136,209,491	20%	9%	\$26,582,782		
Project Director - Jason Wright							
Core & Field Support Funds for all LMG (including Subawards)		Obligation Period		Total Obligation to Date	Percentage of Cost Share Booked (goal is 100%)	Total Cost Share Pipeline	Total Cost Share Booked to Date
		Start Date	End Date				
CORE	PM	9/25/11	9/24/16	\$0	0%	\$13,136	\$294,244
	PRH	9/25/11	9/24/16	\$11,495,001	49%	\$804,765	\$1,132,182
	OHA	3/2/12	9/24/16	\$20,309,938	18%	\$2,920,436	\$723,883
	DCHA	9/25/11	9/24/16	\$14,161,310	24%	\$42,035	\$669,159
	HIDN	6/30/15	9/24/16	\$105,000	0%	\$24,000	\$0
	ESF	6/30/15	9/24/16	\$4,615,000	0%	\$0	\$0
FIELD SUPPORT	Afghanistan	9/23/12	2/28/16	\$38,341,106	253%	\$0	\$19,422,064
	Benin	9/23/12	9/30/15	\$2,361,317	4%	\$18,141	\$20,594
	Côte d'Ivoire	2/1/12	9/24/16	\$5,900,000	0%	\$761,242	\$0
	Ethiopia	9/25/11	9/24/16	\$7,226,108	2%	\$486,644	\$34,919
	Haiti	7/27/12	6/30/16	\$17,246,899	120%	\$4,279,211	\$3,232,600
	Honduras	2/12/13	9/30/15	\$2,658,820	131%	\$1,215,560	\$697,110
	LAC	3/27/14	9/24/16	\$650,000	0%	\$769,651	\$0
	Libya	7/27/12	3/31/15	\$1,500,000	8%	\$0	\$23,622
	Madagascar	11/1/14	9/24/16	\$300,000	0%	\$0	\$0
	MENA	9/1/13	12/31/15	\$258,040	644%	\$396,872	\$332,407
	PASCA	4/25/14	9/24/16	\$3,774,624	0%	\$634,198	\$0
	Uganda	10/1/13	6/30/16	\$500,020	0%	\$0	\$0
	Vietnam	7/27/12	12/31/14	\$2,500,000	0%	\$0	\$0
	West Africa Regional	10/1/13	9/24/16	\$1,843,370	0%	\$16,637	\$0
	Zambia	10/1/13	12/31/15	\$350,000	0%	\$0	\$0
TOTALS				\$136,209,491	98%	\$12,382,528	\$26,582,782
PARTNERS	JHU	2/1/12	6/30/16	\$995,674	135%	\$0	\$269,452
	Medic Mobile	2/1/12	6/30/16	\$176,079	217%	\$0	\$76,579
	IPPF	2/1/12	6/30/16	\$945,045	268%	\$0	\$0
	AMREF	2/1/12	6/30/16	\$741,489	0%	\$1,389,529	\$0
	Yale	2/1/12	6/30/16	\$1,379,048	192%	\$0	\$528,585
Significant Subawards	Alliance	8/1/13	12/31/15	\$2,205,117	75%	\$398,295	\$332,481
	MIUSA	6/21/12	5/31/16	\$1,307,929	122%	\$102,736	\$318,829
	PIA	12/21/12	12/31/14	\$1,907,584	91%	\$0	\$347,594

ANNEX IX: LMG PERFORMANCE MANAGEMENT REPORT SUMMARY

Indicator	CUMULATIVE TOTAL	PY1 Total	PY2 Total	PY3 Total	PY4 Total	Trend	PYS Target (cumulative)	Progress to Date
PQ: Number of organizations that report increased demonstrated capacity to perform a key function for which it has received LMG technical assistance	6	N/A	N/A	0	6		15	
R1: Percent of web survey respondents that report use of an LMG resource (tool, model, approach) that was downloaded from the LMG portal	N/A	N/A	N/A	N/A	1.97%	N/A	2,280 / 4,150 = 55%	N/A
1.1a: Number of global health agencies, private sector partners, and professional networks or associations that have actively partnered with LMG	23	0	7	14	2		10	
1.2a: Number and names of global health agencies, international CSOs, private sector partners, and professional networks or associations that institutionalized LMG tools, models, and/or approaches	5	0	4	0	1		8	
1.3a: Total resources in USD booked as cost share for LMG global activities and implementation of country-level LMG strategies, tools, models, and/or approaches	\$26,135,376	0	\$168,658	\$9,561,945	\$16,404,773		\$40 million	
1.4a: Number and names of meetings, conferences, and KE events at which LMG staff or partners present on priority LMG topics, evidence-based approaches, tools, or research findings	139	20	37	35	47		50	
1.4b: Number of leadership, management, and governance advocacy materials developed and disseminated with USAID, global practitioners, and other key stakeholders	47	3	10	10	24		35	
1.4c: Total number of website visits on LMG web portal	45,624	N/A	6,352	11,290	27,982		6,655	
1.4d: Percentage of new and returning visitors on LMG web portal	N/A	N/A	45.8% new / 54.2% returning	33.9% new / 66.1% returning	70% new / 30% returning	N/A	50% new / 50% returning	N/A
1.4e: Number of likes on the LMG Facebook page	N/A	N/A	263	429	1,136		450	
1.4f: Number of followers of LMG on Twitter	N/A	N/A	163	351	1,079		240	
1.4g: Number of views of LMG videos on YouTube	N/A	N/A	1,947	4,026	1,567		3,500	
R2: Number of global panels or working groups that LMG staff participate in as technical resource or expert on L+M+G	35	N/A	N/A	8	27		13	
2.1a: Number of current tools, models, and approaches assessed to determine gaps for further improvement	16	4	3	4	5		10	
2.1b: Number of LMG current tools, models, and/or approaches adapted or improved and field-tested	15	0	4	5	6		5	

Indicator	CUMULATIVE TOTAL	PY1 Total	PY2 Total	PY3 Total	PY4 Total	Trend	PYS Target (cumulative)	Progress to Date
2.1.c: Number of new LMG tools, models, and/or approaches created and field-tested	30	0	12	9	9		5	
2.2.a: Number of operations research studies, evaluations, or case studies assessing the effects of LMG interventions on health service delivery or health systems performance completed	10	0	0	4	6		10	
2.2.b: Number of abstracts or papers submitted to international conferences and peer reviewed journals	52	0	2	17	33		10	
2.2.c: Number of abstracts or papers accepted and/or published by international conferences and peer reviewed journals	37	0	1	11	25		5	
R3: Number of CSOs and public sector organizations/teams who received leadership, management, and governance interventions and report improvements in health service delivery or health systems performance	79	N/A	6	2	71		80	
3.1.a: Number of teams trained by LMG staff using LMG tools, models, approaches, and/or in-service curricula	2,291	5	159	1,657	470		150	
3.1.b: Number of teams trained using LMG tools, models, approaches, and/or in-service curricula who develop action plans	524	4	119	161	240		250	
3.1.c: Number of teams that previously received training in LMG tools, models, and/or approaches who report completion of an action plan	361	N/A	87	87	187		200	
3.1.d: Number of local facilitators or faculty trained by LMG staff to deliver LMG tools, models, approaches, and/or in-service curricula	659	1	210	220	228		70	
3.1.e: Number of teams trained by local facilitators who previously received training by LMG staff in LMG tools, models, and/or approaches	131	2	30	14	85		40	
3.2.a: Number and names of local, national, and regional CSOs, public sector partners, and universities that institutionalized LMG tools, models, and/or approaches	21	0	5	9	7		8	
3.3.a: Number of local facilitators or faculty who are trained by LMG staff to integrate and/or deliver the pre-service curriculum	75	0	0	38	37		40	
3.3.b: Number of institutions in which LMG staff have begun integrating LMG pre-service training programs by holding engagement meetings with the staff of the training institution, and/or holding a curriculum integration workshop, and/or coordinating a stakeholder validation workshop	6	N/A	0	5	1		10	
3.3.c: Number of LMG pre-service training programs approved by training institution	3	N/A	0	1	2		8	
3.3.d: Number of institutions that have integrated LMG pre-service training programs	9	N/A	N/A	N/A	9	N/A	5	

Indicator	CUMULATIVE TOTAL	PY1 Total	PY2 Total	PY3 Total	PY4 Total	Trend	PY5 Target (cumulative)	Progress to Date
3.3e: Number of students enrolled in integrated LMG pre-service training program	430	N/A	N/A	N/A	430	N/A	750	
3.4a: Number of facilitators trained by LMG staff providing capacity building to health organizations using LMG tools, models, and/or approaches	60	1	0	0	59		105	
3.4b: Number of local institutions trained by LMG providing capacity building to local health organizations using LMG tools, models, and/or approaches	13	0	13	0	0		10	

Notes

Development of the technology platform for Indicator R1 was delayed.
The PY4 AR total for indicator 3.1e excludes Afghanistan's training of 1,938 Family Health Action Groups.

ANNEX X: RESPONSE FROM THE LEADERSHIP, MANAGEMENT AND GOVERNANCE PROJECT

In general, the LMG Project is in agreement with the largely positive evaluation findings. There are, however, a few cases where the information included in the evaluation findings does not accurately reflect the Project's activities. In some of these, an incomplete understanding of the work may have led to conclusions/recommendations that were off target.

This statement is meant to clarify the work done by LMG in these areas, as this document will become a key reference document for stakeholders about the LMG Project.

Page v, re: cost share and IPPF

As of the time of the evaluation, LMG exceeded the 20 percent cost-share expectations, reaching \$29.1 million or 26 percent of total project expenditures. The cost share allowed 10 IPPFAR affiliate family planning programs to scale up leadership, management and governance systems strengthening, with more scheduled this year.

Comment: When reporting their cost share to LMG, IPPF reported using SIDA funds to scale up learning centers in four other Member Associations: Family Guidance Association of Ethiopia (FGAE), Family Health Options Kenya (FHOK), Association Ivoirienne pour le Bien-etre Familial (AIBEF), Family Life Association of Swaziland (FLAS), Association Togolaise pour le Bien-tre Familial (ATBEF).

Page vi, re: East Africa Women's mentoring Network

The effectiveness of the East African Women's Mentoring Network was limited, due to technology issues and the distance coaching and mentoring model selected.

Comment: LMG piloted an online virtual women's mentoring network in PY4. This was intentionally started out as a pilot on a limited scale to assess what worked and what didn't working in virtual south-to-south mentoring. To compensate for difficulties accessing the online Chronus platform, mentors and mentees used Skype, WhatsApp, e-mail, and SMS in addition to or instead of the website.

Page 9, re: Senior Leadership Development (SLP):

The SLP was largely developed by the LMG/Yale Global Health Leadership Institute (Yale/GHLI).

Comment: At the beginning of LMG, MSH and Yale worked together to develop the Senior Leadership Development Program. The program was designed based on MSH's more than 10 years' experience delivering the Leadership Development Program (participative, team based

experiential learning program) and Yale’s experience with their Annual Leadership Conference. The two approaches were merged to produce the SLP.

Page 18, re: Essential Management Package module sequencing

LMG and ICRC should consider collapsing the modules from 10 to five, as Myanmar has done, to allow completion in a more intensive, compressed timeframe.

Comment: Myanmar still completed all 10 modules, but rather than conduct 1 module a week or every two weeks, they held a series of workshops. At each workshop, they conducted several modules. This made a lot of sense for the context of the center in Myanmar which has many staff who spend lots of time in mobile outreach services in the field. Since they are not routinely all in the office together, organizing specific workshops allowed more staff to participate in the full program. The EMP was designed to be delivered this way, each center is supposed to adapt the schedule and frequency of module delivery to their context and needs, as Myanmar did. What LMG and ICRC can do is to share the example of Myanmar so other centers in similar contexts can learn from their experience.

Page 22, re: AHLMN

***AHLMN:** LMG conducted a Virtual Leadership Development Program (VLDP) with five teams from members of the AHLMN network, including the University of Zambia, University of Witwatersand in South Africa, the MOI University of Kenya and the IDM Mananga University in Swaziland. The focus of the VLDP was to develop a plan for how L+M+G could be integrated into pre-service health workforce curricula at the team’s university. However, only two of the many trained network member institutions, Makerere University and Botswana Institute of Management, were able to train their own faculties, because there was no LMG funding to do so the current AHLMN chair noted that it is also not clear whether the VLDP training was incorporated into the curriculum of the health professionals in these institutions, and if so, whether it is examinable. The work done with AHLMN has not yet created a critical mass of trained members in the application of the VLDP who can carry on the legacy of LMG tools in their institutions. The one common issue noted by key informants was the limited funding for AHLMN from Amref and USAID core support to fully complete this work by the time of this evaluation. Another informant noted that, “Working through digital networks is proving difficult.” The evaluators believe that, on balance, this network platform has great promise to disseminate materials (e.g., those produced by LMG and others supported by USAID) in the future.*

Comment: VLDPs are virtual leadership development programs offered by MSH on an online platform. Over the life of the project, LMG conducted two VLDPs focusing on integrating leadership management and governance into university health curricula, the second focusing on AHLMN members. The VLDP worked with teams in universities to help them plan for how they could integrate L+M+G competencies into their health sector training programs. The universities we worked with under the AHLMN VLDP were: University of Zambia, University of

Witswatersrand in South Africa, Moi University in Kenya, the Institute of Development Management in Botswana, and Mananga Center for Regional Integration and Management Development in Swaziland.

The VLDP does not come with funding to help organizations implement their plans, rather it focuses on developing team capacity to develop plans, identify challenges, and monitor progress towards a goal. The VLDP training itself would not be incorporated and made examinable, rather the implementation of the plans developed by the university teams to integrate leadership, management and governance into the pre-service curricula would take universities closer towards making leadership, management and governance and examinable subject. There was no expectation or plan for AHLMN members to conduct VLDPs or implement LMG tools. LMG did provide tools and resources to assist with this, but the team were not trained in implementation or expected to do so.

The VLDP was conducted and completed as per the workplan in PY3, so it's not accurate to state that there was limited funding to fully complete this work.

The comment regarding working through digital networks is not related to the VLDP. This comment may have been related to the AHLMN itself.

Page 36, re IPPF and surgical camp model scale up

IPPF has allocated funding for scaling up RHU's outreach camps for reaching underserved populations, allocating \$220,000 in 2014, \$150,000 in 2015 and \$105,000 in 2016. This will help RHU institutionalize a cost-effective way to offer integrated services to the most vulnerable and reduce missed opportunities.

Comment: IPPF clarified that the amount cited is the annual allocation for supporting the entire Learning Center Initiative, and all 9 host Member Associations are eligible to receive some of this funding. This amount noted was not the amount received by RHU.

Page 56, re: recommendation for implementation of EMP

In the ICRC activity in Ethiopia, for example, the local LMG team in Addis and the RHB team in Harar could have accelerated the timeline for EMP completion and thought through creative ways to overcome staffing challenges faster than the MSH home office team. The Ethiopia team had tackled similar types of challenges in neighboring public health facilities. Côte d'Ivoire's malaria work was the best contrasting example of MSH headquarters effectively supporting a local team's work.

Comment: The EMP implementation in Ethiopia did not rely on MSH home office staff. The center managers were delivering the program to their staff and then ICRC's local Ethiopian staff were providing on-the-ground support and coaching. The staffing issue was at the center itself (which was private, NGO-led) where over 50% of the staff left at once over salary disputes. This was a rather extreme case and outside of the influence of the EMP, particularly because it

happened so early on in the process. It is possible that the local office could have been a resource but we did not have funding to formally utilize their time and expertise.

We appreciate that the evaluation team talked to a large number of people and reviewed a lot of documents and briefings in a short amount of time. Their work has produced helpful comments and insights which will inform the project's final year of implementation.



Global Health Performance Cycle Improvement Project

1331 Pennsylvania Avenue NW, Suite 300

Washington, DC 20004

Phone: (202) 635-9444

Fax: (202) 517-9181

ghpro.dexisonline.com