



**USAID**  
FROM THE AMERICAN PEOPLE



# Leadership, Management and Sustainability Program

2005 - 2010

Final Report







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# Acronyms

ACT	AIDS Care and Treatment Project
ADRA	Adventist Development and Relief Agency
ADS	Asociación Demográfica Salvadoreña
ADZ	Alternative Development Zone
ANC	Ante-natal Care
APLI	ADRA Professional Leadership Institute
APROFAM	Asociacion Pro-Bienestar de la Familia
APROPO	Apoyo a Programas de Población
ART	Antiretroviral Therapy
ARV	Antiretroviral
BMAF	Benjamin William Mkapa HIV/AIDS Foundation
BPHS	Basic Package of Health Services (in Afghanistan)
BUSPH	Boston University School of Public Health
CA	Cooperative Agency
CCM	Country Coordinating Mechanism
CDAI	Centres Departementaux d'Approvisionnement en Intrants
CDC	Center for Disease Control
CDM	Comité de Desarrollo Municipal
CEE	Comunidad Económica Europea
CEPEP	Centro Paraguayo de Estudios de Población
CHAM	Christian Health Association of Malawi
CHW	Community Health Worker
CIES	Centro de Investigaciones y Estudios de la Salud
CIRD	Centro de Información y Recursos para el Desarrollo
COBES	Community Based Education and Service
CORE	Cost Revenue Analysis
CPR	Contraceptive Prevalency Rate
CS	Contraceptive Security
CSO	Civil Society Organization
CYP	Couple-Years of Protection
DFID	Department for International Development
DRC	Democratic Republic of Congo
DSF	Direction de la Santé de la Famille
DSW	Department of Social Welfare
E&E	Europe and Eurasia

ECSA-HC	East, Central and Southern Africa Health Community
ESAMI	Eastern and Southern Africa Management Institute
FBO	Faith-Based Organization
Fin-MAT	Financial Management Assessment
FOM	Faculty of Medicine
FOSACOF	Fully Functional Service Delivery Point
FP	Family Planning
FPMD	Family Planning Management Development Program
FPMT	Family Planning Management Training Project
GAVI	Global Alliance for Vaccines and Immunization
GCMU	Grants and Contract Management Unit
GEN	Global Exchange Network for Reproductive Health
GHC	Global Health Council
GHS	Ghana Health Service
GMS	Grants Management Solutions Project
GTZ	Gesellschaft für Technische Zusammenarbeit (German Aid Agency)
HAPCO	HIV/AIDS Prevention and Control Office
HCM	Healthy Communities and Municipalities
HCT	HIV Counseling and Testing
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HMIS	Health Management Information System
HPI	Health Policy Initiative
HR	Human Resources
HRH	Human Resources for Health
HRM	Human Resource Management
HSS	Health Systems Strengthening
HSSP	Health Services Support Project
ICA	Institute of Cultural Affairs
ICT	Information and Communication Technology
IMCI	Integrated Management of Childhood Illness
IPPF	International Planned Parenthood Federation
IRCU	Inter-Religious Council of Uganda
JSI	John Snow, Inc.
LDP	Leadership Development Program
LMS	Leadership, Management and Sustainability Program
M&E	Monitoring & Evaluation
M&L	Management and Leadership Program
MAIS	Modelo de Atención Integral en Salud

MAQ	Maximizing Access and Quality
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Work
MOMS	Ministry of Medical Services
MOPH	Ministry of Public Health
MOPHS	Ministry of Public Health Services
MOST	Management and Organizational Sustainability Tool
MOU	Memorandum of Understanding
MPH	Master of Public Health
MSH	Management Sciences for Health
MSP	Management Support for Provinces
MSPP	Ministry of Public Health and Population
NGO	Non-Governmental Organization
NHI	National Health Institute
OGAC	Office of the Global AIDS Coordinator
OHA	Office of HIV/AIDS
OSAR	Observatorios en Salud Reproductiva
OVC	Orphans and Vulnerable Children
PAC	Post-Abortion Care
PCM	Project Cycle Management
PEDL	Educational Plans
PEPFAR	President's Emergency Plan for AIDS Relief
PHR	Partners for Health Reform plus
PIHCT	Provider Initiated HIV Counseling and Testing
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Post-Natal Care
PR	Principal Recipient
PROACT	Prevention Organizational Systems AIDS Care and Treatment Project
PROCOSI	El Programa de Coordinación en Salud Integral
PY	Program Year
QAP	Quality Assurance Project
RFE	Rapid Funding Envelope
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RHTC	Regional Health Training Centers
ROLDP	Results-Oriented Leadership Development Program

RPM+	Rational Pharmaceutical Management Plus Program
SDI	Service Delivery Improvement
SESA	Secretariat of Health in Brazil's Northeastern State of Ceará
SFH	Society for Family Health
SR	Sub-Recipient
STOP AI	STOP Avian Influenza
TB	Tuberculosis
Tech-Serve	Technical Support to the Central and Provincial Ministry of Public Health
THRP	Tanzania Human Resource Capacity Project
TOT	Trainings of Trainers
ULAT	Local Technical Assistance Unit
UN	United Nations
UNAN	Universidad Nacional Autonoma de Nicaragua
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
USG	United States Government
VBPH	Virtual Business Planning for Health Program
VCGP	Virtual CSO Board Governance Program
VCT	Voluntary Counseling and Testing
VDC	Village Development Committees
VFCP	Virtual Fostering Change Program
VHRM	Virtual Human Resource Management Program
VLDP	Virtual Leadership Development Program
VSPP	Virtual Strategic Planning Program
WAMA	Wanawake na Maendeleo Foundation
WHO	World Health Organization



# Executive Summary

## The LMS Program: Out of Our Hands and into the World



*USAID's Office of Population and Reproductive Health has a rich experience in funding and furthering leadership and management programs, and has built awareness of how critical leadership and management are for strong national health systems and local health services organizations. Management Sciences for Health (MSH) has a long history of working closely with USAID and partners to build the leadership and management capacities of those working in family planning and reproductive health programs, as well as other health organizations and institutions around the world.*

*From the Family Planning Management Training Project (1985 – 1990) through the Leadership, Management and Sustainability (LMS) Program (2005 – 2010), the nature of technical assistance has evolved from a focus on building individuals' management skills in reproductive health and family planning to today's holistic approach that integrates practical, action oriented leadership and management knowledge and skills into each of the six World Health Organization (WHO) building blocks of health systems strengthening. Skilled, committed and supported health leaders and managers are key to making all building blocks work together to save lives and reduce illness in all areas of primary health care.*

For many years, MSH has been privileged to work closely with USAID and partners to build the capacity of reproductive health programs and other programs around the world. From 1985 through 2010, these programs included the Family Planning Management and Training Project, the Family Planning Management Development Programs I and II, the Management and Leadership Program, and the Leadership, Management and Sustainability Program (LMS).

One of the LMS Program's key achievements has been demonstrating the link between improved leadership, management, and governance and improved health services. This report documents the results of the LMS Program in five key areas including (1) impact on service delivery programs; (2) results in good governance; (3) mainstreaming and scale-up of these practices; (4) virtual programs; and (5) advocacy for leadership and management development.

The Leadership, Management and Sustainability Program was awarded to MSH in August 2005 by USAID's Office

*One of the LMS Program's key achievements has been demonstrating the link between improved leadership, management, and governance and improved health services.*

of Population and Reproductive Health, in the Bureau of Global Health. The LMS Program focused on three key result areas: (1) Improving management and leadership of priority health programs; (2) Improving management systems in health organizations and priority programs; and (3) Increasing sustainability and ability to manage change

A primary goal of the program was to develop managers and leaders who achieve results in the areas of family planning and reproductive health, HIV & AIDS, infectious disease, maternal and child health, and many other areas of service delivery. The LMS Program followed a results model that defined the program's theory of change with an end result of improved services and better health outcomes. The LMS results model was applied in 19 countries: Afghanistan, Bolivia, Democratic Republic of

Congo, Cote d'Ivoire, Egypt, Ethiopia, Ghana, Guatemala, Haiti, Honduras, Kenya, Malawi, Nepal, Nicaragua, Nigeria, Peru, Southern Sudan, Tanzania, and Uganda. Its influence was felt in dozens of additional countries through its inclusion in LMS' virtual programming.

### **Key Results of the LMS Program**

This LMS Final Report documents service delivery results in the areas of family planning and reproductive health that illustrate how leadership and management strengthening have contributed to increased commodity security, couple years of protection, and the use of family planning methods, to name just a few key areas. Evidence from Afghanistan, for example, shows how institutional deliveries in 13 USAID-funded provinces increased from 1,035 in March 2004 to 4,905 in March 2010. Contraceptive prevalence rates increased from 28% in 2006 to 43% in 2009.

In terms of HIV/AIDS programming, this report presents cases of how building leadership and management capacity have contributed to improved HIV counseling and testing rates, raised the number of patients initiated into antiretroviral therapy, and increased the number of orphans and vulnerable children receiving care and support. By standardizing key management systems including human resources, operations, and financial management of public sector and civil society organizations, the LMS Program in Nigeria has expanded HIV/AIDS services. In Ethiopia, results included improved HIV counseling and testing rates and increased voluntary counseling and testing coverage. CSOs in Nigeria have now qualified for direct grants from donors.

In the area of maternal/child health, evidence illustrates how improved leadership and management practices have contributed to an increase in the number of children born in health facilities, the number of mothers receiving prenatal and ante-natal care, and the number of children under age five who are treated for respiratory infections, childhood diarrhea and malaria. In the Democratic Republic of Congo, for one example, LMS supported the Ministry of Health through training as well as provision of pharmaceuticals, medical supplies and materials. Two key technical areas of focus were strengthening integrated management of childhood illness, and expanding prevention, treatment and care for malaria. Under the project, the number of children under age 5 treated for malaria increased by 46% in a five-month period.



*Training of trainers workshop, Egypt*

This report also examines the achievements of the LMS Program in strengthening governance, particularly in three areas: (1) the public sector – building governance capacity in Afghanistan’s Ministry of Health, in municipal development councils in Nicaragua, and regional and municipal governments in Peru; (2) civil society – especially in Africa, where the rapid scale-up of HIV/AIDS programs necessitated partnership with civil society organizations that lacked leadership and management skills; and (3) multi-sectoral partnerships – particularly the Global Fund to Fight AIDS, Tuberculosis and Malaria.

One LMS success story in the area of governance comes from Cote d’Ivoire: after LMS technical assistance, the Country Coordinating Mechanism of the Global Fund received two awards -- \$181 million for HIV/AIDS and \$49 million for TB. Another comes from Tanzania, where the LMS Program provided technical support to enhance the leadership, management and governance of indigenous civil society organizations. This work contributed to the awarding of 113 grants totaling \$15.9 million to CSOs participating in the fight against HIV/AIDS.

Under the LMS predecessor program, the Management and Leadership Program, USAID and MSH developed and successfully implemented new programs and approaches to im-

prove the management and leadership capacity of health care organizations in developing countries. LMS further promoted the mainstreaming and scale up of these approaches in a greater number of organizations, to reach a “critical mass” of practitioners who would bring about substantial, sustainable change in health practices and services, thereby improving the health of their communities. This report highlights how LMS Program interventions at the state level, with partners, and with established institutions and universities built leadership and management skills among participating organizations. It also looks at the impact of mainstreaming and scale up efforts within national health systems, the community, and civil society organizations.

### **Key Lessons Learned**

Over the last five years, the LMS Program has achieved significant results in many countries and settings; all of these experiences have contributed to lessons learned in how leadership, management and governance can contribute to service delivery improvements and long-term health outcomes. This final report documents many of these lessons and encapsulates them into seven “big picture” key messages:

- 1. Managers who lead improve health services. Strengthening leadership and management practices and improving health management systems, when done effectively, contribute to improved health outcomes. A programmatic assessment of the impact of the leadership development program delivered by LMS Kenya offers evidence that these improvements are achievable and sustainable.
- 2. Motivated managers make health systems work. Leadership development can bring new energy to address major challenges faced by health practitioners and increase overall performance and effectiveness. The LMS approach produces a critical transformation for health leaders/managers from an activity mind-set to a results mind-set. This transformation is fundamental to motivating teams, overcoming challenges and achieving better health outcomes in resource constrained settings.
- 3. Multiple pathways exist from leadership and management to improved health services. LMS action-learning approaches include developing the leadership of health teams, empowering communities to create health service demand, increasing sustainability of service delivery programs and other methods.

- 4. Good governance is about people and systems. LMS teams have helped developing country counterparts in public and NGO sectors to establish systems that promote transparency, social participation, and accountability. However, individuals and teams have a limited capacity to support implementation. Developing good governance, like developing leadership capacity, is a process that takes place over time, where people are challenged, offered feedback, and given support throughout the change.
- 5. Start developing managers early in their careers. The largest pool of potential health care leaders and managers are the students of today in medical, nursing and public health schools. The LMS experience demonstrates that it is possible to integrate leadership and management into the pre-service curricula of academic institutions. Due to the hierarchical nature of the university system, it often takes more time to integrate these practices into a curriculum. Our experience shows, however, that once they are integrated this approach is highly sustainable.
- 6. Virtual approaches address needs at scale. One way to reach many more organizations is to tap into the power of information technology. Opportunity exists to innovate and expand virtual approaches using new methods as Internet connectivity increases in the developing world, and as mobilization and support for strengthening health systems grows. Active facilitation and engagement with participants is the key.
- 7. Sustainability requires practical tools that empower people to act. Approaches and tools must be designed for people to use in their own settings, and they should be practical and action-oriented. Complex, proven practices can be distilled into simple, effective and user-friendly practices that contribute to achievements in service delivery.

## Recommendations

During the tenure of the LMS Program, the belief in the need for improved leadership and management has been repeatedly confirmed by USAID Missions, other international donors, local organizations, and additional key stakeholders in the health sector. By the end of the LMS Program, demand from USAID Missions and counterparts from combined core, field support and Associate Awards had reached \$306.8 million with 64% coming from Associate Awards and only 7% from core funding.

To continue to build upon this work, there are several priority programmatic areas that deserve continued attention from donors, implementers and partners for future and similar programs; this report concludes with recommendations for further advancing the evolution of programs to strengthen leadership, management and governance, as follows:

- First, although the LMS Program has made significant progress in strengthening public sector institutions and CSOs involved in the planning and delivery of services across all levels of the health system, there is a need to implement rigorous evaluations of these types of interventions.
- Second, the need to use a select number of robust indicators to assess intermediate and end results is an ongoing effort that deserves critical attention.
- Third, the development of governance capacity for both public sector institutions and CSOs will require increasing attention.
- Fourth, there is a specialized need for developing the leadership and management capacities of those in senior leadership positions.
- Fifth, as new technologies become available in low and middle income countries, the use of virtual approaches constitutes a viable solution to respond to and meet the ever expanding demand for leadership and management development interventions.

As the U.S. Government enters a new era in international development with the implementation of major initiatives such as the Global Health Initiative and PEPFAR II, there is stronger emphasis on sustainability, country ownership, and integration of health services through the strengthening of health systems. Such strategic endeavors and principles will require continued investment in effective leadership, management and governance programs in order to support the successful implementation of these initiatives, accelerate progress towards the attainment of MDG targets in low and middle income countries, and more importantly, save lives and improve the health of the world's most vulnerable and disadvantaged people.

# The Evolution of USAID Support for Management and Leadership Development



*Management Sciences for Health has worked closely with USAID and partner organizations to build the capacity and sustainability of reproductive health and other programs and institutions around the world over several years. These programs include the following: the Family Planning Management Training Project (1985 – 1990); the Family Planning Management Development Programs I and II (1990 – 2000); the Management and Leadership Program (2000 – 2005); and the Leadership, Management and Sustainability Program (2005 – 2010).*

During this time, the nature of technical assistance has evolved from a focus on building individual skills in reproductive health (RH) and family planning (FP) management to a holistic approach today that integrates practical action oriented leadership and management knowledge and skills into each of the six World Health Organization building blocks of health systems strengthening. Skilled, committed and supported health leaders and managers are key to making all building blocks work together to save lives and reduce illness in all areas of primary health care.

*Seven themes have characterized the changes in USAID’s programs over time, including the evolution in the capacity building approach from a focus on individuals and individual management systems to a focus on teams and integrated systems.*

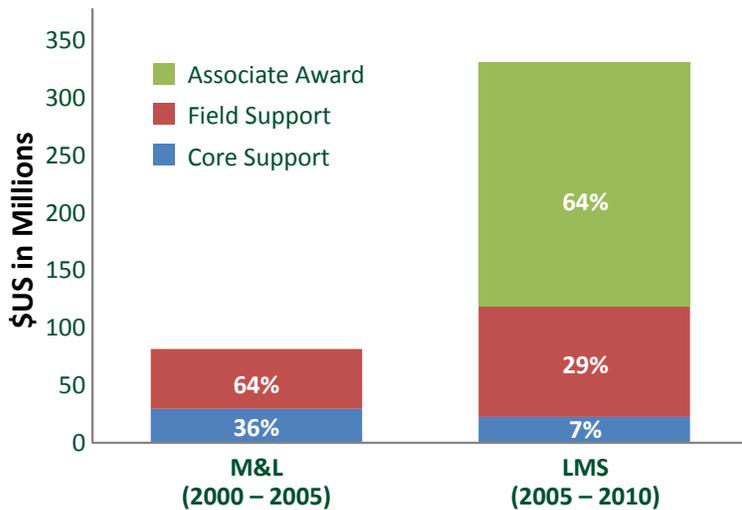
**Figure I: The Evolution of USAID’s Programs for Management & Leadership Development**



Seven themes have characterized the changes in these programs over time: (1) growth in demand and funding; (2) an evolving emphasis on results; (3) the evolution in the approach to capacity building from a focus on individuals and individual management systems to a focus on teams, integrated systems, and organizational/institutional development; (4) an emphasis on action learning, with teams addressing their own real workplace challenges; (5) change from providing technical assistance directly to training a pool of local capacity building consultants to provide technical assistance in management and organizational strengthening; (6) the dramatic growth in virtual programs and networks; and (7) the expansion from an exclusive focus on family planning management to the application of leadership, management and governance strengthening to USAID priority health issues and improving health care delivery.

**I. Demand and funding.** While the budget for the Family Planning Management Training Project (FPMT) (1985 – 1990) was \$18.7 million, with 25% coming from field support buy-ins from USAID Missions, by the Management and Leadership (M&L) Program (2000 – 2005), funding had increased to \$76 million with nearly two thirds from field support. By the end of the LMS Program, demand from USAID Missions and counterparts from combined core, field support and Associate Awards had reached \$306.8 million, with 64% coming from Associate Awards and only 7% from core funding.

**Figure 2.A Demand Comparison Between the M&L and LMS Programs**



**2. Changing emphasis on results.** The Government Performance and Results Act of 1993 required all Federal Agencies to establish an Annual Performance Report to focus on the achievement of measurable results. Although management reviews of the Family Planning Management Development (FPMD) Program identified the importance of documenting links between capacity building and service delivery, the concern rose about the attribution of capacity building to service delivery performance, given other intervening factors. M&L was the first MSH project to be required by USAID to use a results framework, and internally, M&L staff became convinced that it was imperative that capacity building programs be held accountable in this way. The emphasis on greater development of our internal health information systems (HMIS) and monitoring and evaluation (M&E) enabled MSH to demonstrate results, and LMS captured these through a performance monitoring plan with targets. Under LMS, the emphasis on documenting results required extensive work with counterparts to identify baselines and measure progress and LMS had to also strengthen the M&E and communications structure within the project. LMS and USAID staff grew to understand the link between capacity building in leadership and management and health services, but there was still some skepticism at the beginning of the LMS Program. The strategic evaluations conducted during LMS and the first quasi-experimental evaluation of the Leadership Development Program (LDP) in Kenya during Program Year 5 of LMS contributed to the evidence base for the linkages between leadership and management and improvements in health services.

**3. Evolution in the approach to capacity building from a focus on individuals and individual management systems to a focus on teams and integrated systems.** Under the FPMT and FPMD Programs, senior level managers were brought to the U.S. for training, incurring the related high costs of travel, per diem, and lost work hours. This approach, while successful for the individual manager, wasn't optimal for making sustainable changes in organizational performance or transferring knowledge and skills to colleagues who were not able to participate. Under M&L, a practical methodology was developed to strengthen teams in leadership and management at all levels and to allow teams to stay in their workplaces to develop a critical mass for sustainable change and focus on addressing real world challenges. M&L also moved towards greater client engagement around the issue of a holistic systems approach rather than just fixing a single system such as financial management. We asked, "What does it mean for the organization as a whole and what would success look like in terms of performance?" Client engagement and capacity building began for the first time with the end in mind. LMS also began the development of virtual learning to reach teams in their workplaces as described in #5 on the next page.

**4. Change from providing direct technical assistance to building the capacity of local leaders and managers to provide technical support.** FPMT and FPMD I and II were designed, as most developmental assistance programs were at the time, based on the "expert model" of sending highly skilled staff to developing countries to provide technical assistance to individual non-governmental organizations (NGOs), ministries of health, and other client organizations. Although successful in strengthening management systems and structures, this model proved insufficient to meet the growing need for leadership and management development that was becoming evident by 2000. The M&L program piloted several different approaches to meet the need, including supporting a network of international and local consultants with a website and access to consultant opportunities (Technical Cooperation Network). By LMS, the vision had become, "Out of our hands and into the world," as the LMS Program greatly expanded access to leadership and management through its legacy tool, the LDP.

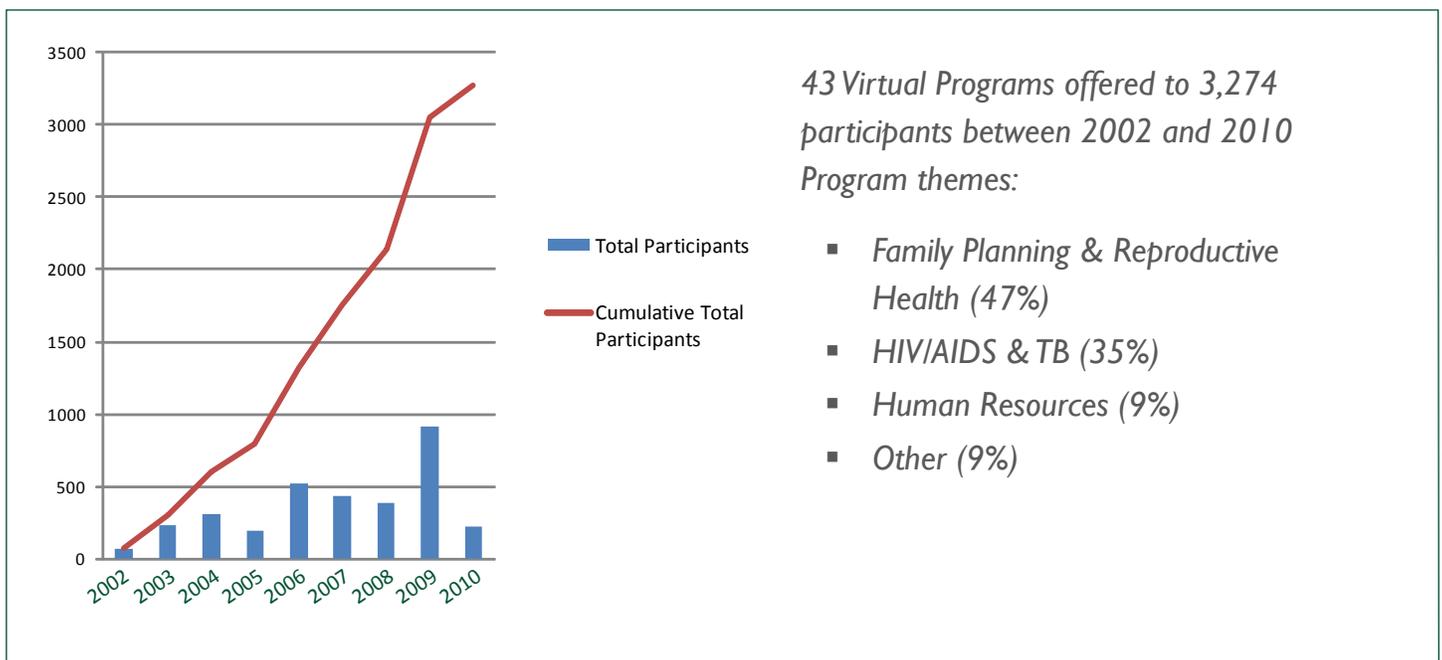
Since 2005, 213 LDPs have been delivered to approximately 860 teams in 30 countries; in addition, more than 350 individuals have learned how to facilitate this program. LMS also worked at the global and regional level with organizations such as the WHO, East Central and Southern Africa Health

Community (ECSA), and the Global Health Council to raise awareness and generate action toward professionalizing leadership and management in health. Using field support, LMS also tested new approaches to rapidly scale-up capacity building for HIV/AIDS civil society organizations (CSOs) in Nigeria and built a pool of local facilitators to scale up access to leadership and management capacity building in Tanzania. A standardized action oriented process for developing managers who lead at all levels, piloted under M&L, was refined under LMS. During LMS, the Managing and Leading Framework, challenge model, LDP Facilitators' Guide and Work Climate Assessment were packaged for transfer and scale-up, and years of experience in leadership management and governance were made available on the web to health managers worldwide through *Health Systems in Action: An e-Handbook for Leaders and Managers*.

### 5. Growth in virtual programs and networks driven by the needs of health professionals.

USAID foresaw the potential of using virtual technology to expand access to leadership and management, and provided M&L with core funding for research and development of virtual programs such as the Virtual Leadership Development Program (VLDP) and virtual networks such as LeaderNet. Under LMS, a suite of virtual management programs was added as well as a new virtual network, the Global Exchange Network for Reproductive Health (GEN), which focused on family planning and reproductive health. LMS reached more than 8,000 health leaders and managers through its networks and learning programs. The expanded reach of the virtual learning programs alone between 2002 and 2010 is captured in Figure 3 below.

**Figure 3. Growth of Virtual Programs**



**6. Early successes in family planning management led to the recognition that leadership, management, and governance issues are applicable to broad areas of health care delivery.**

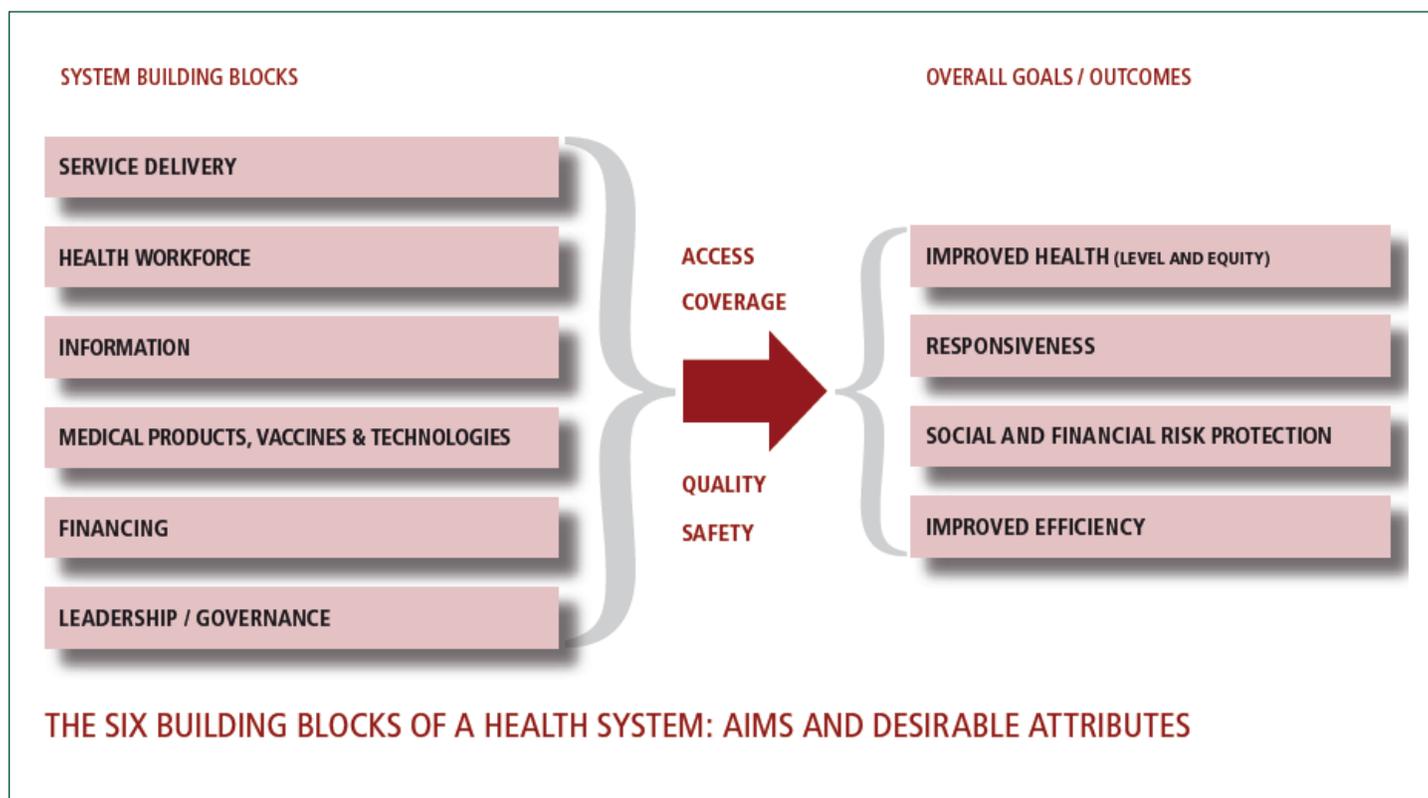
As noted earlier, the focus on building individual skills in RH/FP management has evolved to a holistic approach that integrates practical action oriented leadership and management knowledge and skills into each of the six World Health Organization building blocks of health systems strengthening.

The emergence of good governance as an important ingredient for strengthening health systems expanded LMS’ technical assistance to countries overseeing complex grants for the Global Fund and National HIV/AIDS coordinating bodies. Realizing the importance of advocacy for leadership and management, LMS undertook a global leadership role with international

and national leaders to advocate for the importance and added value of leadership and management development within the contexts of the Millennium Development Goals (MDG), and for in-service and pre-service training to assure that the future generation is well prepared to lead and manage the current health crisis in developing countries.

The evolution and changes described have significantly contributed to improve the delivery of organizational development interventions in various countries and settings. Such improvements in turn have translated into significant results and health outcomes. The following sections of this final report document the significant achievements of the LMS Program in service delivery improvements, governance, mainstreaming and scale-up, and virtual approaches in family planning/reproductive health and other health areas.

**Figure 4. Six Building Blocks of Health Systems: Aims and Desirable Attributes**





# Key Results of the LMS Program



*USAID's Office of Population and Reproductive Health has a rich experience in funding and furthering leadership and management programs, and has built awareness of how critical leadership and management are for strong national health systems and local health services organizations. During the tenure of the LMS Program, this belief in the need for improved leadership and management has been repeatedly confirmed by USAID Missions, other international donors, local organizations, and other key stakeholders in the health sector.*

One of the LMS Program’s key achievements has been demonstrating the link between improved leadership, management, and governance and improved health services. The program has also developed, tested, and scaled up proven pathways to put practical leadership and management skills into the hands of health leaders/managers and their teams, thus improving their own ability to address challenges and achieve results. In addition, the LMS Program continued the development of a suite of virtual learning programs, launched initially under the predecessor Management and Leadership Program, demonstrating that practical skills and knowledge can be delivered through distance learning.

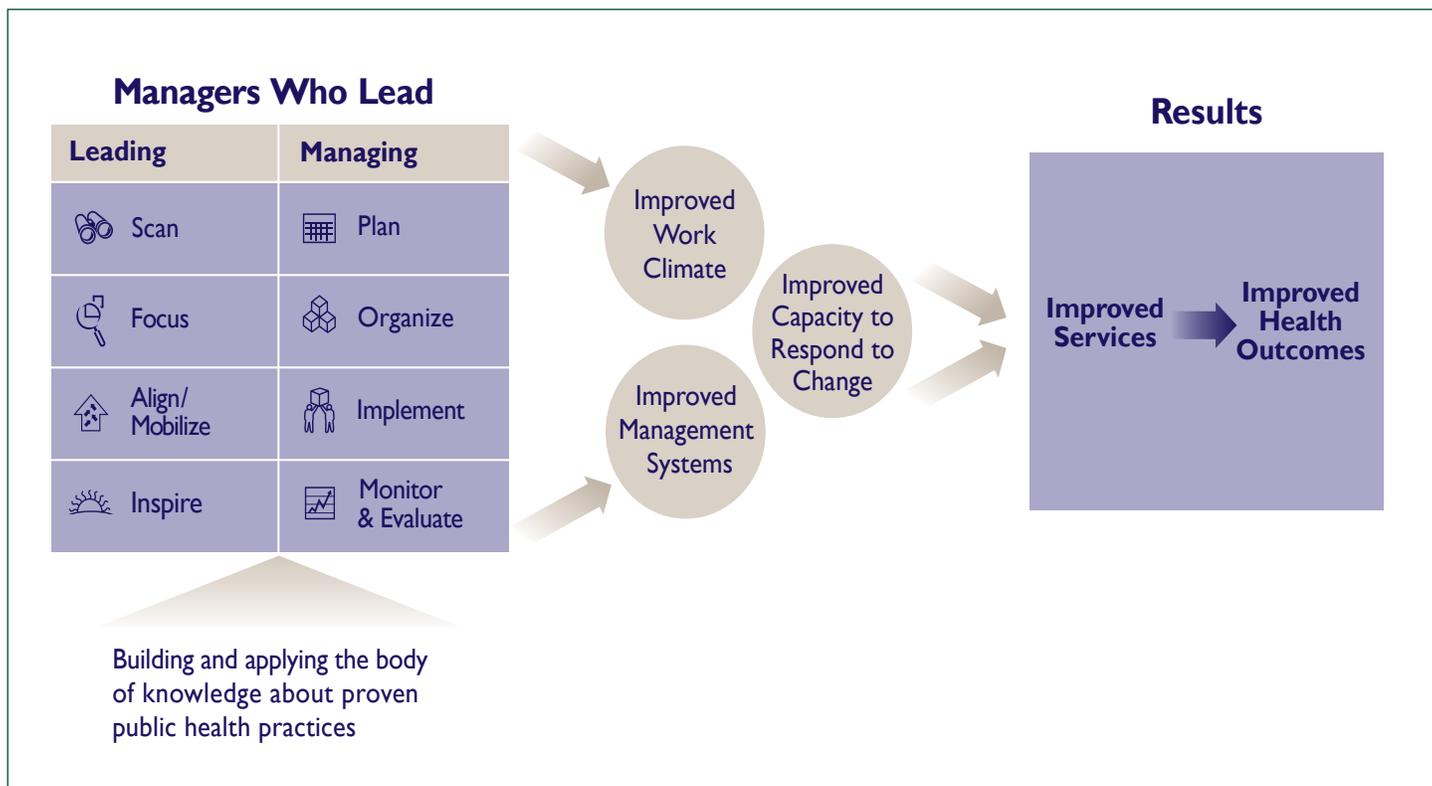
This section is one of two sections presenting the results of LMS’ work over the past five years. In this first section, results are highlighted in the areas of service delivery, governance, mainstreaming, and scale-up of leadership and management practices, virtual approaches, and advocacy work done to promote the awareness of the importance of leadership and management in the health sector.

Section four, “Areas of Accomplishments in LMS Country Programs,” details additional results, highlighting specific interventions in areas such as institutionalizing leadership and management at the national level; increasing the sustainability of family planning/reproductive health networks in Latin America; and strengthening the oversight of Global Fund grants.

### 3.1 Impacting Service Delivery Programs

A goal of the LMS Program has been to develop managers and leaders who achieve results in the areas of family planning/reproductive health, HIV & AIDS, infectious disease, maternal and child health, and many other areas of service delivery. The Leading and Managing for Results Model (refer to Figure 5, below) illustrates how LMS seeks to affect positive change in service delivery and long-term health outcomes. This section details key results in this area.

**Figure 5: Leading & Managing for Results Model**



## LEADING IN THE FACE OF DISASTER

### Despite earthquake, young woman forges ahead with health work

In October 2009, Ernancy Bien-Aimé was eager to address health challenges within her community of Cité Soleil, Haiti. She had just finished a USAID-funded Leadership Development Program (LDP) targeted to youth. Working with her LDP team, she launched a community-wide initiative to educate young people about HIV/AIDS prevention, and reached out to community leaders to enlist them in her cause. And then, on January 12, 2010, Haiti was struck by a 7.0-magnitude earthquake and Ernancy was suddenly faced with new, bigger challenges.

The powerful earthquake left Ernancy with a broken arm, but more damaging was the enormous loss of life and destruction of infrastructure around her. She was especially shaken by the death of one of her young colleagues from the LDP.

“Now my team and I are facing other challenges, because people have many imperative needs like shelter, food, drinkable water, access to health care, psychological support,” said Ernancy. “As youth, we can’t satisfy those primary needs and we kind of feel powerless.”

Ernancy and her fellow youth leaders found support and strength through the Leadership, Management and Sustainability Program of Management Sciences for Health, which had created and organized the LDP for youth. Since the program provides coaches to help sustain the results beyond the initial program period, youth and coaches came together to evaluate what they could



do, post-disaster. Meeting again as a group spurred Ernancy and her team to continue the work they had already begun.

Back in October, Ernancy’s dream was to start a mobile pharmacy to reach members of her community who were sick and could not afford medicines. Now she has expanded that vision, saying “My goal to help create a mobile pharmacy to improve access to medicines is not different today even though the population may have several different needs, like food, water and shelter... Now we are looking forward to getting sponsors and donations to make this dream a reality.”

“The tools and approaches I learned in the LDP are very helpful and they are allowing me to better cope with these challenges,” says Ernancy. “I know that I have to do something to contribute to alleviating the burden of the disaster. I strongly believe that we are going to get out of this bad situation.”

### 3.1.1 Results in Family Planning & Reproductive Health

Integrating leadership and management into family planning/reproductive health services was a key component of the LMS program; USAID’s Office of Population and Reproductive Health was not only the primary LMS funder, but a great champion of these efforts. LMS implemented both global and local interventions on this front. The establishment of the Global Exchange Network for Reproductive Health is one global example (see sections 3.4 and 5.2 of this report); while local interventions took place in 17 countries: Afghanistan, Bolivia, Democratic Republic of Congo, Egypt, Ghana, Guatemala, Haiti, Honduras, Kenya, Malawi, Nepal, Nicaragua, Nigeria, Peru, Southern Sudan, and Tanzania; in some countries, interventions were not specifically family planning oriented – as in the case of the Leadership Development Program offered in Kenya, but nonetheless participating health teams focused on family planning/reproductive health challenges and achieved measurable results in these areas. LMS’ work covered

many areas in family planning/reproductive health, including commodity security, increasing family planning consultations, and revitalizing family planning service delivery. Some of these interventions were implemented in partnership with other cooperating agencies (CAs); see the example the LMS/ACQUIRE family intervention in Tanzania, on page 33.

Ensuring the long-term availability of a range of family planning commodities is critical to successful family planning and maternal/child health programs. Reproductive Health Commodity Security (RHCS)—when women and men are able to choose, obtain, and use quality reproductive health commodities when and where they need them—is a complex task in many developing countries, involving many stakeholders. Key examples of LMS results in these areas come from Haiti and Malawi and are presented here. Other examples of LMS results in family planning/reproductive health can be found in sections 3.4 on page 35, 4.1 on page 44, and 4.4 on page 55, and in Appendix I, the profiles of country programs.

## Haiti

In Haiti, the contraceptive prevalence rate is only 24.8% and the maternal mortality ratio is 623 per 100,000 live births, the highest in the Caribbean region. Poor roads and infrastructure and lack of reliable transportation make it a challenge to ensure that commodities are available at all times where they are needed.

In December 2008, 35 senior stakeholders from various Ministry of Health departments, United Nation Agencies, and international and Haitian non-governmental organizations (NGOs) met in Port-au-Prince to build consensus around a Leadership Development Program focused on commodity security. The program was launched in early 2009 with 10 teams, three from the Ministry of Health and seven from NGOs. Over the course of the program, all teams oriented their challenges to diverse aspects of ensuring an efficient commodity security system in Haiti. These varied from supplying enough stock to remote areas, to having accurate information and a reporting logistics system to avoiding stock-outs.

Examples of some of the results achieved by the end of the program, in August 2009, are illustrated in Table 1 below:

**Table 1. Select Results of Haiti's Commodity Security LDP**

Indicators	Before LDP	Planned	Achieved
Number of new users adopting a modern method of family planning	27 (June 08)	47 (June 09)	51 (June 09)
Quantity of 25 selected drugs in stock	16/25 (January 08)	25/25 (June 09)	25/25 (June 09)
Number of hygiene kits delivered to people living with HIV/AIDS	472 (January 08)	2,000 (January 09)	1,308 (January 09)

What is more important, however, is what followed in the months after the conclusion of the LDP. On January 12, 2010, Haiti was struck by a 7.0-magnitude earthquake. Given the displacement of more than 700,000 Haitians in the Port-au-Prince area alone, the availability and distribution



*LDP workshop, Malawi*

of condoms and other family planning commodities was an essential component of the post-earthquake response. Due to the solid foundation created by the commodity security LDP, LMS was able to work with a local partner NGO, FOSREF, to continue community-based distribution; in the first month following the earthquake, the program distributed more than one million family planning commodities to people in need. As of May 2010, more than 6.8 million commodities had been distributed.

## Malawi

Partnering with JSI/DELIVER, the LMS Program in Malawi delivered a RHCS-oriented Leadership Development Program to improve commodity security by strengthening the capacity of champions at the district and central levels to take advantage of the opportunities and overcome the challenges presented by the decentralization of health services through the country's health sector reform process. Due to limited funds, the program was narrowed to Central Malawi region and focused on a select few teams from each level of the supply chain with the aim of creating vertical relationships, mutual understanding, and alignment around improved commodity security.

After a four-month LDP intervention, the LMS partnership with the DELIVER Project resulted in measurable family planning service delivery outcomes as summarized in Table 2, on the following page.

**Table 2: LDP Results per Team at National, Regional and District Levels in Malawi**

Team Name	Desired Measureable Result at the beginning of LDP	Results Achieved by the end of the LDP
National	Concept paper on policy change regarding the costing of DMPA developed based on facts; presented, reviewed and endorsed by the Secretary for Health by September 2009.	Completed draft concept paper after conducting literature review, consultations with key stakeholders and Technical Working Groups.
Regional Medical Store (Central)	Increase average timely delivery of ordered essential medicines from 20% to 50% in facilities in the central region by September 2009.	100% timely delivery for the month of August 2009.
Nkhotakota District Health Office	By September 2009, 100% of the facilities in Nkhotakota are submitting reports by the 5th of every month, of which 50% are complete and 50% are accurate.	As of September 2009, 47% completeness, 50% accuracy, 95% timeliness; compared to 0% completeness, 0% accuracy and 55% timeliness in April 2009.
Salima District Health Office	Increase the couple years of protection (CYP) from 247 to 2,500 by September 2009.	As of September 2009, CYP increased from 247 to 2,169.
Chipoka Health Center	By September 2009, 100% of pregnant mothers within their 2nd or 3rd trimester attending the antenatal clinic are also delivering at the health facility.	As of September 2009, 95.5% of women who attended the antenatal clinic also delivered at the health facility, representing a 20% increase from September 2008.

### 3.1.2 Results in HIV/AIDS

The LMS program also integrated leadership and management into HIV/AIDS programs and efforts against other infectious diseases. Some of these results are highlighted in sections 4.3 and 4.5 of this report. Separately, this section illustrates key results achieved in Ethiopia.

#### Ethiopia

Ethiopia, which has the third largest population of HIV-infected people in Africa, has a staggering multitude of funding agencies and technical assistance agencies in the area of HIV/AIDS; this, combined with the government's decentralized structure, makes coordinating HIV/AIDS activities particularly challenging. In spite of the significant funding to support Ethiopia in its battle against the HIV/AIDS pandemic, a variety of resource constraints makes for a severely limited absorptive capacity to turn inputs into outputs and outcomes for a better response. The emphasis on speed, orderly and timely accounting, and demonstrable results at all levels, as required by PEPFAR and Global Fund-funded activities, calls for strong management and leadership skills at all levels, not just at the top.

Human resource constraints include low staffing levels and management challenges at the country's HIV/AIDS Prevention and Control Offices (HAPCOs), at both national and regional levels. There are multiple indigenous, bi-lateral, and multi-lateral donors and implementers conducting HIV/AIDS-related activities at regional and local levels, and the combination of partners often presents local authorities with challenges in coordination, monitoring, oversight, and reporting. In this context, LMS has supported the zonal and regional HAPCOs in the areas of coordination and management systems development with the goal of improving the management and delivery of HIV/AIDS services in two regions—Oromia and Amhara; combined, these two regions account for more than 60% of Ethiopia's total population.

The LMS intervention took a three-pronged approach: (1) implementing LDPs for teams from 12 zonal and regional HAPCOs and 37 civil society organizations; (2) conducting a Management and Organizational Sustainability Tool (MOST) to improve the monitoring and evaluation capacity of all target HAPCOs staff; and (3) ensuring that Financial Management Assessment (Fin-MAT) and Human Resource Management Rapid Assessment tools were delivered to HAPCO management staff who had key roles and responsibilities in financial and human resource management.

As of April 2010 (eight months after the LMS/Ethiopia project launch), initial key results included:

- Improving HIV Counseling and Testing Rates:** In March 2010, the Arsi Negele Health Center registered up to 80% of all outpatient clients who received provider initiated HIV counseling and testing (PIHCT) services, a significant coverage level considering that the same health center was able to test only 3% of clients just three years earlier.

- Increasing Voluntary Counseling and Testing (VCT) Coverage:** Health centers in the Amhara region significantly increased the coverage of HIV services delivered to outpatient clients without adding more staff—for one clinic, from 7,000 to more than 25,000 clients. Activities contributing to these results included creating an outreach clinic that brought the services nearer to the community, and newly motivated staff expanded hours to offer VCT services during the weekends.

Table 3 below demonstrates the initial results achieved by the LMS Program in the **Oromia Region** at regional and zonal levels as of 2010 as a result of the LDP.

**Table 3: Service Delivery Results in Oromia Region, Ethiopia**

Team Name	Desired Measurable Result	Results as of January 31, 2010
Regional public sector team	By the end of February 2010, central database established at the regional health bureau level that encompass all stakeholders who are working on HIV/AIDS program so as to create joint planning, Monitoring and evaluation by potential partners.	Data collection and entry is completed for the regional level stakeholders; it is underway for the peripheral stakeholders.
East Shoa public sector team	All new clients coming to Modjo health center (6,000) receive PIHCT and receive their test result in the coming six months (from September 2009 to February 2010). <b>Baseline:</b> 3,504 patients received PIHCT testing and counseling in the last six months.	6,714 people were tested in the period from September to February 2010 (>100%).
West Arsi public sector team	To increase PIHCT service uptake from 823 (20%) in September 2008 to 4,780 (80%) by the end of February 2010 for clients coming to Arsi Negele Health Center. <b>Baseline:</b> HCT provided for 823 (20%) of clients from September 2008 to February 2009.	4,445 clients have received PIHCT service within four month period of LDP implementation (93% achievement).
South West Shoa public sector team	Providing PIHCT service for 80% (835) of pregnant women in Woliso Health Center catchment area at the end of February 2010. <b>Baseline:</b> 40% of pregnant mothers coming to Woliso Health Center were tested.	82% of pregnant women attending ANC at Woliso Health Center received testing.
West Shoa public sector team	Increase PMTCT testing rate among ANC attendants from the current 48% (427) to 95% (840) by the end of February 2010 at Ginchi Health Center. <b>Baseline:</b> Low PMTCT testing coverage, 48%.	86.4% (726) of the 763 ANC attendants at Ginchi Health Center were tested during the last six-month period.
North Shoa public sector team	To increase PIHCT service coverage at Fitcha Health Center from 1,155 (15%) to 4,604 (60%) at the end of February 2010. <b>Baseline:</b> 1,155 people received the service in the last six months of the year 2009.	5054 (>100% of the plan) people utilized the PIHCT service within six months.

### 3.1.3 Maternal & Child Health Results

In July 2006, LMS inaugurated the Healthy Communities and Municipalities (HCM) project in Peru to improve the health, welfare, and development of 515 communities and to expand the program to include other districts and communities in Alternative Development Zones (ADZ). LMS assistance in Peru focuses on applying the concepts and practical approaches of leadership and management to promote healthy lifestyles and behaviors and empowerment of the Peruvian people through community and civic participation.

Based on bi-annual data collected from the majority of the original ADZ communities (92.4%) in June 2006, and again in December 2009, by the Community Development Committees improvements have been made in the following maternal and child health (MCH) indicators:

- The number of children born in a healthcare facility increased from 75% (measured in June 2007 when the indicator was added to the assessment tools) to 81%.
- The number of children ages 6 to 24 months who are drinking clean water increased from 26% to 71%.
- The number of pregnant women seeking prenatal care at a healthcare facility increased from 80% to 92%.

It is important to note that the results generated by the HCM project are not limited to maternal/child health outcomes, and that they manifest at all levels of the LMS Results Model. Additional results, many of which are improvements in transparency and governance, include:

- The HCM project has expanded from its original 515 communities to 1,764 communities within and outside of the Alternative Development Zones; all of these communities have held elections to name local members to Community Development Committees;
- HCM has built the leadership capacity of more than 3,500 community leaders and local authorities;
- The number of children under two years of age who have a birth certificate increased from 69% to 84%.
- In the corresponding municipal governments, local development offices have been established to oversee community development initiatives;
- Community Development Committees attend and participate in municipal budget meetings and are successful at getting their priority projects included in the budgets.

More detailed results from LMS/Peru can be found in section 4.7 of this report.



## Success Story

### The VLDP in Uganda

ReachOut Mbuya, a faith-based organization run by volunteers, provides a full range of support to people living with HIV/AIDS in Mbuya, a Kampala community of 60,000 residents. Founded in 2001 with three volunteers serving 14 clients, ReachOut expanded to serving 1,700 people through 200 volunteers and 11 programs just three years later.

Such rapid scale-up is not without growing pains. New organizational layers appeared, volunteers became managers and found themselves in over their heads. The organization needed better coordination, communication, and systems.

ReachOut enrolled in the VLDP in late 2004. A manager from each department participated with the hope of creating a leadership team. As a result of their participation, the team established regular management meetings, developed job descriptions and performance evaluations for staff, and created a planning system that involved the entire organization and included budgets for each team. "By coming together to develop workplans, we know what each other is doing and what part we are supposed to do," explained Joy Nannyunja, ReachOut's Microfinance Coordinator. "We now know that if we don't do something, we will put back the project." Managers feel confident in their leadership abilities and as a result new initiatives were established, such as male outreach.

Today, ReachOut serves more clients than ever. The VLDP participants remain close. "The module on communications was particularly useful," one participant remarked. "We were able to assess ourselves and then see how others viewed us. We were able to work on improving how we communicate with each other, with upper management, and with staff and clients."

ReachOut's Communication Coordinator. "You need to be actively involved. It's about instilling the confidence in people so they can do their job and do it well." It seems the VLDP did just that.

## 3.2 Results in Good Governance

The Management and Leadership Program had a successful history of strengthening the governance of ministries of health and large non-governmental organizations and NGO networks, especially in family planning and reproductive health in Latin America. Through strengthening the governance of boards of directors, supporting leadership transitions, and improving management structures and systems, organizations to which MSH provided technical support were able to improve performance and achieve greater financial sustainability in an era of declining donor support.

LMS adapted the lessons learned during M&L to this rapidly changing environment in which the nature of the organizations needing governance strengthening and the speed with which it must be accomplished have changed, creating new opportunities and also new challenges. LMS adapted a conceptual model for governance in the health sector taken from *Health Systems Assessment Approach: A How to Manual*, developed for USAID in collaboration with Health Systems 20/20, Partners for Health Reform plus (PHR), The Quality Assurance Project (QAP), and Rational Pharmaceutical Management (RPM Plus) of Management Sciences for Health. The dimensions of good governance in the health sector in this model are:

- Information and Assessment Capacity
- Policy Formulation and Planning
- Social Participation and System Responsiveness
- Accountability and Regulation

LMS efforts focused on good governance in three areas: (1) the public sector—building governance capacity in Afghanistan’s Ministry of Health, in municipal development councils in Nicaragua, and regional and municipal governments in Peru; (2) civil society—especially in Africa, where the rapid scale-up of HIV/AIDS programs necessitated partnership from civil society organizations that lacked leadership and management skills; and (3) multi-sectoral partnerships—particularly the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Specific results of LMS’ governance work with the Global Fund can be found in section 5.6 of this report. The section below documents the results of LMS interventions in the context of decentralization and in conflict-affected countries.

### The LMS Governance Evaluation

*In 2009 – 2010, MSH conducted a review of technical assistance in governance provided to organizations in 13 countries. Evidence from this study confirmed that LMS interventions to improve management and leadership skills have strengthened governance capacity and, consequently, health system performance across a wide range of organizations. The strategic evaluation, “The Role of Leadership and Management in Strengthening Good Governance,” is one of four evaluations carried out by the Monitoring, Evaluation, and Communications Team of LMS. The four studies together document results of the LMS Programs between 2005 and 2010 and generate lessons learned for the benefit of USAID, MSH, and the international development and health community. The complete evaluation can be accessed at <http://www.msh.org/projects/lms/Results/upload/2010-06-09-Strategic-Evaluation-Governance.pdf>*

### 3.2.1 Governance in the Context of Decentralization

In Nicaragua, the main governance challenge at the municipal level has been a lack of coherence between national sector plans (i.e., those of the Ministry of Health or Ministry of Education at the national level) and the real needs of the municipality. The LMS/Nicaragua project, PRONICASS, assisted local municipalities with planning in response to a request from the Ministry of Education, which in turn had established an agreement with the municipal governments. This agreement gave responsibility to the municipal governments for designing Educational Plans (PEDLs) related to the National Strategy for Municipal Development which mandated that plans must be participatory.

Among its management and leadership interventions at all levels of the health care system, PRONICASS facilitated a process for citizen groups (organized by the municipal government) to be trained in the PEDL methodology. One example of the success of strengthening the ability of communities to plan and carry out interventions to improve health occurred in Tuma La Dalia, a rural municipality in the mountainous department of

Matagalpa. A Municipal Development Committee—consisting of local authorities, government institutions with municipal presence, leaders of local educational centers, parents from the community, teachers, students and staff from the mayor's office—led a river cleanup effort to enforce new regulations.

Results were evident for three of the four components of good governance—social participation and system responsiveness, information/assessment capacity, and policy formulation and planning:

About 300 people participated in efforts focused on local coffee plantations that were dumping fermented byproducts of coffee processing, referred to as honey water, into the rivers without filtration. The action plan consisted of (1) gathering baseline data on the quality of the water from the seven rivers (bacterial testing); (2) regular visual inspections of 35 coffee farms that were found to be directly contaminating these rivers to check for the use of filters; and (3) gathering health status data from community residents who use the drinking water. Health status data was monitored weekly by trained commu-

nity health workers who visited the homes and/or worked in the health centers and health posts.

Farms that were found to be non-compliant with environmental laws during follow-up visits were closed down for up to 40 days until they took measures to prevent future contamination and clean up the river. Farm workers were educated about the health benefits of protecting the rivers, and negotiations took place with farm owners to provide better living conditions for farm workers. Enforcement has continued up to the end of the LMS/Nicaragua project, and is now expanding to lower priority areas within the municipality. These measures may also expand to other neighboring departments that have developed an interest in the intervention.

In addition to the governance result, this program impacted the communities' health. Following the intervention, diarrhea cases among those who consumed water from the seven principal rivers in the region were reduced on average from 92.5 to 34.9 cases per month between October 2006 and March 2007.





## **Saving Lives: Leadership Development in San Lorenzo, Nicaragua**

### **Developing Fully Functional Service Delivery facilities in a Nicaraguan Municipality reduces maternal deaths and improves child health**

In 2007, the San Lorenzo health center in rural Nicaragua was recently named the best of Boaco district's six health centers. This recognition caps a period of four years without a maternal death in the municipality, following several years of averaging more than three per year. In addition, child mortality has been reduced, rates of vaccination have increased, and use of the health facilities have increased in the municipality.

How was this progress achieved? Dr. Horacio Moreno, the medical director for the municipality, credits much of their success to the leadership development undertaken with LMS.

Five years earlier, MSH began working with the San Lorenzo health team to develop fully functional service delivery points—a system to make the health center fully capable in specific key areas. As part of this program, later known as “AMAS,” LMS

worked with the San Lorenzo Health Center to develop their leadership capacities among all of their 75 workers.

Starting with the management team and select staff from all levels of the health center, LMS guided the team on a path to achieving results. “We had never really thought about leadership before,” Dr. Moreno explains. “But as part of the program we learned to look inward to assess ourselves, and then at our situation and identify key challenges we wanted to improve upon.” Maternal health was an important issue to the team—three women had died in the past year alone from complications. With nearly 80 percent of San Lorenzo's 28,000 residents living in rural areas, many women would not go in for prenatal visits or even to give birth.

“We recognized that the best way to improve the situation was to connect with the people more,” Dr. Moreno explains. “We went out to every corner of San Lorenzo, to each woman who was expecting.” One thing the team discovered was that women often wanted to give birth in the health center, but couldn't get there in time. The health center maternity home was in poor condition as well—little more than an empty room with a few cots. The team secured funding to renovate the maternity home, providing it with proper bedding, a television, a radio, and some pleasant décor so women would feel more comfortable waiting for their delivery time.

Following their initial success, the team committed itself to bringing the leadership capacities to all its staff. They selected staff to act as facilitators to expand the program institution-wide. “We quickly reached the entire staff,” says Dr. Moreno. “Now new staff are quickly oriented to our system. Now when we see challenges, we don't decide at the top what should be done. We engage the staff most closely connected to the front lines and seek their ideas. It is the ones who are experiencing the challenges first hand that have the most to gain from a solution, and the most insight. Together, we come up with a plan.”

The system for fully functional service delivery points was adopted by the Ministry of Health and incorporated into the ministry's basic systems. As a result, every health center in every municipality of Nicaragua has access to quality monitoring tools, enabling them to track and follow up on their work, and provide the best possible care to their clients.

*Capacity building of provincial health managers is key to providing the Afghan public health system with the flexibility it needs.*

### **3.2.2 Governance in Conflict-Affected Countries**

The LMS/Afghanistan project, Tech-Serve (Technical Support to the Central and Provincial Ministry of Public Health) was launched in July 2006 to strengthen the Afghanistan Ministry of Public Health (MOPH) at all levels (see section 5.1 for more on this topic).

Tech-Serve provides ongoing technical assistance in key public health areas, and engages both central and provincial managers in developing their management and leadership skills to focus on health results and accountability. The Tech-Serve Management Support for Provinces Initiative works directly with provincial health directors and their teams to effectively articulate their health priorities and strategies to address health needs, and to plan, implement and monitor their strategies and activities.

The second half of 2009 saw an increase in security incidents in the 13 USAID-supported provinces where Tech-Serve works, indicating a decline in the security environment. In Program Year 4 (July 2009 – June 2010) of the Tech-Serve Project (Program Year 5 of LMS), Tech-Serve began initiatives in 11 new Quick Impact provinces, where USAID prioritized improving health care as part of efforts to improve governance and increase the faith of Afghan citizens in representative government. Letters threatening government and NGO employees increased during this time. These letters, ask employees to quit serving the government or NGOs, which are believed by insurgent groups to be primarily funded by foreign aid. Because of deteriorating security, the MOPH's exercise of its stewardship role and the delivery of health services by NGOs became more difficult, forcing a need to adapt to this changing environmental context.

Capacity building of provincial health managers is key to providing the Afghan public health system with the flexibility it needs to respond even in a hostile environment. Towards that end, the Leadership Development Program was scaled up through 15 training courses and 200+ monitoring visits to 1,799 health professionals in the provinces. Service delivery is funded by grants to NGOs, through a grant-making system developed by MSH under the REACH Project, a predecessor to Tech-Serve.

## **Afghanistan: Results Found within Governance Components**

### **Information/assessment capacity**

- Provincial health teams have formed networks for sharing lessons learned on common priority health challenges.
- Three databases developed with MSH have transitioned to the MOPH for use and full management responsibility. In addition, over 95% of health facilities nationwide offering the government's Basic Package of Health Services (BPHS) are providing service data on a regular, timely basis.

### **Policy formulation and planning**

- Fifteen national health policies, tools and guidelines have been developed or revised to date in: child health, health financing, complementary basic services, pharmaceuticals, communicable diseases, Avian Influenza, and Health Information Systems.

### **Social participation/system responsiveness**

- The MOPH was awarded and is now managing over \$70 million in grants for the provision of basic health services and essential hospital services.
- Over 11,000 community health workers (CHWs) work out of their homes and in their communities to provide basic health care, including dispensing basic medicines and increasing awareness of certain health topics. The Tech-Serve project works indirectly with these CHWs by training Community Health Supervisors, who provide direct supervision of their work in communities.

### **Accountability/ regulation**

- The structure, systems and policies of the MOPH's Grants and Contract Management Unit (GCMU) have been sufficiently strengthened to allow them to be certified to receive direct US government funding. The GCMU manages 17 grants to NGOs valued at over \$70 million. These NGOs serve more than 17.6 million outpatient clients annually in more than 450 health facilities and 5,300 health posts with over 11,000 CHWs.
- Tools, such as the NGO Scorecard, have been applied to analyze service delivery, using the existing Health Information System and other information. Twenty-six performance evaluations of NGOs were conducted and recommendations were made for grant extensions.

### 3.3 Results in Mainstreaming and Scale-up of Leadership & Management Practices

Under the Management and Leadership Program (2000 – 2005), USAID and MSH developed and successfully implemented new programs and approaches to improve the management and leadership capacity of health care organizations in developing countries. A key mandate of the Leadership, Management and Sustainability Program (2005 – 2010) was to further promote the adoption and successful implementation (mainstreaming) of these approaches in a greater number of organizations (scale-up), to reach a “critical mass” of practitioners who would bring about substantial, sustainable change in health practices and services, thereby improving the health of their communities.

The section below looks at results of mainstreaming and scale-up in areas including LMS work at the state level, with partners, and with established institutions and universities. Additional results are highlighted in section four, which looks at mainstreaming and scaling up leadership and management practices within all levels of national health systems, at the community level, and with civil society organizations.

#### 3.3.1 Mainstreaming and Scale-up at the State Level

From 1998 – 2003, the LMS predecessor programs, FPMD and M&L, assisted the Secretariat of Health in Brazil’s northeastern state of Ceará (SESA) in planning and implementing a face-to-face leadership development program. In 2002, SESA, with the support of M&L and Ceará’s School of Public Health, created LiderNet. This blended learning model of face-to-face and web-based development activities extended the reach of the leadership development program to cover vast geographic areas. Combined, the leadership development program and LiderNet prepared more than 600 managers for the public health system.

In 2003, SESA implemented an LDP with funds from the UK Department for International Development (DFID) and focused on reducing infant mortality in the 37 poorest performing municipalities. The program brought together mayors, community leaders, health care managers and providers. Each team developed an action plan to address the problem of high infant mortality in the municipality. They were encouraged to work with other sectors—not just health. Among the 37 mu-



*Healthy Communities and Municipalities Project, Peru*

nicipalities that participated in the original program with the goal of improving their infant mortality rates, 70% reduced this key health indicator—some by as much as 50%. Overall for the state of Ceará, the infant mortality rate decreased from 26.8 to 21.1 (per 1,000 live births) between 2000 and 2004.

A further example of how these leadership practices were mainstreamed into existing structures:

- LiderNet was institutionalized in the School of Public Health in Ceará, where it continues to serve as a resource for managers in pre-service health programs.
- Leadership development activities have spread within the health sector and throughout other sectors including universities in Ceará and various Brazilian states through a local consultant with whom FPMD/M&L worked.
- Participants have replicated the leadership development program in workplaces, and at municipal and regional levels.

#### 3.3.2 Mainstreaming and Scale-up with Partners

LMS partnered with the Adventist Development and Relief Agency (ADRA) and the Eastern and Southern Africa Management Institute (ESAMI) to scale-up leadership and management capacity, and also worked with other cooperating agencies throughout the life of the project, including: ACQUIRE/ EngenderHealth, IntraHealth/Capacity Project, and STOP Avian Influenza (STOP AI), among others. In addition to the five partners mentioned above, LMS also worked to mainstream leadership and management through collabo-

rations with Ghana Health Services, and Nepal's National Health Training Centre and Institute of Cultural Affairs.

The two specific components of integrating leadership and management into the work of partners and USAID cooperating agencies included: (1) conducting a pilot intervention in a particular country with a partner's project to demonstrate the utility of developing leadership and management capacity; and (2) adapting tools to match the partners' or CAs' model.

## **Adventist Development and Relief Agency**

ADRA focuses on improving health in family planning and reproductive health, HIV/AIDS, primary health care as well as education, economic development, and disaster preparedness throughout its global network of local service delivery partners. ADRA has served as a key player in LMS' overall mainstreaming and scale-up strategy due to its global reach and its professional development program for ADRA country directors and their staff, the ADRA Professional Leadership Institute (APLI). The APLI holds professional development trainings three times per year, and its one-week course on leadership and management devotes two days to LMS methodologies, with the centerpiece being the LDP's challenge model. Since 2008, this course has been offered three times to participants from Latin America, Africa and Asia. LMS has worked with ADRA staff to build the capacity of the facilitators and in May 2009 the course was fully facilitated by ADRA staff, including the International Vice President of Programs, ADRA's LMS Manager, and the ADRA/Ghana Country Director.

LMS also partnered with ADRA in both Nepal and Cambodia. In Nepal, despite the decentralization of authority in the development sector, district and local level managers were not prepared to take on new roles and responsibilities. To address this, LMS and ADRA/Nepal joined with the National Health Training Centre and the Institute of Cultural Affairs (ICA)/Nepal to introduce the Results-Oriented Leadership Development Program (ROLDP) in March 2006. In Phase I, the ROLDP was implemented in three districts involving 31 teams (84 participants) from government offices, local government councils and NGOs working in health, water, sanitation, women in development, and education. Phase II concentrated on building the capacity of trainers from the National and Regional Health Training Centers, developing teaching materials, and expanding the ROLDP concepts and tools to integrate community level participation. Thirty government staff were trained as facilitators, and reached more than 70 health facility operation and management committee members from nine village development committees. MSH's *Managers Who Lead Handbook* was

*“The ROLDP was found to have a high impact among participating organizations. All participants were enthusiastic, dedicated, and optimistic about the programs their teams were implementing.”*

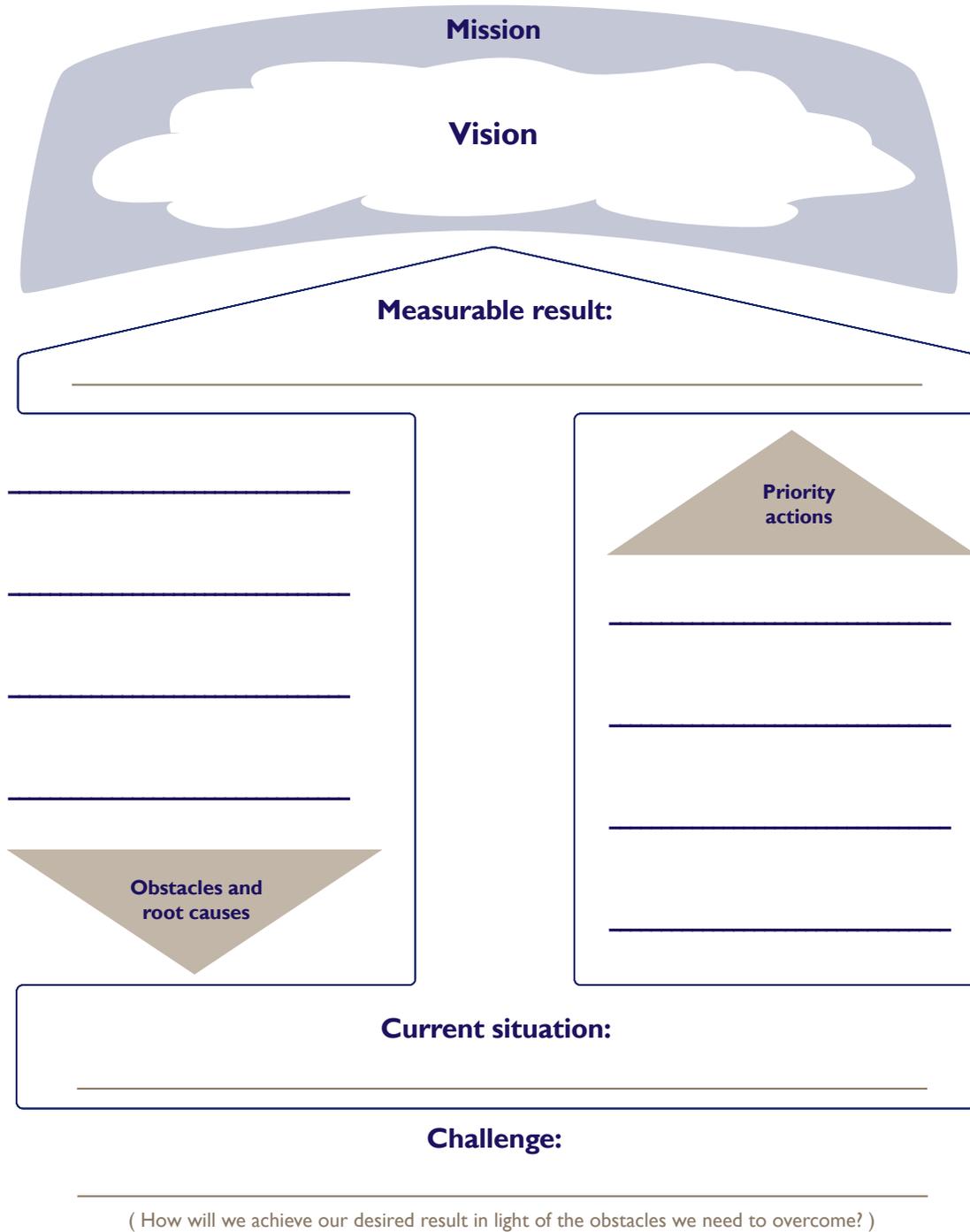
*—ROLDP Independent Evaluator*

translated into Nepali for use at the community level. As of September 2009, 700 participants have been trained by ADRA/Nepal in the ROLDP. The ROLDP in Nepal has continued to expand through the National Health Training Center which is now offering a participatory maternal and child health course.

In Cambodia, the need to improve health delivery systems is seen most clearly in the low level of health facility attendance by the country's rural population, including youth. To address this, the government of Cambodia began to work on a set of national guidelines for youth-friendly sexual reproductive health services to be implemented by the Ministry of Health (MOH). This policy effort was aided by ADRA Cambodia, which identified a need to build the capacity of health center teams and youth groups to foster a sense of trust and affinity between the two groups around reproductive health topics and services. Through the implementation of the Leadership Development Program, ADRA sought to strengthen the leadership and management skills of health service providers at 13 MOH health centers, and to empower community youth to speak up for their health rights by building their leadership and advocacy skills.

In January 2009, the pilot project for health facilities and youth began in the Chamkar Leu-Steung Trong district of Kampong Cham province. An evaluation of the program conducted by ADRA in June 2009 documented that, “health center staff were able to mobilize stakeholders to become involved in disseminating youth reproductive health information and encouraging the participation of youth in the youth groups... The project has contributed to community mobilization and improved collaboration between stakeholders.” Of the youth, it was reported that “through the focus group process, the youth groups provided a positive vehicle for youth to learn very important leadership and management skills, learn about RH issues, engage with and support other youth, and engage with local authorities. This process of participation and building of confidence and self-esteem is a positive outcome in society.”

# Challenge Model



Challenge Model from the Leadership Development Program

## ACQUIRE/EngenderHealth

In Tanzania in 2005, LMS collaborated with ACQUIRE/EngenderHealth and the MOH at the central and provincial levels to integrate the LDP into an ongoing family planning program on a pilot basis. The six-month LDP was conducted for MOH employees from six health facilities and three districts, who were facing the challenge of poor utilization of family planning services.

In December 2006, one year after the start of the LDP, the average number of new family planning clients per month had increased in all nine participating health facilities—in one by as much as 80%. Two of the six health centers reported achieving less than a 20% increase in new family planning clients, partly because during the program, both facilities suffered contraceptive stock-outs due to a lack of district transport to supply commodities. Initially, the ACQUIRE Project, LMS and MOH facilitators demonstrated that integrating the LDP into a service delivery project was effective in improving the performance of health units and ACQUIRE/Tanzania has replicated the LDP in 20 additional facilities in Kigoma.

After this promising beginning, a national shortage of family planning commodities in Tanzania in 2008 impacted the program and the LDP could no longer continue to be scaled up, as illustrated in Table 4 below. While the model of the LDP allows teams to select a challenge that is meaningful, feasible, and within their control to effect, it may be that LDPs that are focused on one uniform measurable result—such as increasing family planning visits—are at risk when external factors change.

**Table 4: Contraceptive Use for ACQUIRE/Tanzania Facilities in Kigoma**

	All users	New users	Recurring users
Total 2005	7410	1391	6019
Total 2007	8274	1752	6522
Total 2008	7447	1492	5955
Changes in contraceptive use			
From 2005 to 2007	11.66%	25.95%	8.36%
From 2005 to 2008	0.50%	7.26%	-1.06%



*Youth participant in an LMS-supported vocational training for OVCs program, Tanzania*

Another risk linked to scale-up is also illustrated in this partnership. The ACQUIRE project ended midway through LMS; the follow on project was more focused on a new mandate and thus couldn't easily integrate the LDP. This is a risk with all project-focused mainstreaming and, moving forward, should be considered when partnering with projects that may have different implementation time periods.

### 3.3.3 Mainstreaming and Scale-up with Established Educational Institutions and Universities

LMS believes that one key to a strong health system is the methodical development of health leaders and managers from the time they begin their schooling, throughout their career, until they retire. This includes leadership and management preparation through pre-service and induction training, giving health professionals the opportunity to become health managers (as opposed to only clinicians), providing opportunities for continual professional development, and ensuring a process of merit based promotions. LMS worked with Uganda's Makerere University, Nicaragua's Universidad Nacional Autonoma, and Boston University in Massachusetts, United States, to mainstream this approach into academic institutions.

## Uganda

Since 2006, the LMS Program has been collaborating with Makerere University's Faculty of Medicine (FOM), the leading medical school in Uganda, integrating leadership development into FOM's Community Based Education and Service (COBES) program. The COBES approach requires each student to spend one to two months per year working at a community health site. There they see firsthand the challenges of the community health system and work to find effective solutions. To date, about 40% of the LDP content has been integrated into the COBES curriculum, thus exposing 1st and 2nd year students and health care workers to leadership principles and practices, and to using the challenge model for participatory problem solving. Additional results in the area of mainstreaming include:

- Nearly 40 Faculty of Medicine and administrative staff have been introduced to the basics of leadership and management;
- Nine faculty members and one administrative support officer have been trained to facilitate the LDP methodology for further capacity building within FOM and the COBES sites;
- A draft COBES/LDP proposal calling for integration of leadership development and management into the entire COBES curriculum is being finalized for submission to the FOM Education Committee, and to the Senate of Makerere University;
- LDP/COBES has become institutionalized in the Office of the Deputy Dean of FOM, ensuring sustainability.

## Nicaragua

The Universidad Nacional Autonoma de Nicaragua (UNAN) Faculty of Medicine and Centro de Investigaciones y Estudios de la Salud (CIES) approached LMS to develop a results-oriented program to prepare medical students to work in the newly reformed health care system, which has become more performance-based. LMS, UNAN, and CIES faculty and administrators designed a Management and Leadership Program for fifth year medical students focused on the development of these skills and how to apply them to directly address health needs in the community. UNAN piloted the curriculum with 33 medical students in 2007. The results:

- Following the pilot, the curriculum was revised, and in September 2008, 175 students and three faculty members began officially using the new curriculum;

- In the rural district of Lechecuagos, a health center serving 7,000 people achieved 90% of scheduled home visits thanks to the work of these young students;
- As a result of its success in Nicaragua, the curriculum has been adapted by the Faculty of Medicine at Mariano Galvez University of Guatemala. On July 6, 2009, the university initiated two pilot courses for 30 medical students and seven physical therapy students.

## Massachusetts, USA

The Boston University School of Public Health (BUSPH) realizes that meeting the UN Millennium Development Goals will require inspired leaders with strong management skills. MSH's focus on building practical skills is a good fit with the BUSPH mission of preparing public health professionals and health managers from the United States and developing countries to lead organizations to face priority health challenges and achieve results.

Since 2006, LMS and BUSPH have co-sponsored a course entitled, "Leading Organizations to Achieve the Millennium Development Goals for Health." The four-week, eight-credit, summer course brings together international and domestic Master of Public Health students and practicing public health professionals and provides them with the opportunity to learn a practical, applicable process for leading and managing teams and organizations to achieve measurable health results. Most participants report at the end of the course that they have gained a strong understanding of leadership and management skills and the need for such in developing countries. The course has been recognized for two years running with the School's "Excellence in Teaching" award, given to only the top five courses.

*"It is now a month since I and Allan Mugisha (IRCU Grants Officer) came back from attending the 'Leading Organizations to Achieve Millennium Development Goals' course in Boston University, USA. It is my pleasure to report that both of us have tangibly benefited from the course in our work at IRCU. The course has been an eye opener in many ways."*

*— Jowad Kezaala, the Secretary General of the Inter Religious Council of Uganda (IRCU)*

Students have effectively applied the challenge model to:

- Train public health faculty in leadership and management skills through a three-week course in India in 2008 and 2009;
- Orient medical and public health students to leadership and management skills involved with four local community health centers;
- Mobilize the deans and several faculty members at BU Medical School and the School of Public Health to develop an interdepartmental/interdisciplinary elective course entitled “Developing and Implementing Successful Community-Based Health Initiatives.”

### 3.4 Results from LMS’ Virtual Programs

With funding from USAID, MSH has developed Web-based distance learning programs, networks, and resources to address gaps in health professionals’ management and leadership skills under the M&L Program. Subsequently, these programs were expanded through LMS. First launched in 2002, these virtual offerings focus on leadership development, business and strategic planning, human resource management, board governance, and other organizational needs. The following table summarizes the LMS portfolio of virtual programs.

These programs are complemented by multi-lingual virtual networks—LeaderNet and the Global Exchange Network for Reproductive Health—that offer seminars and conferences designed for cost-effective worldwide knowledge exchange of health management and leadership issues. Both the programs and the networks are supplemented by the “Health Manager’s Toolkit,” an electronic library of tools and resources from MSH and other organizations that helps build knowledge and skills in leadership, management, and governance. Use of these virtual approaches has expanded significantly. Participation in virtual programs has more than doubled since the programs were first launched; and membership in the two networks has increased more than 13-fold; Table 6 illustrates the expansion of these approaches. More than 8,000 health professionals from 140 countries have gained leadership and management skills.

The following section highlights the results of these programs in the context of family planning and reproductive health and HIV/AIDS. For detailed descriptions of the LMS virtual learning programs, along with a list of all virtual programs that have been implemented under LMS, see Appendix II.

**Table 5: Examples of LMS Virtual Program Results**

Team Challenge	Results
<b>CEMOPLAF (Ecuador)</b> Strengthen small basic pharmacies	All pharmacies completed financial analysis and developed Standard Operating Procedures. Achieved 8% increase in sales and 7% increase in sustainability.
<b>Joint Clinical Research Centre (Uganda)</b> Increase regional access to antiretroviral (ARV) drugs in 26 antiretroviral therapy (ART) clinics	Opened six new ART sites.
<b>Society for Family Health (Zambia)</b> Increase HIV/AIDS Prevention	Provided 250 male circumcisions within six months.
<b>Apoyo a Programas de Población (Peru)</b> Improve access to Family Planning	Secured more than \$47,000 from Peruvian government to make spermicidal latex condoms available for low-income young adults.

**Table 6: Growth in reach of virtual programs and networks between 2002 and 2010**

Virtual Programs & networks	M&L (2002 – 2005)	LMS (2005 – 2010)
Virtual Programs	149 teams, 950+ individuals from 29 countries	300+ teams, 2,400+ individuals from 46 countries
Virtual Networks (LeaderNet and the Global Exchange Network for Reproductive Health)	424 individuals from 30+ countries	6,000+ individuals from 140+ countries
Virtual Conferences (iCoHere website)	263 participants in 2 conferences	548 participants in 2 conferences

### 3.4.1 Virtual Approaches to Achieve Family Planning and Reproductive Health Goals

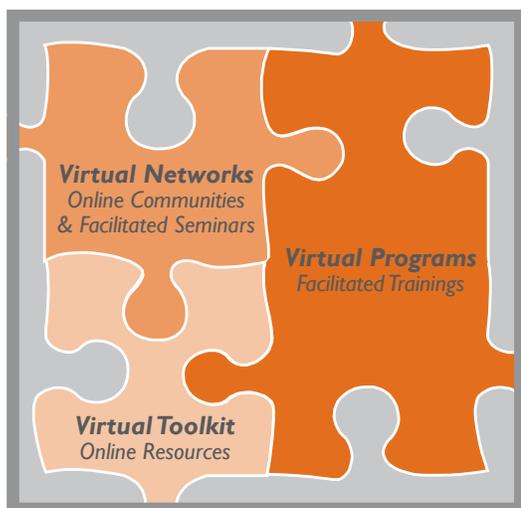
Many LMS virtual learning programs and seminars have furthered family planning and reproductive health (FP/RH) goals, including repositioning family planning, contraceptive commodity security, and post abortion care. In addition to the FP/RH programs and seminars described in this section, all Global Exchange Network for Reproductive Health virtual seminars have focused on priority FP/RH management and leadership topics. As of March 2010, the Global Exchange Network for Reproductive Health had reached 2,871 members from 133 countries.

The following are select results that illustrate accomplishments in the areas of family planning and reproductive health achieved through virtual programs:

#### **Virtual Business Planning for Health Program for family planning teams in Latin America**

The Virtual Business Planning for Health Program (VBPH) is a 20-week program that assists teams in the development of a business plan for a new or extension of a product or service.

The first VBPH program was delivered from April to August 2008 to a total of 67 participants (10 teams) from family planning and reproductive health NGOs in Latin America; by the



### Cost Advantages of Virtual Programs

*Virtual programs can be more cost effective than face-to-face programs, by reducing or eliminating the costs of travel, room, board, and per diem.*

*Virtual programs also enable participants to stay in their work place, enabling them to continue their professional responsibilities and without disrupting health service delivery.*

end, seven organizations had prepared business plans that addressed family planning and organizational priorities. **Results:** (1) The Paraguay-based NGO Centro de Información y Recursos para el Desarrollo focused their business plan on scaling up existing consulting services to family planning and reproductive health organizations in the areas of organizational development, financial administration and management. They surpassed their initial fundraising goal of \$28,500, ultimately securing \$70,000 from the German aid agency GTZ. (2) Apoyo a Programas de Población (APROPO), a family planning NGO in Peru, developed a business plan for a new product, a low-priced latex condom with spermicide, to be marketed to low-income young adults. The team secured \$47,000 from the government to make the condoms available to young adults at various local hotels in the country. **Follow-up:** A second 20-week offering of the VBPH ran through June 2010 for seven teams of FP/RH professionals in Latin America; this offering integrated program improvements identified during the first offering.

#### **Virtual Leadership Development Program focused on Contraceptive Security**

The Virtual Leadership Development Program (VLDP) is a 13-week program that strengthens the leadership of teams by identifying key areas for organizational improvements in a step-by-step process.

LMS worked closely with the USAID Office of Population and Reproductive Health's commodity security team to plan and implement both face-to-face and virtual leadership development programs for teams working on commodity security issues in Latin America and Francophone Africa. USAID funded a VLDP for contraceptive security in the Latin America/ Caribbean region in Spanish for 12 teams (92 individuals) from the Dominican Republic, El Salvador, Paraguay and

**Table 7: Results from Latin America VLDP for Contraceptive Security, 2007**

Team	Challenge	Measurable Result	Achieved by December 2007
<b>Asociación Demográfica Salvadoreña (ADS)</b>	How can we secure funding that will ensure access to education and to sexual and reproductive health services (including contraceptive supplies) for El Salvador's rural population, emphasizing teenagers and youth with limited purchasing power?	In December 2007, we will have \$640,000 to ensure family planning services and commodities for the population of fertile age in 640 rural communities in areas that ADS works in, an average of \$1,000 per community.	The budget of the \$640,000 was approved in December 2007.
<b>Centro Paraguayo de Estudios de Población (CEPEP)</b>	How can we maintain the CYP produced by the PAC Program during 2006, taking into account the new tax status, declining donations, and increase in the population with limited resources?	Maintain the 7,490 CYP produced during the PAC program in 2006.	7,337 (98%)

Honduras. The VLDP was conducted in collaboration with JSI/DELIVER and the Futures/Health Policy Initiative (HPI) Project. DELIVER and HPI brought extensive regional and CS technical expertise to the collaborative effort and provided technical assistance during the action planning process. Teams came from organizations that are members of their countries' national commodity security committees, and LMS leadership development specialists facilitated the program. Follow-up was completed with the LAC teams at six months post-program, and the results were promising. Examples of challenges identified by the teams in the LAC VLDP and the results achieved six months post-program are described in Table 7.

USAID also funded a commodity security VLDP for 65 participants (11 teams) from the Francophone Africa countries of Madagascar, Mali, Rwanda, and Senegal. This VLDP brought together participants from both the public and private sector who were key stakeholders in reproductive health commodity security, such as Ministry of Health representatives from reproductive health programs, teams from international and local family planning NGOs, and organizations focused on the pharmaceutical sector. This offering was conducted in collaboration with HPI/Futures and JSI/DELIVER, who brought extensive regional and technical expertise to the process. Examples of challenges identified and results achieved are outlined in Table 8 (next page).



*Village girl, Nicaragua*

**Table 8: Examples of results from VLDP for Contraceptive Security**

Team	Challenge	Measurable Result	Results as of July 2009
<b>MAHAVITA, Madagascar</b>	Given the fragility of the information system and inability of the management to generate reliable data in a timely manner, how can we improve the management of the supply of contraceptive products so that the districts and health facilities have an adequate level of stock?	By the end of the first quarter of 2009, 75% of the health districts are compliant with the supply process at the SALAMA procurement center.	76.6% of the districts were compliant with performance criteria for monitoring the management of the supply of contraceptives.
<b>Equipe Malienne non-gouvernementale, Mali</b>	How we can convince the Malian State to include a budget line for the purchase of contraceptive commodities and to reinforce the information system for the logistical management in light of the fact there is insufficient political will and socio-cultural constraints for the implementation of a national commodity security plan in Mali?	By May 2009, the Malian national budget ensures the purchase of 10% of the contraceptive commodities and cost of reinforcing the information system for the logistical management.	The budget line exists since the state took over 10.1% of the purchase of contraceptives in 2009.

### **Virtual Fostering Change Program for Post-Abortion Care**

The Virtual Fostering Change Program (VFCP) is a year-long program that helps teams to identify a proven health practice and then scale-up its implementation. The fostering change methodology helps teams to introduce and scale-up a best practice using a systematic pathway in order to improve the health of the populations they serve.

LMS conducted a VFCP for teams working in post-abortion care (PAC) in five Francophone African countries—Burkina Faso, Guinea, Rwanda, Senegal, and Togo—between January 2009 and March 2010. **Results:** (1) The teams from Guinea, Rwanda, and Togo developed and finalized their action plans for implementing their selected best practice in post-abortion care in one to four sites, and also gathered and analyzed data from their selected intervention sites; (2) The team in Rwanda also finalized their action plan, and then conducted a day-long training for 13 participants on providing PAC and the integration of family planning and PAC services; (3) The team from Togo implemented their selected best practice in three of their four sites; and (4) The team from Guinea successfully began implementing their action plan.

### **3.4.2 Virtual Approaches to Achieve Results in HIV/AIDS Programs**

With funding from the Office of HIV/AIDS (OHA), LMS delivered virtual learning programs to human resource managers and their teams as well as to teams from HIV/AIDS public and private sector organizations. Additionally, LMS has received Field Support from USAID Brazil and the USAID Europe and Eurasia (E&E) Bureau for HIV/AIDS-focused virtual programs. Examples of these programs follow.

#### **Virtual Leadership Development Program for HIV/AIDS Teams in Southern Africa**

A VLDP was delivered from April to July 2007 to thirteen teams from Botswana, Malawi, South Africa, Tanzania and Zambia. Teams identified an organizational challenge that they were facing and developed an action plan to address this challenge, achievable within six months. Some examples of challenges identified and results achieved by teams in this VLDP are displayed in Table 9 (next page).

**Table 9: Results of VLDP in Human Resource Management for South African Teams**

Team	Challenge identified	Progress as of April 2008
<b>Society for Family Health (SFH) (Zambia)</b>	How we can offer male circumcision services to clients at voluntary counseling and testing centers given limited space, inadequate supplies, few trained medical providers and fear of work overload on available staff?	The team completed all the activities in the action plan: 250 male circumcisions were provided at 1 SFH site. In addition, 60 have been provided at a private clinic.
<b>Raleigh Fitkin Memorial Hospital (Swaziland)</b>	How can we reduce the average waiting time of clients at the outpatient department by 30% of the current waiting time given the existing obstacles (many queues, insufficient pay point, delay of doctors to attend to patients, high staff patient ratio and discontinuity of care)?	The team obtained a baseline measurement of outpatient department waiting time (approximately four hours). Empirical observations indicate waiting time has been reduced to three hours.
<b>Christian Health Association of Malawi (CHAM)</b>	With inadequate VCT counselors, how can we provide quality and sustainable VCT services in the rural areas within the catchment areas of CHAM units?	The team has implemented VCT in “approximately 25 static sites.” (Target was 25 mobile and static sites.)

### **Virtual Human Resource Management Programs for HIV/AIDS Organizations**

The Virtual Human Resource Management Program (VHRM) is an eight-week program in which teams assess their human resource system and develop an action plan to improve priority areas.

The first offering of the VHRM Program, offered to human resource teams in government and civil society organizations working in HIV/AIDS in Anglophone Africa, was delivered in late 2008 to teams from both the public and private sector. Ten teams enrolled, coming from Ethiopia, Namibia, Tanzania, and Uganda. The second offering of the VHRM Program took place between May and July 2009, with nine teams including three from Asia (Afghanistan, Bangladesh, and Ukraine) and six from Africa (Ghana, Kenya, Nigeria, and Uganda).

Both offerings worked with human resource teams from organizations that address HIV/AIDS; the teams sought to improve their understanding of the role of Human Resource Management (HRM) in an organization and develop the capacity to strengthen HRM systems in order to improve staff satisfaction and performance. **Results:** (1) The Family Guidance Association of Ethiopia identified job descriptions as a priority area; as of January 2009, every employee received a revised, clear job description, in line with the updated and revised Human Resource Management Manual. (2) Uganda’s Straight Talk Foundation identified HR planning as a priority; following the program, a HR plan was developed including a plan for in-service training.

*“...the VLDP not only developed the personal skills of the participants, but also provided an additional ground for reforming health care provision for HIV/TB patients.”*

*—Participant from Ukraine*

### **Virtual Leadership Development Program for HIV/AIDS/TB teams in Eastern Europe/Eurasia**

To enhance the capacity of government and non-government agencies to work together in the areas of HIV/AIDS and tuberculosis, LMS offered a 13-week VLDP in Russian in 2007. Ten teams of 66 senior managers from Belarus, Kazakhstan, Russia, and Ukraine participated, each representing national TB and HIV/AIDS programs. **Results:** (1) Among the teams reporting significant improvements in service delivery as a result of their action plans were the HIV/AIDS and TB teams from Belarus. The HIV/AIDS team’s challenge centered on testing of HIV-infected patients in order to ensure delivery of antiretroviral treatments. Their initial target was to provide antiretroviral treatments to 900 patients; they exceeded this result, with 1,200 patients having received treatment by December 2008. (2) The TB team wanted to increase the number of patients receiving adequate individualized treatment for multi-drug resistant TB by 10%. They surpassed their goal with a 21% increase in the number of patients receiving treatment.

### 3.4.3 Using Virtual Programs to Strengthen Strategic Planning and Board Governance of CSOs

Following the successful LMS Virtual Leadership Development Program, LMS expanded its virtual offerings to a suite of management programs, two of which address components of the good governance model: strategic planning and CSO board governance.

#### The Virtual Strategic Planning Program

The Virtual Strategic Planning Program (VSPP) is a 17-week virtual blended-learning program that supports and guides teams of managers in developing a strategic plan for their institutions. The VSPP is structured around six learning modules, each of which provides strategic planning concepts, practical exercises, and tools.

The VSPP was first offered in Spanish in 2006, to help organizations in five different Latin American countries to develop their own strategic plans and to foster exchange between the teams and program facilitators. As Figure 6 below demonstrates, the large geographical distances between these teams and high number of participants would have made this program prohibitively expensive to carry out face-to-face. Working with each team in isolation would also have eliminated the ability of the teams to share experiences and learn from each other. All 10 teams were able at the end of the program to produce a well structured strategic plan.

**Figure 6. Diversity of participating teams in the first VSPP for Latin America**



There were three additional offerings of the VSPP, one to African organizations, one to African and Asian organizations, and one, to monitoring and evaluation teams through a partnership with the USAID funded MEASURE III Project. For VSPP Africa the program was modified to address challenges that included long distances between participants on the team. This added an extra week of program instruction, a three-week coaching period in the middle of the program, and three weeks for teams to complete their final plan. A total of 70 individuals from 10 teams participated in VSPP Africa, eight of which produced strategic plans. A total of 10 teams participated in the VSPP Africa/Asia program, with seven teams completing their strategic plans. Teams were from three Asian countries (India, Vietnam, and Bangladesh) and three Anglophone African countries (Kenya, Uganda, and Nigeria).

#### The Virtual CSO Board Governance Program

The Virtual Civil Society Organization Board Governance Program (VCGP) is an eight-week program in which teams assess their human resource system and develop an action plan to improve priority areas. The purpose of the VCGP is to help board members and senior CSO staff members understand their respective roles, responsibilities, and main activities, and provide guidance on how to ensure board accountability, transparency and prevention of conflict-of-interest situations. Participants work in teams to explore the fundamental principles of board governance and develop a governance improvement plan with clear division of roles and responsibilities, actions to ensure good governance board policies, and important activities of the board.

The VCGP was offered three times in LMS, once for boards of directors and executive management teams from HIV/AIDS organizations (funded by the Office of HIV/AIDS at USAID), once for organizations working in family planning and reproductive health in Latin America, and once for similar organizations in Anglophone Africa.

Results for the programs were mixed. In Latin America, of the eight teams enrolled, five teams completed the three deliverables for the program consisting of a document of roles and responsibilities between the Board and the Management Team, an annual calendar of activities based on the urgent and important matrix, and policies of transparency and governance. In the VCGP for Anglophone African FP/RH organizations, seven out of the nine teams were able to complete the deliverables. In the VCGP for HIV/AIDS organizations in Anglophone Africa, six out of eleven organizations that originally started the program completed the deliverables.

In terms of these results, above, it is important to note that the challenges faced in delivering Virtual CSO Board Governance Programs are inherent to the nature of governance strengthening itself. Teams involved in governance strengthening are not necessarily “intact teams,” that is, they may not work together on a day-to-day basis, which can make finding time to meet and devote to the work difficult. As is often the case with senior leaders in an organization, only a few very committed individuals may drive the process and participants who do not remain involved can derail the entire program.

## 3.5 Results of LMS’ Advocacy for Leadership & Management Development

One of the mandates of the LMS program was to raise awareness of the key role that leadership and management has in improving public health results. This approach is documented in Section 4, “LMS Approaches at All Levels.” This section presents highlights of our advocacy work resulting in publications, articles or conference presentations.

### 3.5.1 Publications Developed Under LMS

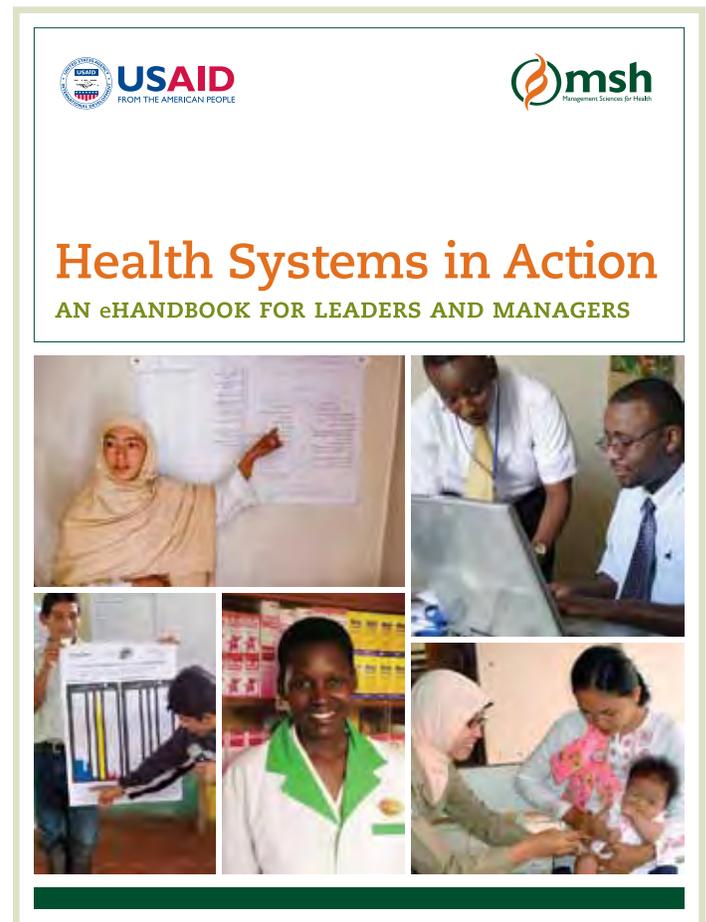
Under M&L, MSH developed and launched the *Managers Who Lead* handbook, a key resource in the face-to-face and virtual Leadership Development Programs that provides managers with practical approaches for leading teams to find solutions to workplace challenges.<sup>1</sup> The bulk of the dissemination of this publication came under LMS, as did translations in Spanish, French and Nepali. The LMS Program also developed and disseminated *A Guide to Fostering Change to Scale-Up Effective Health Services*, to promote skills building trainings around the world to teams that address FP/RH challenges.

In May 2010, LMS launched a new resource, entitled *Health Systems in Action: An e-Handbook for Leaders and Managers*. This “legacy” publication—comprising knowledge gained throughout the work of both the LMS program and its predecessors—is an electronic resource organized around the WHO Health System Strengthening (HSS) Framework and provides leaders and managers of public health programs and organizations with practical and theoretical information to strengthen

and align the building blocks of health care systems to achieve results and save lives.

Other publications that LMS developed or contributed to include:

- “An Urgent Call to Professionalize Leadership and Management in Health Care Worldwide,” MSH Occasional Paper Series, 2006.
- “Challenges and Successes in Family Planning in Afghanistan,” MSH Occasional Paper Series, 2007.
- “Leadership Can Be Learned, but How Is It Measured?” MSH Occasional Paper Series, 2008.
- “Coaching for Professional Development and Organizational Results,” *The eManager*, 2008, No. 1.
- “Strengthening Human Resource Management to Improve Health Outcomes,” *The eManager*, 2009, No. 1.
- “Good Governance in Civil Society Organizations,” *The eManager*, 2009, No. 2.



<sup>1</sup> Management Sciences for Health, *Managers Who Lead: A Handbook for Improving Health Services*, Cambridge Massachusetts, 2005.

### 3.5.2 Articles Published by LMS Advocating for Leadership & Management in the Health Sector

In addition to the publications produced with USAID support under LMS, various articles were published in journals and other media publications, including the following:

- In USAID's *Frontlines*, February 2009 issue, "Listening to Save Lives in San Lorenzo." Author: M. Paydos.
- In report published by Accordia Global Health Foundation, "Building Healthcare Leadership in Africa: A Call to Action," 2009. "Individual Leadership: The Need for a Sustained Commitment to Developing Health Leaders in Africa." Authors: T.M. Riddle and J. Dwyer.
- In *Human Resources for Health*, January 2010 issue. "Scaling up Proven Public Health Interventions through a Locally Owned and Sustained Leadership Development Programme in rural Upper Egypt." Authors: M. Mansour, J. Mansour, A. Hasan El Swesy.
- In Global Health Council's *Global Health Magazine*, winter 2010. "Leadership & Management: The New Prescription for Health Systems Strengthening?" Authors: J. Dwyer and S. Wilhelmsen.
- In InterAction's *Monday Developments*, Jan.-Feb. 2010 issue. "Preparing Doctors and Nurses to Be Managers: Management Training Leads to Improved Health Outcomes." Author: M. Paydos.
- In USAID's *Frontlines*, February 2010 issue "Kenyan Mothers Choose Hospitals for Births." Author: E. Walsh.
- In InterAction's *Monday Developments*, April 2010 issue. "Virtual Programs in Management and Leadership." Uncredited, but authored by K. Chio.

### 3.5.3 Conferences Highlighting Results of LMS Work

The list of conferences and speaking engagements at which LMS team members presented or shared results of LMS work is exhaustive. But these few examples, highlighted below, show how LMS worked to move leadership and management "Out of Our Hands and into the World":

- International AIDS Conference, Vienna, July 2010: presentation by LMS Nigeria team on LMS work.
- Global Health Council Annual Conference, Washington, DC, June 2010: presentations on "Building Capacity for

Achieving Health Goals" and "Building Global Health Careers: It is All About People."

- Gates Family Planning Conference, Kampala, Uganda, November 2009: Participation on panel, "Leading and Managing for Family Planning Results" and separate presentation on virtual facilitation.
- Uganda Family Planning Conference, Kigali, November 2009: Capacity-building workshop on leading and managing change.
- ECSCA Directors Joint Consultative Conference, Arusha, September 2009: the results of Kenya Health Managers Assessment.
- World Federation of Public Health Associations Tri-Annual Conference, Turkey, April 2009: leadership work in the health sector.
- Council on Foreign Relations, New York, December 2008: leadership development.
- USAID, Washington, September 2008: LMS work in Afghanistan.
- Global Health Council, Washington, DC, June 2008: community governance in Peru.



Youth leader presenting to school group, Tanzania



## 4.1 Working at All Levels of the Health System

### Afghanistan, Haiti, and Nicaragua

One of LMS' approaches to mainstream and scale-up leadership and management capacity was to work at all levels of a national health system. This approach was applied in different contexts in Afghanistan, Haiti, and Nicaragua and involved the following components:

- Working with national policy makers to establish standards and policies.
- Reinforcing leadership and management capacity in all sectors of the health system responsible for implementing the policies and standards.
- Integrating leadership and management into national training institutions for sustainability of the process.

LMS has learned that to maintain sustainability in countries with political instability and frequent turn-over of high level ministers, it is essential to establish the leadership and management skills of provincial and facility level managers.

### Key Challenges

Afghanistan currently registers some of the worst health statistics in the world, as a result of decades of ongoing conflict from which it is still struggling to emerge. The health system requires rebuilding and strengthening to make a difference in these statistics. Building on the successful USAID/MSH REACH Project (2003 – 2006), the LMS Program in Afghanistan—known as Tech-Serve—took on the challenge of strengthening the leadership and management of the Ministry of Public Health personnel at the central and provincial levels. The project's goal was to ensure that institutional capacity, adequately trained human resources, and logistics management systems were in place throughout the 13 USAID focus provinces: Badakhshan, Baghlan, Bamyán, Faryab, Ghazni, Hirat, Jawzjan, Kabul, Kandahar, Khost, Paktya, Paktika, and Takhar. These provinces account for 52% of Afghanistan's total population.

In Haiti, severe poverty and political instability have created many difficulties for the health care system. In January 2008, the USAID/Haiti-funded LMS Program was launched to help build a unified national commodity security system, improve leadership and management capacity in the Ministry of Public Health and Population (MSPP), build capacity of local NGOs working

*“Without PRONICASS and this reform process, we would likely be stuck where we always have been. All our budgeting was based on past spending; we didn't work toward goals or target results. It was a nightmare.”*

*—Ministry of Health Central Office Official*

in family planning and HIV/AIDS, coordinate community activities to strengthen HIV/AIDS awareness and prevention initiatives, and address the challenges facing youth in the impoverished community of Cité Soleil. Despite the enormous obstacles in Haiti present after the devastating earthquake of January 12, 2010, LMS continued to collaborate with governmental and NGO partners to advance the work and achieve these objectives.

The LMS Program in Nicaragua, known as PRONICASS, had a broad focus, working with most of the social sector ministries (Health, Education, and Family Welfare), in addition to other institutions and organizations. PRONICASS was implemented during a time of change, with two distinct phases: 2005 – 2006 under the Bolaños government, and 2007 – 2009 under the Ortega government. There was practically no overlap on the health and family welfare activities between the two governments, circumstances which necessitated that PRONICASS redesign its strategy. The Ministry of the Family, where PRONICASS had some of its most dramatic early successes was essentially dismantled in 2007. The central level Ministry of Health was less abrupt in its changes, but nevertheless, over the three years with the current government, work at the central level diminished, particularly at the beginning of 2008. During the entire period, however, PRONICASS worked effectively at the SILAIS (health authorities at the department level) and service delivery level with the Ministry of Health.

Despite these different contexts, however, Afghanistan, Haiti, and Nicaragua also had similar issues, with their health systems facing common challenges such as:

- Inequities in access to health services
- Unqualified and/or inappropriate health staff and poorly equipped facilities
- Compromised flow of resources
- Inadequate financial resources
- Addressing high maternal and child mortality
- Governance in the face of deteriorating security

## The LMS Approach

The LMS teams in the three countries used a variety of approaches to address the many challenges facing the health systems in which they were operating, but two of the approaches were applicable in all places: (1) fostering leadership at all levels in the health system; and (2) implementing and maintaining management systems so that progress could be sustained.

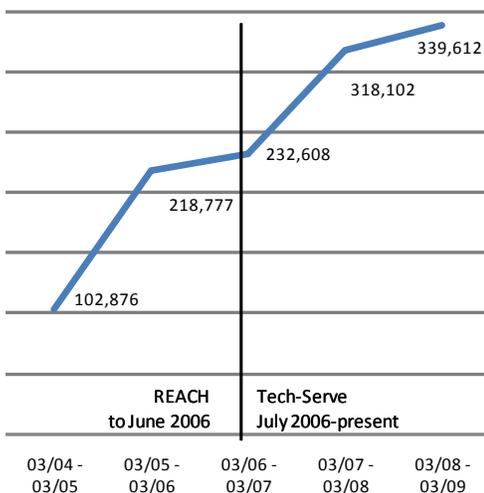
The belief that leadership can be developed and practiced at all levels is a core LMS principal. Putting people first—the people who make the health system work—yields results, whether the people are community health workers in Afghanistan, commodity distribution managers in Haiti, or officials at Nicaragua’s central level of the Ministry of Health. Skilled management and inspired leadership motivate health workers, health managers and health leaders alike to improve the quality of services and, ultimately, improve health outcomes. This people—and team—centered approach is critical to strengthening the health system at all levels.

A second approach common across the three countries was the development and implementation of management systems, evident in the many of the interventions highlighted below.

## LMS Interventions

**Interventions at the Provincial and Central Level in Afghanistan:** Tech-Serve’s objective is to improve the capacity of the Ministry of Public Health to plan, manage, supervise, monitor, and evaluate the scale of access to quality Basic Public Health Services and Essential Package of Hospital

**Figure 7. Family Planning consultations in Afghanistan’s 13 USAID-funded provinces**



Services, particularly for those of highest health risk. Tech-Serve works in seven programmatic areas to achieve these results. Specific interventions during LMS were as follows:

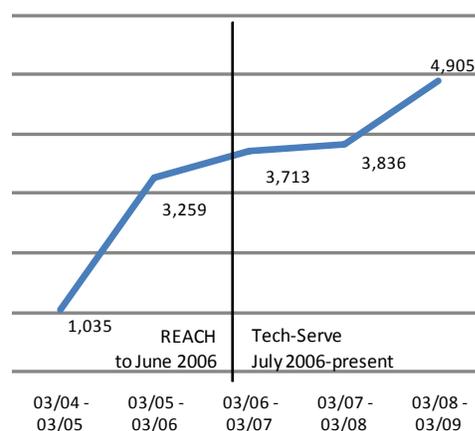
At the provincial level, Tech-Serve provided assistance to the Management Support for Provinces (MSP) Initiative by training and mentoring provincial management teams of the MOPH, which include Reproductive Health Officers, to implement the Leadership and Development Program. Under LMS, the LDP was conducted in all 13 USAID-supported provinces and in over 113 health facilities, with MOPH and NGO facilitators developed by LMS leading the leadership and management development training.

Tech-Serve also provided support at the provincial level to enhance the technical skills of staff, build their knowledge about communication and use of information for better decision-making, and improve performance.

Tech-Serve, through the MSP Initiative, also ensured that all Provincial Public Health Departments had Internet connection and a technical resource center to house documents and publications on health systems, public health, and leadership and management.

At the central level, Tech-Serve strengthened hospital management, procured and distributed essential pharmaceuticals and strengthened the M&E function of the central MOPH. Specific accomplishments included the launching of a multi-pronged effort to strengthen the MOPH Community-based Healthcare initiative in collaboration with Health Services Support Project (HSSP), and supporting the MOPH in updating and translating 15 national guidelines, policies, and assessment tools.

**Figure 8. Institutional Deliveries in Afghanistan’s 13 USAID-funded provinces**



### **Interventions to achieve reproductive health commodity security in Haiti:**

In the fall of 2008, LMS launched multiple activities to contribute to the broader objective of supporting the Ministry of Public Health and Population (MSPP) and its partners in the development of a unified, efficient, and secure national contraceptive commodity management system throughout Haiti. These efforts involved people at all levels of the health system – from family planning professionals at local levels, to officials in the MSPP, representatives from NGO partners, and others.

To ensure the quality and availability of U.S. Government-funded contraceptives, LMS staff worked with family planning professionals at selected sites to conduct an evaluation of compliance with USG regulations, assess each facility's management tools, and ensure that the sites' storage areas were adequate and in good condition. LMS began active distribution of family planning commodities to USG-supported service delivery points in every department of Haiti.

At the same time, LMS began strengthening local capacity through a Leadership Development Program for key partners in commodity security programs, including representatives from the MSPP and local and international non-governmental organizations. Concurrently, LMS strengthened the MSPP's commodity management system at the central and department levels, specifically through assistance to the national system for distribution/supply of commodities and transport of condoms and family planning methods funded by UNFPA and stored at the central warehouse.

The project succeeded in ensuring regular supply of condoms and other family planning commodities according to the norms of the CDAI (departmental-level medical warehouses). To ensure more effective management of commodities, the right tools are necessary; therefore, in November 2008, LMS collaborated with various departments within Haiti's health system, the UNFPA, and USAID to develop a form to be used at the departmental level to facilitate a more accurate estimate of condom use and needs at the service delivery level, where all information related to condom use is gathered to fill out the form.

### **Interventions at the Central, Departmental and Community Level in Nicaragua:**

At the central level, PRONICASS responded to the request of the Nicaragua government in 2007 to assist with the operationalization and implementation of a family and community health care model known as the Modelo de Atención Integral en Salud (MAIS), which had been developed under the prior USAID/MSH project, Management and Leadership Program. PRONICASS ef-



*Delivering commodities post-earthquake, Haiti*

orts included assisting in the preparation of the implementation guides; financing the training of national level facilitators; and participating in the training and implementation of the model down to the sector level in three SILAIS (health authorities at the department level): Leon, Nueva Segovia and Boaco.

At the department level, PRONICASS carried out leadership development activities in all three SILAIS and with the central level of the Ministry of Health, specifically with the multidisciplinary team of more than 30 staff that was supporting the implementation of the new family and community health care model. The MOH, as part of this effort, adopted a register in which vital characteristics of each family member and the family itself are collected and analyzed. PRONICASS designed a family registry software that permitted entering this family health information in a database and consolidating it at the community level, which included important variables such as the number of women of reproductive age using a family planning method; and indicators of nutrition and growth for children less than one year of age.

One of the most promising areas of work in Nicaragua was at the community level, in the area of citizen participation. Given that its original charge included increasing transparency, PRONICASS began working with Municipal Development Committees (Comité de Desarrollo Municipal, CDM), created by law to provide civil society input into local planning and control. Working initially with four CDMs and in close cooperation with the Institute for Municipal Development and with the Association of Municipalities, PRONICASS developed a guide to organizing and broadening citizen participation in the CDM.

## Key Results

As a result of LMS work at all levels of the health systems in Afghanistan, Haiti, and Nicaragua, the countries reported these results:

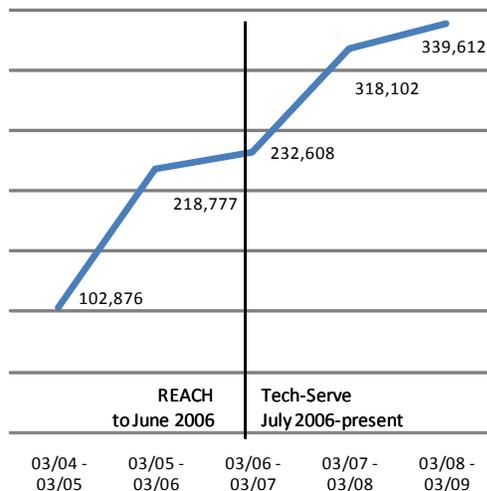
### Afghanistan

- More than 1,800 health professionals, including senior Ministry of Public Health and NGO managers, were trained in leadership and management development, and other priority public health subjects to equip them with the necessary skills to achieve better health outcomes.
- The Tech-Serve Project supplied a total to \$15.9 million of essential drugs and contraceptives since its inception.
- The MOPH is now certified to administer USAID funds, and manages 17 health service provision contracts with local and international NGOs, thereby increasing access and equity to health care across the 13 provinces.
- An expansion of the Tech-Serve Project, particularly the Management Support to Provinces component, into an additional 11 new Quick Impact provinces, increasing the budget from \$50M to \$83M. These Quick Impact provinces are in the southern and eastern regions of the country, in areas of strategic importance to the US Government.

In addition, improvements at service delivery points were at least partially responsible for some of the gains in service coverage, including:

- In all USAID-supported facilities, there was an increase from March 2005 to March 2009 in the total number of services provided related to: (i) DPT3 vaccinations, (ii) new FP consultations, (iii) TB case detection, and (iv) institutional deliveries:
  - » DPT3 vaccinations more than doubled
  - » Family planning consultations increased eight fold
  - » TB detection had a 2.5 fold increase
  - » Institutional deliveries increased more than three fold
- Contraceptive prevalence rates (CPR) in three pilot districts doubled in two years. The approach has been expanded to all districts in 13 focus provinces through more than 11,000 community health workers. In all 13 provinces, CPR increased from 28% (2006) to 43% (2009).
- Couple years of protection increased from 39,905 (2006) to 254,060 (2009).

**Figure 9. DTP3 Vaccinations in 13 USAID-funded Provinces**



### Nicaragua

- Guides to implement the national health care provision model were used nationwide in the first year of the implementation of the model. PRONICASS also provided technical guidance and operational support for the reproductive health care protocol, development of community health diagnosis and planning guide benefiting directly some 1,000 primary health care providers in all 17 SILAIS and 1200 health units.
- PRONICASS and the MOH developed the new maternal health norms (including family planning) which were formally approved in November 2006. They are currently being applied nationwide.
- In the three PRONICASS SILAIS (Leon, Nueva Segovia and Boaco) the application of the guides to implement the national health care provision model has led to the visits to over 121,000 households (77% of all of those in the three SILAIS) by teams of health staff and community health workers.
- The MOH has adopted the family registry software and made its use mandatory nationwide. With PRONICASS technical assistance, 71 of 154 municipalities are entering family health data.
- The guide to increasing citizen participation in the Municipal Development Committees was subsequently used to broaden and improve citizen participation in 22 municipalities in León and Nueva Segovia. PRONICASS worked with 80 CDM members to define required competencies, then evaluated competency gaps and developed a training curriculum to respond to the gaps and identified mostly local resources to provide the training.

## Haiti

- LMS Haiti has built the health system capacity to establish a standardized and secure commodity management and distribution system, including improved compliance with USG family planning regulations at more than 271 sites and clinics.
- Despite multiple obstacles, in the five months following the January 2010, earthquake, LMS distributed more than 8.6 million family planning commodities including 8.2 million condoms; 240,830 oral contraceptives; 203,000 injectable methods; and 940 implants.

*“After January 12th we were certainly confronted with new challenges. However a leader never abandons. And it is in this sense that we will work more and more to... respond to the needs of the Haitian population in way of reproductive health.”*

*—Judith Sanon, Manager, Department of Family Health, Haiti’s Ministry of Health*

## Lessons Learned from LMS’ Work at All Levels of the Health System

- Frequent and sustained follow-up between staff at all levels of the health system is key to consolidating knowledge, sharing information, etc.
- Changes in senior leadership are inevitable; by focusing capacity building efforts on lower levels, there is a greater chance to assure sustainability of interventions.
- The LDP process of involving managers at all levels in a six-month process of skill building and problem solving is a successful strategy for capacity building in many countries.
- Capacity building is more than training – it needs to address the structures and processes of an organization, as well as human resource issues, anti-corruption, personnel retention, etc.
- The definition of roles and responsibilities is key to achieving outcomes and results.
- Change can be institutionalized from the bottom up.

## 4.2 Leadership & Management Ownership at the National Level

### LMS in Kenya, Nepal, and Ghana

Even while realizing that effective leaders and managers are the foundation for achieving the Millennium Development Goals for health, many countries’ Ministries of Health are faced with weak management capacity at district and facility levels, hindering attempts to improve public health. LMS’ programs in three countries—Kenya, Nepal and Ghana—worked with health leadership to tackle this specific challenge and move toward institutionalizing leadership and management through country-led efforts.

This section specifically examines LMS efforts in Kenya; see the boxes on page 50 and 51 for highlights of programs in Nepal and Ghana.

### Key Challenges

Following the establishment of a coalition government in Kenya in February 2008, the Ministry of Health was split into two ministries: the Ministry of Medical Services (MOMS), primarily responsible for curative services; and the Ministry of Public Health and Sanitation (MOPHS), primarily responsible for preventive services. Each ministry is further responsible for providing oversight to facilities at the various levels of the health system. The MOMS covers national referral hospitals, provincial hospitals, and district-level hospitals, and the MOPHS covers health centers, dispensaries, and the community level.

While the split of the Ministries has created some challenges in the coordination of activities and communication in the sector, it has successfully shifted some of the health sector focus onto preventive services. One of the major objectives is the successful implementation of a series of health reforms that include the decentralization of funding and management away from the central ministry level to the provincial and district level, rationalization of staff, and restructuring the operations of key parastatal organizations. While the reform process has begun and continues to be a major focus for the Ministries, in order for it to be successful, staff at the provincial and district level require a higher level of competence in management and key management systems to support the process.

*By including a wide range of stakeholders in the curricula development process, and given the Ministry of Health's high level of leadership on this issue, Kenya's training institutions have seen that it is in their interest to integrate leadership and management into the existing curricula.*

## **The LMS Approach**

Stakeholder/partner involvement and ownership was an essential component of LMS activities in Kenya. Two areas where this approach yielded good results: curriculum development and priority hospital reforms.

LMS facilitated a sector-wide stakeholder working group to develop three curricula in leadership and management in the areas of pre-service, in-service, and senior leadership training. Working group members include ministry staff, leaders from public and private training institutions including Kenya Medical Training College, Galilee College and the United States International University in Kenya, as well as accreditation and professional associations. The goal was to ensure that medical professionals gain the necessary skills they need prior to entering the system, and to urgently fill the training gap for those who are currently posted in health management positions. By including a wide range of stakeholders in the curricula development process, and given the Ministries of Health's high level of leadership on this issue, training institutions have seen that it is in their interest to integrate leadership and management into the existing curricula.

The involvement of key members of the ministry has been equally important in the Priority Hospital Reform work. Membership in the working group has included more ministry staff than USAID project staff, ensuring the ministry's true leadership role in this initiative. In addition, when there was internal conflict regarding some of the recommendations made, ministry working group members were able to solidly defend the recommendations and have been working on bringing other colleagues on board.

Strong coaching and mentoring for transfer of skills was another key to success in Kenya. The LMS/Kenya team made it standard practice in the LDP to follow-up with a coaching visit after each workshop, and six months after the program's conclusion, in order to continue to support participants and encourage them to select new challenges.

## **LMS Interventions**

The LMS Program began working with the Kenya health sector in November 2007 on the development of a National Assessment of the Management and Leadership Competencies of Health Managers which was carried out in collaboration with the Ministry of Health before it was split into two ministries. The National Assessment and the resulting draft National Strategy for Leadership and Management have been the foundation for the LMS Program activities which began in July 2008.

In February 2009, LMS offered an LDP to health managers from Central, Coast, Eastern, Rift Valley, and Nyanza Provinces posted to the district levels. The program raised the visibility of leadership and management in the health sector, resulting in strong interest at the national level. This yielded the creation of a strategy toward institutionalizing leadership and management nationally within the sector, and resulted in a high level of demand for leadership and management training and technical assistance in strengthening management systems. LMS also supported the roll out of an additional LDP to Ministry Staff based at headquarters between September 2009 and March 2010.

In support of the Hospital Reform Agenda, LMS has been leading and coordinating the Priority Hospital Reform Working Group, a MOMS/USAID partnership set-up by the MOMS Permanent Secretary, focusing priority reforms on "level 5" hospitals, which includes hospital facilities at the provincial level.



*Maternity ward, Kenya*

# Programmatic Assessment

## The Kenya Leadership Development Program:

### Linking Management and Leadership Training to Service Delivery Outcomes

With support from USAID's Office of Population and Reproductive Health, Management Sciences for Health conducted a collaborative programmatic assessment in Kenya in 2009-2010 to evaluate the impact of the Leadership Development Program (LDP) on service delivery outcomes through a rigorous study using comparison groups. The main objective of the assessment was to demonstrate whether the LDP intervention produces changes in health outcomes that do not occur in comparison areas where the LDP was not implemented. For a complete description of the LDP, see page 73.

### Study Design

This study used a quasi-experimental design that compared before and after measures of a key indicator addressed by 67 LDP teams against comparison groups that did not receive the intervention. Measurements of health service indicators were taken in intervention districts and facilities where the LDP was delivered and in comparison districts and facilities at three time periods between 2008 and 2010: before each LDP (baseline), at the end of each LDP (endline), and approximately six months after each LDP ended (sustainability measure). If the changes observed in the intervention group are not observed in the comparison groups, the changes can reasonably be attributed to the intervention.

In the absence of random assignment of teams receiving the LDP, the equivalence of intervention and comparison groups was

increased by matching on selected criteria. The LDP intervention in Kenya involved training and coaching participants from 67 teams as they applied proven leadership and management practices in four workshops during the six month program. The LDP had not been conducted in comparison areas at the time of the study.

### Data Collection

Data were collected for the LDP teams from February to April 2010 by contacting each of the 67 team leaders by email and/or telephone to confirm the results reported at the time of each LDP and to obtain additional data, including a sustainability measure. Qualitative data were collected by interviewing the 67 LDP team leaders on the factors that supported or hindered the sustainability of results.

Data for comparison areas were collected over a one week period in August 2010 by Health Management Information Systems (HMIS) Officers employed by the Government of Kenya. In each comparison area, HMIS Officers extracted data from service delivery registers and district health records for the three time periods examined in this study.

### Data Analysis

With support from a team of independent consultants at Harvard University, intervention districts and facilities were matched with districts and facilities where the intervention had not taken place in order to compare health outcomes. Districts and facilities were matched separately using the Coarsened Exact Matching (CEM)<sup>1</sup> program in Stata v. 11. Matching criteria at the district level included district population and geographic location. Criteria for selecting facility matches included geographic location, type of facility, number of beds, and family planning service statistics.

<sup>1</sup> CEM is a relatively new method for improving the estimation of causal effects by reducing imbalances in covariates between treated and comparison groups. For further information of CEM, see: <http://gking.harvard.edu/cem/>



10 teams focused on increasing the proportion of pregnant women receiving four or more antenatal care visits



23 teams focused on increasing the proportion of pregnant women delivering with a skilled birth attendant



25 teams focused on increasing the percentage of fully immunized children under age one

The analysis of the study focuses on the achievements of teams of health managers, doctors, and nurses who received the LDP intervention. The study reports average coverage rates of the priority health indicators that LDP teams chose to address, as opposed to individual health indicators. Results from all teams were weighted equally to control for differences in the volume of service for different indicators. For example, service volume for total inpatient and outpatient visits would be higher than immunization, or delivery by a skilled birth attendant.

A percent coverage for the three time periods of the analysis were obtained for each team, and the results were averaged for each time period for all 67 teams. Data were obtained for the set of comparison areas for the same three time periods for which each LDP team took its measurements. The results of each LDP team were compared to the averaged results for the group of comparison areas to which it was matched.

For districts, numerators and denominators were obtained for each of the indicators for match areas as was done for each LDP team, and a percent coverage was computed. For most facilities, denominators (number of “eligible population” in the comparison area) have not been established by the Kenya HMIS. Therefore, the analysis had to be based upon numerators only.

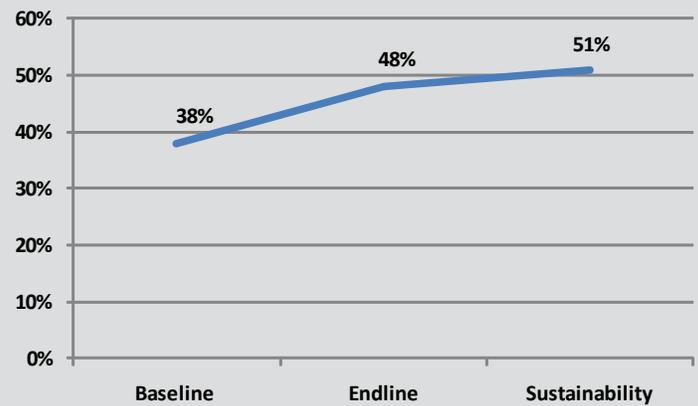
For the intervention facility teams and matching facilities, the basis of the analysis was a computation of percent change from baseline to endline, and from baseline to sustainability measures. Results for intervention and comparison areas, therefore, are presented separately at district and facility levels as the type of analysis had to be different for district and facility teams in comparison areas.

Significance tests were calculated using the Statistical Package for the Social Sciences (SPSS) v. 18.0.0. Qualitative data were analyzed using NVivo v. 8.0.340.

## Results

The combined results for the 67 LDP teams included in the analysis are shown in Figure 10. For all 67 teams at district and facility levels that received the LDP intervention, the average coverage rate for selected health indicators was 38% at baseline, 48% at endline, and 51% at approximately six months after the LDP had ended, showing that the teams, on average, were able to improve their measureable results and to sustain the improvements approximately six months after the end of the LDP. The health indicators included fully-immunized children under one, women who delivered with a skilled birth attendant, pregnant women who had four or more antenatal care visits, and other indicators measured between 2008 and 2010.

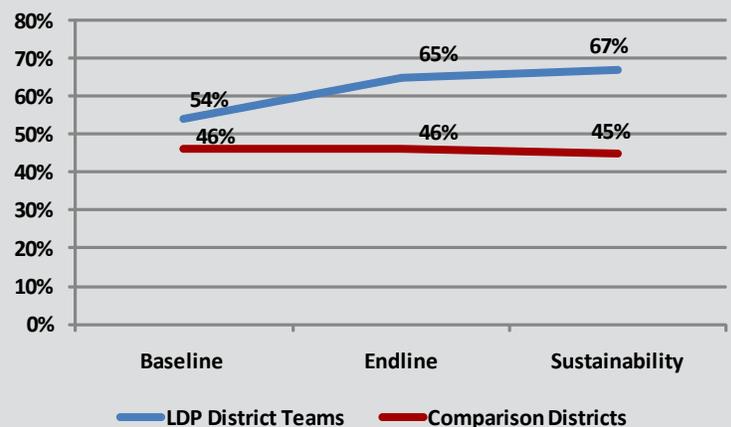
**Figure 10: Results from LDP Teams at District and Facility Levels: Average Coverage Rates for Selected Health Indicators (2008-2010)**



Source: LMS Kenya Project, MSH

Results for district-level intervention teams in relation to comparison districts are shown in Figure 11. For the 18 district-level teams that received the LDP intervention, the average coverage rate for selected health indicators increased from 54% at baseline to 65% at endline, and 67% at approximately six months after completion of the LDP, indicating that the LDP did produce and sustain positive results at district level. Selected health indicators at district level included fully-immunized children under one, women who delivered with a skilled birth attendant, and others. Comparison areas remained stable, with average coverage rates of 46%, 46%, and 45%, respectively, for the three time periods.

**Figure 11: Results from LDP Teams and Comparison Areas at District Level: Average Coverage Rates for Selected Health Indicators (2008-2010)**



Source: LMS Kenya Project, MSH; Kenya HMIS Ministry of Health

# Programmatic Assessment (continued)

Difference in means from baseline to endline measures for the treatment and comparison groups at the district level was highly significant ( $p = 0.001$ ). The difference in means from baseline to the sustainability measures for the two groups was also significant ( $p = 0.0465$ ).

At the facility level, LDP teams also reported significant results: the average coverage rate for selected health indicators increased 121% from baseline to endline, and 137% from baseline to approximately six months after the end of the LDP. Selected health indicators at facility level included fully-immunized children under one, women who delivered with a skilled birth attendant, pregnant women who had four or more antenatal care visits, and others. Comparison facilities showed a modest increase of 9% from baseline to endline, and 26% from baseline to the sustainability measure.

Difference in means from baseline to endline measures for the intervention and comparison groups at the facility level was highly significant ( $p = 0.0015$ ), as was the difference in means from baseline to the sustainability measures for the two groups ( $p = 0.0105$ ).



LDP participants in Kenya

Two thirds of the teams were able to sustain results. Qualitative data revealed three contributing factors most cited for sustaining results: 1) increased demand for health services generated through social mobilization and health education; 2) increased access to services by providing more outreach sites or more service hours or days; and 3) improved work climate due to renovated staff quarters, training, or supervision.

For the one-third of teams unable to sustain results, the hindering factor cited most often was staff shortages, which led to decreased access to health services (e.g. fewer outreach sites, suspended mobile services, or long lines, especially on market days). Other reasons cited included a shortage of medicines - especially vaccines - and supplies, drought, and lack of security.

## Discussion and Data Limitations

The study results show that the LDP intervention does improve health service delivery outcomes, and that these improvements were sustained after the LDPs ended. These results can be plausibly attributed to the intervention as the same changes were not observed in the comparison groups.

The results from this study contribute to a growing body of evidence on the effects of leadership and management development interventions on health outcomes. Such interventions can significantly strengthen health systems in similar settings in Sub-Saharan Africa and other regions to improve the health status of vulnerable and disadvantaged populations.

Data limitations include:

- a lack of information about the population eligible for services at the facility level (i.e. denominators);
- the focus of LDP teams on different indicators with different service volumes;
- sample sizes too small for comparing average coverage rates by indicator for intervention and comparison groups.

These limitations suggest the need for further research with an even more rigorous study design.

## Key Results

- In partnership with the Ministry, completed a National Assessment on the Leadership and Management Competencies of Health Managers. Findings showed that over 90% of health managers surveyed view leadership and management as an important part of their job and 61% felt that they were inadequately prepared or not prepared at all for their jobs.
- Developed standardized leadership and management curricula for pre-service, in-service and senior leaders.
- Trained 365 health managers at the provincial level and 29 at the central level through the Leadership Development Program. Through the LDP, teams addressed challenges in their workplace and achieved measurable results.
- Facilitated the MOMS/USAID Priority Hospital Reform Technical Working Group to support priority reforms for level 5 facilities. LMS conducted a needs assessment for three pilot hospitals and conducted visioning and strategic planning workshops for each.
- Supported Faith Based Umbrella Organizations and the Division of Reproductive Health to strengthen key management systems so that they could meet their organizational mandate in a more effective and efficient way by conducting Management and Organizational Sustainability Tool (MOST) Workshop.

## Lessons Learned from LMS' work of Institutionalizing Leadership and Management through Ownership at the National Level

**Strengthening and expanding the capacity of local technical assistance providers is essential for scale-up.** LMS/Kenya was fortunate to have a group of local consultants and experts, which resulted in minimal short-term technical assistance from international consultants. This was possible because of past and ongoing USAID investments that have produced a pool of qualified Kenyan trainers and facilitators in leadership and management. This local capacity is critical to sustainability and to the scale-up of leadership and management strengthening across the health sector.



## Institutionalizing Leadership and Management in Nepal

In March 2006, LMS, in collaboration with the National Health Training Centre, ADRA/Nepal, and the Institute of Cultural Affairs/Nepal, introduced the LDP (locally referred to as the Results-Oriented Leadership Development Program or ROLDP).

In Phase I of the project, the ROLDP was launched in three districts involving 31 teams (84 participants) from government offices and NGOs from health, water, sanitation, women in development, education, and local government councils. Phase II concentrated on building the capacity of trainers from the National and Regional Health Training Centers (RHTCs), developing teaching materials, and encouraging community level participation. Thirty government staff were trained as facilitators, reaching more than 70 Health Facility Operation and Management Committee members from nine Village Development Committees. The *Managers Who Lead* handbook was translated into Nepali, as were other materials for use in community trainings. As of May 2010, more than 700 participants have been trained by ADRA/Nepal in the ROLDP.

Members of the International Rescue Committee who attended a ROLDP training were so impressed that they replicated the program for six Village Development Committees in Surkhet district. ADRA/Nepal has had 10 people trained in facilitating the ROLDP and has applied it in several community programs, including the Family Planning and Safe Motherhood program; Leadership and Good Governance project; and the Sustainable Women's Economic Development project.

A spontaneous spinoff also occurred in Nepal when the RHTC in Pokhara applied the ROLDP approach. It revitalized its underutilized training facility through implementation of a local fund raising strategy. The Centre received MOHP approval to become a "Centre of Excellence" for training and leadership serving international, national, and regional participants. It is conducting leadership training for district hospital and health office personnel in response to requests.

# Success Story



## **Institutionalizing Leadership and Management in Ghana**

The goal of the Ghana Health Service (GHS) agency is to provide and manage comprehensive and accessible health services with special emphasis on primary health care at regional, district, and sub-district levels. As the result of an LDP, the interventions undertaken by the GHS have the promise to improve performance of regional and district programs and to markedly reduce maternal and child mortality. The program focused specifically on senior leaders, and also developed facilitators through a training of trainers so the LDP could be further rolled out with the mobilization of additional resources.

All teams who participated in the first LDPs in the Central region in 2008 – 2009 met or exceeded their measurable results. For example, the Regional Health Directorate team in Cape Coast increased family planning coverage in the region from 13.5% in May 2008 to 18.5% by July 2008. By December 2008, family planning coverage had further increased to 43.6%, which was described as “quite unprecedented.”

**Integrating leadership and management into existing structures and processes is necessary for sustainable change.** The LMS experience in Kenya has shown that leadership and management activities cannot be sustained unless they are built into existing structures and processes. Ministry personnel at every level are overburdened with competing tasks and unlikely to take on additional projects or activities that are not essential to their current role. By making leadership and management part of everyone’s business, it is possible to affect a shift in organizational culture that leads to better coordination and communication, improved work climate, stronger management systems, and an enhanced ability to respond to change.

In the Ashanti region, teams also met or exceeded their measurable results. The Ashanti Regional Hospital team at Kumasi South Hospital faced the challenge of renovating the hospital to meet a pending accreditation by the national health insurance authority. Renovations were desperately needed; the hospital was dilapidated and dirty, and received many patient complaints. Through the LDP, the team mobilized resources and stakeholders, transformed the hospital, and put in place sustainable measures to ensure cleanliness of the renovated facility. The hospital received its National Health Institute accreditation, and the number of clients has increased dramatically. As a result of these positive changes, a member of Kumasi’s Parliament has committed 20,000 Ghana cedi (around \$14,000) for a new optometry department.

As of 2010, GHS has secured funding through a health systems strengthening grant from GAVI to roll out the LDP in other regions of Ghana. The first four LDP workshops and coaching visits for 75 participants under this roll-out have taken place in the Ashanti region, and GHS plans to reach all 27 regions by 2011.

**Moving from planning to action is necessary to achieve results.** Participants of the LDP consistently rated themselves as strongest in planning and weakest in implementation, and required specific help to make the leap. The LMS Kenya team found several strategies helpful including:

- If the leaders of an organization believed in the process and the results to be accomplished, they held teams accountable;
- Identifying and achieving quick wins inspired teams and recommitted them to the process;
- Measuring results provided evidence that the intervention was working and further motivated participants; and
- Creating a sense of urgency and setting deadlines were crucial.

## 4.3 Strengthening the Capacity of Nascent Civil Society Organizations

### LMS in Nigeria and Tanzania

Although MSH has a long history of providing technical support in leadership and management and governance of large established NGOs, especially in Latin America, the LMS approach in the African context needed to be adapted to the large number of organizations needing support, their almost total lack of systems to accurately and transparently account for funds, and the speed at which these organizations needed to be certified by USAID to receive and administer funds from PEPFAR and successfully meet their proposed HIV/AIDS prevention, care and treatment targets. LMS has been working in both Nigeria and Tanzania since the program's inception, taking different approaches to the common goal of building capacity. In addition, similar work has been more recently launched in Ethiopia (see boxed story on page 53).

### Key Challenges

Civil society organizations in both countries have an important role to play in the provision of health and HIV/AIDS services, particularly at the community level. While numerous mechanisms exist to support the engagement of civil society, the effectiveness of these efforts is mitigated by overall weaknesses in organizational systems and structures, including poor planning and coordination, outdated or non-existing organizational strategic plans, policies and procedures, unmet human resource needs, and numerous other deficiencies in management, leadership, and governance practices.



Youths at new RFE-supported community center, Tanzania

### The LMS Approach

In Nigeria, the approach was based on LMS principles for developing managers who lead, and was applied within the context and understanding that local CSOs were better served by focusing technical assistance on supporting the entire organizational structure, and developing and implementing organization wide systems in a participatory manner. The Nigeria Capacity-Building project is a good example of rapid scale-up through a two-prong approach: it provided overall capacity building to several CSOs simultaneously through standardized workshops using LMS tools, and it also provided more tailored mentoring to address specific challenge areas where needed.

In Tanzania, recognizing the need to build long-term local capacity, LMS shifted from a previous technical assistance model reliant on external experts to one that drew upon the strengths of local consultants and staff, and equipped them with up-to-date knowledge, resources and tools. One method of doing this: LMS took advantage of visiting experts to deliver short, highly focused Training of Trainers workshops for these local capacity builders. In this manner, LMS was able to create a pool of local experts with a common framework, vocabulary, and understanding of the various approaches appropriate for the Tanzanian context. When engaging with civil society clients, LMS emphasized participatory approaches: capacity builders involved staff at all levels of an organization in management assessments, guided them as teams to diagnose their own organizational weaknesses and technical assistance needs, and then supported them to take action to improve their leadership and management practices.

### LMS Interventions

#### Nigeria

- In Nigeria, LMS provided technical assistance to more than 70 CSOs through workshops delivered on the following topics and MSH tools: board development; Quickstart Assessment, Management and Organizational Sustainability Tool (MOST); leadership development; financial systems strengthening, management information systems; financial management; grants management; policy implementation; human resource management; concept paper development; proposal development; strategic planning; operational policy implementation; project management; technical working sessions; and USAID Orientation.

## Tanzania

- To strengthen the skills of local capacity builders, LMS Tanzania conducted seven Trainings of Trainers (TOT) workshops on proven LMS tools and approaches including: Consulting for Results, Leadership Development Program (2 TOTs), human resource management, board governance, monitoring and evaluation, and coaching and mentoring.
- LMS engaged with Mildmay International Tanzania to complete priority actions which included updating their organizational strategic plan; training staff on financial management systems and procedures; and building capacity in human resource management and leadership through participation in MSH Virtual Learning Programs.
- LMS helped the Department of Social Welfare (DSW) at the Ministry of Health and Social Welfare (MOHSW) address critical organizational and performance gaps, many of them directly related to impending, wide-scale changes in top level leadership and management. LMS facilitated a program on management and leadership for 25 staff, and guided staff to work as a team to improve skills in delegation, short term planning, data analysis, reporting, and fundraising with proposal writing. With technical support from the capacity builders, DSW reviewed and updated their Strategic Plan and developed a concept paper.
- LMS engaged with Wanawake na Maendeleo Foundation (WAMA) to support them in updating their organizational strategic plan; designing a monitoring and evaluation system and electronic database; and participating in MSH Virtual Learning Programs to build capacity in human resource management and leadership. LMS also paired a local capacity builder with an external expert in CSO board governance to facilitate a workshop on board roles and responsibilities.
- As a local partner on the USAID-funded Tanzania Human Resource Capacity project (THRP)—an Associate Award primed by IntraHealth—LMS worked with the Benjamin William Mkapa HIV/AIDS Foundation (BMAF). LMS employed local experts to help BMAF identify priority needs and develop an action plan for organizational strengthening. LMS deployed capacity builders to work with BMAF to: diagnose and resolve bottlenecks in the use of accounting software; train accountants in the accounting software; develop an information and communication technology (ICT) policy and strategies; and design a strategy and build capacity for district-level HRH interventions.

*As a result of LMS technical assistance in Nigeria, six CSOs were awarded \$32.9 million in USG funds; collectively they have reached a total of 179,118 people with HIV/AIDS service packages.*

- LMS provided technical assistance to another local THRP implementing partner, the Christian Social Services Commission, helping to build their organizational capacity to manage larger funds and programs. Work included a participatory self-assessment workshop using the LMS MOST, and follow-up targeted technical assistance to develop a streamlined HR manual, review and update their ICT policy and strategies, and streamline their finance and accounting manual.
- In collaboration with Deloitte Consulting, Ltd., LMS provided technical support to Rapid Funding Envelope (RFE) applicants and sub-grantees. Capacity building activities were built into every phase of the RFE grant-making cycle: during the application process, capacity building centered on providing constructive feedback to unsuccessful applicants; later, local experts from Deloitte and LMS conducted pre-award assessments and provided



*Rapid Funding Envelope CSO member, Tanzania*

training to all sub-grantees on results-based management, compliance with donor requirements, work planning, monitoring and evaluation and reporting, and effective implementation. Finally, LMS provided ongoing support related to program planning and implementation (including M&E) through site visits, careful review of quarterly reports and work plans, and through refresher training, all contributing to help heightened organizational capacity.

## Results

### Nigeria

- LMS provided comprehensive technical assistance for passing a pre-award audit to 10 CSOs in order to receive US Government funds directly.
- Six of these organizations were awarded \$32.9 million in US government funds and are now managing these resources. Collectively, they have reached a total of 179,118 people with a number of HIV/AIDS service packages through March, 2010.

### Tanzania

- Through the TOTs, LMS created an informal local network of approximately 23 consultants and seven professional staff from MSH with knowledge, skills and experience in organizational capacity building. Two of these capacity builders have gone on to offer their own courses based on the TOTs delivered by LMS.
- MILDMAY: organizational strengthening support from LMS has enabled MILDMAY to involve a wider spectrum of stakeholders, improve the effectiveness of meetings, and inspired a sense of ownership among staff.
- WAMA credits LMS with strengthening its board of directors' leadership and governance and eliminating conflicting roles between management and the board, improving the performance of work teams, and implementing a more effective monitoring system.
- RFE: Under LMS, the RFE has awarded four rounds of grants totaling \$15.9 million, resulting in 113 awards to CSOs participating in the fight against HIV/AIDS. The RFE has strengthened the management, leadership and governance capacity of indigenous CSOs, and has been a springboard to new activities and funding. For example, after participating in the RFE, at least four sub-grantees have gone on to win PEPFAR grants and another six have become successful Global Fund recipients.

## Success Story



### Working with CSOs in Ethiopia

In Ethiopia, among the organizational challenges facing young CSOs are a shortage of skilled personnel, lack of knowledge and skills in project planning and M&E, irregular/unsupportive supervision and feedback, and a lack of diversified funding sources, with local resources often overlooked.

Since August 2009, LMS Ethiopia has been providing ongoing technical support to a number of CSOs in the Oromia and Amhara Regions in areas such as leadership, management, program planning, implementation, and M&E. In particular, LMS is helping the people in these organizations practice leadership at all levels with a focus on achieving and sustaining results. Specific interventions include:

- **Two Leadership Development Programs.** The CSOs involved are mostly small, grassroots organizations providing AIDS-related services in coordination with the public sector HIV/AIDS Prevention and Control Offices, and most have selected challenges focused on improving or expanding HIV testing and counseling or care and support services.
- **MOST workshops.** LMS is also helping the CSOs assess their organizational management practices, identify gaps, and develop and implement action plans to address these gaps.
- **Project Cycle Management (PCM) workshops.** More than 30 CSOs are learning to improve the ways in which projects are planned and carried out in order to achieve objectives. The project cycle process also provides a structure to ensure that stakeholders are consulted and that relevant information is available, so that informed decisions can be made at key stages in the project.

Some early results from the LDP include:

- One CSO reported that Provider Initiated Testing and Counseling services in their clinic increased to 17%, from a baseline of 5% at the same time last year.
- A CSO which had selected a measurable result of providing long term family planning methods to 228 people within six months reached 177 people during the first three months of the LDP, putting it on track to reach more than 350 people within six months.



ProACT Project Launch, Nigeria

## Lessons Learned from LMS work with Nascent CSOs in Nigeria and Tanzania

**Rapid scale-up of leadership and management capacity is possible to get skills into the hands of counterparts.** The desperate situation of the growing HIV/AIDS epidemic in many countries in Africa has made rapid scale-up of leadership and management skills necessary. There is simply not enough time or resources to provide the traditional one-on-one technical assistance. This high volume approach has reached a large number of CSOs and their leaders and managers while maintaining costs at a reasonable level and increasing the ownership of the process by the CSOs.

**There are several paths to rapid scale up of CSO services.** In Nigeria, the use of outside experts for a series of targeted workshops was an effective approach. In Tanzania, by building up a local network of expert consultants, CSOs long-term needs were addressed in a cost effective and culturally appropriate manner. When scaling up through local consultants, the quality of replication needs to be assessed. LMS is continuing to evaluate the effectiveness of this strategy in maintaining the quality of the leadership and management capacity built in the various CSOs.

**Technical assistance to CSOs should be approached from the perspective of helping the organizations to achieve their respective missions.** Capacity building of nascent CSOs is most effective when the demand is driven by the client organization.

**The participatory approach is critical in planning and implementing interventions when working with nascent CSOs.** LMS activities were most successful when a selection of members from different areas within the organization were involved in the process.

## 4.4 Increasing the Sustainability of Second Generation Family Planning & Reproductive Health Networks

### LMS in Bolivia, Guatemala, and Honduras

From the mid '60s to the mid '90s, International Planned Parenthood Federation affiliates (some funded by USAID) and other USAID funded organizations in Latin America led a family planning revolution that lowered average fertility rates dramatically. At the same time contraceptive prevalence grew from lows of 10% in some countries in Latin America to over 50% in others. Starting around the mid '90's, investment in family planning worldwide decreased. Latin American countries that were 'graduated' or 'graduating' in this way from USAID assistance found they needed to develop innovative strategies to ensure continued contraceptive security and rational use of available resources in the absence of donor support. This led family planning organizations to find ways to mobilize all potential sources for procuring and providing contraceptives, including public-private partnerships, the development of large networks for economies of scale, and community-based distribution of family planning commodities.

### Key Challenges

**Bolivia**—In Bolivia, health outcomes vary widely between urban and rural areas and indigenous and non-indigenous populations. In the mid-1990s, the government embarked on the process of decentralizing health services to help address these inequities and, in a major push, established a universal insurance package for basic health services to be delivered at the municipal level. In January 2003, this program was expanded to cover health services for pregnant women and children under five. While the introduction of health insurance has improved equity and access to health care, it also threatened the sustainability of family planning/reproductive health NGOs, which were suddenly on a reimbursement schedule that did not cover their costs. The USAID/Bolivia Mission requested LMS to strengthen the institutional capacity of Centro de Investigación, Educación, y Servicios (CIES), Bolivia's International Planned Parenthood Foundation affiliate, and to improve its financial sustainability. Founded in 1987, CIES provides reproductive health services in nine clinics throughout Bolivia.

*“Without a doubt, the technical assistance of MSH has been fundamental to our institutional development and results achieved by APROFAM.”*

—Carlos Bauer, executive director, APROFAM

**Guatemala**—Asociacion Pro-Bienestar de la Familia (APROFAM), founded in 1964, is a nonprofit organization and member of the IPPF. APROFAM is a leading provider of family planning/ reproductive health, maternal health, and child health services in some of the country’s most underserved rural areas. The organization provides low-cost, quality services to low-income populations through a network of 32 health clinics and 4,000 rural health workers working across the country’s 22 departments. The LMS intervention began by providing limited technical assistance to APROFAM to address the challenges of modernizing its organizational structure, compensation performance plan, and professional review template. Later, when the Observatorios en Salud Reproductiva, a constituency of civil society organizations monitoring the equity of reproductive health in Guatemala, encountered similar challenges in building sustainability, LMS efforts expanded to include this network.

**Honduras**—Honduras is on course to graduate from USAID family planning funds in five years. LMS has been working with the Local Technical Assistance Unit (ULAT), improving their capacity to provide quality, results-based consulting services to the Ministry of Health. ULAT is implementing a strategy to institutionalize family planning services in all health facilities, build capacity, and strengthen clinical services. In addition, the strategy focuses on improving the contraceptive logistics system and increasing demand for FP services. To address these challenges, LMS/ULAT has worked within all levels of the health system, including the Health Secretariat/Ministry of Health, ASHONPLAFA (Honduran Association for Family Planning, an IPPF affiliate), and the Honduran Social Security Institute, as well as the network HONDUSALUD, a group of NGOs and CSOs working in health in Honduras.

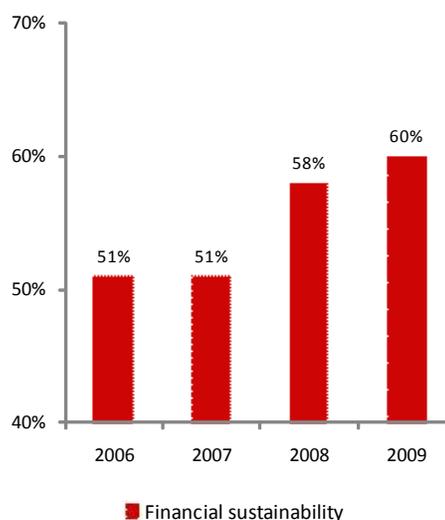
Despite the complex local context in each country, all programs were struggling with common weaknesses such as governance challenges at the national level; limited coverage areas, especially in the poorest, most vulnerable areas; weaknesses in organizational structure and financial instability.

## The LMS Approach

To increase the sustainability of these family planning/reproductive health networks, LMS programs in the three countries relied on targeted interventions under these umbrella approaches:

- **Focus on health outcomes:** The networks were able to redesign their managerial approach to improve sustainability while keeping their focus on the end health outcomes of improving family planning and reproductive health services.
- **Practice leadership at all levels:** The strategic planning process involved inputs and support from actors at all levels and in all areas in order to be sustainable.
- **Everyone can learn to lead:** Recipients of technical assistance in Bolivia and Guatemala were taught leadership skills that could be applied directly to their daily work and encouraged to design strategic lines for the redesign of their organization.
- **Sustain progress through management systems:** By investing in business, marketing and strategic plans, as well as new structures, new governance mechanisms, and new information systems, the networks were able to integrate leadership and management practices into their organization’s routine systems and processes, increasing the long-term outlook for sustainability.

**Figure 13. Financial Sustainability of CIES – Bolivia**



## LMS Interventions

**Bolivia**—LMS has worked with CIES to implement several tools to strengthen the organization and improve its financial sustainability including the LMS Work Climate Assessment, MSH’s Cost Revenue Analysis (CORE), the Business Planning for Health program, and human resources manual and training program. LMS has also supported a series of workshops for the CIES staff to enhance leadership skills, incorporating areas of change management, negotiation, strategic thinking, and motivation. These tools and workshops have promoted CIES to update its mission, structure and strategies in a new strategic plan for 2007 – 2011. LMS has also worked with CIES to develop monitoring dashboards, which are featured on the CIES website to monitor the results of services offered.

**Guatemala**—LMS worked with APROFAM to design and implement a strategic plan (2005 – 2009), as well as a Board of Directors Administrative Manual, a communications system for work groups, and a variable compensation scheme for all personnel. Another key intervention included the redesign APROFAM’s organizational structure, through a participatory process involving the management team, aimed at preparing the institution for a new growth and development phase. For the Observatorios en Salud Reproductiva (OSAR), LMS organized an intensive three-day workshop, where participants drafted a shared mission, vision, and strategic objectives, which were all subsequently incorporated into a central strategic plan to be utilized by all OSARs as part of its sustainability plan.

**Honduras**—LMS interventions with the HONDUSALUD network have focused on improving the organizational structure of its board of directors, and implementing management systems to ensure organizational sustainability. It has also worked to design a community component for the National Health framework. This work complements LMS work with the health secretariat, which has included the adaptation and application of the country’s “strategic methodology of family planning services” as well as the design and implementation of an automated system for inventory management, and a strategy to increase family planning coverage in rural areas.

## Key Results

### Bolivia

- CIES achieved IPPF affiliate status in May 2008 by successfully meeting 97 quality standards, building on years of collaboration since the MOU was first established between the organizations in 1995.

- CIES was certified by domestic and international bodies (CEE, UNFPA, PROCOSI)
- All nine regional offices (including the national office) of CIES now have an operating quality assurance system.
- A web-based management dashboard is now used to track key performance and financial indicators on a monthly basis by senior management.
- Operation expenses were reduced by nearly 50% due to analysis, control and monitoring.
- Approximately 20 new services were implemented/offered either in all regions or tailored to the needs of the regional population, including: 4D sonography, educational services in alliance with microfinance organizations and universities, health services for men and adolescents using an adolescent service model, and Voluntary Testing and Counseling for HIV.

### Guatemala

- Forty-seven senior leaders of APROFAM, including 26 women, have been trained in leadership and management development.
- After reorganizing their organizational structure, APROFAM’s Board of Directors and Executive Director completed the LMS Virtual NGO Board Governance course, resulting in a formalized division of roles and responsibilities, the creation of an annual calendar of board activities, and a draft policy on transparency and accountability.
- APROFAM has made substantial progress in increasing the effectiveness of the rural development program, improving institutional sustainability, strengthening governance and transparency, defining board and management roles, and designing a dashboard to facilitate monitoring and continuous improvement of senior staff performance.
- Twelve participants from eleven different departments of Guatemala have been trained in strategic thinking and planning.

## Honduras

- HONDUSALUD: Results for LMS' work with this network are still in progress, through a project currently underway that is organizing the board of directors and implementing a management system. The LMS/HONDUSALUD designed community component for the National Health framework is in the final phase of design and validation.
- The project has also achieved results in the family planning area outside of its work with the network. With the health secretariat, this includes:
  - » The application of the "Strategic methodology of FP services," despite myriad challenges resulting from the temporary suspension of support to Honduras (due to the coup d'état in 2009).
  - » The purchase of approximately \$2 million in contraceptives (with the exception of 2009, when funds were approved, and an agreement with UNFPA was signed, but the transfer wasn't made to UNFPA due to the political situation).
  - » A strategy to increase family planning coverage in rural areas is now in the final phase of development.

## Lessons Learned from LMS work in Latin America with Family Planning/ Reproductive Health Networks

**Without a strong organizational foundation in place, networks, NGOs, CSOs and other organizations will not readily adapt to change.** All of these cases demonstrate the importance of building a strong organizational foundation, replete with a focused board, a sound strategic plan, functioning management systems, and leadership practices that permeate all levels of the organization. Only with the foundation in place can an organization respond to changes such as national insurance schemes, a national strategic methodology, or challenges such as a need to expand services.

**LMS approaches and tools are adaptable across many countries and cultures.** The system of variable compensation developed for APROFAM could be modified and adapted for any IPPF affiliate. The strategic plans developed for the different networks varied in scope and breadth, but were appropriate for local context and resources.



## Tanzania's HIV Affected Elderly Coming out from the Darkness

Their stories are darkly similar. Sofia's only son died from AIDS just a year after his wife, and now Sofia raises their only child. Her neighbors refused to speak with her because she had "AIDS in her house." Adija, 60 years old and a widow, is raising her three grandchildren, their parents having succumbed to AIDS years ago. Monaisha's daughter died shortly after giving birth, leaving a nine-month old grandchild. Hadija's daughter died during childbirth, leaving the newborn and three other grandchildren in Hadija's care. Selina is raising her five grandchildren, two HIV positive, struggling to come up with school fees for them each year. Seeing these situations firsthand, several organisations working in the area asked: "What can we do?"

Tanzania's population over the age of 60 is estimated at more than 1 million. Of these, roughly half have been affected by HIV in some way.

The Kilimanjaro NGO Cluster on HIV/AIDS and Reproductive Health Interventions (KINSHAI) is an "umbrella" organization that unites 60 small CSOs that all work in the area of HIV/AIDS and reproductive health. In 2006, KINSHAI led a partnership to implement an RFE-funded project aimed at elderly persons affected by HIV in the Same and Hai districts of Kilimanjaro Region. Eight support groups were established, each limited to an initial membership of 25. All the initial members were at least 60 years of age and caring for at least one child orphaned by HIV/AIDS.

From each of the groups, four individuals were trained by KINSHAI to provide peer support. This support included HIV/AIDS information such as preventing infection when providing home-based care to someone living with AIDS.

The transformation in the targeted districts was dramatic. Each initial group of 25 members has more than doubled in number. People too young to qualify and others with no link to HIV/AIDS also joined to show support and for the social aspects. "Before, it was like living in isolation," Sofia explains. "But now I feel like a member of the community."

"This project has given these people a sense of hope," explains Francis Selasin, the project officer. "It has also raised the profile of the partner organizations involved." For many of the members of these groups, the partnership led by KINSHAI "has been a gift from God."

## 4.5 Integrating Leadership & Management in Service Delivery Programs

### LMS in the Democratic Republic of Congo and Nigeria

Throughout the life of the project, LMS has worked with health organizations and institutions in the public and private sectors to build leadership and management practices, strengthen management systems, and prepare staff at all levels to respond to change, all in an effort to enable these organizations and institutions to deliver quality services and contribute to improved health outcomes. The examples of LMS' work in the Democratic Republic of Congo (DRC) and Nigeria provide vastly different contexts in which to examine efforts to use leadership and management development to strengthen ownership and scale-up of service delivery programs while at the same time contributing to improved health outcomes.

#### Key Challenges

The Democratic Republic of Congo, formerly known as Zaire, is the third largest country in Africa by area, and has a population of approximately 66 million. In 1998 the Second Congo War began, devastating the country and killing over 5 million people, more than any other war since World War II. Many of the DRC health indicators are worse today than they were in 1990. The government's 2005 Health System Strengthening Strategy makes health zones the entry point for all health interventions, but the concept of provincial and zonal management of health services is a new one, and the government does not have the resources to fund the health care system at adequate levels. Donors are attempting to fill the gap, but each health zone is supported by a different donor and a variety of different FBOs and NGOs deliver services, exacerbating the problem of a fragmented, uncoordinated health care system.

On top of this, health workers and district/zone staff are demotivated by low salaries, poor working conditions and the lack of equipment, drugs and medical supplies. The local communities are discouraged from seeking health care and from playing an active role in managing the health facilities by lack of basic services provided and the low quality of care, which in turn makes it harder for the health system to function effectively. Challenging transportation logistics only make the situation more difficult.

*In both the DRC and Nigeria, capacity building at the local level—focusing on the LMS principle that everyone can learn to lead—was a key approach. Both programs also leveraged the idea of partnership—at the community level in the DRC, and at all levels of the government in Nigeria.*

Contrast this with Nigeria, where a long period of stability has allowed the government to reenergize the entire health sector. Over 200 new health centers have been constructed in the past four years; another 200 are to be built during the next four years. A basic package of minimum health services and a national service statistics project have been established at those health centers, emphasizing a preventative strategy, including vaccinations, reproductive health, and other maternal and child health services. Of course, the country does have its health challenges: Among the most daunting of Nigeria's public health issues is HIV/AIDS. An estimated 2.95 million people in the country are seropositive, and only 35% of those eligible for treatment are receiving it.

#### The LMS Approach

While the LMS DRC and Nigeria programs had distinctly different goals, they both were geared toward increasing the utilization and quality of health care services. In the DRC, this involved the quantity and quality of the basic package of primary health care services for three million people, and strengthening the capacity of the Ministry of Health and NGO partners in the management and delivery of health services.

In Nigeria, the strategic objective of the AIDS Care and Treatment Project (ACT) was originally specifically geared toward HIV/AIDS and TB care and treatment services, while the follow-on Prevention Organizational Systems AIDS Care and Treatment Project (ProACT) added a focus on prevention, gender mainstreaming, and other areas such as maternal and child health, family planning, malaria and nutrition.

In both countries, capacity building at the local level—focusing on the LMS principle that everyone can learn to lead—was a key approach. Both programs also leveraged the idea of partnership—building partnerships at the community level in the DRC and, in Nigeria, strategically partnering with the government at all levels—federal, state, local, and community.

## LMS Interventions

### Democratic Republic of Congo

- LMS introduced the Fully Functional Service Delivery Point (locally known as FOSACOF), a methodology developed by MSH to give staff at hospitals and health centers the tools to improve the quality of service delivery and service management across a range of primary health care and infectious disease services. The FOSACOF was rolled out to approximately 115 selected health facilities between October 2009 and June 2010.
- The project implemented a Leadership Development Program with teams from all 23 health zones and three health districts, to build leadership and management capabilities.
- The LMS project supported the Ministry of Health through training and provision of pharmaceuticals, medical supplies and materials. The key technical areas of focus for the project include:
  - » Strengthening integrated management of childhood illness (IMCI) as well a wide range of maternal and child health and family planning services through collaboration between health facility and community.
  - » Strengthening and expanding prevention, treatment, and care for TB and malaria.
  - » Promoting access to clean water and improved hygiene and sanitation through the “village assaini” (clean/healthy village) model.

### Nigeria

- LMS introduced a modified LDP in a reduced timeframe, with state level MOH staff and key stakeholders.
- The challenge model was applied at the facility level to increase TB detection.
- Technical trainings were offered in HIV/AIDS/TB testing, care, treatment and prevention for health care providers.
- Trainings in M&E Data Management (Data Clerk Volunteers) and Provider Initiated Testing and Counseling (PITC) were held for volunteers.
- 13 grants of \$10,000 were given to Nigerian CSOs working with HIV prevention, orphans and vulnerable children, and community home based care in support of their organizational objectives.



LDP workshop, Nigeria

## Key Results

### Democratic Republic of Congo

- From January to March 2010, 23,599 people in the LMS-supported health zones were counseled in family planning and 87% accepted a method. The total number of people counseled increased 77% from the previous quarter, made possible through the outreach activities of community health workers (more than 1,000 have been trained).
- The rate of births assisted by qualified personnel in LMS-supported health zones was 94% in March 2010, up from 73% the previous quarter and 60% the quarter prior to that.
- The rate of coverage of prenatal care increased from 87% for October – December 2009 to 98% for January – March 2010, while the rate of postnatal consultations increased from 49% to 70%. These increases can be attributed to new awareness-raising activities by community health workers.
- The rate of treatment for children under age 5 with acute respiratory infections remains low at 45% due to shortages of antibiotics at the health centers, but the number of children treated nonetheless increased 27% (from 13,168 to 16,717) from Oct – Dec 2009 to Jan – Mar 2010. The rate of treatment of childhood diarrhea is similarly low at 39% but the number of children treated increased even more dramatically, by 73% (from 6,492 to 11,242).
- The number of children under 5 treated correctly for malaria increased by 46%, from 25,427 for October 2009 – January 2010 to 35,227 for January – March 2010. This can be primarily attributed to availability of medicines supplied by the project, as well as to trainings conducted on proper management of malaria.

- While the FOSACOF approach is so far only being piloted in 115 selected health facilities in the LMS zones, it is already proving to strongly contribute to improving the quality of health services in the selected facilities, and consequently increasing the use of such services. Results from the 10 follow-up evaluations that have been completed so far show that, after approximately six months:
  - » Across the nine areas measured (such as infrastructure and clinical quality), scores for the 10 health facilities increased by 13% on average (from 32% to 45%).
  - » Improvements were most marked in health facilities with the lowest starting points (two of the lowest improved over 30%).
  - » The final range of scores across the 10 facilities was 41% to 62% (compared to 22% to 45%).

## Nigeria

Under LMS' ACT Project, concluding in July, 2009:

- 144,643 people were tested for HIV/AIDS and received their results, including 30,260 pregnant women
- 3,265 patients were newly initiated into antiretroviral therapy
- During this period 93,739 tests were performed for HIV, TB, and syphilis
- 2,745 OVC were provided with services
- 570 HIV positive patients received TB treatment
- 399 pregnant, HIV+ women received ARV prophylaxis

Under LMS' current ProACT Project, between August, 2009 and March, 2010:

- 85,496 people were tested for HIV/AIDS and received their results
- 2,858 patients were newly initiated into antiretroviral therapy, including 147 children
- During this period 45,199 tests were performed for HIV, TB, and syphilis
- 1,165 OVC were provided with services
- 2,226 patients were tested for HIV/AIDS and received their results in a TB setting
- 186 HIV positive patients received TB treatment
- 27,072 pregnant women were tested for HIV, counseled and received results
- 327 pregnant, HIV+ women received ARV prophylaxis

## Lessons Learned from LMS Work in Service Delivery Programs that Integrate Leadership and Management

### Managers who lead improve health services.

Strengthening leadership and management practices and improving health management systems, when done effectively, contribute to improved health outcomes.

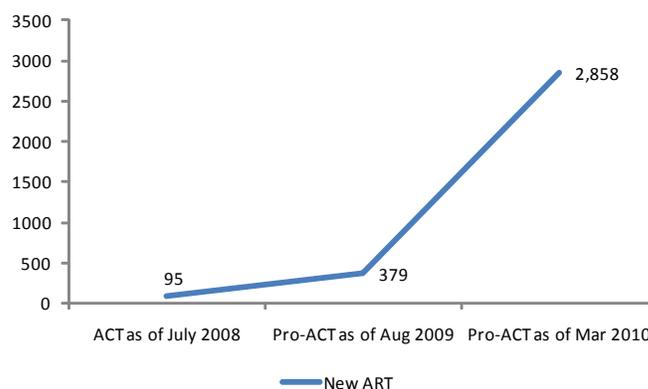
### Multiple pathways exist from leadership and management to improved health service delivery and outcomes.

Strengthening the ownership and scale-up of service delivery programs is just one method; another is to empower communities to create health service demand.

### Integrating leadership and management development can play a significant role in scale-up of service delivery for vulnerable populations.

By standardizing key management systems including human resources, work plan development, operations, and financial management of both public and private groups, the LMS Program in Nigeria continues to expand and solidify HIV/AIDS services.

**Figure 13. New ART Services Provided in Six USAID-supported States in Nigeria**



## 4.6 Strengthening the Oversight of Global Fund Grants

### LMS in Cote d'Ivoire, Nigeria, Tanzania, and Zanzibar

From June 2006 through December 2007, the Office of the Global AIDS Coordinator (OGAC) provided funds to LMS to undertake a pilot program of emergency technical support to countries receiving grants from the Global Fund to Fight AIDS, TB and Malaria (Global Fund). The countries included Cote d'Ivoire, Guinea, Honduras, Nicaragua, Nigeria, Pakistan, Mainland Tanzania, and Zanzibar. In addition, LMS received longer term field support funding from USAID missions through 2010 to continue working with Country Coordinating Mechanisms (CCMs) in Cote d'Ivoire, Nigeria, Tanzania, and Zanzibar to strengthen governance and oversight of grants.

### Key Challenges

In general, Global Fund projects encounter barriers to grant implementation because of issues with partnership, project management, financial management, human resources, and drug procurement issues. In working with the CCMs, LMS identified a number of challenges with leadership, management, and governance. Common problems included:

- Failure of the CCM membership to work together as an effective body due to conflicting perspectives of civil society and government members
- Lack of clear processes and responsibilities for oversight
- Conflicts of interest when CCM members, Chairs or Vice Chairs are representatives of Principal Recipient (PR) or Sub-Recipient (SR) institutions
- Excessively voluminous, non-quantified, and tardy reporting to the CCM

*“They went from being a chronic non-recipient of GF monies to a recipient three years in a row. The [Cote d'Ivoire] CCM is one of the rare African CCMs that has a budgeted workplan and effectively carries out its leadership role by regularly monitoring GF grantees' activities.”*

—PEPFAR review team

### The LMS Approach

With CCMs LMS worked on problems of leadership, management and governance in parallel based on the five functions of a CCM, which are as follows:

- The organization and functioning of management and support structures
- Harmonization of grants
- Proposal design
- Oversight of grant implementation
- Communication

Particular emphasis was placed on development of simplified information tools and mobilizing technical expertise to help the CCM in the long term.

### LMS Interventions

To provide support, LMS established consultant teams with English, French, Portuguese, and Spanish language capacity; English and French were the pertinent languages for Cote d'Ivoire, Nigeria, Tanzania, and Zanzibar. LMS Global Fund Support Program specialized in strengthening Global Fund CCMs, Principal Recipients, and Lead Sub-Recipients; arranging and coordinating partnerships; financial and project management; and technical assistance with work planning, budgeting, monitoring, reporting, governance, and leadership.

### Key Results

#### Information/Assessment Capacity

One of the chief obstacles to oversight and effective decision making for these multi-sectoral bodies was the lack of effectively presented information. LMS successfully introduced CCM and principal recipient dashboards to address this challenge in Nigeria, Tanzania, Zanzibar and, most recently, in Cote d'Ivoire, which led to improved oversight of grants and resolutions to problems in implementation. MSH's Grants Management Solutions Project reached agreement with the Global Fund to launch the development of a generic grant dashboard in 2009.

#### Policy Formulation and Planning

Country Coordinating Mechanisms and National AIDS Commissions receiving LMS technical support now have approved planning and budgeting processes documented in governance and operations manuals. Tanzania's Conflict of Inter-

est policy appears on the Global Fund website page for CCMs as a “good practice” document. This conflict of interest policy has served as a model for transfer to other countries via the work of the MSH GMS Project.

### **Social Participation and System Responsiveness**

CCMs receiving technical support have improved representation from the civil society sector as a result of membership renewal in several programs. The Cote d’Ivoire CCM intervention led to the CCMs voting on a broad program of reform to make them more representative, transparent, and participative. In Cote d’Ivoire, LMS’ flagship LDP was adapted for the CCM to engage CCM members using a transformative process over a period of time, and to provide them with tools for action within their committees to improve oversight, proposal development, communication, and M&E.

### **Accountability/Regulation**

LMS provided technical support to CCMs for developing:

- By-laws, transparent membership election procedures, and conflict of interest policies that have brought supported CCMs into compliance with Global Fund guidelines;
- Governance and operations manuals that have established clear accountability for functioning and clarity with regard to partnership arrangements and responsibilities;
- Structures such as oversight and M&E committees that have enabled CCMs to more effectively carry out grant oversight functions.

In July 2009, the Cote d’Ivoire CCM received official legal status as a non-governmental organization affiliated with the Ministry of Health. After LMS technical support, the CCM was awarded two Round 9 awards at \$181 million for HIV/AIDS and \$49 million for TB.



At CCM support workshop, Cote d’Ivoire

*In Cote d’Ivoire, results have been significant: after LMS technical support, the CCM was awarded two Global Fund Round 9 awards—\$181 million for HIV/AIDS and \$49 million for TB. It can now focus on the important work of monitoring and evaluating grant performance, to ensure high quality programs are offered to better serve the people of Cote d’Ivoire.*

### **Governance in the context of the Global Fund**

**Tools and approaches to strengthen good governance of Global Fund Grants can be successfully transferred from one country to another.**

The executive dashboard first developed for the Global Fund in Nicaragua was then transferred to Nigeria, Tanzania, Cote d’Ivoire, and Zanzibar. Through the Grants Management Solutions Project (GMS), the dashboard as an oversight tool has been mainstreamed within the Global Fund as a recommended best practice. The Leadership Development Program that was used to strengthen governance in Peru, Egypt and Afghanistan was successful in inspiring the CCM members in Cote d’Ivoire to work together and assume a national leadership role.

**Good governance is a front-end requirement without which programs may not exist at all.**

The ultimate desired end result is improved access to life saving health services and improved health. However, intermediate results in terms of improved governance structures, systems and performance of Global Fund multi-sectoral bodies are just as crucial. Without these tangible changes, CCMs risk losing their funding or not being funded at all.

**Good governance is a specialty area requiring its own technical expertise.**

The specific governance requirements of the Global Fund require technical expertise in Global Fund processes and requirements and knowledge of tools and approaches that promote accountability, transparency and social participation of multi-sectoral organizations. Immediate emergency technical support is required when Global Fund Grants are at risk of losing their funding, but for long term sustainability, CCMs need in-depth assistance in carrying out their five functions and capacity in leadership and management practices to enable them to do so.

## 4.7 Community Level Governance: LMS in Peru

In 2000, Peru began the process of decentralization and the health sector is the most decentralized to date. However, decentralization started quickly and proceeded in spite of weak capacity in many regions. A participatory community engagement strategy has showed promise for strengthening local governance, but change agents are needed to develop skills in leadership and management in order to mobilize resources and align community health needs with local and regional development plans.

### Key challenges

In 2006, LMS was asked to manage a project begun two years earlier under PRISMA called Healthy Communities and Municipalities Project (HCM). The objective of the HCM project is to improve maternal, child, and reproductive health of the communities that have signed coca-eradication agreements. The project focuses on lifestyle and behavior changes in the family, school, and health centers, and educating the whole community about prioritizing health in everyone's lives.

Although the participatory community engagement strategy showed promise for strengthening local governance, change agents were needed to develop skills in leadership and management in order to mobilize resources and align with local and regional development plans. Sustainability of the initiative could only be guaranteed through a process of embedding the program in municipal and regional health planning and linking it with quality improvement of local health services.

## The LMS Approach

The project worked to develop the capacity of leaders at all levels—family, community, health establishments, and throughout levels of the government—from the local municipal to the national level at the Ministry of Health.

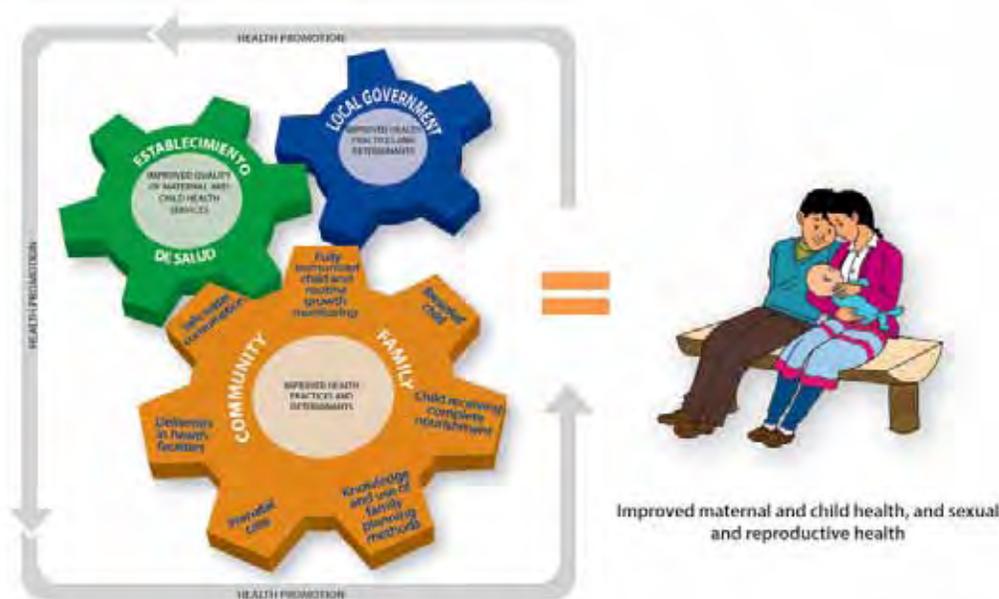
Leadership and management practices were integrated into the systems and processes of community development committees and local governments that worked with the project, an approach geared to sustaining progress through the various management systems.

## LMS Interventions

The HCM project created and offered continuous support to SISMUNI, a municipal public health information system. The HCM model enabled communities to monitor their own maternal and child health indicators, such as the number of adolescent pregnancies and the number of children consuming clean water. This information was inputted into SISMUNI so that local government could use it to create data-based development plans for their communities, without the need to rely on assistance from the central level of the government.

## Key Results

- HCM has expanded from its original 515 communities to 1,764 communities. All of these communities have held elections to name local members to Community Development Committees, whose members are responsible for carrying out the monitoring of maternal and child health indicators.



- 86% of communities participating in the program since 2006 have continuously applied a diagnostic tool to measure progress of key health indicators on a bi-annual basis.

## Lessons Learned about Community Governance in Peru

**Governance interventions work well in the context of decentralization.** HCM worked to develop the leadership and management capacities of community development committees, health establishment personnel, and municipal government authorities in order to mobilize them to oversee the health systems in their communities.

## One Small Community Rises to Become a National Model

Throughout Peru, the child malnutrition rate averaged 25% in 2007. In many rural and remote regions, that rate soars to over 50%. Yet in the small community of Almendras, made up of 40 families in a remote region of Northern Peru, none of the children under five are malnourished. In the past two years, every infant has been exclusively breast fed for six months, and all children under five are receiving five meals a day. What has brought about this change? One factor has been the community's early adoption in Healthy Communities and Municipalities (HCM) Project in 2005.

Almendras is one of 557 communities to voluntarily discontinue coca production in exchange for assistance in alternative crops and other development, including the HCM Project. The first phase of the project is to organize the community. In the first week of the program, eight families from Almendras signed on to the project. Through their example, another eight quickly joined in and soon every family in the community was taking part. "We prepared our own diagnostic plan, we organized and worked together to create improvement, and now we are monitoring the results," explained Ernesto Jesus-Perez, a member of the community among the first to participate. "The community no longer waits for an authority to help them. We have taken control of our development."

"We have achieved many improvements," Mr. Perez explained. "Before, diarrhea, stomach problems, and sickness were common. Now it's really rare for someone to be sick." Additionally, all three women who have become pregnant in the last year received full prenatal care and gave birth in a health facility. The

**Strengthening governance structures and systems is challenging.** This work is even more difficult in unstable environments, such as that of the Alternative Development Zone of Peru, where this program was first launched.

**Champions for good governance exist and should be nurtured.** The project organized visits by community leaders and district health managers from areas struggling with poor health indicators to districts that were successfully implementing the HCM strategy and seeing improvement in their health indicators. This approach has been integral in piquing the interest of new potential champions.



community health promoter has also given training in modern family planning methods to every woman of reproductive age. While some trainings in the methods are provided at the small health post in the community, the health promoters primarily rely on individual home visits, discussing the methods with both the wife and husband. "The change has been significant," the health promoter explained. "We had the family planning supplies in stock at the health posts, but no one used them. But in the past year, now there is steady use."

Almendras has become a "Model Community" for the HCM project. The mayor of Sapasoa (the town Almendras is a part) noticed the improvements immediately. "The change in behavior is amazing. I believe that development starts with the individual, and in these communities we have seen evidence of this. They've learned now to solve their problems, and how to best come to the municipality for activities requiring additional support."

# LMS Approaches at All Levels



*The Leadership, Management and Sustainability Program was awarded to MSH in August 2005 by USAID's Office of Population and Reproductive Health, in the Bureau of Global Health. LMS was focused on the following key result areas:*

- **Improving management and leadership of priority health programs.** *LMS worked to develop a critical mass of managers who lead at all levels of health systems to advocate for, and implement, inspired leadership and sound management.*
- **Improving management systems in health organizations and priority programs.** *LMS worked to transfer approaches and skills to organizations to ensure that management structures and systems contribute to sustainable organizational success.*
- **Increasing sustainability and ability to manage change.** *LMS enabled organizations and individuals to lead and manage concerted responses to complex health challenges at all levels in NGOs and the public sector, multi-sectoral bodies, national governments, and international agencies.*

As a result of the work undertaken in LMS' predecessor programs, the LMS senior leadership team believed that there were several root causes for the lack of attention and funding to prepare health leaders/managers to succeed in these important roles (see box to the right).

Through the M&L Program, MSH gained experience with and research on working with high-performing health managers. As a result of this work, MSH created the Leading and Managing Framework (Figure 7, next page), a model which embodies the practices necessary to develop leadership and management skills. It is used to help leaders manage complex systems; build leadership capabilities at all levels of their organizations; and capture, apply, and spread knowledge in the field of international health.

This section looks at the LMS approaches to developing leadership and management capacity. These included institutionalizing leadership and management into pre-service programs; building leadership and management capacity through in-service training; virtual approaches to reach more leaders and managers; organizational development and health systems strengthening; and advocating for leadership and management development.

## Root Causes of Lack of Preparation in Health Leadership and Management

- *The role of health care managers is not sufficiently valued.*
- *The costs of poor leadership and management are not clearly perceived.*
- *“Magical thinking”—presuming doctors and nurses are automatically good leaders.*
- *The roles of managers have changed, but their preparation has not kept pace.*
- *Effective ways of improving leadership and management skills were not previously clear.*
- *A predominance of vertical programs*

## Principles of Developing Managers Who Lead

LMS approaches were designed to focus on health workers, managers, and leaders—those at all levels within the system—and were based on the following principles:

**Focus on health outcomes.** Good management and leadership result in measurable improvements in health services and outcomes. Only by focusing on organizational challenges can managers develop their ability to lead.

**Practice leadership at all levels.** Good leadership and management can, and must, be practiced at every level of an organization. Working with their teams, managers can confront challenges and achieve results.

**Every person can learn to lead.** Leadership practices improve through a process of facing challenges and receiving feedback and support. By using this process, managers develop the leadership abilities of their staff.



**Leadership is learned over time.** Becoming a manager who leads is a process that takes place over time. This process works best when it is owned by the organization and takes on critical organizational challenges.

**Sustain progress through management systems.** Gains made in health outcomes must be sustained by integrating leadership and management practices into an organization's routine systems and processes.

Figure 14. Leading & Managing Framework

# Leading & Managing Framework

*Practices that enable work groups and organizations to face challenges and achieve results*

## Leading

### SCANNING



- Identify client and stakeholder needs and priorities.
- Recognize trends, opportunities, and risks that affect the organization.
- Look for best practices.
- Identify staff capacities and constraints.
- Know yourself, your staff, and your organization — values, strengths, and weaknesses.

**ORGANIZATIONAL OUTCOME:** *Managers have up-to-date, valid knowledge of their clients, the organization, and its context; they know how their behavior affects others.*

### FOCUSING



- Articulate the organization's mission and strategy.
- Identify critical challenges.
- Link goals with the overall organizational strategy.
- Determine key priorities for action.
- Create a common picture of desired results.

**ORGANIZATIONAL OUTCOME:** *Organization's work is directed by well-defined mission, strategy, and priorities.*

### ALIGNING / MOBILIZING



- Ensure congruence of values, mission, strategy, structure, systems, and daily actions.
- Facilitate teamwork.
- Unite key stakeholders around an inspiring vision.
- Link goals with rewards and recognition.
- Enlist stakeholders to commit resources.

**ORGANIZATIONAL OUTCOME:** *Internal and external stakeholders understand and support the organization's goals and have mobilized resources to reach these goals.*

### INSPIRING



- Match deeds to words.
- Demonstrate honesty in interactions.
- Show trust and confidence in staff, acknowledge the contributions of others.
- Provide staff with challenges, feedback and support.
- Be a model of creativity, innovation, and learning.

**ORGANIZATIONAL OUTCOME:** *Organization displays a climate of continuous learning and staff show commitment, even when setbacks occur.*

## Managing

### PLANNING



- Set short-term organizational goals and performance objectives.
- Develop multi-year and annual plans.
- Allocate adequate resources (money, people, and materials).
- Anticipate and reduce risks.

**ORGANIZATIONAL OUTCOME:** *Organization has defined results, assigned resources, and an operational plan.*

### ORGANIZING



- Ensure a structure that provides accountability and delineates authority.
- Ensure that systems for human resource management, finance, logistics, quality assurance, operations, information, and marketing effectively support the plan.
- Strengthen work processes to implement the plan.
- Align staff capacities with planned activities.

**ORGANIZATIONAL OUTCOME:** *Organization has functional structures, systems, and processes for efficient operations; staff are organized and aware of job responsibilities and expectations.*

### IMPLEMENTING



- Integrate systems and coordinate work flow.
- Balance competing demands.
- Routinely use data for decision making.
- Coordinate activities with other programs and sectors.
- Adjust plans and resources as circumstances change.

**ORGANIZATIONAL OUTCOME:** *Activities are carried out efficiently, effectively, and responsively.*

### MONITORING & EVALUATING



- Monitor and reflect on progress against plans.
- Provide feedback.
- Identify needed changes.
- Improve work processes, procedures, and tools.

**ORGANIZATIONAL OUTCOME:** *Organization continuously updates information about the status of achievements and results, and applies ongoing learning and knowledge.*

## 5.1 Institutionalizing Management & Leadership into Pre-Service Programs

As the demand to incorporate leadership and management into pre-service curricula grew, LMS drew upon its most experienced experts in leadership development to bring together stakeholders and design approaches suitable for the university environment. The results of the LMS Program's work in pre-service programs have been highlighted in section 3.3 on pages 30.

Successful leadership and management programs not only prepare future leader/managers, but also help them achieve significant advances in the outcomes of their health programs. As nations transform their health systems in the future, so too must their educational institutions adapt to best prepare their country's future leaders in health. The follow are the requirements for integrating leadership and management into curricula.

**Client's need and interest:** Look for client ownership of the process. If the program does not respond to an expressed need, you will not be successful. This includes support from senior leadership for the initiative including resource allocation.

**An internal champion:** It is critical to identify a person from within the institution who is fully committed to the idea and willing to lead the process of change and identify and overcome obstacles along the way.

**A curriculum integration team:** It is also critical to have committed faculty and teachers who will adapt and implement the new curriculum and work with the champion towards the formal adoption of the curriculum.

**A facilitator:** One staff person or consultant on the ground who can provide a local presence including ongoing support and offering direction to the curriculum integration team will keep things moving.

**Training of trainers:** Preparation of faculty and teachers is a key step to ensure they are committed, competent, and prepared to teach the new curriculum.

**Flexibility:** The leadership and management curriculum needs to be flexible to fit the academic institution's context.

**Build on what is already there:** It is important to build on the successes of the existing program; for example, building on an existing practicum or field component. If there is no field component, this becomes an opportunity to explore that option, thus enhancing the existing program.



## Success Story

### Preparing Future Doctors and Nurses to Lead and Manage

"I was appointed a district medical officer in 1993, straight from a surgery ward, and within a week I had to manage an entire district," explains Dr. Willis Akwahle, Director of the Malaria Control Program in Kenya. "It was a totally different world."

While the roles that doctors and nurses play in the delivery of health care in developing countries have changed dramatically, the preparation they typically receive in medical and nursing education has not kept pace. Second, the role of health managers is not as valued as the role of the clinical specialist. As Dr. Abdo Hassan Alswasy, a Consultant in Obstetrics and Gynecology in Aswan, Egypt, explains, "When I was in medical school, I thought my job would be to treat suffering people. I received no leadership and management training in medical school."

One way to increase the quality of management and leadership is to better prepare future health workers while they are still in pre-service training at medical and nursing schools.

In 2008, the School of Medicine at the Universidad Nacional Autonoma de Nicaragua worked with LMS to design a management and leadership course for fifth-year medical students. The course emphasized results-based planning, allowing students to work in teams and tackle a real-life health challenge. The first year of the program received positive feedback from the vast majority of students. One noted, "The course is giving us tools that perhaps we won't use directly with patients but we will need to be able to give patients better care and services."

After evaluating and revising the program, UNAN has now fully funded and institutionalized the management and leadership program into its regular curricula for medical students. Additionally, two other universities in Nicaragua have begun to replicate the course for their programs.

## 5.2 In-Service Leadership & Management Development

The LMS approach also included delivering accessible programs, networks, and tools for learning that provided a pathway for health professionals who have already launched their careers—and even those who are well settled into a career path—to learn new skills and apply them in their work. These included:

- **Leadership Development Programs:** Six-month, face-to-face programs for health teams to develop and implement a focused action plan to achieve measurable results. Facilitation and coaching is provided by MSH organizational development specialists.
- **Virtual Leadership Development Programs:** 13-week programs available in multiple languages for health teams to develop and implement a focused action plan. Facilitation is provided by MSH organizational development specialists.
- **Virtual Networks:** Multilingual online networks that host periodic seminars and conferences, allowing for cost-effective worldwide knowledge exchange in priority health management and leadership issues.
- **Virtual Resources:** The Health Manager's Toolkit is a comprehensive, multilingual electronic library of tools from MSH and other organizations that help build knowledge and skills in leadership, management, and governance. LMS also launched a new resource, *Health Systems in Action: An eHandbook for Leaders and Managers*, in May 2010 at the LMS End of Project Conference. To view this publication, go to: <http://www.msh.org/resource-center/health-systems-in-action.cfm>.

Participation in the leadership programs has more than doubled since they were first launched under M&L in 2002. Membership in the virtual networks has increased more than 13-fold to 8,000, with the average number of participants per seminar steadily increasing over time.

### The Leadership Development Program

The Leadership Development Program helps organizations to develop managers who lead with a vision of a better future. The LDP can be used in any type of organization—private and nonprofit; district level ministries; at the clinic level. It works on the premise of developing managers at all levels. The program has three major learning objectives for participants:

- Learn the basic practices of leading and managing so that managers are capable of leading their workgroups to face challenges and achieve results;
- Create a work climate that supports staff motivation;
- Create and sustain teams that are committed to continuously improving client services.

Teams engage in the program over a period of four to six months. Teams discuss strategies for—and actively address—their challenges through all program activities. To help organize and support their work, five kinds of program activities are held:

- Senior alignment meetings, an initial meeting which generates commitment and ownership of the LDP among key organizational stakeholders;
- LDP workshops, a series of workshops during which participants learn core leading and managing practices and concepts;
- Local team meetings, on-the-job meetings between workshops in which participants transfer what they learned to the rest of their work team, discuss strategies to address their challenges, and apply leading and managing practices;
- Regular coaching, in which local health managers support the teams in implementing the tools of the LDP;
- Stakeholder meetings, in which stakeholders are periodically updated and enlisted as resources to support the teams.

The LDP can be quickly integrated into an organization's daily work, as it focuses on real challenges in the work place. Teams choose their challenge based on current problems they face on a daily basis that is preventing them from achieving results. This allows them to immediately apply the leading and managing practices they are learning in the LDP workshops to real life situations.



Medical students at Makerere University, Uganda

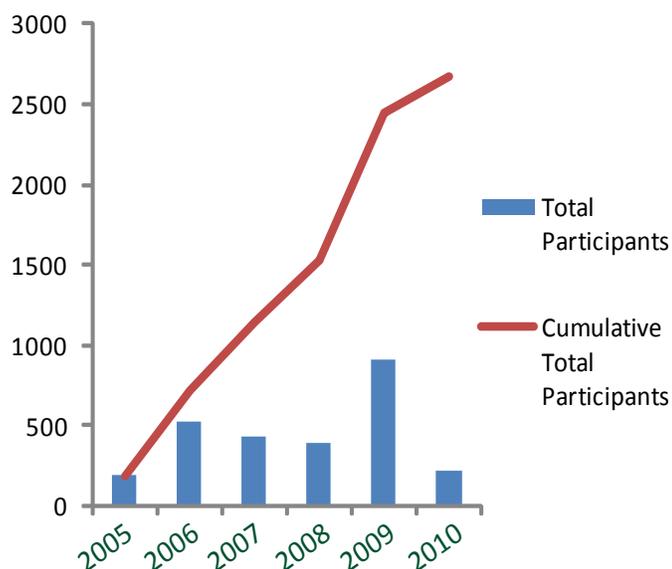
## Virtual Programs

Often, face-to-face capacity building approaches are not available to mid- and lower-level managers, women, marginalized populations, or in rural areas, and when they are available, they involve sending an individual health professional to off-site workshops and programs for periods ranging from one day to two to three weeks. This can be slow and costly, and may disrupt health service delivery.

When participants return from workshops to their workplaces, it can be difficult to transfer their newly acquired skills and knowledge to their colleagues and generate support for change. Other disadvantages of traditional approaches include a theoretical rather than practical focus, the participation of too few staff from the same organization, and the cost of these events.

The creation of the Virtual Leadership Development Program (VLDP) responded to these challenges, and contributed significantly to the scale-up of leadership and management approaches and tools under LMS. A single program offering can reach up to 120 people from as many as 12 different countries. LMS has also developed a number of other virtual programs, which continue to grow. Demand for virtual programs during LMS has increased approximately ten-fold since 2005, as shown in figure 8 below.

**Figure 15. Virtual Programs under LMS from January 2005 to January 2010**



## Virtual Networks: The Global Exchange Network for Reproductive Health and LeaderNet

Under LMS, access to state of the art family planning information and knowledge exchange opportunities, normally reserved for top leadership, was expanded through virtual conferences and seminars. In 2002, the vision of leadership in USAID's Office of Population and Reproductive Health was to keep countries that were "graduated" or "graduating" from population assistance connected with each other and current with the changing ideas and technologies in reproductive health. As a result, the idea of the Global Exchange Network for Reproductive Health was born.

This online network offers periodic, one-week online forums in English, Spanish, and French, to promote the exchange of information and proven practices on priority management, leadership, and governance issues in reproductive health and family planning. It also covers other USAID Global Leadership Priorities such as repositioning family planning, contraceptive security, and HIV and family planning services integration.

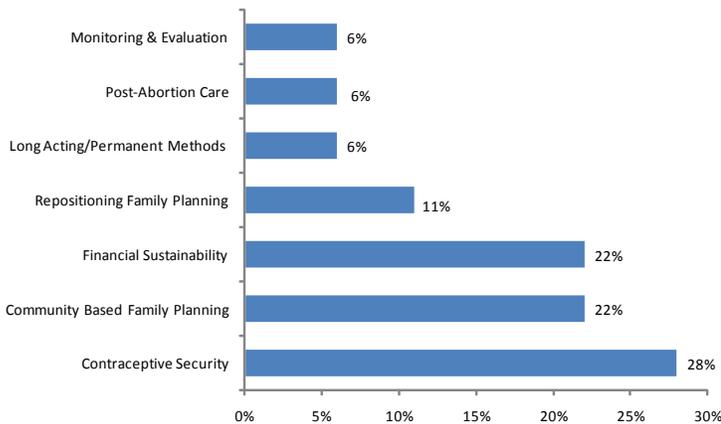
At the launch of LMS in 2005, the Global Exchange Network for Reproductive Health had just 294 members. As of March 2010, it had a total of 2,871 members from 133 countries in North and South America, Africa, Europe, and Asia.

A December 2008 survey completed by 264 respondents was used to assess and improve future Global Exchange Network for Reproductive Health offerings. Of the 264 respondents:

- Seventy percent (70%) reported using resources, knowledge, or practices from the Global Exchange Network for Reproductive Health in their work;
- Fifty-two percent (52%) reported making organizational improvements as a result of participating in the Global Exchange Network for Reproductive Health;
- Eighty-four percent (84%) reported reading/download-ing forum resources;
- Eighty-six percent (86%) would recommend the Global Exchange Network for Reproductive Health to a colleague.

Over 70% of survey respondents applied their learning to their daily work, indicating that these low cost virtual experiences play an important role in building the leadership and management skills of professionals, and strengthening the quality and sustainability of reproductive health and family planning services and programs.

**Figure 16. Global Exchange Network for Reproductive Health Seminar Themes**



Another global community—LeaderNet—focuses on issues of leadership and governance which managers face in their professional lives. LeaderNet seminars are multi-lingual, and are offered in English, Spanish, Portuguese, and French.

LeaderNet has seen rapid expansion since 2005. Attendance in seminars has increased from an average of 74 participants from 35 countries per seminar in 2007, to an average of 181 participants from 68 countries per seminar in 2010. Seminars are consistently highly rated by program participants.

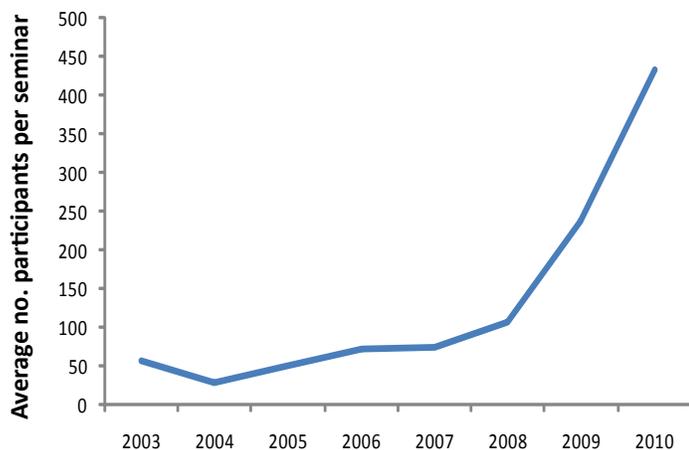
A survey conducted in 2009 documented leadership, management, and governance skills members learned during seminars and applied afterwards in their day-to-day work. Key findings from the 113 survey responses analyzed included:

- Seventy-one (71%) of seminar participants in “Performance-Based Financing of Health Services: Paying for Results not Processes” (May 2008) used the resources after the seminar. Of those, 30% met with stakeholders to discuss performance problems and desired results.
- Of those respondents who participated in the seminar “Moving up the Leadership Ladder,” 79% utilized the resources to identify their strengths and weaknesses as a manager to improve managerial skills.

## Survey Results of GEN Members (N=264)

- 70% reported using resources, knowledge, or practices from GEN in their work
- 52% reported making organizational improvements as a result of participating in GEN
- 84% reported reading/downloading forum resources
- 47% participated in GEN events by posting to the forum/seminar
- 84% and 74%, respectively, would like to continue to receive updated information on reproductive health and management skills from GEN
- 86% would recommend GEN to a colleague

**Figure 17. Average Number of LeaderNet Participants per Seminar**



## Approaches and Implementation of Leadership Programs under LMS

LMS relied on eight primary strategies to scale-up virtual and face-to-face management and leadership learning programs, virtual forums and virtual conferences during LMS:

### **Offer what health professionals want and need.**

A primary strategy was to shape content around the requests of health professionals from around the world. LMS continuously gathered information from program participants, MSH field offices, local organizations, and USAID missions related to requests for leadership, management, and governance technical assistance. Content was adapted to technical areas such as family planning, contraceptive commodity security, HIV/TB co-infection, and human resource management.

### **Base virtual content on successful, field tested approaches.**

LMS' virtual learning programs for leadership development, strategic planning, business planning, human resources management, and CSO board governance were all based on field applications. This approach shortened the development time of products and assured use of tested, quality materials.

### **Deliver engaging, relevant content that can be readily applied.**

The LMS programs and seminars stressed practical, action oriented activities so participants left with skills and tools they could apply immediately to enhance the performance of their organizations. Dynamic facilitators kept individuals and teams engaged and motivated, and acknowledged their progress toward completing program requirements.

### **Train new facilitators and develop the skills of existing facilitators.**

To deliver 14 virtual programs and 12 seminars and forums in one year, as LMS did in 2009, the LMS Scale-up team trained 43 new facilitators for virtual learning programs, bringing the total of qualified virtual facilitators in multiple languages to 49. Additional face-to-face facilitators, program managers and administrative coordinators were also trained to support these efforts.

### **Make improvements based on feedback.**

After action reviews follow the delivery of each program and seminar, and have proved valuable for identifying performance gaps and potential improvements from the perspective of both participants and facilitators.

### **Offer seminars in multiple languages simultaneously.**

By offering resources in multiple languages, and providing almost real-time translation of discussion posts throughout these seminars, health professionals were able to talk to each other asynchronously across time zones. One participant noted that the challenges being discussed were so similar, that it felt as if everyone was from the same country. Through this feature, participants realize the “answer is in the room,” meaning that instead of relying on experts to give advice, people learn from each other and develop confidence in their own solutions.



VLDP for HRM, Uganda

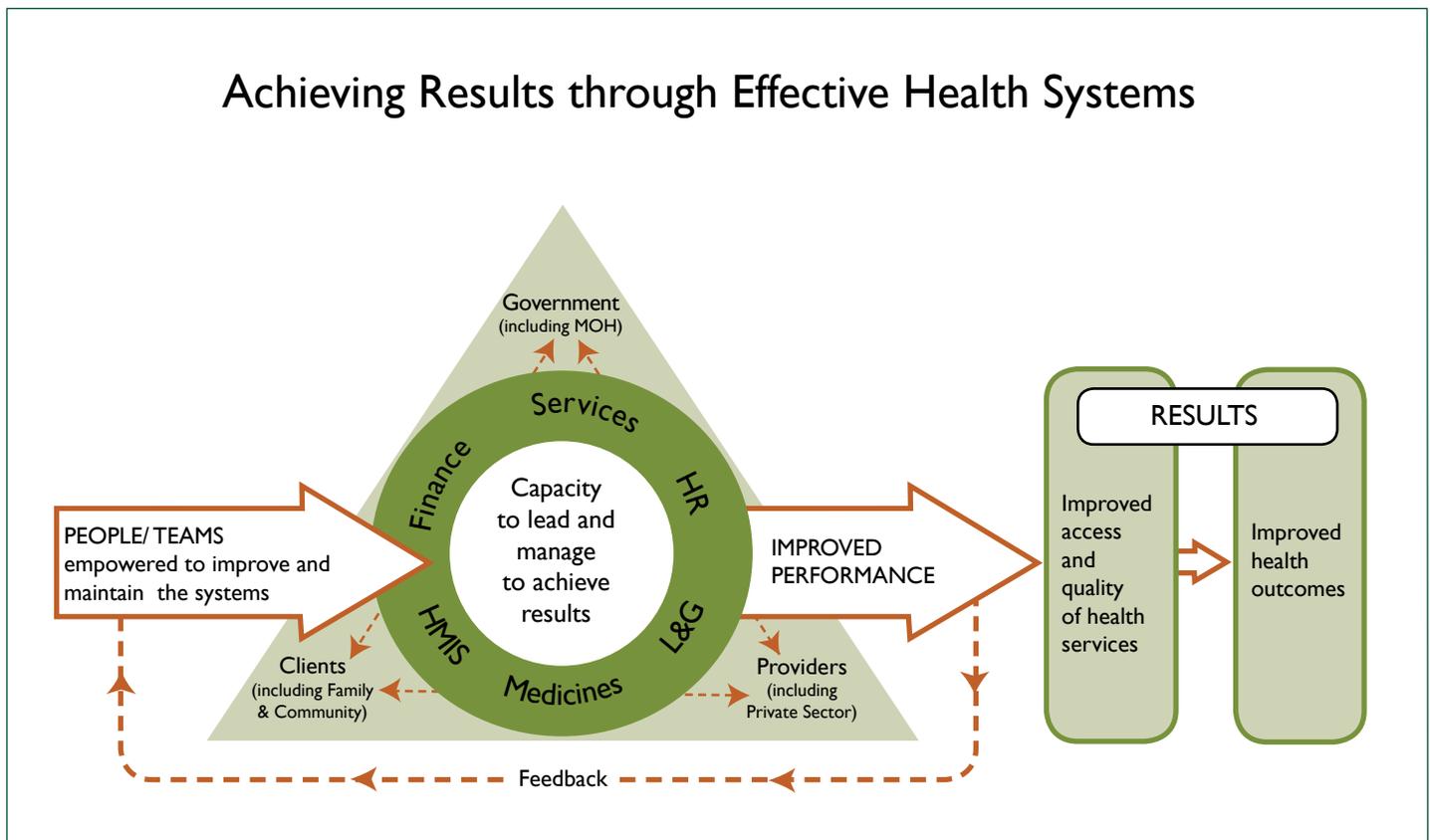
**Use a blended learning approach.** Blended learning is defined as the use of various learning methodologies and approaches. In LMS virtual programs, participants completed individual work on the website such as reading case studies, completing module exercises and self-assessments, and participating in online discussion threads. They also participated in face-to-face group meetings with their fellow team members to discuss what occurred in the module and conduct assigned group work. This approach strengthened teams by having them learn skills and solve challenges together.

**Partner with USAID projects, cooperating agencies, and other organizations.** By developing partnerships with cooperating agencies and other USAID-funded initiatives, LMS was able to maximize the USAID investment by combining LMS' strengths with the strengths of various partners to deliver more programs and seminars to teams and individuals.

## 5.3 Organizational Development and Systems Strengthening

One of the biggest challenges in a health care system is how to turn a demoralized or overworked and stressed staff into a proactive, motivated team focused on delivering quality health services every day. Weak management systems are major contributors to frustration and the sense of futility that countless professionals feel about not producing or not being able to effectively contribute to improved health outcomes. Under LMS, MSH and USAID made the case for putting people at the center of health systems strengthening interventions, since it is people who make support systems and service delivery happen.

**Figure 18. Health Systems Strengthening Model**



## A Framework for People-Centered Health Systems Strengthening

MSH has adapted the WHO building blocks and framework, making human capacity to lead and manage the health system the core of health systems strengthening. To achieve better health outcomes, all components of the health system must work together. Health systems that are able to respond to the needs of their clients and stakeholders require many successful components, including:

- Clinical and administrative personnel at all levels who have the knowledge, skills, and tools to lead and manage well to address challenges and achieve results;
- Clients who have adequate information to use health services and whose use is not impeded by poor quality, high fees, or gender barriers;
- Leadership and governance procedures and practices that engender commitment and accountability;
- Human resources policies and procedures that deliver a supported and motivated workforce;
- Financial management that allows managers, donors, and overseeing bodies to know about revenue obtained or generated, assets owned and expenses incurred, and how those results compare to previous years or planned results;
- Health Management Information Systems (HMIS) and associated monitoring and evaluation practices that facilitate effective problem-solving, informed decision-making, and formulation of policy based on evidence;
- Medical and health technologies delivered appropriately in the right quantities and at the right time and place.

To support capacity development in these areas, MSH developed a suite of program offerings, including the face-to-face and Virtual Leadership Development Programs. In addition, MSH developed virtual programs tailored to organizational development and health systems needs. These included the following:

- **The Virtual Strategic Planning Program:** a 17-week blended learning program that guides senior teams through the four basic questions of the planning process in order to produce strategic plans for their organizations. During the program, teams review their organizations' missions and visions, analyze their current situation, and define strategic objectives and strategies in order to achieve their organizational vision. Throughout the program, teams determine the mechanisms necessary to meet their objectives and implement new strategies, strengthening their ability to plan and to think strategically.

- **The Virtual Business Planning for Health Program:** a 20-week program that builds expertise in business planning. It covers topics such as capturing and packaging breakthrough ideas, identifying target markets and marketing strategies, and determining the best complement of staff to design and launch the new product or service. The program also helps NGOs navigate the financial aspects of a business plan, projecting both social and financial return on investment.
- **Virtual Human Resource Management Program:** an eight-week program designed for teams of HR managers, health program and operations managers who want to improve human resource management in their organizations.
- **Virtual CSO Board Governance Program:** an eight-week program designed for teams from civil society organizations including members on the board of directors, the executive director, and senior managers. The purpose of this program is to understand the board's roles, responsibilities, and main activities; ensure board accountability and transparency; and prevent conflict-of-interest situations.
- **Virtual Fostering Change Program:** This year-long program is an extension of the written publication, *A Guide to Fostering Change to Scale-up Effective Health Services*. Participating teams are guided through the change planning process for scaling up proven health interventions.

The evidence for the critical role of leadership and management in closing the gap between what is known about public health problems and what is done to solve them is growing.<sup>2,3,4</sup> The LMS Program's work in health systems strengthening demonstrated the need for strong leadership and management across all building blocks of the health system, not just the "leadership and governance" or "human resource" subsystems. Leadership, management, and governance are cross-cutting and essential to the smooth functioning of an institution, organization, or facility as well as to each management system.

<sup>2</sup> Frenk J (2010) The Global Health System: Strengthening National Health Systems as the Next Step for Global Progress. *PLoS Med* 7(1): e1000089. doi:10.1371/journal.pmed.1000089.

<sup>3</sup> Peters D et al. Improving Health Service Delivery in Developing Countries – From Evidence to Action. The World Bank. 2010.

<sup>4</sup> Dwyer J, Wilhelmsen S. Leadership and Management: The New Prescription for Health Systems Strengthening? *Global Health Magazine*. 2010.

## 5.4 Advocating for Leadership & Management Development

An important mandate of the LMS Program was to advocate for improved health leadership and management while demonstrating the links to improved health services. As LMS staff learned more about the realities of health managers in the field and what resonated with target audiences, the approach to advocacy evolved.

The LMS advocacy activities focused on three key groups: donors, technical assistance providers, and clients. The goal with donors was to increase the understanding of the impact of leadership and management on health care service delivery, so that donors would invest in this area. With technical assistance provided to clients, the LMS goal was to create champions who would further advocate for leadership and management technical support.

Advocacy efforts were designed to move target audiences along the continuum from awareness to action:



A variety of activities were employed to advance along this continuum, including presentations at key international conferences such as the Global Health Council Conference, the East, Central and Southern Africa Health Community Annual Minister's Meeting, and the International AIDS Conference. The LMS team also conducted outreach to the media as well as thought leaders in think tanks and other organizations that provide technical assistance. Between 2007 and 2010, LMS began experimenting with innovative ways of reaching out to potential champions using the LeaderNet virtual community of practice.

### Professionalizing Leadership and Management

LMS conducted a global survey in 2005 on leadership and management in international health care in order to document the realities of health leaders and managers on the ground. The results of this survey were used to inform an LMS publication, *An Urgent Call to Professionalize Leadership and Management in Health Care Worldwide*. This document served as a "manifesto" for addressing the root causes of a lack of attention to and investment in the preparation of health leaders and managers to succeed in these critical roles.

### Key Strategies in Advocating for Leadership and Management Development

- *Demonstrate link between improved leadership and management and improved health services*
- *Talk from the perspective of the health managers themselves*
- *Get hard data to reveal the realities of health managers to support key messages*
- *Design messages around root causes for lack of attention to leadership and management*
- *Create a shared vision for improved health results through stronger leadership and management*
- *Cultivate ownership via champions*
- *Demystify health leadership and management through proven pathways to develop practical skills and knowledge.*

Survey findings also led to recommendations for improving health leadership and management, such as merit-based promotions, civil service reform, focusing on standards, pre- and in-service training, and using virtual approaches to reach managers who do not typically have access to trainings. The Urgent Call provided LMS with voices from the field so the program could share the experiences of health managers in their own words. The Urgent Call publication was also shared with others through presentations at organizations such as the USAID Service Delivery Improvement (SDI) Division, the World Bank Human Resource Management and Reproductive Health Sections, WHO consultative meetings, and MAQ (Maximizing Access & Quality) Mini University.

## Leadership & Management by Design, not Default

One of the challenges in the work with professionalizing leadership and management was the vagueness of the term ‘professionalizing.’ The term means different things to different people, and was often interpreted differently from the meaning that LMS was trying to convey: ensuring that health management is seen as a valued, standardized profession.

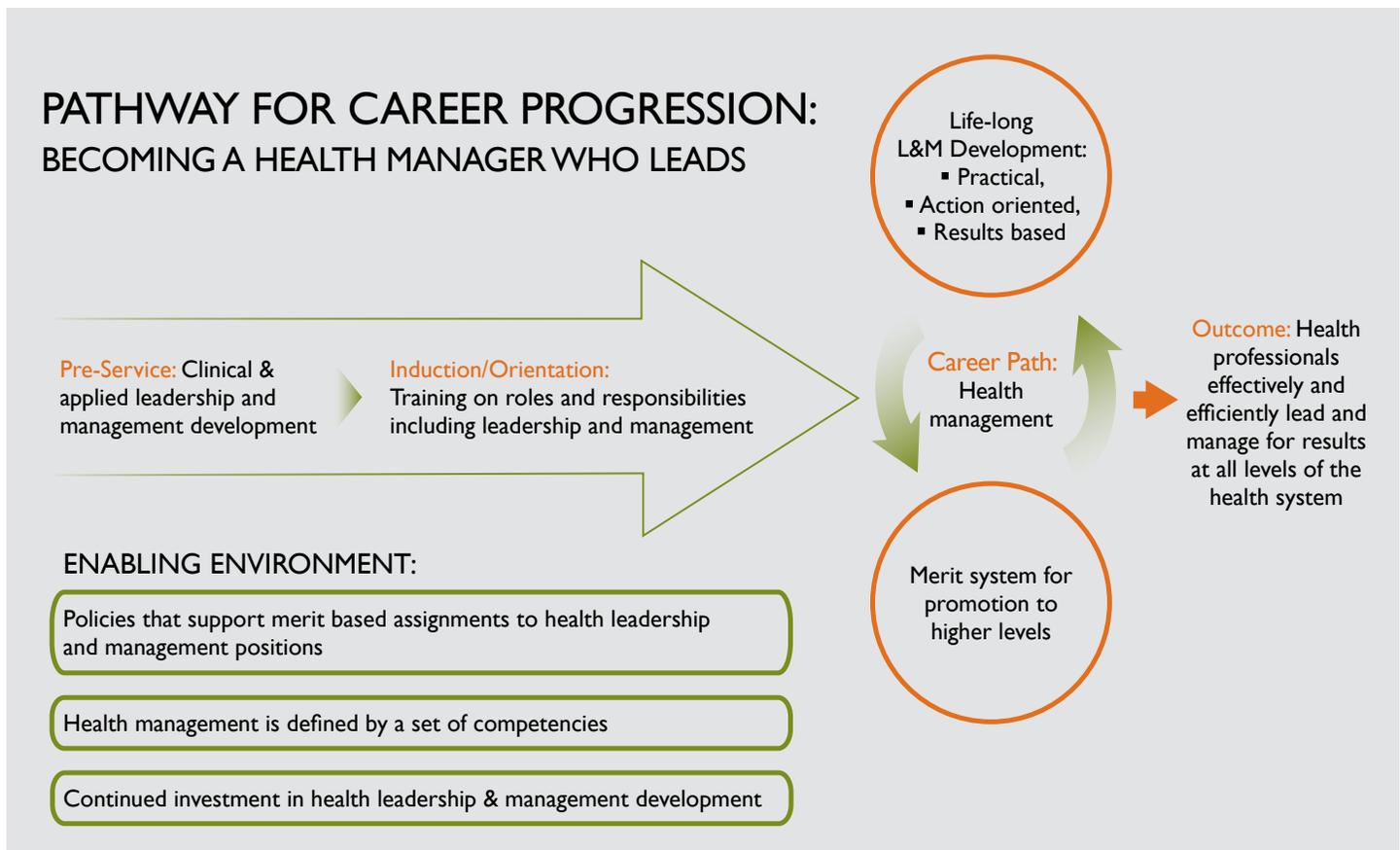
To advance this work, LMS proposed undertaking a small survey of health managers in Kenya to gain more knowledge about the realities of their professional lives. The local USAID Mission and the Ministry of Health saw the value in this information and decided to fund a national level survey in 2008. The survey focused on perceptions of the value of leadership and management, the preparation health workers including clinicians received in this area, and the challenges they faced on a daily basis. The findings of the survey provided additional evidence to support what was already well known to

LMS staff—health managers are frequently asked to take on leadership and management responsibilities that they neither want nor are prepared for.

The results provided LMS with a clearer understanding of how the various pieces of professionalizing leadership and management could come together—through career paths for health managers. LMS began to advocate a systematic approach: choosing interested health managers with high potential, providing them with leadership and management skills as well as with progressive opportunities to actually use them. To be successful, these health managers would require continued professional development to keep abreast of new issues in management and leadership. See an example of this career path in figure 12.

The idea of career paths for health managers provided a way to clearly express the need for the variety of interventions to strengthen health leadership and management through continual professional development—from pre-service education to retirement. This approach was previously discussed in section 5.1.

Figure 19. Career Path Model



## Lasting Impacts

In January 2007, the WHO hosted a Consultative Meeting entitled “Strengthening Health Leadership and Management in Low Income Countries.” Assembled at the meeting were a range of high level stakeholders from WHO headquarters and its regional and country offices, senior MOH leadership from several countries, the East, Central and Southern Africa Health Community (ECSA-HC), CDC, U.K. National Health Services, and the Gates Foundation, to develop a framework and strategies for supporting leadership and management capacity building in developing countries. As a result of the paper LMS released earlier that year, An Urgent Call to Professionalize Leadership and Management in Health Care Worldwide, MSH was the only U.S.-based NGO invited to attend to present its experiences in strengthening leadership and management. MSH and WHO continued to collaborate on similar efforts, such as at the ECSA-HC Minister’s Meeting.

LMS has also helped shape regional policy within Africa. With the support of LMS, the health ministers at the East, Central and Southern Africa-Health Community Ministers meetings adopted resolutions to strengthen leadership and management at the senior level and take a systematic approach to change processes during the 2008 and 2009 meetings. These resolutions were inspired by the outcomes of the Health Ministers’ Leadership Roundtable which LMS has been hosting at the minister’s meeting since 2006.



Coaching session at Makerere University, Uganda

*LMS’ work has shown that when the health managers and leaders who are responsible for running the health system have the skills necessary to make the system work effectively, then health results follow. If the people do not have the skills... health improvements will not happen.*

## New Areas for Advocacy

As a result of the efforts made by USAID’s Office of Population and Reproductive Health and many other organizations and individuals, there is now an increasing focus on the need for strong leadership and management in health. However, the work is not yet finished. The newest area for advocacy is for people-centered health systems strengthening. People make health systems work from the health manager who creates district reports on health needs using the HMIS system, to the HR manager who ensures that the clinics and hospitals in her province have the staff they need, and to the procurement officer who ensures that essential drugs are in stock.

LMS’ work has shown that when the health managers and leaders who are responsible for running the health system have the skills necessary to make the system work effectively, then health results follow. If the people do not have the skills to make the system work, health improvements will not happen, no matter how well designed the system is. The LMS Advocacy team is now integrating the ideas of leadership and management by design into discussions on health systems strengthening and the need for people-centered efforts.

Another area for future advocacy work will be with international professional associations such as the World Federation of Public Health Associations as well as national groups such as public health and hospital administrator associations. These associations are able to reach large numbers of health professionals and are organized bodies that can be a voice for health leadership and management. Many of them are also looking for networks to tap into that will provide activities for their members and ways to help their members improve the quality of support they receive. In order to have the necessary impact, health professionals from around the world will need to come together to make changes including policy changes that reflect the importance of leadership, management and governance within health systems, programs, and organizations. Developing the advocacy skills of health professional associations is one way to tap into this potential source of energy.



# Key Lessons Learned



*The LMS Program has made great strides in getting LMS interventions “out of our hands and into the world,” to scale-up the approaches and tools which have proven effective in strengthening management and leadership practices, building stronger health systems, and improving access and quality of primary health care services. This document continues the process by sharing key lessons learned that may impact future programming in leadership, management and governance.*

*The learning process was formalized through a series of strategic evaluations in the fourth and fifth years of the project. Carried out by the LMS Monitoring, Evaluation, and Communications Team, the internal evaluations offered a comprehensive, cross-program examination of select LMS field programs. In project year four, three studies analyzed programmatic results through the separate lenses of results in health service delivery, mainstreaming and scale up of proven leadership and management practices, and strengthening good governance in health. In project year five, the evaluations were updated and revised to include the most recent programmatic achievements, and a fourth study was undertaken focusing on the use of virtual approaches.*

*A few lessons learned have been presented earlier in section four, in the context of LMS country programs’ areas of accomplishment. The following pages cover the select lessons learned from the LMS strategic evaluations, and conclude with seven key “big picture” messages that MSH believes will be useful to development colleagues looking to carry out the next phases of leadership, management and governance work.*

## 6.1 How Strengthening Leadership and Management can Improve Service Delivery

The process of strengthening the leadership and management practices of health care practitioners is an important early step in improving service delivery. The LMS experience illustrates that strengthening these skills is a continuous process that must be maintained over time, supported by a good work climate and effective management systems. Evidence from Afghanistan (pages 46-48), the Democratic Republic of Congo (page 60), Ethiopia (pages 23-24), Nigeria (page 61) and Peru (page 25) demonstrate the link between improved leadership and management and improved health service. Key lessons in this area can be summarized as follows:

- Leadership development interventions play an important role in strengthening health systems, including service delivery improvements at any level of the system.
- Empowering communities through the strengthening of leadership, management and governance practices creates demand for health services that positively affect service delivery outcomes.
- A comprehensive approach for strengthening the management capacity of civil society organizations contributes to increasing and sustaining health services.
- Leadership and management development of CSOs and public health groups plays a significant role in achieving and sustaining health services for vulnerable populations.
- Short-term leadership development interventions can improve service delivery outcomes despite the complex environment that low-income settings present for the effective delivery of public health interventions.

## 6.2 The Role of Leadership and Management in Good Governance

The concept of good governance has gained prominence in development assistance over the past decade as the result of the growing emphasis on improving economic performance and poverty reduction in developing countries. LMS adapted the lessons learned from the L&M program to respond to this dynamic environment and, over the course of the project, gained additional insight into the connections between good governance, leadership and management and the health sector.



### *Developing Leaders to Expand Family Planning in Afghanistan*

Using skills learned in LMS's Leadership Development Program, Zakia, a nurse in Bamyan Province, led a team to help her health center increase the number of couples using family planning. Addressing challenges such as low awareness in the community, her team contributed to a doubling of the use of contraceptive pills and an eight-fold increase in the number of condoms distributed from 2007 to 2009.

"Everyone here no longer thinks of problems as obstacles in our way, but challenges we must face," says Zakia.

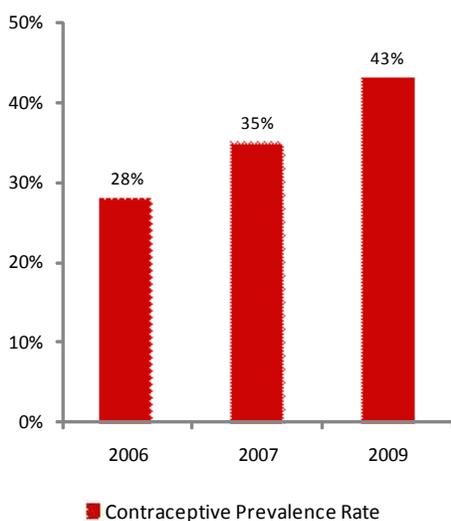
To facilitate achievements such as those of Zakia's team, LMS has also helped health facilities maintain adequate stocks of contraceptives and trained female community health workers to be knowledgeable in family planning services. LMS has contributed to an overall increase in the use of contraception in Afghanistan from 5 percent in 2003 to more than 40 percent today.

Key lessons in this area can be summarized as follows:

- Good governance can be developed at all levels of the health system. Although governance is often conceived as a senior level function, the LMS Program was committed to an inclusive model of governance in which individuals at all levels have a part to play, and civil society is an equal partner with government.
- Calls for good governance are not sufficient in the absence of supportive systems. Health managers need strong systems to withstand political change, and leadership and management skills for direction and accountability to exercise good governance.

- Governance is different from management. Oversight of good governance differs significantly from traditional management and monitoring and evaluation. Information tools developed for Global Fund CCM oversight under LMS highlight general progress and flag specific problems, but do not go to the level of detail required for routine management.
- Good governance interventions can be paired with health system reform. The empowering effects of leadership and management tools for multi-sectoral governance are useful for improving governance in decentralized health systems in which all decisions were previously made at the central level.
- Strengthening governance structures and systems is challenging, especially in unstable environments. Throughout the evolution of the M&L and LMS programs, the development community has been witnessing a paradigm shift in technical assistance with models such as the Global Fund increasingly placing the responsibility for good governance in the hands of the countries themselves, while at the same time requiring a degree of transparency and accountability that even developed countries can find hard to consistently achieve.

**Figure 20. Contraceptive Prevalence Rate in 13 USAID-supported Provinces in Afghanistan**



### 6.3 Mainstreaming and Scale-Up of Leadership and Management Practices

As noted earlier in section 3.3, a key mandate of the LMS program was to reach a “critical mass” of development practitioners

with new approaches and skills in leadership and management, so that these practitioners could bring about substantial, sustainable change in health practices and services. Among the key lessons learned in this area:

- For mainstreaming and scale-up strategies to be successful, they must be flexible and address local players and conditions. LMS learned that leadership and management capacity building can first be mainstreamed and scaled-up in one province or state and then be expanded to other provinces or states.
- A critical mass of practitioners can help sustain leadership and management practices regardless of political changes. The LMS experience illustrated that it was possible to create a mass of managers at the regional level – managers who were less likely to be ‘lost’ in a political transition – who were then able to continue to transfer knowledge to other local colleagues.
- There are challenges in partnering with both government and private institutions; the high rate of staff transfers and turnover at the ministry level affects long-term implementation. More effort needs to be made to find local partners who can promote leadership development, especially those that have the ability for successful scale up.
- Integrating new approaches to leadership and management skills building is most likely to happen when the approach allows the counterpart organization to achieve its own goals of improving organizational performance.
- The most common change made by groups who collaborated with LMS on leadership and management capacity building interventions was a renewed focus on achieving results and on achieving them through a participatory, transformative process that engages health workers at all levels.

### 6.4 How Virtual Approaches Scale Up Access to Leadership, Management and Governance Development

The need for capacity development in management, leadership, and governance is large, and using virtual technologies is a way to meet this demand. Throughout the eight years MSH has been delivering virtual programs focused on developing these skills, several key lessons have emerged:

**Table 10. Results from Latin America VLDP for Contraceptive Security, 2007**

Team	Challenge	Measurable Result	Indicators	Achieved by December 2007																		
Asociación Demográfica Salvadoreña (ADS)	How can we secure funding that will ensure access to education and to sexual and reproductive health services (including contraceptive supplies) for El Salvador's rural population, emphasizing teenagers and youth with limited purchasing power?	In December 2007, we will have \$640,000 to ensure family planning services and commodities for the population of fertile age in 640 rural communities in areas that ADS works in, an average of \$1,000 per community.	1) Percentage of financing obtained, with respect to the total amount desired (\$640,000) 2) Number of communities for which we have obtained financing, considering the average of \$1,000 per community.	The budget of the \$640,000 was approved in December 2007.																		
Centro Paraguayo de Estudios de Población (CEPEP)	How can we maintain the CYP produced by the PAC Program during 2006, taking into account the new tax status, declining donations, and increase in the population with limited resources?	Maintain the 7,490 CYP produced during the PAC program in 2006.	Number of CYP produced from January - December 2007 in the PAC program.	7,337 (98%)																		
Paraguay MOH	How can we ensure the availability and accessibility of the four contraceptives in the basic basket for groups of women and men from the country's 46 poorest districts, according to the IPG index?	By December 2008, 85% of the service points of the Ministry of Health in the 46 selected districts have the basic four contraceptives accessible and available.	% of stockout by method 100% of Human Resources leaders trained in CYP Dec. 2007	<table border="1"> <thead> <tr> <th colspan="3">% of stockout by method</th> </tr> <tr> <th></th> <th>Mar07</th> <th>Dec07</th> </tr> </thead> <tbody> <tr> <td>IUD</td> <td>9.5%</td> <td>3.9%</td> </tr> <tr> <td>Oral</td> <td>7%</td> <td>5.5%</td> </tr> <tr> <td>Depo</td> <td>15%</td> <td>7.9%</td> </tr> <tr> <td>Condom</td> <td>11%</td> <td>4%</td> </tr> </tbody> </table> <p>100% of Family planning Human Resources leaders trained in CYP Dec. 2007</p>	% of stockout by method				Mar07	Dec07	IUD	9.5%	3.9%	Oral	7%	5.5%	Depo	15%	7.9%	Condom	11%	4%
% of stockout by method																						
	Mar07	Dec07																				
IUD	9.5%	3.9%																				
Oral	7%	5.5%																				
Depo	15%	7.9%																				
Condom	11%	4%																				

- Successful programs are responsive to the needs and interests of participants. The LMS online programs and seminars were designed around needs expressed by LMS client organizations and partners, priority topics identified through workers in the field, and feedback from previous participants. One example of challenges and results, from a Virtual Leadership Development Program focusing on contraceptive security, can be seen in Table 10.
  - Measuring and reporting results can motivate participants. When teams set goals and achieve them, they are inspired to share their results with others, and to continue applying what they have learned.
  - Balance standardized and customized program content. While it is important to standardize programs to ensure quality and allow for easy replication, it is also necessary to be able to adapt these programs to the context and needs of client organizations.
  - Dynamic facilitation is a key to success. Participants will not stay engaged in a program or online discussion if the program is not dynamically facilitated by qualified facilitators.
  - The potential for using virtual approaches is growing. More about this can be found in the final section of this report, “Looking Ahead,” starting on page 89.
- 3. Multiple pathways exist from leadership and management to improved health services. LMS action-learning approaches include developing the leadership of health teams, empowering communities to create health service demand, increasing sustainability of service delivery programs and other methods.
  - 4. Good governance is about people and systems. LMS teams have helped developing country counterparts in the public and NGO sectors to establish systems that promote transparency, social participation, and accountability. However, individuals and teams have a limited capacity to support implementation. Developing good governance, like developing leadership capacity, is a process that takes place over time, where people are challenged, offered feedback, and given support throughout the change.
  - 5. Start developing managers early in their careers. The largest pool of potential health care leaders and managers are the students of today in medical, nursing and public health schools. The LMS experience demonstrates that it is possible to integrate leadership and management into the pre-service curricula of academic institutions. Due to the hierarchical nature of the university system, it often takes more time to integrate these practices into a curriculum. However, once they are integrated, this approach is highly sustainable.
  - 6. Virtual approaches address needs at scale. One way to reach many more organizations is to tap the power of information technology. Opportunity exists to innovate and expand virtual approaches using new methods as internet connectivity increases in the developing world, and as mobilization and support for strengthening health systems grows.
  - 7. Sustainability requires practical tools that empower people to act. Approaches and tools must be designed for people to use in their own settings, and they should be practical and action-oriented. Complex, proven practices can be distilled into simple, effective and user-friendly practices that contribute to achievements in service delivery.

## 6.5 Learning Across All Areas of Leadership, Management and Governance

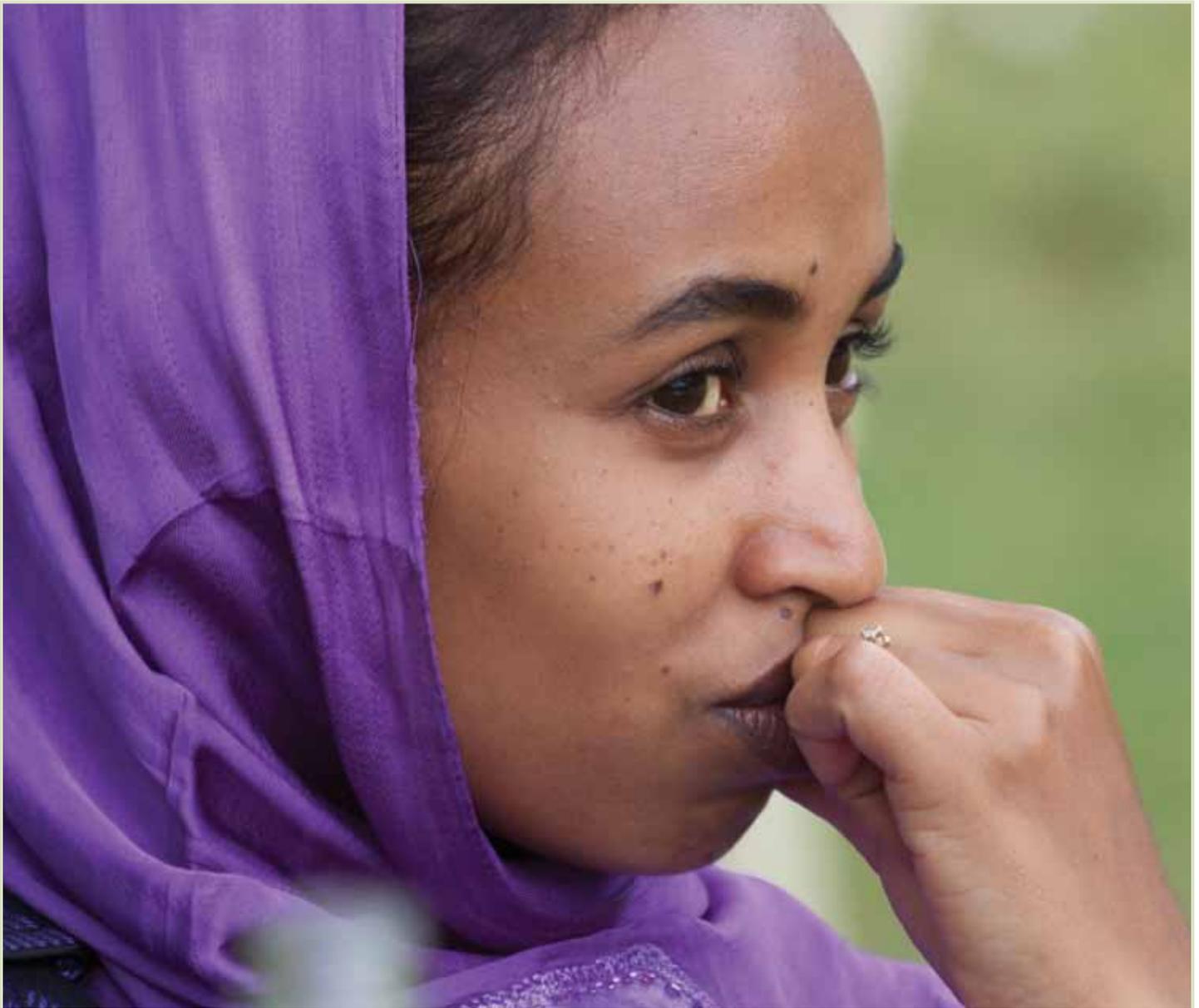
MSH has collaborated closely with USAID and other partner organizations to build the capacity and sustainability of health programs and institutions around the world over the course of several programs. The strategic evaluations performed during the LMS Program have helped crystallize much of the knowledge gained during this time. Seven “big picture” key messages can be drawn from the sum of all these experiences:

- 1. Managers who lead improve health services. Strengthening leadership and management practices and improving health management systems, when done effectively, contribute to improved health outcomes. The programmatic assessment of the impact of the leadership development program offered through LMS Kenya (see pages 50-51) offers evidence that these improvements can be sustained.
- 2. Motivated managers make health systems work. Leadership development can bring new energy and effectiveness to health practitioners’ work.

Although the LMS Program is nearing conclusion, there is still work to do related to leadership, management and governance in the health sector. To continue to build upon the knowledge gained throughout the LMS Program and its predecessors, MSH has identified key priority areas that deserve continued attention from the development community. These areas are discussed in the final section of this report, on the following pages.



# Looking Ahead



*The LMS Program has developed the organizational capacity of programs and institutions in various settings and contexts, which have translated into significant results and lessons learned in service delivery improvements and long-term health outcomes. To continue to build upon this work, there are priority programmatic areas that deserve continued attention from donors, implementers and partners for future programs.*

## 7.1 Key Priority Areas of Leadership, Management and Governance

First, although the LMS Program has made significant progress in strengthening leadership, management, and governance of public sector institutions and CSOs involved in the planning and delivery of health services across all levels of the health system, there is a need to implement rigorous evaluations of these types of interventions. Doing so would help to develop a stronger research base for the evidence to link leadership and management strengthening to service delivery improvements and long-term health outcomes.

Under LMS, MSH conducted a rigorous programmatic assessment of leadership development programs in Kenya to assess the plausibility of positive health outcomes due to leadership and management development; this study used a quasi-experimental evaluation design with both treatment and comparison groups of health managers. The study results showed definitively that the LDP intervention does improve health service delivery outcomes, and that these improvements are sustained. In addition, these results can be plausibly attributed to the intervention as the same changes were not observed in the comparison groups.

The LMS experience has shown that there are both benefits and challenges in doing these types of rigorous studies — challenges for implementing agencies, partners and donors who invest resources in leadership and management development interventions. Future studies of these types will require prospective evaluation designs, using mixed methodologies — quantitative and qualitative — and participatory evaluation approaches to better assess and explain program performance, effectiveness, and the impact of programmatic interventions. Although many stakeholders will benefit from such studies, the outcomes of these rigorous evaluations should have policy makers and decision makers allocating resources as their main target audience in order to provide compelling evidence for the adoption and implementation of evidence-based policies for greater health impact within and across countries, regions, and globally. This endeavor will require a commitment of resources from all key stakeholders, including donors, implementers, and partners.

Second, the need to use a select number of robust indicators to assess intermediate and end results is an ongoing effort that deserves critical attention. Through the LMS Program, MSH developed a menu of leadership and management indicators



*LDP participant, Peru*

that have served to guide many field programs in measuring performance through improved management systems, work climate, and ultimately health outcomes. However, as WHO's approach to health systems strengthening continues to build momentum and consensus in the adoption of a common framework with its six building blocks, the operational use of such a framework, and more importantly the measuring of those six core elements, will require a systemic approach with robust metrics to assess efficiency, effectiveness, and impact on the health of vulnerable populations. The complexity of such HSS building block systems will require a solid foundation of strong leadership and management among public sector institutions and CSOs involved in the implementation and alignment of the HSS framework and health care delivery services in the health systems of low and middle income countries.

Third, the development of governance capacity for both public sector institutions and CSOs will require increasing attention. A key lesson learned from LMS is the recognition that good governance is not only about systems but the people behind those systems. It is imperative to build the capacity of those in charge of CSOs and public sector institutions to develop and adopt good governance practices. One of the remaining gaps in the governance model for the strengthening of Global Fund grants, for instance, is the degree to which new and complex structures, even when their governance is approved, are better able to address the substantial health challenges posed by HIV/AIDS, tuberculosis and malaria as well as improved maternal and child health. Longer technical support timeframes and a commitment to invest in follow up evaluations of this and similar initiatives are necessary to fully document the impact of applying the governance model used by the LMS Program.

Fourth, there is a specialized need for developing the leadership and management capacities of those in senior leadership positions. Government leaders, whether ministers of health, director generals, or permanent secretaries, are the stewards of their countries' health systems. While much attention has been paid to strengthening health systems, the support needed by those who are the stewards of these systems is too often neglected. The approach to developing senior leadership capacity should emphasize orientation, coaching and mentoring, to provide the support senior leaders need as they work with their colleagues and with others from the global health community, including funders, academic institutions, NGOs and civil society.

Fifth, as new technologies become available in low and middle income countries, the use of virtual approaches constitutes a viable solution to respond to and meet the demand for leadership and management development interventions. Through the LMS Program, MSH envisions four specific approaches as the next frontier for knowledge exchange: (1) It is imperative to adapt content and learning approaches to multiple delivery formats, including print, CDs, web and mobile phones, in order to increase the reach and impact of learning opportunities; (2) There is a need to maximize the use of open-source platforms and applications, which facilitate transferability and provide cost savings since they require less custom computerized programming; (3) Virtual offerings can leverage their social learning components to expand capacity building opportunities for learners and organizations; and (4) As access to virtual applications remain variable and uneven, it is critical to select appropriate technologies and hybrid approaches, including partnerships with local institutions, based upon local needs. Since the M&L Program began using innovative technologies in 2002, technology has evolved and LMS has continued to adapt to these changes. Moving forward, new applications will increasingly support the delivery of leadership and management interventions and contribute to expanding the range of virtual offerings facilitated through emerging web 2.0 and mobile applications.

Finally, as the U.S. Government enters a new era in international development through major global initiatives, including the Global Health Initiative and PEPFAR II, there is stronger emphasis on sustainability and country ownership within the health system strengthening framework. Donors, researchers and global practitioners increasingly agree that leadership

and management will play a significant role as the underlying factor to support the delivery of evidence-based public health interventions in greater scale to maximize impact. This will require continued investment in effective leadership and management programs in order to support the success of such global initiatives, accelerate progress towards the attainment of MDG targets in low and middle income countries, and more importantly, save lives and improve the health of the world's most vulnerable and disadvantaged people.

## 7.2 Summary of Associate Award Activity

The work begun under the LMS Program will continue through Associate Awards in the following countries:

- **Afghanistan:** extension granted to current Tech-Serve program through September 2011
- **Egypt:** a two-year Associate Award, Improving the Performance of Hospital Nurses, commenced in November 2009. Extended to 2013.
- **Haiti:** a five-year Associate Award, the Leadership, Management and Sustainability Program in Haiti, commenced in March 2010.
- **Kenya:** a five-year Associate Award, the Leadership, Management and Sustainability Program in Kenya commenced in March 2010.
- **Nigeria:** two five-year Associate Awards are now in place. The Pro-ACT project, commenced in August 2009. PLAN-Health commenced June 2010.
- **Southern Africa:** a five-year Associate Award, Building Local Capacity for Delivery of HIV Services in South Africa, was granted in August 2010 and is now underway.
- **West Africa:** a two-year Associate Award, the West Africa Leadership and Management Strengthening Project, (WA-LEAD) was awarded in July 2010 and is now underway.

<sup>5</sup> Omaswa, F. and Bouffard, J.I. Strong Ministries for Strong Health Systems. African Centre for Global Health and Social Transformation and The New York Academy of Medicine. 2010.

## **Mustafa: Sharing His Story to Encourage Others to Know Their HIV Status**

When Callista Ike, Community Care Specialist for the MSH Project, Leadership Management and Sustainability AIDS Care and Treatment (LMS-ACT), first met Mustafa, a 36 year old man who came to the hospital to support his HIV-positive sister, she never imagined that just two months later he would be helping to triple counseling and testing rates at his regional hospital.

Mustafa's sister had tested positive for HIV through PITC (Provider Initiated Testing and Counseling) at a government owned, and MSH supported hospital in Taraba state, Nigeria. It was while Mustafa was accompanying his sister that, as part of the PITC program initiated by MSH, he received HIV/AIDS pre-test information in the waiting room. Mustafa gave his consent to be tested, and learned that, like his sister, he too was HIV positive.

Callista Ike met Mustafa during a routine site support visit to the hospital, when he pulled her aside and asked to speak with her privately. She feared he was going to tell her that he was abandoning his sister, but as it turned out he was just looking for someone to confide in. Ms. Ike realized he was in need of some additional counseling after learning of his HIV positive status.

The support he received encouraged Mustafa to begin mentoring his friends and neighbors in his community to go to the hospital for HIV testing. Ms. Ike noticed that most of the people he referred

tested positive. When she asked him about this, he responded "Ma, you see, anyone of my friends or neighbors who complains of similar health problems as I used to experience, I will quickly encourage to go for HIV screening."

Mustafa's dedication to helping others and concern that others could be carrying the disease without even knowing it as he had, inspired him to work at the hospital as a volunteer. The LMS-ACT team formally trained him as one of their PITC support volunteers and introduced him to the HIV Coordinator of the hospital. As staffing needs in the hospital are a constant challenge, Mustafa's help was happily accepted.

As a result of Mustafa's enthusiasm and success, he plays an increasing role in promoting counseling and testing alongside MSH and hospital staff, serving as a role model and mentor for his fellow HIV positive peers. He now travels to PITC points of service in other MSH-supported hospitals to work with the facility staff, where the response to his work has been equally encouraging. Mustafa even participated in the MSH HIV Counseling and Testing training usually reserved for health care professionals, and in December, 2008, he played a vital role in the World AIDS Day counseling and testing outreach that MSH conducted, by assisting in mobilizing and sensitizing the community in their local language.

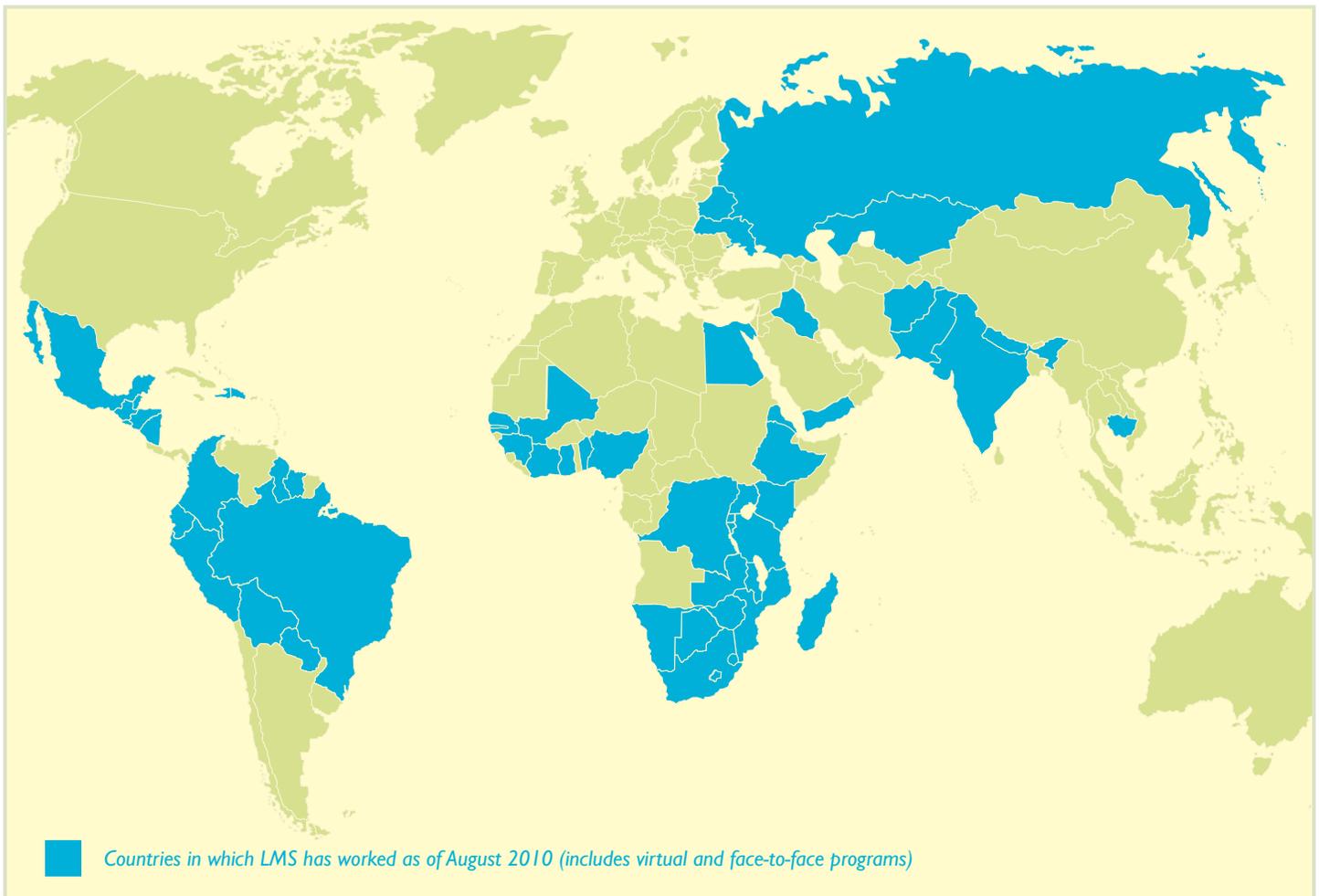
Today Mustafa, as one of MSH's 59 PITC support volunteers in Nigeria, has already changed the lives of hundreds of HIV positive people by urging them to learn their status, and by encouraging them to seek and adhere to treatment as he and his sister have.







# Appendix I: Country Program Profiles



## **LMS Field Projects**

<i>Afghanistan</i>	<i>Ghana</i>	<i>Nicaragua</i>
<i>Africa Bureau</i>	<i>Guatemala</i>	<i>Nigeria</i>
<i>Bolivia</i>	<i>Haiti</i>	<i>Peru</i>
<i>Cote d'Ivoire</i>	<i>Honduras</i>	<i>Southern Sudan</i>
<i>Democratic Republic of Congo</i>	<i>Latin America/Caribbean Bureau</i>	<i>Tanzania</i>
<i>Egypt</i>	<i>Kenya</i>	<i>Uganda</i>
<i>Ethiopia</i>	<i>Nepal</i>	

## Afghanistan

The Technical Support to the Central and Provincial Ministry of Public Health (Tech-Serve) project is a five-year Associate Award under LMS. The project's objective is to improve the capacity of the Ministry of Public Health (MOPH) to plan, manage, supervise, monitor, and evaluate the scale of access to quality Basic Public Health Services (BPHS) and Essential Package of Hospital Services (EPHS), particularly for those of highest health risk.

Tech-Serve works in seven programmatic areas:

- **Management Support to Provinces**, offering targeted and systematic training, mentoring, and professional networking to improve health services delivery at the provincial level.
- **Capacity building of the MOPH at the central level in departments key to health services delivery**, with support focusing on the development and review of policies, guidelines, and instruments.
- **Scaling up family planning through the Community-Based Health Care initiative**, including support to the MOPH Community Based Health Care Department and Reproductive Health/Family Planning Department.
- **Assisting the Health Economic and Finance Directorate** of the MOPH to “contract out” implementation of the BPHS and the EPHS through a competitive process to service delivery NGOs.
- **Hospital Management Strengthening**, working closely with the MOPH to develop hospital-related policies, strategies, and standards to be applied nationally in all reformed hospitals.
- **Pharmaceutical management and provision of pharmaceuticals to NGOs**, ensuring the provision of quality pharmaceuticals to health facilities and health posts.
- **Monitoring and Evaluation and Health Management Information Systems**, supporting the MOPH in the development, approval, and implementation of a five-year Health Information Systems Strategy for Afghanistan.

**Program dates:** July 2006 – September 2011

**Budget:** \$83,548,458

**Challenges addressed:** By the fall of the Taliban in 2002, the health system in Afghanistan had significantly deteriorated and the health status of Afghans was poor. Challenges addressed by the REACH project, predecessor to Tech-Serve, included:

- A fragmented health system
- Inequities in access to health services
- Unqualified and/or inappropriate health staff
- Poorly equipped facilities
- Compromised flow of essential medicines

- Inadequate financial resources
- Low life expectancy (47 years for men, 45 years for women)
- One in four children died before age 5
- Maternal mortality rate of 1,600 per 100,000 live births

By 2006, these challenges had been partially addressed. The health system had been strengthened and health status had improved. However, new challenges were taken on by the project, including:

- The need to focus on both expansion of service and quality improvement
- Addressing the root causes of high maternal and child mortality
- Governance in the face of deteriorating security
- Lack of women in the health care system
- Strengthening the continuum of care

### Key results:

- More than 1,800 health professionals, including senior Ministry of Public Health and NGO managers, were trained in leadership and management development, and other priority public health subjects to equip them with the necessary skills to achieve better health outcomes.
- As a result of training community health supervisors and community health workers (CHWs), two-thirds of all family planning services are conducted by CHWs at the community level. The contraceptive prevalence rate increased to 40.6% (up 10% from the start of the project), as reported in a household survey conducted by the health service delivery organizations.
- The Tech-Serve Project supplied a total to \$15.9 million of essential drugs and contraceptives since its inception.
- The MOPH is now certified to administer USAID funds, and manages 17 health service provision contracts with local and international NGOs, thereby increasing access and equity to health care across the 13 provinces.

Tech-Serve is an Associate Award that will continue through September 30, 2011.

## Africa Bureau

The Regional Center for Quality Health Care (RCQHC) and the African Network for the Care of Children Affected by HIV/AIDS (ANECCA) which are headquartered in Kampala, Uganda, as well as the East Central and Southern Africa Community of Health (ECSA-HC), which is headquartered in Arusha, Tanzania, are organizations with a key role in improving health outcomes for populations in the region. LMS has been providing technical assistance in capacity building, leadership and management to these organizations in order to help them increase their financial and institutional sustainability.

**Program dates:** October 2008 – November 2010

**Budget:** \$547,664

**Challenges addressed:** Although USAID has been providing support to RCQHC, ECSA-HC and ANECCA for many years, there is a concern that the organizations do not have the organizational systems and financial diversification necessary to make them sustainable in the long run. In particular, these groups do not have a clear organizational visions and strategies, and receive most of their funding from USAID. To address these challenges, LMS has been working with RCQHC, ECSA-HA and ANECCA to help them develop strong, relevant strategic and business plans as well to strengthen other areas of the organizations.

**Key results:** ECSA-HC is an inter-governmental regional organization working to foster and strengthen regional cooperation and capacity to address the health needs of its nine member states. LMS has been working with the ECSA-HC Secretariat, the focal point for activities of the ECSA Health Community in the region, since 2007, with the following results:

- With LMS technical assistance, ECSA-HC has developed organizational key documents including a strategic plan and a business plan
- ECSA-HC, with LMS support, engaged potential donors through a broad donor roundtable meeting and targeted visits to potential donors

RCQHC is an institution dedicated to advancing the quality of health care in the East, Central and Southern African region. LMS has been working with RCQHC since 2008, with the following results:

- RCQHC has developed strategic, business and marketing plans
- LMS and RCQHC developed materials and a curriculum for a course on best practices in health management that RCQHC plans to deliver.

ANECCA is a network that brings together clinicians and social scientists to improve the quality of clinical and non-clinical care of children affected by HIV/AIDS in Africa by providing capacity building training for health professionals working in pediatric HIV care, producing comprehensive training materials for pediatric HIV care and conducting a pediatric HIV care mentoring program. LMS has been working with ANECCA since January 2010.

- ANECCA held a strategic planning meeting with key stakeholders with LMS support, and developed a strategic plan based on the meeting
- With LMS support, ANECCA has completed and submitted two proposals to non-USAID donors (Action for Children and UNICEF)
- With LMS assistance, ANECCA has set up a Google groups platform to improve communications with network members.

## Bolivia

USAID/Bolivia requested LMS assistance for the Centro de Investigación, Educación y Servicios (CIES)—a newly named affiliate of the International Planned Parenthood Federation (IPPF). Founded in 1987, CIES provides reproductive health services through nine clinics and health centers located in eight of the nine departments of the country. CIES has been highly dependent on funding from USAID and IPPF since its creation, and has seen its financial security threatened through reductions in donor support and inadequate reimbursement levels from the national insurance program. In response to a request to support CIES, LMS carried out a needs assessment to identify and prioritize organizational management systems that required strengthening and to develop a long-term capacity building plan.

The three main objectives of LMS technical assistance to CIES were: 1) to increase the demand for its reproductive health services, 2) improve its financial sustainability from 51% to 85% by the year 2011, and 3) strengthen its leadership practices and management systems, especially in the area of human resources management.

**Program dates:** October 2006 – September 2010

**Budget:** \$1,050,000

**Challenges addressed:** As an organization offering sexual and reproductive health services, CIES addressed both internal organizational challenges as well as external challenges, including a high maternal mortality rate and limited access to modern contraceptives in Bolivia.

The major internal organizational challenges include a weak human resources system, a low financial sustainability rate, a poor marketing system and lack of standards to monitor service quality.

**Key results:**

- CIES successfully decentralized management functions and processes to 8 regional offices. Annual operating plans, control manuals and financial, human resources and procurement systems were developed and implemented.
- A web-based management dashboard is now used to track key performance and financial indicators on a monthly basis by senior management.
- The regional staff of CIES is being trained in the Business Planning for Health program to contribute to the overall sustainability plan of CIES. Five regions have completed their training and have developed a business plan for which they are now identifying funding sources. LMS has contributed funding for the two best plans.
- A marketing plan was developed for all CIES offices at the national and regional levels. This plan focused on marketing new services offered based on the unmet needs identified.

- A Quality Assurance system was developed across CIES. Standards to monitor quality were established based on two fundamental principles: providers' needs and users' rights.
- CIES applied MSH's Cost Revenue Analysis Tool to determine the cost of each service provided and to project the volume of revenue necessary to achieve sustainability. As a result, operational expenses were reduced by nearly 50% due to analysis, control and monitoring.
- CIES was certified by domestic and international bodies (IPPF, CEE, UNFPA, PROCOSI).
- CIES, with LMS support, drafted a human resource manual, and a corresponding training program for staff; furthermore, a performance management system was developed and implemented.
- The following processes were standardized:
  - » Quality Procedures Manual and
  - » Rules and regulations governing clinical procedures.
- Approximately 20 new services were offered, including:
  - » 4D Sonography;
  - » More complex laboratory tests; and
  - » Educational services in alliance with microfinance organizations and universities.

## Côte d'Ivoire

LMS conducted an assessment in Côte d'Ivoire in May 2007 as part of a pilot project established by the Office of the US Global AIDS Coordinator to provide urgent, short-term technical support to countries receiving grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria. The assessment determined that the Global Fund's Country Coordinating Mechanism (CCM) was not in compliance with CCM guidelines and that its members had a weak understanding of the five basic functions of a CCM. In addition, they showed little familiarity with the rules, regulations, and documents related to their work, and considerable confusion existed regarding the routing of CCM financing from the Global Fund itself. Fortunately, the CCM members were aware of their problems and committed to reform.

The initial intervention, which focused on structural reform of the CCM to bring it into compliance with Global Fund guidelines, was successfully completed in early 2008. LMS received field support funding from PEPFAR to for longer term strengthening of the CCM's management and leadership capacity in order to improve oversight capabilities and build a sustainable orientation program to ensure that as membership renewal occurs, the CCM will continue to function at a high level.

**Program dates:** November 2008 – August 2010

**Budget:** \$900,000

## Challenges addressed:

**Need for senior leadership development & governance:** LMS offered an adapted Senior Leadership Development Program for CCMs. The program was designed to help the CCM sub-committees focus on concrete challenges facing both the CCM and the HIV/AIDS programs in Côte d'Ivoire and provided CCM members with the opportunity to observe through site visits the management and leadership challenges facing HIV/AIDS programs in the country. Members have created their own mission: to be "One of the Top 10 CCMs."

**Lack of expertise in monitoring & evaluation:** LMS assessed the capacity of both the CCM and Principal Recipients in the area of M&E and supported them to create Excel-based performance monitoring dashboards to improve their Global Fund grant management.

**Support for proposal development:** LMS provided assistance with a variety of proposal development components for Rounds 8, 9 and 10 including: gap analysis, development of technical strategies, writing, budgeting, and harmonization of multiple proposals for a comprehensive approach.

**Need for skills in resource mobilization and donor harmonization:** LMS trained CCM members in how to mobilize additional resources and also to map their sub-recipient sites and services being offered to harmonize interventions with other donors.

A key in the design of this program has been that LMS focused on introducing and building sustainable systems with the CCM that the CCM now manages itself. LMS trained in-country consultants in each phase of the program to carry on technical assistance at the end of the LMS program. Local Ivorian consultants have now been trained in all the governance and oversight tools, like the CCM Dashboard and the LDP. The CCM can draw upon this pool of trained consultants in the future.

## Key results:

- Awarded more than \$360 million in Global Fund Grants in Rounds 8 and 9
- Included in the above: two successful proposals for Round 9 totaling \$217 million, including the first HIV/AIDS grant awarded to Côte d'Ivoire since Round 5 in 2006
- Recognized by PEPFAR as a "model CCM" at the CCM Regional Meeting in Dakar, Sénégal in February 2010.
- Recognition of the CCM's legal status in-country
- Creation of bylaws and a governance manual
- Reconstitution of the 25-member CCM, including majority membership from civil society and the private sector
- Transparent election and redefinition of roles and responsibilities of the CCM bureau and sub-committees
- Secretariat participation in both regional and international Global Fund board meetings.

## Democratic Republic of Congo

The overall goal of the LMS/DRC project is to reduce infant, child and maternal morbidity in 23 health zones of two provinces in central DRC, and the project has three main objectives:

- Increase the quantity and quality of the package of health services offered to about 3 million people in the Kasai Oriental and Kasai Occidental provinces
- Increase demand and service utilization in the target health zones
- Strengthen the capacity of the DRC Ministry of Health and NGO partners in the management and delivery of health services

LMS/DRC staff are working closely with MOH counterparts at the district, zonal and health facility level to accomplish these objectives by organizing trainings and community education, engaging in supportive supervision, and providing supplies, materials and financial support. A key innovation of the project is bringing together the Leadership Development Program and the Fully Functional Service Delivery Point approach to give district and zonal supervisors and health facility staff a framework of leadership and management skills as well as detailed quality improvement tools to enhance health service delivery.

**Program dates:** October 2008 – October 2010

**Budget:** \$10,729,800

**Challenges addressed:** While the Democratic Republic of Congo's 2005 Health System Strengthening Strategy makes health zones the entry point for all health interventions, provincial and zonal management of health services is a new concept and the government of DRC does not have the resources to fund the health care system at adequate levels. Donors are attempting to fill the gap, but each health zone is supported by a different donor and a variety of different FBOs and NGOs deliver services, exacerbating the problem of a fragmented, uncoordinated health care system.

On top of this, health workers and district/zone staff are demotivated by low salaries, poor working conditions and the lack of equipment, drugs and medical supplies—often focusing on the lack of resources rather than on what they can do to provide higher-quality health care services to the population. The local communities are discouraged from seeking health care and from playing an active role in managing the health facilities by lack of basic services provided and the low quality of care, which in turn makes it harder for the health system to function effectively. Challenging transportation logistics only make the situation more difficult.

### Key results:

**LDP:** Teams from the 23 health zones and three health districts completed the program in June 2010, with most teams achieving significant results relating to improved primary health care such as:

- Increased prenatal coverage
- Increased vaccination coverage
- Increase in provision of malaria prophylaxis to pregnant women
- Increased utilization of family planning services

**The Fully Functional Service Delivery Point:** The FFSDP methodology was rolled out to 115 health facilities with preliminary assessments of each facility made between December 2009 and January 2010. Follow up evaluations were completed in 30 facilities, with these preliminary results:

- Across nine areas measured by the tool, scores for the 30 health facilities increased by 13% on average (from 32% to 45%)
- Improvements were most marked in health facilities with the lowest starting points (two of these facilities improved more than 30%)
- The final range of scores across the 30 facilities was 41% to 62% as compared to the initial range of 22% to 45%

**Other Trainings:** LMS has trained over 4,800 health care providers, community health workers and health managers in areas including: primary health care management, malaria treatment, family planning, health information systems, secure blood transfusion and management of childhood illnesses.

**Materials and Logistics Support to the MOH:** To enable supervision visits, 22 motorcycles were provided along with gasoline, oil and travel allowances for field visits by health district and health zone staff. To support the vaccination program by ensuring cold chain for vaccine storage, replacement parts and fuel for generators were provided to the health centers. In addition, USAID provided LMS with 82,500 insecticide treated mosquito nets and a large stock of family planning commodities (including 41,000 packets of pills, 120,500 doses of Depo-Provera and 312,000 condoms) which the project delivered to the health zones and health centers.

**Water and Sanitation:** 100 water sources and 500 family latrines have been constructed so far, and 20 more water sources are under construction. These activities are complemented by the involvement of the local communities, which are establishing sanitation committees to manage and maintain the water sources.

**Renovations:** Renovations were completed at 18 health facilities in order to make them more safe, sanitary, effective and inviting places to receive health care services.

The LMS/DRC project received a four-month no-cost extension that allowed the project to continue activities through October 2010. Support for primary health care in the zones currently supported by LMS is expected to continue through the Integrated Health Project (IHP) recently awarded to MSH.

## Egypt

Improving the Performance of Nurses (IPN) in Upper Egypt is a partnership between MSH and the Nursing Program of the Om Habibeh Foundation, an Aga Khan Foundation affiliate. The program's goal is to build the leadership and management capacity of hospital and primary health care facility nurses for improvement in the areas of infection control, basic nursing skills, and communication, in the governorates of Aswan, Luxor, Qena, Sohag and Assiut. The IPN program applies the Leadership Development Program as the core technical approach for the intervention. In the first phase of the project, the IPN will target facilities in Aswan. The second and third phases will target hospitals in Luxor and Quena, and in Sohag and Assiut respectively.

Using the Leadership Development Program methodology, nurses will gain skills in leadership and management. Through participation in the program, nurses at all levels will successfully identify and address the three key health care challenges mentioned above and achieve measurable results.

**Program dates:** November 2009 – July 2013

**Budget:** \$3,626,688

**Challenges addressed:** Nursing in Egypt is an undervalued profession, despite the fact that nurses are critical to the health professional workforce and the provision of care, especially in rural areas. Nurses are poorly trained and have low morale. As a result the quality of health care in Egypt is poor, especially in the area of infection control. The IPHN program aims to address these challenges by empowering nurses to improve infection control, basic nursing skills, and communication in the hospitals in which they work.

**Key results:** Through the program, nurses at all levels will successfully identify and address key health care challenges and achieve measurable results. More specifically, the project's expected results are:

- Nurses are aware of and committed to adhering to the Ministry of Health standards and guidelines for infection control, basic nursing care, and communication.
- Nurses are empowered to take initiative to face the challenges and produce better results in the three focus areas.
- Increased local capacity through a group of trained facilitators.

## Ethiopia

Ethiopia has strong government structures as well as a degree of decentralization that is far advanced compared to its neighbors. However, the country also has a staggering multitude of actors (funding agencies and technical assistance agencies) in the health sector, especially in the area of HIV/AIDS. The combination of these two conditions makes coordinating HIV/AIDS activities particularly challenging.

One of the major bottlenecks for strengthening the HIV/AIDS response is low personnel levels and management challenges in the country's national and regional HIV/AIDS Prevention and Control Offices (HAPCOs). There are multiple indigenous, bi-lateral, and multi-lateral donors and implementers conducting HIV/AIDS-related activities at regional and local levels, and the combination of partners presents challenges in coordination, monitoring, oversight, and reporting. In this context, USAID asked LMS to provide support to the zonal and regional HAPCOs in the areas of coordination and management systems development with the goal of improving the management and delivery of HIV/AIDS services.

**Program dates:** October 2008 – August 2010

**Budget:** \$2,700,000

**Challenges addressed:** The goal of the LMS project in Ethiopia is to contribute to the reduction of the HIV/AIDS burden by ensuring that effective coordination of activities exists, and that funds provided through the GFATM and PEPFAR flow unencumbered through the health system to produce intended results at all levels. The project's main objectives include:

- Zonal and regional HAPCOs/Health Bureaus more effectively plan, coordinate, and manage HIV/AIDS activities through the application of improved leadership practices and stronger management systems.
- Civil Society Organizations and other non-governmental organizations are better able to provide HIV/AIDS services through improved leadership practices and stronger management systems and are more able to access funds through improved proposal development processes. The CSOs selected will be those working on HIV/AIDS activities in partnership with the HAPCOs in the project's zones in Oromia and Amhara Regions.
- PEPFAR partners improve their coordination with each other and with the MOH and Global Fund partners leading to less duplication of or gaps in activities and better overall management of HIV/AIDS programs in Ethiopia.

**Key results:**

- In March 2010, 12 teams from HAPCOs and Health Departments completed the Leadership Development Program. Nearly all teams chose to focus on the challenge of increasing the number of people counseled and tested for HIV/AIDS in their respective zones. All 12 teams achieved at least 85% of their measurable result target, with 10 reaching or exceeding it. Examples include:
  - » One team increased PMTCT coverage from 48% to 86.4%
  - » Another team increased Provider Initiated HIV Counseling and Testing from 15% to 70%

- » From August 2009 to January 2010, one health center tested 25,266 people for HIV compared to 7,025 during the same period one year earlier
- In December 2009, Leadership Development Programs were launched with teams from 37 civil society organizations involved in the implementation of HIV/AIDS activities. These programs concluded in June 2010.
- Support in developing stronger management systems has been provided to HAPCOs, HDs and CSOs, which included:
  - » MOST workshops with 15 HAPCOs and 12 CSOs;
  - » HRM Rapid Assessment workshops with 7 HAPCOs/HDs;
  - » M&E training with approximately 50 participants.
- The project has coordinated Joint Review and Planning Meetings in all 12 zones. These meetings have proven helpful in improving coordination of HIV/AIDS activities by bringing together government, private sector and NGO partners to discuss the planning and implementation of HIV/AIDS activities, and have stimulated a sharing of lessons learned and strategies amongst the organizations.
- Eleven senior leaders have acquired new leadership and management skills.
- In October 2009, a training of trainers workshop was conducted for 22 new facilitators who came from GHS, MOH, the Ghana Institute of Management and Public Administration and the Adventist Development and Relief Agency (ADRA).
- The Human Resource team in the Senior Leadership Strengthening Process workshops achieved their measurable result: “By February 2010, a Nursing Staffing Norm for Atua District Hospital is developed.” The team adapted the National Nursing Staffing Norm to calculate the difference in the number of nurses needed for the hospital and the number of nurses currently working at the hospital. The Director of Human Resources at GHS has expressed interest in applying the adapted norm nation-wide.
- The Infection Control team in the Senior Leadership Strengthening Process workshops developed an infection control committee, adopted the GHS Infection Control Policy, and implemented training to ensure the hand washing practice in the Pantang District hospital now conforms to GHS standards.

## Ghana

Since mid-2008, LMS has been working with the Ghana Health Services (GHS), an implementation branch of the Ghana Ministry of Health, focusing both on capacity-building for regional health teams and increasing the awareness and competency of leadership and management skills among senior leaders.

**Program Dates:** January 2008 – August 2010

**Budget:** \$300,000

**Challenges addressed:** In light of the growing degree of managerial responsibility delegated to districts and hospitals, the role of the Ghana Health Service (GHS) agency is to provide and manage comprehensive and accessible health services with special emphasis on primary health care at regional, district and sub-district levels. The interventions undertaken by the GHS have the promise to improve performance of regional and district programs and to markedly reduce maternal and child mortality. GHS regional and district teams have developed plans to provide these services and now face the difficult challenge of ensuring their full implementation and impact. This requires a level of engagement and leadership and management skills not generally present in the district and regional teams.

### Key results:

- GHS has secured funding from a health systems strengthening grant from GAVI to roll out the LDP in other regions of Ghana. The first LDP workshop under this roll-out took place in the Ashanti region.

## Guatemala

LMS has provided technical assistance to three different clients in Guatemala: Asociacion Pro-Bienestar de la Familia (APROFAM), Creciendo Bien and Observatorio en Salud Reproductiva (OSAR).

APROFAM, founded in 1964, is a nonprofit organization and member of the International Planned Parenthood Federation (IPPF). APROFAM offers family planning/reproductive health, maternal health, and child health services in some of the most underserved rural areas of Guatemala. LMS technical assistance to APROFAM included revising the organizational structure to prepare for a new phase of growth and development, redefining the role of the board of directors, and designing a new compensation system. The participatory process included members of APROFAM’s board of directors, technical staff, and management staff working in consensus.

Creciendo Bien (“Growing Well”) is a successful child health program supported by the First Lady of Guatemala’s Secretariat for Social Welfare (SOSEP). It was founded in 2004 in response to the critical situation of child malnutrition in Guatemala’s poorest and most vulnerable communities. In February 2007, USAID/Guatemala requested LMS assistance to conduct a strategic planning exercise for program sustainability. Through this work, LMS assisted in restructuring the program and documenting its health care model using a participatory approach. The Foundation of the Institute of Nutrition for Central America and Panama (FANCAP), an organization that ensures food security and nutritional assistance in Central America, will continue to administer the management and service delivery of Creciendo Bien, ensuring sustainability.

At the request of USAID, LMS recently provided technical assistance to the Observatorios en Salud Reproductiva (OSAR), a constituency of civil society organizations monitoring the equity of reproductive health, with particular emphasis on family planning and maternal health. During an intensive three-day workshop, participants drafted a shared mission, vision, and strategic objectives, which were incorporated into a central strategic plan to be utilized by all OSARs.

**Program dates:** September 2005 – June 2010

**Budget:** \$358,818

**Challenges addressed:** The LMS program in Guatemala sought to improve the organizational and financial sustainability of various institutions in order to ultimately improve reproductive health in the country. To achieve this goal, LMS worked with APROFAM to modernize its organizational structure, compensation performance plan, and professional review template, enabling APROFAM to move into a new stage of development and achieve higher levels of institutional self-sustainability.

Creciendo Bien was a highly successful initiative, but due to its political origins, it was necessary to develop certain mechanisms to allow the program to function throughout the years. LMS led the process of ensuring the sustainability of the program by conducting an evaluation of the short- and long-term goals and developing strategic lines of action of Creciendo Bien.

Through the technical assistance provided to OSAR, LMS hoped to achieve integration of a single strategic plan, incorporating the mission, vision, and objectives for all OSAR groups, which was supported by USAID and other external agents. This plan created and strengthened the foundation of the organization's work and enabled the use of OSAR resources in a coherent, coordinated and synergistic way at the national level.

### **Key results:**

- Forty-seven senior leaders of APROFAM, including 26 women, were trained in leadership and management development.
- After reorganizing their organizational structure, APROFAM's Board of Directors and Executive Director completed the LMS Virtual NGO Board Governance course, resulting in a formalized division of roles and responsibilities, the creation of an annual calendar of board activities, and a draft policy on transparency and accountability.
- APROFAM has made substantial progress in increasing the effectiveness of the rural development program, improving institutional sustainability, strengthening governance and transparency, defining board and management roles, and designing a dashboard to facilitate monitoring and continuous improvement of senior staff performance.

- Thirty-three Creciendo Bien technical staff, including 13 women, were trained as trainers in the service delivery model and quality standards process.
- During a three-day strategic planning workshop for the OSARs, twelve participants from eleven different departments of Guatemala were trained in strategic thinking and planning.
- Twenty-seven senior leaders from eleven OSARs and three international NGOs attended the final day of the workshop, which featured a results presentation and a discussion on the overall impact the strategic plan will have on reproductive health in Guatemala.

## **Haiti**

Severe poverty and political instability have created many difficulties for people in Haiti and their health care system. In January 2008, the USAID/Haiti Mission funded the LMS Program through field support to focus attention on the commodity security system, build leadership and management capacity within the Ministry of Public Health and Population (MSPP), build capacity of local NGOs working in family planning and HIV/AIDS to address the enormous unmet needs of youth in Cité Soleil (including sexually transmitted infections, HIV/AIDS, sexual violence, risky behaviors, family planning, and other sexual and reproductive health issues), and coordinate community activities to strengthen HIV/AIDS awareness and prevention initiatives. LMS is strengthening management systems and leadership skills at all levels within health care organizations and programs to effectively address change and improve health outcomes in the areas of family planning, reproductive health, HIV/AIDS, infectious disease, and maternal and child health. LMS partners include the following organizations: the Ministry of Public Health and Population, Fondation pour la Santé Reproductrice et l'Éducation Familiale, Fondasyon Kole Zepòl, Haitian Olympic Committee, Maison l'Arc en Ciel, and the Women's League of Cité Soleil.

**Program dates:** January 2008 – March 2010 (TB Program January 2008 – October 2010)

**Budget:** \$7,531,239

### **Challenges addressed:**

- **Better coordination among and capacity of HIV/AIDS activities:** LMS works with the MSPP at the departmental level to better coordinate community mobilization activities and strengthen HIV/AIDS awareness and prevention initiatives in key subject areas, such as multiple concurrent partnerships, as well as key rural and isolated geographic areas. In support of the Cité Soleil Initiative, LMS works with several local organizations to build capacity in HIV/AIDS awareness and related issues.

- **Improve an inadequate commodity management and security system:** LMS supports Haiti's MSPP to establish one unique and secure commodities management system for the health sector, focusing on management and distribution systems for U.S. government-funded condoms and FP commodities.
- **Reinforce limited capacity to provide family planning and reproductive health services to underserved populations:** LMS partners with the MSPP and non-governmental organizations (NGOs) in Haiti to build capacity across a wide range of FP and RH initiatives, providing education, training and technical assistance, and furthering the integration of FP services into the overall health system.
- **Lack of leadership and management capacity in national tuberculosis (TB) program:** LMS builds leadership and management capacity of the National TB program and is rolling out the DOTS model to three new areas (through MSH's SDSH bilateral program).
- In 2009, LMS completed three Leadership Development Programs: one for the MSPP, one for youth and one focusing on commodity management. Selected results included:
  - » Delivery of 1,308 hygiene kits to people living with HIV/AIDS
  - » 4,450 young people ages 10 – 24 counseled on HIV/AIDS
  - » 400 pregnant women attending at least two prenatal visits
- LMS supported training of 4,000 members of Fonkoze's microcredit program on family planning and reproductive health matters.
- In 2009, LMS worked with the Women's League of Cité Soleil to implement a training program on community distribution of family planning commodities, which resulted in the program reaching more than 10,000 community members in four months.

Activities are being continued through a five-year Associate Award that began March 15, 2010, and goes through March 14, 2015.

LMS has achieved results through interventions such as:

- **The LDP:** The LDP helps organizations to develop managers who lead, particularly in the field of health services, through a series of workshops that address real-life critical challenges. Working in their real work teams, participants learn leading and managing practices that make it possible to face challenges and inspire and teach their coworkers to apply these practices to real workplace challenges. LMS has implemented LDPs with the 10 departments of the MSPP; with partners working in commodity security, and with local NGOs focusing on youth and HIV activities in Cité Soleil.
- **Behavior Change Communications/Community Mobilization:** LMS works with partners to create educational programs designed to stimulate behavior change and ultimately reduce health risks. A recent HIV outreach and education program for factory workers in Port-au-Prince promoted the adoption and maintenance of safe behaviors in regards to HIV.
- **Strengthening Health Systems:** LMS is working with partners to build capacity in leadership and management to ensure sustainability of the country's health systems. These programs are cross-cutting in the following sectors: commodities, FP, and HIV/AIDS.

### Key results:

- Despite multiple obstacles, in just the first month following the January 12, 2010, earthquake, LMS distributed more than 1 million family planning commodities: over 1.2 million condoms; 44,000 oral contraceptives; 33,200 injectable methods; and 100 implants. In May 2010, LMS distributed 2,692,750 family planning commodities: over 2.5 million condoms; 93,600 oral contraceptives; 75,600 injectable methods; and 550 implants.

## Honduras Country Coordinating Mechanism

LMS provides logistical support to the Technical Unit of the Country Coordinating Mechanism in Honduras.

**Program dates:** March 2006 – September 2010

**Budget:** \$1,392,000

**Challenges addressed:** Honduras currently has a concentrated HIV/AIDS epidemic estimated at 0.7% prevalence; however only half of the estimated 12,000 people needing ARV treatment, are receiving it. The World Health Organization estimates that there are 11,561 reported cases of malaria in the country, and more than 5,048 people who are suffering from tuberculosis. The Country Coordinating Mechanism was formed in 2003 and currently manages five grants: two in HIV/AIDS, one in tuberculosis and two in malaria, representing close to \$80 million dollars in resources for the country. Given the size of this portfolio, it has become critical to have a highly effective CCM, principal recipients and sub recipients to manage it well.

LMS started providing assistance to the CCM, principal recipients and sub recipients in 2006 to define roles and responsibilities, improve proposal writing skills, develop a monitoring and evaluation plan and strengthen the participation of the civil society organizations.

**Key results:** In March 2010, LMS worked with the CCM to finalize a two-year budget and work plan to be presented to the Global Fund. The CCM is taking advantage of the Global Fund's expanded funding policy, which allows CCMs to request funding over \$50,000 USD per year. A primary goal of the LMS technical assistance was to provide the CCM with the tools and confidence

to reach out to potential donors and diversify their funding. As a result of this assistance, the CCM has been able to present their budget and workplan to potential donors and to mobilize resources. For example, it secured verbal commitment from the Secretary of Health in Honduras and GTZ to commit 8% and 5% respectively for the two years while USAID/Honduras has also agreed to commit 19% for the first year. In addition to this funding, these financial commitments will exceed the 20% cost-share quota the Global Fund is expecting from all CCMs globally. These outcomes mark the first steps toward accomplishing the CCM's goal of diversifying their funding.

In addition to these results, the CCM has also achieved the following:

- The CCM wrote an HIV Round 9 proposal that has been selected by the Global Fund. This is the first HIV proposal that focuses specifically on providing services to orphans and vulnerable children in Honduras. Upon signature of the grant, Honduras will receive US\$21,899,376 in resources.
- Since 2006 the CCM has put in place defined roles, responsibilities and functions for all of its members. A norms and procedures manual also exists and continues to be used and updated by the members.
- The Management Dashboard, an electronic tool which links financial, managerial and performance data into a single presentation for CCM oversight, was introduced to address the challenge of effective monitoring and evaluation.
- Currently the CCM has members representing 11 different organizations and institutions including the government of Honduras, USAID, ONUSIDA, PAHO as well as representatives from 8 civil society organizations for people living with HIV/AIDS, Malaria, Tuberculosis and other vulnerable groups.

## Honduras Local Technical Assistance Unit

In May 2007, LMS received a request from USAID/Honduras to manage the pre-existing Local Technical Assistance Unit (ULAT) and was tasked with providing ULAT logistical support and improving their capacity to provide quality, results-based consulting services to the Ministry of Health (MOH) of Honduras. Currently the MOH is developing programs and strategies which seek to increase and improve equitable social sector investments and increase the use of quality maternal and child health and reproductive health services. In response to the government's public health needs, the ULAT program focuses on the following technical components: family planning, reform, MCH, and HIV/AIDS communications.

**Program dates:** May 2007 – November 2010

**Budget:** \$10,949,742

**Challenges addressed:** Honduras is currently preparing to graduate from USAID family planning funds. In this context, ULAT is working toward strengthening leadership at all levels of the health system and redefining health care models to increase coverage and service to the Honduran population under a decentralized model of management.

The local unit is also implementing a strategy to institutionalize FP services in all health facilities as well as build capacity, and strengthen clinical FP services throughout the country. This strategy focuses on improving the contraceptive logistics system and increasing demand for FP services. The FP strategy is being implemented in 100% of the health facilities in the country and more than 1,787 staff members from the Health Secretariat have been trained in the strategy. Additionally, FP is now incorporated into the agenda of the various management levels, from the central MOH, to regional levels, down to hospitals and networks including the Honduras Institute of Social Security, the NGO provider HONDUSALUD and the local IPPF affiliate ASHONPLAFA .

In addition, ULAT has worked in implementing a strategy in HIV/AIDS and Maternal and Child Health communications to increase the knowledge of high risk pregnancies, breastfeeding, infant care and childhood diseases. Under this component ULAT also seeks to increase the demand for FP and reduce high-risk behaviors in those populations most affected by HIV/AIDS through radio soap operas, presentations and youth-led theater groups.

Finally, ULAT also works to reform collaboration with the MOH to create and implement a framework for decentralized service provision and to increase transparency and accountability in the health care system. Under this component, staff were key participants in the development of the Conceptual , Political and Strategic Health Sector Reform Framework, which the MOH made public in March, 2009 as well as in the Sub-Sectoral Plan to reduce maternal and child mortality. The World Bank, Government of Honduras, and the Inter American Development Bank also participated in the development of this plan, which is an important part of the health sector decentralization reform process in the poorest departments in Honduras.

**Key results:** In June 2009, Honduras experienced a military coup d'état ousting its civilian president, Manuel Zelaya. In response to these events, USAID issued a suspension of non-humanitarian activities that required interacting with senior members of the government, thus forcing ULAT to change its strategy to work with the private sector. Despite these challenging conditions, the team was able to continue some key activities and achieve the following results:

- In coordination with board of directors from ASHONPLAFA, ULAT conducted a market, technical, and institutional feasibility study to implement four new business plans (labor services, ambulatory surgeries, expansion of laboratory services, and medicine sales) aiming to achieve the financial sustainability needed for ASHONPLAFA to co-finance its own FP services.

- The technical unit was able to create a concrete process for programming local health activities for MANCORSARIC, a group of the rural communities of Copán Ruinas, Santa Rita, San Jerónimo and Cabañas, which together operate as a decentralized health service provider. The process created was based on the requests of the client and the MOH and will serve as a template for other decentralized providers who are programming and integrating activities under the Reform.
- With the MOH, ULAT validated the service delivery component of the National Health Care model. In total, 23 people (8 men and 15 women) who were part of the management and technical teams of the MOH, participated in the validation process.
- In the area of HIV prevention, the six-month long radio soap opera “Orgullo Garifuna” (Garifuna pride), which aims to increase knowledge of HIV prevention methods among the general population and reduce the stigma and discrimination against people living with HIV/AIDS, aired in 36 Garifuna communities, where the HIV prevalence is highest. Garifunas are a minority ethnic group of Afro Caribbean descent in Central America.
- From October to December 2009, ULAT trained 120 leaders (64 men and 56 women) of the Garifuna community in 3 workshops; use of HIV prevention messages in scenic arts, project planning and results communication.

## Kenya

The objective of the LMS/Kenya program is to build leadership and management capacity throughout the health sector and to help increase the value placed on leadership and management positions. The LMS/Kenya program does this by building the capacity of individuals and teams at all levels and across the sector through short term training programs, development of appropriate and responsive leadership and management curricula and coaching and mentoring support. In addition, we build the capacity of health related organizations and institutions by working with them to strengthen their management systems so that they can effectively and efficiently deliver their intended products and services. LMS/Kenya’s vision is to see empowered people leading and managing health organizations with effective systems; and deliver positive and lasting changes in people’s health.

**Program dates:** May 2008 – June 2010

**Budget:** \$2,750,000

**Challenges addressed:** During the 1990s there was a decline in several key health indicators in Kenya. The Government of Kenya, in the introduction to the National Health Sector Strategic Plan Two (NHSSP II) (2004 – 2010), attributed this decline to failures in management systems and coordination. In response, the GOK developed the NHSSP II to improve coordination, plan-

ning, and implementation through the creation of Annual Operational Plans (AOPs) as well as a Joint Program of Work and Funding across the sector. Both the AOP process and the Joint Program have been implemented; however, a mid-term review of the NHSSP II concluded that Kenya was unlikely to meet the plan’s health targets by the end of the implementation period in 2010.

Some of the specific health sector challenges include the absence of a legislative framework to support decentralization, inadequate consultations amongst MOH staff and other key stakeholders, weak management systems, low morale at all levels of personnel, and inadequate funding and low level of resource accountability. One of the major objectives of the NHSSP II is the successful implementation of a series of health reforms that include the decentralization of funding and management away from the central ministry level to the provincial and district level, rationalization of staff, and restructuring the operations of key parastatal organizations. While the reform process has begun, in order for it to be successful, staff at the provincial and district level will require a higher level of competence in management and key management systems to support the process.

### Key results:

- By August 2009, 83 teams from district hospitals, district management teams, faith-based hospitals, health centers, and rural health clinics had completed the Leadership Development Program; all are now focused on improving health service delivery in areas such as increasing immunization coverage and births in health facilities.
- In November 2009, LMS/Kenya provided technical assistances to the Kenya Episcopal Conference and Muslim Health Secretariat in the areas of proposal development, strategic planning and Health Management Information Systems.
- LMS/Kenya collaborated with Kenya Medical Training College, United States International University, and Galilee College to develop a Health Systems Management course with a curriculum built upon the strengths of each institution. LMS also supported the enrollment of 20 officials from Kenya’s Ministries of Health in the first offering of this Health Systems Management course.
- LMS/Kenya also supported the roll out of an LDP to Ministry Staff based at HQ between September 2009 and March 2010, with 29 participants comprised of five deputy heads of department/ division; four senior officers and 20 officers. The teams made significant progress on their planned project activities and most had recorded results at the output level. Overall, the results were good, with various teams exceeding their targets.
- In support of the Hospital Reform Agenda, LMS/Kenya has been leading and coordinating the Priority Hospital

Reform Working Group, a MOMS/USAID partnership focusing priority reforms on level 5 hospitals. The group has been mandated to work with three “pilot” sites—Coast Provincial General Hospital, Western Provincial General Hospital, and Machakos District Hospital—to move them toward greater autonomy and improved service delivery. In-depth assessments of the three hospitals were completed in October 2009. In February 2010, LMS held a visioning workshop to review the findings and recommendations; the workshop had wide participation from MOMS staff at all levels and from all departments, with 70 participants in total. This work will be carried forward under the Associate Award mentioned below, starting with Strategic Planning Workshops for the three pilot hospitals.

Activities are being continued under a five-year Associate Award, which was launched on April 16, 2010.

## Latin America/ Caribbean Regional Bureau

During the last year of the Management & Leadership program, the Business Planning for Health Program (BPH) was adapted for use by municipalities to help officials identify projects, products and services which would benefit the quality of life of their communities and improve their health. During the first year of the LMS program, the USAID/LAC Regional Bureau allocated funds to implement this adapted BPH in municipalities in Nicaragua and Honduras. Discussions were held with USAID/LAC in the fall of 2006 to identify which additional Latin American country programs would be interested in participating in the BPH Program for municipalities for the following project year. Both USAID/El Salvador and USAID/Peru expressed interest in the program and were identified as the two countries that would participate in the BPH.

**Program dates:** October 2006-May 2008

**Budget:** \$509,789

**Challenges addressed:** The Business Planning Program for Municipalities and CORE Plus tool were first administered in the municipalities of Santa Lucía and El Jícaro in Nicaragua; the participating teams addressed challenges dealing with sanitation and the creation of a municipal development fund to overcome the lack of access to affordable credit in the community. In Honduras, teams came from the municipalities of Copán Ruinas, Santa Rita de Copán, Cabañas and San Jerónimo. These four teams together worked on an action plan to build and equip a maternal health clinic, addressing the lack of such a facility in their area.

In the next round, five municipalities in El Salvador (San Pablo Tacachico, Panchimalco, Agua Caliente, El Paisnal, and Tejutla) participated in the BPH Program. The challenges they addressed were varied, relating to safe housing, a clean and safe water supply, and other environmental issues. In Peru, eight municipalities participated: Saposoa, Cainerachi, Chazuta, Nuevo Progreso, Aguaytia, Puerto Inca, Sivia, and Hermilio Valdizán. Their challenges ranged from constructing first aid stations, ensuring clean and safe water supplies, recycling organic and inorganic waste, to developing eco-tourism related businesses.

### Key results:

- In San Pablo Tacachico, El Salvador, the project to introduce clean water in four communities received funding from Plan International, and was being implemented at the close-out of LMS/LAC activities (May 2008).
- In Peru, all of the projects received partial committed funds from the involved communities, municipalities, or regional governments by May 2008.

Activities were completed by the end of May 2008.

## Nepal

In the context of a major decentralization effort, the government of Nepal requested assistance from USAID/Nepal to enhance the management and leadership capacity of personnel in district and local health facilities. USAID/Nepal asked Management Sciences for Health to provide technical assistance through the Leadership, Management, and Sustainability (LMS) Program. The objectives of the LMS/Nepal Program were the following:

- Demonstrate that strengthening management and leadership capacities can improve health programs and offer the foundation for improved overall quality of life.
- Increase the ability of district and lower level staff to lead and manage effectively.
- Strengthen the capacity of central and district level Ministry of Health staff, select Nepali organization staff and implementing partner organizations staff to deliver management and leadership development interventions, creating a foundation for replication and scale up.

**Program dates:** March 2006-March 2008

**Budget:** \$917,225

**Challenges addressed:** The Government of Nepal was looking for leadership development programs to empower local level officials to lead development in the decentralized context. They wanted an approach that would demonstrate that improvements in leading and managing practices could produce results with the existing available resources.

## Key results:

With the project goals in mind, the National Health Training Centre (NHTC) of the Ministry of Health and Population (MOHP), with technical assistance from MSH, The Adventist Development and Relief Agency (ADRA)/Nepal, and the Institute of Cultural Affairs (ICA)/Nepal set out to implement the Results Oriented Leadership Development Program (ROLDP) in three pilot districts: Banke, Jhapa, and Rupandehi. The program was well received, so it went on to a second phase. Key results included:

- During the two phases of the program, more than 160 health managers participated in leadership development activities.
- Fifty-two ADRA professionals from 25 countries have been trained in the LDP methodology via the ADRA Professional Leadership Institute; ADRA has used these skills to mobilize resources for many different projects. Two examples: a reproductive health project that addressed the needs of 300,000 Nepalese (with funding of \$1.3 million from the European Community); and a USAID-funded family planning project that increased contraceptive prevalence rate by 9% in the intervention area (from 44% to 53%).
- The continued use of ROLDP methodologies ensured that the project has endured beyond LMS' project life cycle, thus increasing the value of USAID/Nepal's original investment. ADRA/Nepal trained seven organizations in ROLDP, ICA/Nepal has trained hundreds of participants and NHTC continues to hold decentralization workshops. At the LMS End of Project Conference in May 2010, an ADRA Nepal staff member reported that more than 700 people have been trained using the ROLDP methodology.
- The MSH Managers Who Lead Handbook was produced in Nepali and 400 copies were distributed to clients of the NHTC, government agencies, donors, and NGOs.

LMS activities were completed in 2008.

## Nicaragua

PRONICASS directly supports Intermediate Result (IR) 3.1 "Increased and Improved Social Sector Investments and Transparency" within USAID/Nicaragua's current Country Plan Strategic Objective 3 "Investing in Healthier, Better Educated People." Given its broad, social sector focus, the project has worked with most of the social sector ministries (Health, Education, Family Welfare), in addition to providing assistance to the Nicaraguan Social Security Institute, the Emergency Social Investment Fund, the government of the Southern Autonomous Atlantic Region, the Secretariats of Education of both the RAAS and the Northern Autonomous Atlantic Region, the Ministry of Finance, the Nicasalud Health Federation and, especially to one of its members, PROFAMILIA, the local IPPF

affiliate. The project also worked directly with the Municipal Development Institute and with national and departmental associations of municipalities.

**Program dates:** August 2005 – August 2010

**Budget:** \$13,577,350

**Challenges addressed:** A central challenge in Nicaragua is the lack of organization of the available resources dedicated to social service programs. The result is an often inefficient and ineffective use of these limited resources. Throughout the lifespan of LMS, PRONICASS was tasked with confronting including but not limited to these in implementing projects in several social sectors:

**Institutional capacity building challenge with Nicasalud:** In 2005, PRONICASS received an urgent request from USAID to assist Nicasalud in becoming certified for direct USAID financing. The USAID health strategy called for providing funding for community health activities directly through Nicasalud, rather than through a central project as had been done in the past.

**Supporting the Global Fund CCM:** LMS was requested by the USAID Mission in Nicaragua to provide technical assistance to rapidly strengthen management of all Global Fund projects being implemented in the country. Management development assistance was required to ensure compliance with terms of existing projects. The project specifically called for strengthening the management and improving the communication of the CCM as well as clarifying its internal roles and responsibilities.

## Key results:

- PRONICASS has been working with 49 organizations to apply leadership and management skills to improve performance in service delivery. More than 4,400 senior leaders have been trained, including over 2,500 women. PRONICASS has helped transform and update the curriculum of seven medical specialties, including Pediatrics and Obstetrics, in public medical schools.
- Twenty-nine communities and 750 people in the departments of Leon, Nueva Segovia and Boaco were trained in how to implement the new health care model of the Ministry of Health.
- PRONICASS provided technical assistance to the Ministry of Education to develop educational plans to improve local development. To date, over 114 schools in 14 municipalities (15% of the country) have begun this school planning process involving the participation of 3,500 school directors, teachers, students and parents.
- Technical assistance provided by PRONICASS resulted in USAID certification of Nicasalud in mid-2006. Under a second request for LMS support, a contract performance monitoring system was established. PRONICASS completed its assistance with the design of the remaining Nicasalud systems—governance, communications and federation network management.

- During the first phase of PRONICASS, the project extended its institutional reorganization efforts to eight federation members and has worked with them and the Nicasalud technical office in helping align institutional operations with organization's mission, vision and legal mandate.
- The Ministry of Family Welfare (MIFAMILIA) offered one of the best opportunities for PRONICASS to clearly link planning and budgeting, i.e. what produced results-based budgeting. In 2007, a results-based budget for MiFamilia was submitted to the Ministry of Finance. This experience served as the basis for the creation of a Guide to Results-Based Budgeting which has served as one of the reference documents used by the Ministry in training all other ministries in preparing their annual budgets.
- In 2006, PRONICASS developed its Guide for the Development of Competency-Based Job Training. The guide and the general approach have been widely validated and applied with primary health care physicians and nurses in León, community health workers in León and Nueva Segovia, with medical students at UNAN Managua, in the curricular transformation of seven specialties including pediatrics and obstetrics and gynecology in both UNAN Managua and UNAN León and in the development of the diploma/certificate program in management and leadership for first level health care managers in León.
- PRONICASS prepared a set of workshops and a variety of tools (case studies, multiple choice tests, clinical rounds, case presentations, etc.) for use by medical clinical professors, training over 80 of them from Managua's 10 main teaching hospitals. This evolved into a certificate program with the UNAN León medical school which has benefitted over 130 medical tutors.
- PRONICASS has worked with PROFAMILIA (the largest IPPF affiliate in the country) in developing four information system modules: 1) billing, 2) inventory, 3) statistics and 4) advance funds. These information systems are used in all of PROFAMILIA clinics to permit a more efficient, effective and transparent administration.

## Nigeria LMS AIDS Care and Treatment Project (LMS-ACT)

LMS-ACT was a 20-month, PEPFAR funded associate award under LMS that ended in July 2009. The project was designed to rapidly scale up availability and increase accessibility to quality comprehensive AIDS prevention, care and treatment services. While the ACT project met this objective, it also developed the capabilities of Nigerian public sector and NGOs in leadership and management in support of service delivery of integrated HIV/AIDS programs including HCT, ART, PMTCT, Palliative Care, TB/HIV and OVC. In addition, the project emphasized building health systems that were responsive to the needs of HIV/AIDS and TB clients. The project built health workers' skills in technical HIV/AIDS and TB preven-

tion and control and supported them in the provision of comprehensive AIDS services.

**Program dates:** October 2007 – July 2009

**Budget:** \$17,213,632

**Challenges addressed:** Nigeria has some of the worst basic health indicators, including one of the lowest levels of family planning use in the world. One in five children in Nigeria dies before reaching their fifth birthday. However, a long period of relative political stability including the country's first ever civilian transfer of power in 2003 has allowed the government to reenergize the entire health sector.

Among the most daunting of Nigeria's public health issues is HIV/AIDS. Although Nigeria's HIV prevalence is lower than that of the adjacent southern Africa region, averaging 4.6%, an estimated four million people were living with HIV/AIDS in 2007, placing the country second only to South Africa in terms of global infection burden. In addition, one million or more children under age 17 were thought to have lost a parent to AIDS.

There are marked regional differences in HIV prevalence: from 2.5 percent in the North West, it increases to 9.3 percent in the South East, and 12 percent in the Cross River region. While the Federal Ministry of Health's National AIDS and STI Control Programme called for delivering comprehensive AIDS prevention, care, and treatment services to 25 percent of the population by 2008. In 2007, the majority of people living with HIV were still in need of AIDS services.

LMS helped address these challenges by developing leaders and managers at all levels of Nigerian health care organizations and programs, in both the public and nongovernmental sectors, to effectively respond to change and improve health outcomes in the area of HIV/AIDS.

**Key results:** Between October 2007 and July 2009:

- 76,252 people were tested for HIV/AIDS and received their results.
- 1,399 patients were newly initiated into anti-retroviral therapy, of which 52 were children, and 47 were pregnant females
- During this period 91,172 tests were performed for HIV, TB, and syphilis
- 937 OVC were provided with services
- 1,460 patients tested for HIV/AIDS and received their results in a TB setting
- 371 HIV positive patients received TB treatment
- 22,195 pregnant women tested for HIV, counseled and received results
- 160 pregnant, HIV+ women received ARV prophylaxis

A five-year, \$60 million dollar Associate Award began in July 2009 entitled Prevention and Organizational Systems – AIDS Care and Treatment (ProACT).

## Nigeria Capacity Building Project

The Capacity Building (CB) Project provides comprehensive, continuous institutional capacity building support to strengthen the essential management and operations systems of nascent Nigerian NGOs and CSOs. This support is to enable NGOs and CSOs to receive and administer funds from PEPFAR to successfully meet their proposed HIV/AIDS prevention, care, and treatment targets.

In addition, the CB Project provides institutional capacity building support to selected government institutions and the Nigeria Country Coordinating Mechanism (CCM) to improve their ability to provide nationwide coordination, thereby increasing synergies and effectiveness of the PEPFAR programs.

The CB Project also supports the PEPFAR Health Professionals Fellowship, designed to develop the skills and strengthen the management and leadership capacity of health care providers to deliver HIV/AIDS services.

**Program dates:** July 2006 – June 2010

**Budget:** \$14,469,403

**Challenges addressed:** The LMS Nigeria CB Program is working with CSOs to build their capacity to access, manage, and report on USG funds and strengthening the coordination roles of public sector groups to effectively lead the national HIV/AIDS, TB, and OVC response.

**Key results:** Results of the LMS Nigeria CB Project include:

- Provided comprehensive technical assistance for passing a pre-award audit to 10 CSOs in order to receive U.S. Government funds directly.
- Six of these 10 organizations were able to directly access funds and are managing a total of \$32.9 million in U.S. government funds. They have collectively reached a total of 179,118 people with a number of service packages through March 2010.
- Provided concept paper, proposal development, leadership, management, and financial management technical assistance to an additional 60 CSOs. Trained 107 health-care professionals including doctors, nurses, and laboratory specialists with the PEPFAR Health Professional Fellowship Program.
- Through the PEPFAR Fellows, reached over 270,000 people with HIV/AIDS prevention, care, and treatment in 16 months.
- Provided technical assistance to the following eight key Government of Nigeria agencies in the Federal Ministry of Health and Federal Ministry of Women Affairs and Social Development:
  - » Department of Public Health;
  - » Department of Family Health;

- » Department of Planning, Research and Statistics;
  - » National HIV/AIDS Division;
  - » National Tuberculosis and Leprosy Control Program;
  - » OVC Division of the Federal Ministry of Women Affairs;
  - » National AIDS Control Agency;
  - » Country Coordination Mechanism for the Global Fund.
- In May 2008, eight senior leaders from the OVC unit of the Ministry of Women's Affairs participated in a two-week study tour to share best practices with counterpart organizations and NGOs in South Africa and Uganda.
  - Support the National HIV/AIDS Division with data systems including computer and a local area network
  - Development of a website for the OVC Division to help it disseminate OVC program guidelines and service standards <http://www.ovcnigeria.org/>.

A five-year, \$25 million Associate Award Project entitled Program to build Leadership and Accountability in Nigeria's Health System (PLAN-Health) launched in June 2010 to continue activities.

## Nigeria ProACT

A follow on to LMS-ACT, ProACT continues to support HIV/AIDS and TB services in the six project states of Kogi, Niger, Kwara, Kebbi, Taraba, and Adamawa, while placing a stronger emphasis on building government and CSO capacity (organizational systems development) to strengthen health and HIV/AIDS systems for delivery of integrated health and HIV/AIDS and TB services. HIV prevention and AIDS care and treatment services, together with selected wrap around services (maternal, neonatal and child health including family planning, malaria, and nutrition) will form the core package of services. Using gender-based approaches and through small grants program for local CSOs, This project supports strengthening of community organizational systems for management of HIV/AIDS as a chronic illness and overall improvements in community health.

**Program dates:** July 2009 – July 2014

**Budget:** \$59,997,873

**Challenges addressed:** ProACT is addressing challenges in health systems strengthening including government leadership and stewardship for effective governance; in the area of HIV prevention including community mobilization and advocacy; in community care, HIV counseling and testing, and services for orphans and vulnerable children; in clinical services including prevention of mother-to-child transmission, adult care and treatment, TB/HIV, and pediatric care and treatment; and challenges in laboratory services and supply chain management.

**Key results:** Between August 2009 and March 2010:

- 85,496 people were tested for HIV/AIDS and received their results.
- 2,858 patients were newly initiated into anti-retroviral therapy, including 147 children
- 45,199 tests were performed for HIV, TB, and syphilis
- 1,165 OVC were provided with services
- 2,226 patients were tested for HIV/AIDS and received their results in a TB setting
- 186 HIV-positive patients received TB treatment
- 27,072 pregnant women were tested for HIV, counseled and received results
- 327 pregnant, HIV+ women received ARV prophylaxis

## Peru

The Healthy Communities & Municipalities (HCM) project aims to improve maternal and child health of communities in Peru traditionally abandoned both by the government and private investment. Since 2006, the LMS program has supported HCM, and is now working in 1,764 communities to foster behavior changes that will result in the improvement of social development indicators, women's health, and child health indicators. HCM empowers communities through civil participation, by promoting and implementing public health policies, and reorienting social services toward promotion and prevention. LMS assistance in Peru focuses on applying the concepts and practical approaches of leadership and management to promote healthy lifestyles and behaviors and empowerment of the Peruvian people through community and civic participation.

**Program dates:** 2006 – 2010

**Budget:** \$13.3 million

**Challenges addressed:** Over the past decade, Peru has made significant progress in reducing the production of coca, stabilizing its economy, and increasing access to social services. Despite these advances, health indicators in many regions of Peru remain low, and important public health initiatives, such as clean drinking water and adequate family planning and reproductive health services, are absent in certain areas, particularly in the more remote sections of the country. Further complicating matters is that service delivery is perhaps weakest in the coca growing regions of Peru, which suffer from a high concentration of corruption and drug-trafficking.

The LMS challenge is to improve the health, welfare and development of hundreds of Peruvian communities dispersed throughout the country. This task is ambitious and requires a foundation in both strong leadership practices and management systems, especially systems that allow for the collection, organization and use of data and information to gauge progress and inform decision making.

**Key results:**

- HCM has expanded from its original 515 communities to 1,764 communities within and outside of the Alternative Development Zone; all of these communities have held elections to name local members to Community Development Committees.
- More than 850 organizations in these communities are now applying leadership and management practices to health service delivery challenges.
- A total of 3,500 men and women have been trained in these areas, including 243 senior leaders (147 women).
- More than 340 primary health centers have measured their quality of attention to child health, resulting in 45 improvement projects.
- More than 100 workshops have been held to train female community leaders and adolescents about family planning and their sexual and reproductive rights.
- 86% of communities participating in the program since 2006 have continuously applied a diagnostic tool to measure progress of key health indicators on a bi-annual basis.
- The project has received recognition in Peru from both the public and private sectors, which has fostered strategic partnerships that have facilitated the expansion of the project and the institutionalization of its methodology and tools. These partners include the National Center for Nutrition and the General Directorate for Health Promotion, both of the Ministry of Health; and Barrick Mining Company and Cementos Lima.

## Southern Sudan

In Southern Sudan, LMS assisted the Government of Southern Sudan (GOSS) to develop supportive policies relating to family planning and strengthen the capacity of champions within the GOSS to advocate for the importance of family planning in the context of maternal health, child survival, and family economics. LMS took a group of officials from the Ministry of Health (MOH) to on a study tour to Rwanda and placed a consultant with MOH's Reproductive Health Unit to support the development of policies and strategies relating to family planning. In addition to primarily working on the development of a national family planning policy, the consultant also provided technical input in areas such as maternal and child health policy development, and worked to engage NGO, CSO and private sector actors in promoting the importance of family planning issues.

**Program dates:** October 2008 – December 2009

**Budget:** \$300,000

**Challenges addressed:** Southern Sudan has the highest maternal mortality rate in the world at 2,037 deaths per 100,000 live births, and an extremely low contraceptive prevalence rate of

less than 1%. In this post-conflict country, the idea of family planning is still highly sensitive, but the Ministry of Health has made promotion of child spacing in the context of maternal health and child survival part of its agenda. The development of a national Family Planning Policy and raising awareness about family planning among policy makers and MOH/GOSS staff were seen by USAID and the MOH as key steps in moving this agenda forward.

**Key results:** In April 2009, the LMS project conducted a one-week study tour, bringing a group of eight family planning champions from Southern Sudan to Rwanda, where they saw first-hand the achievements of a program that faced similar post-conflict challenges, and learned from the successes, challenges and failures experienced by their Rwandan colleagues.

In December 2009, LMS finalized the Family Planning Policy, which has been adopted by the MOH while awaiting formal approval by Parliament. MSH's Sudan Health Transformation Project II supported a National Consensus Workshop in November to review the draft policy with the participation of roughly 50 people from the Ministry of Health, other branches of the government, UN agencies, international and local NGOs, and private clinics and pharmacies. Over the two-day review, participants discussed the family planning situation in the country and made detailed recommendations on the content of the policy document.

MSH's Sudan Health Transformations II Project (SHTPII) is continuing much of LMS' work in Sudan in a wide range of areas including family planning.

## Tanzania

LMS Tanzania provided technical assistance in the areas of management, leadership, and governance to local public and private sector organizations working in HIV/AIDS with the goal of strengthening the local capacity to lead, manage, and coordinate effective HIV/AIDS programs. To this end, the project focused on six interrelated objectives:

- Support the Tanzania Commission for AIDS (TACAIDS) to enable them to effectively lead and coordinate the national multi-sectoral response to HIV/AIDS.
- Support the Zanzibar AIDS Commission, national ministries, and the District AIDS Coordinating Committees to lead and manage HIV/AIDS programs effectively.
- In collaboration with Deloitte Consulting Co., manage the Rapid Funding Envelope (RFE), a grant-making mechanism that pools funds from multiple donors and awards grants to local CSOs.
- Strengthen Global Fund programs and performance by building capacity of the Country Coordinating Mechanisms, supporting the establishment of effective Secretariats, and improving oversight and reporting.

- Build the capacity of local consultants and link them with CSOs and public sector departments working in HIV/AIDS to provide targeted technical assistance.
- In collaboration with IntraHealth, strengthen the leadership and management capacity of local implementing agencies and central and local government authorities to address human resources for health challenges.

**Program dates:** September 2005 – June 2010

**Budget:** \$5,665,000

**Challenges addressed:** Working with a range of CSOs and public sector teams, LMS Tanzania sought to address the root causes of ineffective HIV/AIDS programs, including lack of planning and coordination, outdated or non-existing organizational policies and procedures, unmet human resource needs, and other deficiencies in management, leadership and governance practices. Recognizing the need to build the capacity of local entities to resolve their own challenges and thereby contribute to long-term, locally sustainable improvements in HIV/AIDS policies and systems, LMS Tanzania emphasized participatory approaches in all technical assistance work, and made extensive use of local capacity building experts to deliver technical assistance interventions. Whereas TACAIDS had been the primary beneficiary of technical support under the M&L Program, the LMS approach transitioned to a focus on supporting TACAIDS' mandate through a broader effort to build capacity of civil society clients, the public sector, and the structures supporting Global Fund implementation on the mainland and Zanzibar.

**Key results:**

- LMS has worked with 162 CSOs, public sector institutions, Global Fund CCMs, technical working groups, and other structures on the mainland and Zanzibar, strengthening their capacity to improve and expand HIV/AIDS services at all levels.
- LMS supported four open rounds of grant making for the RFE, resulting in 111 awards to local Tanzanian NGOs participating in the fight against HIV/AIDS, totaling approximately \$15 million.
- Under LMS, Global Fund CCMs have updated or established Operations and Procedures Manuals, Bylaws, Secretariats, and technical oversight committees that use Executive Dashboards, pioneered by LMS, for improved oversight and reporting. LMS also spearheaded the effort to renew CCM constituent membership through transparent processes.
- LMS provided organizational development and capacity building technical support to the Tanzania Commission for AIDS; the Zanzibar AIDS Commission; three departments or programs of the Ministry of Health and Social Welfare, and five CSOs playing key roles in the national response to HIV and AIDS.

- LMS established an informal network of 25 local capacity builders, equipping them with proven tools and best practices through a series of short, focused Training of Trainers workshops on topics of management, leadership, and governance. These consultants then worked with CSOs and public sector teams in need of technical assistance.
- As a result of the LDP implemented in Zanzibar, 45 teams (200 individuals) from the MOHSW, line ministries, and the 10 District AIDS Coordinating Committees developed and implemented action plans to further workplace HIV and AIDS programs and interventions.

The USAID mission in Tanzania is continuing the work of LMS through other projects or with support from other donors.

## Uganda

Under the Leadership, Management and Sustainability Program, MSH provided technical support to Uganda's Joint Clinical Research Centre (JCRC), a leading provider of HIV/AIDS treatment services in Uganda, to strengthen various management components—such as human resources management, commodity management, and safety and quality assurance—and to strengthen the management capacity of the teams of doctors, nurses, adherence officers and other staff working at its six regional centres of excellence, including the support systems these staff members required, e.g. supervision, from JCRC at the central level in Kampala.

LMS provided support that continued from the predecessor project, M&L, to help the Inter Religious Council of Uganda (IRCU) obtain a three-year cooperative agreement with USAID/Uganda to further build upon its achievements, expand coverage of services, and consolidate its capacity as the premier organization coordinating the faith-based response to HIV/AIDS in Uganda. At USAID/Uganda's request, LMS provided support for the Chairman of the IRCU's HIV/AIDS Advisory Board and the IRCU PEPFAR Grants Manager to attend the MSH-Boston University course on "Leading Organizations to achieve the MDGs in Health" offered in Boston in July 2007.

**Program dates:** April 2006-July 2010

**Budget:** \$1,347,447

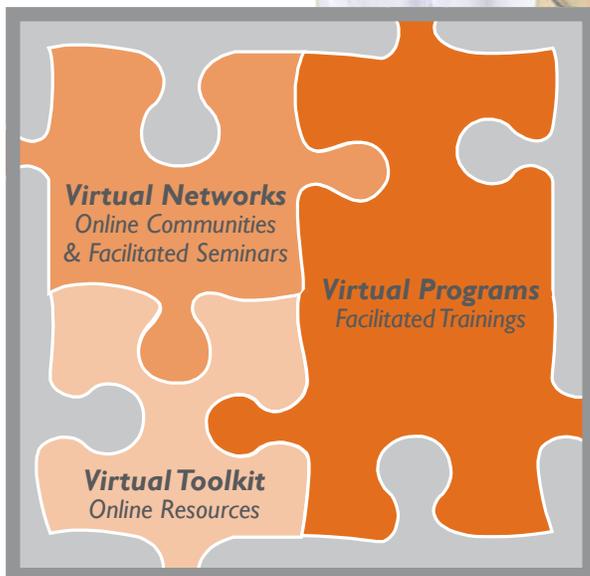
**Challenges addressed:** The JCRC began in 1991 as a small research center with five employees. By 2006, the organization had grown to 230 employees working in more than 40 locations, providing treatment to more than 60,000 persons living with AIDS. LMS was tapped to help the JCRC strengthen the leadership and management capacity of managers in its laboratory network and the management systems of JCRC as a whole to manage growth and strengthen performance.

## Key results:

MSH provided technical assistance to IRCU to help the network more effectively lead the FBO response to the HIV/AIDS epidemic and strengthen its management capacity to issue and oversee grants. Through local partnerships, these organizations are capitalizing on the religious health service delivery structure and community groups to provide HIV/AIDS care and treatment services to orphans and people living with HIV/AIDS. MSH helped transform the vision of IRCU's founding religious leaders into a functioning organization which recently underwent a USAID pre-award assessment and is now receiving PEPFAR funding directly from USAID.

Activities will be completed by the end of the LMS Leader Award.

# Appendix II: Virtual and Face-to-Face Programs



*LMS improves the leading and managing capacities of organizations and health systems with a focus on achieving measurable results. This section includes a basic description of all LMS Virtual Programs as well as details on all the Leadership Development Programs implemented during LMS.*

## 1. The Virtual Leadership Development Program (VLDP)

Languages available: Arabic, English, French, Spanish, Portuguese, Russian

Length of Program: 13 weeks

Developed under the USIAD-funded Management and Leadership (M&L) Program (2000-2005), the Virtual Leadership Development Program (VLDP), is MSH's farthest-reaching virtual program to date. The VLDP is a 13-week program available in English, French, Spanish, Portuguese, Arabic and Russian, strengthens the capacity of health teams to identify and address organizational and service delivery challenges. During the VLDP, each team plans and develops an action plan that addresses a real organizational or programmatic challenge facing them.

The VLDP is designed in seven modules, one introductory, five content modules, and one conclusion module. The five content modules of the VLDP cover the following topics:

- Introduction to leadership in health institutions
- Facing leadership challenges
- Competencies in leadership
- Communication
- Change management

Leadership and organizational development experts facilitate the program, providing support and feedback to participants via email, telephone and Web site postings throughout the program. Experts in monitoring and evaluation assist the facilitation team when the participants are working on their leadership action plans.

The VLDP results in improved health outcomes through the implementation of a leadership action plan as well as improved teamwork and workgroup climate. The VLDP has been successfully adapted and implemented, helping teams of health professionals around the world to address health management challenges related to Reproductive Health and Family Planning, HIV/AIDS, and tuberculosis, among others.

## 2. The Virtual Strategic Planning Program (VSPP)

Languages available: English, Spanish

Length of Program: 17 weeks

The Virtual Strategic Planning Program is a blended learning program that guides senior teams through the four basic questions of the planning process in order to produce strategic plans for their organizations. The VSPP is structured in six modules, and delivered over a period of 17 weeks. The program's team of facilitators supports teams from public health organizations in the creation of strategic plans. Each module is structured with a theoretical framework, individual readings, exercises, group work, and exchange between participants and the facilitators through the website's asynchronous chat board and email. During the program, the organizations' missions and visions are reviewed. Teams also analyze their current situation and define strategic objectives and strategies in order to achieve their organizational vision. Throughout the program, teams determine the mechanisms necessary to meet their objectives and implement new strategies and the participants strengthen their ability to plan and to think strategically.

## 3. Virtual Business Planning for Health Program (VBPH)

Languages available: Spanish, (CD-Rom version available English, French, Spanish)

Length of Program: approximately 20 weeks

The Virtual Business Planning for Health program (VBPH) helps organizations build expertise in business planning. The VBPH covers topics such as capturing and packaging breakthrough ideas, identifying target markets and marketing strategies, and determining the best complement of staff to design and launch the new product or service. The VBPH helps NGOs navigate the financial aspects of a business plan, projecting both social and financial return on investment. The tools, techniques, and worksheets supplied during the learning experience simplify the complexities of business planning, while helping participants balance their enthusiasm with market realities. In the past, many of the ideas carried out by NGOs have been shaped by the donors and external parties that provide the funding. The VBPH program encourages organizations to identify and offer innovative products and

services based on market research and client needs instead of adapting ideas to correspond to donor priorities.

The VBPH was first offered in 2008 under the LMS Program, based on the CD-Rom version that had been developed under the M&L Program and offered 18 times in that form.

## 4. Virtual Human Resource Management Program (VHRM)

Languages available: English

Length of Program: 8 weeks

The Virtual HRM Program is an eight week program designed for teams of HR managers, health program and operations managers responsible for HR who want to improve HRM in their organizations. The purpose of this program is to help health managers better understand the role of HRM in their organization, learn how they can strengthen it in order to improve staff satisfaction and performance, and develop an action plan to strengthen organizational outcomes and personnel performance.

## 5. Virtual CSO Board Governance Program (VCGP)

Languages available: English, Spanish

Length of Program: 8 weeks

The Virtual CSO Board Governance Program is an eight week program designed for teams consisting of Board of Directors members, the Executive Director and senior management of a Civil Society Organization. The purpose of this program is to understand the board's roles, responsibilities, and main activities; ensure board accountability and transparency; and prevent conflict-of-interest situations.

## 6. Virtual Fostering Change Program (VFCP)

Languages available: English, French

Length of Program: 1 year

The Virtual Fostering Change Program is an extension of A Guide to Fostering Change to Scale-up Effective Health Services. As the Guide was, the VFCP will be a collaboration of the Implementing Best Practices (IBP) Initiative that will be led by Management Sciences for Health. The purpose of the Virtual Fostering Change Program is to guide teams through the change planning process for scaling up proven health interventions using a blended learning virtual approach. The target audience is Ministry of Health National, Regional/Provincial or District Technical Program Teams (those in charge of introducing new policies and practices) and Technical Program Teams from FBOs and NGOs working at the district, regional/provincial or national level. The program is offered in 3 phases:

Phase 1: Identifying the need for change and preparing for demonstration (8 to 10 weeks)

Phase 2: Supporting the demonstration (6 to 8 months)

Phase 3: Preparing for Scale (4 weeks)

## LMS Virtual Program Deliveries (August 2005 – March 2010)

Program Title	Language	Focus	Country(ies)	Types of Organizations	Funding Source
2005					
VLDP Haiti	French	Leadership Strengthening for HIV/AIDS organizations	Haiti	MOHs, NGOs	HS -2007, Haiti bilateral
VLDP Iraq	English	Leadership Strengthening for MOH priorities: child health, environmental health, etc.	Iraq	MOH	BASICS Project
2006					
VLDP HRM	English	Leadership Strengthening for HRM	Uganda, Nigeria, Namibia, Kenya, Tanzania, Lesotho	MOHs, NGOs	1/2 LMS Pop Core; 1/2 Capacity Project
VLDP Haiti II	French	Leadership Strengthening for HIV/AIDS organizations	Haiti	MOHs, NGOs	HS-2007, Haiti bilateral
VLDP Iraq II	Arabic	Leadership Strengthening for MOH priorities: child health, environmental health, etc.	Iraq	MOHs	BASICS Project
VLDP Peru	Spanish	Leadership Strengthening for Family Planning organizations	Peru	CAs	LMS Peru Field Support
VLDP Rwanda	French	Leadership Strengthening for HIV/AIDS organizations	Rwanda	MOHs	BPF-HIV Project, Rwanda bilateral
VSPP I LAC	Spanish	Strategic Planning	Peru, Guatemala, Nicaragua, Bolivia, Ecuador	NGOs	LMS: Pop Core

Program Title	Language	Focus	Country(ies)	Types of Organizations	Funding Source
2007					
VLDP HRM II	English	Leadership Strengthening for HRM	Nigeria, Malawi, Ethiopia, Madagascar, Rwanda, Uganda, South Africa	MOHs, NGOs	1/2 LMS Pop Core; 1/2 Capacity Project
VLDP CS (LAC)	Spanish	Leadership Strengthening for Contraceptive Commodities Security	Honduras, El Salvador, Paraguay, Dominican Republic	MOHs, NGOs, Social Security Institute, Etc.	LMS: Pop Core-CS
VLDP OHA	English	Leadership Strengthening for HIV/AIDS organizations	Tanzania, Botswana, Swaziland, Zambia, Malawi	MOHs, NGOs	LMS: OHA Core
VLDP Rwanda II	French	Leadership Strengthening for HIV/AIDS organizations	Rwanda	MOH	BPF-HIV Project, Rwanda bilateral
VLDP EE	Russian	Leadership Strengthening for HIV/AIDS and TB co-infection	Kazakhstan, Russia, Ukraine, Belarus	MOHs, NGOs	LMS: E&E Bureau Field Support
VSPP II Africa	English	Strategic Planning	Nigeria, Malawi, Namibia, Afghanistan, Kenya, Uganda	NGOs, Academic Institutes, Public Sector	LMS: Pop Core
2008					
VLDP Pre-service	English	Pre-service integration of leadership & management curricula	Egypt, Kenya, Uganda, Mexico, Tanzania, South Africa, Yemen	Academic Institutes	LMS: Pop Core
VLDP for Family Planning	English	Leadership Strengthening for Family Planning organizations	Tanzania, Ethiopia, Malawi, Uganda, Kenya	MOHs, NGOs	Capacity Project

Program Title	Language	Focus	Country(ies)	Types of Organizations	Funding Source
2008 (continued)					
VLDP CS	French	Leadership Strengthening for Contraceptive Commodities Security organizations	Mali, Madagascar, Rwanda, Senegal	MOHs, NGOs, Pharmacy Task Force	LMS: Pop Core
VLDP Public-Private Partnerships	English	Leadership Strengthening for Public-Private Partnerships in FP/RH	Nigeria, Ethiopia, Swaziland, Ghana, Kenya	MOHs, NGOs	LMS: Pop Core; PSP-One
VBPH	Spanish	Business Planning	Peru, Paraguay, Honduras, El Salvador	NGOs	LMS: Pop Core
VHRM	English	Human Resource Management	Tanzania, Ethiopia, Namibia, Uganda	MOHs, NGOs	LMS: OHA Core
2009					
VLDP M&E I	English	Monitoring & Evaluation, HIV/AIDS	Botswana, Ghana, Guyana, India, Kenya, Nigeria, Swaziland, Uganda, Zambia	NGO, FBO, public sector	MEASURE Evaluation
VLDP M&E II	English	Monitoring & Evaluation, Family Planning	Ethiopia, Kenya, Malawi, Myanmar, Nigeria, Uganda, Zimbabwe	NGO, FBO, public sector	MEASURE Evaluation
VLDP M&E III	English	HIV/AIDS	Ethiopia, Kenya, Nigeria, Tanzania, Uganda	CAs, MOH, NGO, FBO	MEASURE Evaluation
BLDP Rwanda	French	HIV/AIDS	Rwanda	MOHs	Rwanda MSH Bilateral
VSPP	English	HIV/AIDS	Bangladesh, Kenya, India, Uganda, Vietnam, Nigeria	Public sector, NGOs, academic, FBO	LMS: OHA Core
VCGP	English	Family Planning	Afghanistan, Ethiopia, Kenya, Nigeria	NGOs	LMS: Pop Core

Program Title	Language	Focus	Country(ies)	Types of Organizations	Funding Source
2009 (continued)					
VCGP 2	Spanish	Family Planning	Guatemala, Nicaragua, Honduras	NGOs	LMS: Pop Core
VCGP 3	English	HIV/AIDS	Ethiopia, Ghana, Kenya, Uganda	NGOs	LMS: OHA Core
VLDP OHA	English	HIV	Kenya, Ethiopia, Zambia, Tanzania, Uganda, Lesotho, Zimbabwe, South Africa	MOHs, NGOs	LMS: OHA Core
VHRM 2	English	Human Resource Management	Afghanistan, Bangladesh, Ghana, Kenya, Nigeria, Uganda, Ukraine	MOH, NGOs, FBOs	LMS: OHA Core
VLDP Brazil	Portuguese	HIV/AIDS	Brazil	NGOs (CSOs)	LMS: Brazil Field Support
VLDP Peru	Spanish	Health Promotion	Peru	MOHs	LMS: Peru Field Support
VFCP PAC (Ongoing)	French	Post Abortion Care	Burkina Faso, Guinea, Rwanda, Senegal, Togo	MOHs, CAs, NGOs	LMS: Pop Core
VFCP ANE	English	Maternal and Child Health	Afghanistan, Indonesia, Jordan, Nepal	NGOs	LMS: Pop Core

Program Title	Language	Focus	Country(ies)	Types of Organizations	Funding Source
2010					
VBPH 2	Spanish	Family Planning	Bolivia, Honduras, El Salvador, Dominican Republic, Peru	NGOs	LMS: Pop Core
VSPP M&E	English	HIV/AIDS	Botswana, Cambodia, Ghana, India, Nigeria, Ukraine, Uganda, Sudan, Zambia	CAs, FBOs, public sector	MEASURE Evaluation
VLDP OECS	English	HIV/AIDS	Eastern Caribbean states	MOHs, Global Fund Project teams	Organisation of Eastern Caribbean States (OECS, a Global Fund Principal Recipient)
VLDP FP Africa	English	Family Planning	Cameroon, Kenya, Ghana, Liberia, Tanzania, Namibia, Nigeria, Sierra Leone, Ethiopia, Zimbabwe	NGOs (IPPF Affiliates)	LMS Pop Core

## LMS Face-to-face Leadership Development Program Deliveries by Country

Country	MSH Center and Program	Number of LDPs	Funding Source
Afghanistan	CLM/LMS Technical Support to the Central and Provincial Ministry of Public Health (Tech-Serve)	130	Associate Award
Benin	CHS Basic Support for Institutionalizing Child Survival, Phase III (BASICS)	1	Core
Bolivia	CHS Stamping Out Pandemic and Avian Influenza (STOP AI)	1	Core
Botswana	CLM/LMS Southern Africa Human Capacity Development (SAHCD)	1	Associate Award
Burundi	CHS Extending Service Delivery for Reproductive Health and Family Planning (ESD)	1	Core
Cambodia	CLM Leadership, Management, and Sustainability Program (LMS)	1	Core
Cote d'Ivoire	CLM Leadership, Management, and Sustainability Program (LMS)	1	Field Support
Cote d'Ivoire	CLM Monitoring and Evaluation to assess and Use Results, Phase III (MEASURE)	1	Core
DRC	CHS/ AXCES The Integrated Health Services Program in the Democratic Republic of Congo	1	Bilateral
DRC	CLM Leadership, Management, and Sustainability Program (LMS)	4	Field Support
Egypt	CLM Leadership, Management, and Sustainability Program (LMS)	4	Associate Award
El Salvador	CHS Stamping Out Pandemic and Avian Influenza (STOP AI)	1	Core
Ethiopia	CLM Leadership, Management, and Sustainability Program (LMS)	4	Field Support
Ghana	CLM Leadership, Management, and Sustainability Program (LMS)	1	Core
Ghana	CLM Leadership, Management, and Sustainability Program (LMS)	1	Field Support
Guatemala	CHS Stamping Out Pandemic and Avian Influenza (STOP AI)	1	Core
Guyana	CHS Guyana HIV/AIDS Reduction and Prevention (GHARP) I and II	8	Bilateral
Haiti	CLM Leadership, Management, and Sustainability Program (LMS)	7	Field Support, Associate Award
Honduras	CLM AIDS Support and Technical Assistance Resource Program, Sector 2–Capacity Building (AIDSTAR II)	1	Field Support
India	CLM Monitoring and Evaluation to assess and Use Results, Phase III (MEASURE)	1	Core
Kenya	CLM/LMS Capacity Project	4	Field Support

Country	MSH Center and Program	Number of LDPs	Funding Source
Kenya	CLM Leadership, Management, and Sustainability Program (LMS)	2	Core
Kenya	CLM Leadership, Management, and Sustainability Program (LMS)	9	Field Support
Lesotho	CLM/LMS Southern Africa Human Capacity Development (SAHCD)	2	Associate Award
Malawi	CLM Knowledge for Health (K4H)	1	Core
Malawi	CLM Leadership, Management, and Sustainability Program (LMS)	1	Core
Mali	CLM Leadership, Management, and Sustainability Program (LMS)	1	Core
Nepal	CLM Leadership, Management, and Sustainability Program (LMS)	1	Field Support
Nigeria	CHS Nigeria Indigenous Capacity-Building (NICAB)	1	Bilateral
Nigeria	CLM Leadership, Management, and Sustainability Program (LMS)	3	Associate Award
Pakistan	CHS Primary Healthcare Revitalization, Integration, and Decentralization in Earthquake-Affected Areas (PRIDE)	1	Bilateral
Paraguay	CHS Stamping Out Pandemic and Avian Influenza (STOP AI)	1	Core
Rwanda	CHS Rwanda HIV/PBF (Performance-Based Financing) Project	1	Bilateral
South Africa	CHS Integrated Primary Health Care (IPHC)	1	Bilateral
Sudan	CLM/LMS Southern Africa Human Capacity Development (SAHCD)	3	Associate Award
Swaziland	CLM/LMS Southern Africa Human Capacity Development (SAHCD)	2	Associate Award
Tanzania	CLM/LMS Capacity Project	4	Field Support
Tanzania	CLM Leadership, Management, and Sustainability Program (LMS)	1	Core
Tanzania	CLM Leadership, Management, and Sustainability Program (LMS)	4	Field Support





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