

# **Lessons Learned in Mainstreaming and Scale-Up of Leadership and Management Capacity**

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LMS Monitoring, Evaluation and Communications Team

May 2010

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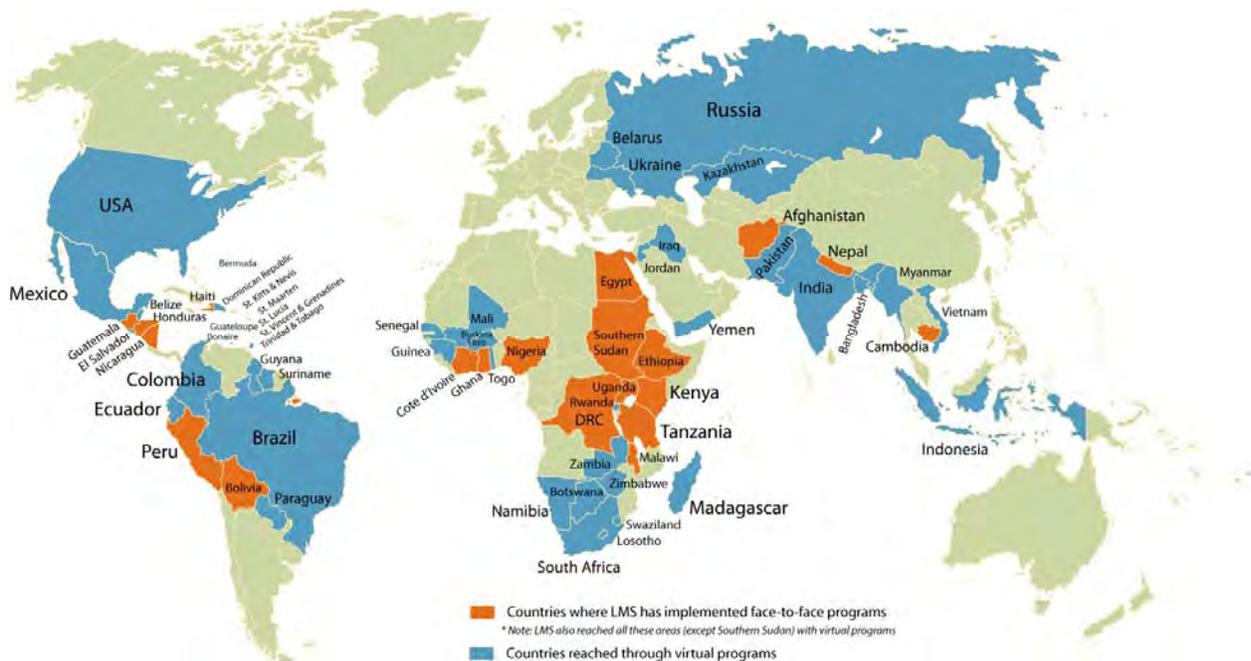
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 Leadership, Management and Sustainability Program  
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Leadership, Management and Sustainability Program

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## **ACKNOWLEDGEMENTS**

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This study is part of a series of four Strategic Evaluations carried out by the Monitoring, Evaluation, and Communications Team (MEC) of the Leadership, Management and Sustainability (LMS) Program. The four studies together offer a cross program examination of LMS Programs between 2005 and 2010 to document results and generate lessons learned for the benefit of USAID, MSH, and the international development and health community. Although there is some overlap between the results documented, each of the studies analyzes them through its own lens, whether of improving health service delivery, mainstreaming and scaling up proven practices in leadership and management, use of virtual approaches, or strengthening good governance in health.

MEC implemented the strategic evaluations in two phases with a preliminary report released in January 2009 and a final report completed in May 2010. The objectives of the two phases are identical; the phased reporting allowed for an early assessment of results achieved during the LMS Program in Years 1 through 3 and a portion of Year 4. Phase II added new or additional findings from the balance of Year 4 and Year 5. This final report was updated with additional data, findings and lessons learned that became available from field programs prior to the closing of LMS in August 2010. All strategic evaluation reports and their abridged summaries will be shared with interested stakeholders, including the larger international health community.

These evaluation studies would not have been possible without the contributions of many people. We are deeply grateful to LMS managers at head office and in the field for filling out the many capture forms we requested; to our counterparts in the countries where LMS works who so generously shared their experiences with us; to all those who contributed to the writing and reviewing of the reports. We are also grateful to USAID's Office of Population and Reproductive Health for its support to the LMS Program and the interest in documenting results through the evaluation studies. We hope that the studies will contribute to the growing body of literature on health and development so that future programs can have an even greater impact on improving the health of people around the world.

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## GLOSSARY OF ACRONYMS

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ACQUIRE Project	Access, Quality, and Use in Reproductive Health
ADRA	Adventist Development and Relief Agency
AIDS	Acquired Immunodeficiency Syndrome
AMREF	African Medical and Research Foundation
CA	Cooperating Agency
CBO	Community-Based Organization
COBES	Community Based Education and Service
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
ESAMI	Eastern and Southern Africa Management Institute
FBO	Faith-Based Organization
FOM	Faculty of Medicine
FOSREF	Foundation for Reproductive Health and Family Education
FP	Family Planning
FPMD	Family Planning Management Development
GAVI	Global Alliance for Vaccines and Immunization
GHS	Ghana Health Services
HCM	Healthy Communities and Municipalities
HIRD	High Impact Rapid Delivery
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR	Human Resources
ICA	Institute of Cultural Affairs
LDP	Leadership Development Program
LMS	Leadership, Management and Sustainability Program
M&E	Monitoring and Evaluation
M&L	Management and Leadership Program
MAEC	Maison l’Arc-en-Ciel
MCH	Maternal and Child Health
MEC	Monitoring, Evaluation and Communications (Team, LMS)
MMR	Maternal Mortality Rate
MOH	Ministry of Health
MOHP	Ministry of Health and Population
MOPH	Ministry of Public Health
MOST	Management and Organizational Sustainability Tool
MSH	Management Sciences for Health
NGO	Non-Governmental Organization
PEPFAR	President’s Emergency Fund for AIDS Relief
PRONICASS	Nicaragua Social Reform Project

PROSALUD	Bolivian Network of Self-Financing Primary Health Care Centers
REACH	Rural Expansion of Afghanistan's Community-based Healthcare
RH	Reproductive health
RHTC	Regional Health Training Centre
ROLDP	Results-Oriented Leadership Development Program
SESA	Secretariat of Health in the Northeastern state of Ceará, Brazil
SILAIS	Local System of Integrated Health Care
SISMUNI	Sistema de Información Municipal de Salud Communal (Municipal Health Information System)
SPH	School of Public Health
TA	Technical assistance, Technical Advisor
UNESCO	United Nations Educational, Scientific & Cultural Organization
USAID	U.S. Agency for International Development
USG	U.S. Government
VLDP	Virtual Leadership Development Program

## EXECUTIVE SUMMARY

During the Management and Leadership Program (M&L), between 2000 and 2005, USAID and Management Sciences for Health (MSH) developed and successfully implemented new programs and approaches to improve the management and leadership capacity of health care organizations in developing countries. To deepen the impact of M&L, USAID developed a new program—the Leadership, Management and Sustainability Program (LMS) — to further promote the adoption and successful implementation (mainstreaming) of proven management and leadership approaches in even more organizations (scale-up) to reach a “critical mass” of practitioners that will bring about substantial and sustainable change in health practices and services, leading to the improved health of populations. LMS has used the following definitions for mainstreaming and scale-up and developed relevant strategies to achieve results.

**Mainstreaming:** Institutionalize and sustain proven leadership and management practices and approaches in organizations. Mainstreaming is one effective strategy for scale-up, but effective scale-up can occur via other strategies.

**Scaling up:** Expanding the number of people and organizations that are effectively applying leadership and management practices and approaches to achieve improved results.

The purpose of this strategic evaluation is to document LMS’ processes for mainstreaming and scaling-up leadership and management capacity. Through this evaluation LMS has documented how it has fostered the transfer, application, integration and/or institutionalization of management and leadership capacity for improving organizational performance and health service delivery. By building on conceptual models of successful scale-up developed by other practitioners, the evaluation contributes new knowledge to the growing body of literature guiding efforts to expand access to life saving public health interventions by MSH, cooperating agencies, universities, donors, and the international health community. This evaluation answers the following questions:

1. What strategies has LMS pursued to mainstream and/or scale-up leadership and management capacity?
2. What conditions need to exist for each strategy to be successful? Given local conditions and specific organizational challenges, what strategies are most effective?
3. How have counterparts and/or partners integrated or institutionalized programs and approaches introduced by LMS? What changes, if any, have recipient groups made that have been influenced by the application and their institutionalization?

Since 2005, LMS has pursued strategies that have proven to be successful in mainstreaming and scaling-up leadership and management capacity. To explore the effectiveness of the strategies LMS has utilized, a sample set of programs financed with USAID Core, Field Support, and Associate Award funds has been pre-selected for this study. The sample reflects the variety of both deliberate approaches pursued by LMS, and replication and adaptation of MSH approaches by program recipients. The sample also includes programs that ended during M&L so that sustained capacity development can be examined.

This evaluation documents 15 case studies where LMS interventions are directly impacting organizational performance and/or service delivery at more than one level of the health system. Examples are organized by presenting each strategy that LMS has employed, the component of that strategy, the evidence as illustrated by specific country examples, and the lessons learned from each strategy.

The strategies and corresponding components used to mainstream and scale-up LMS approaches have been carried out in the following areas:

1. All levels of a national health system
  - a. Leverage initial and available entry points to scale-up nationally to all levels of the health system.
  - b. Work with national policy makers to establish standards and policies.
  - c. Reinforce leadership and management capacity in all sectors of the health care system responsible for implementing the policies and standards.
  - d. Integrate leadership and management into national training institutions for sustainability of the process.
2. Provincial or state level in a country
  - a. Work at the provincial or state level to influence others in a decentralizing environment.
  - b. Work with health care facilities within a state or province and then scale-up within that state or province which can then influence other states/provinces.
  - c. Developing a critical mass of people that believe in and are implementing L&M practices into their daily work.
3. At the community level and with youth groups
  - a. Empower local leaders with L&M to take actions to improve their own health and demand quality services.
  - b. Establish a dialogue between community members and the formal health care system.
  - c. Create simple tools that can be easily adopted to strengthen leadership and management.
4. With partners and USAID cooperating agencies
  - a. Conduct a pilot in a particular country with a partner's project to demonstrate the utility of developing L&M capacity.
  - b. Adapt tools to match the partners' or CAs' model.
5. High volume technical assistance for rapid mainstreaming and scale-up
  - a. Identify a large cadre of CSOs to provide standardized L&M training to others.
  - b. Tailor follow-up to meet the specific needs of each CSO.
  - c. Build the capacity of a large cadre of local consultants who can then provide technical assistance tailored to the needs of individual CSOs.
6. With established institutions and universities
  - a. Develop a relationship with a champion at the institution or university.
  - b. Adapt L&M modules and training to meet the curricula of the institution or university.

This study offers key lessons learned from experiences in mainstreaming and scaling-up management and leadership capacity. In the Afghanistan, Kenya, and Nicaragua case studies, we discuss carrying out locally-led research to get buy-in for leadership and management capacity building at the **national level**. Working at the **provincial and state levels** in Brazil and Egypt, we learned that L&M capacity building can first be mainstreamed and scaled-up in one province or state and then be expanded to other provinces or states. Working at the **community level** in Peru and with youth groups in Haiti, local staff learned they could successfully employ simple tools from the LDP to establish dialogue between the communities and the formal sector and coordinate health service delivery for better health outcomes.

In many of the countries where LMS works, we have learned that aligning leadership and management skills building with the working style of **partners and USAID cooperating agencies** helps those partners and agencies more effectively mainstream and scale-up L&M at both the central and country levels. To get L&M into the hands of counterparts more quickly, mainstreaming and scale-up through **short-term, high volume technical assistance** was a successful method in Nigeria and Tanzania that also ensured high quality program replication. Finally, working with **established institutions and universities** in Nicaragua, Uganda, and the United States taught us that pre-service integration of L&M is a long-term process, and that the true measure of success is in student learning and application.

Specifically the lessons learned for each mainstreaming and scaling up strategy were:

Mainstreaming and Scaling Up with **All Levels of a National Health System**

1. Demonstrated L&M results inspire other countries to follow suit.
2. Carry out locally lead research to get buy-in for L&M at the national level.
3. Involve central and regional managers when building L&M capacity to ensure sustainability.

Mainstreaming and Scale-Up at the **Provincial or State Level in a Country**

1. L&M capacity building can first be mainstreamed and scaled-up in one province or state and then be expanded to other provinces or states.
2. A critical mass of practitioners can help sustain L&M practices regardless of political changes.

Mainstreaming and Scale-Up at the **Community Level and with Youth Groups**

1. Leadership development programs use simple tools that stick.
2. Establishing a dialogue between communities and the formal health sector improves health outcomes.

Mainstreaming and Scale-Up by **Working with Partners**

1. Capacity building approaches must match how the partner works.
2. Partners can successfully mainstream and scale-up when they work at the country level.
3. Ensuring documentation of challenges and results achieved must be a key component in all partnerships.

**High Volume Technical Assistance** for Rapid Mainstreaming and Scale-Up to CSOs

1. Rapid scale-up of leadership and management capacity is possible to get skills into the hands of counterparts.
2. The easy application of the tools facilitates the rapid scale-up.
3. Scaling up through local consultants is feasible but the quality of replication needs to be assessed.

Mainstreaming and Scaling Up with **Established Institutions and Universities**

1. Pre-Service integration of L&M is a long term process but leads to greater sustainability.
2. The measure of success is in student learning and application.
3. Adapting traditional in-service programs can be challenging.

## **PURPOSE OF THE EVALUATION**

The purpose of this strategic evaluation is to document LMS' processes for mainstreaming and scaling-up leadership and management capacity. Through this evaluation LMS has documented how it has fostered the transfer, application, integration and/or institutionalization of management and leadership capacity for improving organizational performance and health service delivery. By building on conceptual models of successful scale-up developed by other practitioners, the evaluation contributes new knowledge to the growing body of literature guiding efforts to expand access to life saving public health interventions by MSH, cooperating agencies, universities, donors, and the international health community.

## **APPROACHES AND METHODOLOGY**

### **Selection of Programs for Review and Description of Sample**

To explore the effectiveness of the strategies LMS has utilized, a sample set of programs financed with USAID Core, Field Support, and Associate Award funds has been pre-selected for this study. The sample reflects the variety of both deliberate approaches pursued by LMS, and replications and adaptations of MSH approaches by program recipients. The sample also includes a few programs that ended during M&L so that sustained capacity development can be examined.

Lessons have been learned about the conditions that need to exist within a counterpart institution, a partner, or a CA for a strategy to be effective. In M&L and LMS, client organizations and collaborating partners are deliberately selected, and the strategies used are the best adaptations of standardized management and leadership approaches to local contexts. We have not controlled for external variables that may have an influence on results, so we do not claim a strict cause and effect relationship. What we are able to do is to build a case for a strong association based on the strength of the evidence collected and the number of programs and countries for which the associations are documented.

This evaluation documents 15 case studies in over 17 countries where LMS interventions are directly impacting organizational performance and/or service delivery at more than one level of the health system (Table 1). In all of the countries, with the exception of the United States, one principal counterpart has been the public sector. Other organizational counterparts include non-governmental organizations (NGOs) in eight countries, faith-based organizations (FBOs) in two countries, and pre-service institutions in three countries. In 65% of the countries, LMS collaborated with multiple counterparts to build leadership and improve management systems. Examples are organized by presenting each strategy that LMS has employed, the component of that strategy, the evidence as illustrated by specific country examples, and the lessons learned from each strategy.

**Table 1. Selected Country Case Examples under M&L and LMS Programs (2000-2010)**

<b>Country</b>	<b>Organization Type</b>	<b>Leadership and/or Management Systems Strengthening (MSS)</b>	<b>Mainstreaming and scale-up strategy used</b>
Afghanistan	Public Sector	Leadership and MSS	1. All levels of a national health system
Brazil	Public Sector	Leadership	2. Provincial or state level in a country
Cambodia	Public Sector/ FBO	Leadership	4. With partners and USAID CAs
Egypt	Public Sector	Leadership	2. Provincial or state level in a country
Ghana	Public Sector	Leadership	4. With partners and USAID CAs
Kenya	Public Sector/ NGO	Leadership and MSS	1. All levels of a national health system 4. With partners and USAID CAs
LAC: Bolivia, El Salvador, Guatemala	Public Sector/ NGO	Leadership and MSS	4. With partners and USAID CAs
Nepal	Public Sector/ NGO	Leadership	4. With partners and USAID CAs
Nicaragua	Public Sector/ Pre-service	Leadership and MSS	1. All levels of a national health system 6. With established institutions and universities
Nigeria	Public Sector/ NGO/FBO	MSS	5. High volume technical assistance for rapid mainstreaming and scale-up
Peru	Public Sector	Leadership	3. At the community level and with youth groups
Swaziland	Public Sector/ NGO	Leadership	4. With partners and USAID CAs
Tanzania	Public Sector/ NGO	Leadership and MSS	4. With partners and USAID CAs 5. High volume technical assistance for rapid mainstreaming and scale-up
Uganda	Public Sector/ Pre-Service	Leadership and MSS	4. With partners and USAID CAs 6. With established institutions and universities
United States (Boston, MA)	Pre-Service	Leadership	6. With established institutions and universities

Note: The strategies used to mainstream and scale-up LMS approaches have been carried out in the following areas:

1. All levels of a national health system
2. Provincial or state level in a country
3. At the community level and with youth groups
4. With partners and USAID cooperating agencies
5. High volume technical assistance for rapid mainstreaming and scale-up
6. With established institutions and universities

## I. INTRODUCTION

Between 2000 and 2005 under the Management and Leadership (M&L) program, Management Sciences for Health (MSH) developed and successfully implemented new programs and approaches to improve the management and leadership capacity of health care organizations in developing countries. The mandate of the Leadership, Management and Sustainability (LMS) program, from 2005 to 2010, is to further promote the adoption and successful implementation of proven management and leadership approaches in even more organizations to reach a “critical mass” of practitioners who will bring about substantial and sustainable change in health practices and services, leading to the improved health of populations.

An explicit mandate of LMS is to work directly with counterpart organizations, the East and Southern Africa Management Institute (ESAMI), the Adventist Development and Relief Agency (ADRA), and Cooperating Agencies (CAs) to expand their leadership and management capacity to reach more individuals and organizations.

The five fundamental principles that have guided LMS in developing managers who lead are:

1. **Focus on health outcomes.** Good management and leadership result in measurable improvements in health services and outcomes. Only by focusing on real organizational challenges can managers develop their ability to lead.
2. **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 at all levels – from health posts to national institutions – can confront challenges and achieve results.
3. **You can learn to lead.** Leadership practices improve through a process of facing challenges and receiving feedback and support. In this way, managers develop the leadership abilities of their staff.
4. **Leadership is learned over time.** Becoming a manager who leads is a process that takes place over time, and works best when it is owned by the organization and takes on critical organizational challenges.
5. **Sustain progress through management systems.** Gains made in health outcomes can be sustained only by integrating leadership and management practices into an organization’s routine systems.

## 1.1 Key Definitions

**Mainstreaming:** Institutionalize and sustain proven leadership and management practices and approaches in organizations.<sup>1</sup> Mainstreaming is one effective strategy for scale-up, but effective scale-up can occur via other strategies.

**Institutionalization (as defined by any of the following):**

- a) A deliberate process for leadership and management development is in an organization's annual operational plan and/or budget.
- b) Managers within an organization replicate all or part of a leadership and management approach independently or with limited technical assistance.
- c) A pre-service academic institution has incorporated action-oriented management and leadership development into its curriculum.
- d) An organization mandates the use of tools or programs to strengthen management and leadership.<sup>2</sup>

**Leadership:** Mobilizing others to envision and realize a better future.

**Managing:** Planning and using resources efficiently to produce intended results.

**Leading and managing:** Enabling self and others to set direction, face challenges and achieve results.

**Scaling up:** Expanding the number of people and organizations that are effectively applying leadership and management practices and approaches to achieve improved results.<sup>3</sup>

**Sustainability:** The capacity to perform effectively in the future.<sup>4</sup>

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<sup>1</sup> "Mainstreaming to Scale Up Model and Guide," LMS, MSH, October 2006.

<sup>2</sup> LMS Performance Monitoring Plan, 2006.

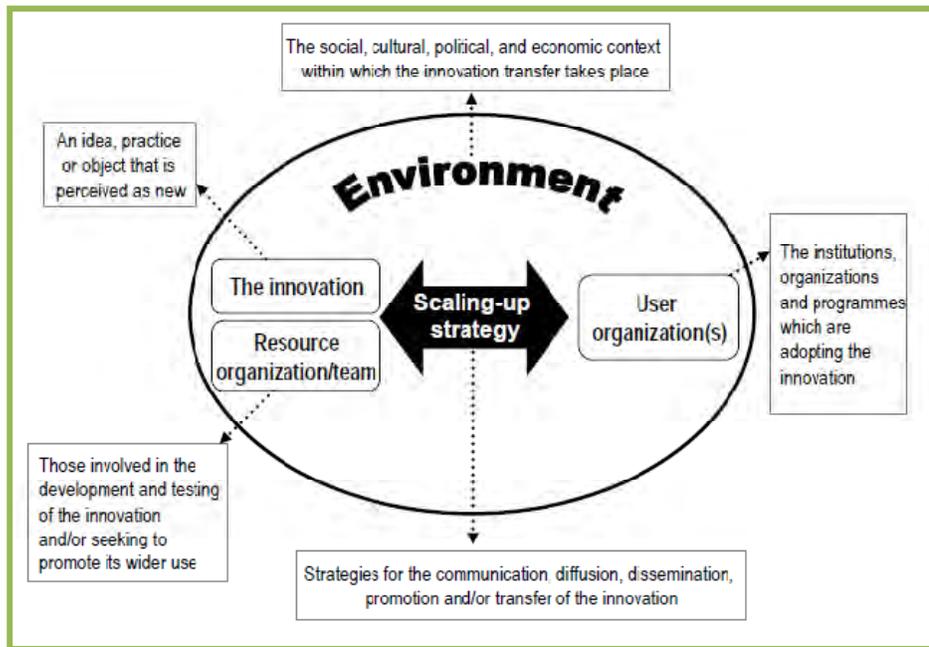
<sup>3</sup> "Mainstreaming to Scale Up Model and Guide," LMS, MSH, October 2006.

<sup>4</sup> Ibid.

## I.2 Conceptual Framework

A review of the literature on scaling-up health service innovations was conducted in order to develop a methodology that would reflect the latest knowledge about the processes and components that may facilitate or create barriers to the transfer, integration, institutionalization and scaling-up of evidenced-based leadership and management practices. The process of going to scale developed by Ruth Simmons and Jeremy Shiffman<sup>5</sup> was adapted to fit the LMS context and is presented in Figure 1. The process in the oval represents the components in the LMS mainstreaming and scale-up process, and the colored boxes represent the elements of the study that will address each component.

**Figure 1: Framework for Mainstreaming and Scale up of Leadership and Management Capacity**



## I.3 Data Collection

A capture form (Appendix I) was prepared to record information on each project included in the portfolio for the study, and in some cases completed by LMS staff based in the field. Sources of data include: trip reports; quarterly, semi-annual and annual reports prepared by project staff for USAID reporting purposes; and semi-annual Management Reviews and formal evaluation reports prepared by LMS for USAID. Where possible, a questionnaire prepared for this study was sent to counterparts in client organizations to complete (Appendix II). If necessary, a phone interview with counterparts was scheduled to clarify incomplete or unclear information recorded in the questionnaire. Finally, the study drew upon information collected for documentation of mainstreaming and scale-up activities prepared in anticipation of the USAID external evaluation of LMS in March 2009.

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<sup>5</sup> Simmons R and Shiffman J. Scaling up Health Service Innovations: A Framework for Action. In "Scaling Up Health Service Delivery: From Pilot Innovations to Policies and Programmes", edited by Ruth Simmons, Peter Fajans and Laura Ghiron, World Health Organization, Geneva: 2006.

This study answers the following core questions:

1. What strategies has LMS pursued to mainstream and/or scale-up leadership and management capacity?
2. What conditions need to exist for each strategy to be successful? Given local conditions and specific organizational challenges, what strategies are most effective?
3. How have counterparts and/or partners integrated or institutionalized programs and approaches introduced by LMS? What changes, if any, have recipient groups made that have been influenced by the application and their institutionalization?

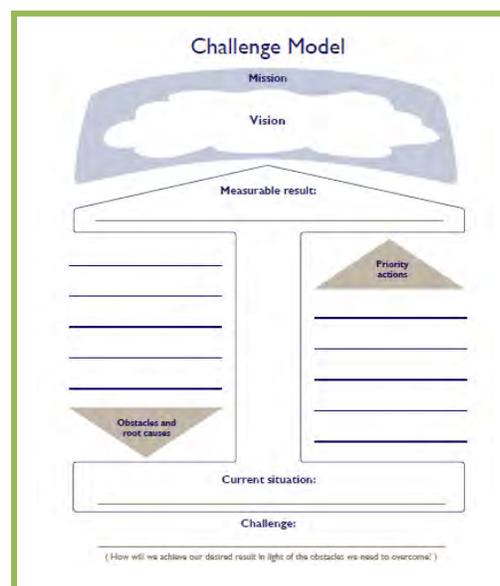
## 2. MAINSTREAMING FOR SCALE-UP: APPROACHES AND TOOLS

LMS has several tools to build the capacity of health managers at all levels of the health system. For this evaluation we have highlighted two of our legacy tools: the Leadership Development Program and the Management and Organizational Sustainability Tool. LMS has defined a legacy tool as: (1) **flexible**, in that the tool has been field tested, improved upon and adapted over a number of years and in a number of settings; (2) **having field success**, indicated by a successful evaluation; (3) **available in multiple languages**; and (4) **packaged for replication**, including a manual for facilitators. This evaluation also includes examples of leadership and management training approaches, and lessons we have learned through applying these approaches.

### 2.1 Tool I: Leadership Development Program

The Leadership Development Program (LDP) was developed under the M&L Program in 2002 and has subsequently been mainstreamed and scaled up during LMS in many settings with teams working in all sectors of the health system. The LDP is a four to six month process that develops the leading and managing capacity of people working at all levels of health organizations. Over a series of three to four workshops, each lasting two to three days, teams of health managers and their staff apply action learning and problem-solving techniques to address real workplace challenges and design an action plan to achieve measurable results. Throughout the process, LDP facilitators provide feedback and support during coaching visits to the various teams. The LDP has been introduced in a number of countries for teams in government and non-government agencies at central, provincial, and district levels, and at facilities ranging from large hospitals to community dispensaries.

The core of the LDP is the Challenge Model, a simple tool which enables teams to take a systematic look at how to produce desired measurable results. Teams work together to clarify the mission of their organization and create an inspiring shared vision. They scan their environment and focus on measurable results they can achieve within a short time period. They conduct a systematic analysis to understand their current situation, including the role of stakeholders, the obstacles they are facing, and the root causes that are preventing them from achieving their results. They then formulate their challenge and develop action plans to meet the challenge and come closer to their vision. They design a monitoring and evaluation (M&E) plan that focuses on measurable results, and they learn how to work as a team to align and mobilize human and financial resources to achieve those results.



By the time teams have completed the LDP, participants have:

- Addressed real challenges facing their organization and made solid performance improvements;
- Improved workplace climate as people learn how to listen and communicate effectively, recognize one another's accomplishments, and work in teams to achieve results;
- Taken responsibility for challenges and developed optimism about moving forward;
- Incorporated new leadership and management capabilities at all levels of the organization.

The LDP challenges teams to achieve a measurable result that is part of the larger mission and vision within six months. Teams can then re-apply the process to new challenges and continue to achieve results.

## 2.2 Tool 2: Management and Organizational Sustainability Tool

The Management and Organizational Sustainability Tool (MOST) is a structured, participatory process that allows organizations to assess their own management performance, develop a concrete action plan for improvement, and carry out their plan. The cornerstone of the MOST process is a 3-day workshop. During the workshop, the organizational leadership and selected staff come together to build consensus about the stages of development of their organization's management practices, the improvements needed, and an action plan for making those improvements. MOST has been used successfully in South Africa, East Africa, Latin America and the Caribbean and is available in English, French, Portuguese and Spanish.



Through the MOST process an organization will:

- Assess the current status of management systems;
- Identify feasible changes that will make the organization more effective;
- Develop specific plans to implement the changes;
- Generate staff buy-in needed to support management improvements.

MOST has been delivered to a variety of types of organizations such as government, volunteer, faith-based, and non-profit organizations focusing on advocacy, general health resources, and HIV/AIDS.

The strength of the MOST is that it is a participatory process that allows employees to pinpoint strengths and weaknesses of their organizational structure. After every workshop, the participants leave with comprehensive action plans. The first plans of action usually involve strengthening human resources policy, which organizations have found useful. The workshop process also encourages dialogue between junior and senior level staff and puts everyone on an equal playing field.

### **3. STRATEGIES TO MAINSTREAM AND SCALE-UP LEADERSHIP AND MANAGEMENT PRACTICES**

Since 2005, LMS has pursued several strategies that have proven to be successful in mainstreaming and scaling-up leadership and management capacity. To explore the effectiveness of the strategies LMS has utilized, a sample set of programs financed with USAID Core, Field Support, and Associate Award funds has been pre-selected for this study. The sample reflects the variety of both deliberate approaches pursued by LMS, and replication and adaptation of MSH approaches by program recipients. The sample also includes a few programs that ended during M&L so that sustained capacity development can be examined.

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  - b. Work with national policy makers to establish standards and policies.
  - c. Reinforce leadership and management capacity in all sectors of the health care system responsible for implementing the policies and standards.
  - d. Integrate leadership and management into national training institutions for sustainability of the process.
2. Provincial or state level in a country
  - a. Work at the provincial or state level to influence others in a decentralizing environment.
  - b. Work with health care facilities within a state or province and then scale-up within that state or province which can then influence other states/provinces.
  - c. Developing a critical mass of people that believe in and are implementing leadership and management practices into their daily work.
3. At the community level and with youth groups
  - a. Empower local leaders with leadership and management to take actions to improve their own health and demand quality services.
  - b. Establish a dialogue between community members and the formal health care system.
  - c. Create simple tools that can be easily adopted to strengthen leadership and management.
4. With partners and USAID cooperating agencies
  - a. Conduct a pilot in a particular country with a partner's project to demonstrate the utility of developing leadership and management capacity.
  - b. Adapt tools to match the partners' or CAs' model.
5. High volume technical assistance for rapid mainstreaming and scale-up
  - a. Identify a large cadre of CSOs to provide standardized leadership and management training to others.
  - b. Tailor follow-up to meet the specific needs of each CSO.
  - c. Build the capacity of a large cadre of local consultants who can then provide technical assistance tailored to the needs of individual CSOs.
6. With established institutions and universities
  - a. Develop a relationship with a champion at the institution or university.
  - b. Adapt leadership and management modules and training to meet the curricula of the institution or university.

The following case studies document LMS' strategies and evidence of mainstreaming and scale-up as well as lessons learned from each strategy employed. This documentation will contribute to the body of knowledge on best practices for improving the leadership and management capacity of health professionals and for improving health impact.

### 3.1 Mainstreaming and Scaling Up with all Levels of a National Health System

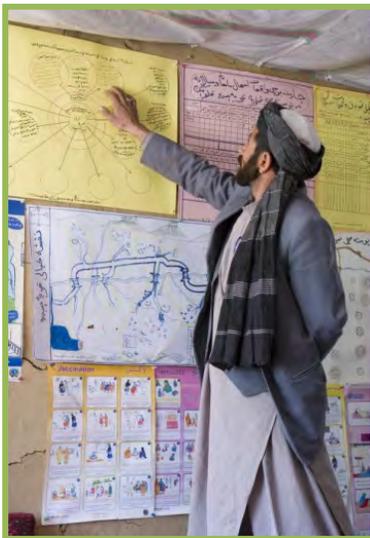
One of LMS' approaches to mainstreaming and scale-up of leadership and management capacity is by working at all levels of a national health system. This approach has been applied in Afghanistan, Kenya and Nicaragua and involves the following components:

- Leverage initial and available entry points to scale-up nationally to all levels of the health system.
- Work with national policy makers to establish standards and policies.
- Reinforce leadership and management capacity in all sectors of the health care system responsible for implementing the policies and standards.
- Integrate leadership and management into national training institutions for sustainability of the process.

As seen in the following case studies, LMS has demonstrated with this strategy that leadership and management can be mainstreamed and scaled-up nationally. LMS has learned that to ensure buy-in from the national health officials, it is important to involve them in the assessment of their current L&M capacity. 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.

#### 3.1.1 Afghanistan

Since July 2006, LMS has provided technical leadership and management support to the central and provincial Ministries of Health to strengthen and expand public access to the Government's Basic Package of Health Services and Essential Package of Hospital Services. Tech-Serve staff are working together with the Director General of Provincial Health in the central Ministry of Public Health (MOPH) to lay the foundations for the MOPH's self-sufficiency in development of provincial leadership teams.



The Leadership Development Program was introduced in the project's 13 focus provinces during the M&L Program and REACH, the previous USAID-funded bilateral project implemented in Afghanistan by MSH. Fifteen doctors from Afghanistan visited Egypt in May 2005 to learn about the LDP implemented in Aswan Governorate, and subsequently five of the provinces initiated their own LDPs. LMS has continued to focus on technical assistance to support effective implementation and scale-up of the LDP at the provincial level. In part due to the decentralization of the LDP, it has become an important tool for improving leadership and management capacity despite high personnel turnover at the MOH in Afghanistan.

#### Interventions at the Central Level

Tech-Serve continues to strengthen hospital management, monitoring health services, procure and distribute essential pharmaceuticals and strengthen the M&E function of the central MOPH. Specific accomplishments include the launching of a multi-pronged effort to strengthen the MOPH Community-based Healthcare initiative in collaboration with Health Services Support

Project (HSSP). Tech-Serve also supported the MOPH in updating and translating 15 national guidelines, policies, and assessment tools.

#### Interventions at the Provincial Level

At the provincial level, Tech-Serve provides assistance to the Management Support for Provinces (MSP) Initiative by training and mentoring provincial management teams of the MOPH, which include Reproductive Health (RH) Officers, to implement the Leadership and Development Program. To date, the

LDP has been conducted in all 13 USAID-supported provinces and in over 185 health facilities. MOPH and NGO facilitators developed by LMS are leading leadership and management development training.

Additional assistance provided by Tech-Serve at the provincial level includes enhancing the technical skills of staff; building their knowledge about communication, collection and use of information for better decision-making; and performance improvement through training, mentoring, and networking involving Provincial Public Health Offices (PPHOs) and Provincial Public Health Coordination Committees (PPHCC). Furthermore, in the 13 USAID-supported provinces, Tech-Serve has assisted the MOPH in responding to 28 important disease outbreaks, including measles, ARI, acute watery diarrhea, cholera, and pertussis, as well as rare communicable diseases, such as Crimean Congo hemorrhagic fever.

Of particular note is the work done to support all provincial hospitals in the focus areas. Provincial hospital visits to Badakhshan, Khost, Paktya, and Ghazni were completed to assess compliance with the national hospital standards. Hospital standard trainings were carried out for Bamyan, Takhar, Baghlan, Jawzjan, and Faryab provincial hospitals.

The use of the LDP within the MOH began with a two-day orientation and a 5-day facilitator training with Tech-Serve and MOPH staff in September 2006. This was followed by coaching visits for the provincial Public Health Advisors and the workshops for them to share experiences and successes with each other in June 2007. Technical assistance provided by LMS has created a cadre of senior professional LDP facilitators, including Tech-Serve and Central MOPH staff, PHAs, Provincial Health Department and NGO staff from the 13 focus provinces.

**Evidence of mainstreaming/scaling up:** The number of health facilities that have implemented the LDP to improve priority health indicators increased from 40 in October 2007 to 113 in September 2009, and there are currently 387 health professionals who can serve on an LDP facilitation team. Priority results areas targeted by the LDP include family planning, maternal and child health, immunizations, and communicable diseases. More than 15 training courses have been offered, and more than 200 monitoring visits have been conducted by Tech-Serve and MOPH staff. In the 13 provinces where the LDP has been administered, significant improvement in core health indicators have been achieved.

At the service delivery point, the project completed renovations in 10 PPHOs and provided office equipment to the Paktya PPHO. Moreover, Tech-Serve has distributed \$15.9 million of essential drugs to meet basic health needs, including contraceptives (\$4.5 million), and TB medications to grantees, and achieved a 38% reduction in the average lead time for supplying drugs to NGOs.

In all USAID-supported facilities, there was an increase from March 2005 to March 2009 in the total number of services provided related to DPT3 vaccinations, new FP consultations, couple years protection, TB case detection, and institutional deliveries.

At the community level, Tech-Serve's promotion of the use of Community Health Workers (CHWs) to expand access to basic health services, including FP, has contributed to the achievement of a more than fourfold increase in community-based provision of FP services by CHWs since 2005. CHWs are now the

#### **FP/RH results in Afghanistan**

In 2008-09, 485 community health supervisors (CHSs) and community health workers (CHWs) were trained on family planning and injectable contraceptive services. In 2009 the Tech-Serve project conducted a household survey in a representative sample of the project target area: 71 management units where CHWs and CHSs delivered family planning services. Survey results indicated a Contraceptive Prevalence Rate (CPR) with modern family planning methods of 43%, demonstrating an increase from 28% measured at baseline in 2006. Because most of the CHWs and CHSs had received special training in family planning through the Tech-Serve project prior to the survey, the higher CPRs found in the sampled areas reflect, at least in part, the contribution of the project to such an increase in CPR among women of reproductive age.

source of 66% of all FP consultations provided to clients served at public and NGO health facilities nationwide. Now that the community elements are in place, attention is turning to also integrating longer term FP methods to meet the needs of women and families who want them.

The project has also contributed to the uninterrupted supply of contraceptive stocks in both health facilities and health posts. Eighty-six percent of health posts and 98% of health facilities had proper contraceptive stock during monitoring visits by the MOPH during the previous 12 months. Overall, CHWs provide one-third of all health care provided in the 13 USAID-supported provinces.

### 3.1.2 Kenya

In 2008, the Kenyan Ministry of Health, through the support and coordination of MSH, conducted a Leadership and Management Assessment of its health sector. The assessment exposed the critical need for leadership and management training among managers. Recommendations from the assessment included (1) strengthening pre-service training; (2) strengthening in-service training; and (3) institutionalizing senior manager training at the Ministry headquarters level. In addition, leadership and management strengthening was complicated when the Ministry split into two separate Ministries: the Ministry of Medical Service (MOMS) and the Ministry of Public Health and Sanitation (MOPHS).

LMS, in collaboration with the MOMS and MOPHS, developed a multi-pronged approach to address leadership and management training needs in alignment with the recommendations from the assessment. LMS has worked with both ministries as well as FBOs and NGOs to develop and implement a leadership and management capacity building strategy. To address leadership and management training at an institutional level, LMS has worked with the Kenya Medical Training College (KMTC) to revise a curriculum on Health Systems Management and to support 20 Ministry officials in attending a course on this topic.



LMS has also facilitated a joint MOMS/USAID working group to address priority hospital reform issues. This working group was established by the Permanent Secretary for Medical Services to identify key reform areas in provincial hospitals surrounding issues of autonomy, commodities, HR issues, leadership, and management. The LDP was implemented in February 2009 with 365 health managers comprising 83 teams from Central, Coast, Eastern, Rift Valley, and Nyanza Provinces to create action plans for addressing these key reform issues.

These LDP teams came from district hospitals, district management teams, faith-based hospitals, health centers, and rural health clinics. Each team was focused on improving health service delivery in areas such as increasing immunization coverage, increasing births in health facilities, and decreasing patient waiting time in the facility. In August 2009, 12 of these teams, selected by their peers and facilitators, presented their results at a National Results Workshop in Nairobi. The Permanent Secretary, Minister of Medical Service, other senior Ministry officials, and USAID/Kenya officials attended the event. During the National Results Workshop, the report on the “Assessment of Leadership and Management in the Health Sector in Kenya” was launched. The Ministry of Medical Services plans to widely disseminate the report to a number of facilities including the government of Kenya, NGOs and the mission, private institutions, and divisional, district and provincial teams in an effort to raise awareness about leadership and management needs so appropriate actions can be taken to address the challenges identified.

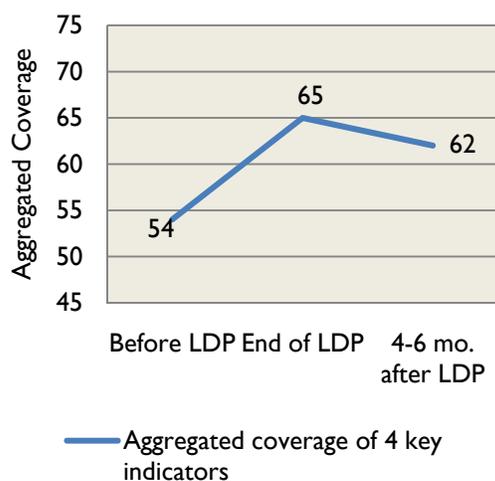
As a component of hospital reform, in-depth assessments of the three hospitals were completed in October 2009. The assessment process engaged and maintained a high level of participation from the ministry, USAID partners, and hospital staff. This process has been critical for strong coordination of activities and for each of the three groups to establish and maintain ownership of the process. Each part of the assessment was conducted with a representative from USAID and MOMS, and it engaged hospital staff at virtually every level. In February 2010, LMS held a visioning workshop to review the findings and recommendations from the joint MOMS/USAID Working Group on priority hospital reforms (PHR), discuss them in working groups and plenary sessions, and reach consensus on the majority of reforms proposed. The Workshop had participation from 70 MOMS staff at all levels and from all departments.

In November 2009, LMS/Kenya conducted a three-day workshop in Health Management Information Systems (HMIS) for the Kenya Episcopal Conference (KEC). Additionally, a proposal development training workshop was held for 11 KEC participants (six from the secretariat and five from their dioceses), who received training in writing winning proposals.

**Evidence of mainstreaming/scaling up:** The expansion of the LDP continues in the central level of the MOMS and MOPHS, which launched an LDP between September 2009 and March 2010. Each Ministry has four Departments participating in the program.

Among the participants are teams from the Department of Malaria Control, Department of Reproductive Health, Department of Nursing, and Department of Clinical Standards.

**Figure 2: Aggregated coverage of key indicators between 2009 and 2010 in Kenya**



This roll-out of the LDP, with the support of both Kenyan Ministries of Health, is an ideal opportunity to carry out a retrospective assessment to measure the long-term, sustained impact of the LDP on health services. Not only can we measure the results of the initial LDP, but in the case of three provinces (Rift Valley, Nyanza, and Nairobi), we can measure changes that result from a follow-on LDP process that concluded in August 2009. The main objective of the assessment is to demonstrate that the leadership development approach offers an effective model for application and scale-up within Kenya.

A total of 68 of these LDP teams were included in this assessment, which focused upon those public sector teams with quantifiable results in the Rift

Valley, Nyanza, Central, Eastern, North Eastern, and Nairobi Provinces. Eighteen of the 68 teams implemented interventions that covered all or most of the district, and the remaining 50 teams implemented interventions in their own facilities. Teams addressed increasing coverage of fully-immunized children under age two (25 teams), increasing deliveries by a skilled birth attendant (23 teams), increasing antenatal care visits to four (11 teams), and other health care challenges (9 teams).

Data for each of the 68 teams were collected for three time periods: before implementation of the LDP, at the end of the LDP at the time of the last workshop in a series of four, and at the time of the survey four to 12 months after the end of the LDP. Qualitative data were also collected to examine how staff retention affected the measurable results and those factors that influenced whether the results were sustained after the end of the LDP process. Preliminary results show that for all 68 teams, coverage for the team's key outcome indicator was at 54 percent before implementation of the LDP. At the end of the LDP process, about four to

six months later, coverage had increased to 65 percent. At the time of the survey, four to 12 months after the end of the LDP, coverage had gone down somewhat but was still at 62 percent, eight percentage points above the baseline coverage (See Figure 2).

### 3.1.3 Nicaragua

The Nicaragua/PRONICASS leadership development program, initiated under the M&L program in 2001, works to increase the Ministry of Health (MOH) staff's awareness of the importance of leadership in the context of human resource management. MSH worked in collaboration with MOH human resource personnel to develop a curriculum that incorporates many of the same elements of the LDP including use of the Challenge Model. The training has been decentralized from the MOH facilitators to district and municipal teams, using an adaptation of the LDP that has permitted municipalities to replace a dominant autocratic approach to leadership with a shared approach.

PRONICASS has also carried out management and leadership training for district health authorities or SILIAS, and for hospital and municipal management teams of the Ministry of Health from the departments of León and Nueva Segovia. As a result of the trainings, 1,118 SILIAS health professionals and 35 faculty from the National Autonomous University of Nicaragua nursing and ancillary health careers departments are better able to identify and respond to health and human resources challenges (see more detailed examples in section 6.2 Mainstreaming and Scaling up in an Institution or University: The National Autonomous University of Nicaragua)

**Evidence of mainstreaming/scaling up:** Under the current phase of the PRONICASS program, leadership development is being implemented in two of the 17 district health authorities. Within this area, 550 trained MOH facilitators have facilitated leadership development programs with over 4,000 (2,500 women) health care and social workers in the public health system. In the municipality of Murra, family planning coverage among women of reproductive age increased from 9% in August 2007 to 40% by February 2008.

Another important area of work has been in citizen participation. PRONICASS began working with municipal development committees (Comité de Desarrollo Municipal, or 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 CDMs. This guide was used to expand and improve citizen participation in the 22 municipalities within León and Nueva Segovia. PRONICASS also developed and validated a guide to social auditing designed for application at the municipal level and oriented to health and education.

One of PRONICASS' areas of greatest innovation has been in results-based budgeting. This method of budgeting, initiated with the Ministry of the Family, includes defining and costing final and intermediate products of the Ministry. The Ministry of Finance regularly uses the *Guide to Results-Based Budgeting* developed by PRONICASS as a reference. This methodology has provided clarity and transparency around the results-based approach while honoring the Ministry of Finance's program-based budgeting. The *Guide to Results-Based Budgeting* was an example of a management innovation that was simple to mainstream because it was a tool that helped finance and planning directorates of all state-financed organizations improve the way they work. The guide also requires little maintenance compared to larger, more complex tools that are problem specific and adapted completely to local contexts.

The work of PRONICASS is an example of scaling up leadership and management practices at all levels of a national health system. By integrating into high levels of the MOH with leadership through the LDP and in management through adapted tools and guides Nicaragua has in turn improved L&M capacity at all levels of the health system.

However, the Leadership Development Program has not been mainstreamed in the sense that the delivery is still highly dependent on LMS inputs. This is due in part to the political changes in Nicaragua in 2007 which resulted in subsequent replacement of senior managers at the central and district levels. PRONICASS responded by training an entirely new set of staff, numbering in the hundreds, at the health facilities. LMS has learned from the experience in Nicaragua that while working at the provincial or state level can be exhausting, time consuming and at times difficult to achieve results, the work at the national level can be undermined by the changes in direction at the political level. PRONICASS continues to adjust and adapt to the dynamic political climate and to build leadership and management capacity at all levels of the national health system in an effort to sustain managers who lead.

### **3.1 Lessons Learned**

**1. Demonstrated L&M results inspire other countries to follow suit:** High level buy-in gained from seeing the LDP in action in Egypt was critical for the successful transfer of the LDP to Afghanistan. Scale-up of the LDP across Afghanistan has been significant, and has been adopted by the training unit of the Ministry of Health.

**2. Carry out locally led research to get buy-in for L&M at the national level:** In Kenya the National Assessment of the health managers' management and leadership competencies provided the ministries with the data to help them decide what changes needed to be made in the way health professionals are trained, as well as how to restructure the system to support leadership and management on a larger scale. The ministries' involvement in the assessment lends a credibility to the findings and recommendations that would not have existed had the staff themselves not led the charge. This commitment enabled the assessment team to quickly gain buy-in.

**3. Involve central and regional managers when building L&M capacity to ensure sustainability:** Political changes and instability particularly affect personnel turnover of ministers of health or high level officials. If the minister is the only member of his/her team that is the champion of integrating leadership and management skills, then the partnership and support for this integration can be quickly lost with a change in personnel. For national mainstreaming and scale-up, it is essential to involve staff from various levels in the hierarchy to ensure continuation and sustainability regardless of political change.

### **3.2 Mainstreaming and Scale-Up at the Provincial or State Level in a Country**

MSH has not only worked with national level ministries to mainstream and scale-up their leadership and management practices. In Egypt and Brazil, MSH has worked with regional governments to build the capacity of local health officials and scale-up proven practices. The components of this strategy include:

- Work at the provincial or state level to influence others in a decentralizing environment.
- Work with health care facilities within a state or province and then scale-up within that state or province which can then influence other states/provinces.
- Developing a critical mass of people that believe in and are implementing L&M practices into their daily work.

Under the M&L program in Egypt, MSH built capacity in the Aswan Governorate in 2002 and as a result of their success the project has been scaled-up to other provinces under their own initiative. In Brazil, MSH worked with the Secretariat of Health in the Northeastern state of Ceará (SESA) between 1998 and 2002; to date they have scaled-up the leadership development program and expanded to other states on their own and with other donor funding.

### 3.2.1 Brazil

The Brazil Leadership Development Program was implemented from 1998 to 2002 under the USAID funded Family Planning Management Development (FPMD) and M&L Programs. The challenge was to rapidly decentralize the health system in Brazil by SESA with improved regulation and coordination. To do this, it became essential to expand the health care leadership base.

From 1998-2003, FPMD and M&L assisted SESA in planning and implementing a face-to-face leadership development program, at the time known as PDL, which covered such topics as: developing personal competencies; communication and creativity; conflict resolution; negotiation skills; how to motivate staff; how to develop teams; time management; strategic planning; and total quality management. Through extensive exchange between M&L staff and leadership experts in Ceará, the PDL took on many elements of the current LMS LDP, including use of the leading and managing framework (Appendix III).

To continue the improvement of leadership and management skills, SESA, with the support of M&L and the School of Public Health for the state of Ceará, created LiderNet in 2002. 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.

**Evidence of mainstreaming/scaling up:** The leadership development program and LiderNet prepared over 600 managers for the public health system. Out of the 37 municipalities that participated in the PDL to improve infant mortality rates, 70% were able to reduce their infant mortality—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.

LiderNet was institutionalized in the School of Public Health in Ceará, where it also serves as a resource for managers in pre-service health programs. The PDL and LiderNet have evolved in length of training and content since initially offered, at first due to funding issues, and subsequently due to their integration into the School of Public Health's training course on Regional Health System Management. Following the close of M&L, continuing support was provided by the United Kingdom's Development Fund for International Development as well as from the Pan-American Health Organization and Inter-American Development Bank.

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 PDL in workplaces, and at municipal and regional levels.

### 3.2.2 Egypt

In 2002, to improve access to and quality of services in the Aswan Governorate in rural Upper Egypt in the face of low morale among health workers and managers, MSH introduced leading and managing practices. This was a collaborative process with health officials of the Aswan Governorate and the methodology for identifying and addressing service delivery challenges led to creating of the Leadership Development Program.

By 2003 after the implementation of the LDP, 75% of the 10 teams, from primary health units, district and rural hospitals had achieved 95% or more of their desired results, and 80% of the teams selected a new challenge without prompting. Three districts—Aswan, Daraw, and Kom Ombo—increased the number of new family planning visits by 36%, 68%, and 20%, respectively, compared to the same period the year before. An additional three teams achieved notable increases in the average number of prenatal care visits per client.

Gaafra Health Center achieved an average of 3.6 postpartum visits per client as of the end of June 2003, up from 0.2 visits in June 2002.

In 2005 the Aswan LDP facilitators chose the governorate-wide challenge of reducing the maternal mortality rate (MMR) from the 2005 rate of 86.9 per 100,000 live births to 50. To accomplish this, LDP facilitators brought Safe Motherhood Committees to every district in the governorate. Between 2006 and 2007, the Aswan Governorate reduced the MMR from 50 per 100,000 live births to 35.5 per 100,000.

**Evidence of mainstreaming/ scaling up:** In Egypt, the central government and MOH did not support and were disinterested in building the leadership and management capacity of their health personnel. The USAID funding was available for only one year of this pilot phase. Despite the lack of central level funding, between 2003 and 2005, using its own resources, the Aswan Governorate trained 35 doctors and nurses as well as 140 new primary health care workers as facilitators and replicated the LDP to cover all 185 health facilities in the Governorate.

Aswan facilitators have also transferred LDP approaches to other governorates in Egypt. Through TAHSEEN, a USAID-funded project implemented in Egypt by the Catalyst Consortium, the Upper Egypt governorates of Minya, Bani Swaif, and Fayoum were trained in LDP approaches and tools. A video on the Aswan LDP experience, “Seeds of Success,” was produced by LMS and has become a powerful tool to enable the successful transfer of the LDP methodology to other programs and countries such as Nepal, Afghanistan, Uganda, and Ghana. This is an example of how leadership and management practices can be mainstreamed and scaled-up first in all of the health facilities in once province and then due to the evidence of their success can be mainstreamed and scaled up to other provinces without needing the support or funding from the central level MOH.



### 3.2 Lessons Learned

**1. L&M capacity building can first be mainstreamed and scaled-up in one province or state and then be expanded to other provinces or states:** To integrate leadership and management approaches and tools to many provinces or states, begin by building the capacity in one province or state. As the examples in Brazil and Egypt demonstrate, when one province or state achieves results, others are inspired to follow suit, and the methodology can expand to other areas.

**2. A critical mass of practitioners can help sustain L&M practices regardless of political changes:** It was possible to create a critical mass of managers who lead in a region who all speak the same language and understand the health challenges who can then transfer this knowledge to other colleagues. These regional managers are less likely to be lost in a political transition than high level officials and therefore are better able to maintain the sustainability of leadership and management practices.

### 3.3 Mainstreaming and Scale-Up at the Community Level and with Youth Groups

Leadership and Management development is not only for the formal health sector but can also be integrated into capacity building for rural communities and among youth groups. LMS has utilized this strategy in Peru and Haiti to improve health outcomes; the components include:

- Empower local leaders with leadership and management to take actions to improve their own health and demand quality services.
- Establish a dialogue between community members and the formal health care system.
- Create simple tools that can be easily adopted to strengthen leadership and management.

#### 3.3.1 Peru

LMS was brought in by USAID/Peru to manage and implement the Healthy Communities and Municipalities (HCM) Project which was previously implemented by another CA and a local NGO. Currently HCM works in 1,764 rural communities to foster behavior changes that will result in improved maternal and child health.

Since the leadership development component was new to the project, a first step was for the LMS/Peru staff to take MSH's Virtual Leadership Development Program (VLDP), as a means to become familiar with LMS' approach to leadership development, key concepts, and tools. The success was evident, and at the request of the Ministry of Public Health, LMS repeated the VLDP country-wide in March 2009, offering it to 13 health promotion teams.

The Moral Leadership and Community Management Program, based on the traditional LDP, brings together community leaders and village development committee members with health and education sector personnel to collaborate toward improving the communities in which they work. The program engages participants in a series of five workshops as they work together to think strategically and plan their future as a community. The participatory methodology of the program fosters the development of leadership capacities as teams discuss the themes of democracy, respect, and solidarity. Since 2006, 2,240 community leaders and 614 members of village development committees have completed the program.



In addition to the leadership component, HCM also is building management capacity of community leaders and municipal governments through the implementation of the HCM designed community-based health information system (known as SISMUNI in Spanish). First developed in 2006, SISMUNI and the corresponding data collection instruments are practical tools used by community leaders to document demographic, economic, and health information about their community, as well as identify the community's priority actions that must be achieved to become a certified "healthy community." HCM staff provides technical assistance to local leaders as they administer biannual assessments using these tools. HCM and the tools also facilitate the communication between the communities and the municipal governments' officials. The information provided by SISMUNI help community leaders, health establishment personnel, and local officials plan and budget according to the health needs of the specific communities.

Based on bi-annual data collected from the majority of the original Alternative Development Zone 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 under age two who have their birth certificate increased from 69% to 84%.
- 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%.

**Evidence of mainstreaming/scaling up:** In both face-to-face and virtual forums, these leadership and management capacity strengthening approaches have reached more than 850 communities and organizations in Peru. Their focus on a team-based approach, applying program concepts to participants' current situations, reframing problems as challenges to be overcome, achieving measurable results, and bringing about sustainable change sets these programs apart from traditional training courses.

The HCM project has also implemented the LDP with more than 400 health and education managers from 45 municipal governments, 40 local health networks, and one regional government to promote greater participation by the municipality in priority issues concerning health.

These leadership skills have helped village development committees to regularly collect basic health data about their other community members. As of March 2010, the HCM project has expanded to reach 1,764 rural communities throughout Peru. Of the original 515 communities that have applied the healthy communities and municipality strategy since 2006, to date 86% of these communities have completed the bi-annual needs assessment and documentation of key health indicators. This information has provided the corresponding municipal governments with demographic and economic information about their community facilitated the identification of priority actions needed to improve the health of the community members. Information is entered into the Web-based SISMUNI, so that local government and national officials can easily access it, run reports, and use this data for policy development and decision making. Fifty-four local governments are using data from SISMUNI for budgeting and monitoring.

### 3.3.2 Haiti

In Haiti, youth represent more than 50% of the population and are the most vulnerable group for HIV/AIDS and unwanted pregnancies, with a high incidence of clandestine abortions. A high rate of HIV/AIDS and other sexually transmitted infections combined with a lack of leadership to address the crisis have resulted in a large population of disaffected youth who believe that this situation is hopeless. To help improve this situation LMS/Haiti has offered two youth Leadership Development Programs in Cité Soleil, Haiti, a priority intervention zone for the Government of Haiti.

“I remember seeing these youngsters’ faces on their initial workshop and telling myself how innocent they looked... Six months later, with the results they have shown on their work presentation, I see major changes in them, their attitude... When they sit together today, you hear words like scanning, challenges, and plans... the leaders’ vocabulary... [they] indeed are committed to change... it really shows...”

- Dr. Antoine Ndiaye,  
LMS Project Director, Haiti

The second LDP was launched in February 2009 with a senior alignment meeting that included 35 representatives from the two local LMS partner non-governmental organizations, Maison l'Arc-en-Ciel (MAEC) and FOSREF, as well as the Ministry of Health and USAID. The three participating youth teams are improving their skills to become better equipped to lead their peers to overcome the enormous challenges of reducing sexually transmitted infections, HIV/AIDS, sexual violence, and other sexual and reproductive health issues. Participants have noted that “the LDP is bringing about a genuine change in how we think, act, and work in Cité Soleil...a real and profound social transformation...that capitalizes on the energy of youth and transforms it into a positive force for collective action for the well-being of the people of Cité Soleil.” In October 2009 the teams reported the following results:



- 400 pregnant women attended at least two prenatal visits.
- 4,450 young people ages 10-24 received counseling.
- Delivery of 1,308 hygiene kits to people living with HIV/AIDS.

**Evidence of mainstreaming/scaling up:** On January 12, 2010, Haiti was struck by a 7.0-magnitude earthquake and the Haitian youth were suddenly faced with new, bigger challenges. The story of how one young LDP participant, in the disaster’s aftermath, is continuing her work is a testament to how leadership capacity has been mainstreamed into her life.

The powerful earthquake left Ernancy Bien-Aimé, a youth LDP participant, with a broken arm. More damaging, however, 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 from the LDP, which provides coaches to help sustain the results beyond the initial program period. Post-disaster, the youth and their coaches came together to evaluate what they could do. Meeting again as a group spurred Ernancy and her team to continue the work they had already begun.

Upon finishing the LDP (five months prior to the earthquake), Ernancy’s dream was to start a mobile pharmacy to reach members of her community who were sick and could not afford medicines. After the earthquake 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. 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.”

Another reflection on how the youth LDP has impacted communities comes from Fritz Moise, the director of youth NGO FOSREF. In a conversation with LMS staff, he noted that the young man who participated in the youth LDP who died during the earthquake, Jean Jair Mondesir, was given a Cité Soleil funeral with all of the honors, and that community leaders up to the highest level attended to show their support and respect for this remarkable young man.

“I don’t know how you would document something like this, but before he participated in the LDP, he would have been just another young guy who died in Cite Soleil, and no one would ever have known,” Dr. Moise said. “But because of what he became—because he participated in the LDP—he spoke in churches, in the community, in the schools—everyone knew who he was and respected him. He was a leader.”

### 3.3 Lessons Learned

**1. Leadership development programs use simple tools that stick:** The LDP and similar programs encourage participants to focus on the short term future when the present may be extremely difficult or even traumatizing to deal with. Through tasks that are easy to understand and apply teams are empowered to create actions plans to achieve quick wins within six months that then lead to larger health impacts. The power of these quick wins gives communities and youth groups the energy and encouragement to continue to tackle health and development problems one step at a time.

**2. Establishing a dialogue between communities and the formal health sector improves health outcomes:** When communities are given simple tools to evaluate their health indicators and development progress they become better informed about their current situation and areas of need. This information combined with leadership and management skills is extremely empowering and gives community leaders the confidence to not only improve their own health indicators but to demand better health services and to start a dialogue with their local government to plan accordingly.

### 3.4 Mainstreaming and Scale-Up by working with Partners

Partnering is an important way to maximize the USAID investment in LMS’ leadership and management tools and approaches. The explicit mandate of LMS was to work directly with counterpart organizations to build leadership and management capacity as well as through partners East and Southern Africa Management Institute (ESAMI) and Adventist Development and Relief Agency (ADRA) to reach more individuals and organizations. Partnering is also an excellent way to add content and value to our programs especially in areas of specialization of our partners, such as family planning, reproductive health, and avian influenza. In addition to partnering with ADRA and ESAMI, LMS has worked with various Collaborating Agencies (CAs) including: ACQUIRE/EngenderHealth, IntraHealth/Capacity Project, STOP AI, among others.

The specific components of integrating leadership and management into the work of partners and USAID cooperating agencies include:

- Conduct a pilot in a particular country with a partner’s project to demonstrate the utility of developing leadership and management capacity.
- Adapt tools to match the partners’ or CAs’ model.

#### 3.4.1 Adventist Development Relief Agency

LMS established a partnership with the Adventist Development and Relief Agency, a faith-based humanitarian and development agency that builds the capacity of community-based organizations and public-sector counterparts. ADRA focuses on improving health in FP/RH, 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).

#### Cambodia

The need to improve health delivery systems in Cambodia is seen most clearly in the low level of health facility attendance by the country’s rural population. In the critical area of reproductive health (RH) services for youth, the barriers to youth access in this rural context include lack of confidentiality, poor relations with

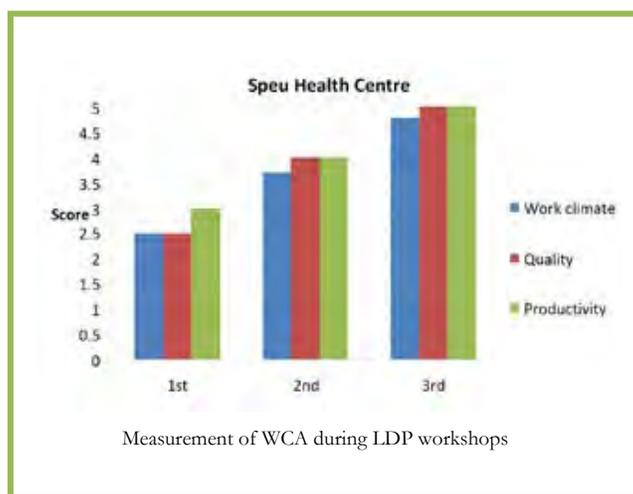
health staff, illiteracy among the population, low prioritization by parents for RH services, and plain shyness. In recognition of the need to provide youth with opportunities for improved mental, social, and physical health, the government of Cambodia began work on a National Youth Policy including 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 RH 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.

The Cambodia LDP was championed and led by the ADRA/Cambodia Country Director, with limited long-distance technical assistance from LMS headquarters. The Country Director was introduced to the LDP through an intensive one-week orientation organized by MSH and conducted in Nepal in November 2006.

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 many accounts of growth on an individual level, in the health centers and their communities: “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.”

The Work Climate Assessment (WCA) is an important tool for benchmarking any change in workplace climate as perceived by the employees. As part of the Cambodia Youth LDP, the WCA was offered before the LDP intervention, half way through, and at the conclusion of the program. The Speu Health Center LDP team is a shining example of a perceived improvement in quality, productivity, and work climate in the health center as employees worked through the LDP modules as a team (Figure 3). ADRA’s evaluation of the program documented that the improved work climate was exemplified by “more delegation of responsibilities, clearer roles and responsibilities of staff, improved team work environment, corrective feedback rather than apportioning blame.”

**Figure 3. Speu Health Center Improvement in Quality, Productivity, and Work Climate**



The Cambodia LDP is an excellent example of mainstreaming and scale-up of this key programmatic approach to developing leadership and management capacity at all levels.

### **ADRA's Professional Leadership Institute**

A primary way ADRA is mainstreaming LMS practices is through APLI, ADRA's Professional Leadership Institute, which holds professional development trainings three times per year for its worldwide staff. The one-week course on Leadership and Management devoted two days to LMS methodologies, with the centerpiece being the Challenge Model from the LDP. Each participant left the course with the challenge to apply their new knowledge and skills in their country office and programs. 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.

### **ADRA Benefits from Application of MOST**

ADRA has also utilized the Management and Organizational Sustainability Tool. Partnering with LMS, ADRA conducted a three-day MOST workshop in May 2006 for 25 participants representing health centers and hospitals. All eight participating teams, including the senior management team from the ADRA country office, completed an assessment of their current management capacity and prepared a MOST management improvement plan. ADRA/Tanzania's country director reported that: "attendees expressed their appreciation many times for the new materials and insights that they gained. People came with a variety of backgrounds so for some these concepts were totally pristine. Others . . . are veterans, but even they found it stimulating and revitalizing. [LMS] made sure that we moved from self-assessment to creating achievable goals in a seamless flow of activities and sharing. We fully intend to be proactive in supporting change within our health sector over the next 12 months, I believe that ADRA HQ will back up the initiative in every way possible so as to ensure results."

## **3.4.2 ACQUIRE/EngenderHealth**

### **Tanzania**

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 staff from six health facilities and three districts. The challenge for this predominantly rural region of Tanzania was poor utilization of family planning services and poor coordination between districts and health centers resulting in situations where health centers felt isolated and unsupported.

As of 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.

Results in Table 2 show that after a 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. 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. The original model of the LDP allowed teams to select a challenge that was meaningful and also feasible and within their control to effect.

**Table 2. Contraceptive use for ACQUIRE/Tanzania Facilities in Kigoma**

	All contraceptive use	New contraceptive use	Recurring contraceptive patients
<b>Total 2005</b>	7410	1391	6019
<b>Total 2007</b>	8274	1752	6522
<b>Total 2008</b>	7447	1492	5955
<b>Changes in contraceptive use</b>			
<b>Change from 2005 to 2007</b>	11.66%	25.95%	8.36%
<b>Change from 2005 to 2008</b>	0.50%	7.26%	-1.06%

Another risk to scale-up is that ACQUIRE ended midway through LMS and the new follow on project was more focused on its new mandate and framework and thus couldn't integrate the LDP easily. This is a risk with project-focused mainstreaming and is a lesson learned for LMS when working with projects that may have different time periods than LMS.

### 3.4.3 ESAMI

MSH chose East and Southern Africa Management Institute a partner because it is an established and respected management institute covering 12 eastern and southern African countries. LMS' vision was to move ESAMI more toward training health care managers and leaders by mainstreaming LMS approaches to leadership and management into their curriculum. LMS also envisioned using ESAMI consulting services to scale-up LMS services. And, that ESAMI and MSH could co-manage country programs.

LMS and ESAMI were able to partner to deliver several programs and trainings to build the leadership and management capacity of health professionals. Specifically the accomplishments were the following areas:

**MOST:** MSH and ESAMI staff provided technical assistance with the MOST to the Joint Clinical Research Centre in Uganda.

**LDP:** Three ESAMI consultants/faculty were trained as LDP facilitators and have successfully implemented this program in Tanzania.

**VSPP:** ESAMI staff co-facilitated the first Virtual Strategic Planning Program, a 17-week program that supported teams as they developed an organizational strategic plan, in Africa. Plans were developed to market this program through ESAMI in 2009, however this did not take place.

**Short Leadership Courses:** Two leadership courses have been co-designed, however given the structure of ESAMI as a management institute, and that faculty are rewarded for delivering short courses that meet certification requirements in management, LMS' offerings did not meet the needs of ESAMI. This is not necessarily the case with all management institutes; however LMS did not understand and respond to the ESAMI business model well enough. LMS initially asked ESAMI to work within LMS and MSH's structure, using the VLDP and the LDP rather than adapting to the structure of ESAMI. LMS did realize that neither of those leadership development programs fit the formats of ESAMI's business needs. By the time LMS offered ESAMI short courses, specifically adapted for ESAMI, it was too late to get their buy-in and key involvement.

**Institute for Leadership:** Although it is in its incipient stage, ESAMI did establish this institute as a result of its partnership in LMS. To date this has not expanded as well as ADRA's Professional Leadership Institute.

LMS also faced some challenges when working with ESAMI. With regards to communications, it became difficult to coordinate with LMS due to large time differences and to the lack of responsiveness of the ESAMI/LMS coordinator. MSH subsequently requested a change in personnel for this position. Other challenges included:

**Business Model:** ESAMI is a for-profit institute which derives its revenue from course enrollment and consulting services. On the other hand MSH is geared to respond quickly to the needs of USAID Missions. The competing demands on ESAMI staff made coordination difficult.

**Pedagogy:** LMS experienced challenges caused by very different teaching theory and practices. The participatory, user-centered and team approaches which MSH finds so effective are not necessarily a part of the ESAMI practice.

Through MSH experience with ESAMI, many lessons were learned including that the expectations of a partnership should be realistic at the outset. MSH expected greater cooperation and underestimated the differences in business models and organizational culture at ESAMI, making it difficult to mainstream and scale-up leadership and management activities.

### 3.4.4 Ghana

To respond to a growing degree of managerial responsibility that has been delegated to districts and hospitals, Ghana Health Services (GHS) implemented a recently created High Impact Rapid Delivery (HIRD) planning process. Ghana Health Services, an autonomous service agency established to implement national policies under the control of the MOH, with a special emphasis on primary health care at regional, district, and sub-district levels, lacked leadership in the process of implementing HIRD.

LMS used Core funds as seed money to introduce the LDP from January to July 2008. The pilot program, "Leading Together to Achieve Results" was implemented with seven teams from the Regional Health Directorate and six districts in the central region of Ghana. A local facilitation team was organized by LMS, led by ADRA/Ghana, and included faculty members from Winneba University School of Education, Ghana Institute for Management and Public Administration, and two GHS staff.

An example of one result for the Ajumako Enyan Essiam District health team was an increase in family planning coverage in the District from 13.5% to 18.5% in five months.

**Evidence of mainstreaming/scaling up:** In September 2008 GHS announced its intention to scale-up the LDP to the remaining nine regions of the country using available resources from Global Alliance for Vaccines and Immunization (GAVI). To promote sustainability the facilitation team included former LDP participants.

As of December 2009, the process of scaling up the LDP in the Ashanti region had begun. They used the LDP facilitator guide available on LeaderNet and rolled it out with two regional teams and five district teams. The teams addressed health challenges such as increasing immunization coverage, increasing deliveries in a facility, and decreasing maternal mortality. Although LMS was originally assured that GAVI funds were available to fund the LDP roll out, we learned that the regions had to fund the LDP with their own funds. In Ashanti they are using funding related to achieving the MDGs. There will be no funds for implementation, and so teams are being urged to integrate LDP action plans into their regular operational plans. This lack of

funding could affect the quality and the amount of coaching in between workshops as well as when and if teams will be able to roll out the LDP with the second and third cohorts of districts.

In March 2010, a Leadership Development Program focused on strengthening and coordinating senior leadership in the Ghana Health System and the Ministry of Health successfully concluded. Participants aimed to remove obstacles generated at the central level to quality service delivery and staff performance at the facility level. One Senior Leadership LDP team took on the challenge of improving infection prevention practices in the outpatient department (OPD) of Pantang Hospital in Accra, Ghana. The team identified sources of inadequate infection prevention and created a proactive committee that establishes standards and meets monthly to deliberate on technical issues. The OPD has adopted the Ghana Health Services Infection Control Policy, and infection prevention and control practices now conform to those standards.

A second Senior Leadership LDP team focused on developing a system for establishing a Nursing Staffing Norm for defining staffing requirements and addressing over- and under-staffing. This system was designed to be scaled-up for use at the national level. The team developed the staffing norms and applied it at the Atua District Hospital in Eastern Ghana, where there were concerns about inadequate numbers of nurses.

To develop the staffing system, the LDP team conducted desk research and fieldwork to review literature and previous GHS and MOH staffing norm procedures, and to collect information on nursing activities at the hospital, composition of current staff, and current workload. The team demonstrated that Atua District Hospital required 40 professional and 27 auxiliary nurses to adequately deliver services. To respond to this recommendation, the hospital will need to hire an additional seven professional nurses and five auxiliary nurses. Next steps at Atua District Hospital include liaising with the Director Human Resource Development and the Eastern Regional Health Director to determine necessary resources to hire the nurses and to discuss measures to put in place to attract nurses to the facility. The Nursing Staffing Norm methodology was well received, and there is support for scaling up the norm nationally.

### **3.4.5 IntraHealth/Capacity Project**

#### **Kenya**

From May to November 2007, MSH collaborated with IntraHealth's Capacity Project to launch a leadership development program with a team of two Kenyan facilitators and two faculty from Kenya Institute of Administration (KIA) to address the problem of poor work climate in 10 rural health facilities. The LDP has since been scaled-up with support from Capacity/Kenya and the APHIA II NEP Project to 31 more facilities in the Northeast Province. During this process several challenges arose:

1. The participatory approach of the LDP module was not in sync with the lecture teaching style at the institution.
2. KIA usually works with senior level officials from different countries rather than district mid-level managers that would be trained through LDPs.
3. The Capacity Project had little control over who was sent to the trainings; as a result trainers were not all at the same level of competence and commitment.
4. Contracting challenges with KIA made it difficult to utilize this pool of facilitators.

Despite the obstacles in formally institutionalizing the LDP, elements of the program have become integrated into the institution. KIA participants have incorporated many of the LDP concepts into their lectures to improve the delivery of leadership and management trainings, specifically lecturers have integrated the concepts of action plans and conducting follow-up.

In 2008, USAID/Kenya transferred all leadership development activities to MSH. The new Training and Curriculum Coordinator for LMS is working with the Ministry of Health and other stakeholders to institutionalize leadership and management training by creating curricula for three levels: pre-service, in-

service, and senior management. This will help develop leadership and management skills throughout a health worker's career. For details on the Kenya LDP, see section 1.2 Mainstreaming and Scaling Up with all Levels of National Health System: Kenya.

### Swaziland

From March to September 2007, MSH collaborated with IntraHealth's Capacity Project to develop management and leadership capacity within six government and mission hospitals. LMS hired a very experienced South African professional as senior technical advisor to oversee the local facilitation team which was expected to conduct the LDP. Examples of challenges selected were improving waste management, improving tidiness, reducing outpatient waiting times, and improving the patient assessment process in outpatient departments. The senior technical advisor is no longer with MSH, and it has been difficult to get information on results. In a phone conversation in January 2009, the hospital administrator from Raleigh Fitkin Memorial Hospital reported continuing successes at his hospital and suggested continuation at other facilities.

This is a good example of the difficulty MSH can face in obtaining follow-up data when a CA is implementing and funding the projects. When building leadership and management capacity is not part of the mandate of the CA, it is not their priority to collect and document the results from those participating in leadership development programs. To improve the documentation of results, it is important that CAs establish a budget for follow-up with the teams post-program.

### 3.4.6 Nepal

In Nepal, the decentralization of authority in the development sector had been implemented at the district level in 12 of 75 districts, but district and local level managers were not prepared to take on new roles and responsibilities. The LDP (called Results-Oriented Leadership Development Program or ROLDP in Nepali) was implemented in two phases beginning in March 2006 by LMS in collaboration with the National Health Training Centre, ADRA/Nepal, and the Institute of Cultural Affairs/Nepal. In Phase I, the ROLDP was introduced 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, 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 as well as other training materials were translated into Nepali for use in community level trainings. As of September 2009, 700 participants have been trained by ADRA/Nepal in the ROLDP.

**Evidence of mainstreaming/scaling up:** The ROLDP in Nepal has continued to expand to the National Health Training Center which is now offering a participatory maternal and child health course. The course primarily focuses on empowering community dynamics for Health Facility Management Committee members, Mothers' Group members, Female Community Health Volunteers and other potential community leaders. At the end of the course participants will be able to identify and prioritize

#### Nepal family planning and reproductive health results, March 2006-2007:

- UNESCO Bank Club increased the contraceptive prevalence rate in Jayaspur, a largely Muslim community, from 5% to 13%.
- Nepal Family Health Program increased distribution of misoprostol to prevent postpartum hemorrhage from 45% to 61%.
- Women's Development Office/Jhapa and the Women's Agriculture Cooperatives organized reproductive health awareness classes that reached 500 youth in rural areas.
- Association of Medical Doctors of Asia/Rupandehi constructed a Community Health Centre in the district.

community based interventions to strengthen maternal and child health, design evidence based operational plans for community interventions, and monitor and evaluate their progress.

Five Regional Health Training Centers (RHTC) incorporated ROLDP concepts and tools into trainings for all levels, and trained 30 trainers from the national and regional training centers. Many NGOs that participated continue to use the ROLDP in ongoing district and community level programs. For example, members of the International Rescue Committee who attended a ROLDP training were so impressed that they replicated the program for six VDCs in Surkhet district. ICA/Nepal has trained 400 participants. Ten ADRA staff were trained in facilitating the ROLDP. ADRA/Nepal has applied the ROLDP in several of its community programs, including the Family Planning and Safe Motherhood program in the Eastern Region; Leadership and Good Governance project in Kavre district; Sustainable Women's Economic Development project in Kavre and Rupandehi districts; Population, Health, and Environment project in Bardiya and Kailali districts; and Sustainable Economic and Environmental Development project in Banke, Bardiya, and Kailali districts. As of September 2009, 700 participants have been trained by ADRA/Nepal in the LDP.

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.

### 3.4.7 Stamping Out Pandemic and Avian Influenza Project

#### Bolivia, El Salvador and Guatemala

MSH is sub-contracted to Development Alternatives, Inc (DAI) for the Stamping Out Pandemic and Avian Influenza (STOP AI) Project, which is working to mitigate the economic hardship caused by avian influenza and to prevent animal-to-human and further human-to-human infection. At first glance, this would not seem a likely setting for the LDP, but a senior member of the STOP AI staff read the *Managers Who Lead* Handbook and was struck by the realization that better management and leadership could help resolve many of the technical problems he was facing. He arranged a rapid, "just-in-time" orientation with LMS/Cambridge staff and then initiated LDP workshops in Latin America. The first workshop was held in Paraguay in 2008 and subsequent workshops were held in Bolivia, El Salvador, and Guatemala.



STOP AI LDP training in Guatemala

In Guatemala, senior leaders from the four key laboratories were chosen to participate in a Senior Alignment Meeting. As a result, 12 people committed to become co-facilitators, and to send eight to 10 people from each of their institutions to participate in the LDP. A similar process is currently ongoing with teams in Bolivia, El Salvador and Paraguay to enable them to use the challenge model to develop actions plans and implement key activities.

In Paraguay the first three workshops for seven teams from the Ministry of Health and Agriculture labs were held between August 2008 to May 2009, however there was no budget for a fourth workshop. All the work plans related to a common challenge of creating standard operating procedures. However, lack of time for follow-up and delays caused by

elections has become a problem, as has the lack of a local champion to promote the LDP or enlist local support to ensure that the LDP process continues.

El Salvador and Bolivia are facing similar budgetary problems – rather than budgeting for all four workshops as once, thinking of the LDP as a complete package – they have only set aside money for the first three workshops which have subsequently been delayed because of national elections. STOP AI has recognized the need to align senior leaders, get local commitment and support to be able to sustain the process over time.

The recent H1N1 pandemic influenza outbreak in late 2009 and early 2010 imposed a new challenge on the implementation of the LDP workshop in Bolivia and Paraguay, which are focused on Quality Assurance in labs. As the new pandemic flu overwhelmed the public health systems, it also created a difficult circumstance to the people participating in the LDP workshops. Staff chose to dedicate themselves to the emergency, postponing the implementation of their recently developed challenge models and action plans. The agricultural teams did not have the same emergency situation; however, the workshops were put on hold until the emergency resolved because one of the objectives of the LDP is to create common scenarios for the animal health and human health folks working side by side. As the pandemic flu relaxed its initial wave, the team has been able to re-schedule and the Bolivian teams resumed updating their challenge models and re-scheduling their actions plans. Facilitated by Dr. Oscar Morales and Dr. Horacio Espinosa the teams completed Workshop #2 and are now practicing their leadership and management skills towards the achievement of results that bring them closer to their vision of implementing their quality assurance systems.

### 3.4 Lessons Learned

**1. Capacity building approaches must match how the partner works:** The Leadership Development Program approach to working in teams over a four-month period to build capacity fit very well into ADRA's system and helped ADRA to achieve its goal. However, because of ESAMI's business model the LDP was not easily implemented or mainstreamed.

**2. Partners can successfully mainstream and scale-up when they work at the country level:** ADRA has multiple mechanisms for delivering, mainstreaming, and scaling up the LDP as well as other leadership and management tools and approaches. The country directors have autonomy to implement their own programs and have ownership over the tools while the APLI gave ADRA the ability to scale-up the application of the LDP and other tools to other country directors. However this is not the case for some of the CAs; it was difficult for them to mainstream leadership and management approaches throughout their organizations. For example, the ACQUIRE country program in Tanzania had difficulty influencing and mainstreaming leadership and management approaches into its parent CA; and EngenderHealth had no mechanisms available for that kind of bottom up transfer.

**3. Ensuring documentation of challenges and results achieved must be a key component in all partnerships:** Overall, there was a notable value added in exposure to and development of leadership and management skills among partners using the LDP. For MSH, however, the ultimate goal of an LDP is to see improved public health outcomes over time, which entails follow-up to record measurable public health results achieved by the challenges selected by participating teams. While projects like Capacity have been able to integrate the LDP into programs for more finite goals (such as catalyzing and empowering leaders), there is currently a lack of documentation of challenges and follow-up with teams after the LDP has been completed. A commitment and funding is needed for continual follow-up to ensure that public health outcomes are achieved. In future cases where MSH is not the primary provider, clarification and alignment of goals and expectations for the LDP should be established from the beginning, including delegation of responsibility and establishing a process for follow-up, measuring and reporting results.

**4. Institutionalizing the LDP into Local Facilities:** There are challenges in partnering with both government and private institutions; the high rate of staff transfers and turnovers at the ministries affects the

long term availability of trained facilitators, and local training institutions often overextended consultants. Therefore, more focus and effort needs to be put into finding the right local partner to secure buy-in to the LDP methodology, and more effort needs to be made in identifying partnering institutions that have the capacity for successful scale-up. This includes a commitment to following up with teams after the completion of the LDP workshops to document the results they have achieved and provide any assistance to improve those results.

### **3.5 High Volume Technical Assistance for Rapid Mainstreaming and Scale-Up to CSOs**

Investments by the global donor community in strengthening the response to HIV/AIDS, Malaria, Tuberculosis and other communicable diseases have contributed greatly to improvements in prevention and treatment of these diseases. However, the pace of this rapid scale-up has created new challenges for building capacity for leadership and management skills among young civil society and faith-based organizations to absorb large increases in funding and to develop systems and processes to manage funds and account for their use.

To improve the L&M skills of these CSOs LMS had used the approach of providing high volume technical assistance to these CSOs, specifically:

- Identify a large cadre of CSOs to provide standardized L&M training to others.
- Tailor follow-up to meet the specific needs of each CSO.
- Build the capacity of a large cadre of local consultants who can then provide technical assistance tailored to the needs of individual CSOs.

MOST workshops, as the one that was held in Nigeria, allow multiple CSOs to be trained at the same time and to acquire skills to write concept papers and proposals that meet the requirements of USAID's Annual Program Statement, as well as to assist them in identifying areas of their organizational management systems that need improvement. The approach taken by LMS Tanzania to train a pool of local facilitators to scale-up capacity building shows promise but will require more in depth evaluation to determine if it is effective.

#### **3.5.1 Nigeria Capacity Building**

Many Civil Society Organizations (CSOs) in Nigeria are recognized as leaders within their communities, providing critical access to HIV/AIDS health services. USAID is looking to support and leverage these CSOs' leadership and legitimacy among community members by providing them with PEPFAR grants. However, many of the CSOs are nascent organizations with limited capacity to absorb funds, manage activities well, and accurately report on finances and results, and are therefore not eligible for PEPFAR funding. USAID/Nigeria is addressing this crucial issue by supporting LMS in providing capacity building support to those CSOs that are potential implementing partners.



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. Through

rapid scale-up, more CSOs are able to apply for and receive direct funding from the U.S. Government (USG).

**Evidence of mainstreaming/scaling up:** The Nigeria CB project is a good example of rapid scale-up. The Capacity Building (CB) Project of LMS/Nigeria has to date provided comprehensive, continuous institutional capacity building to strengthen the essential management and operational systems of 48 Nigerian NGOs, and faith-based organizations. The CB Project approach is two-pronged, providing overall capacity building to several CSOs simultaneously through standardized workshops using LMS tools, and providing more tailored mentoring to address specific gaps where needed. LMS has conducted workshops on “Concept Paper and Proposal Development,” “Financial Systems Strengthening,” and “Assessing Financial Control and Cash Control Using QuickStart.” MSH’s Management and Organizational Sustainability Tool was adapted for CSOs to measure and assess management and operational systems for project management, monitoring and evaluation, financial management, strategic and annual planning, leadership development, and sound governance structures.

By using standard participatory tools, the MOST and QuickStart workshops have allowed multiple CSOs to be trained at the same time and to acquire skills to write concept papers and proposals that meet the requirements of USAID’s Annual Program Statement (APS), as well as to assist them in identifying areas of their organizational management systems that need improvement.

As of December 2009, six nascent indigenous were able to receive USG funds, thus contributing to their sustainability and potential for increasing access to services for the populations they serve. Documenting improvements in access, quality and efficiency of the HIV/AIDS services these CSOs provide will take place over the next six months.

### 3.5.2 Tanzania: Rapid Funding Envelope and Capacity Building for HIV/AIDS CSOs

While the challenges facing CSOs in Tanzania are very similar to those in Nigeria, in Tanzania LMS took a different approach to the need for rapid scale-up of governance capacity, by training a pool of local capacity building consultants to provide technical assistance in management and organizational strengthening. LMS

focused its assistance on nascent CSOs that were receiving small grants under the Rapid Funding Envelope (RFE), an innovative CSO funding mechanism set up under the M&L program.

Established in 2002, the RFE's purpose is to enable civil society institutions in Tanzania to participate fully in the national multi-sectoral response to the AIDS epidemic. To do so, the RFE provides grants to Tanzanian non-profit civil society organizations, academic institutions, and civil society partnerships for essential, short-term projects aligned with the National Policy on HIV/AIDS and the National Multi-Sectoral Strategic Framework. This multi-donor partnership was launched jointly with TACAIDS, ZAC, nine bilateral donors, and one private foundation. Technical oversight and screening of proposals is provided by MSH/LMS, and grant management and financial oversight is provided by Deloitte and Touche.

Prior to undertaking capacity building, a rapid assessment was carried out of capacity building needs of a sample of civil society RFE sub-grantees to identify areas of weakness or gaps in organizational capacity; to assess the frequency and magnitude of these gaps, and inform capacity building options to address them. Planning, both strategic and operational, M&E and



reporting, and board governance were problems for all but the big, well-established CSOs.

**Evidence of mainstreaming/scaling up:** The approach used to train local capacity builders followed the LMS consulting for results model, in which local consultants learn a structured pathway to engage CSOs; work with them to identify gaps in performance; trace the gaps back to root causes in terms of organizational systems and processes; and finally to implement action plans. In each instance, LMS provided a seasoned expert to lead a Training of Trainers workshop in conjunction with one or more of the local capacity builders as co-facilitators, thus helping to build both technical and facilitation skills at the same time.

For the RFE, more than 30 CSOs have been strengthened, three becoming direct PEPFAR partners and five becoming Global Fund partners. Local consultants provided in-depth coaching and technical assistance to CSOs including the Christian Social Services Commission, Tanzania Youth Alliance (TAYOA), Mildmay Tanzania, and Wanawake Maendeleo (WAMA).

To date, 166 sub-grants totaling approximately USD \$22.1 million have been awarded to 136 local Tanzanian CSOs participating in the fight against HIV/AIDS. The grants have ranged between USD \$30,000 and USD \$200,000 in size. The RFE has had two positive external evaluations, and LMS has gradually expanded its role to provide capacity building for these CSOs with a focus on governance and monitoring and evaluation. In FY 2009 alone LMS staff provided technical and program training to 46 participants from RFE Round 6 sub-grantees and field visits to over 40 sub-grantees to provide capacity building.

There are still unanswered questions about the RFE and the LMS Tanzania models of capacity building which require a full scale evaluation. These questions concern the outcomes/results of CSOs in achieving HIV/AIDS service gains such as use of services by Most At-Risk Populations, behaviour change, and orphans/vulnerable children's quality of life. A survey of consultants will document their use of the LMS tools and approaches to build good governance with other organizations, and a survey of the organizations targeted for capacity building under LMS will also try to tease out the success of local capacity builders in successfully carrying out the five phases in the Consulting for Results Framework.

### **3.5 Lessons Learned**

**1. 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.

**2. The easy application of the tools facilitates the rapid scale-up:** The power of the LDP and MOST tools is that they can be applied by others and CSOs can take ownership of the process. This facilitates the continued scale-up and mainstreaming of the approaches without continued technical assistance and funding from LMS.

**3. Scaling up through local consultants is feasible but the quality of replication needs to be assessed:** LMS is continuing to evaluate the effectiveness of this strategy in maintaining the quality of the L&M capacity built in the various CSOs. Maintaining quality of the trainings provided by counterparts during this rapid scale-up can be challenging and LMS is continuing to monitor this.

## **3.6 Mainstreaming and Scaling Up with Established Institutions and Universities**

LMS believes that a key to the success of any health system and to improving health service delivery, is to take a systematic approach to the development of health leaders and managers, from the time they begin their schooling to the time they retire. This approach includes leadership and management preparation through pre-service and induction training, allowing health professionals to choose to become health managers, providing opportunities for continual professional development and merit based promotions. LMS' approach to training health professions begins with equipping them with clinical, leadership and management knowledge and skills at their institutions. By using this approach in pre-service LMS hopes that students will be able to use L&M skills to face daily challenges in their workplace and are empowered to mobilize teams to face challenges.

LMS has worked with Makerere University in Uganda, Universidad Nacional Autonoma in Nicaragua, and Boston University in Boston, Massachusetts to:

- Develop a relationship with a champion at the institution or university.
- Adapt L&M modules and training to meet the curricula of the institution or university.

### **3.6.1 Uganda: Makerere University**

Makerere University's Faculty of Medicine (FOM) graduates 200 doctors per year, and is the leading medical school in Uganda. In 2004, FOM launched Problem Based Learning along with Community Based Education and Service (COBES). The COBES approach requires each student to spend one to two months a year working at a community health site, and the curriculum consists of six modules spread over the first four years of the undergraduate medical course. LMS has been collaborating with FOM since 2006 to integrate the LDP into the COBES program. There was shared recognition by stakeholders in both institutions that the LDP was ideally suited to fill a gap in the training of FOM students to equip them with the knowledge, skills and attitudes essential to face the leadership and management challenges they will encounter in the real life medical field.

Results from an evaluation by an external consultant in June 2008 found:

- Students felt the LDP had prepared them to be better doctors by improving their leadership and organizational skills and teaching them to develop time-bound action plans in an organized way. The courses empowered them to conduct discussions and negotiations with greater confidence and turn problems into a challenge for which they can take responsibility.
- Faculty had a better appreciation of the power of creating a vision and mission in focusing and mobilizing the students. They used the Challenge Model to problem solve and were better able to manage limited resources such as time, funds, materials and equipment.
- The LDP action plans prepared by the two pilot health facility sites were difficult to evaluate because team framed their measurable results in terms of percentages but did not specify the baseline data with accurate denominators. Therefore, although the evaluator was able to get raw data on the number of deliveries and immunized children in June 2008, he could not say if the teams had reached their desired measurable result.

To date, the process of integrating the LDP into Makerere University Faculty of Medicine’s COBES program has achieved concrete results, including the following:

- Exposed nearly 40 FOM faculty members and administrative staff to the basics of leadership and management;
- Trained a core team of nine FOM faculty members and one administrative support officer to facilitate the LDP methodology for further capacity building within FOM and the COBES sites;
- Achieved about 40% preliminary integration of LDP into the COBES curriculum focusing on exposing 1<sup>st</sup> and 2<sup>nd</sup> year students and health care workers to leadership principles and practices, and the Challenge Model for participatory problem solving;
- 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;
- Enlisting a support of a champion for the LDP/COBES has helped the LDP become institutionalized in the Office of the Deputy Dean of FOM, ensuring the sustainability of the process.

During the COBES/LDP Project, two teams of faculty from Makerere University’s School of Public Health continued their improvement of leadership and management capabilities by enrolling in MSH’s Virtual Leadership Development Program. They have developed their own action plans to further train faculty in the LDP methodology and to sensitize faculty and administrators at the SPH about the need to incorporate a leadership component in their courses. The process has also involved other institutions including Mbarara University of Science and Technology Faculty of Medicine in Uganda, and Muhimbili College of Health Sciences (now Muhimbili University of Health and Allied Sciences) in Tanzania where the participating team developed, tested, and implemented a tool for measuring students’ leadership skills during clinical rotations.

### **3.6.2 Nicaragua: Universidad Nacional Autonoma de Nicaragua**

The Universidad Nacional Autonoma de Nicaragua Faculty of Medicine (UNAN FOM) and Centro de Investigaciones y Estudios de la Salud (CIES) needed to develop a results-oriented program to prepare medical students to work in the new health care system which is in the process of reform to become more performance-based. They also created a generic leadership and management program for medical students, doctors, and other health professionals to improve their leadership and management skills to enable them to better implement the new model of health care being rolled out by the Ministry of Health.

LMS, UNAN FOM, and CIES faculty and administrators designed a Management and Leadership Program for fifth year medical students. The unique seven-module program focused on developing students’ leadership and management skills, and applying these skills to address health needs in the community. The modules utilize a participatory teaching methodology with case studies and group work to simulate a team-based environment. UNAN piloted and revised the curriculum with 33 medical students in 2007. In September 2008, 175 students and three faculty members began officially using the new curriculum.

“This experience has proven to be an important part of the formation of future doctors, particularly with regard to primary health care, where more and better services are urgently needed. Working in the communities, students learn to provide person-to-person, human-centered quality care, determine what people need to stay healthy, carry out prevention, and build relationships with people. All this ensures that students receive not only a solid scientific foundation, but a humanistic one as well.”

—Dr. Mercedes Cáceres,  
Vice-Dean of the Faculty of Medicine



Most participants report at the end of the course that they have gained a strong understanding of leadership and management needs in developing countries and of key principles of leadership and management development. The course has been recognized for two years running with the School's "Excellence in Teaching" award, given to only the top five courses. Students noted in their evaluation that "[the course] changes your entire public health perspective;" "this is probably the best course I've taken at BU;" and "this should be a required course for all International Health concentrators if not for all SPH students."

The Leading Organizations Towards Achieving the MDGs course will be offered again in 2010.

### 3.6 Lessons Learned

**1. Pre-Service integration of L&M is a long term process but leads to greater sustainability:** Due to the hierarchical nature of the university, it takes more time to integrate leadership and management practices into a curriculum. However, once it is integrated it is highly sustainable

**2. The measure of success is in student learning and application:** This is often more difficult to measure than a facility level six-month challenge, which can easily produce baseline and follow-up data. It is unrealistic to expect that service delivery results will be immediately visible because students have improved leadership and management skills. These are long term results and will take time to evaluate.

**3. Adapting traditional in-service programs can be challenging:** Typical programs and learning modules from in-service training must be adapted to fit the nature of pre-service institutions and learning styles of a classroom. The approach in Nicaragua was easily scaled up because the modules from the leadership and management program fit into the fifth year curriculum which already had a traditional management course. Integrating an action based approach like the LDP, which was designed for health practitioners to tackle a real work place challenge will take more adjustments and time to get right. Pre-service programs with community rotations are a good fit with the LDP.

#### 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 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."

## 4. CONCLUSIONS

Returning to the research questions posed at the beginning of this evaluation:

1. What strategies has LMS pursued to mainstream and/or scale-up leadership and management capacity?
2. What conditions need to exist for each strategy to be successful? Given local conditions and specific organizational challenges, what strategies are most effective?
3. How have counterparts and/or partners integrated or institutionalized programs and approaches introduced by LMS? What changes, if any, have recipient groups made that have been influenced by the application and their institutionalization?

This evaluation enables us to draw conclusions about LMS mainstreaming and scale-up strategies and make recommendations for how to select the best strategy for mainstreaming and scale-up in a particular context.

This evaluation documented 15 case studies where LMS interventions are directly impacting organizational performance and/or service delivery at more than one level of the health system. The strategies LMS employed include the following:

1. All levels of a national health system
2. Provincial or state level in a country
3. At the community level and with youth groups
4. Integrating L&M into the work of partners and USAID cooperating agencies
5. High volume technical assistance for rapid mainstreaming and scale-up
6. With established institutions and universities

For all of these strategies to be successful in other health programs in the future they need to achieve several goals. They must be flexible and address local conditions and local players; champions need to be identified and nurtured early on; scale-up should be planned from the beginning; local facilitators and teams must be empowered to take ownership of their challenges, and local institutions should be identified to “house” and sustain the intervention; tools must be simple, practical, and accessible; and the strategy should yield substantive results rapidly (“quick wins”). The LDP embodies many of the key points above, and proved to be a successful strategy in many different environments. One of the key recommendations from this study is that the choice of any strategy from the list above should always be accompanied by a commitment on the part of the CA and counterparts to achieve these goals.

In the Afghanistan, Kenya, and Nicaragua we found that by carrying out locally-lead research to get buy-in for leadership and management capacity building at the **national level**. As well as, demonstrating how leadership and management results can inspire other countries to also integrate L&M training into their health systems. Working at the **provincial and state levels** in Brazil and Egypt, we learned that L&M capacity building can first be mainstreamed and scaled-up in one province or state and then be expanded to other provinces or states. Also, a critical mass of practitioners can help sustain L&M practices regardless of political changes at the national level. Working at the **community level** and with youth groups in Peru, local staff learned they could successfully employ simple tools from the LDP to establish dialogue between the communities and the formal sector and coordinate health service delivery for better health outcomes.

In many of the countries where LMS works, we have learned that aligning L&M skills building with the working style of **partners and USAID cooperating agencies** helps those partners and agencies more effectively mainstream and scale-up L&M at both the central and country levels. To get L&M into the hands of counterparts more quickly, mainstreaming and scale-up through **short-term, high volume technical assistance** was a successful method in Nigeria and Tanzania that also ensured high quality program

replication. Finally, working with established institutions and universities in Nicaragua, Uganda, and the United States taught us that pre-service integration of L&M is a long-term process, and that the true measure of success is in student learning and application.

As is evident from the country examples chosen for this study, a number of counterparts and partners have integrated or institutionalized programs and approaches introduced by LMS. This was most likely to happen when the approach allowed the counterpart to achieve its own goals of improving organizational performance and/or services. It was least likely to happen when political shifts left the program without its original champions. The most common change made by recipient groups as a result of integrating action-oriented leadership and management has been to the focus on achieving results and on achieving them through a participatory, transformative process that engages health workers at all levels. The three pre-service examples in the study illustrate the changes in teaching from traditional theory and lecture-based approaches to a practical action-based approach that have been brought about as a result of integrating LMS leadership and management approaches.

What is clear is that the LDP is the most easily mainstreamed and scaled up of all of LMS programs. Although MSH tools such as MOST and QuickStart, the Workgroup Climate Assessment, and other assessments for specific areas such as human resource and financial management can be extremely useful when applied with a client organization, they are not so easily taught or transferred for organizations to make their own. In the country cases where such tools have been applied, that rationale in fact was not primarily to mainstream such tools, rather they served to facilitate a rapid, participatory assessment of organizational needs so that appropriate TA could be provided to rapidly improve organizational performance and scale-up service delivery capacity and access to or effective use of donor financial resources. For this reason, the LDP is a highly effective first step in an intervention designed to address organizational performance and service delivery challenges that may have many other components.

## APPENDIX I

### Capture Form

Reviewer name:	
Date form completed:	
Project Name/Country:	
Dates of program implementation:	
Total Project Budget:	
Project Manager:	
Name(s) of respondents to questionnaire/ data source(s)	
Organization Type (government, private, NGO/FBO etc)	
Organization's geographical coverage (national/provincial/district)	
Geographical coverage of the LMS Program	
What was the challenge facing the organization? Why was the LMS tool or approach introduced?	
Description of the intervention to mainstream and scale-up leadership and/or management capacity and the strategies used	
Description of any L&M strategies/activities implemented by the counterpart that contributed to mainstreaming and scale-up of the L&M tool or approach	
What were the results of the mainstreaming or scale-up in terms of organizational or service delivery improvements?	
Did application of the tool or approach spread to other geographic regions or parts of the organization?	
Was the LMS tool or approach modified? If so, how?	
Is the tool or approach still in use? If so why, and if not why not?	
What were the success factors?	

## APPENDIX II

### Draft Questionnaire/Interview Guide

Name of Program:

Name/Title of Respondent:

Date:

[Insert background information on the study, rationale, how data will be used]

[Insert background information on the specific M&L or LMS Program intervention(s)]

1. Why was the M&L or LMS approach/program introduced? In other words, what specific challenge(s) was your organization (or team in the case of the VLDP) facing?
2. How was the M&L or LMS approach/program introduced to your organization (or team)?  
[Question purpose: to get the counterpart to recall the process implemented to introduce the approach from his/her point of view]
3. Is your organization (or team) continuing to apply the M&L or LMS approach/program? Yes/No.
4. If no, why not? (Use the 5 whys approach to probe for root causes.)
5. If yes, describe:
  - a. Why does the M&L or LMS approach continue to be applied? [Wait for answer, probe if appropriate: what are its benefits to your organization (or team)?]
  - b. How has the M&L or LMS approach continued to be applied? For example, has your organization (or team) put into place any formal requirements, other processes or structural changes to sustain the continued use of the approach?
  - c. Have you modified the M&L or LMS approach in any substantive way? If no, why not? If yes, please describe.
  - d. Has application of the M&L or LMS approach expanded to other parts of your organization and/or to other geographic regions since your collaboration with M&L or LMS ended? If yes, please describe these expanded applications.
6. Have there been any recent changes in organizational performance and/or service delivery that you attribute to any improvement in leadership and management capacity? If no, why not? If yes, please describe. Do you have any results data you could share with us?
7. What are some lessons learned from your experience in applying the M&L or LMS approach?
8. [For MSH bilaterals, ADRA, CAs only]: What benefit to your program did you see from use of the M&L or LMS approach?

## APPENDIX III

### 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.