

Documenting Mainstreaming Strategies for In-service and Pre-service programs

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MAINSTREAMING LEADERSHIP AND MANAGEMENT APPROACHES

ASSESSMENT AND DOCUMENTATION OF RESULTS

I. INTRODUCTION

A. The Leadership Development Program

The primary LMS approach to bringing leadership and management to organizations is the Leadership Development Program (LDP), a four- to six-month intervention in which teams of health managers and their staff apply action learning and problem-solving techniques to address real workplace challenges. The LDP aims to:

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

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 vision. They scan their environment and focus on measurable results that 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 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.

The LDP was developed by MSH in 2002 and has been introduced in # settings with # teams ranging across all sectors of the health system. It has been used as an *in-service* intervention by teams in government agencies and NGOs at central, provincial, and district levels, and at facilities ranging from large hospitals to community dispensaries.

LMS has also implemented *pre-service* leadership and development programs through three mechanisms:

- 1) Pilot programs to introduce leadership and management concepts and practices into the curricula at African, Latin American, and Near East medical schools;
- 2) A Virtual Leadership Development Program (VLDP), through which 11 teams from academic institutions for future health professionals explored the integration of leadership and management into medical, nursing, and other health care curricula;
- 3) Adaptation of the LDP as a summer course at Boston University School of Public Health (BUSPH).

B. Mainstreaming defined

In order to scale up successful leadership and management development practices, the Leadership, Management and Sustainability (LMS) Program is committed to mainstreaming the key elements of

the program into other organizations. We have defined **mainstreaming** along continuums of inputs and outcomes.

Our definition encompasses three levels of **inputs** which are defined by seven variables. Table 1 shows the inputs, with descriptors of the variables at each level.

TABLE 1. Levels and definitions of inputs for mainstreaming of LDPs in the LMS Program

Transfer Level	INPUTS						
	LMS LOE	Senior Alignment Meeting	Stakeholder Buy-in	Champion	Teams	Participants	Organizational and/or Country Culture
1	Low LOE: One-shot intervention (LDP orientation, handout of materials, single workshop, with no systematic follow-up)	No senior alignment meeting held	No buy-in from influential stakeholders	No clearly identified champion	Teams composed of people who don't normally work together, have few common interests or concerns	Key participants drop out before completing LDP	Organizational and/or country culture is hierarchical, doesn't encourage teamwork
2	Medium LOE: Full LDP workshop sequence delivered by local facilitators and coached through virtual contact with LMS staff	Senior alignment meeting held but key decision-makers aren't invited or leave early	Influential stakeholders gain awareness but offer no tangible support	Champion(s) powerless, little authority or influence	Relatively intact teams at the start of the LDP, but changing personnel over course of the LDP	Participants attend workshops but don't carry out assigned activities between workshops (e.g., engaging wider workplace team in LDP)	Organizational and/or country culture gives lip service to teamwork but remains hierarchical
3	High LOE: <ul style="list-style-type: none"> • LDP workshop sequence conducted by certified facilitators • Follow-up by MSH staff (core or mission funded, or piggyback on other initiatives) • Systematic on-site coaching/mentoring • External evaluation 	Key decision-makers attend the meeting and participate actively throughout	Enthusiastic stakeholder support (advocacy, in-kind contributions, funding)	Champion(s) with authority and influence	Intact teams with consistent membership, physical proximity, and common interests and concerns	Key participants are present and engaged in every part of the LDP	Organizational and/or country culture supports teamwork and works to break down hierarchy

We have defined the **outcomes** along a continuum from the *initiation* of key elements into an organization (“seeds are planted”), to the *integration* of some elements into the organization’s work (“seeds take root, begin to sprout”), to the ultimate goal: the *institutionalization* of proven practices and approaches within the organization (“seeds bear fruit”). Table 2 shows the outcomes, again with descriptors of each variable.

TABLE 2. Levels and definitions of outcomes from mainstreaming of LDPs in the LMS Program

Outcome Level	OUTCOMES				
	Individual Changes	Team Achievement of Measurable Results	Team Working Styles	Inter-team Connections	Plans for Future LDPs
1 <i>Initiation</i> Seeds are planted	Individuals respond positively to LDP experience but exhibit no major behavioral changes	Most teams complete the LDP, fail to achieve measurable result, and don’t look further into the reasons	Most teams complete LDP but show no change in working styles	Teams that have worked on the LDP together initiate new connections, begin to exchange information, ideas. Examples: <ul style="list-style-type: none"> • Curative & PHC facilities • Different levels of government (district & facility; facility & community) • NGOs and government • Inter-governmental units (ministries) 	Teams complete the LDP but their organizations fail to plan for future LDP applications
2 <i>Integration</i> Seeds take root, begin to sprout	Individuals change: <ul style="list-style-type: none"> • Some of those who are low on the totem pole (women, minorities, youth, non-doctors) speak out • Some individuals use LDP approaches in personal or professional lives 	Most teams complete the LDP, make progress towards their measurable result, and use LDP tools (challenge model, workplans, M&E plans) to explore reasons for not fully achieving the result	Most teams begin to show leader shifts (Handbook, p 3). They “work smarter”—do what they were doing before but more effectively	Inter-team connections are maintained over time; teams use each other as resources. Examples: <ul style="list-style-type: none"> • Curative & PHC facilities • Different levels of government (district & facility; facility & community) • NGOs and government • Inter-governmental units (ministries) 	Teams propose future LDP applications but their organizations fail to include the LDP in annual plans and budgets
3 <i>Institutionalization</i> Seeds bear fruit	Individuals who were participants become active participants, leaders, and/or facilitators in the ongoing LDP process	Most teams achieve a measurable public health result and maintain or improve achievements over time	Most teams incorporate key elements of the LDP into their routine work (use LDP language; work collaboratively; respond to problems by tackling them as new challenges	Inter-team collaboration yields public health results Examples: <ul style="list-style-type: none"> • Curative & PHC facilities • Different levels of government (district & facility; facility & community) • NGOs and government • Inter-governmental units (ministries) 	Teams propose future LDP applications and their organizations include the LDP in annual plans and budgets

II. OBJECTIVES OF THIS ASSESSMENT

This body of experience offers a rich opportunity to determine the extent to which the LDP has been mainstreamed, and to identify the critical factors that can encourage or impede mainstreaming. LMS has accumulated a variety of evidence of successful mainstreaming. Even where participating teams have produced uneven results, there are dozens of compelling reports and stories of individuals and teams maintaining core elements of the program over time. This assessment is designed to consolidate and update the existing evidence, filling in as many gaps in information as possible in order to gain a more complete and up-to-date picture.

The objectives of the assessment are, therefore, to:

- Present our mainstreaming definition and strategy;
- Document the various programs and activities LMS has implemented to mainstream leadership and management approaches through the Leadership Development Program, both pre-service and in-service (through core and field support);
- Present results achieved to date: the extent to which LDP components have been mainstreamed, are being replicated;
- Compare LMS mainstreaming approaches with regard to efficiency, effectiveness, and sustainability;
- Determine the conditions that contribute to successful mainstreaming.

III. RESEARCH QUESTIONS

1. What did the participating organizations/institutions (including LMS) expect to achieve through the LDP?
2. To what extent did they meet those expectations within the initial LDP intervention?
3. What inputs did LMS provide to enable the organizations to mainstream L&M approaches and tools beyond the initial intervention?
4. To what extent has mainstreaming actually occurred?
5. What conditions were in place when mainstreaming succeeded?
6. What conditions obstructed success?

IV. METHODOLOGY

A. Document review

We used as much written information as possible from the Mainstreaming eRoom: trip reports, reports of workshops and coaching sessions, entries from the Facilitators' Network Newsletters, LMS Evaluation Notes, and other write-ups for public dissemination. These documents were immensely helpful but, in some instances, incomplete or out of date. Whenever possible, we sought updates from people who had been involved in the programs, contacting them either in person or through email.

B. Interviews

The richest sources of information were face-to-face interviews with LMS/MSH facilitators in Cambridge or in the field or, in a few instances, with representatives of partner organizations and institutions. The interviews were open-ended, but we used formats that covered all the research questions cited in Section IV above, along with a summary and supplementary comments. The

interview questions were, understandably, somewhat different for the pre- and in-service LDPs. The completed interview forms are found in Annex I.

C. Placement of in-service activities along input and outcome continuums

Because both inputs and outcomes lie along a continuum, the in-service programs studied may not fall neatly into one level or even into the designated spaces between levels, as seen in Table 1. But we found that this tool helped to differentiate among LDP initiatives and suggested points at which the level and type of input was linked with the mainstreaming outcome.

As seen in Table 3, we applied the descriptors to each LDP intervention and totaled the numbers of entities that matched each descriptor. We then looked for relationships between inputs and outcomes within specific LDPs and, where feasible, more broadly across the LDP groupings. With such a small number of programs and so much variety within and between them, statistical analysis would be unrealistic. Nevertheless, our methodology has yielded a number of findings that appear frequently and strongly enough to be considered as the LDP expands into new geographic and technical areas.

D. Summaries of pre-service experience and of activities in unanticipated settings

It became apparent early in this assessment that the variables on the input/outcome continuums weren't applicable to the pre-service institutions. The pre-service curriculum prepares students for application of the LDP and challenge model to their future work, unlike the in-service LDP which addresses challenges currently facing intact working teams. Most of the variables along the input continuum are not relevant at this stage. We have, however, categorized the programs according to the three outcomes on the mainstreaming continuum – initiation, integration, and institutionalization – and highlighted the most salient inputs and conditions in narrative form.

We have applied the same methodology to four additional activities that do not fall into either the in-service or pre-service categories but have demonstrated some aspects of mainstreaming: ADRA Professional Leadership Institute, USAID's Avian Influenza Project, the orientation of staff from Justice Resource Institute (JRI) and International Consultants and Associates (IC&A), and the HCI Project in Peru.s

V. FINDINGS

A. In-service activities

Table 3 summarizes the results of this assessment program by program, using the previously presented descriptors of the levels of input and outcome (see Tables 1 and 2). From this table, we have observed that:

- Of 8 LDPs with a high LMS level of effort (2.5 – 3), all but 1 team achieved their desired results.
- 2 of the 4 teams with a low LMS level of effort (1 – 1.5) achieved their desired results.
- All teams reported individual changes between 2 and 3 (we don't know about Lesotho).
- Plans for future LDPs are generally dependent on project funding; we didn't find any examples of organizations drawing on their own budgets in a major way.

TABLE 3

Country	INPUTS							OUTCOMES				
	LMS LOE	Senior Alignment Meeting	Stakeholder Buy-in	Champion(s)	Teams	Participants	Organizational and/or Country Culture	Individual Changes	Team Achievement of Measurable Results	Team Working Styles	Inter-team Connections	Plans for Future LDPs
Afghanistan	3	3	3	3	3	3	1: country 2: MSH/REACH	2.5	3	2.5	2.5	3
Cambodia, ADRA	1	1	1	3	3	3	1: country 3: ADRA	3	3	3	?	?
Egypt: Aswan Governorate	3	3	3	3	3	3	1: country 1: MOH	3	3	3	3	3
Ghana	3	3	3	3	3	3	1: country 3: ADRA	2.5	3	3	3	2.5
Guyana (Public Sector)	3	1	1	3	1	2	1: country 1: MOH	2.5	1.5	2	2	3
Guyana (NGOs)	3	2.5	3	3	3	3	1: country 3: NGOs	2.5	2.5	3	2	3
Kenya, Capacity Project	3	1	2	1	3	3	1: country 2.5: IntraHealth	3	2.5	3	?	1
Lesotho	1	1	1	1	?	?	1: country 2.5: IntraHealth	?	?	1	?	?
Nepal	3	3	3	3	3	3	1: country 3: ADRA	3	2.5	3	3	3
Southern Sudan	1.5	?	?	3	1.5	1	1: country 2.5: IntraHealth	2	1	?	1	?
Swaziland (LDP#1, 2007)	1.5	1.5	1	1	3	2	1: country 2.5: IntraHealth	2.5	2	1	?	2.5
Tanzania (Kigoma)	2.5	1	3	3	3	3	1: country 3: EngenderHealth 2: ESAMI	3	2.5	3	?	2
Zanzibar	1	3	3	?	3	3	1: country 2: ESAMI	3	3	3	?	3

Three additional findings surfaced from interviews and document review.

- Of the two LMS subcontractors with an organizational commitment to the LDP approach, one, ADRA, has successfully mainstreamed the LDP approach and scaled it up to new settings after the initial project ended. In the case of ESAMI this mainstreaming has not taken place. A major barrier proved to be the lack of fit between the LMS business model and ESAMI's. 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 have also made coordination difficult. ESAMI consultants immediately go on to other full time consultancies after each LDP workshop and so don't have the time to commit to follow up coaching or visits with teams
- Mainstreaming and scale-up to new settings outside of the original collaboration did not spontaneously occur in organizations to which LMS was the subcontractor (EngenderHealth, FHI), even when local staff had been oriented and trained.
- We found elements of the LDP being used in some unanticipated settings:
 - Although the LDP was not designed specifically for use at the community level, its principles were seen as consistent with participatory approaches to community development (Peru, Bamyan Province in Afghanistan, Nepal Phase 2).
 - The LDP was viewed as very appropriate for internal use in a domestic organization with a compatible culture (JRI).

B. Pre-service activities

Pre-service leadership and management development is an intervention that prepares future health professionals for their respective fields. The pre-service LDP teaches faculty and students in schools of medicine and public health applicable leadership and management concepts and practices that they can use in their future careers. In pre-service programs that integrate LDP tools and approaches into their curriculum, students learn to identify and address the priority health challenges in their communities. The pre-service experience in East Africa has been developed in universities where a field practicum is a degree requirement, so students learn and apply leading and managing practices by implementing an action plan in a health care facility.

LMS has completed four pre-service education programs: Makerere College of Health Sciences, Universidad Nacional Autonoma de Nicaragua (UNAN), Boston University School of Public Health (BUSPH), and Suez Canal University. Each of these programs has also yielded "spin-offs" to other universities or schools of public health, which are currently at various stages of design, implementation, and formal approval as part of the degree curriculum.

Table 4 categorizes each pre-service LDP activity according to a simplified version of the three outcome levels, since the in-service descriptors do not apply.

Table 4. A comparison of outcomes for mainstreaming of leadership and management into pre-service programs

Institution	Initiated seeds are planted	Integrated seeds take root, begin to sprout	Institutionalized seeds bear fruit
Makerere College of Health Sciences, FOM			X
Mbarara College of Health Sciences, FOM			X
Makerere School of Public Health			X
Muhimbili (MUHAS) School of Public Health			X
Nicaragua UNAN Faculty of Medicine			X
CIES Post Graduate Program for Public Health		X	
Mariano Galvez University of Guatemala, FOM	X		
Boston University School of Public Health			X
Suez Canal University, Egypt (first through VLDP)		X	

1. Makerere College of Health Sciences, Faculty of Medicine

In Uganda, MSH began working with the Makerere College of Health Sciences Faculty of Medicine in 2006 to pilot the LDP in the college's Community Based Education and Service (COBES) and Problem Based Learning (PBL) programs. A generic pre-service curriculum was developed, piloted, and revised for use during the first and second years of the medical school curriculum. Students also spend 2-3 weeks each year of their five-year program at a community health site where they apply the LDP with the support and supervision of a field-site tutor. As of December 2008, the curriculum was in final stages of approval by the various curriculum review committees, with the expectation that the curriculum will be approved by March 2009, in time for implementation with the students entering in June 2009.

The Makerere pilot led to introduction of the pre-service LDP in several other settings. **Mbarara MUST College of Health Sciences in Uganda** has adapted and revised the Makerere College curriculum and is in the final stages of curriculum approval for use with 2nd and 3rd year medical students and for students in the Schools of Nursing, Pharmacy, Radiology, and Laboratory Science. **Makerere School of Public Health in Uganda** and the **Muhimbili (MUHAS) School of Public Health in Tanzania**, with the support of the LIPHEA project, adapted the curriculum into a short course for pre-service and in-service training of health managers and public health professionals.

A **pre-service Virtual Leadership Development Program (VLDP)** involved 11 teams from seven countries (Uganda, Kenya, Tanzania, South Africa, Egypt, Yemen, and Mexico), and was held from January – April 2008. The internet-based VLDP combined face-to-face teamwork with distance learning practices and focused on how the teams could strengthen leadership and management curricula in pre-service programs. The VLDP also strategically involved faculty and administrators from Makerere College of Health Sciences sharing their first-hand LDP experience with participants from other universities and schools of public health.

Several factors contributed to the successful institutionalization of the LDP in the Makerere College curriculum:

- One faculty member was a strong champion who expanded his role to that of facilitator and advisor to other universities and schools in Uganda and Tanzania.
- A committed leadership development team was established from the onset of activities and, despite some dropouts, continued to work together throughout the effort.
- The LDP was a “natural fit” with the COBES and PBL programs.

- The invitation of observers from other universities and schools of public health to the pilot LDP at Ndejje Health Facility served as a springboard for expansion of the pre-service LDP to other sites.
- Experienced faculty who were initially resistant to coaching/training reportedly shifted their views and made changes in their teaching approaches on the basis of their positive LDP experience.

2. Universidad Nacional Autónoma de Nicaragua (UNAN), Faculty of Medicine

In Latin America, the **Centro de Investigaciones y Estudios de la Salud de la Universidad Nacional Autónoma de Nicaragua (CIES/UNAN)** team designed a management and leadership curriculum for 5th year medical students. This 7- module curriculum focuses on the development of the students' leadership and management skills and aims to teach students how to lead and manage for better health results in the country's primary health units. CIES/UNAN piloted the curriculum with 33 medical students in 2007. Following the pilot, the curriculum was revised and in September 2008, 175 students and three faculty members began officially using the new curriculum.

This initial pilot with CIES/UNAN has fostered replication in other faculties within UNAN. The curriculum has been adopted by the **CIES Post-Graduate Program for Public Health**, and efforts are currently underway to adapt the modules for use with the **UNAN Faculty of Medicine** for their **Master of Family Planning and Reproductive Health**. The curriculum is also being adapted by the **Faculty of Medicine** in **Mariano Galvez University of Guatemala**.

Key factors that contributed to the success of the UNAN Pre-Service experience include:

- The spirit of political and educational reform in Nicaragua provided an opening for the university to modify its curriculum.
- LMS had the flexibility to adapt its management and leadership approaches and tools to the needs and priorities of the universities in Nicaragua.
- The CIES/UNAN initiative had the full support and assistance of the Nicaragua-based MSH project team.
- A paid Field Coordinator managed the effort from start to finish, particularly encouraging follow-through on assignments between site visits from the technical advisors/consultants.

3. Boston University School of Public Health (BUSPH)

A third approach to pre-service LDP brings together international and domestic MPH students and practicing public health professionals for a course which is co-sponsored by MSH and **Boston University School of Public Health**, entitled "Leading Organizations Towards Achieving the Millennium Development Goals (MDGs)." The four-week summer course provides participants with the opportunity to learn a practical, applicable process for leading and managing teams and organizations to achieve measurable health results. It also allows participants to reflect on and improve their own leadership capabilities.

In addition to integrating students and public health professionals in the classroom, participants are also connected virtually to MSH's projects in the field. Through this connection, they identify real challenges related to the MDGs, and to use the Challenge Model to develop action plans to address them. 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 development. During the three

years the course has run, there is evidence that numerous participants have effectively applied the Challenge Model to situations in their work and communities. One participant used the Challenge Model to train public health faculty through a three-week course held in India in 2008 and scheduled to be repeated in 2009. Another participant organized a two-day workshop to orient medical and public health students to the Challenge Model, involving the students with four local community health centers. This same participant also mobilized the deans and several faculty at BU Medical School and the School of Public Health to develop an interdepartmental/interdisciplinary elective for-credit course entitled “Developing and Implementing Successful Community Based Health Initiatives” open to first- and second-year medical students and students in the SPH.

From this LMS/BUSPH collaboration, two conditions have emerged as important for mainstreaming:

- The integration of international and domestic students and public health professionals enabled participant teams to learn from each other and use the Challenge Model to address real public health challenges. In 2008, funding limitations prevented the participation of international public professionals, thereby preventing the rich interchange between the students and the field practitioners that had been present in the first two years.
- Giving their final presentations at MSH headquarters brought students out of the classroom and onto the scene of an international public health organization. Their presentations were reviewed and critiqued by MSH professional staff, giving them the opportunity to interact with an extended network of public health professionals.

4. Pre-service VLDP – Suez Canal University (SCU), Faculty of Medicine (Egypt)

In early 2008, 10 faculty members from **SCU Faculty of Medicine** participated in a Virtual Leadership Development Program (VLDP) for pre-service teams that was conducted over the course of three months. This faculty team tackled the challenge of integrating structured (action-oriented) leadership and management training into the curriculum. Their desired result was to start an LDP for fourth-year medical students during their community medicine rotation, to be implemented in a community-based site/hostel focused on infection prevention. A follow-up inquiry conducted in December 2008 determined that the SCU team had made significant progress in the implementation of their action plan and had started training students and facilitators/field tutors on the new curriculum. One VLDP participant replicated some aspects of the VLDP with family health center managers affiliated with the SCU and has also included LDP content in a module for the doctoral degree in family medicine. Following the VLDP, SCU requested LMS technical assistance to train a critical mass of staff and tutors to facilitate and teach the pre-service curriculum to students and Community Based Education site teams. The main objective of this TOT is to familiarize the participants with the content and the facilitation methodology of the LDP.

One of the unique characteristics of the SCU pre-service VLDP experience was that they received multiple visits prior to the VLDP from a senior LDP facilitator; these client engagement visits effectively stimulated interest in and enthusiasm for the LDP.

Another noteworthy highlight from the pre-service VLDP comes from **Muhimbili University (MUHAS), Tanzania**, where the participating team developed, tested, and implemented a tool for measuring students’ leadership during clinical rotations. A full report on the pre-service VLDP is available through the Scale-up Team Assessment.

C. Additional activities

Four activities that could not be categorized neatly as in-service or pre-service offered findings that pertain to mainstreaming.

1. *ADRA Professional Leadership Institute (APLI)*

After ADRA/Nepal's very positive experience with the ROLDP, ADRA International decided to incorporate elements of the LDP into the curriculum that **APLI** offers to ADRA's professional staff. In fact, APLI has now added to its syllabus a one-week Leadership and Management course in which two days are devoted to LDP methodologies, with the Challenge Model as the centerpiece. In 2008, two ADRA staff from the LMS partnership co-taught the course in Bangkok to 23 course participants, including many Country Directors and other top ADRA professionals from 12 countries. Each participant left the course with the challenge to apply their new knowledge and skills in their country office and programs and to record their leadership and management success story in video form by October 2008. (That deadline has now been extended to the end of January 2009, so we have not yet seen the videos and have no confirmation that they are indeed being produced.)

Three conditions contributed to this example of institutionalization within a partner CA:

- ADRA's culture is compatible with the participatory, non-hierarchical, results-oriented LDP approach.
- As a training program, the LDP fits well with the competency-based courses that APLI already offers their staff.
- ADRA/Nepal was a full partner throughout both phases of the Nepal LDP and had already initiated the LDP as part of their own country programs.

2. *USAID's Stamping Out Pandemic and Avian Influenza (STOP AI) Project*

MSH is sub-contracted to DAI for the 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, and eight more are planned in other Latin American countries.

Three conditions led to this unexpected mainstreaming effort:

- The Handbook was a powerful stand-alone mechanism for introducing the LDP in an unconventional setting.
- Even with minimal orientation, an individual who was strongly committed to the LDP as a way to fill a real programmatic need proved to be a highly effective champion.
- LMs was willing and able to orient an MSH colleague quickly, trusting that his thorough understanding of the LDP and his clear sense of how to apply it in his project would make him a successful advocate and practitioner.

3. *Justice Resource Institute (JRI), Boston, MA*

In January 2007, an LMS staff member sent a copy of the "Managers Who Lead Handbook" to the Director of the Health Division at JRI (an acquaintance). JRI is a Boston-based NGO that "provides education, housing and support services to children and adults with physical, emotional and learning

disabilities.” Their staff includes highly experienced facilitators with expertise in curriculum design. They “loved” the Handbook, found it completely compatible with their perspective, and decided to use it within their own organization. Five of their staff then participated in a three-day LDP orientation at MSH, designed by LMS to create a new cadre of facilitators/coaches to meet the expanding demand for LDPs. Since that time, there have been some efforts to engage their staff as lead facilitators in LDPs overseas, but, due to administrative and logistical obstacles, none of the potential assignments has as yet materialized.

However, after the orientation, JRI conducted a five-day pilot internal LDP at their Massachusetts Department of Public Health sites, facilitated by staff members who had attended the LMS orientation. The intent was to strengthen the five participating units/teams and generate sharing and collaboration across the units. They based the training on the Handbook, adapting some of the content as they went along and blending it with some of their own exercises. They considered the pilot successful in team building and cross-unit sharing and have incorporated key elements of the LDP into their staff training curriculum. They also plan to use root cause analysis for their internal evaluation process.

Four conditions contributed to this mainstreaming example:

- JRI’s culture was fully compatible with the participatory, non-hierarchical, results-oriented LDP approach.
- JRI sent very skilled, experienced facilitators to the orientation - people who were immediately receptive to the LDP and able to apply it in their own organizational context.
- Once again, the “Managers Who Lead Handbook” provided a compelling introduction to the LDP in an unexpected organizational setting .
- Even with only a one-shot orientation and the failure to entirely meet the original expectations of LMS and JRI, the well-designed orientation generated a group of capable, enthusiastic facilitators who have institutionalized what they learned within their own organization.

4. Training Community Leaders to Improve Leadership and Management Practices, Peru

In January, 2008, LMS launched a program to train community leaders to improve leadership and management practices with 13 teams from rural communities. The program, first piloted in Weslala, Nicaragua, emphasized community values (punctuality, respect, solidarity, responsibility, confidence, forgiveness and reconciliation, and democracy) to build social capital: a commitment to the health and development of the community. Although the program was not a replica of the LDP, the hope was that it would give communities a language and conceptual understanding that would enable them to work more effectively with their health centers, whose staff had participated in the LDP. The program didn’t fully meet that goal, but it featured a similar participatory methodology and spirit of optimism, engaging participants in exercises that are somewhat comparable to the Challenge Model: for example, the “tree of dreams,” which created a shared vision and actions for reaching it. And it did directly use LDP language in addressing the four practices of leading – scanning, focusing, aligning/mobilizing, and inspiring – simplifying the explanations and drawing examples from the day-to-day lives and concerns of the

participants. And, although it did not use LDP language for the management practices, the program did engage participants in planning activities, organizing, implementing the activities, and looking back to see what they had/had not accomplished (a less complex form of monitoring and evaluating).

The primary condition that supports mainstreaming in this program is that the four leadership practices – scanning, focusing, aligning/mobilizing, and inspiring – proved to be easily accessible and meaningful to community members if applied to day-to-day activities.

VI. LESSONS LEARNED

A. Critical factors applicable to both in-service and pre-service activities

- This assessment confirms the importance of senior staff buy-in; a well-trained, committed facilitation team with a strong leader; and a champion for the LDP: a “transforming agent” who hangs in against all obstacles, displays integrity by doing what s/he agrees to do, takes action, and achieves results.
- The “Managers Who Lead Handbook” is a valuable tool that can be highly effective in attracting organizations and individuals to the LDP.
- Well-trained, motivated local facilitators/coaches/tutors can become effective champions for mainstreaming and scale-up.

B. Learnings from in-service programs

- Even with only a one-shot orientation and the failure to entirely meet the original expectations of LMS and JRI, a well-designed, compelling orientation has generated capable, enthusiastic facilitators who creatively integrate and disseminate what they have learned (Ghana, JRI, Lesotho).
- Translation of LDP materials into local languages is essential for full understanding participation of participants. This is particularly important as the LDP is introduced at lower levels of the health system and village committees, where team members may be less accustomed to speaking and reading English in their day-to-day work. (Nepal, Tanzania)
- When their organizational culture is compatible with the LDP approach and they have been full partners throughout the program, CAs are likely to promote and fund the LDP program as part of their own country activities. This reduces or eliminates the need for ongoing LMS involvement
- If we want other CAs to mainstream LDP into their programs (Tanzania), we need to
 - be sure that they genuinely want the LDP, that it helps them meet their organizational goals
 - plan together from the start for mainstreaming and scale-up to other settings
 - publicly acknowledge their successes as well as those of MSH/LMS.

C. Learning from pre-service programs

- Across the pre-service activities, four factors stand out as important for successful mainstreaming:
 - An effective leadership development team serves two important functions: leading the process of curriculum design and facilitating decision-making and approval for the formal adoption of the curriculum.

- Universities with a community-based component provide a valuable opportunity for practical application of the LDP in the health service delivery setting.
- To make the LDP accessible to a wider range of institutions, two approaches have proven useful: 1) Including the LDP in a newly-developed Generic Pre-service Curriculum and 2) being flexible enough to adapt relevant aspects of the LDP to the existing curriculum at the institution.
- A staff person or consultant on the ground in country is needed to provide ongoing support and direction to keep things moving even between TA visits.
- A university that meets the critical factors noted above can overcome the challenges of limited funding and limited external technical assistance and can achieve the desired outcome: having the LDP modules adapted and approved as part of the curriculum (UNAN, Makerere, Mbarara)
- Short courses can be developed and delivered outside of the formal curriculum as a way to rapidly expand utilization of the course in both pre-service and in-service settings. (MUHAS, Makerere SPH)
- Strategic involvement of the Dean, senior administrators, and members of the curriculum review committee in LDPs and VLDPs motivates participants and facilitates decision making processes, including final curriculum approval (Makerere, VLDP MUHAS FON)
- Practical work at the health units requires consistent support/supervision, and careful preparation of the faculty/health facility tutors (Makerere, Mbarara)

VII. QUESTIONS FOR FURTHER EXPLORATION

A. Questions applicable to both in-service and pre-service activities

- How can we best maintain quality while expanding/extending the LDP? How can we balance ongoing LMS presence/“control” with the need for organizations to own the program and adapt it to their situations?

B. In-service activities

- How effective is the LMS virtual network, LeaderNet, and the LDP Newsletter in motivating facilitators to remain engaged? To act as champions in expanding the LDP? Are there other approaches that should be considered?
- How effective is the full apprenticeship training model vs. the intensive orientation with virtual mentoring (“just-in-time”) model?
- Should other CAs be encouraged to build capacity to carry out LDPs on their own? (The LMS proposal states: “Out of our hands into the world.”)
- Can CAs do it effectively if leadership and management are tangential to their main concerns/mandates?

C. Pre-service activities

- Where are the essential links between pre-service and in-service training in the LDP? Can you merge pre- and in-service training, linking the university with the MOH, other ministries, or NGOs?
- Is it effective to prepare MOH staff and university staff for pre-service efforts through VLDP in combination with hands-on LDP training for university faculty?

- Should academic programs, such as the BUSPH course, be expanded to offer an optional supplementary component for students to conduct an internship or field practicum? This would enable them to implement and follow through on the Challenge and Action Plan that they developed during the course., but it would be a labor intensive undertaking for MSH to become involved in long term mentoring of students in field projects.
- How can we best define and measure the results/effectiveness of pre-service leadership and management training in a way that extends beyond course grade/evaluation into the practical application of the LDP in their careers?

VIII. CONCLUSION

This assessment has shown that, with senior staff buy-in; a well-trained, committed facilitation team with a strong leader; and one or more effective champions, the LDP has been mainstreamed in both in-service and pre-service settings. In the process, the program has often been adapted to the local setting. With in-service interventions, this most often meant changes in timing and some simplification of concepts. With pre-service interventions, it meant adjustment to fit into an existing curriculum. But the core – the challenge model – has always been retained. In many instances, the program has proven powerful enough that participants have become champions and found creative ways to bring it to new audiences.

The assessment has also shown that, although many in-service LDP teams have made impressive changes in their working relationships – working more collaboratively and successfully addressing management challenges – they do not always reach the public health targets they have set for themselves. Over the long term, teams that attain measurable public health results are the most effective advocates for mainstreaming within their organizations and, ultimately, scale-up to a larger audience. When teams fail to reach their desired results, the main obstacle appears to be that those results do not meet the “SMART” criteria – meaning are not specific, measurable, appropriate, realistic, and/or time bound. This is where facilitators/coaches can be most helpful, working with their teams to carefully analyze proposed results against the SMART criteria. They may have to return to the task several times as the teams monitor their progress and come to terms with their success or lack of success in carrying out their action plans. This should be emphasized in the training of new facilitators/coaches, with enough exercises to be sure that they themselves fully understand and can use the criteria.

One challenging aspect of this assessment was the sporadic nature of the documentation of LDP activities. LMS has developed a simple framework and schedule to capture regular, consistent, and systematic feedback about the initial LDP and about the process of mainstreaming as the LDP is scaled up. For the next phase of mainstreaming, we hope that LMS will be able to enforce the reporting requirement for all lead facilitators/coaches. Their feedback can then be used to identify common threads across diverse activities, to shape adjustments to the approach during implementation, and to conduct more comprehensive evaluations over the long term. In this way, the LDP will retain its strength as a powerful force for change.

Annexes

In-service

Afghanistan

Cambodia - ADRA

Egypt – Aswan Governorate

Ghana

Guyana - public sector and NGOs

Kenya – Capacity Project

Lesotho

Nepal

Southern Sudan

Swaziland

Tanzania – Kigoma

Zanzibar

Pre-service

Boston University SPH

Makerere University FOM

Makerere University SPH – LIPHEA Project

Mbarara University FOM

Muhimbili University of Health and Allied Sciences (MUHAS) SPH

UNAN FOM and CIES SPH Universities

Afghanistan

The setting	Afghanistan; 13 provinces plus Kabul, supported by USAID's Tech-Serve project.	Trip Reports and Other Key Documents
Interview with: Date:	Morsi Mansour (with a few comments from Joan Mansour), Steve Solter, Alain Joyal 11-26-08, 12-29-08, 1-27-09	<ul style="list-style-type: none"> • Trip reports: July 07, January 08, April 08, • Informal report (Vriesendorp), Nov 08 • Notes in Network Newsletter, June 08
Start/end dates	2006-2010	
Brief Background and current status	Grew out of 2005 study tour of Aswan, Egypt LDP (under REACH). Tech-Serve has funded the LDP as a way to implement its Management Support for Provinces (MSP) initiative and meet project targets. Reportedly impressive results in several provinces (especially Bamyan, somewhat in), mixed results in others (Herat, Kandahar). COP has become a powerful advocate for LDP, claims that "all of Afghanistan needs it."	
7. What did the participating organizations expect to achieve	MSH Tech-Serve: COP had incomplete information about LDP methodology, had "neutral" feelings but went along with what was in the proposal. Other staff skeptical about	

through the LDP?	<p>how it could help achieve programmatic goals.</p> <p>LMS: Saw Afghanistan as chance to incorporate LDP as a standard part of capacity-development programs.</p> <p>MOPH: General Director of Provincial Health was very invested, involved—had been to Aswan. Others less so.</p>	
8. What challenges did they take on in their LDPs?	Were steered to select 1 of 7 Tech-Serve indicators (e.g., increase immunizations, TB detection, deliveries in health facilities, etc.) Tech-Serve set targets.	
9. To what extent did they successfully meet those challenges within their proposed timeframe?	Most sites succeeded in meeting or exceeding targets.	

<p>10. To what extent did they maintain their successes over time?</p>	<p>Mixed results. Hard to get information from remote, dangerous provinces Bamyán Province is usually cited as an ongoing success; has been visited often and examples have been written up. Dynamic Provincial Health Director (PHD) there has become champion. Herat is often mentioned (also with a strong PHD), though the results there seem to be less consistent across different sites. Then most successful provinces are those where security is best, allowing staff from Kabul to visit and provincial staff to get to local sites to monitor progress and coach.</p>	
<p>11. What inputs did LMS provide to enable the organizations to mainstream L&M approaches and tools?</p>	<ul style="list-style-type: none"> • LMS LOE: No core funds, high LOE from project funds. • LDP materials: Standard materials. Facilitators' Guide and exercises translated into Dari and partly into Pashto. • TOT: 21 central-level and Tech-Serve staff; 13 provincial LDP teams; • Follow-up <ul style="list-style-type: none"> – Coaching/mentoring: LDP coordinator tries to follow up monthly with each province; difficult in provinces with security issues. Little input from MSH HQ. – TA: Vriesendorp visit in April 08 to conduct 2 TOT workshops and hold short alignment meeting with senior MOPH staff. – Phone/email contact: – Other: 	
<p>12. To what extent has mainstreaming actually occurred?</p>	<p>General enthusiasm for LDP throughout government and NGOs where it has been applied and results can be seen. ~ 60 teams have been trained, 100 planned by the</p>	

	<p>end of the project. Mostly dependent on project funding, though Bamyan and Herat are allocating some provincial resources to it.</p> <p>Tech-Serve has small, cohesive core team; facilitators have fanned out in 12 provinces. Project has made this a priority, set aside considerable funds and staff time to scale up within Tech-Serve provinces.</p> <p>TB Cap started in Afghanistan in 08; LDP has been adapted to track and improve detection rates.</p> <p>Afghan Public Health Institute (APHI) sent 2 senior staff for TOT; one has co-facilitated an LDP.</p>	
<p>13. What conditions were in place when mainstreaming succeeded?</p>	<ul style="list-style-type: none"> • MSH marketing: Core LDP facilitators led early study tour to Egypt, conducted Senior Alignment meeting. • Marketing from LDP/VLDP “convert”: Tech-Serve COP • Champion: Tech-Serve COP, country LDP coordinator, some Provincial Health Advisors. • Team: Facilitation/coaching teams are committed, eager to do their work, but have very inconsistent knowledge and skills. Facility teams are generally intact and motivated. • Institutional “home”: APHI within MOPH • Buy-in from senior mgt: Very successful Senior Alignment Meetings have garnered support. • Resources (money, staff): Well funded by Tech-Serve project. • Organizational/country culture: Country culture largely inconsistent with LDP approach—no good models for 	

	<p>teamwork. Professional culture (doctors/nurses) very hierarchical; especially difficult for women. Accountability for results inconsistently applied.</p> <ul style="list-style-type: none"> • Supportive systems: Project systems make logistics, operations relatively smooth. Reasonably effective HMIS was introduced under REACH; service providers are used to reporting quantitative results. <p>Other:</p>	
14. What conditions obstructed success?	<ul style="list-style-type: none"> • [Lack of items above] <ul style="list-style-type: none"> – Within Tech-Serve, some staff view the LDP as a vertical program, don't grasp it as an approach to be applied throughout the health system. – In dangerous provinces, Tech-Serve can't provide the support needed to monitor, mentor, and coach provincial LDP teams. – Some trained facilitator/coaches don't fully grasp LDP methodology. They use the language but haven't really absorbed the concepts. This lack of understanding is transmitted to the sites where they have trained staff. – There is some tendency to treat the LDP as more of a belief system than a methodology; to view it as an end in itself rather than as a process for improving leadership, management, and health conditions. • Initiation within project that ended: Projects ongoing; staying power remains to be seen. • Staff turnover: Not a serious problem. <p>Other:</p>	

15. Other findings	The program has succeeded best with strong local leadership, one or more individuals who completely understand the LDP, use its language and model the L&M practices in their own work. When this is lacking, staff may misunderstand and misuse the process (e.g., take on multiple challenges at once, fail to put forth SMART results, etc.).	
Analysis, conclusions, recommendations		
16. What do we know now about mainstreaming leadership and management approaches into organizations (counterparts, other CAs, other TA providers) that we didn't know at the start of LMS?	It's important to integrate LDP monitoring with the local M&E system in order to track progress accurately against indicators.	
17. What are some key questions that may remain to be explored in the future concerning mainstreaming?	How to maintain the quality of facilitation and coaching as a program is scaled up and direct monitoring from a core local team (or from LMS) becomes less feasible.	

AFGHANISTAN SUMMARY AND COMMENTS

The Afghanistan LDP was, to a great extent, a product of the 2-week study tour to the Aswan LDP in 2005, which exposed 15 managers from REACH, the MOPH, and 6 provinces to the LDP in action at district offices, health centers, and villages. The tour also featured a visit to the Grand Imam of Al-Azhar (author of a pamphlet justifying family planning within the Islamic faith). The study tour created considerable enthusiasm among the participants, because of their firsthand view of effective teams coupled with the blessings of Egypt's most eminent religious leader. Back in Afghanistan, they reported on their visit but didn't succeed in convincing other decision makers of the value of the LDP. They requested follow-up from LMS, and the LMS staff members who had initiated the original Aswan program came to Afghanistan where they held a Senior Alignment Meeting for REACH staff as well as staff of the MOPH. They then trained the first facilitation team in a 5-day workshop with participants from Kabul and Bamyan. At this point, a strong champion emerged from Bamyan: the youngest, most enthusiastic participant in the training, who ultimately became a master trainer and remains a passionate leader of the Afghan program.

It appears that these early interventions contributed to strong stakeholder buy-in. The LDP was built into the Tech-Serve proposal and has received considerable project resources. The original intent under Tech-Serve was to introduce the LDP in 4-5 provinces during the first project year, where it could be carefully implemented, monitored, and fine-tuned, to serve as a model for other provinces later on. For a variety of reasons, it was introduced in all 13 provinces at once, somewhat weakening the intervention and making it more difficult to monitor the longer-term results. Bamyan is reportedly the most successful LDP province and the one that most visitors go to. The program is being adapted and simplified for use by community health workers. According to an LMS visitor, "Bamyan has become Aswan!" A visit to Bamyan "converted" a skeptical Tech-Serve staff member who saw solid improvements at the Provincial Health Office (PHO), at a 2-person NGO facility, and in a community where a supervisor and his wife had used the LDP as a way of significantly reducing the incidence of diarrhea among children. In Herat, despite some uneven performances from site to site, the USAID CTO noted that the LDP has been particularly successful in facilities where JHPIEGO was concurrently applying its performance-improvement initiative; the symbiosis between the two approaches is apparently very effective.

It is not easy to monitor the program closely over time. Several provinces are in areas where security risks make external visits virtually non-existent. The COP has, however, gone to Kandahar – perhaps the most dangerous province – and found some facility

teams working together productively and collaboratively, reaching their targets, and attributing their success to the LDP. He has also reported uneven results from some other provinces that are not struggling with security issues but that seem to lack a real understanding of LDP tenets and practices. In a visit to Baghlan, Takhar, and Jawzjan Provinces, he noted LDP practices enabled the PHO teams to be “better represented in the provincial level general meetings and other events.” He stated that other members of the provincial health teams and NGOs had approached the PHO for training. PHO team members questioned the ability of some of the Tech-Serve Trainers for effective facilitation of LDP sessions. Some PHO team members felt that the quality of training was poor; they reported that they were confused about LDP and needed more “technical clarification.” From this and other evidence, the COP surmised that some trainers from Tech-Serve were not capable of teaching the LDP process and tools. To bolster this perception, the Tech-Serve Core Facilitators Team rated 21 trained facilitators as follows: 2 are “good”; 4 are “average”; 7 are “below average”; 8 are “weak.” If this admittedly subjective rating reflects reality, there is much work to do to strengthen the quality of facilitation, especially as the LDP is expanded to new sites.

Cambodia – ADRA

The setting	Cambodia, World Relief/ADRA SPY Project (PEPFAR)	Trip Reports and Other Key Documents
Interview with: Date:	Steve Solter 12-29-08	<ul style="list-style-type: none"> • Informal report: “Mission Possible” • LDP Facilitator Network Newsletter, June 08
Start/end dates	?? 07	
Brief Background and current status	Spontaneous, just-in-time intervention: 2.5-day LDP training aiming to boost morale of a distressed project management team (11 members) threatened with loss of funding if the project didn’t meet PEPFAR indicators within 6 months.	
18. What did the participating organizations expect to achieve through the LDP?	Unknown	

19. What challenges did they take on in their LDPs?	Based on PEPFAR indicators: training # volunteers, reaching # men/women with messages; treating children with respiratory problems and diarrhea, educating mothers about acute respiratory infections.	
20. To what extent did they successfully meet those challenges within their proposed timeframe?	Highly successful; all indicators were met or exceeded.	
21. To what extent did they maintain their successes over time?	Unknown	
22. What inputs did LMS provide to enable the organizations to mainstream L&M	<ul style="list-style-type: none"> • LOE: Minimal • LDP materials: Adapted segments of Handbook • TOT: Facilitator had been trained in Nepal • Follow-up <ul style="list-style-type: none"> - Coaching/mentoring: Unknown 	

<p>approaches and tools?</p>	<ul style="list-style-type: none"> - TA: - Phone/email contact: Other: 	
<p>23. To what extent has mainstreaming actually occurred?</p>	<p>In a sense, this episode represents mainstreaming of the LDP approach within ADRA, based on and adapted from the Nepal experience</p>	
<p>24. What conditions were in place when mainstreaming succeeded?</p>	<ul style="list-style-type: none"> • MSH marketing: None • Marketing from LDP/VLDP “convert”: • Champion: Provincial Projects Advisor for ADRA office in Phnom Penh – very skilled in LDP and had some faith that it could work in this situation • Team: Project management team intact, strong motivation to turn things around – jobs at stake. • Institutional “home”: None • Buy-in from senior mgt: None • Resources (money, staff): None • Organizational culture: Country culture not conducive to LDP; ADRA culture very much so (sub-contractor to MSH for LMS project) • Supportive systems: None Other: 	

25. What conditions obstructed success?	<ul style="list-style-type: none"> • [Lack of items above] <ul style="list-style-type: none"> – Project team discouraged, feeling hopeless, on the road to failure. • Initiation within project that ended: • Staff turnover: • Other: 	
26. Other findings		
Analysis, conclusions, recommendations		
27. What do we know now about mainstreaming leadership and management	This experience shows that a dedicated champion, highly skilled as a facilitator, can adapt the LDP with minimal resources and achieve powerful results.	

approaches into organizations (counterparts, other CAs, other TA providers) that we didn't know at the start of LMS?		
28. What are some key questions that may remain to be explored in the future concerning mainstreaming?		

SUMMARY AND COMMENTS

This is a remarkable instance of the complete turnaround of a failing project through a creative “just-in-time” adaptation of the LDP. The facilitator, ADRA’s Provincial Project Advisor, was assigned to work on M&E with the SPY project team, which was not meeting its FY 07 PEPFAR requirements and was in danger of losing funding; he “could feel the negative environment in the office, . . . despair, cynicism, blaming others, . . . perhaps afraid of losing their job.” He decided to try to apply the LDP in a 2.5-day workshop, thoughtfully selecting a few tools and approaches that might motivate the team: operational district coordinators, a training specialist, an M&E officer, and the project manager and assistant project manager. He drew on “Asian family and cultural values,” used many local examples, and found the right Khmer terminology to convey the unfamiliar concept of a challenge as vs. an insoluble problem.

The results were striking: by the last day, “they took ownership of the training and forgot about me.” The evaluation at the end of the fiscal year showed that the project had more than met all the PEPFAR indicators. In one instance – outreach with messages for HIV prevention – the project reached 6 times the required number of men and women; in the treatment of children with diarrhea, they achieved more than 10 times the required number!

He later heard that the 6 operational district coordinators had taken the challenge model to their field teams and developed action plans with those teams. It would be interesting to interview the project manager and/or other members of the project team to get their perception of the LDP and determine whether further mainstreaming has taken place.

Egypt - Aswan

The setting	Aswan Governorate, Egypt	Trip Reports and Other Key Documents
Interview with: Date:	Morsi Mansour 12-11-08	<ul style="list-style-type: none"> • LMS Evaluation Notes, July 04, Sept 05 • “Seeds of Success,” 2006: writeup and video • Mansour and Mansour: “Improving Health Services through a Locally Owned and Sustained LDP in Rural Upper Egypt”: (draft for submission to WHO, 2008)
Start/end dates	2002-03	
Brief background and current status	Original LDP. In collaboration with Ministry of Health and Population (MOHP), designed to “improve quality and accessibility of reproductive health services in 3 districts. . . by giving health managers and clinic staff leadership skills to improve the performance of service delivery.” Enrolled 10 teams of 41 PHC personnel from primary	

	health units and 1 rural hospital. Aswan has maintained reductions in MMR; other governorates have been trained in the LDP. Visit from Afghan officials led to replication in 13 Afghan provinces.	
29. What did the participating organizations expect to achieve through the LDP?	MOHP: "Increase managers' ability to create high-performing teams and lead them to achieve [public health] results"	
30. What challenges did they take on in their LDPs?	Increasing antenatal and post-partum visits, addressing unmet family planning needs	
31. To what extent did they successfully meet those challenges within their proposed timeframe?	<ul style="list-style-type: none"> All but 1 of 10 teams improved; 75% of the teams achieved 95% of targets. 	

<p>32. To what extent did they maintain their successes over time?</p>	<ul style="list-style-type: none"> • After 1 year, prenatal and child care visits continued to increase. 	
<p>33. What inputs did LMS provide to enable the organizations to mainstream L&M approaches and tools?</p>	<ul style="list-style-type: none"> • LOE: High • LDP materials: Translated into Arabic; adapted and simplified for front-line facilities, CHWs, community clinic boards; maintained core components while removing some details • TOT: Intensive facilitator training, strong facilitation team • Follow-up <ul style="list-style-type: none"> – Coaching/mentoring: Intensive during project year; in later years more sporadic, generally limited to collection of M&E data – TA: See “Other” – Phone/email contact: Some <p>Other: Original Egyptian champion now works for LMS; attends annual conference of LDP facilitators, offers some informal TA</p>	

<p>34. To what extent has mainstreaming actually occurred?</p>	<p>2003</p> <ul style="list-style-type: none"> • Without USAID funding, 3 districts introduced the program to 15 new health facilities. • All teams maintained more positive attitudes; were using data for planning; were carrying out action plans with existing resources. <p>2004</p> <ul style="list-style-type: none"> • Expansion to 100 health facilities in Aswan Governorate • LDP elements incorporated into supervisory system <p>2005</p> <ul style="list-style-type: none"> • Expansion to 184 facilities in Aswan <p>Current</p> <ul style="list-style-type: none"> • 6th generation of LDP underway • Each generation brings on new facilitators • Annual conferences are initiating evidence-based practices that draw on data from LDP sites 	
<p>35. What conditions were in place when mainstreaming succeeded?</p>	<ul style="list-style-type: none"> • MSH marketing: Program introduced by very committed senior LMS staff • Marketing from LDP/VLDP “convert”: MOHP physician became powerful advocate; has maintained contact, attends yearly meetings. • Champion: Aswan physician: originally skeptical, became convert as well • Team: Original team remains highly committed, continues to meet; viewed as “think tank” by prior Director of Health • Institutional “home”: MOHP Health Directorate 	

	<ul style="list-style-type: none"> • Buy-in from senior mgt: Prior Director of Health was strong supporter of original project and expansion • Resources (money, staff): Originally USAID funding • Organizational culture: Able to overcome hierarchical structure, build multi-level teams • Supportive systems: • Other: 	
36. What conditions obstructed success?	<ul style="list-style-type: none"> • [Lack of items above] <ul style="list-style-type: none"> – Strongly hierarchical culture, nationally and within MOHP – Punitive supervisory system • Initiation within project that ended: <ul style="list-style-type: none"> – Reliance on local funding required shorter training, less coaching and follow-up • Staff turnover: • Other: New Director of Health knows nothing of LDP; Aswan champion (and LMS representative) will try to engage him 	
37. Other findings		
Analysis, conclusions, recommendations		
38. What do we know now about mainstreaming leadership and management approaches into organizations		

(counterparts, other CAs, other TA providers) that we didn't know at the start of LMS?		
39. What are some key questions that may remain to be explored in the future concerning mainstreaming?	How can you maintain the quality of the LDP through succeeding generations of facilitators and teams?	

SUMMARY AND COMMENTS

The Aswan experience has been extensively documented through a variety of print and audio-visual materials (see list on matrix). As the first LDP, this was the time to test and refine the approach, but it appears that virtually all the positive inputs we have identified were present: a high LOE during the introductory year; the emergence of a strong and capable local champion; the effective use, translation, and adaptation of LDP materials; intensive facilitator training which yielded an exceptional facilitators' team; systematic follow-up and coaching. LMS determined that these factors were responsible for the success of the program, and the Aswan initiative became the basis for all future LDPs, beginning with the Afghan visit and replication.

But the continuation and expansion within Aswan Governorate after the one-year grant (with less striking but still measurable public health gains) is harder to explain, since some of these inputs were sharply reduced or diluted as the program expanded to new districts. One possible explanation lies in the ongoing support of the General Director of Health for Aswan Governorate and the tireless advocacy of the physician who emerged as champion during the project year.

It is hard to gauge the impact of the continuing interest of the LMS staff member who became an enthusiast and co-led the program when he worked for the MOHP. He maintains long-distance contact with the key players, offers ongoing moral support, and attends annual facilitators' conferences.

Six years is an impressive length of time for any program to persist and expand without external funding. It remains to be seen if the new Aswan General Director will become an LDP supporter; if he doesn't, it will be important to determine whether earlier Aswan teams continue to use the challenge model and other elements of the LDP approach – whether the LDP has truly been institutionalized.

Hoped-for expansion to other governorates has faltered in the face of lack of buy-in from the central MOHP and the intention of USAID to “wean” Egypt from dependence on foreign aid. At this time, future scale-up is uncertain.

Ghana

The setting	Ghana, Central Region	Trip Reports and Other Key Documents
Interview with: Date:	Mainly document review; one interview with Sylvia Vriesendorp 1-8-09	<ul style="list-style-type: none"> • Concept Paper: “Ghana: Leading Together to Accelerate Results” • Trip reports, Jan 08 (Launch) and July 08 (Presentation of Results)
Start/end dates	1/08 to 7/08	
Brief background and current status	Program led by ADRA. Worked with 6 district teams and 1 team from the Regional Directorate. Participants: nurse managers/directors of nursing services; directors/deputy directors of health services; public health nurses; medical superintendents; senior admin staff. Completed in August, results presented at international conference in Ghana.	
40. What did the participating organizations expect to achieve through the LDP?	Ghana Health Service (GHS) <ul style="list-style-type: none"> • Managers at different levels: address key challenges they have identified together in their High Impact Rapid Delivery (HIRD) workplans • Managers at central level: increased confidence in leadership and management skills and in the leadership and management in the selected region; • Regional and district managers: increased clarity about 	

	<p>their roles vis-à-vis other levels in the health system</p> <ul style="list-style-type: none"> • Regional and district teams: implement action plans to address challenges within HIRD work plans and achieve desired measurable results that met HIRD requirements. <p>LMS and ADRA: Would co-facilitate LDP for the first time and prove capable of doing future facilitation/coaching on their own.</p>	
41. What challenges did they take on in their LDPs?	<p>Improve performance of regional and district programs and markedly reduce maternal and child mortality.</p> <p>Examples:</p> <ul style="list-style-type: none"> • Make staff friendly to clients (meet set of criteria) • Increase FP coverage • Increase supervised deliveries • Improve functioning of CHPS (Community-based Health Planning and Services) • Increase exclusive breast feeding • Improve IPT3 coverage among pregnant women 	
42. To what extent did they successfully meet those challenges within their proposed timeframe?	<p>All 7 teams progressed towards desired results, many surpassing their targets. Teams reported improved relationships between hospital and district health teams. All teams selected new challenges to take on for the future.</p>	
43. To what extent did they maintain their successes over time?	<p>3 teams of the 7 have maintained or added to their successes.</p>	

<p>44. What inputs did LMS provide to enable the organizations to mainstream L&M approaches and tools?</p>	<ul style="list-style-type: none"> • LOE: High • LDP materials: Standard • TOT: LMS conducted • Follow-up <ul style="list-style-type: none"> – Coaching/mentoring: On-site coaching of facilitators through 1st workshop and return to help coach teams for final presentations – TA: – Phone/email contact: Frequent contact with facilitators throughout LDP; continuing now after LDP has ended • Other: 	
<p>45. To what extent has mainstreaming actually occurred?</p>	<p>Unclear whether GHS will cover even minimal expenses in the future. But there are other indicators of mainstreaming:</p> <ul style="list-style-type: none"> • GHS/Central Region will hold another dissemination meeting at the end of 2008 to see even more results and invite the districts not included in this LDP • GHS has asked for 500 Handbook CDs in preparation for rollout of the LDP in other regions, using GAVI funds • ADRA plans to apply LDP methodology to its own staff • One facilitator is teaching elements of LDP in nursing school classes 	
<p>46. What conditions were in place when mainstreaming succeeded?</p>	<ul style="list-style-type: none"> • MSH marketing: LMS gained USAID core funding through long positive association with the mission’s Senior HPN Advisor. MSH publications have had a strong influence on the Director General. • Marketing from LDP/VLDP “convert”: 	

	<ul style="list-style-type: none"> • Champions: GHS Director-General; ADRA Country Director • Team: Very strong, experienced team of facilitators • Institutional “home”: GHS • Buy-in from senior mgt: Strongly supported by senior decision makers from GHS, USAID, ADRA, GIMPA (Ghana Institute for Mgt and Public Administration); GHS called Senior Alignment Meeting, which had a big turnout • Resources (money, staff): Funding through USAID • Organizational culture: As LMS sub-contractor, ADRA is in full accord with LDP approach; GHS is hierarchical, “typical African public-sector culture.” • Supportive systems: ADRA systems support the LDP. • Other: 	
47. What conditions obstructed success?	<ul style="list-style-type: none"> • [Lack of items above] • Initiation within project that ended: • Staff turnover: A new district has been created; some facilitation team members will be moved • Other: The government has promised funds to maintain/expand program but hasn’t delivered. 	
48. Other findings	MSH publications (specifically <i>The Manager</i>) have had a strong influence on the Director General and helped to make him receptive to the LDP.	
Analysis, conclusions, recommendations		

49. What do we know now about mainstreaming leadership and management approaches into organizations (counterparts, other CAs, other TA providers) that we didn't know at the start of LMS?	Confirms the importance of senior staff buy-in; well-trained, committed facilitation team with leader who acts as a champion.	
50. What are some key questions that may remain to be explored in the future concerning mainstreaming?		

SUMMARY AND COMMENTS

Ghana represents nearly ideal conditions for the successful completion of an LDP. It had wholehearted buy-in from USAID and from the highest levels of the Ghana Health Service (GHS), which viewed the LDP as offering a framework and focus for the government's high-priority HIRD program. It had influential champions from the GHS and ADRA; thorough training (using the apprenticeship model) and strong performance of the facilitator team, ongoing coaching (face-to-face and distance) by an LMS master facilitator/coach. It was culturally consistent with the GHS's emphasis on the need to improve staff attitudes, empower staff, foster accountability, build leadership skills, and build collaboration. To date – one year after the launch – there are several indications of mainstreaming, including government funding of high-level meetings related to the LDP, but the LMS master facilitator/coach has raised the critical question: whether the government will contribute the resources needed to mainstream and expand the LDP in the future.

Guyana – Public Sector and NGOs

The setting	Guyana, MSH subcontract to Family Health International (FHI) under the GHARP Project	Trip Reports and Other Key Documents
Interview with: Date:	Lourdes de la Peza, Maryellen Glennon 12-17-08, 12-22-08	<ul style="list-style-type: none"> • LDP assessment report, Dec 08 • MSH/Guyana annual report, 07 • LDP Facilitator Network Newsletter, June 08
Start/end dates	3/05 to 8/07	
Brief Background and current status	This was/is not an LMS program; is funded by project housed in MSH's Center for Health Services. Program has completed 7 workshop series: 143 participants in 52 teams. Teams drawn from all sectors and levels: health centers, public and private hospitals, line ministries, GHARP NGOs.	
51. What did the participating organizations expect to achieve through the LDP?	<p>FHI: Contribute to GHARP objective for strengthening the HR system – fostering retention, effective performance, and supportive supervision. (But no clear understanding of how LDP could advance technical interventions, strengthen HIV/AIDS programs.)</p> <p>MSH, LDP Facilitation Team: Teams would use LDP tools</p>	

	<p>to resolve issues in HIV/AIDS programs and increase program effectiveness by thinking systematically, collaborating, planning more effectively, being held accountable.</p> <p>NGOs: Improve practical management of HIV/AIDS programs to meet PEPFAR targets, enable teams to “work smarter”; no clear understanding of role of leadership.</p>	
52. What challenges did they take on in their LDPs?	<p>Predominantly related to GHARP goals: Increase # clients adhering to ART protocol; increase % OVCs receiving care/support; sensitize providers against stigma/discrimination; provide HIV/AIDS information to men. Some challenges related to team management: increase attendance at meetings, increase participation in planned activities.</p>	
53. To what extent did they successfully meet those challenges within their proposed timeframe?	<p>According to assessment in 12/08, NGOs quite successful: 8 out of 11 teams reported achieving desired result. MOH teams less so; 7 of 14 reported success, but only 4 attributed success to working systematically as teams.</p>	

<p>54. To what extent did they maintain their successes over time?</p>	<p>MOH: 4 individuals formed new teams to continue working on GHARP challenges.</p> <p>NGOs: 5 out of 8 successful teams chose new challenges and were using challenge model to address them.</p> <p>.</p>	
<p>55. What inputs did LMS provide to enable the organizations to mainstream L&M approaches and tools?</p>	<ul style="list-style-type: none"> • LOE: None; all inputs came through GHARP, housed in a different MSH center • LDP materials: Standard materials provided; LDP facilitation team adapted/simplified Facilitators' Guide, added exercises relevant to local context. Created coaching/mentoring "cheat sheet." • TOT: Local LDP team (MSH resident advisor, 2 local consultants, 1 coordinator) has trained 18 core facilitators to mentor/support those who have already been trained in the LDP and expand the methods and principles within their geographic region. • Follow-up <ul style="list-style-type: none"> – Coaching/mentoring: Each LDP facilitation team member is assigned to coach/mentor several participant teams. They meet every 3 months for 6 months, then every 6 months. Face-to-face whenever possible, by phone (using a standardized mentoring sheet) if necessary. – TA: Through process described above. – Phone/email contact: Other: 	

56. To what extent has mainstreaming actually occurred?	<p>Generally: Many teams use tools that “resonated” for them (e.g., 5 Why’s, Urgent/Important Matrix). Anticipating the end of GHARP, MSH focus shifted from LDP workshops and coaching/mentoring to mainstreaming of leadership practices by:</p> <ul style="list-style-type: none"> • establishing and training a Core Group to extend and support the LDP • adapting and integrating LDP core concepts into national health training curricula • establishing LDP Graduate Network • piloting LDP methods in decentralized planning in Region 5. <p>NGOs: Tools and methods have often been incorporated into teams’ ways of working. Teams report meeting more regularly; meetings “more structured and meaningful.”</p> <p>MOH: Most teams don’t meet regularly or have much team identity, but there are a few striking success stories against all odds. (See Summary and Comments below.)</p>	
57. What conditions were in place when mainstreaming succeeded?	<ul style="list-style-type: none"> • MSH marketing: Initially through LMS staff member who assessed HR performance in the public sector, found leadership lacking, and suggested LDP to address HR concerns. • Marketing from LDP/VLDP “convert”: • Champion(s): Members of the LDP facilitation team • Team: Facilitation team very strong, committed. NGO teams largely intact, participated throughout LDP. • Institutional “home”: Still dependent on GHARP 	

	<ul style="list-style-type: none"> • Buy-in from senior mgt: <ul style="list-style-type: none"> – NGOs: Initial meetings with Executive Director of each NGO led to solid buy-in. – MOH: Unsuccessful effort to hold Alignment Meeting; senior officials didn't show up, sent lower-level staff. Unable to meet with MOH Permanent Secretary. • Resources (money, staff): To date only from GHARP • Organizational culture: Country culture doesn't foster teamwork or accountability; this is evident in MOH teams. NGO cultures far more consistent with LDP values and approaches. • Supportive systems: GHARP systems Capacity project systems support the LDP. • Other: 	
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<p>58. What conditions obstructed success?</p>	<ul style="list-style-type: none"> • <i>[Lack of items above]</i> <ul style="list-style-type: none"> – MOH teams often geographically dispersed or “hybrid” – artificially constructed of people who didn’t work together. Many failed to meet after LDP. – Inability to bring decision makers to Senior Alignment Meeting. – Lack of integration into GHARP; seen as separate initiative rather than way of enhancing GHARP program and contributing to PEPFAR results. – Inadequate preparation of LDP facilitation team. • <i>Initiation within project that ended:</i> GHARP not yet ended; some LDP built into MSH proposal for follow-on project. • <i>Staff turnover:</i> Cited as an issue in only one instance. <i>Other:</i> 	
<p>59. Other findings</p>		

Analysis, conclusions, recommendations		
60. What do we know now about mainstreaming leadership and management approaches into organizations (counterparts, other CAs, other TA providers) that we didn't know at the start of LMS?	Even the most conscientious training and follow-up coaching can't compensate for poorly constructed teams and the lack of support from key institutional stakeholders(as seen in the MOH teams in Guyana). But the power of the LDP occasionally breaks through these barriers to create remarkable success stories (see examples under Summary and Comments below).	
61. What are some key questions that may remain to be explored in the future concerning mainstreaming?		

SUMMARY AND COMMENTS

The Guyana LDP had its origins in a Human Capacity Development (HCD) assessment in 2004. Carried out through the GHARP project, this assessment – conducted by an MSH staff member – was viewed as partial preparation for coming decentralization in the context of PEPFAR-supported HIV/AIDS programs. The assessment showed that there were virtually no human resource managers at regional and district levels, so that providers and managers would need to carry out new responsibilities on their own, operating as teams in the face of poor communication among levels, unclear roles, and chronic absenteeism. The MSH staff member recommended the LDP as a way of introducing systematic thinking and teamwork to enhance the HIV/AIDS effort and contribute to PEPFAR results.

The resulting program has been the subject of a methodical assessment by an MSH staff member with no prior involvement in the program. Her work confirms many of the perceptions of the MSH Resident Advisor and adds compelling details to support her findings. In particular, it highlights the differences between MOH and NGO experiences and results, beginning with Senior Alignment Meetings and the composition of LDP teams. The senior decision makers invited to the **MOH** meeting failed to attend and sent junior staff in their place; they never understood or bought in to the LDP. It would appear that the GHARP leadership didn't understand the importance of this meeting and failed to lay the groundwork that would have given it credibility among MOH decision makers. Perhaps for the same reason, the GHARP leadership didn't permit MSH staff to meet directly with the Permanent Secretary who controlled crucial MOH activities. MSH staff tried to meet with regional authorities, but they lacked the power (and often the understanding) to support the initiative.

Partly as a result of the lack of higher-level understanding and involvement, many of the original MOH teams in LDP Series 1 and 2 failed to meet the criteria for intact working groups. They were usually made up of people who worked for GHARP but had little if any intersecting responsibilities in their day-to-day work and were often geographically dispersed (for example, a team of 5 people from 5 different health centers; a team of staff from separate departments in a hospital; a team of nurses who worked different shifts). It is no wonder that many of these teams were unable to create a genuinely shared vision, to work together towards a common result after the LDP workshops, or, in many cases, to meet at all. Further, the hierarchical nature of the MOH was reflected in the multi-level teams, where senior staff were unable to accept lower-level staff as colleagues, and many participants were understandably reluctant, when they came back to work, to share the LDP tools and approaches with staff members of higher

status. Of the 14 original MOH teams visited during the recent assessment, only 5 met the criteria for intact teams, and only 2 were still meeting.

The **NGOs** fared far better. One-on-one meetings with their Executive Directors created buy-in to the LDP. Although these organizational leaders didn't fully appreciate the shifts in thinking and acting that the LDP would bring, they did believe that it could help them manage their work better and carry out their mandates under PEPFAR. 9 of the 11 original NGO teams met the criteria; 8 were still meeting regularly and acting as a team at the time of the assessment.

The LDP facilitation team was highly effective. Though they had to learn the LDP "by the book" without the benefit of training from a skilled, experienced practitioner, they fully grasped the concepts and practices and worked to build strong facilitation skills. They knew their audience and geared the workshops to participants' needs and capacity. They took the initiative to adapt LDP materials for the HIV/AIDS context; they also simplified the approach, revised the sequence, and added day-to-day examples to make the program more accessible to the staff of grassroots NGOs who had less formal education and little if any management experience. These adaptations seem to have accomplished their purpose without compromising the essential content of the program. Both MOH and NGO participants were generally positive about the workshops; there was general agreement that the LDP tools and methods "give them a new way of thinking. . . [and] help them make better decisions not just in their work but in their personal life." The LDP facilitators reinforced learning through coaching sessions with each team between workshops. They maintained this contact after the workshops in regularly scheduled mentoring sessions, to encourage teams to continue applying the LDP methodologies and practices.

In the effort to mainstream LDP principles and practices, the MSH team has introduced four important initiatives:

- **Training of 18 Core Group members from NGOs and ministries.** This group is mandated to mentor/support those who have already been trained in the LDP and to expand the methods and principles within their geographic regions.
- **Adaptation and integration of the LDP core concepts and tools into the national nursing curriculum.** 5 nursing tutors attended the Core Group training, and more are slated for LDP training. This group will take the lead in reviewing the nursing curriculum and preparing for LDP integration.
- **Steps taken toward integrating LDP planning methods into the MOH planning cycle.** To strengthen decentralized planning at the regional level, the LDP facilitation team worked with 18 participants from 11 Region 5 health centers and the Regional Health Officer (RHO) to develop the region's HIV/AIDS workplan for FY 2008. They used the LDP methodology to guide health

centre staff in identifying priority HIV/AIDS interventions and then worked with the RHO to synthesize the inputs of the health center staff, set region-wide HIV/AIDS program objectives and targets, and prepare the associated budget request.

- **The LDP Graduate Network established** as a step toward institutionalizing LDP methods throughout the country. The LDP team designed and conducted workshops for graduates of LDP Series 1-3 to review LDP tools and methods, increase participants' ability to develop SMART measurable results, share experiences in implementing action plans, and outline the mechanism for continued collaboration among participants. A "buddy system" paired graduates with colleagues from other institutions. Core Group members also attended these workshops as part of their apprenticeship.

One disappointing feature of the Guyana LDP was the lack of integration with the GHARP project. The project leaders were generally positive about the LDP but treated it as a separate, vertical initiative, rather than as a force that could support and enhance technical interventions and strengthen the HIV/AIDS program. Everyone involved in promoting the LDP felt that the program was somewhat marginalized by the project. A recent LDP designed specifically for GHARP attracted only half of the eligible staff members; none of those who attended were senior staff. And although most teams chose GHARP goals as their challenges, GHARP itself fostered parallel interventions, used a different "language," and provided different tools to seek similar results. Despite intensive, ongoing efforts, neither of two MSH Resident Advisors could change this perception. As described above, this lack of integration contributed to the failure to attain buy-in from MOH decision makers and ultimately had a negative effect on the makeup of the MOH teams.

Kenya – Capacity Project

The setting	Kenya, MSH subcontract to IntraHealth under the Capacity Project	Trip Reports and Other Key Documents
Interview with: Date:	(Primarily document review) Mary O’Neil 12-30-08	<ul style="list-style-type: none"> • Trip reports, June and Nov 07 • Report of LDP Workshop #3
Start/end dates	May to November 07	
Brief Background and current status	Initiated to supplement Capacity’s work climate improvement intervention. 8 district hospital teams, 2 FBO hospital teams, 1 team from MOH HQ. Local facilitation team: 2 Kenyan consultants (master facilitators), 3 faculty from Kenya Institute of Administration (KIA), 2 Capacity country office staff.	
62. What did the participating organizations expect to achieve	<p>Capacity: Make better progress on action plans for improving work climate.</p> <p>LMS: Help Capacity meet its expectations with a local</p>	

through the LDP?	facilitation/coaching team, and offer suggestions for institutionalizing the LDP for health workers.	
63. What challenges did they take on in their LDPs?	Generally related to work climate rather than specific health services: nurses as leaders, improved staff morale, improved work processes, functional systems, implementation of health agenda	
64. To what extent did they successfully meet those challenges within their proposed timeframe?	At time of Workshop #3, 7 of 11 were working well towards meeting challenges; 2 needed intensive coaching to work through major obstacles, and 2 had made no progress. No info on site-by-site results at end of LDP.	
65. To what extent did they maintain their successes over time?	Not known	

<p>66. What inputs did LMS provide to enable the organizations to mainstream L&M approaches and tools?</p>	<ul style="list-style-type: none"> • LOE: Capacity funded • LDP materials: Standard • TOT: LMS lead facilitator worked with Kenyan master facilitators (MSH consultants) to orient and coach local facilitation team. • Follow-up <ul style="list-style-type: none"> – Coaching/mentoring: Provided by Kenyan consultants – TA: – Phone/email contact: • Other: 	
<p>67. To what extent has mainstreaming actually occurred?</p>	<p>Not known—no systematic follow-up. But in Nov 07, the GOK launched a new program: Improving Leadership and Change Management Programme (ILCMP), to expand the LDP and teams from the first cohort presented their end-of-LDP results to the new facilitators-in-training: 9 out of 11 had “excellent” results.</p>	
<p>68. What conditions were in place when mainstreaming succeeded?</p>	<ul style="list-style-type: none"> • MSH marketing: Began under L&M Project with HRM assessment, leading to work-climate intervention and then to LDP. • Marketing from LDP/VLDP “convert”: • Champion: None clearly identified • Team: Facilitator team generally solid, though KIA hasn’t always followed through as expected • Institutional “home”: KIA? MOH Human Resources Dept? • Buy-in from senior mgt: Not described in trip reports 	

	<ul style="list-style-type: none"> • Resources (money, staff): Capacity • Organizational culture: Country culture not conducive to LDP; IntraHealth/Capacity quite consistent with LDP • Supportive systems: Capacity project systems support the LDP. • Other: 	
69. What conditions obstructed success?	<ul style="list-style-type: none"> • [Lack of items above] <ul style="list-style-type: none"> – Lack of anticipated MOH representation on facilitation team – 2 of 3 KIA facilitators withdrew; 1 remaining facilitator was in and out of workshop sessions • Initiation within project that ended: • Staff turnover: A factor in 2 unsuccessful sites Other: 	
70. Other findings		
Analysis, conclusions, recommendations		
71. What do we know now about mainstreaming leadership and management approaches into organizations		

(counterparts, other CAs, other TA providers) that we didn't know at the start of LMS?		
72. What are some key questions that may remain to be explored in the future concerning mainstreaming?		

SUMMARY AND COMMENTS

Trip reports indicate that the LDP was quite successful, with 9 out of 11 teams meeting their challenges and describing their successes at the end of 6 months. They presented their results to a group of new facilitators; the LMS staff member who worked with the facilitation team stated, “This allowed the newly trained facilitators to see the fruits of a complete program and its potential to transform health system performance at all levels.

Unfortunately, we have not been able to determine the extent to which these teams have institutionalized the LDP approach. As of this writing, we have requested information from a lead facilitator in Kenya.

Lesotho

The setting	Lesotho, MSH subcontract to IntraHealth under the Capacity Project	Trip Reports and Other Key Documents
Interview with: Date:		Draft trip report, 3/08
Start/end dates	3/08 (1 week)	
Brief Background and current status	LMS was to implement the first stage of a new LDP with 5 hospital team from the Christian Health Association of Lesotho (CHAL). The specific tasks were to: establish the local facilitation team, prepare for the senior alignment meeting with the CHAL Secretariat, customize material for Workshop #1 and coach the local team in conducting that workshop	
73. What did the participating organizations expect to achieve through the LDP?	??	

74. What challenges did they take on in their LDPs?	??	
75. To what extent did they successfully meet those challenges within their proposed timeframe?	??	
76. To what extent did they maintain their successes over time?	??	
77. What inputs did	<ul style="list-style-type: none"> • LOE: Low 	

<p>LMS provide to enable the organizations to mainstream L&M approaches and tools?</p>	<ul style="list-style-type: none"> • LDP materials: • TOT: Conducted by senior technical advisor and facilitators from prior LDP in Swaziland • Follow-up <ul style="list-style-type: none"> – Coaching/mentoring: – TA: – Phone/email contact: • Other: 	
<p>78. To what extent has mainstreaming actually occurred?</p>	<p>??</p>	
<p>79. What conditions were in place when mainstreaming succeeded?</p>	<ul style="list-style-type: none"> • MSH marketing: Sylvia Vriesendorp • Marketing from LDP/VLDP “convert”: • Champion: • Team: 2 committed and enthusiastic lead facilitators from Swazi LDP. They worked well with 2 highly skilled local facilitators provided by Institute of Development Management (IDM). • Institutional “home”: • Buy-in from senior mgt: • Resources (money, staff): • Organizational culture: • Supportive systems: 	

	Other:	
80. What conditions obstructed success?	<ul style="list-style-type: none"> • [Lack of items above] <ul style="list-style-type: none"> – Lack of buy-in by Acting Country Director – Communication breakdown between regional and country offices and within country office – Printing/photocopying and Internet facilities not functional – Last-minute changes in travel arrangements distracted participants • Initiation within project that ended: • Staff turnover: Other: 	
81. Other findings		
Analysis, conclusions, recommendations		
82. What do we know now about mainstreaming leadership and management approaches into organizations		

(counterparts, other CAs, other TA providers) that we didn't know at the start of LMS?		
83. What are some key questions that may remain to be explored in the future concerning mainstreaming?		

SUMMARY AND COMMENTS

This LDP benefited from the experience gained in the earlier Swazi LDP, also conducted under MSH's subcontract with IntraHealth's Capacity Project. The lead facilitators had worked together throughout the Swazi LDP and were able to convey the needed concepts and skills to an excellent team of local facilitators, despite some frustrating communications gaps and logistical problems. The two local facilitators, provided by the Institute of Development Management (IDM) – a training institute for civil servants – skillfully co-facilitated the first workshop.

The senior technical advisor to both this and the Swazi LDP is no longer with MSH, and at this time we have no written or verbal information on the rest of the LDP.

Nepal

The setting	Nepal, District public health offices and local facility teams. Conducted by National Health Training Centre (NHTC) of the MOHP. TA from LMS/Nepal, ADRA, and ICA/Nepal.	Trip Reports and Other Key Documents
Interview with: Date:	Brief conversation with Sylvia Vriesendorp, but mainly document review 1-8-09	<ul style="list-style-type: none"> • Evaluation Report, ROLDP Nepal, 3/07 (immediately after workshops) • “Nepal: The Results-Oriented Leadership Development Program,” USAID/MSH publication, no date • Close-out Report for ROLDP Project in Nepal • Powerpoint presentations 3-31-08: <ul style="list-style-type: none"> – ROLDP Dissemination Workshop – “ADRA Nepal: ROLDP Experiences and Future Plan”
Start/end dates	Phase 1: 3/06 to 2/07 Phase 2: 3/07 to 3/08	
Brief Background and	<i>Phase 1</i> (district level): 3 pilot districts; 31 teams, 84	

current status	<p>participants. Evaluated by independent consultant, positive results led to Phase 2.</p> <p><i>Phase 2 (community level):</i> Focus on building capacity of local facilitators (30 government staff trained), developing Nepali-language training materials, fostering community participation through village development committees.</p>	
84. What did the participating organizations expect to achieve through the LDP?	<p>Govt of Nepal: Empower local bodies to be “front-runners in development in the decentralized context” with newly defined roles and responsibilities</p> <p>LMS:</p> <ul style="list-style-type: none"> • Demonstrate that strengthening management and leadership can improve health programs and contribute to quality of life • Increase ability of district and lower-level staff to lead and manage effectively • Strengthen capacity of MOHP staff, some NGOs, and partner organization (ADRA) to deliver M&L interventions as a foundation for replication and scale-up <p>ADRA: Become proficient in LDP approaches and be strong members of the facilitation/coaching team</p>	
85. What challenges did they take on in their LDPs?	<p>Phase 1: Smoke-free campus, effective sanitation program, community forest program, bicycle ambulances to increase marginalized groups’ access to health</p>	

	<p>services, engagement of support staff in facility improvements</p> <p>Phase 2: Hand-operated water pump, OB/Gyn checkup room, meeting from for health facility management committee</p>	
86. To what extent did they successfully meet those challenges within their proposed timeframe?	<p>Phase 1: 90% achieved or exceeded desired results.</p> <p>Phase 2: 6 teams achieved results in time, 3 were in the process when followed up in March 08.</p>	
87. To what extent did they maintain their successes over time?	<p>Many teams report continued use of ROLDP tools and approaches. 2 teams from Phase 1 are using ROLDP concepts in community capacity-development programs. No reported formal follow-up for Phase 2 after the program ended, but it seems that most of their challenges were one-shot achievements which don't require maintenance. Much anecdotal evidence of continuing use of ROLDP approaches by teams at all levels.</p>	
88. What inputs did LMS provide to enable the organizations to mainstream L&M	<ul style="list-style-type: none"> • LOE: High • LDP materials: Handbook translated into Nepali; new training materials developed. • TOT: Local facilitator/coaches trained from the start; intensive training of government facilitators in Phase 2 	

<p>approaches and tools?</p>	<ul style="list-style-type: none"> • Follow-up <ul style="list-style-type: none"> – Coaching/mentoring: ADRA/Nepal and ICA/Nepal have maintained on-the-ground contact – TA: – Phone/email contact: Informal contacts from MSH HQ Other: 	
<p>89. To what extent has mainstreaming actually occurred?</p>	<ul style="list-style-type: none"> • ADRA/Nepal has replicated ROLDP in all its Nepal health projects, has trained facilitators in 4 new districts and 5 partner CBOs. Is applying ROLDP in a new EC project for RH in 3 districts. Is using ROLDP approaches internally. Has transferred the approach to other countries. • ICA/Nepal has trained 400 participants since the end of the program and has produced an adapted LDP manual in Nepali. It has “internalized” ROLDP in its day-to-day work. • NHTC continues to hold decentralization workshops featuring ROLDP methodology; aimed to reach 170 facilities in 08. • International Rescue Committee is applying ROLDP concepts with 6 village development committees 	
<p>90. What conditions were in place when mainstreaming succeeded?</p>	<ul style="list-style-type: none"> • MSH marketing: USAID requested program • Marketing from LDP/VLDP “convert”: • Champion: Many facilitators became champions for new programs; • Facilitation/coaching team: Very strong, well trained, benefited from ongoing presence of ADRA and ICA • Institutional “home”: National Health Training Centre and Regional HTC of MOHP. • Buy-in from senior mgt: Strong support from national 	

	<p>and then district stakeholders, gained through Leadership Dialogue</p> <ul style="list-style-type: none"> • Resources (money, staff): CAs and other international organizations have incorporated ROLDP into programs with varied funding sources. • Organizational culture: Country culture hierarchical, but ADRA and ICA closely attuned to LDP values • Supportive systems: ADRA has solid systems that have benefited the ROLDP <p>Other:</p>	
91. What conditions obstructed success?	<ul style="list-style-type: none"> • [Lack of items above] None noted • Initiation within project that ended: • Staff turnover: <p>Other:</p>	
92. Other findings		

Analysis, conclusions, recommendations		
93. What do we know now about mainstreaming leadership and management approaches into organizations (counterparts, other CAs, other TA providers) that we didn't know at the start of LMS?	<ul style="list-style-type: none"> • When their organizational culture is compatible with the LDP approach and they have been full partners throughout the program, CAs are likely to promote and fund the LDP program as part of their own country activities. This reduces or eliminates the need for ongoing LMS involvement. • The LDP is very appropriate for use by facility teams and village committees. Translation and adaptation of key LDP materials are essential as the program is introduced at lower levels of the health system. • Well-trained, motivated local facilitators/coaches can become effective champions for mainstreaming and scale-up. 	
94. What are some key questions that may remain to be explored in the future concerning mainstreaming?		

SUMMARY AND COMMENTS

The Nepal experience has been thoroughly documented as an example of mainstreaming at its best – as illustrated by the adoption of a unique and very appropriate name: Result-oriented Leadership Development Program (ROLDP). All the conditions that seem to contribute to successful LDPs were in place from the start: a well-planned and executed Leadership Dialogue with stakeholders at the national level who developed a common vision; district-level versions of that event; thorough training of the local facilitators/coaches and ongoing support of the local facilitation team; a “home” in the training wing of the Ministry of Health and Population. In both Phases 1 and 2, the ROLDP was fully implemented with consistent participation throughout. And the materials were adapted and translated to make them fully accessible to participants at all levels.

Perhaps the most valuable resource was the on-the-ground presence of ADRA and ICA, both of which found the LDP relevant to their values and their country programs. ADRA adopted the ROLDP for its own organizational leadership development and incorporated it into its projects at district and facility level. ICA has trained 400 participants since the end of the program. It has also written an illustrated manual in Nepali that adapts the LDP approach to the local context. ADRA International was impressed with the Nepali experience and ultimately introduced the LDP in Cambodia and in the ADRA Professional Leadership Institute (APLI), which prepares ADRA staff to manage its international programs.

A few examples of the success of the program:

- The UNESCO Banke Club is an NGO that works at district and community levels. It used the ROLDP to meet a longstanding challenge: how to communicate the health benefits of family planning. By the end of the program, CPR in the relevant communities had increased from 5% to 13%.
- ADRA has incorporated a ROLDP component into its EC-funded reproductive health project, to be implemented in three conflict-affected districts.
- The Director of the Regional Health Training Centre in the city of Pokhara – one of the original ROLDP participants – has achieved the personal vision he described in his first workshop, turning his center into an international training center. He claims that the ROLDP helped him to discover “the magic of leadership.”
- The National Health Training Centre is using ROLDP concepts learned during the TOT in its capacity-building programs for health professionals. It has printed the Nepali adaptations of LDP materials.

- Various organizations and individuals are using the Nepali version of the Handbook for personal reference and/or as teaching materials.

Southern Sudan

The setting	Southern Sudan, MSH subcontract to IntraHealth under the Capacity Project	Trip Reports and Other Key Documents
Interview with: Date:	Mary O’Neil 12-30-08	<ul style="list-style-type: none"> • Reports: LDP Sessions 1 and 2, December 06, February 07 • Coaching report, May 08 • Article: “The role of leadership in HRH development in challenging public health settings,” WHO Department of Human Resources for Health, November 08 • LDP Facilitator Network Newsletter, June 08
Start/end dates	December 06 to February 07	
Brief Background and current status	Designed to develop HR and leadership capacity among managers at central and regional levels. 10 teams: 4 states, 1 transitional area, 1 teaching hospital, 1 government secretariat, 1 NGO. LDP adapted for 2 workshops vs. the usual 3, because of acute travel limitations. Follow-up coaching visit more than 1 year later.	

95. What did the participating organizations expect to achieve through the LDP?	Capacity, LMS, and MOH HR Director: All aligned in intent for LDP to help address HR challenges: low salaries, unavailability of jobs, lack of infrastructure, low levels of education; attract health workers back into the country after 2 decades of civil strife.	
96. What challenges did they take on in their LDPs?	Teams theoretically agreed on absenteeism as the common HR challenge, but they then chose other challenges (e.g., get essential hospital equipment, improve distribution of drugs, reduce late-coming).	
97. To what extent did they successfully meet those challenges within their proposed timeframe?	Most teams hadn't fully grasped SMART criteria, didn't achieve desired results.	

<p>98. To what extent did they maintain their successes over time?</p>	<p>Hard to know. Follow-up coaching sessions took place more than 1 year after LDP. Aimed to reach 5 of the 10 teams, teams, but only 3 sessions actually took place, with a total of 9 participants (out of the 31 who completed the LDP (see details in Summary and Comments below). Coaching sessions appear to have focused on new challenges rather than original ones.</p>	
<p>99. What inputs did LMS provide to enable the organizations to mainstream L&M approaches and tools?</p>	<ul style="list-style-type: none"> • LOE: Low • LDP materials: Unknown; assume materials for exercises were distributed. Lack of Arabic translations a serious impediment for at least one team. • TOT: 2 well-trained MSH/Capacity consultants in turn trained 3 local coaches/facilitators (rapid, just-in-time TOT for post-workshop coaching) • Follow-up <ul style="list-style-type: none"> – Coaching/mentoring: More than a year after LDP, MSH/Capacity consultants with 2 local coaches/facilitators visited 3 sites. Had hoped to meet 3 other teams at central site, but conflicting political events, local fighting, and staff redeployment kept 3 teams from participating. – TA: None – Phone/email contact: • Other: 	

100. To what extent has mainstreaming actually occurred?	High dropout of LDP teams; of the 3 available for follow-up, it seems that some LDP principles have been absorbed, but the process wasn't maintained. In 2007, Capacity undertook a 2 nd LDP, taking into account lessons learned from this one.	
101. What conditions were in place when mainstreaming succeeded?	<ul style="list-style-type: none"> • MSH marketing: Initially through LMS staff member who joined Capacity assessment team and suggested LDP to address HR concerns. • Marketing from LDP/VLDP "convert": • Champion(s): MOH Director for HR Development and Planning; Capacity Project Coordinator for South Sudan • Team: Facilitation/coaching team strong • Institutional "home": MOH HR Directorate? • Buy-in from senior mgt: Minister of Health, DG Preventive Health Services, and WHO representative opened 1st LDP workshop. • Resources (money, staff): Capacity Project • Organizational culture: Country culture not conducive to LDP; IntraHealth/Capacity quite consistent with LDP • Supportive systems: Capacity project systems support the LDP. • Other: 	

<p>102. What conditions obstructed success?</p>	<ul style="list-style-type: none"> • [Lack of items above] <ul style="list-style-type: none"> – Exceptional challenges of post-conflict environment (travel and communications extremely limited, fighting in LDP district,) curtailed attendance at 2nd workshop and severely affected attendance at coaching sessions: – Long time between LDP and coaching sessions, with virtually no interim contact, reduced momentum and enthusiasm – • Initiation within project that ended: • Staff turnover: Several participants were redeployed, transferred, or left service. Other: 	
<p>103. Other findings</p>		

Analysis, conclusions, recommendations		
104. What do we know now about mainstreaming leadership and management approaches into organizations (counterparts, other CAs, other TA providers) that we didn't know at the start of LMS?	<p>LDP participants need to fully grasp – and meet – the criteria for SMART measurable results in order to have a chance of achieving their desired results.</p> <p>Timely coaching and follow-up appear to be critical to maintaining LDP practices.</p>	
105. What are some key questions that may remain to be explored in the future concerning mainstreaming?		

SUMMARY AND COMMENTS

Southern Sudan represents one of the most difficult environments conceivable for completing the LDP process; mainstreaming is highly unlikely in these circumstances. Two decades of conflict have virtually destroyed the infrastructure, making the customary sequence of LDP workshops and interim coaching impractical. Some of the adaptations (2 workshops rather than 3, coaching of some teams in a central setting rather than at their work sites) could have been acceptable had it not been for the lack of contact between the 2 workshops and the year-long lapse before the coaches re-appeared in May, 2008.

The coaches reported, "It appeared that the time lat between the last workshop . . . and the time of the first coaching follow-up . . . tended to dampen the enthusiasm built during the workshop." One participant expressed the resulting frustration, saying, "I am happy to see you because I have been looking for you without success. I thought you were to come earlier. I got stuck in applying leadership skills we learnt in Juba, and I tried contacting you . . . without success. . . ."

In addition to these logistical difficulties, the second workshop revealed that most of the teams hadn't understood the SMART criteria and needed to re-frame their measurable results. This could have been effective if they had been supported by coaching, either in site visits or by phone or email, but because of the difficulties cited above, they were left on their own and faltered in their efforts to go forward with the challenge model. The facilitation/coaching team recommended that future LDPs be carried out in one 6-day session, with the first follow-up coaching session 2 months after the workshop and a second session 2-3 months later.

However, the coaching team found some promising results among the 3 teams they worked with. They reported, "It was clear that the participants took the LDP enthusiastically; had had real attempts to practice skills learnt with success; and in some instances have gotten stuck and required support."

It will be useful to evaluate the second LDP that was implemented from October to June 2007, to see the extent to which the learnings from this first LDP experience were applied in the later one. This would certainly constitute a form of mainstreaming.

Swaziland

The setting	Swaziland, MSH subcontract to IntraHealth under the Capacity Project.	Trip Reports and Other Key Documents
Interview with: Date:	Sylvia Vriesendorp, Mary O’Neil, Leonard Dlamini (phone contact by Kristin Stelljes) 11-26-08, 12-30-08, 1-7-09	<ul style="list-style-type: none"> • Trip reports 3/07, 6/08 • Coaching visits report 9/07 • Case study: Raleigh Fitkin Memorial Hospital, 12/07
Start/end dates	3/07 to 9/07	
Brief Background and current status	MSH’s mandate was to develop management and leadership capacity within 6 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.	
106. What did the participating organizations expect to achieve through the LDP?	<p>Capacity Project: Build leadership to deal with human resource issues: absenteeism, low motivation.</p> <p>LMS: Same, along with addressing public health challenges</p>	

107. What challenges did they take on in their LDPs?	Improving waste management, improving tidiness, reducing outpatient waiting times, improving the patient assessment process in out-patient departments.	
108. To what extent did they successfully meet those challenges within their proposed timeframe?	All teams except one made good progress; that team was dropped from the program. 1 team (Raleigh Fitkin) won LMS prize in 08 for its achievements (see summary and Comments below).	
109. To what extent did they maintain their successes over time?	Last written report was from 9/07, and senior technical advisor is no longer with MSH. LMS staff member's informal phone conversation with hospital administrator at Raleigh Fitkin on 1-6-09 reports continuing successes at his hospital and suggests continuation at other facilities.	
110. What inputs did LMS provide to enable the organizations to mainstream L&M approaches and tools?	<ul style="list-style-type: none"> • LOE: Medium • LDP materials: Handbook and ME&E Guide were held up in customs, arrived barely time for initial TOT. Facilitators' Guidelines not yet developed—LMS master facilitator drafted a guide for the local lead facilitator • TOT: "Just-in-time" training by LMS master facilitator • Follow-up <ul style="list-style-type: none"> – Coaching/mentoring: Site visits from 	

	<ul style="list-style-type: none"> - TA: - Phone/email contact: • Other: 	
111. To what extent has mainstreaming actually occurred?	2 nd LDP launched in June 08. Reports that original teams are using LDP approaches, maintaining leadership/management practices – especially Raleigh Fitkin Memorial Hospital (see Summary and Comments below)	
112. What conditions were in place when mainstreaming succeeded?	<ul style="list-style-type: none"> • MSH marketing: • Marketing from LDP/VLDP “convert”: • Champion: • Team: Local facilitators were particularly effective coaching teams that weren’t moving forward between workshops. Country director/lead local facilitator was “a star.” • Institutional “home”: • Buy-in from senior mgt: Senior alignment meeting held • Resources (money, staff): • Organizational culture: • Supportive systems: • Other: 	

113. What conditions obstructed success?	<ul style="list-style-type: none"> • [Lack of items above] <ul style="list-style-type: none"> – Initially, some facilitators resisted participatory methods and rejected feedback – Issues around recognition/acknowledgment and payment of facilitators were persistent and distracting • Initiation within project that ended: • Staff turnover: • Other: 	
114. Other findings		
Analysis, conclusions, recommendations		
115. What do we know now about mainstreaming leadership and management approaches into organizations (counterparts, other CAs, other TA providers) that we didn't know at the start of LMS?		
116. What are some key questions that		

may remain to be explored in the future concerning mainstreaming?		
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SUMMARY AND COMMENTS

The Swazi LDP began as a “seat-of-the-pants” orientation/training effort: the master facilitator/coach from Boston found a team of 5 facilitators with uneven capacity and some resistance to feedback. LDP materials shipped from Boston were held up in customs, and the local master facilitator had to devote an entire day to obtaining them. There were some issues pertaining to payment for facilitation team members, which distracted the most competent facilitator. There were interpersonal struggles among team members.

Despite this unpromising start, the team managed to guide the LDP teams through the complete series of workshops and provide coaching sessions in-between. A large part of the credit goes to the local master facilitator, a South African consultant, who carried out his role admirably and overcame numerous obstacles – logistical, interpersonal, and technical. The report of coaching visits in Sept 07, before the third LDP workshop, shows considerable progress in team spirit, innovation, and proactive attitudes by most of the teams: “The program has put a breath back into teams and the hope that their challenges are not insurmountable.” Examples of achievements from individual sites include: moving a key extended team member from resistance to responsiveness and full participation in meeting the challenge; significantly improving conditions at a hospital that had been declared unfit and slated for closure; creating a culture of information-sharing throughout the facility.

One outstanding example is Raleigh Fitkin Memorial Hospital (RFMH), which won the LMS Leadership and Management Award in Dec 07. This mission hospital identified the challenge of increasing accurate and timely patient assessments in the outpatient department in the face of the lack of clear policies and procedures for assessment. The RFMH team met its target and has maintained the reduced waiting times, accuracy of diagnosis, and increased patient satisfaction that they achieved through the LDP.

A new LDP cohort was initiated in June 08, with 12 teams drawn from hospitals, lab services, health centers, and clinics. Other teams are using RFMH as a “benchmark,” and RFMH team members are acting as coaches for some of the new teams. Their hospital administrator is an enthusiastic LDP champion, speaking about the RFMH experience wherever he goes in Swaziland; he has also gone to Lesotho to help train people in the LDP there. He states that the LDP has inspired more networking and partnering in the country, and that LDP teams have learned to scan for ways they can improve the quality of patient care without waiting for someone from outside to provide resources or tell them what to do. RFMH is taking the lead with all of

the coaching they are doing.” One RFMH clinic is included in the current LDP, and the Administrator states that his aim is to scale the program up to all 17 RFMH clinics.

Tanzania – Kigoma

The setting	Kigoma, Tanzania: Remote rural province.	Trip Reports and Other Key Documents
Interview with: Date:	Cary Perry 11-24-08	<ul style="list-style-type: none"> • LMS Evaluation Notes, April 07 • Mujomba report, July 06 • LDP in Kigoma Region: Report on LDP Scale Up Training (Source? Date?)
Start/end dates	1/06 to 6-06	
Brief Background and current status	3 district teams, 6 teams from health facilities. Participants also from MOH, EngenderHealth staff, and EH implementing partners. LMS senior staff co-facilitated with trained local consultant, assisted by ESAMI.	

<p>117. What did the participating organizations expect to achieve through the LDP?</p>	<p>MSH</p> <p>Joseph Dwyer: Transfer LDP approach to at least one other country through EngenderHealth</p> <p>ACQUIRE Project: A change process that would motivate health center teams, yield better FP results</p> <p>ESAMI: Build their Leadership Institute, increase business by branching out (more courses/participants, more TA assignments)</p> <p>EngenderHealth HQ: Use the LDP to expand COPE?</p> <p>USAID: (stated in RFTOP): mainstream LDP into every aspect of ACQUIRE Project</p>	
<p>118. What challenges did they take on in their LDPs?</p>	<p>Increase use of FP (based on ACQUIRE mandate and focus)</p>	
<p>119. To what extent did they successfully meet those challenges within their proposed timeframe?</p>	<p>1 year later: All 9 health centers and 2 district hospitals had increased monthly # of new FP clients (2 centers by less than 20%). Kigoma District Council voluntarily replicated the LDP in 5 dispensaries, 4 of which increased new FP visits.</p>	

<p>120. To what extent did they maintain their successes over time?</p>	<p>Intended follow-up has been postponed because of illness within the family of the evaluator.</p>	
<p>121. What inputs did LMS provide to enable the organizations to mainstream L&M approaches and tools?</p>	<ul style="list-style-type: none"> • LOE: Medium-high • LDP materials: Local facilitators verbally translated key components of Handbook into Swahili • TOT: Conducted by MSH consultant as key facilitator through all 3 workshops; apprenticeship model • Follow-up <ul style="list-style-type: none"> – Coaching/mentoring: Done by local facilitators, limited by family illness of key facilitator – TA: – Phone contact: • Other: 	
<p>122. To what extent has mainstreaming actually occurred?</p>	<ul style="list-style-type: none"> • Some health center staff participants introduced LDP approaches to improve FP services at their dispensaries. • ACQUIRE and the MOH have organized LDPs for 24 additional low-level facilities (dispensaries and health centers) in 2 districts, using local facilitators working in 	

	Swahili.	
123. What conditions were in place when mainstreaming succeeded?	<ul style="list-style-type: none"> • MSH marketing: Contact with personal/professional acquaintances; Aswan experience was persuasive • Marketing from LDP/VLDP “convert”: • Champion: ACQUIRE country director informed, enthusiastic, committed. Official MOH champion not really interested; Kigoma champions emerged during workshops • Team: • Institutional “home”: • Buy-in from senior mgt: 2-day senior alignment meeting, well prepared in prior meetings and agreements between LMS and ACQUIRE. • Resources (money, staff): LDP incorporated into ACQUIRE Project Associate Award • Organizational culture: EngenderHealth very compatible; • Supportive systems: • Other: Excellent LMS/ACQUIRE partnership. LMS let go! ACQUIRE staff were the “doers,” LMS provided support. 	

124. What conditions obstructed success?	<ul style="list-style-type: none"> • [Lack of items above] <ul style="list-style-type: none"> – Systems: At district level, participants didn't know baseline indicators—reflection of poor feedback through HMIS. – Culture: ESAMI more didactic, hierarchical. • Initiation within project that ended: ACQUIRE now over; is LMS incorporated into follow-on RESPOND? • Staff turnover: • Other: In replication, many dispensaries have only 1 staff, so the core LDP concept of working as a team doesn't apply. 	
125. Other findings	<ul style="list-style-type: none"> • Need to work in the language with which participants are most comfortable; explain English-language written materials in that language. 	
Analysis, conclusions, recommendations		
126. What do we know now about mainstreaming leadership and management approaches into organizations (counterparts, other CAs, other	<ul style="list-style-type: none"> • If we want other CAs to mainstream LDP into <i>their</i> programs, we need to be genuinely interested in their success. Be very careful that our PR materials don't overemphasize LMS/MSH successes at their expense. • Mainstreaming occurs at several levels, each of which has different requirements for success. <p>Example: The strategy of working side by side with a</p>	

<p>TA providers) that we didn't know at the start of LMS?</p>	<p>CA's project to deliver the LDP often succeeds in getting that project to mainstream the LDP, but the trickle-up expectation (e.g., that EngenderHealth would transfer the LDP to another country) needs additional conditions.</p> <p>(ADRA Worldwide was impressed with ADRA Nepal's participation in the LDP and has transferred it to the APLI and Cambodia, but they were an LMS partner with the expectation that the transfer would happen. EngenderHealth didn't have that kind of relationship with LMS; nor was it clear to them that they would have the longer-term capacity needed to transfer the LDP out of Tanzania.</p>	
<p>127. What are some key questions that may remain to be explored in the future concerning mainstreaming?</p>	<ul style="list-style-type: none"> • How many years/how much funding for follow-up and support are needed to sustain the LMS approach after the initial effort? • How can the LDP be adapted to low-level facilities with only 1 staff member? • How can you best plan ahead to integrate the LDP and maintain momentum when a project ends and the funding source dries up? 	

SUMMARY AND COMMENTS

ACQUIRE staff heard about the LDP through personal and professional contacts with LMS senior staff. Based on the Aswan experience, they saw LDP as potentially useful in energizing their Tanzanian program and scaling up their FP successes. Once she learned about the program, the ACQUIRE Country Director became very enthusiastic—a champion.

At the senior alignment workshop in January 06, increasing family planning clients was selected as the challenge for all teams, because of the ACQUIRE mandate and funding. But the intent was for the teams to have genuine ownership of the process by gearing their approaches to their own needs and situations.

The expectations of LMS and ACQUIRE were compatible, and the partnership worked very well. MSH “let go,” viewed ACQUIRE staff as the doers. It became obvious early in the first workshop that, for health center staff, participants needed to work in Swahili, which hadn’t been planned. This required local facilitators to jump in sooner than planned and conduct sessions in Swahili, with LMS staff and consultant acting more as coaches than as lead facilitators.

The achievements of the LDP as cited in the LMS Evaluation Notes of April 07 are impressive. To determine longer-term effects, the LMS-trained local consultant had been hired to conduct a follow-up assessment in the fall of 08. Her findings would have contributed greatly to this study, but serious family illness has delayed the assessment.

In October 06, local facilitators from EngenderHealth and the MOH began replication of the LDP in 24 new facilities in 2 districts of Kigoma. Local facilitators conducted the first workshop (largely in Swahili) with guidance from experienced facilitators. Health center teams from the original LDP presented their results to the new participants, generating a lot of interest and enthusiasm. There was a strong recommendation to translate the Facilitators’ Guide into Swahili.

Zanzibar

The setting	Zanzibar, conducted by Eastern and Southern African Management Institute (ESAMI), sub-contractor to MSH under LMS	Trip Reports and Other Key Documents
Interview with: Date:	Ken Heise, Adeline Moshi (both via email) 1- 2 to 1-5-09	<ul style="list-style-type: none"> • ESAMI final report: Leadership Program for District AIDS Committees – Zanzibar – Tanzania, November 07 • Report on Follow-up Activities Supported by MSH/LMS, July 08
Start/end dates	August 06 to Sept 07	
Brief Background and current status	2 ESAMI facilitators. 40 participants, members of Zanzibar’s District HIV/AIDS coordinating committees (DACCOMs) – multi-sectoral bodies with specific TORs under the Zanzibar AIDS Commission (ZAC) but no action plans for implementation.	
128. What did the participating organizations expect to achieve through the LDP?	ZAC and ESAMI: Production of detailed action plans; strengthened leadership and management skills among DACCOMs, leading to improved health outcomes at	

	district level.	
129. What challenges did they take on in their LDPs?	<p>These changed between workshops 2 and 3 (see Summary and Comments below).</p> <p>Final challenges included: Monitor/evaluate work of village committees and NGOs; provide VCT services in rural areas; increase # people using VCT; engage donors in provision of reagents; increase AIDS awareness in SHACCOMS (village committees); increase District Response Initiative activities; increase individual awareness of HIV status.</p>	
130. To what extent did they successfully meet those challenges within their proposed timeframe?	<p>From the final report, it appears that they had either achieved their measurable results or were well on the way to doing so (final workshop was in Sept, end date for achieving results was the following December).</p> <p>All districts improved work climate, reported improved team spirit, coordination of activities, collaboration with other partners in their districts, knowledge sharing with colleagues, applying LDP skills to address daily challenges,</p>	

	increased confidence in ability to plan and coordinate HIV/AIDS activities.	
131. To what extent did they maintain their successes over time?	<p>Team from MSH/LMS Dar es Salaam made follow-up visit to 3 districts in July 08. Participants reported “dramatic changes” in:</p> <ul style="list-style-type: none"> • capacity to plan, implement action plans • team spirit among team members and other stakeholders/implementing partners • coordination of activities within districts and SHACCOMS • flow of data from school youth clubs, NGOs, and health facilities • ability of LDP graduates to apply knowledge and skills gained to other development projects and committees 	
132. What inputs did LMS provide to enable the organizations to mainstream L&M approaches and tools?	<ul style="list-style-type: none"> • LMS LOE: Low • LDP materials: Facilitators delivered LDP in Swahili, verbally translating key components of Handbook • TOT: LMS had trained ESAMI facilitators • Follow-up <ul style="list-style-type: none"> – Coaching/mentoring: – TA: – Phone/email contact: • Other: <ul style="list-style-type: none"> – Logistical assistance from MSH office in Tanzania – Visit from LMS staff member who co-facilitated one workshop, reinforced and clarified M&E concepts 	

	and processes	
133. To what extent has mainstreaming actually occurred?	In field visits in 2007, ESAMI and others found LDP concepts and language being used by people who hadn't attended the LDP. In all 10 districts, DACCOMS had made good progress in managing their programs. Another LDP is now underway for Technical AIDS Committees of 8 ministries. Not sure about funding source: PEPFAR?	
134. What conditions were in place when mainstreaming succeeded?	<ul style="list-style-type: none"> • MSH marketing: • Marketing from LDP/VLDP "convert": • Champion: None identified • Team: ESAMI facilitator team worked well together. DACCOM team members attended all 4 workshops. • Institutional "home": ZAC? • Buy-in from senior mgt: Successful alignment meeting with 26 senior officials of local governments, as well as Permanent Secretary of Ministry of Local Government. High-level officials also attended final 2-day conference where teams reported their results. • Resources (money, staff): • Organizational culture: ESAMI culture somewhat hierarchical, but they seem to have bought wholeheartedly into LDP methodology. • Supportive systems: Other: 	

<p>135. What conditions obstructed success?</p>	<ul style="list-style-type: none"> • <i>[Lack of items above]</i> <ul style="list-style-type: none"> – Logistical issues: ESAMI team based in Arusha, Tanzania; workshops took place “900 KM and 2 plane trips away” – Some concerns about ESAMI’s scheduling and report writing – DACCUM teams didn’t meet criteria for intact working groups – Participants’ lack of essential knowledge of HIV/AIDS programming impeded their ability to handle M&E functions (e.g., establish SMART results, determine indicators) – Participants’ written and spoken English was limited; course materials in English, requiring adaptation and ongoing translation into Kiswahili. • <i>Initiation within project that ended:</i> • <i>Staff turnover:</i> • <i>Other:</i> 	
<p>136. Other findings</p>		

Analysis, conclusions, recommendations		
137. What do we know now about mainstreaming leadership and management approaches into organizations (counterparts, other CAs, other TA providers) that we didn't know at the start of LMS?	With the right training and motivation, facilitators from more didactic institutions can do a very creditable job applying the LDP methodology.	
138. What are some key questions that may remain to be explored in the future concerning mainstreaming?		

SUMMARY AND COMMENTS

This LDP was an outgrowth of the LDP in Kigoma Region, Tanzania, where trained ESAMI staff had co-facilitated. The 2 ESAMI facilitators followed the LDP sequence, with translation into Kiswahili and some adaptation to increase understanding of relatively unsophisticated DACCOM participants. The team began with a very effective Senior Alignment Meeting with the leaders of 10 districts and central officials, as well as the Permanent Secretary of the Ministry of Local Government. They stayed throughout the day and ended up with a common understanding of the challenges facing their districts and agreement on the need for leadership practices. The ESAMI team reported that these dignitaries later supported the plans that emerged from the DACCOM participant teams – a testimonial to the value of a well-designed alignment meeting.

It is clear from the final report of the ESAMI team that the participants had some difficulty formulating SMART measurable results. Their initial effort in the first workshop yielded results at the impact level, unachievable within the proposed timeframe of their action plans. The visit from an LMS expert in M&E, who is very well versed in the LDP methodology, seems to have helped them frame more feasible results – those that they presented at their final 2-day conference.

ESAMI facilitators, an MSH staff member, and a World Bank representative made field visits to all 10 DACCOMS in 2007. They were struck by the fact that LDP concepts and language (root cause, work climate assessment, challenge model) were being used by people who hadn't attended the LDP. In all 10 districts, DACCOMS had made good progress in managing their programs. They had identified stakeholders to work with, held SHACCOM meetings, developed M&E plans, agreed to monthly meetings, and developed reporting tools.

During the follow-up visit from LMS/Dar es Salaam in July 08, the 3 DACCOMS visited appeared to have retained skills, attitudes, and some practices from their LDP. They requested additional LDP trainings for other DACCOM members. LMS/Dar es Salaam hopes to organize a workshop or forum this year to reinforce the LDP and do further capacity building with this group.

Boston University SPH

Pre-Service Format: Summary of LDP Pre-Service Experience		
The Setting:	Boston University, School of Public Health	
	Interview with: Dr. Jim Wolff (by Kathleen O’Sullivan) Date: Dec. 23, 2008	Trip Reports/other Documents
1. What did the participating organizations expect to achieve through the LDP?		
2. To what extent has mainstreaming actually occurred?	The course offered by MSH staff, including Dr. Jim Wolff who is also Associate Professor at BU-SPH is called “Leading Organizations Towards Achieving the Millennium Development Goals (MDGs).” The course was offered the summers of 2006, 2007, 2008. The Managers who Lead handbook has been picked up, particularly for its materials related to negotiation, for use by another course taught at BU SPH by David Javich. A spin-off from this course has also reached out to using the Challenge Model for Indian Public Health Faculty at the Indian Council for Medical Research.	
3. Did students take on challenges in their LDPs? And if so, what challenges did they take on in their LDPs?	Yes, students work with the Challenge Model and develop action plans for field settings, but the difficulty is that they are not able to have the hands on experience of implementing them in the field. Leigh Sweet, a former student, is an example of someone who has brought the LDP and challenge model to life through her work. After taking the LDP course here, she felt all students should be	

	<p>exposed, so she met with the Deans of the SPH and the Medical School at BU, prepared a draft of the curriculum which was submitted early Dec. 08. It will be an elective course for 1st and 2nd year students for both the Medical School and the SPH. The course, entitled “Developing and Implementing Successful Community-based Health Initiatives”. There is a full course proposal form on file.</p> <p>Leigh Sweet also developed a program called Shoes for Trash for kids in Guatemala.</p> <p>Leigh also organized a 2 day workshop for medical and SPH students to link them to 4 community organizations in the Boston area. She is one example of a student/participant who embraced the leadership and management principles and ran with them.</p>	
4. What conditions were in place when mainstreaming succeeded?		
a. MSH marketing	John Simon was receptive to the initial proposal of this idea by Sarah Johnson and Jim Wolff at the end of M&L when the idea was to invest in curriculum design in a way that would involve the MDGs and also have a virtual component. By bringing MSH and BUSPH together for this, it gave the course more of a real-life professional development opportunity.	
b. Recommendation from LDP/VLDP alumni		
c. Champion(s)	Jim Wolff, as a member of staff at MSH and member of faculty at BU SPH, played a vital role linking the two	
d. Team of Facilitators/Coaches	Jim Wolff, Sarah Johnson, Sylvia Vriesendorp, Joan Mansour, Morsi Mansour, Ann Buxbaum	

e. Institutional “home”	BU SPH	
f. Buy-in from senior mgmt		
g. resources		
h. organizational culture		
i. supportive systems		
5. What conditions obstructed success?		
6. What inputs did LMS provide to enable the university to mainstream L&M approaches and tools?		
a. LOE		
b. Training Materials		
c. TOT		
d. Coaching/Mentoring	Visits to local organizations such as Dorchester House and the Cambridge Health Alliance were useful in providing students/participants with some field-learning during the course.	
e. Phone/email		
7. What do we know now that we didn’t know at the beginning?	The use of the Challenge Model in academic versus NGO world brings unique considerations -students can design/pull together a challenge, but there is no way to follow up	
8. What are some key	-what is the right blend of MPH students and public health	

<p>questions that remain to be explored for future mainstreaming?</p>	<p>professionals in from field projects? One thought is that is would be ideal to have 6 students and 6 field practitioners per course to make it possible to design a challenge and go back and work with students on the challenge. This needs more thought/work.</p> <p>-can we connect students with an MSH field project at the end of the course – for example, establish an add-on internship/practicum to the course which would also count for credit where students actually implement the action plan in the field.</p>	

SUMMARY AND COMMENTS

History: Course taught in 2006, 2007, 2008 (only 11 students, none from field)

S. Johnson and Wolfy talked to John Simon, Chair, at the end of M&L they invested some \$\$ in curriculum design – framing it as part of the MDGs, and there was a virtual component. BU/MSH joint effort gives it more of a real life experience. Idea was to get working professionals in the classroom with MPH students.

Initial idea of involving field MSHers was as professional development for MSH staff. Jono committed funding/sending 2 MSHers from field (Adama Kone) Tried also in 2008, but not able to do this.

Leigh Sweet also developed a program called Shoes for Trash for kids in Guatemala.

Makerere FOM

Pre-Service Format: Summary of LDP Pre-Service Experience		
The Setting:	Makerere College of Health Science, Uganda	
	<p>Interview with: Morsy Mansour (by Kathleen O’Sullivan) Date: Nov. 25 , 2008 Dec. 16, 2008</p>	<p>Trip Reports/other Documents Trip Reports: May 8-12, 2006 August 6-11, 2006 January 2007 May 2007 June 8-28, 2008 Sept. 8-18, 2008 “PreService Best Practices” May 2007 “Introducing L&M of MSH into Makerere Univ. Medical School” (no date)</p> <p>Evaluation of Makerere Pilot, June 2008 Internal meeting notes on Makerere Evaluation, Aug 2008</p>
9. What did the participating organizations expect to achieve through the LDP?	<p>To integrate the Leadership Development Program of MSH into the COBES curriculum. To strengthen the ability of the students to indentify the health challenges in their communities, work in teams and using the leading</p>	

	and managing practices to design actions to address these challenges.	
10. To what extent has mainstreaming actually occurred?	<p>From the initial suggestion of the idea of the LDP to Makerere in May 2006 until June 2009 when regular classes are expected to begin using the approved LDP/ COBES curriculum, 3 years will have transpired involving LDP introduction, training of trainers, pilot field implementation, curriculum design and revision and curriculum review board approval.</p> <p>From this initial effort with Makerere, the LDP Pre-Service approach has also been mainstreamed with 3 other academic institutions in Uganda and Tanzania.</p> <p>Makerere wanted to integrate the LDP into the COBES curriculum. This is an intense community based program, students must spend 4-10 weeks/year working in the community</p> <ul style="list-style-type: none"> -in 2006 30 staff were oriented to LDP -A series of workshops and meetings were held -1st pre-pilot trial was held at St. Stephen's led by Dr. Sam Lubugo and Dr. Hussain Oria (with support from Morsi) for St. Stephen 's Hospital staff and 3 students to give the trainers experience familiarity with the LDP facilitation. -the pilot was completed for 4th year students, with a pilot field practicum at Ndejje Health Center with students, faculty and staff. Faculty from Makerere SPH and Muhimbili University also attended. -Additional faculty and staff participated in training through a VLDP <p>-Sept. 2008 submitted a draft of the LDP to the curriculum review</p>	

	<p>committee</p> <ul style="list-style-type: none"> - December 2008 – currently finalizing a 4 module curriculum using feedback from curriculum review committee. <p>The faculty included the integration of the LDP in the 10 year strategy for Education of the College of Health Sciences.</p> <ul style="list-style-type: none"> -Makerere curriculum will be implemented for students in year 1&2 -Based on that pilot experience, revisions are being made to the curriculum that integrates LDP for medical students in years 1&2, with the classes to start in June 2009. -LMS will fund a TOT for 20-25 trainers in March. 2009 for Faculty and Staff that will implement the curriculum. - A critical mass of LDP facilitators now exists that is able to scale up this approach in Uganda, Tanzania and beyond. 	
<p>11. Did students take on challenges in their LDPs? And if so, what challenges did they take on in their LDPs?</p>	<p>Students in St. Stephen COBES site addressed the challenge of how to increase the number of deliveries conducted in the hospital.</p> <p>In Ndejje the challenges was about how to increase the immunization coverage and the number of deliveries by trained medical personnel.</p>	
<p>12. What conditions were in place when mainstreaming succeeded?</p>	<ul style="list-style-type: none"> - MSH/LMS existence in Makerere SPH through the VLDP Alumni. -The awareness in the MOH and in Makerere of the importance of leadership and management development for health professionals. -COBES and problem based learning has similar principals as team work, participation, students learn and practice in a real work environment. 	

j. MSH marketing		
k. Recommendation from LDP/VLDP alumni	Initial introduction to Makerere was done by a LDP alumni (Dr. Bazeyo) that introduced MSH to Dr. Sam Lubugo	
l. Champion(s)	Dr. Sam Lubugo, initial champion, has since retired, and handed over to Dr. Josephine Kasalo (she is requesting administrative assistance personnel to assist keeping this going)	
m. Team of Facilitators/Coaches	Morsi Mansoor, Joan Mansoor, local Leadership Team of about 9 people not including the Dean.	
n. Institutional "home"	In 2004, the Medical school curriculum included Problem Based Learning (PBL) and Community Based Education and Service (COBES) comprised of 6 modules over years 1-4 as part of the undergraduate medical school curriculum. This PBL/COBES approach provided the ideal "home" for LDP.	
o. Buy-in from senior mgmt	There was buy in from the Dean of the Medical School (he attended the first LDP orientation), and support from the Ministry of Health	
p. resources	<p>Money: The COBES program had a limited budget to support the field placements of the students at the health facilities, although this was cited by students as not being sufficient.</p> <p>MSH/LMS funded the pre-pilot trial at St. Stephens Hospital for the 9 faculty/staff to be trained as facilitators to then carry out the pilot at Ndejje health centers.</p> <p>Staff: Makerere faculty and staff initially viewed this as an opportunity for professional development and were eager to participate. There was a spirit of volunteerism, to an extent, by the Leadership Development Committee, but this fluctuated over time.</p>	

	Morsi tried to support Makerere to get funds from the USAID mission (at mission suggestion) to support the COBES program, but the mission deferred and said it might be folded into a procurement.	
q. organizational culture		
r. supportive systems	The approval system for change or update in the curriculum is complex and lengthy, involving a 1) curriculum review committee, 2) education committee, 3) faculty board	
13. What conditions obstructed success?	<ul style="list-style-type: none"> • Academics always busy • Strong need for continuous coordination/administrative support • Resistance to change from some faculty members • Bureaucracy within the university system • Turnover rate, both at the university and at the practicum sites – need to retrain staff and faculty • Lack of resources to support the implementation <ul style="list-style-type: none"> ○ Lack of continuous funding for COBES – students have only 1 month in the field ○ No established mechanism for funding LDP– was initially funded by donors with some support from the university <ul style="list-style-type: none"> ▪ Funds that are currently available are not supporting what they would like to implement for COBES <ul style="list-style-type: none"> • No appropriate accommodation for students in rural areas • Not enough supervision • Not enough materials/books to read • Not enough money for food, transport • Not enough support for tutors <ul style="list-style-type: none"> ○ Health officer in the facility = tutors, not always trained in the LDP, high 	

	<p style="text-align: center;">turnover</p> <ul style="list-style-type: none"> • Infrequent trips, so enthusiasm waxes and wanes • Expectation that USAID will always fund things 	
14. What inputs did LMS provide to enable the university to mainstream L&M approaches and tools?	<p>The TA in the form of:</p> <ul style="list-style-type: none"> - LDP orientation and training. - Plan for the integration - Adaptation of the LDP to COBES curriculum and design. - Piloting the integration. - Supporting the approval of the integration. 	
f. LOE	It seems to be that 8 TDYs were conducted, involving M.Mansour, I.Grumb, J.Mansour	
g. Training Materials	Faculty and Staff received copies of the LDP facilitators Guide, the Generic pre-service LDP Curriculum and the Managers Who Lead Handbook. Students received copies of the LDP handouts (Participants Handouts) and had access to copies of MWL, but didn't receive their own copy.	
h. TOT	Yes, TOT were conducted for faculty and staff	
i. Coaching/Mentoring	Yes, M. Mansour provided coaching for Dr. J. Lubugo	
j. Phone/email	Phone/email was used, but really not reliable do to poor phone connection and limited/unreliable internet.	
15. What do we know now that we didn't know at the beginning?	<ul style="list-style-type: none"> • Need to have continuous support at the local level - best to hire a MSH local consultant from the onset, that is trained in LDP and that is respected by the university faculty • Need to be upfront with universities about the investments needed in terms of time and efforts, and need to work with them to develop an action plan with timeline and responsibilities • Need to select universities with community based programs • Can develop short leadership and management courses for schools of public health that are easier than integrating leadership and management curriculum into the curriculum of the Health institutions that need approval from different levels of authorities. 	

	<ul style="list-style-type: none"> • It is difficult to successfully provide support long-distance with a limited budget • There is a need to train tutors every year, due to high turnover of staff at the health facilities • Important to include members of the curriculum review committee as part of the core leadership team from the beginning, so that they are fully on board, understand the program and can help facilitate approvals. • To institutionalize, need to have physical presence of Advisor/TA to keep things moving. 	
<p>16. What are some key questions that remain to be explored for future mainstreaming?</p>	<ul style="list-style-type: none"> • The link between pre-service and in-service training in LDP needs to be considered for each new university/setting, particularly when thinking of field placement of pre-service students so that they are able to receive the support and mentoring they need. • The merging of pre-service and in-service training is a big issue – need to link the university and the ministry of health with support from donor (USAID local mission). The need in the MOH is high and Dr. Luboga communicated with the seniors in the MOH and there is high demand for the L&M development at all levels of the MOH. 	

SUMMARY AND COMMENTS

Current Status:

Starting in 2006, MSH conducted a pre-service LDP pilot with Makerere University College of Health Sciences. The experience in Makerere led to expansion of the pre-service LDP in several other settings including

- a. Mbarara College of Health Sciences, Uganda
- b. Makerere School of Public Health, Uganda
- c. Muhimbili (MUHAS) School of Public Health, Tanzania
- d. VLDP Pre Service with 12 teams from 7 countries (Uganda, Kenya, Tanzania, South Africa, Egypt, Yemen, Mexico)

Based on the pilot experience, the following decisions were made about the curriculum:

- At Makerere, four LDP modules (introduction to L&M, focusing and planning, monitoring and mobilizing, inspiring) will be covered during the 1st and 2nd academic years. As of December 2008, the curriculum was in final stages of review and adoption by the various curriculum review committees.
- The LDP curriculum will be taught by faculty, students will address real issues/challenges with the faculty of medicine during their tutorials
- Students in teams will design their leadership projects (from the challenge model) with the COBES site staff. This projects will be carried by the COBES site staff to address the priority health challenge in their community and implement actions to produce better health results (as demonstrated in the two LDP/COBES pilots in St. Stephen and Ndejje).

The Makerere Leadership Development Team with support from MSH will conduct a TOT to train more COBES site tutors and additional faculty in MARCH 2009.

Makerere Pre-Service VLDP – one team of 9 professors from the Faculty of Medicine participated in this VLDP (including Dr. Sam Lubugo the Deputy Dean for Education at that time, Dr. Charles, research and some heads of the departments). The challenge they took on was to have 50% of faculty staff and 50% of COBES site tutors trained in L&M. The two sub-approaches they planned on implementing was to have L&M incorporated into the COBES curricula for all the 5 undergraduate student programs (Medical, Nurses, Pharmacy, Dental, Lab.) and to have 20 Leadership Alignment workshops conducted at the district level in health centers that

serve as COBES sites. At the time of the final report on the VLDP in April 2008, the team had started drafting the integrated COBES curriculum and was meeting weekly to coordinate their work.

Challenges faced at Makerere that are indicative of the challenges at the various pre-service sites:

Senior decision makers at Makerere resist change, as they believed they were already graduating qualified doctors. The faculty facilitators invited students to a focus group where they heard feedback on why, when and how to incorporate the LDP into their COBES curriculum. Dr. Luboga then communicated this to the curriculum committee as supporting feedback for the curriculum modification to include LDP.

It was challenging figuring out how to enable faculty to facilitate the program given their resistance to coaching and their belief that they already know how to teach because they are professors.

Since Makerere was used as a spring-board for expansion of the pre-service LDP to other sites, it was challenging to serve multiple audiences at the same time during the workshops – the need to train professors, the medical staff and the medical students as well as showcase the experience for potential replicators who were observing.

Dr. Sam Luboga was a strong champion – The experience with Makerere has shown that integrating a program into a medical school curriculum is a long process and involves enrolling many senior stakeholders. Unless it is adopted formally into the curriculum, it will remain an external program led by one person, and will end when that person’s involvement ends.

The limited funding was also a challenge. In 2007, MSH assisted Makerere with the preparation of a proposal for submission to USAID for further funding of the LDP/COBES implementation and scale up (in response to a suggestion by USAID to submit one). Following submission of the proposal, USAID informally advise the team that the mission has decided to issue a larger RFP for strengthening the health system.

Makerere SPH – LIPHEA Project

<i>Pre-Service Format: Summary of LDP Pre-Service Experience</i>		
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The Setting	Makerere School of Public Health (SPH), Uganda (in collaboration with the LIPHEA Project)(2 teams in VLDP Pre Service)	
	Interview with: Morsy Mansour (by Kathleen O’Sullivan) Date: Nov. 25 , 2008 Dec. 16, 2008	Trip Reports/other Documents Trip Reports: May 8-12, 2006 August 6-11, 2006 January 2007 May 2007 June 8-28, 2008 Sept. 8-18, 2008 Evaluation of Makerere Pilot: June 2008 VLDP Final Report June 2008
Overview and Status	See below	
17. What did the participating organizations expect to achieve through the LDP?	To develop a short leadership course that includes action-learning and practical leadership approach.	
18. To what extent has mainstreaming actually occurred?	The LDP tools (the leading and managing practices and the Challenge Mode) is the core of the short leadership that was developed and they are successfully using in pre-service and in-service leadership training.	
19. Did students take on challenges in their LDPs? And if so, what challenges	Yes. Each MPH student will have to develop a challenge/project in order to graduate.	

did they take on in their LDPs?		
20. What conditions were in place when mainstreaming succeeded?	-The collaboration between the LIPHEA and MSH/LMS that was initiated by the CTOs of the projects. -The willingness of LIPHEA to build on MSH validated experience in leadership development. -MSH/LMS existence in East Africa through the Pr-service LDP and the VLDP Alumni.	
s. MSH marketing		
t. Recommendation from LDP/VLDP alumni	Yes.	
u. Champion(s)	Dr. William Bazeyo, the Deputy Dean of Makerere SPH	
v. Team of Facilitators/Coaches	M.Mansour visited Makerere SPH and plans to visit in March 09	
w. Institutional "home"		
x. Buy-in from senior mgmt	Yes	
y. resources	-received support from LIPHEA	
z. organizational culture		
aa. supportive systems	LIPEA project and MSH TA and support (Morsi)	
21. What conditions obstructed success?		
22. What did LMS provide to enable the university to mainstream L&M approaches and tools?	- Training on the Pr-service LDP - Resources: LDP Facilitators Guide and the Handbook Managers Who Lead. - Virtual coaching and support.	
k. LOE		
l. Training Materials	Managers Who Lead handbook, LDP facilitators guide	

m. TOT	-Faculty members were trained on LDP process, methodology and contents. They participated in the 2 day orientation in Makerere SPH and at Ndejje with Makerere FOM and some of them attended the strategic leadership course of Bill and Melinda Gate Institute in Baltimore.	
n. Coaching/Mentoring	-had exposure to the LDP/COBES through the pilot at Ndejje, but not extensive mentoring or support from MSH	
o. Phone/email	Yes	
23. What do we know now that we didn't know at the beginning?	<p>The work with LIPHEA at Makerere SPH has led to two significant additional activities:</p> <ul style="list-style-type: none"> -Makerere SPH now hosts the steering committee to establish the Higher Education Alliance for Leadership in Health (HEALTH) to integrate LDP in SPH in the region -M.Mansour has been asked by the university (Dr. William Bazeyo) to develop an L&M course focused more on applied management. This is due to the requirement that District Health Officers have an MPH, but the experience has been that the MPH alone is not sufficient to prepare the District Health Officers to do their job, so the SPH will add L&M modules as part of the MPH degree program. <p>The entry into the university system through the LIPHEA project was good while the project was operating, but when the project ended, the LDP activities no longer had the funding or support to continue.</p>	

24. What are some key questions that remain to be explored for future mainstreaming?		
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SUMMARY AND COMMENTS

Makerere School of Public Health (SPH) was the lead in the LIPHEA project along with Muhimbili SPH)

-MSH approached the SPH

-This is a blended pre-service and in-service program

-32 LDP facilitators were trained (as of June '08)

-Short Leadership course was developed (with Muhimbili MUHAS/Tanzania) and have started to conduct training for health managers.

- Trained 64 health managers at Makerere SPH

-SPH (in collaboration with MUHAS) have revised the curriculum for the following degree programs:

- Master of Public Health (including distance learning) and also has a leadership track/option as a specialization -Bachelor of Environmental Health Science
- Masters in Health Services Research
- Masters in Public Health Nutrition

The entry into the university system through the LIPHEA project was good while the project was operating, but when the project ended, the LDP activities no longer had the funding or support to continue.

- A critical mass of LDP facilitators now exists that is able to scale up this approach in Uganda, Tanzania and beyond.

Pre Service VLDP -Two teams (total of 11 faculty/staff) participated in VLDP

One team selected the challenge to strengthen the leadership training of the MPH officers to help them pass on leadership skills to Health Center Staff. By August of 2008, they expected all 1st year MPH students to have received additional PH leadership training and to have carried out specific LDP type activities during their 4 month field practicum/assignment. The team wrote the materials needed for a 1 day workshop for the MPH officers, and they met with the Dean of Makerere University SPH and began work on

materials for presentations to the board and seminar. The second team took on the challenge of creating a team of faculty able to provide quality training in leadership, with the expectation that by October 2008, 8 faculty would conduct a one week workshop for 30 in-service health workers.

Mbarara FOM

<i>Pre-Service Format: Summary of LDP Pre-Service Experience</i>		
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	Mbarara College of Health Science (MUST), Uganda	
	Interview with: Morsy Mansour (by Kathleen O’Sullivan) Date: Nov. 26, 2008 Dec. 16, 2008	Trip Reports/other Documents Trip Reports: May 8-12, 2006 August 6-11, 2006 January 2007 May 2007 June 8-28, 2008 Sept. 8-18, 2008 Evaluation of Makerere Pilot: June 2008
Overview and status	See below Mbarara was a spin-off from Makerere, so many of the observations and experiences are merged with those of Makerere.	
25. What did the participating organizations expect to achieve through the LDP?	To integrate the Leadership Development Program of MSH into the Community Based Education curriculum. To strengthen the ability of the students to indentify the health challenges in their communities, work in teams and using the leading and managing practices to design actions to address these challenges.	
26. To what extent has mainstreaming actually occurred?	The LDP has been incorporated into the curriculum, and it has started the approval process. Contingent upon formal approval, it will be officially implemented starting in June 2009. A critical mass of LDP facilitators now exists that is able to scale up this approach in Uganda, Tanzania and beyond.	

27. Did students take on challenges in their LDPs? And if so, what challenges did they take on in their LDPs?	We didn't pilot with Mbarara. We used the pilot that we did with Makerere and the lesson learned as a Model for the integration.	
28. What conditions were in place when mainstreaming succeeded?	<ul style="list-style-type: none"> - MSH/LMS experience with Makerere FOM. - The credibility of Dr. Luboga and Makerere. -The awareness in the MOH and in Mbarara of the importance of leadership and management development for health professionals. -Community Based Education and problem based learning has similar principals as team work, participation; students learn and practice in a real work environment. 	
bb. MSH marketing	M.Mansour proactively sought out a second pre-service option in Uganda, to ensure that all eggs were not just in the Makerere basket.	
cc. Recommendation from LDP/VLDP alumni	Dr. Sam Lubugo was an important advocate for LDP to Mbarara, and he and M.Mansour visited the university together to make the initial Senior Alignment Meeting.	
dd. Champion(s)	Dean Jerome Kabayenga and Deputy Dean Dr. Samuel Maling– Deputy Dean is more involved in the process.	
ee. Team of Facilitators/Coaches	Morsi Mansoor, Dr. Sam Lubugo	
ff. Institutional “home”	Mbarara MUST has a Community Based Education program which provided the ideal “home” for LDP.	
gg. Buy-in from senior mgmt	Dean and Deputy Dean are very involved.	
hh. resources	Money: very little money through MUST. MSH has provided technical support and training.	

	Staff: There is a Leadership team of +/- 8 members, including the Dean and Deputy Dean. The Dean sent his assistant to each meeting to report back to him.	
ii. organizational culture		
jj. supportive systems		
29. What conditions obstructed success?	<p>Cross-reference with Makerere list:</p> <ul style="list-style-type: none"> • Academics always busy • Strong need for continuous coordination/administrative support • Resistance to change from some faculty members • Bureaucracy within the university system • Turnover rate, both at the university and at the practicum sites – need to retrain staff and faculty • Lack of resources to support the implementation <ul style="list-style-type: none"> ○ Lack of continuous funding for COBES – students have only 1 month in the field ○ No established mechanism for funding LDP– was initially funded by donors with some support from the university <ul style="list-style-type: none"> ▪ Funds that are currently available are not supporting what they would like to implement for COBES <ul style="list-style-type: none"> • No appropriate accommodation for students in rural areas • Not enough supervision • Not enough materials/books to read • Not enough money for food, transport • Not enough support for tutors 	

	<ul style="list-style-type: none"> ○ Health officer in the facility = tutors, not always trained in the LDP, high turnover ● Infrequent trips, so enthusiasm waxes and wanes ● Expectation that USAID will always fund things 	
30. What did LMS provide to enable the university to mainstream L&M approaches and tools?	<p>The TA in the form of:</p> <ul style="list-style-type: none"> - LDP orientation and training by Dr. Morsi and follow up and coaching by Dr. Luboga. - Plan for the integration - Adaptation of the LDP to CBE curriculum and design. - Supporting the approval of the integration from MSH local consultant.. 	
p. LOE	<ul style="list-style-type: none"> ● Multiple trips over the course of 3 years. 	
q. Training Materials	<p>Faculty and Staff received copies of the LDP facilitators Guide, the generic pre-service LDP curriculum, Managers Who Lead Handbook. Students received copies of some tools and had access to copies of MWL, but didn't receive their own copy.</p>	
r. TOT	<ul style="list-style-type: none"> ● Alignment meeting was conducted, then training of 20 staff + Dean + Deputy Dean ● No LDP pilots were conducted 	
s. Coaching/Mentoring	<ul style="list-style-type: none"> ● S. Lubugo played coach/mentor role – making 2 follow up and coaching visits to Mbarara. 	
t. Phone/email	<ul style="list-style-type: none"> ● Most communication with Dean Kabayenga? From Mbarara, Dr. Samuel Molling – Deputy Dean is more involved in the process ● Morsi called and emailed 	
31. What do we know now that we didn't know at the beginning?	<ul style="list-style-type: none"> ● Need to have continuous support at the local level - best to hire a MSH local consultant from the onset, that is trained in LDP and that is respected by the university faculty ● Need to be upfront with universities about the investments 	

	<p>needed in terms of time and efforts, and need to work with them to develop an action plan with timeline and responsibilities</p> <ul style="list-style-type: none"> • Need to select universities with community based programs • Can develop short leadership and management courses for schools of public health that are easier than integrating leadership and management curriculum into the curriculum of the Health institutions that need approval from different levels of authorities. It is difficult to successfully provide support long-distance with a limited budget • There is a need to train tutors every year, due to high turnover of staff at the health facilities 	
<p>32. What are some key questions that remain to be explored for future mainstreaming?</p>	<ul style="list-style-type: none"> • The merging of pre-service and in-service training is a big issue – need to link the university and the ministry of health with support from the donors (USAID local mission). The need in the MOH is high and Dr. Luboga and a Ministry of Health representative in Mbarara curriculum review committee communicated with the seniors in the MOH and there is high demand for the L&M development at all levels of the MOH. 	

SUMMARY AND COMMENTS

M.Mansour proactively sought out a second pre-service option in Uganda, to ensure that all eggs were not just in the Makerere basket. MSH conducted a pre-service LDP pilot with Makerere University College of Health Sciences and Mbarara was a spin-off from this initial experience.

- 2007 started when M.Mansour and J.Lubugo went to MUST for an alignment meeting and then did training for 20 faculty/staff with the Dean and Deputy Dean's participation as well.
- Originally just in the Medical students, but later spread to nursing, pharmacy, radiology, laboratories programs.
- Curriculum development of 4 modules is the same as that of Makerere University, but planned to be covered in years 2&3 of curriculum for Medicine, Nursing, Pharmacy, Medical, Laboratory Science. This is a less-intense community based program than the Makerere campus program with 10 weeks of community based work required over the life of the degree.
- No pilot field implementation was carried out, as we used the design and the lesson learned from Makerere LDP/COBES pilot.
- In Sept. 2008, a draft LDP curriculum for Makerere and Mbarara was submitted to the curriculum review committee for review, and in December they were working to incorporate feedback from the committee.
- In December 2008, they were just about to start the approval request for Mbarara
- Morsi is planning a training for tutors in Feb. 2009
- Aiming for curriculum approval in March 2009 and full implementation in June 2009
- There is a need for additional staff to be trained in LDP facilitation by MSH local consultant.

MUHAS SPH – LIPHEA Project

<i>Pre-Service Format: Summary of LDP Pre-Service Experience</i>		
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The Setting:	MUHAS SPH - Muhimbili University of Health and Allied Sciences, School of Public Health, Tanzania (in collaboration with the LIPHEA Project) (Leadership short course)	
	<p>Interview with: Morsy Mansour (by Kathleen O’Sullivan)</p> <p>Date: Nov. 25,26, 2008 Dec. 16, 2008</p>	<p>Trip Reports/other Documents</p> <p>Interview Document: Integration of LDP into MUHAS Curricula, Nov.6, 2008 (by Kristin.Stelljes)</p> <p>Trip Reports: May 8-12, 2006 August 6-11, 2006 January 2007 May 2007 June 8-28, 2008 Sept. 8-18, 2008</p> <p>Evaluation of Makerere Pilot: June 2008</p> <p>VLDP Final Report June 2008</p>
33. What did the participating organizations expect to achieve through the LDP?	To develop a short leadership course that includes action-learning and practical leadership approach.	
34. To what extent has mainstreaming actually occurred?	MUHAS has incorporated leadership into the Development Studies Curriculum of the junior class (1 st and 2 nd years out of 5). All students must take the Dev.Studies course, including nursing, medical doctor, public health, pharmacy and dental surgeon programs. Leadership and	

	<p>Management is a required class which has an exam at the end that students must pass to graduate. Content is purely theoretical. 260 students have completed this rotation since 2007.</p> <p>The LDP content has been adapted into a short course applicable for either pre-service or in-service training, as it is a course outside of the required curriculum. It was offered first to academics and then to trainers from the eight zonal training centers. People are very excited about the program. 9 academics attended the first offering of the course and 34 zonal trainers have taken the course.</p> <p>MUHAS planned to provide the short course content to the zonal training centers and then work with them to adapt it to their own setting. However, LIPHIA funding ended and MUHAS no longer has money available for this follow up. They are not sure if the zonal trainers are implementing the short course as the MUHAS staff would like or if they are scaling up the use of the course within their zone.</p> <p>A critical mass of LDP facilitators now exists that is able to scale up this approach in Uganda, Tanzania and beyond.</p>	
<p>35. Did students take on challenges in their LDPs? And if so, what challenges did they take on in their LDPs?</p>	<p>During the Community health 1 week rotation, the students are broken up into teams to focus on key health problems in Tanzania (malaria, HIV/AIDS, Maternal health, etc). As part of this rotation, they shadow a Hospital In Charge and a District Medical Officer asking questions related their problem area (Malaria, HIV/AIDS, maternal health...) and they use this to complete a challenge model.</p> <p>There has not been follow up to yet see if the DMOs ever implement the student's action plans. Morsi plans to visit in March to follow up.</p>	

36. What conditions were in place when mainstreaming succeeded?	The collaboration between the LIPHEA and MSH/LMS that was initiated by the CTOs of the projects. The willingness of LIPHEA to build on MSH validated experience in leadership development. MSH/LMS existence in East Africa through the Pr-service LDP and the VLDP Alumni.	
kk. MSH marketing	<ul style="list-style-type: none"> • J.Mansour and M. Mansour went to meet with the LIPHEA team and met Dr. Urassa at GWU in Washington. • 20 people from MUHAS Muhimbili SPH and Makarara SPH went to Ndijje for a 2 day brief orientation to LDP. 	•
ll. Recommendation from LDP/VLDP alumni	The LIPHEA project was key to inspiring MUHAS SPH staff to incorporate leadership and management into their curriculum.	
mm. Champion(s)	Dr. David Urassa, Sr. Lecturer, Community Health Department Head, Associate Dean	
nn. Team of Facilitators/Coaches	M.Mansour, I. Grum	
oo. Institutional “home”	Medical students receive L&M training under the SPH Community Health Department. As part of the medical doctor program, students have 12 week rotations through different areas of medicine, including community health. During the community health rotation, students spend 1 week on L&M.	
pp. Buy-in from senior mgmt	The Dean of MUHAS SPH went to Kampala and was part of the planning meetings, so is fully supportive. Having Dr. David Urassa, Associate Dean as the Champion has been very important	
qq. resources	MSH funding LOE and traveling for Morsi and Ida and the workshop in Ndejje Health Center LIPHEA funding Covered the expanses of Tanzanian faculty travel and accommodation in Uganda, the coast of the 2 day workshop.	
rr. organizational culture		

ss. supportive systems	At MUHAS, staff can adapt course content without extensive review, so leadership was incorporated into the program, but is not a formal part of the curriculum. David Urassa would like to incorporate leadership into the curriculum so that it will be a required course component - which will prevent drop-out/off of LDP when new faculty who were not part of LIPHEA project are hired.	
37. What conditions obstructed success?	<ul style="list-style-type: none"> • Faculty that did not go to Makerere to participate in the training question the difference between leadership and management • David Urassa said it is hard to incorporate experiential learning into pre-service. The model adopted by MUHAS is more theory because they lack time to make it truly experiential. • They have developed the zonal training center short course to make it more experiential for in-service participants • The addition of the leadership component is an extra work-load for the professors, as it is an add-on to the management components. • LIPHEA funding ended and MUHAS does not have money for follow-up, so they don't know if the zonal trainers are implementing the short course as the MUHAS staff wants, or if they are scaling up use of the course in their zone. 	<ul style="list-style-type: none"> •
38. What did LMS provide to enable the university to mainstream L&M approaches and tools?	<ul style="list-style-type: none"> - Training on the Pr-service LDP - Resources: LDP Facilitators Guide and the Handbook Managers Who Lead. - Virtual coaching and support. 	
u. LOE		
v. Training Materials	Managers Who Lead handbook, LDP facilitators guide	
w. TOT	All of the management trainers from MUHAS SPH went to workshops on LDP Process, Methodology and contents. Davia Urassa went to the 2 day orientation in Makerere SPH and at Ndejje with Makerere FOM and SPH and he also went to Germany and	

	DC	
x. Coaching/Mentoring	Via phone and email only	
y. Phone/email	Yes	
39. What do we know now that we didn't know at the beginning?	<ul style="list-style-type: none"> • Curricula of schools should be changed to include more experiential learning and practical training. • Training development should involve professors and students so they can provide input on what they prefer. 	•
40. What are some key questions that remain to be explored for future mainstreaming?	<ul style="list-style-type: none"> • The Associate Dean MUHAS SPH wants Morsi work with the Zonal training centers. MSH has funding for Morsy's travel, but not for large workshop that involves travel. The Assoc. Dean is going to talk to the head of continuing education at the MOH to see if she can provide funding – she was part of the team that went to Uganda, so she has had exposure to the LDP. • 	•

SUMMARY AND COMMENTS

- This is a short course developed to serve either pre-service and in-service participants
- MUHAS SPH faculty members were trained on LDP methodology and content
- had exposure to the LDP/COBES through 2 day LDP orientation workshop and the LDP/COBES pilot at Ndejje, but not extensive mentoring or support from MSH
- Received support from LIPHEA – LIPHEA had about \$1 million/2 years for overall project, not just this activity
- 260 students have gone through the course since 2007 (data as of Nov. 2008)
- Short LDP is under development and have started to conduct training for health managers

VLDP Pre Service – MUHAS School of Nursing

7 Administrators and staff (including the Dean of the SON) participated and took on the challenge of integrating leadership assessments into the managerial competence assessment tool. VLDP participants developed a draft of the Leadership Competency Student Evaluation Tool and efforts were underway in June 2008 to review the curriculum to adopt an action oriented approach to learning. It seemed that this team made good progress toward addressing the challenging during the VLDP and shortly thereafter.

UNAN FOM and CIES SPH

<p><i>Pre-Service Format:</i></p> <p><i>Summary of LDP Pre-Service Experience</i></p>		
<p>The Setting</p>	<p>Nicaragua School of Medicine/Public Health UNAN – Pre-Service Education with CIES(Center for Investigations and Studies on Health) and the Medical Faculty of UNAN Managua</p> <p>Pilot Modules implemented Apr-Jun 2007</p> <p>Design of Curriculum Feb-Mar 2008</p>	
	<p>Interview with: Hector Colindres</p> <p>Date: Nov. 20, 2008 (by Kathleen O’Sullivan)</p>	<p>Trip Reports</p> <p>a.) Feb. 11-17, 2007</p> <p>b.) June 2-6, 2008</p> <p>c.) August 18-29, 2008</p> <p>d.) evaluation report not yet ready</p>

Brief Background and current status:	See summary and comments below.	
139. What did the participating organizations expect to achieve through the LDP?	The medical faculty of the UNAN was looking to prepare their students with very practical skills to apply on the job and to ensure that their university preparation is them for the reforms that are taking place within the government.	a.) Inter-institutional coordination team worked to design national level generic program to form a new generation of managers and leaders of health institutions from across Nicaragua, capable of effectively implementing a new model of care and achieving results that serve the needs of the population.
140. What challenges did they take on in their LDPs?	<i>The students do not implement the LDP in a workplace/practicum as this is not part of this approach.</i> The overall challenge for the university was to design and pilot a LDP curriculum for 5 th year medical students tailored to the unique situation of Nicaragua, they wanted to focus on planning for results and quality assurance	c.)the plan included an evaluation by the team of professors and student participants –with specific recommendations for improvements.

	through a comprehensive and practical curriculum.	
141. To what extent did they successfully meet those challenges within their proposed timeframe?	The team working on this initiative/program accomplished its goals, and fully implemented the pilot curriculum during the course of the academic year, and then revised and updated the curriculum based on faculty and student (through the faculty) feedback	
142. To what extent did they maintain their successes over time?	The review and revision of the curriculum based on the pilot experience was carried out, and the revised curriculum is now being implemented.	
143. What inputs did LMS provide to enable the organizations to mainstream L&M approaches and tools?	<p><u>LOE:</u> High</p> <p>Hector spent about 30 days of paid time, and many, many more hours of nights/weekends to design, develop and revise the curriculum in coordination with the local contacts. Staff from the bilateral project (MSH/PRONICASS) were pivotal to this effort too, as Claritza Morales did all the administration and coordination and kept in close contact with the Field Coordinator/Lic. Yadira Medano.</p> <p><u>Training Materials:</u> 7 full modules were developed, along with all the guides and training materials needed as well as the bibliographical references.</p> <p><u>TOT:</u> 3-4 day workshops/TOT were held during the 3 TA visits of Hector, and involved UNAN faculty and faculty</p>	

	<p>from other universities</p> <p><u>Intensive Technical Assistance:</u></p> <p><u>Coaching:</u> Claritza/Pronicass provided ongoing support to the counterparts, meeting with them, participating in their workshops and the program itself. Hector provided long-distance coaching via skype and email.</p>	
<p>144. To what extent has mainstreaming actually occurred? (Again refer back to the definition and vision under Q1.)</p>	<p>The program is fully institutionalized, in the sense that it is a formal part of the university curriculum.</p> <p>Facilitators are facilitating the program without technical assistance from LMS/MSH.</p> <p>In terms of “spin-offs” from this initial effort with UNAN/CIES, there has been interest both in Nicaragua and in Guatemala.</p> <p>The Dean of the UNAN Faculty of Medicine and the head team facilitator expressed their wish to adapting it and implementing into the curricula of Master degree program focus in Family Planning and Health Sexual and</p>	<p>c.)CIES/UNAN will integrate this into the Masters of Public Health program and in the Masters of Epidemiology.</p> <p>b.) As of September, CIES was considering the possibility of conducting a pilot course for the private sector in Honduras based on demand for this type of course there.</p>

	<p>Reproductive of UNAN. Also, since at the end of November 08, it was implemented into the post graduates program of CIES, especially into the Public Health Program.</p> <p>Other universities such as UNAN Leon have expressed interest in utilizing it as well.</p> <p>Lastly, at the end of Jan 2009, H.Colindres will start adapting this M&L pre service program for the Faculty of Medicine in Mariano Galvez University of Guatemala.</p>	
<p>145. What conditions were in place when mainstreaming succeeded? What seemed to be lacking when it didn't succeed?</p>	<p><u>Champion/change agent:</u> Having a field coordinator was vital to the success(Lic.Yadira Medrano)</p> <p><u>Structural home for L&M initiative:</u> The mission of CIES is to improve the preparation and training of medical and public health professionals, so they were advocates for this program. The multi-disciplinary team that worked on this worked together to adapt and improve the program.</p> <p><u>Commitment of senior management:</u> Dean of the university (UNAN) was fully supportive and participated in several strategic sessions. Participants from other universities/faculties (nursing, etc) were invited to be part of the process – thereby expanding the network of influence and engagement.</p> <p><u>Donor or other stakeholder involvement:</u> USAID was fully briefed of the plan, and they participated in meetings,</p>	<p>a.) integral approach allows focus, and avoids multiple efforts on the same issue.</p> <p>a.) gives flexibility for each institution to adapt to the level it needs (pre-service, clinical specialties, technical personnel, nursing and in-service).</p> <p>a.) allows for involvement of all formative institutions in the review, validation and approval of the content, tools and materials produced for the national level.</p> <p>a.) this integrated process also</p>

	<p>workshops, presentations. They were not drawn into the dialogue/negotiations with the university. It appears that UNAN was in the drivers seat, wanting this program, and they were able to direct the inputs they wanted from outside contributors such as MSH to help them achieve their goals.</p> <p><u>Adequate financial resources:</u> a small but adequate budget supported the activities such as photocopies, refreshments, etc.</p> <p><u>Source of the LDP initiative:</u> Hector made a presentation.</p>	<p>allows for the development of a network of teams able to design and facilitate implementation of the program, and scale up to other programs and institutions of the country.</p>
<p>Other</p>	<p>In terms of Hector’s perception of the effectiveness and efficiency of this approach as a way of mainstreaming the LDP into the pre-service curriculum of the University in Nicaragua, he stated that he thinks that the focus of this initial pre-service curriculum designed for UNAN has been on the management skills aspects of the LDP, however, he anticipates that future complementary courses could be developed with more complete LDP approaches and tools.</p>	

Analysis, conclusions, recommendations:		
<p>8. What do we know now about mainstreaming leadership and management approaches into organizations (counterparts, other CAs, other TA providers) that we didn't know at the start of LMS?</p>	<p>A great deal of flexibility is needed to adjust the LDP to the particular needs of the country. Hector felt that there was initial resistance to this flexibility/adaptation of the LDP from LMS at the onset of the activity, which made it more difficult to implement at the onset, but this was not a problem at the end.</p> <p>The amount of work this required was far beyond what was initially estimated. Hector estimates that a good 4 months of effort would be ideal (rather than the 30-35 days)</p> <p>It appears that having someone named as the Field Coordinator, who takes the responsibility seriously, and who has the support of her/his superiors is an important factor in seeing this through.</p>	<p>c.) Students asked for printed documents as some have difficulty with internet access, but they also asked that things be posted on the university website for easy electronic access</p>
<p>9. What are some key questions that may remain to be explored in the future concerning</p>		

mainstreaming?		
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SUMMARY AND COMMENTS

1st year activities, considered pilot phase, were completed with 33 students in 5th (final) year of medicine. During the 2nd year, the curriculum was revised and the 6 modules are officially integrated as part of the public health degree curriculum, with 174-177 students and 3 faculty currently participating in the program (Dec. 2008).

At the onset, (Center for Investigations and Studies on Health) CIES and MSH signed an agreement outlining the work to be done and responsibilities. Hector made 3 technical assistance visits to the field, and documented the work, highlighting the key issues and status, along with clear articulation of roles and responsibilities of people involved in the effort.

3 key factors that contributed to the success of the UNAN Pre-Service experience:

- The context of reform in Nicaragua meant that the opportunity was open for the university to reexamine its curriculum and to make changes
- The fact that the LDP team working on this was flexible and adjusted the LDP program to the unique needs of Nicaragua was essential and demonstrated respect for the particular needs of the country and its professionals. The team was able to achieve a balance between retaining core aspects of LDP, and adapting it to the local needs.
- Having the full support of the MSH project team (especially Claritza and Barry) from the ProNicass project was essential, and having the support of the Dean of the University and USAID was also helpful.

3 key recommendations:

- A great deal of flexibility is needed to adjust the LDP to the particular needs of the country. Hector felt that there was initial resistance to this flexibility/adaptation of the LDP from LMS at the onset of the activity, which made it more difficult to implement at the onset, but this was not a problem at the end.
- The amount of work required to develop and institutionalize a pre-service curriculum was far beyond what was initially estimated. Hector estimates that 4 months of effort would be ideal (rather than the 30-35 days actual experience with UNAN).
- Important to name a Field Coordinator, preferably paid staff, who takes the responsibility seriously, and who has the support of her/his superiors is an important factor in managing the effort from start to finish, particularly in-between site visits from the technical advisors/consultants.