



**USAID**  
FROM THE AMERICAN PEOPLE

**USAID**  
ASSIST PROJECT  
*Applying Science to Strengthen  
and Improve Systems*

---

## TECHNICAL REPORT

---

# Landscape Analysis of Global Learning Networks to Inform the Development of a Learning Laboratory for Quality Universal Health Coverage

---

JUNE 2016

---

This landscape analysis of global learning networks was prepared by University Research Co., LLC (URC) for review by the United States Agency for International Development (USAID) and authored by Lani Marquez (URC), Nancy Dixon (Common Knowledge Associates), and Kate Fatta (URC). The report was produced under the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, which is made possible by the generous support of the American people through USAID and its Office of Health Systems.



## **TECHNICAL REPORT**

# **Landscape Analysis of Global Learning Networks to Inform the Development of a Learning Laboratory for Quality Universal Health Coverage**

JUNE 2016

Lani Marquez, University Research Co., LLC  
Nancy Dixon, Common Knowledge Associates  
Kate Fatta, University Research Co., LLC

### **DISCLAIMER**

The contents of this report are the sole responsibility of University Research Co., LLC (URC) and do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

## Acknowledgements

The authors thank colleagues at the World Health Organization (WHO) Universal Health Coverage and Quality (QHC) Unit for their collaboration in designing the landscape analysis and conducting interviews with WHO staff to inform the design of the Quality Universal Health Coverage (QUHC) Global Learning Laboratory: Ruben Frescas, Shams Syed, Nana Mensah-Abrampah, Isabelle Wachsmuth, Lopa Basu, and Lukas Herrmann.

We are especially indebted to the individuals who generously availed their time and insights to help us better understand the experience of their learning networks: Amanda Folsom, Results 4 Development; Luis Ortiz, Management Sciences for Health; Sakil Malik, University Research Co., LLC (URC); Kathyana Aparicio, Mart Leys, and Rachel Gooden, WHO; Basile Keugoung, Health Service Delivery Community of Practice; Allison Gamble Kelley, Financial Access Community of Practice; Madeleine Mulholland and Stephen Dorey, Commonwealth Health Hub; Shamaila Usmani, London School of Hygiene and Tropical Medicine; Ian Spillman, Stre@mline/Kisiizi Hospital, Uganda; and Tonny Tumwesigye, Uganda Protestant Medical Bureau. We are also appreciative of Lord Nigel Crisp's insights on global learning exchanges.

This report was prepared by URC under the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, which is funded by the American people through USAID's Bureau for Global Health, Office of Health Systems. The project is managed by URC under the terms of Cooperative Agreement Number AID-OAA-A-12-00101. URC's global partners for USAID ASSIST include: EnCompass LLC; FHI 360; Harvard T. H. Chan School of Public Health; HEALTHQUAL International; Initiatives Inc.; Institute for Healthcare Improvement; Johns Hopkins Center for Communication Programs; WI-HER, LLC; and the WHO Department of Service Delivery and Safety.

For more information on the work of the USAID ASSIST Project, please visit [www.usaidassist.org](http://www.usaidassist.org) or write [assist-info@urc-chs.com](mailto:assist-info@urc-chs.com).

## Recommended citation

Marquez L, Dixon N, Fatta K. 2016. Landscape Analysis of Global Learning Networks to Inform the Development of a Learning Laboratory for Quality Universal Health Coverage. *Technical Report*. Published by the USAID ASSIST Project. Bethesda, MD: University Research Co., LLC (URC).

# TABLE OF CONTENTS

Acronyms .....	ii
<b>Executive Summary.....</b>	<b>iii</b>
<b>I. Introduction .....</b>	<b>1</b>
A. The Proposal for a Global Learning Laboratory for Quality in the Context of Universal Health Coverage.....	1
B. Desired Characteristics for the Global Learning Laboratory for QUHC.....	1
<b>II. Objectives and Methods.....</b>	<b>3</b>
A. Objectives .....	3
B. Methods .....	3
<b>III. Findings from the Literature Review .....</b>	<b>5</b>
A. The Name of the Network.....	5
B. Stages of Community Development .....	5
C. Success Factors of Communities .....	5
D. Global Health Policy Networks.....	6
E. Evaluation of Communities .....	6
<b>IV. Findings from Learning Network Key Informant Interviews .....</b>	<b>6</b>
A. Recruitment/Membership.....	6
B. Responsibilities/Expectations of membership .....	6
C. Mechanisms for Learning/Interaction.....	7
D. Governance and Support.....	7
E. Documentation and Products.....	8
F. Key Advice .....	8
<b>V. Considerations for the Design Meeting.....</b>	<b>9</b>
<b>Appendices.....</b>	<b>13</b>
Appendix 1: Review of the Literature on Communities of Practice and Learning Networks .....	13
Appendix 2: Interview Guide for Key Informants of Selected Learning Networks .....	26
Appendix 3: Learning Networks of the Key Informant Interviews .....	28
Appendix 4: Other Learning Networks Examined through Web Research.....	35

## **Acronyms**

APPS	African Partnerships for Patient Safety
ASSIST	USAID Applying Science to Strengthen and Improve Systems Project
CoP	Community of practice
GLL	Global Learning Laboratory
GRN	Global Reading Network
JLN	Joint Learning Network
LN	Learning network
MHIN	Mental Health Innovation Network
MOH	Ministry of Health
MSH	Management Sciences for Health
PSQ	Patient Safety & Quality
QHC	Universal Health Coverage and Quality Unit of WHO
QUHC	Quality Universal Health Coverage
SDS	Service Delivery and Safety Department
TEN	Technical Exchange Network
UHC	Universal Health Coverage
URC	University Research Co., LLC
USAID	US Agency for International Department
WHO	World Health Organization

# **Executive Summary**

## **Introduction**

The Universal Health Coverage and Quality (QHC) Unit within the World Health Organization (WHO) Department of Service Delivery and Safety (SDS) has decided to create a *global learning laboratory* (GLL) to harness and consolidate the growing knowledge base on Universal Health Coverage (UHC) and quality.

To help inform the unit's thinking about the GLL for Quality UHC (QUHC), WHO asked the United States Agency for International Development (USAID) to support, through the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, a landscape analysis on global learning networks that enable cross-country knowledge generation and transfer. The landscape analysis would draw key lessons and highlight issues that should be considered in the design to the GLL for QUHC. WHO approached the USAID ASSIST Project because of the project's broad expertise in knowledge management and the operation of web platforms with an explicit learning agenda.

The QHC Unit has defined the purpose of the GLL for QUHC as "to create and support a safe space to share lessons, challenge ideas and spark innovations to inform wider audiences on practical lessons learned from frontline experiences relating to quality UHC." The expected participants in the GLL encompass frontline providers, administrators, policy makers, advocates, civil society, experts and academics, as well as colleagues from all levels of WHO and in particular colleagues in WHO country offices. The QHC Unit has planned that the initial focus of GLL activities will be on the triangulation of UHC, quality, and specific technical areas related to service delivery.

The GLL for QUHC will have as its virtual hub a space on the newly launched Integrated Care for People website (<http://www.integratedcare4people.org/>), which WHO has developed to support learning and information exchange related broadly to WHO's integrated care for people strategy.

This report describes the methods and findings of the landscape analysis and highlights key issues that WHO should consider in making final decisions on the objectives, structure, and operating principles for the GLL for QUHC.

## **Methods**

We searched the literature through Google Scholar, ABI Inform, and PubMed using terms such as, "meta analysis", "evaluation", and "success factors" crossed with "community", "learning laboratory", and "learning network." Other resources were identified through interviews with key informants. Thirteen studies related to communities were reviewed. Six of the studies were specific to health care (including three communities addressing health care policy), and seven reviewed communities in other sectors. Three of the studies were specific to health care policy communities.

The landscape analysis also drew on in-depth interviews with key informants representing nine global learning networks, most of which were health related. These nine were selected from a longer list of global learning networks of potential interest for which we gathered information available on the Internet.

The landscape analysis was also informed by interviews with the following stakeholders: (via Skype) the Coordinator of the Integrated Care for People web platform which will host the GLL for QUHC; two Uganda-based participants in the 2013 PQS and UHC Learning Laboratory; and Lord Nigel Crisp, the former Special Envoy for Patient Safety, to gather their perspectives on how the GLL for QUHC can best meet its objectives.

## **Findings**

Each of the terms "community," "community of practice," "learning network," "network," and "learning laboratory" carries with it a number of connotations. WHO may want to consider using the term "learning

network” which, according to the literature review may more aptly convey the intentions of the GLL for Quality UHC, rather than either “learning laboratory” or “community.” Key attributes of a learning network defined in the literature include: Defined and finite group; shared learning agenda; specified time frame; dedicated resources; and identified deliverables. However, if any term other than “community” or “community of practice” is used, we recommend it be accompanied by a description to insure that it carries the intended meaning.

Communities appear to develop through a series of stages that follow a recognizable pattern. The pattern implies that each stage needs to be supported and the actions of leaders conform to the stage of development. The first stage of community life of generating value for its members is critical for future development. Even when a community has move to another stage, there is a continuing need for individual members to benefit from the activities of the community

Global health networks that influence policy are most likely to produce effects when: 1) They construct a compelling framing of the issue, one that includes a shared understanding of the problem, a consensus on solutions and convincing reasons to act; and 2) They build a political coalition that includes individuals and organizations beyond their traditional base in the health sector.

A network in which members share an intent and focus, but do not share the same repertoire of practice (e.g., researchers, policy makers, academics, and practitioners) requires greater time and intent to build a shared language, trust, and relationship between members. This is most effectively accomplished by bringing members together in a face-to-face setting, both initially and periodically during the life of the network.

The key informant interviews explored eight key attributes of the selected networks: Recruitment/membership; responsibilities/expectations of membership; mechanisms for learning and interaction of members; governance and support; and documentation and products. Informants were also asked what key advice they would offer WHO to consider in the design of the GLL for QUHC based on their experience.

## **Considerations for Design of the GLL for QUHC**

Reflecting on the interviews and the literature, we identified 10 issues that we recommend the WHO QHC Unit consider in their final decisions about the design of the GLL for QUHC.

- 1) Purpose of the GLL for QUHC: what are you expecting to accomplish
- 2) Time-boundedness/timeframe for accomplishing this
- 3) Naming the network
- 4) Position on the IntegratedCare4People web platform
- 5) Open versus closed
- 6) Expectations of participants
- 7) Recruiting participants
- 8) Stages of development of the GLL and roll-out of the web pages/topical groups
- 9) Support/moderation for nurturing participation
- 10) Monitoring and evaluating the GLL

These issues will be discussed with WHO during a GLL Design Workshop in Geneva at the end of May.

## I. Introduction

### A. The Proposal for a Global Learning Laboratory for Quality in the Context of Universal Health Coverage

The Universal Health Coverage and Quality (QHC) Unit within the World Health Organization (WHO) Department of Service Delivery and Safety (SDS) was created in 2015 and is interested in building a broad learning agenda focused on quality improvement within the context of Universal Health Coverage (UHC). The unit wants to harvest lessons from the frontline for adaptation and application of quality UHC (QUHC) strategies in varied settings, to catalyze local change.

The QHC Unit has decided to create a *global learning laboratory* to harness and consolidate the growing knowledge base on UHC and quality. A learning laboratory is a concept that originated in education to refer to a physical place where learners can obtain additional support or resources, such as a designated room in a school. But increasingly, the term is used to refer to virtual platforms or mechanisms—often associated with technology and innovation—that generate and share information and resources on a particular topic area across users in different locations. It is an outreach effort to capture the experiences and lessons of front line perspectives across a wide range of disciplines.

The Global Learning Laboratory (GLL) for QUHC would ideally be composed of frontline providers, administrators, policy makers, advocates, civil society, experts, and academics, as well as colleagues from all levels of WHO. The GLL could capture and disseminate information in a continuous manner, allowing participants to cross-fertilize positive change across countries on the provision of quality health services in the context of UHC.

The QHC Unit is particularly interested in how specific technical topics intersect with the QUHC agenda, and has engaged in discussions with WHO colleagues and contributors in the topical areas of water, sanitation, and hygiene (WASH); infection prevention and control (IPC); quality policy and strategy; reproductive, maternal, newborn, child, and adolescent health; primary health care; and others. The unit envisions its GLL for QUHC as a platform for sharing lessons, resources, and tools related to reinforcing the role of quality in UHC.

The GLL for QUHC will have as its virtual hub a space on the newly launched Integrated Care for People website (<http://www.integratedcare4people.org/>), which WHO has developed with the Escuela Andaluza de Salud Pública in Spain to support learning and information exchange related broadly to WHO's integrated care for people strategy.

To help inform the unit's thinking about the GLL for QUHC, WHO asked the United States Agency for International Development (USAID) to support, through the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, a landscape analysis on global learning networks that enable cross-country knowledge generation and transfer. The landscape analysis would draw key lessons and highlight issues that should be considered in the design to the GLL for QUHC. WHO approached the USAID ASSIST Project because of the project's broad expertise in knowledge management and the operation of web platforms with an explicit learning agenda.

This report describes the methods and findings of the landscape analysis and highlights key issues that WHO should consider in making final decisions on the objectives, structure, and operating principles for the GLL for QUHC. The authors hope that the findings will also be useful to others who are embarking on the development of cross-country learning networks.

### B. Desired Characteristics for the Global Learning Laboratory for QUHC

The QHC Unit of WHO has held internal discussions and consultations with other WHO colleagues to begin to define the desired characteristics for its GLL for QUHC. The unit's thinking also draws on a prior experience with a learning laboratory that the WHO SDS Department convened in 2013—the Universal

Health Coverage – Patient Safety & Quality Learning Laboratory, which consisted of in-depth interviews with representatives from four countries and a two-day in-person meeting in Geneva to discuss a synthesis document which had been drafted based on the interview.

The purpose of the GLL for QUHC has been defined as “*to create and support a safe space to share lessons, challenge ideas and spark innovations to inform wider audiences on practical lessons learned from frontline experiences relating to quality UHC.*”

The expected participants in the GLL encompass frontline providers, administrators, policy makers, advocates, civil society, experts and academics, as well as colleagues from all levels of WHO and in particular colleagues in WHO country offices. The QHC Unit plans to elicit interest in participating in the GLL for QUHC from WHO Member States and other actors with current working relations with WHO SDS.

The QHC Unit has planned that the initial focus of GLL activities will be on the triangulation of UHC, quality, and specific technical areas related to service delivery. Initial technical areas identified include: Reproductive, Neonatal, Maternal, Child and Adolescent Health (RNMCAH); Water, Sanitation and Hygiene (WASH); Infection Prevention Control (IPC); Palliative Care, Primary Health Care (PHC); National Quality Policy and Strategy (NQPS); Migrant and Marginalized Populations; Emergency and Essential Surgical Care; and Compassion. Each of these topics has a team at WHO headquarters that is interested in participating in the GLL to address how quality and UHC intersect with their topic. The thinking is that focusing the interaction among members of the GLL for QUHC in relation to common interests in these topic areas will facilitate more meaningful discussions and sharing.

GLL interactions are envisioned to be a combination of email sharing, conference calls, webinars, and some in-person events. The GLL for QUHC will have a dedicated section within the integratedcare4people.org website to provide a home repository for documents and announcements and a threaded discussion forum but also have spaces unique to each topical area where a sub-set of GLL members interested in that topic could communicate and share resources. It is expected that insights and ideas shared within the topical area spaces will also feed into the content on the main GLL for QUHC web space to work towards a common understanding of how different streams of work contribute to quality UHC.

WHO staff are expected to be the moderators and conveners of virtual discussions and in-person meetings as well as integrators of lessons and information, which would be shared among all GLL members and eventually synthesized in an annual report for dissemination across WHO Member States.

To inform the design of the GLL for QUHC, members of the QHC Unit team interviewed nine colleagues from technical teams to better understand the structural and support elements that should be in place to support topical interest groups within the GLL. The majority of those interviewed said they would like to see the technical/thematic groups bring clarity and consensus (“harmonization”) to how the topics intersected with quality and UHC and also develop advocacy tools/products to help inform or influence policymakers. They anticipated there would be need for strong moderation of the groups and the GLL to balance the discussions and needs of the groups and ensure progress toward set milestones. At the same time, some of those interviewed expressed reservations about the amount time that would be needed to moderate a technical/thematic group. They also acknowledged the potential challenge of the GLL for QUHC being seen as yet another parallel learning network that might be seen as competing with other existing learning networks. To address this challenge, they suggested that leveraging and connecting with some of these existing networks with similar interests help to jump start the GLL.

## **II. Objectives and Methods**

### **A. Objectives**

The objectives of the landscape analysis exercise were to review key literature on learning networks and communities of practice and explore the experience of several global learning networks, particularly those related to health care, to extract key lessons and recommendations for consideration by the QHC Unit at WHO as they design and launch their GLL for Quality UHC. The landscape exercise also sought to explore the views of participants and stakeholders involved in previous global learning activities organized by the WHO SDS Department.

### **B. Methods**

Initially the literature was searched through Google Scholar, ABI Inform, and PubMed using terms such as, “meta-analysis”, “evaluation”, and “success factors” crossed with “community”, “learning laboratory”, and “learning network.” We then adopted a snowball technique to identify grey literature and reports related to the topic. Thirteen studies related to communities were reviewed. Six of the studies were specific to health care, and seven reviewed communities in other sectors. Three of the studies were specific to health care policy communities. Two studies reviewed the literature in order to develop frameworks for evaluation.

Of particular interest is the USAID study of its own Learning Networks because of the similarity to the intent of the QUHC Learning Laboratory. A second study by Bertone et al. which assessed communities of practice in health policy that had developed evaluation processes was also found to be of particular relevance. The full literature review is found in **Appendix 1**.

The landscape analysis drew on in-depth interviews with key informants representing nine global learning networks, most of which were health related. These nine were selected from a longer list of global learning networks of potential interest for which we gathered information available on the Internet. Some of the nine were suggested by the QHC team at WHO, while others were identified by the authors as networks of potential relevance to the proposed GLL for QUHC. The nine learning networks examined are listed in the table below.

#### **Learning Networks Explored through Key Informant Interviews**

Learning network	Year founded	Number of members	Main ways members interact	Entry into the group
African Partnerships for Patient Safety	2005	180	Exchange visits, face-to-face workshops, discussion boards	Invited to join by the moderators
Commonwealth Health Hub	2015	750 from 53 countries	Listserv; can post comments on a threaded discussion. Eventually plan to have a collaboration section.	Apply to join
Financial Access Community of Practice (CoP)	2009	950	Post comments to the listserv; contact other members; country groups in two countries meeting virtually and face-to-face	Apply to join
Global Reading Network	2015	1600	Participation in webinars and in-person events	Apply to join

Learning network	Year founded	Number of members	Main ways members interact	Entry into the group
Health Service Delivery CoP	2009	1423 from 76 countries	Listserv; collaborative projects; can contact other members; HSD CoP events tagged onto other meetings	Apply to join
Joint Learning Network (JLN) for UHC	2011	25 member countries, plus donors	In-person workshops funded by JLN, participation in collaboratives, co-development of products	Apply to join, but must be from a country that is a member of the JLN and the application must be approved by the country coordinator
Management Sciences for Health (MSH) Technical Exchange Networks (TENs)	2009	720 MSH staff around the world	Listserv; threaded discussions; materials posted on the Intranet; #TENDay; brown bags	Open to all MSH employees. Members self-identify.
Mental Health Innovation Network	2013	1900	Listserv; webinars; member-to-member contacts; MHIN events tagged onto other meetings; post blogs and innovation case studies	Apply to join
Patients for Patient Safety (PFPS) CoP	2005	400 from 66 countries	Listserv; national meetings; occasional workshops	Must have attended a PFPS workshop or be recommended by a country PFPS coordinator

Key informants were contacted by email, in some cases initially by WHO staff, who then connected them with the authors, and in other cases, directly by one of the authors. Five of the interviews were conducted by one author, and the other four in pairs or by all three authors, with one author taking notes. Five interviews were conducted by Skype, two via telephone, and the remaining two interviews were conducted in person.

Each interview lasted approximately one hour, during which the informant was asked about specific topics with sub-questions, shown in **Appendix 2**. Not every informant was asked every question; instead we allowed the conversation to follow topics that seemed to yield insights that could be useful to the QHC team at WHO. Notes from each interview were posted on Google Drive to make them accessible to all three authors. Summary information about each of the nine learning networks is provided in **Appendix 3**.

In addition to the nine learning networks examined through in-depth interviews, we gathered information on another six learning networks through Internet research, to look at trends and how they addressed specific design questions. Summary information on these additional learning networks is provided in **Appendix 4**.

The landscape analysis was also informed by interviews with the following stakeholders: (via Skype) the Coordinator of the Integrated Care for People web platform which will host the GLL for QUHC; two Uganda-based participants in the 2013 PQS and UHC Learning Laboratory; and Lord Nigel Crisp, the former Special Envoy for Patient Safety, to gather their perspectives on how the GLL for QUHC can best meet its objectives.

### **III. Findings from the Literature Review**

#### **A. The Name of the Network**

Each of the terms “community,” “community of practice,” “learning network,” “network,” and “learning laboratory” carries with it a number of connotations. Aside from Lord Crisp’s call for global learning laboratories for health systems innovations [14] and the [USAID Learning Lab](#), we found little literature related to the term “learning laboratory” within health care communities or communities in general. WHO may want to consider using the term “learning network” which, according to the literature review may more aptly convey the intentions of the Learning Laboratory for Quality UHC, rather than either “learning laboratory” or “community.” The attributes of a learning network are:

- *Defined and finite group*
- *Shared learning agenda*
- *Specified time frame*
- *Three levels of focus*
- *Integrated approach to knowledge cycle*
- *Dedicated resources*
- *Deliverable commitments*” [2]

However, if any term other than “community” or “community of practice” is used, we recommend it be accompanied by a description to insure that it carries the intended meaning. It may be useful to reference the Crisp article and borrow some of its language about laboratories where partners can support each other to create local innovations and where lessons for others can be drawn out.

#### **B. Stages of Community Development**

Communities appear to develop through a series of stages that follow a recognizable pattern. The pattern implies that each stage needs to be supported and the actions of leaders conform to the stage of development. Although the patterns identified in the research differ in the number of stages and the labels, all moved through the following pattern:

- Focus on activities that benefit individual members and their organizations, such as solving local problems;
- Build a shared context and learning agenda;
- Reorient to focus on the external environment.

The first stage of community life of generating value for its members is critical for future development. Even when a community has moved to another stage, there is a continuing need for individual members to benefit from the activities of the community. To quote Bertone et al. [6] a community of practice (CoP) “*not generating value for its members in an efficient manner loses support and may even disappear.*”

#### **C. Success Factors of Communities**

Many of the studies offered lists of factors that were necessary to the success of a community. The following factors were common across the studies:

- Active leadership that helps the community become effective and promotes the community externally;
- The existence of a core group of members that are fully engaged;
- Establishment of trust and motivation to share information;
- Setting aside time periodically to review the group’s progress and ways of working;
- Goal congruence between members and the network;
- Find ways to influence industry – seeking to purposefully influence the behavior of others who were not initially a part of the learning network;

- Hold formal meetings of the community monthly, either virtually or face-to-face.

## **D. Global Health Policy Networks**

Global health networks that influence policy are most likely to produce effects when:

- They construct a compelling framing of the issue, one that includes a shared understanding of the problem, a consensus on solutions and convincing reasons to act;
- They build a political coalition that includes individuals and organizations beyond their traditional base in the health sector.

A network in which members share an intent and focus, but do not share the same repertoire of practice (e.g., researchers, policy makers, academics, and practitioners) requires greater time and intent to build a shared language, trust, and relationship between members. This is most effectively accomplished by bringing members together in a face-to-face setting, both initially and periodically during the life of the CoP. Such a network also needs to set aside time for self-reflection as the community develops and changes, both to ensure that the evidence the network is producing is not overly influenced by dominant members and that dissenting views can be freely voiced.

## **E. Evaluation of Communities**

Two frameworks for evaluation were identified [1,6]; both include a list of indicators. Wenger et al.'s [1] model also employs stories connected to the indicators.

The full review of the literature is located in [Appendix 1](#).

## **IV. Findings from Learning Network Key Informant Interviews**

Key themes emerging from the key informant interviews are grouped along the attributes examined in the interview guide.

### **A. Recruitment/Membership**

Most of the networks examined are open to new members who apply through a web form that must be approved by a network moderator. Several of the networks have fairly low thresholds for entry; anyone with a legitimate reason for joining is approved. For communities like the Health Services Delivery (HSD) and Financial Access CoPs, the strategy of opening membership to anyone interested seems to have paid off in creating more potential opportunities for responses by having a larger pool of members.

The Joint Learning Network (JLN) and the current membership scheme for the Patients for Patient Safety (PFPS) CoP rely on country-based applications to join: individuals must be connected with a member country group to be able to join the network. For the both of these networks, this model is seen as essential to demonstrate country-level commitment and integration.

The Commonwealth Health Hub has something of a mixed model, with automatic membership of senior government officials in Commonwealth countries but also openness to application for membership by individuals.

### **B. Responsibilities/Expectations of membership**

While all networks examined, most had few real requirements or obligations for membership other than maintain a respectful tone in their interactions.

One interviewee commented that a one-year engagement seems too short—that a three-year period might be more realistic to give participants time to engage.

One informant, who had experience with several learning networks commented, “*I have struggled to get professionals to be active on any site.*” When asked about how the networks assure safety (i.e., that

members feel safe to express views and share experiences without fear of criticism), the informant said, “*Make it clear at the start, who’s a member [by sharing information about the different members], how the platform works. Say, please don’t use the site for personal messages.*”

### C. Mechanisms for Learning/Interaction

The two prior participants in the WHO Patient Safety & Quality (PSQ) Learning Laboratory convened in 2013 expressed that the most important aspect of the prior event was meeting people from different backgrounds and completely different contexts but recognizing through conversation that they faced similar challenges. One noted that regional groupings might allow members to focus on issues that are particular to their region mechanisms. He noted that people are most interested in practical details—how to do it, sharing detailed descriptions of successful experiences in “bite-sized” pieces, in straightforward language so they are readily applicable. Another noted that what he found especially valuable about the 2013 meeting is that “*each person brought something unique to the table. There was a broad spectrum of thinking that could be brought together.*”

The learning networks studied rely primarily on email communications to share news and start threaded discussions. The Global Reading Network and the PFPS CoP both use newsletters sent out to the listserv and webinars to sustain a basic level of interest in the network. The Global Reading Network also uses small working groups led by volunteers to develop products or specific activities. For example, its practice working group has about 12 members, of whom 7 or 8 people are actively involved, However, the working groups are mainly headquarters-led, with little country representation.

The HSD and Financial Access CoPs and the Mental Health Innovation Network (MHIN) all encourage members to complete short profiles about themselves that all other members can view. One informant noted that listservs like HIFA incorporate such profiles into each member post to the listserv, so that a post by a member also contains in the body of the email the short profile of the member. This serves the purpose of providing context/background on the author and supports the creation of a sense of connection among members.

Networks like the JLN, the PFPS CoP, and the MHIN rely primarily on in-person meetings to connect and convene members of the network. The MHIN has not found the openness of the network to inhibit sharing; rather, they feel that people are more willing to share their work and ideas in an open forum, since more people are likely to see it.

The African Partnership for Patient Safety (APPS) platform on EZcollabs.org had a mother page for the APPS and then six child hubs for each of the six WHO regions, as well as an overall document library to which members could contribute and a discussion board. The discussion board was not used very much. Most of the members of the platform were engaged in partnership visits between hospitals, where members would interact directly. The APPS web platform was more like a repository of useful information that came out of the partnership exchanges between hospitals. While the APPS platform was a closed group, the moderator observed that members were rarely hesitant to share information to a larger audience once they had shared it with the closed group.

Informants from Management Sciences for Health’s Technical Exchange Network (TEN) noted that it is helpful to think through how participants will engage with technology and how to make that attractive to them. Their experience has been that “*people want to come together and create something together that they couldn’t have done on their own.*”

### D. Governance and Support

The role of the moderator in nurturing and summarizing threaded discussions varied widely in intensity, from spending time editing and summarizing every comment sent to the moderators to copy-editing and reviewing case studies. The Commonwealth Health Hub and the MHIN have both communications staff

and knowledge exchange staff supporting the learning network, recognizing that both kinds of support were needed.

Moderators of learning networks all stressed the large time commitment needed to moderate and nurture the network. Moderators of multi-pronged networks like the APPS and PFPS CoP noted that they never had enough time to devote as much time as they would have liked to each of the sub-groups in the network.

Moderating all posts is a best practice that all the learning networks studies followed. Spam and inappropriate messages did not appear to be much of problem, although all lists used moderation prevent such problems.

Of the learning networks examined, only the JLN and the Global Reading Network had an explicit governance structure. The JLN's country-led Steering Group has representation of all nine original JLN countries plus one-third representation by the later countries and donors. The Global Reading Network has a written Charter of Operations that articulated the network's vision, mission, functions, and governance structure. The governance structure calls for a Steering Committee with multiple organizations represented and co-chaired by volunteers from other organizations. In practice, members of the steering committee have suggested they function more as an Advisory Committee rather than Steering, since the strategic directions of the network are largely determined by the funding agency.

## E. Documentation and Products

Among the networks studied, the JLN is the most focused on developing concrete products, but at the same time invests the most resources in convening group members for specific tasks. The JLN uses a highly consultative process, with a country-led Steering Committee to define priorities and face-to-face meetings to build relationships and develop products. For other networks, like the MSH TENs and the MHIN, a few products have arisen organically in response to member ideas.

The IntegratedCare4People web platform is developing a "Practices" database which will contain structured case studies following a format that has been developed over several years by the WHO EURO office. The practice case studies are intended to describe drivers, barriers, and change management strategies from experiences making services more integrated and people-centered. The platform team is creating guidelines for the cases and plans to proactively partner with other institutions to create these. The GLL UHC team may want to explore whether developing a collection of case studies on quality UHC might be of interest, including addressing topics of the technical/thematic groups.

The MHIN has a similar model for structured descriptions of mental health innovations and a well-developed template and process for working iteratively with members to develop them.

Some of the networks have also developed helpful tools for new members and sub-group moderators, such as standardized welcome letters explaining key aspects of the community.

## F. Key Advice

As a parting question, informants were asked to offer their best advice to WHO and others who are starting up a new learning network:

- *Clearly define the scope and purpose of the community and make that explicit so people know who can be members and how to join*
- *UHC and especially QUHC means different things to different people. Some people thinks it means working with the poorest people, others think you have to get the middle class involved. For this reason, it has the potential to be the greatest waste of money. For example, the policy on UHC in Rwanda is very different from that in Ghana. Perhaps think about bringing together countries that have the same overall policy approach to UHC.*

- *Don't wait until everything is perfect to launch it. Just get it started. Once people get engaged, it's really interesting and rewarding.*
- *Think big and start small, for example, identify the three things to do at a local level to quickly get the quality right.*
- *Be reactive and proactive. Deliver what people in the field need. People want tools they can customize easily and quickly.*
- *Be demand-driven; process is just as important as the product.*
- *Investigate if there are existing networks doing similar work and take advantage of those. It becomes politically incorrect to start something new that creates more chaos and takes away resources.*
- *Scan the environment to find out how to position what WHO is doing – to find a niche this Learning Laboratory could fill, maybe start with just a few countries.*
- *Make sure the leaders from the countries are on board. Too many initiatives have junior practitioners working with a donor organization, but it never gets to the level of the country leaders so it dies away. Make sure it is authorized and supported by someone in the country.*
- *Having a regular flow of information is quite important, so people see there is learning and site activity. Once it's going, people will contribute. People first need to see the benefit from engagement.*
- *Use alternative methods to make information more accessible, such as infographics, webinars, and social media.*
- *Overbudget for support but don't overpromise what you can deliver.*
- *Involve a large range of stakeholders at the outset as a Steering Committee to advise the learning network.*
- *Be clear about what is the added value of the community and who is benefitting from it. Does it serve a felt need or is it just serving the interests of its creators?*
- *Let it grow before structuring, as people prefer to position themselves first. ("Setting up Communities" on IntegratedCare4People)*

## V. Considerations for the Design Meeting

Reflecting on the interviews and the literature, we identified 10 issues that we recommend the WHO QHC Unit consider in their final decisions about the design of the GLL for QUHC.

### 1. Purpose of the GLL QUHC: what are you expecting to accomplish

The expressed purpose of the GLL QUHC to share lessons, challenge ideas, and spark innovation suggests a more intensive interaction among connected colleagues who know each other and have established some degree of trust, either through face-to-face interactions or connections through trusted mutual colleagues. The draft description of the Architecture for the GLL suggests that these deeper-level conversations would occur within the technical or thematic groups and that the outputs or products of the interactions within each group would need to be determined by each group itself. It is therefore more difficult to decide at the QHC Unit level what the overall GLL for QUHC will produce, since the real sharing and "co-production" of new knowledge seems designed to occur mainly within topical groups.

It is worth exploring what the value-added of the overall GLL for QUHC will be and what overarching activities will be implemented as the GLL, to feedback reflections from the topical/thematic groups to the entire membership, identify cross-cutting lessons, convene a general listserv on quality and UHC, moderate cross-cutting threaded discussions, or capture stories or case studies of innovative quality UHC interventions that don't fit neatly into the technical/thematic groups.

WHO technical staff interviewed by QHC Unit team mentioned written products like reports, briefs, advocacy tools, and newsletters and webinars as desirable products from the topical groups. At the

same time, there was recognition of the importance of face-to-face meetings to stimulate substantive interactions. Both participants in the 2013 UHC & PSQ Learning Lab event in Geneva commented that the most useful thing about their participation was the chance to talk to colleagues from other countries. These observations and the KM literature suggest that in-depth discussions that generate new insights are most likely to happen during in-person events. It is probably not realistic to expect that such discussions will take place spontaneously during telephone calls, especially if the members of a topical/thematic group don't already know each other.

It will be important to be clear about what the GLL hopes to accomplish overall, independent of what transpires in the topical/thematic groups, and what kinds of products and meaningful participation by members are possible without face-to-face interactions. It may be useful to think of what the GLL overall can do versus what the topical/thematic groups will do, which will depend on the active engagement of other WHO technical teams.

## **2. Time-boundedness/timeframe for accomplishing this**

A second key consideration is how long does the QHC Unit expect to support the GLL. Is there a short-term horizon of one or two years, or is this a direction that the unit is prepared to develop over many years? One can observe something of an inverse relationship between intensity of interaction/engagement and duration of the participant's connection to the network. If the GLL is expected to produce concrete products in a short time frame (6-18 months, for example), then the selection of participants should emphasize those who want to collaborate intensively in the near term, as opposed to creating a structure that might be more sustainable but slower paced in its outputs.

The HSD, Financial Access, and PFPS CoPs have built up sizeable followings (over 700 members) through promotion at conferences/workshops and word of mouth over a period of several years. While these groups face resource constraints, they have been creative in finding ways to sustain membership interest and group purpose. These groups have a certain stability but for the most part don't expect a lot from their members. Participation is open and voluntary, and members seem to jump if they have a particular need or question that others in the group might answer, or if they want to respond to a solicitation for collaborators on a project.

Does the GLL for QUHC need to harvest some early fruits to justify its investment, or can it progressively build up member engagement over time? Defining the timeframe for the GLL's expected outputs will influence the strategy.

## **3. Naming the network**

The literature reviewed pointed to the name of the group as being important for conveying what kind of an enterprise it is. Will potential members you are seeking understand the significance of the term "learning laboratory"? How does that name convey something unique and different from learning community or learning network? Names raise expectations, and different people may have very different understanding of what the chosen name signifies. Interestingly, one of the key informants said that they had considered the term "laboratory" but decided against it when several low-income country colleagues said that it made them think of colonialism and experimentation by high-income countries at the expense of low-income countries. Lord Crisp's elegant description of a mechanism for partnership and globally sharing lessons from locally created solutions may be useful to cite in the description [14].

## **4. Position on the IntegratedCare4People web platform**

Another consideration is the position of the GLL for QUHC on the IntegratedCare4People web platform. Will the GLL for QUHC be an overarching Community on the IntegratedCare4People web platform or will each technical/thematic group be its own Community? Can the platform support linked "child" Communities under the aegis of an overarching "mother" GLL for QUHC Community? If so, how do the "child" Communities function and how is overall membership in the "mother" Community managed?

The requirements for moderation of a separate Community for each technical/thematic group may be considerably more than what technical staff at WHO expect to provide to moderate a technical/thematic group. It will be important to define carefully what independent functionality a “child” Community has and how its administration relates to the administration of the “mother” Community.

Another consideration for the GLL for QUHC as a Community on the IntegratedCare4People web platform is how it will address or connect with the five Integrated Care for People core strategies: empowering and engaging people; strengthening governance and accountability; reorienting the model of care; coordinating services within and across sectors; and creating an enabling environment.

## **5. Open versus closed**

Most of the groups examined are fairly open, allowing basically any users who find out about the network to readily join it. This strategy has the advantage of casting a wide net to draw in many more participants, increasing the chances of bringing in people with creative ideas or innovative experiences who might bring something unexpected to the network as well as increasing the size of the audience with whom the GLL shares information, announcements, and potentially, products. On the contrary, it is hard to see a rationale for trying to restrict membership in the GLL as a whole, especially if the overarching GLL for QUHC Community on IntegratedCare4People is the gateway for entry into the technical/thematic groups.

The topical/thematic groups are another matter. The comments from interviewed WHO technical staff about topical/thematic area group participation suggest that small, closed, by invitation or application groups are what is desired to foster deep discussion around specific topics.

## **6. Expectations of participants**

A critical consideration is what benefits will participants in the GLL for QUHC derive and what will motivate them to participate in the GLL for QUHC. Almost all key informants interviewed stressed that expected engagement beyond passively receiving emails or listening to webinars requires that activities respond to felt needs of participants. It may not be realistic to expect that the technical/thematic topics identified by the QHC Unit directly respond to needs of potential members.

WHO technical staff interviewed by the QHC team acknowledged that most people who are deeply interested in the QUHC topic are also very busy, such that the rationale for what they get out of participating must be very clear and compelling. WHO staff identified information sharing, seeking input from colleagues, and collaborative projects as the key activities they would expect to see in the technical/thematic sub-groups of the GLL. It will be important to consider these activities from the point of view of potential participants to make sure they meet their needs.

A related issue is to recognize the natural ebb and flow of voluntary membership, such that members may participate actively for a time, but may also experience periods when they are not able to participate. An overly restrictive threshold for participation may result in exclusion from the group of busy people.

## **7. Recruiting participants**

Several informants pointed to the need to take into account the many existing networks that have interests in UHC and quality of health care, including the Health Harmonization for Africa CoPs, the JLN working group on UHC, and the Commonwealth Health Hub. Building relationships with such groups could bring in groups of members, create opportunities for joint activities and products, and rapidly expand the reach of the GLL for QUHC. Such a strategy requires considerable attention on the part of GLL moderators to build relationships and gain an understanding of these other networks through participation in them.

The PFPS CoP’s strategy of recruiting country-sponsored groups to bring in new members is an interesting strategy that could be useful if the GLL for QUHC decides to focus initially on a smaller number of countries or seeks official country participation. Participants from the 2013 PQS & UHC Learning Laboratory could be approached to help identify other potential participants in the same country.

At the same time, it is important to keep in mind that country-based participants may be more interested in interacting with people from other countries, to learn about other experiences.

Finally, if the purpose of the GLL is to influence policy, it will be important to engage policymakers in the network, even though they are less likely to participate in online fora. Linking deliberately with the JLN and the Commonwealth Health Hub may offer a practical way of connecting with policymakers.

## **8. Stages of development of the GLL and roll-out of the web pages/topical groups**

As noted in the literature, there are stages of development of any community. The literature cites the importance of community members perceiving that their needs are aligned with the goal of the community and feel a sense of commitment to others in the group before they are likely to get deeply involved in co-creation of group products. Developing such a sense of shared purpose takes time.

The suggestion made by interviewed WHO technical staff for frequency of GLL topical area group events (monthly or more frequent meetings, especially in the beginning; quarterly webinars) seems ambitious, especially given the unclear time commitment of technical teams to the moderation role. Before committing to start up specific technical/thematic groups, it may be useful to develop a clear identity for the GLL as a whole by establishing the broad parameters of the community's interests before narrowing the focus to specific technical/thematic topics. Webinars, surveys, or calls for case studies could still be implemented for technical/thematic topics without segregating those interested into a separate community. In this way, the GLL for QUHC could demonstrate that it is concerned with many different aspects of how quality and UHC intersect and not just on narrowly defined topics. Sub-groups for specific tasks or topics could develop organically, in response to felt needs.

## **9. Support/moderation for nurturing participation**

Experience suggests that the level of support required to support each topical area group should not be underestimated, and it remains to be seen if technical teams at WHO are ready to invest the level of effort needed to nurture a vibrant and productive group. It is not clear whether the overall moderator of the GLL QUHC will be able to establish a meaningful connection with all topical group members so as to be able to stimulate their participation in topical group activities. The experience of the learning networks studied suggest that participants are more likely to respond and engage with topical technical experts who they perceive can provide expert knowledge in the topic.

Suggestions from WHO technical colleagues that participants could be motivated by being recognized by having their names on products may be true for some members, but it is more likely that members are looking for some direct benefit to their work or professional development from participation in the network.

Having a procedure in place for how new members are welcomed is important—who contacts them and what is said is important for setting and fulfilling expectations as well as helping new members feel a connection to the group. The Commonwealth Health Hub has a nice example of a new member agreement which spells out what is expected of members—the “rules of participation” and explains that posting ideas and examples in The Commonwealth Health Hub brings them into the public domain. How new members of the GLL for QUHC will be welcomed and the role of technical teams in welcoming new members who are interested in their topic will be important aspects to define early in the life of the GLL.

## **10. Monitoring and evaluating the GLL**

WHO technical staff interviewed by QHC Unit GLL team mentioned measures of participation of GLL members as a “proxy for success,” and the draft GLL Architecture document emphasized frequency of participation on calls. Such measures reflect presence but not engagement and may not really serve the purpose of assessing the vitality of the GLL. Consider the evaluation frameworks examined in the literature review, including the use of stories to demonstrate the value of participation in the GLL. It will also be important in the start-up planning to designate times when the QHC Unit will periodically review the GLL’s progress and ways of working, to make necessary adjustments.

## Appendices

### Appendix 1: Review of the Literature on Communities of Practice and Learning Networks

#### Nancy M. Dixon

This review of the literature was undertaken to inform the design of the World Health Organization Service Delivery and Safety Department's Global Learning Laboratory (GLL) for Quality Universal Health Coverage (QUHC).

Initially, the literature was searched through Google Scholar, ABI Inform, and PubMed, using terms such as, "meta-analysis", "evaluation", and "success factors" crossed with "community", "learning laboratory", and "learning network." We then adopted a snowball technique, to identify grey literature and reports related to the topic. Thirteen studies related to communities of practice or learning networks were reviewed. Six of the studies were specific to health care, and seven reviewed communities in other sectors. Three of the studies were specific to health care policy communities. Two studies reviewed the literature in order to develop frameworks for evaluation.

This review first looks at the terms, "Network", "Learning Network", and "Community." We found no studies that referenced "Learning Laboratory," excluding those related to the teaching of foreign language or software development. However, it should be noted that USAID has a website labeled "USAID Learning Lab" which hosts a number of "Learning Networks" as well as providing resources such as toolkits, case studies, events, and blogs.

Following the section on terms, we examine the stages of development of communities over time. Next, we address success factors for a community, with particular focus on communities whose intent it is to impact policy. We look at possible evaluation processes, and finally, we offer recommendations based on this review.

#### What's in a Name?

Etienne Wenger, Beverly Trayner, and Maarten de Laat [1] differentiate "networks" and "communities" in terms of social structures and in terms of how each learns. Wenger and his colleague, Jean Lave, originated the term "Community of Practice" before the advent of social media and before the resulting introduction of the term "networks." Wenger has followed the development of communities and subsequent networks and is considered the leading authority on this topic. The excerpts below from Wenger et al. [1] are useful for WHO to consider for how the terms community and network may be applied to the GLL for QUHC:

#### Community

*"...Community... refers to the development of a shared identity around a topic or set of challenges. It represents a collective intention – however tacit and distributed – to steward a domain of knowledge and to sustain learning about it."*

*"The learning value of community derives from the ability to develop a collective intention to advance learning in a domain. This shared commitment to a domain and to the group of people who care about it is a learning resource. It tends to make information flows relevant. Over time, a joint history of learning also becomes a resource among the participants in the form of a shared practice – a shared repertoire of cases, techniques, tools, stories, concepts, and perspectives."*

*"The challenge of community is that it requires sustained identification and engagement. Negotiating and renegotiating a reason to learn together, helping each other, following up on ideas, developing shared resources, sustaining a social space for learning – all this requires time*

*and commitment. Not everyone has to have the same level of commitment, but there has to be enough for the community to feel alive as an entity.”*

*“The work of community is to develop the learning partnership that creates an identity around a common agenda or area for learning. It is to specify why people are there, what they can learn from each other, and what they can achieve by learning together. It is to develop a collective sense of trust and commitment.”*

## **Network**

*“Network … refers to the set of relationships, personal interactions, and connections among participants who have personal reasons to connect. It is viewed as a set of nodes and links with affordances for learning, such as information flows, helpful linkages, joint problem solving, and knowledge creation.”*

*“The connections in a network can function as learning ties providing access to information flows and exchanges. This access can be intentional or serendipitous. It can be direct – involving a personal connection, or indirect – involving a series of connections. Participation in a network does not require a sustained learning partnership or a commitment to a shared domain. In this sense, learning in a network does not have to have an explicit collective dimension.”*

*“At the collective level, the strength of networks in enabling serendipity and emergent behaviors has a flipside: the absence of collective intention and identity makes it more difficult to steward a domain systematically. When connections remain largely local important insights can remain hidden because there is no intention to recognize and negotiate their importance through the mobilization of a committed group.”*

*“The challenge of network is that it requires a strong sense of direction on the part of individuals. Learning takes place as participants leverage the availability and spread of information to pursue enterprises they care about and develop their ability to do so. The value of networks as learning resources depends on an individual to act as responsible nodes and evaluate the relevance of information flows for themselves and for the broader network.”*

*“The work of network is to optimize the connectivity among people. It is to increase the extent and density of the network by strengthening existing connections, enabling new connections and getting a speedy response. It is to increase the network’s potential to give rise to unexpected connections.”*

## **Learning Networks**

USAID conducted a study of its own “learning networks” [2]. USAID defines a learning network as “composed of a finite number of organizations represented by a defined group of individuals whose common interest is the development and pursuit of a shared learning agenda to be explored over predetermined period of time with a known end-date.” The agenda of learning networks is focused on three levels–organization, network, and industry--incorporating knowledge generation, capture, dissemination, and application. Networks are obligated to complete deliverables associated with the three levels of learning.

### ***Characteristics of USAID-sponsored learning networks [2]:***

- *“Defined and finite group*
- *Shared learning agenda*
- *Specified time frame*
- *Three levels of focus*
- *Integrated approach to knowledge cycle*
- *Dedicated resources*

- *Deliverable commitments*"

These characteristics serve to differentiate a learning network from other types of communities of practice. As such, they serve as a think tank, training ground, and support network to practitioners and organizations.

Each of the terms carries with it a number of connotations. Any term employed would need to be explained further to insure that it makes clear the intended meaning. Given the above definitions, we suggest that the term "learning network" may more aptly describe the intentions of the Global Learning Laboratory for Quality UHC.

For the purposes of this review, we will use the term associated with each study, that is, if a study uses "community", we will use that term in describing their findings; when the study speaks of networks, we will reference that term.

### **Stages of Development**

Our review of the literature revealed that many researchers find that communities develop through stages or in a sequence. Although the naming of each stage and the number of stages differ, the trajectories in most are congruent.

Gongla and Rizzuto [3] studying communities within IBM, an early organizational implementer of communities of practice, identified four stages in 2001:

1. Potential stage – focus on building connections
2. Building stage – focus on creating memory and shared context
3. Engaged stage – focus on learning
4. Adaptive stage – focus on innovation

In 2006, Dixon [4] studied thirty communities, within an oil company, over a period of two years. Observing the changes in the communities over time, Dixon identified five stages of community development. Not all of the thirty communities developed through all stages. Some never moved beyond the second stage, yet proved valuable to the organization. The task of the leader/coordinator differed in each stage.

1. **Networking:** Before communities (CoPs) were formed within this organization, members within a technical specialty shared ideas with each other and learned from each other informally on the basis of each member's personal network.
2. **Knowledge Sharing:** Formal communities were formed, and a coordinator was identified for each. An on-line space was made available for members to ask and answer questions. Periodic face-to-face meetings of each CoP were held. The primary reason individual members joined their respective CoP was to obtain help with problems they faced in their day-to-day work. The role of the coordinator was as convener of both face-to-face and online meetings, actively monitoring the online Q&A, and carried out the social role of connecting members who were addressing similar problems. The outcomes of the community work lacked visibility to anyone outside of the community, as the benefits were specific to individual members.
3. **Competence Development:** Over time, members of a CoP began to consider not only their short-term needs for getting problems solved, but also the longer-term needs of building a technical organization they could take pride in. They continued to be interested in getting help for their daily work, but widened their interest to developing themselves through the community and to helping others who were just coming into the organization. A sense of "we" had developed among members. The coordinator role was reduced because members began taking responsibility for tasks that needed doing. The community efforts were more visible to those outside of the community, gaining the community a reputation for being active and valuable.

4. **Organization Influence:** When and if a CoP developed a sense of itself as a whole, it then began looking outside of itself to consider its role in the larger organization. The communities that reached this stage were able to offer the decision makers of the organization a perspective on changes and forecasts related to their topic focus, e.g., white papers, scenarios. Such an offer might have seemed presumptuous coming from any one individual, but the power of community legitimized this proffer. Over time the organization began turning to the CoPs to request their advice on issues related to the CoP topic. The coordinator role became more of a strategist, looking to where the industry was moving and was more actively engaged in representing the community to the sponsoring organization.
5. **Across Discipline Synergies:** At this stage the communities were able to look beyond their own boundaries to collaborate with other communities to address issues that both were facing in the larger context. To participate in this kind of activity, the CoP had developed a clear sense of its own strengths and limitations, and members were actively seeking new opportunities to contribute to the total system of which the CoP was a part. It was at this stage that innovations began to occur. At this stage of community development, the community coordinator employed the skills of collaboration. The coordinator had or developed a knowledge base broader than his or her own discipline in order to see the possibilities that could emerge from working jointly with other communities.

USAID [2] in studying of its own “learning networks” found that:

*“Organizations come to the learning network with their own needs, learning questions and projects. Members take advantage of peer coaching on their own issues by other members of the network. Over time, the network is able to identify commonalities and important differences among organizations, leading to a collective learning agenda, and generates deeper learning than a single organization would allow. Later in the life of the network there is a reorientation to audiences outside of the learning network and the learning network develops products to fill gaps that exist in the larger community.”*

In each of these examples, the change of focus occurred over time and in a similar pattern that may indicate a natural sequence in community life. It may also indicate a need for different leadership skills for different stages of development.

## Success Factors and Responsibilities of Communities

Agrawal and Joshi [5] conducted a review of communities in 2011, referencing only empirical papers in business journals. They reviewed 42 articles, 17 of which studied CoPs in the business domain, 6 in the educational domain, 3 in the governmental, and 2 in the health care domain. The following themes emerged from these studies:

- Leadership
  - Particularly in virtual communities..."it is very important for the successful launch of the community that the leaders are highly motivated and involved in the community and that they are able to 'sell' the importance of the community topic to its members."
  - Leaders have both a driver (in terms of helping the community become effective) and a promoter role (which focuses on steering the CoP in the right direction and publicizing the achievements and impact of CoPs on organizational goals). These roles include:
    - Stimulating members to participate in the community;
    - Sharing his/her own expertise with the community members;
    - Coordinating CoP related activities;
    - Making external contacts;
    - Connecting the community members with each other;

- Promoting the community to management;
  - Alerting members to interesting external activities.
- Composition of CoPs
  - A critical mass of people who are fully engaged with the community is crucial for community survival. But CoPs often entail bringing together a mix of totally different people from totally different backgrounds. The lack of a shared experience should be recognized and deliberate steps to create a cohesive community should be taken.
- Goal congruency
  - The success of CoPs depends on the match between the objectives of the CoP and the daily work of participating members
  - CoPs that support “knowledge in action,” that is, knowledge embedded in work practices, rather than declarative knowledge, are more successful
  - Sticking to strategic objectives is critical
  - Setting clear and measurable objectives provide CoP members with a concrete direction to follow.
- Governance
  - Forming a governance committee with sponsors and CoP leaders
  - Providing ongoing support to develop knowledge-sharing cultures, including adequate resources and regular monitoring of CoP leadership, impacts CoP success
  - Top management’s willingness to provide financial resources to support face-to-face meetings of the CoP members is critical
- Engagement
  - Open communication: Establish trust and motivation to share information, which is critical to the establishment of a successful community of practice. To do so it is important to:
    - Identify individual skills of the COP members
    - Focus on intrinsically motivating the members
    - Set individual challenges
    - Develop relational resources
  - Shared vocabulary – within a CoP creates a common lingo to interact with each other to facilitate the transfer of information
  - Remembering previous lessons – passing on the learning and experiences of older members to the newer members creates a shared framework of reference and community memory which members can identify with
  - Learning from each other – through interactions among members who share the same interests is the key to CoP survival.

Agrawal and Joshi [5] suggest that community connectedness strongly predicts community effectiveness and member satisfaction.

In 2013, Bertone et al. [6] assessed CoPs which were formed to impact health policy. Their goal was to develop the conceptual framework for analysis and assessment of transnational CoPs in health policy. Through the study they also identified risks related to policy recommendations made by CoPs.

Bertone et al. note that CoPs that are focused on health care policy have requirements beyond more typical CoPs that might be focused on topics such as software development or even those in health care centered on a specific disease. The difference lies in the need to bring together participants e.g., researchers, practitioners, policy makers, and academics, that do not share the same repertoire of practices. This difference results in health policy CoPs experiencing challenges related to creation, development, and impact. For example:

*"A homogeneous CoP focusing on a narrow domain and aimed at promoting a particular view on health policy can produce clear policy messages, but with the risk of the CoP or its members over estimating the external validity of the related knowledge. A CoP focusing on broader issues and with a heterogeneous membership in terms of societal preferences may remain relatively open to possible options but possibly at the cost of the capability to produce recommendations."*

To avoid either risk, Bertone et al. suggest CoPs practice self-reflection related whether the view of dominant members or of a majority tends to be accepted as valid evidence. They also suggest CoPs take the time necessary to evolve and mature, reflecting the earlier studies of Agrawal and Joshi<sup>5</sup> and Dixon<sup>4</sup>. Therefore, to be effective, CoPs must be able to sustain their activities over time.

Bertone et al. suggest the following *core group responsibilities* for CoPs focused on health care policy:

1. **Clarifying the domain of focus:**
  - o Defining the strategic objectives of the CoP
  - o Ensuring that enough focus is kept on the repertoire of practices,
  - o Promoting and making the CoP visible
  - o Carrying out public appraisals and (self) assessments of the community.
2. **Cultivate the community dimension of the CoP**, going across knowledge regimes and creating an environment that is conducive to knowledge exchange, that includes:
  - o Power structure – mitigate external, pre-existing hierarchies among members to ensure wide participation
  - o Regulatory mechanisms – avoiding contributions that are inappropriate for their content (spam) and their form (interpersonal conflicts)
  - o Level of trust – ensure trust and a collaborative climate to enable the sharing of knowledge, particularly of a tacit nature
  - o Passion for the topic, commitment, and ownership of members are important to forge a common identity of the community
3. **Aligning the CoP's activities and products to individual and organizational expectations of benefit.** If individuals and organizations have (intrinsic or extrinsic) reason to participate actively in the CoP, more knowledge and time resources will be mobilized.
4. **Choosing and adopting the relevant ICT:** Including in the platform design features that are appealing enables the socialization of new members and encourages commitment and appropriate contribution by members in a cost-effective manner.

In 2013, USAID commissioned made a study of its own learning networks [2]. The report identified eight practices that contribute to the success of a learning network:

1. Take advantage of opportunities for strategic learning at organization, network and industry levels – be strategic about when and how to engage at each of these levels. As noted above, USAID found that the initial focus is on members' needs and then on creating a learning agenda and only later do members focus externally. Being aware of and responsive to these stages increases the network's success.

2. Focus intentionally on specifying desired outcomes – setting aside time periodically to review its progress and ways of working and to continually modify network level learning agendas and work plans.
  - o Help members understand what the learning network is and how its goals and way of working are different from other teams or working groups;
  - o Collectively inventory the learning issues and questions that individual organizations are curious about and want to work on;
  - o Encourage members to share their previous experiences with learning networks and create working norms for the new network;
  - o Draft work plans based on exemplary approaches to broaden understanding of learning issues.
3. Be attentive to the evolution of the network overtime; learning networks are dynamic groups that change and evolve over time.
  - o As the network's attention shifts over time from their organization to the network, and then to the industry, it needs to manage these shifts by keeping track of where the group's focus is and where it should be.
  - o A network that exists for any significant period of time will see its membership change. The network needs to see this as natural and take conscious advantage of the new perspectives and energy new members bring.
  - o A network's energy and momentum will have ups and down over time, and meeting agendas should anticipate and take this into account.
4. Make conscious choices about the use of collective time:
  - o Frequency of meetings – most learning networks involve a mix of face-to-face and online meetings, but consistently meeting monthly in a variety of settings.
  - o Each meeting needs a clear agenda, with members having input to the agenda.
  - o Use face-to-face meetings to launch a network and at phase shifts.
  - o Establish an online space (e.g., Adobe Connect, Maestro) that will support the work.
5. Be open to and support members playing different roles over time:
  - o Generate and support group norms regarding participation early on;
  - o Track how ideas develop, who is involved, and make way for different members to take on leadership roles;
  - o In particular, consider how the sponsoring organization is involved.
6. Support and enable optimal group functioning through the use of an effective facilitator who can help the group attend to the process of working effectively in the pursuit of the network's learning objectives:
  - o Develop clear terms of reference for the facilitator especially if the facilitator is a member of the network;
  - o If the facilitator is a member of the network, rotate the role among members;
  - o Call on outside facilitation for important decisions or when the group is not functioning effectively.
7. Build a high level of trust among members because many factors work against having trustful relationships, e.g., having a funder in the group, concern about proprietary organization information, and of course, personalities. Given these difficulties, participants still mention "trust" as what makes a network effective.
  - o Develop agreements about what gets shared outside of the network conversation and what "stays in the network";
  - o Take time to build relationships within the network, articulating individuals' expectations and interests;

- Recognize that the sponsor should be open rather than predefining deliverables and by supporting an equal playing field;
  - Take advantage of face-to-face meetings to make room in the learning network agenda for activities that build personal relationships;
  - Periodically check in on how the group is functioning.
8. Find ways to influence industry, seeking to purposefully influence the behavior of others who were not initially a part of the learning network:
- Leverage existing relationships and outside networks to bring additional perspectives to the learning network;
  - Map the audiences that members wish to influence and the messages they want to convey;
  - Make new industry-level connections;
  - Develop easy-to-use, actionable knowledge products;
  - Act as applicants for the adoption of those knowledge products within the industry.

Shiffman et al. [7], in 2016, studied six global health networks in matched pairs to compare the effectiveness of global health communities in impacting policy development, as well as to examine how global health networks emerge. They define a “*global health network*” as “*webs of individuals and organizations linked by a shared concern for a health condition*.”

The communities studied were “tobacco use” compared to “alcohol harm”; “maternal mortality and morbidity” compared to “neonatal mortality and morbidity”; and “tuberculosis” compared to “pneumonia”. In each pair, the first was more effective in changing policy than the second.

Shiffman et al. found that the emergence of a global health network is a confluence of forces with the configurations slightly different for each. The forces include:

- New information on the scope of the problem;
- The condition’s appearance in new forms or geographic regions;
- Dissatisfaction with existing efforts to address the condition and with the way the condition was publicly understood;
- New evidence on how to address the problem;
- New global agreements creating expectations that states and other actors move to address the issue;
- Mobilization to counter industries marketing products the use of which causes disease;
- Concern that a particular population group was being harmed.

In each case, the convergence of several of these factors led to a decision by one or more concerned individuals to bring together actors previously working in isolation with the intent of building ties among them and spurring collective action.

As an example, “...in 1967, a network of tobacco control scientists and activists coalesced around the first World Conference on Tobacco or Health, 3 years after an influential US Surgeon General’s report unequivocally stated the harm caused by smoking. In the 1990s, tobacco control proponents from around the world augmented their networked activities around the negotiations of a global treaty on tobacco control—an idea that had been created and promoted by leading network members. During the treaty negotiations, the network brought together dozens of NGOs working on the issue, leading to the creation of a formal network organization in 1999—the Framework Convention Alliance (FCA).” Currently, the “FCA functions as a formal coalition of NGOs around global tobacco control treaty; over past decade, expansion and decentralization of network including new funding partner networks, regional networks, and national-level coalitions.”

By contrast the alcohol harm network has consisted largely of only researchers, linked by an understanding of alcohol harm as a threat to public health. They have faced other groups that view the issue not as a public health but as an individual behavioral or medical problem. Narrow network composition as a result of a lack of consensus across like-minded groups on the nature of the problem has hampered advocacy and is one reason for inadequate resources and national policies to address alcohol harm. *"The Global Alcohol Policy Alliance formed in 2000 brings together more than 200 alcohol policy and public health advocates from about 30 countries, in effort to broaden the network beyond Europe and North America."*

In terms of factors shaping network emergence, both the tobacco and alcohol networks had leadership through individual mobilizers and were able to frame the issue in the way the public understood. The alcohol network, however, lacked global agreements and new information on the scope of the problem, both of which were present for the tobacco network. Public health framing competes with individual behavioral and medical framings.

Whereas for tobacco use, the coalition was relatively broad, with researchers and advocates from high and low-income countries, the alcohol coalition was narrow, largely with researchers from high-income countries. Whereas for alcohol, the issue was framed as a public health threat with industry as the vector of the disease, alcohol, the public health framing competed with individual behavior and medical framings.

Shiffman et al. concluded that:

- Global health networks play major agenda-setting and policy development roles, particularly by influencing how problems and solutions are understood and by recruiting new actors to address the issues that concern them.
- Global health networks are most likely to produce effects when:
  - (1) *"Their members construct a compelling framing of the issue, one that includes a shared understanding of the problem, a consensus on solutions and convincing reasons to act and;*
  - (2) *(2) They build a political coalition that includes individuals and organizations beyond their traditional base in the health sector, a task that demands engagement in the politics of the issue, not just its technical aspects."*

They note, however, that maintaining a focused frame and sustaining a broad coalition are often in tension: effective networks find ways to balance the two challenges.

## Evaluation of Communities

The model by Bertone et al. [6] provides a useful framework through which to assess a community that is focused on health policy. In developing the model, Bertone et al. reviewed 25 key papers related to CoP assessment. Using this framework, it is possible for a community to periodically conduct a self-assessment of each of the six components of the community's actions as well as what Bertone et al. refer to as spill-over effects (e.g., individual behaviors) in order to identify both progress and under-used resources and knowledge.

**Component 1: Available Resources.** There are four critical resources for communities to have in order to function effectively. They include:

1. Knowledge resources, including expertise of members; access to journals, as well as other knowledge platforms;
2. Time resources, that members choose to spend in the community activities, as well as time their organizations permit members to spend on community activities;
3. Financial and material resources, including funds, meeting space, materials and web space;
4. Political resources, the involvement of key organizations, as well as the recognition and reputation of the community.

**Component 2: Strategies to Mobilize Resources.** The authors see the core group of facilitators of the community as critical in mobilizing resources. They identify four key tasks in this regard that are explained in detail above, but are again listed here.

1. Clarifying the domain of focus;
2. Cultivating the community dimension of the CoP;
3. Aligning the CoP's activities and products to individual and organizational expectations and benefit;
4. Choosing and adopting relevant ICT.

**Component 3: Knowledge Management Processes.** The quantity, quality, and relevance of CoP activities are assessed including: workshops, online discussions, webinars, as well as interactive processes, such as, private emails, calls between members, and informal meetings. The key question is, do such activities focus on improving the repertoire of practices.

**Component 4: Expansion of Knowledge.** Knowledge management processes that bring about the expansion of knowledge include:

1. Different types of knowledge, implicit, explicit, scientific evidence, field experience, expert opinions;
2. "Knowing" that is potential (stored in the form of knowledge capital) or fully applied;
3. Knowledge at the individual or collective level.

**Component 5: Knowledge-based Policies and Practices.** The key objective is that policy decision and implementation practices have a sounder base. But evidence in health policy is often partial and context-based. The assessment must be able to discern when the views of dominant members create greater certainty than exists in the evidence. And the assessment must look for practices in the community's interactions that encourage dissident opinions and that support self-reflection.

**Component 6: Better Health and Welfare Outcomes.** The authors acknowledge that it would be helpful to be able to measure whether practices lead to improved outcomes and reduced health inequalities. They however recognize that it is difficult to measure the proportion of change that could be assigned to a CoP.

The authors note that the methodology of the assessment might differ for each component. They have provided indicators and questions relevant for each of the elements of the conceptual framework.

Wenger et al. [1] in their article "Promoting and assessing value creation in communities and networks: a conceptual framework", also provide a framework on which to build an assessment for each of five "cycles":

#### **Cycle 1. Immediate value: Activities and interactions**

- For communities, this includes activities such as helping a member with a difficult case during a meeting, a useful conversation online, a good tip provided by a colleague, a story about something that went wrong, a visit to another location, or conducting a small research project.
- For networking, this cycle includes meeting someone, getting an address, connecting, asking a question of the network, passing a piece of information along, or giving input.

#### **Cycle 2. Potential value: Knowledge capital, which can take several forms:**

- Personal assets (human capital): such as a skill, or a key piece of information;
- Relationship and connections (social capital): The ability to ask questions because one knows who to ask and who to trust, which can be as valuable as personal information or commitment;
- Resources (tangible capital): Access to documents, tools and networked information sources;
- Collective intangible assets (reputational capital): Reputation of the community or network;

- Transformed ability to learn (learning capital): Participating in a facilitated network or community, which can be enlightening for people for whom formal training methods have always been the only way to learn.

### **Cycle 3. Applied value: Changes in practice**

Leveraging capital requires adapting and applying it to a specific situation. For instance, reusing a lesson plan or a piece of code, exploiting synergy between business units, changing a procedure, or implementing an idea.

### **Cycle 4. Realized value: Performance improvement.**

Reflect on what effects the application of knowledge capital is having on the achievement of what matters to stakeholders, including members who apply a new practice.

### **Cycle 5. Reframing value, new framework**

Value in this cycle is achieved when social learning causes a reconsideration of the learning imperatives and the criteria by which success is defined.

For each cycle, Wenger et al. provide a list of indicators coupled with storytelling related to the indicators. The authors note:

*"The idea is to leverage the complementarity between stories and indicators. As stories traverse the cycles, they are likely to refer to elements that are also monitored as indicators at each cycle, such as exciting conversations, oft-downloaded documents, interesting new practices, or relevant measures of performance. In the process, stories substantiate indicators, give them life, and make them more meaningful by connecting them into more extensive processes of value creation."*

*"Conversely, when used as a proxy, the significance of a good indicator is that it is a short-hand for a set of imagined value-creation stories. For instance, if a document has been downloaded a large number of times from a community website, one can assume that there exist a number of value-creation stories running through that document."*

## **Recommendations**

The literature review helped to identify some critical elements to build upon for the construction of a conceptual framework for QUHC Learning Laboratory.

**Terms:** Each of the terms “community,” “community of practice,” “learning network,” “network,” and “learning laboratory” carries with it a number of connotations. We found no literature related to the term “learning laboratory” within health care communities or communities in general (excepting the USAID website). WHO may want to consider using the term “learning network” which, according to the literature review may more aptly convey the intentions of the Learning Laboratory for Quality UHC, rather than either “learning laboratory” or “community.” However, if any term other than “community” or “community of practice” is used, we recommend it be accompanied by a description to insure that it carries the intended meaning.

**Stages of Development:** Communities appear to develop through a series of stages that follow a recognizable pattern. The pattern implies that each stage needs to be supported and the actions of leaders conform to the stage of development. Although the patterns identified in the research differ in the number of stages and the labels, all moved through the following pattern:

- Focus on activities that benefit individual members and their organizations, such as solving local problems;
- Build a shared context and learning agenda;

- Reorient to focus on the external environment.

The first stage of community life, that is, generating value for its members, is critical for future development. Even when a community has moved to another stage, there is a continuing need for individual members to benefit from the activities of the community. To quote Bertone et al. [6] a CoP “*not generating value for its members in an efficient manner loses support and may even disappear.*”

**Success Factors:** Success factors of communities include:

- Active leadership that helps the community become effective and promotes the community externally;
- The existence of a core group of members that are fully engaged;
- Establishment of trust and motivation to share information;
- Setting aside time periodically to review the group’s progress and ways of working;
- Goal congruence between members and the network;
- Find ways to influence industry— seeking to purposefully influence the behavior of others who were not initially a part of the learning network;
- Hold formal meetings of the community monthly either virtually or face-to-face.

Global health networks that influence policy are most likely to produce effects when: 1) They construct a compelling framing of the issue, one that includes a shared understanding of the problem, a consensus on solutions and convincing reasons to act; and 2) They build a political coalition that includes individuals and organizations beyond their traditional base in the health sector.

A network in which members share an intent and focus, but do not share the same repertoire of practice (e.g., researchers, policy makers, academics, and practitioners) requires greater time and intent to build a shared language, trust, and relationship between members. This is most effectively accomplished by bringing members together in a face-to-face setting both initially and periodically during the life of the CoP.

A network in which members share an intent and focus, but do not share the same repertoire of practice (e.g., researchers, policy makers, and practitioners) need to set aside time for self-reflection as the community develops and changes, both to ensure that the evidence the network is producing is not overly influenced by dominant members and that dissenting views can be freely voiced.

**Evaluation:** Two frameworks for evaluation are available; both include a list of indicators [1, 6]. Wenger et al.’s model also employs stories connected to the indicators [1].

## References

1. Wenger E, Trayner B, de Laat M. 2011. “Promoting and assessing value creation in communities and networks: a conceptual framework.” Report 18. Open University, Ruud de Moor Centrum.
2. “Practices of Successful Learning Networks: Documenting Learning from the GROOVE Learning Network.” August 2013. Knowledge-Driven Microenterprise Development (KDMD) project, implemented by the QED Group, LLC.
3. Gongla P, Rizzuto C. 2001. “Evolving communities of practice: IBM Global Services experience.” *IBM Systems Journal* 40:842-862.
4. Dixon N. 2006. Developmental Stages of COPS: Oil Company Case Study, *Develop*.

5. Agrawal S, Joshi K. "A Review of Community of Practice in Organizations: Key Findings and Emerging Themes. Proceeding of the 44<sup>th</sup> Hawaii International Conference on System Sciences." 2011.
6. Bertone M, Meessen M, Clarysse G, Hercot D, Kelley A, Kafando Y, Lange I, Pfaffmann J, Ridde V, Sieleunou I, Witter S. 2013. "Assessing Communities of Practice in health policy: A conceptual framework as a first step towards empirical research." *Health Research Policy and Systems* 11:39.
7. Shiffman J, Schmitz H, Berlan D, Smith S, Quissell K, Gneiting U, Pelletier D. 2016. "The emergence and effectiveness of global health networks: findings and future research" *Health Policy and Planning* 31:i110–i123.
8. Gneiting U, Schmitz H. 2016. "Comparing global alcohol and tobacco control efforts: network formation and evolution in international health governance." *Health Policy and Planning* 31:98-109.
9. Roberts J. 2006. "Limits to Communities of Practice." *Journal of Management Studies* 43:3.
10. Ranmuthugala G, Plumb J, Cunningham F, Georgiou A, Westbrook J, Braithwaite J. 2011. "How and why are communities of practice established in the healthcare sector? A systematic review of the literature." *BMC Health Services Research* 11:273.
11. McDonald P, Viehbeck S. 2007. "From Evidence-Based Practice Making to Practice-Based Evidence Making: Creating Communities of (Research) and Practice." *Health Promotion Practice* 8(2):140-144.
12. Stuckey B. 2004. "Making the most of the Good Advice: Meta-Analysis of Guidelines for Establishing an Internet-Mediated community of Practice." Paper presented at the IADIS Web-Based Communities Conference, Lisbon, Portugal, March 2004.
13. Peters LD, Johnston WJ, Pressey AD, Kendrick T. 2010. "Collaboration and collective learning: networks as learning organisations". *Journal of Business & Industrial Marketing* 25(6):478-484.
14. Crisp N. 2014. "Mutual learning and reverse innovation—where next?" *Globalization and Health* 10(14).

## Appendix 2: Interview Guide for Key Informants of Selected Learning Networks

Web research on the learning network (to be conducted prior to the interview)

Name of the learning network (LN)	
When founded	
Stated purpose or objectives of the LN	
Is the LN open or closed?	
Website? If yes, identify the structure of the website	
Listserv?	
Online discussion forums or message boards?	

Questions by Interview Topic
What is your elevator speech for how you describe the LN?
Interviewee's role in the network
<b>Recruitment/membership</b>
Who are your members?
How were they identified?
How are initial and/or new members identified or recruited?
Are there minimum requirements for entry into the LN? For staying in the LN?
Who approves membership?
How do people find out about the LN?
Is there a maximum number of participants? If so, why?
<b>Responsibilities/ expectations of membership</b>
Do members have to fulfill any actions to maintain membership (e.g., minimum participation level)?
Are members ever "un-membered"—kicked out or asked to leave?
<b>Mechanisms for learning and interaction</b>
How do members interact to learn from each other?
Are there in-person meetings? If so, how often?
How do members get to know each other?
How are the needs and interests of LN members identified?
What has the LN done to sustain member engagement or maintain interest in the LN?
<b>Governance</b>
Is there a governance structure? If so, what does it look like? (Ask if there is written charter—can get copy?)
How are decisions made?
Is there a core team? How many people, what are their roles?
Can members join the core team?
Is there a high-level sponsor? What role does he/she play in the network?

**Support Roles**

How many people support the LN?  
How much time does supporting it take? What takes the most time?  
IT support?  
Budget or level of effort?

**Documentation and products of the LN**

Does the LN regularly document its work or report on its work?  
Who is the intended recipient of the reports/documentation?  
Who does the documenting?  
Does the LN create synthesis products of what has been learned?  
If so, how are these created?  
Who defines the products?  
Does the LN have a repository?  
How are contributions vetted/promoted?  
How does the LN ensure the integrity of contributions?

**Parting questions**

How has the network evolved over time?  
What about the network are you most proud of?  
What is your key advice to someone starting a new network?  
What have I not asked about that would be helpful for us to know as we design this new network?

### Appendix 3: Learning Networks of the Key Informant Interviews

African Partnerships for Patient Safety (APPS)
<p><b>Purpose:</b> The Partnerships were a two-year twinning arrangement of hospitals in developing countries and hospitals in Europe. A web platform was created to support the partnerships, with a main platform on the <a href="http://ezcollabs.org">ezcollabs.org</a> website and six regional patient networks.</p> <p><b>Recruitment of members:</b> Hospitals were selected, and staff in these hospitals became members of the website. Other were recommended by existing members or WHO staff.</p> <p><b>Responsibilities/expectations of membership:</b> There is no requirement for how to participate to remain a member and on the listserv.</p> <p><b>Mechanisms for learning and collaboration:</b> Members could post comments and resources on the website, and there were discussion boards. Patients were particularly active on the discussion boards in the regional hubs. WHO also convened three in-person workshops which brought together representatives from the paired hospitals during their two-year partnership.</p> <p><b>Support roles:</b> One staff member supported the website and regional hubs, and each regional hub had a regional technical moderator.</p> <p><b>Documentation and products:</b> WHO staff developed annual reports about the APPS. One product co-developed by 5-6 members was an engagement strategy and advocacy tool.</p>
Commonwealth Health Hub ( <a href="https://www.thecommonwealth-healthhub.net">https://www.thecommonwealth-healthhub.net</a> )
<p><b>Purpose:</b> The Commonwealth health hub is a knowledge-sharing initiative provided by the Commonwealth Secretariat. It aims to provide a virtual “one-stop-shop” service center to support health policymakers and professionals across the Commonwealth who are concerned with improving national policies and practice that can help countries achieve their health and wellbeing goals.</p> <p><b>Recruitment of members:</b> The core membership of the Health Hub is about 750 members from 53 countries. About 150 of these are High Commissioners and senior MOH officials who receive only the digest of the threaded discussions via email. In addition to these official members, there are about 600 other people who joined the community or who were suggested by their bosses—Chief Medical Officers, MOH staff, WHO Country Offices, professional bodies, regulatory agencies, etc. Initially, the group was populated with officials Commonwealth Health officials, who were also asked to nominate others to be added to the listserv. Individuals can apply to join online; applications must be approved by the moderator.</p> <p><b>Responsibilities/expectations of membership:</b> There is no requirement for how to participate to remain a member and on the listserv. Member must agree to a Membership Agreement to ensure that the Health Hub and Community of Practice provide a positive and constructive service to all its members.</p> <p><b>Mechanisms for learning and collaboration:</b> The Health Hub currently sponsors “Community Discussions”—time-limited, moderated threaded discussions with one topic for 2-4 weeks of comments (first community discussion was launched in March 2016). They will soon be launching a “Service Center” where member can download tools and resources, country profiles, health policies and plans (searchable by Commonwealth country), expert referrals (how member countries can access the Commonwealth Fund for TA), and collaboration. Through the Community Service Center, members will be able to ask for recommended resources; comment on draft policies and projects; and engage in discussions to identify insights.</p> <p><b>Support roles:</b> There are two full-time staff of the Commonwealth Secretariat who support the Health Hub: one moderates the discussions, writes the framing text and questions, and summarizes the discussion. The other facilitates the listserv and approves member applications.</p>

**Governance:** The Commonwealth Advisory Committee on Health thus does not directly oversee the activities of the Health Hub, but they do set directions/priorities for the Health Unit, which indirectly affects what the Health Hub focuses on. The Advisory Committee on Health set the priorities for the Health Unit of access to UHC, health security, and NCDs, so these are topics that the Health Hub will be expected to address in some fashion.

**Documentation and products:** The final report on their first community discussion on global health security will go out to the full list of 750 members. It will cover the discussions held in the COP and have some reflection. The draft is currently 6-7 pages. Each report will be uploaded to the hub site and over time a suite of reports will build up. Not sure what will happen with them down the road. May create space for each of the thematic areas: global health security, UHC, NCDs, as needed. May bring the reports together to make a book.

### Financial Access to Health Services CoP (<https://hhacops.org/fahs>)

**Purpose:** This CoP began in 2009 and is intended to facilitate the exchange of information and ideas among individuals in Africa committed to increasing financial access to health care. It is not an official network of designated country representatives. The COP was created to be a non-bureaucratic mechanism for professionals to communicate on the topic.

**Recruitment of members:** Members come through word of mouth and from events like regional conferences where the CoPs are promoted and information shared on how to sign up. People participate as individuals, not necessarily speaking for their institution. There are about 950 members in the Financial Access CoP and about 7000 members of the HHA CoPs overall (the HSD community had 1423 members as of 4/8/2016). Many people are members of more than one CoP, but most have a “main” CoP. The CoP does not have any hierarchy which works for most members. There are no requirements for entry other than completing the online application stating the reason for wanting to join. The facilitators approve membership. It is a bilingual CoP, with about 70% of the conversation in French and about 30% in English. The three facilitators are bilingual, but Allison does most of the French to English translation.

**Responsibilities/expectations of membership:** There is no requirement for how to participate to remain a member and on the listserv.

**Mechanisms for learning and collaboration:** The main mechanism for conversation is the listserv. The discussions emerge organically—sometimes originating with a facilitator, and sometimes with a query from a member. All comments are moderated (that is, must be approved by one of the three facilitators). Like the HSD CoP, the FA CoP also does collaborative projects: an idea comes up on the conversation, and there are calls for who wants to participate or work on it. Members, including those representing aid agencies or NGOs, can suggest collaborative projects and are encouraged to send information to the facilitators or publish an application on the website. The COP also takes advantage of regional events (especially of African Health Economics and Policy Association—AfHEA—which has a biannual conference) to hold an annual workshop of the facilitators of all the HHA COPs and the core groups associated with the RBF and EBPB COPs (about 25 people in all). Last year, some of the members of the HHA decided they wanted to create country hubs that would allow country-specific conversations across all of the thematic areas of HHA CoPs. A group in Benin and a group in DRC decided to create country hubs. The Benin hub meets mainly in person. The DRC hub connects mainly virtually, since they are spread out around the country.

**Governance:** The FA CoP does not have a formal governance structure. It has a mutual understanding among the three facilitators. For the HHA Communities, the governance structure is fairly informal. They have made it a practice to hold an annual workshop with all the CoP facilitators and core groups. The facilitators of the three main CoPs are in regular communication.

**Support roles:** The three moderators are paid 30-50% time by UNICEF, although this funding ends in 2016.

**Documentation and products:** They are required to provide an annual report to UNICEF for its funding. At the end of a particularly lively discussion, one of the facilitators tries to write up a short synthesis of the main points made in conversation. These are archived on the CoP website and highlights are shared in the annual report.

### **Global Reading Network (<http://globalreadingnetwork.net/>)**

**Purpose:** The Global Reading Network brings together donors, practitioners, government officials, national and international civil society organizations, and other stakeholders committed to improving reading outcomes for primary grade children around the world. With support from the United States Agency for International Development (USAID) and other key donor and development partners, the Network collects, develops, and disseminates evidence-based practices to increase the impact, scale, and sustainability of primary grade reading programs.

**Recruitment of members:** The Global Reading Network (GRN) currently only has subscription to network with 1,600 listserv subscribers. The listserv sends out announcements for webinars/workshops and monthly newsletter. New subscribers are recruited at conferences and events.

**Mechanisms for learning and collaboration:** REACH project is quite active and it is the funding mechanism to make GRN successful. They hold webinars (mostly trainings) monthly and topics are decided by USAID and steering committee members and are a blend of in person and online (40 countries represented in the webinars) and REACH has the money to do in person trainings in the field, which they are planning to do in conjunction with international conferences or regional meetings. Also supposed to do 2-3 international conferences and the first will be on international literacy day in September in DC. The GRN also has task teams though they have not yet completely emerged.

**Governance:** In May 2014 USAID, URC and other similar organizations met and in a few months had drafted the GRN charter for the steering committee and set up working groups: policy, evidence, practice to focus on for the first few years of the network. The core group in the beginning converted into steering committee. There are co-chairs that change after 2 years (currently, one is from the World Bank and one is from Save the Children).

### **Health Service Delivery CoP (<https://hhacops.org/cop-hsd-pss-bilingual?ReturnUrl=%2fcop-hsd-pss-bilingual%2fdiscussions>)**

**Purpose:** HSD COP is to empower local actors in Sub-Saharan Africa, especially at the health district level, in improving the performance and quality of health services. Launched in 2009, the HSD CoP was an attempt to break down silos between district officials, program managers, health professionals, researchers, policymakers and international organizations, to create a platform where they come all come together to discuss issues of interest. It was created as a bilingual community, with posts in French and English.

**Recruitment of members:** The HSD CoP is nominally closed to members, but the threshold for membership is very low, such that anyone can sign up. The HSD CoP has 1423 members from 76 countries. The countries with the largest number of members are: Burkina Faso (204), Senegal (141), Ivory Coast (82), Cameroon (81), Uganda (59), Democratic Republic of Congo (53), and Belgium (50). Members are a mix of health professionals, policymakers, technical agencies, and donors.

The facilitator promotes the HSD CoP with senior MOH officials and explains what benefits come from the network in terms of sharing information and opportunities for collaboration and much of the COP's growth is due to snowball effect of colleagues telling other colleagues about it.

**Responsibilities/expectations of membership:** There are no explicit requirements of membership. Members are encouraged to contribute to the discussions, but there are no minimum expectations.

**Mechanisms for learning and collaboration:** There are six mechanisms through which members connect and share: 1) *Blog*: The blog is posted on the site <http://www.health4africa.net/> which is managed by the Institute of Tropical Medicine Antwerp- Belgium with funding from the Belgian Federal Cooperation and UNICEF. Blogs can be written by members, and are often invited. Basile asks people to write blogs to share work they are 2) *Newsletter* published in French using MailChimp. The newsletter is published by the Institute of Tropical Medicine and is called *Politiques Internationales de Santé* (PIS) with an English version known as *International Health Policies* (IHP) newsletter which is sent out to subscribers via MailChimp. The newsletter is sent out every 2-4 weeks by a staff member of the Institute of Tropical Medicine. The newsletter is posted on [www.santemondiale.org](http://www.santemondiale.org). 3) *Online discussion forum* on <https://hhacops.org/cop-hsd-pss-bilingual> (described above). Sometimes the HSD COP promotes themed discussions which might go on for 3 or 4 weeks. 4) *Research and publications*: The HSD CoP distributes key guidelines and documents, often at the initiative of the Facilitator. The HSD CoP developed proceedings/reports coming out of their conferences and workshops. These are posted in the Library section of <https://hhacops.org/cop-hsd-pss-bilingual> and also in the Resources section of <http://www.health4africa.net>. 5) *Face-to-face events* like the Regional Conference on District Health Systems held in Dakar, Senegal in November 2013, and a workshop held in Cotonou, Benin in December 2015 on using ICT to improve health district management. These events receive other funding from donors (UNICEF, WHO) and partner organizations (Institute of Tropical Medicine). 6) *Collaborative projects* like an ongoing one in Benin and Guinea called “Projet de Mobilisation 2.0 des Equipes cadres de district (Mob 2.0)”. One is about performance improvement at the district level using a structured online self-assessment process which in turn provides ideas on how to address gaps found, and allows for comparison of information across districts.

**Governance:** The lead facilitator does most of the moderation (90%). UNICEF provides some funding for the HSD CoP, paying for some of the facilitator's time, as well as funds for travel to meetings and some time for IT, newsletter publication (using MailChimp), and facilitation support from the Institute of Tropical Medicine of the University of Antwerp.

**Documentation and products:** The facilitator and colleagues from the Institute of Tropical Medicine and others involved in the main events have developed reports or proceedings from these that have been posted on the various websites. Every two months, they submit a report to UNICEF reporting on the activities of the CoP in the past two months. Usually the reports are 3-4 pages.

### Joint Learning Network (<http://www.jointlearningnetwork.org/>)

**Purpose:** The JLN is a network of policy makers and practitioners from 25 member countries working in institutions to lead charge in universal health coverage and face challenging issues, such as implementation and reform. Once countries have policy commitment they often face numerous challenges across a range of issues and “how to” questions that lend themselves to a joint learning approach and codifying that can be used by many.

**Recruitment of members:** The JLN works with a membership model. Countries join one of 2 tiers of membership: Full, which is the original 9 countries, means they have set up a country core group (CCG) which is a multi-stakeholder group that captures and translates learning. Full members have opportunity to have seat on governance structure; have access to funded travel for certain workshops; access to the JL fund. 2nd tier is Associate. These countries can participate at their own expense.

The CCG structure is to set up a process of collective decision making. CCG TOR specifies that there needs to be strong leadership. The JLN gives guidance on forming the group.

The purpose of the CCGs is to: 1. Feed up to global network their priorities; 2. Serve as the vehicle through which global knowledge gets translated back to country as they are tapped into the political and reform process in the country.

**Mechanisms for learning and collaboration:** At the global level the Steering Group sets priorities of JLN, 4 goals that support UHC progress in countries: expand coverage to priority populations, Primary Health Care, improving quality, and increasing financial sustainability. Priorities get mapped with funding, then an initiative or collaborative process is born overseen by the Steering Group. Each activity has its own facilitation team.

The main approach is collaborative and these take different forms. To start, a country expresses interest in being involved in a particular area so they come together with a challenge in mind and together the group drills down on a particular challenge they want to work on and define what they want for their country and what kind of product they want to make (checklist, tool kit). Over time they work together to build out the product. Facilitators structure and frame and document conversations and the knowledge that comes out goes into the tool. Countries will test and pilot tools and feed back in to the group and refine product.

**Documentation and products:** Over the last year, a number of products have been finalized. 65% of community members said they had adapted the tools and used them in their own context.

One such product is a 200-page costing manual tool. It was launched and then hugely downloaded in Ethiopia (they later joined JLN) and Egypt is asking for more support to do costing reforms and adapt the manual to their context. The JLN has developed a training of trainers on the costing document to help disseminate it and help countries use it. They are working on a bite-sized learning product with interview and video that will drive people to the product if they want to delve more deeply.

### **Management Sciences for Health (MSH) Technical Exchange Networks (TENs)**

**Purpose:** Technical Exchange Networks (TENs) are MSH's main peer-to-peer knowledge exchange with 3 goals: 1: to increase access to information; 2: to connect the global community; and 3: to provide information for staff to take action. TENs began in 2009 with HIV, while most other groups started in 2012-2013. TENs are focused on specific technical areas relevant to MSH staff, such as HIV, Healthcare Financing, and Gender & Youth.

**Recruitment of members:** The TENs are comprised entirely of MSH staff around the world. Staff are not required to join any and are not required to pick one in the area they work. However, they are encouraged to join 2-3 and are discouraged against trying to be part of all of them (in order to prevent email overload).

**Responsibility/expectations of membership:** There are no specific expectations or requirements for members other than that the TENs are relevant to current work or an area of professional development.

**Mechanisms for learning and collaboration:** The TENs are a listserv-based group, using the Knowledge-Gateway platform. In larger TENs, they mostly send information and sometimes these generate discussion, but the proportion of posts that actually become discussions can be low (e.g. 25%). In the smaller TENs, usually under 50 members, like healthcare financing and gender and youth, there is a greater proportion of discussions. Both number of posts and proportion of discussions are important metrics for the TENs. When there is a meeting or conference coming up, they will ask who is going and if they can share notes. Interactions in the smaller TENs tend to be more informal. In the MNCH TEN, there was a self-sustained month-long discussion on female genital cutting in which people shared opinions, personal stories, gently dissenting opinions and more. The co-chairs ended up holding a meeting on the topic because interest was so high. The M&E TEN has many members but very practical in terms of sending information that does not usually turn into a discussion. Data

visualization is a topic that repeatedly comes up so a seminar on data visualization was held with access to many resources.

At HQ, they have been having "#TENdays" in the office café, during which MSH staff can come, enjoy snacks, and discuss various topics, including how they use the TENs and what is being discussed through the TENs.

**Governance:** There are 3 HQ-based co-chairs who coordinate, one of whom is the Global Administrator in the Performance, Learning and Impact (PLI) unit. Messages are not moderated unless they are shared by someone who is not part of the specific TEN they are sending the message to. TENs are very organic without appointed leaders.

**Support roles:** There is a 5-person coordinating group (including staff from PLI, the two technical groups, and internal communications). The Global Administrator sees to the functioning of the TENs as communities of practice and provides troubleshooting technical support.

**Documentation and products:** There is no requirement for TENs to produce products. However, the Leadership Development TEN did a crowdsourcing exercise asking if members wanted to participate in developing a booklet on leadership. Using Google Docs they worked together to create the booklet (<https://www.globalhealthknowledge.org/blog/crowdsourcing-abcs-managers-who-lead>). A proposed product is under development in the Gender & Youth TEN.

### Mental Health Innovation Network (<http://mhinnovation.net>)

**Purpose:** This community of mental health innovators - researchers, practitioners, policy-makers, service user advocates, and donors from around the world – seeks to share innovative resources and ideas to promote mental health and improve the lives of people with mental, neurological, and substance use disorders.

**Recruitment of members:** People find out about the network by word of mouth and through existing members, many of whom are mental health champions. The network is also promoted at mental health conferences, including two yearly events sponsored by Grand Challenges Canada.

**Responsibilities/expectations of membership:** There is no requirement for how to participate to remain a member and on the listserv.

**Mechanisms for learning and collaboration:** The website managed by the London School of Hygiene and Tropical Medicine gathers standardized write-ups of mental health innovations, sponsors webinars, and promotes events and blogs by members through the listserv and a monthly newsletter. Members can also read the profiles of and connect with other members.

**Support roles:** Originally, a grant from Grand Challenges Canada supported two Research Fellows and one research assistant to support the network and the development of innovation case studies. Now they have a communication manager who develops policy briefs, runs the network's Facebook and Twitter, etc., and a part-time knowledge exchange manager who manages the website content and the community moderation.

**Documentation and products:** The main product of the network has been the innovation cases, which involves a lot of back and forth with submitting organizations to achieve the standardized presentation of the innovation (1-2 days per case). The network has also sponsored innovation fairs at mental health conferences, to showcase innovations. The team at the London School has to submit semi-annual and annual reports to Grand Challenges Canada.

### Patients for Patient Safety (PFPS) Community of Practice

**Purpose:** The PFPS community of practice (CoP) is a global platform for communication and knowledge-sharing. The CoP facilitates PFPS advocates' (champions) discussion and networking, as

well as the sharing of ideas, successes, experiences and lessons learned. By sharing knowledge and experiences, PFPS advocates contribute to policy and initiatives aimed at promoting patient engagement in health care and improving patient safety worldwide.

**Recruitment of members:** To become a member, one must have participated in a PFPS workshop and must be part of the MOH-led patient safety group in their country. Members come into the CoP supported by host country organizations, so WHO is interacting with country level PFPS groups rather than individuals. Composed of 400 members from 56 countries and of different backgrounds. There is also a mailing list that has another 500 members.

**Responsibilities/expectations of membership:** There are no requirements to stay a member. They have only had to remove someone once. In 2015 they migrated from the original platform to the new one hosted by WHO. At that time, they asked people to resign up for the CoP if they wanted to continue participating. Those that did not were removed from the list.

**Mechanisms for learning and collaboration:** There is a CoP platform that is hosted by WHO and it allows all members to post comments and files but all posts are moderated. Members can share tools, resources, articles. Recently a member used the CoP list to conduct a survey for the development of a framework and received a lot of responses from member. New members tend to be more active because they are supported by a host organization moderator for each group. Moderators look after the network in each country, collect contributions, and report on behalf of the country. If country moderators don't contribute, there is the risk for them to be removed/replaced as moderator.

In 2013, they held a successful series of webinars with the support of members. These are now organized with the Canadian Patient Safety Institute (CPSI). The webinars are open to the public and recordings are posted on the public pages of the PFPS section of the WHO website. They are trying to do 4 webinars per year.

**Governance:** The advisory group for PFPS program is also the advisory group for the CoP. The group met in person in 2013 and have calls frequently. Two members per region currently serve and nominations are for 2 years. WHO pays for advisory group members to come to Geneva for an annual meeting.

**Documentation and products:** The CoP has not created any documents, but participants informed the development of The Global Framework on Patient and Family Engagement, so it will be a co-production, recognizing both the network and the members.

## Appendix 4: Other Learning Networks Examined through Web Research

### UNHCR Learn Lab: <http://innovation.unhcr.org/labs/learn-lab/>

**Purpose:** The Global knowledge and Learning Lab has been set up in 2012 under their executive office and by innovation unit leadership in collaboration with disaster platform (provides resources online for Humanitarian aspects) and education unit. The purpose is to create a culture of innovation with new opportunities for education specifically for refugees

**Recruitment of members:** There is online registration for external participants. UNHCR staff have automatic access. The platform provides profile of student and Learning profile based on the needs of student and follow the courses they have done and proposes recruitment, promotion and career development. Introduction of members by leadership academy. Profile of target audience: refugees, community, universities, students, staff

**Mechanisms for learning and collaboration:** They have 60 different events including workshops on education (in partnership with UNESCO and UNICEF), design thinking and external events. Joint summer School with University of Geneva. Their virtual Global Learning Lab/Center provides quality assurance on education programme (based on standards of UNHCR and UNESCO) and intervention assessment through peer to peer mechanism. Discussion forum through Emergency Network but only for collaborators of Global Learning Lab. They have a Fellowship programme on innovation. Members submit their application which describes innovation design process and support members until the Project is alive. They have an accelerator programme to promote creativity and reach level of scale. Impact evaluation of education programmes through mentorship. Evaluation of the scale-up. 10 challenges mechanism lead by education unit with support of DFID and UNICEF focus on refugees. They have a listserv, newsletter, and broadcast.

**Governance:** Based on consortium of universities (10 academics from over the world for high education level) and NGOs provide free access to refugee population (remote camps) to e-learning programme courses based on the relevance of the culture and local context. They provide certificate, diploma and degree with University of Geneva can be recognized at global and national levels.

**Challenges:** Some overlaps between these programmes and need to focus on synergies between different subject matters Solution to address these challenges: Knowledge map with different perspectives; Develop a framework for the consortium and bank of knowledge on this approach and engage universities to learn from previous experiences

**Support roles:** UNHCR have steering committee to review directions, actions, lessons learned and how to do next stages.

**Documentation and products:** There are case examples that follow the same format describing different experiences: define, identify, test, refine, scale-up. UNHCR 2014 Innovation Report: <http://innovation.unhcr.org/report2014/> The innovation.unhcr.org site also has an overview of the different Learn Lab projects I spoke about, along with all of the projects we support The Humanitarian Education Accelerator – see <http://www.he-accelerator.org/> UNHCR's Global Learning Centre - <https://unhcr.csod.com/client/unhcr/default.aspx> Disasterready.org – which has many great courses from partners globally.

### Kaiser Permanente's Innovation Learning Network: <http://www.innovationlearningnetwork.org/#home>

**Purpose:** The Innovation Learning Network is an organizational-based membership network made up of healthcare systems, health foundations, safety net providers, design/innovation firms, and

tech companies. Although their individual missions vary, all member organizations carry a common goal: to make healthcare better through good design.

**Recruitment of members:** There are 42 organizations that are members and employees of these organizations can join as individuals. As of 2010, there were 971 members.

**Mechanisms for learning and collaboration:** *Virtual sessions* The bulk of the sharing takes place during these sessions. Twice a month they hold hour-long “Virtual Thursday” webinars highlighting an innovation or prototype, with a focus not just on the content, but on the “innovation journey” as well. *In person meetings* where innovators learn skills and methods to push their thinking forward, and where lasting relationships are forged with other like-minded innovators. *Collaboratives* Small, self-organizing project groups that come together around a shared interest in a content area. Past groups formed around topics like Personal Health Records, Ambulatory of the Future, CareAnyWhere and Innovation Culture & Competencies.

**Governance:** A 4-person governance board that met quarterly with the ILN Director. They guide, nurture, and develop the strategy and direction of the network. The board members are also part of a 10-person Sponsor team who are champions of change, innovation, and design in their respective organizations. There is a group of 20 Network Weavers who are the network’s hubs, facilitating flow of information between their organizations and the network and create connections to transfer knowledge across systems.

**Support roles:** They are a member-led organization but are run by three employees (Director, Network Operations, and Network Experience Lead) from Kaiser Permanente.

**Documentation and products:** Annual publication “Insights” shares activities undertaken during the year and pieces written by members. They also produce reports on specific activities undertaken by collaboratives.

#### **USAID Learning Lab <http://usaidlearninglab.org/>**

**Purpose:** Learning Lab is USAID’s platform for generating and sharing information, tools, and resources on how development practitioners can work together to integrate learning throughout USAID’s Program Cycle. Here, USAID staff and partners jointly create, share, refine, and apply practical approaches to more effectively ground programs in evidence and quickly adapt based on new learning and changing contexts, thereby maximizing development outcomes.

**Responsibility/expectations of membership:** There are many groups formed on different subject areas (for example, KM reference group, program cycle network, evaluation interest group) and anyone can join. Members can propose new groups, but the member proposing the group must be willing to facilitate it, too.

**Mechanisms for learning and collaboration:** Learning Lab provides collaborative online spaces for international development professionals to build networks, identify good practices, and find solutions to problems. Currently there are 18 groups. The smallest has 5 members and the largest 179. The online spaces are intended to be member-driven and sustainable and the lab provides guidelines on facilitating the groups. Some groups are open to membership (2 of 18), some are moderated, the rest are invitation only. Group membership allows users to post new discussions, comment, and share resources with a small community of goal-oriented professionals. There is an “ask and answer” section for members to pose questions to USAID, though people from outside USAID respond to queries also.

**Documentation and products:** There are 590 resources currently available and they are a mix of community contributions and additions from USAID. Members are invited to submit resources.

## **Working Out Loud <http://workingoutloud.com/>**

**Purpose:** A Working Out Loud circle is a small peer support group in which you build a network of relationships toward an individual goal you care about. Working Out Loud is a practice that combines conventional wisdom about relationships with modern ways to reach and engage people. It starts with three questions: What am I trying to accomplish? Who can help me? How can I contribute to them to deepen our relationship? Instead of networking to get something, you lead with generosity, investing in relationships that give you access to other people, knowledge, and possibilities. Part of the process is learning ways to make your work visible and frame it as a contribution. Working Out Loud circles help you build your own network toward a goal you care about in 12 weeks. These small peer support groups are now in 16 countries and in organizations ranging from multi-national firms to universities to humanitarian groups. The thing they all have in common is wanting their people to feel intrinsically motivated to be more collaborative and effective.

**Recruitment of members:** People create circles based on their interest and need. Some are with coworkers and friends and others can be with strangers. It is recommended to form circles within companies for more benefits.

**Mechanisms for learning and collaboration:** A circle meets for an hour a week for 12 weeks, and a simple 2-page guide helps circles take small steps each week. 12 weeks is seen as long enough for people to develop new habits, and short enough so the effort is focused and sustainable. Circles are confidential and members provide detailed feedback on each individual's goals and progress. One member is the facilitator and the role is not managing the group as much as serving them: inviting members, organizing meetings, facilitating discussions in the meetings, nudging people who need to be nudged, and making sure no one is left behind. By the end, participants have developed a larger, more diverse network and a set of habits they can apply toward any goal. There are guides for each week of the process with suggested questions to ask and exercises to do as a group. It even includes how long each step should last. These are available under creative commons so they can be adapted.

**Governance:** Circles govern themselves. Within companies, management is meant to encourage the circles but not drive them.

## **CHW Central <http://www.chwcentral.org/> and <http://www.healthsystemsglobal.org/twg-group/5/Supporting-and-Strengthening-the-Role-of-Community-Health-Workers-in-Health-System-Development/>**

**Purpose:** CHW Central is an online community of practice that brings together program managers, experts, practitioners, researchers, and supporters of CHW programs. The website is a virtual meeting place to share resources and experiences and to discuss and develop questions and ideas on CHW programs and policy.

**Recruitment of members:** Members are self-selected and partner organizations can join.

**Mechanisms for learning and collaboration:** The CHW Hub is a product of the partnership between CHW Central and the Health Systems Global Thematic Working Group (TWG) on Supporting and Strengthening the Role of Community Health Workers in Health System Development. This thematic working group works to raise awareness of the crucial role that community health workers play within the health system; Bring together a diverse individuals and networks to share knowledge in a structured and facilitated manner; Convene practitioners and decision-makers in order to better understand the real world challenges being faced and encourage the use of the existing and emerging evidence base in policy and practice; Promote an institutionalized practice of monitoring interventions and evaluating results by all decision-makers and practitioners; and Amplify the voices of community health workers and community groups

within these dialogues. This work includes: supporting dialogue online; arranging events, for example at the Global Symposium on Health Systems; facilitating learning across the group, for example through webinars; supporting research; and publishing and evidence translation into products, which meet the needs of diverse audiences.

**Documentation and products:** The website houses announcements, information about meetings and events relevant to the members, content and archives including new research, best practices, policy discussions, etc.; resources; links; and the CHW HUB. The CHW HUB supported the publication of a special issue of the Human Resources for Health journal also.

#### **UNDP Global Learning Network**

[http://www.undp.org/content/undp/en/home/ourwork/capacitybuilding/focus\\_areas/focus\\_area\\_details4/pppsd/global-learning-network.html](http://www.undp.org/content/undp/en/home/ourwork/capacitybuilding/focus_areas/focus_area_details4/pppsd/global-learning-network.html)

**Purpose:** The Global Learning Network supports the aims of the PPPSD program at the global level. It aims to increase the effectiveness of local PPPs by providing the link between generating experience in the field and the analysis of this experience into resources which can be shared and used by others to strengthen their approach.

**Recruitment of members:** PPPSD actively seeks partnership with other organizations working in PPP for service delivery in order to share knowledge and develop resources which can be used to build the capacity of all stakeholders and inform future service delivery interventions.

**Mechanisms for learning and collaboration:** *Facilitate the exchange of public private partnership (PPP) experiences:* PPP for service delivery (PPPSD) promotes the exchange of PPP experiences by supporting workshops and other networking events which bring together those involved in PPP projects from around the world. PPPSD has hosted two such global networking events and plans to continue to seek to provide opportunities for local level practitioners to meet to exchange experiences to effect positive change. *Facilitate the development of PPP resources:* PPPSD actively seeks to mine knowledge from its local level experiences and to use this knowledge to produce resources which can be used in the field by all partners to a PPP project. They have produced a toolkit on PPPs at the local level, a lessons learned study covering all of their projects to date, and a number of other documents and resources detailing what they have learned in the field. *Develop PPP Professional Capacity:* To this end PPPSD developed training materials which have been used by a number of universities and training institutions around the world to train the next generation of PPP professionals as part of their degree requirements. These materials and the other tools that PPPSD has developed are available for use by any involved in PPPs.

**Support roles:** A global community of practitioners has been established to provide direct support through extending the knowledge and expertise of reputable practitioners, training institutions and centers of excellence at national and local levels. Some of these partners are playing a regional node role and are coordinating sub-networks to broaden the service delivery options and to contribute to bringing capacity development support where it is most needed at the national and local levels.



**USAID APPLYING SCIENCE TO STRENGTHEN  
AND IMPROVE SYSTEMS PROJECT**

University Research Co., LLC  
7200 Wisconsin Avenue, Suite 600  
Bethesda, MD 20814

Tel: (301) 654-8338  
Fax: (301) 941-8427  
[www.usaidassist.org](http://www.usaidassist.org)