



CENTER FOR
GLOBAL HEALTH
THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER
WASHINGTON DC



2011

Presence of Leadership and Management in Global Health Programs: Compendium of Case Studies

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Acknowledgements

This project was made possible through support provided by the Sustainable Management Development Program at the Department of Health and Human Service's Centers for Disease Control (CDC) and the CDC Foundation from contract number ECNS-906-26N. The project wishes to acknowledge the invaluable contributions of all participating key informants. In particular, special thanks to the information and resources provided by the United States Agency for International Development's Health Systems Division, The George Washington University's (GWU) Department of Global Health, Health Service Management and Leadership as well as the Department of Human Organizational Learning. The successful completion of this compendium would not have been possible without the dedicated efforts of the project research staff at the GWU Center for Global Health. Many thanks to Clifford Davison, Kate Wilson and Ekaterina "Katya" Noykhovich for the long hours of reviewing hundreds of documents and thoughtful contributions in summarizing the cases. Also, thanks to Melissa Ward for reviewing and editing hundreds of pages of text. The contents of this report express the views and opinions held by the authors and do not reflect the position of the Center for Global Health, GWU or its sponsoring agents.

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Recommended Citation

Peterson, E.A., Dwyer, J., Howze-Shiple, M., Davsion, C.Y., Wilson, K., and Noykhovich, E. (2011) *Presence of Leadership and Management in Global Health Programs: Compendium of Case Studies*. The Center for Global Health, The George Washington University: Washington DC.

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Acronym List

ACDI/VOCA	International Cooperative Development Association/Volunteer Development Corps
ART	Anti Retroviral Treatment
BPHS	Basic Package of Health Services
CCL	Center for Creative Leadership
CDC	United States Centers for Disease Control
CSOs	Civil Society Organizations
CMO	Chief Medical Officer
CPR	Contraceptive prevalence rate
DANIDA	Danish International Development Agency
DFID	United Kingdom Department for International Development
DOTS	Directly Observed Therapy-Short Course
EMR	Electronic Medical Record
GAVI	Global Alliance for Vaccines and Immunisation
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HIS	Health Information System
HMIS	Health Management Information System
HMN	Health Metrics Network
HSS	Health System Strengthening
IDSR	Integrated Disease Surveillance and Response
IMCI	Integrated Management of Childhood Illnesses
JHU	John Hopkins University, Bloomberg School of Public Health
JSI	John Snow Institute
KAP	Knowledge, Attitudes and Practice
L&M	Leadership and Management
LATH	Liverpool Associates in Tropical Health
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MOH	Ministry of Health
MSH	Management Sciences for Health
NCHL	National Center for Health Care Leadership
OVC	Orphans and Vulnerable Children
PAHO	Pan American Health Organization
PEPFAR	US President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PLWHA	People Living with HIV/AIDS
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-child Transmission
PPP	Public-Private Partnership
SMDP	CDC's Sustainable Management Development Program
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UN FAO	UN Food and Agriculture Organization
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNFPA	The United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

The past decade has been one of tremendous interest and support for advancing health on a global scale. Yet, funding is still limited for the scope of global health needs. There is growing awareness that well lead and managed global health solutions are required to achieve effective, efficient and sustainable health programs, especially at the scale needed to attain Millennium Development Goals and other global targets. As former CDC director William H. Foege points out, “lack of management skill appears to be the single most important barrier to improving health throughout the world.” Leadership and management practices create opportunities for improving program performance, strengthening workforce capacity, enhancing connections with target populations, and increasing the ability to respond effectively to change. Further, at a high level, leadership and management are essential to achieve country-ownership goals. The leadership and management capacity within national systems will be a key driver for effectively steering global health development into the future. While there is a strong understanding that good leadership and management are important, the evidence base for this assertion is sparse. The purpose of this project is to review the current evidence of the impact of leadership and management on health and to contribute to that evidence base through a case study series.

All programs have leadership and must be managed. Identifying the quantifiable difference that *good* leadership and management make on global health achievements and proving causation is complicated. As a result, the link between good leadership and management and health is still considered a “soft” science. Yet the for-profit business world offers evidence documenting impressive increases (two-30 fold) in productivity, profitability, and achievement as a result of investing in leadership and management (General Electric, 2010) (Lewin Group, 2003) (Motorola, 2010). Global health has some similar emerging evidence. There is recent research that demonstrates strengthening leadership and management capacity can increase health service delivery. In Kenya, coverage of key interventions increased 67% at the district level and 137% at the facility level two years after strengthening local management capacity (Management Sciences for Health, 2010). These changes led to increased health effects at the population level. While there is great potential for the impact of good leadership and management on health outcomes, it is unclear whether that potential is more generally applicable to the full range of global health outcomes. It is also necessary to discern what leadership and management practices contribute to improved health and how they can be successfully operationalized.

Over 300 documents were reviewed in the initial assessment of the “state of the evidence” of good leadership and management’s contribution to improved health outcomes. Only a few global health case studies were found; most very recent with the renewed emphasis on health system strengthening and results-driven programming in the global health policy arena. The background review informed the development of a conceptual framework. This meta-model linked the leadership and management principles to the program cycle and health effects. Researchers also consolidated identified leadership and management principles into 81 characteristics, grouped into twelve leadership and management domains. The characteristics were applied in the systematic analysis of the case studies. The twelve domains were organized as follows (See [Appendix II](#) for domain and characteristic definitions):

Leadership:

- Scanning
- Community Engagement
- Setting Direction
- Governance
- Staff and Work Climate Development

Management:

- Planning
- Staffing
- Structuring
- Management Systems
- Monitoring and Evaluation

Cross-cutting:

- Commitment to Leadership and Management
- Leadership and Management Development

A single case in clinical medicine is often seen as a sentinel case; raising a hypothetical question that requires further evidence. The second step, in establishing evidence after a sentinel case is identified, is to collect and examine a series of cases. We applied this principle to the issue of leadership and management's impact on health. Over 400 successful global health programs were reviewed. A subset of these, that had sufficient documentation to assess leadership and management characteristics, was selected. The selected programs covered eight broad health topics (Chronic disease; Health leadership and management training; Health systems strengthening; Infectious disease; Maternal child health; Nutrition; Primary health care; and Specialty services), and 38 countries from all six WHO geographic regions. The 57 cases were analyzed in-depth and summarized in a management focused template, based on information available from desk reviews and key informants. Content analysis was used to determine retrospectively the reported presence in the program implementation of the previously defined 81 leadership and management characteristics.

Each case study also documented the program's measure of success as well as the level and size of the impact. Program achievements were stratified into the following levels: health effect (i.e., changes in mortality or disease rates), increased service outputs (i.e., provision, access, and coverage or utilization of program services or health interventions), or improved processes (e.g., cost reduction, decreased wait times, increased operational efficiency, health workers trained, facilities built, etc.). The size of impact came directly from the reports and was usually reported as percentage change since onset of the program. The ranges of changes were categorized as improvements in process, service delivery outputs and health effects. Improvements for processes ranged from 46-483%, changes in increased service delivery outputs ranged from 125-571% and changes in health effects ranged from 61-175% increases. Finally, the cases were scored for strength of performance assessment (i.e., high, average or low based on how well the case measured and assessed activities and achievements). Only cases that explained how they measured their reported improvements were included and this information was captured in the strength of performance assessment. The case series shows repeated and strong association of applied leadership and management characteristics with very significant health improvements.

The database generated by the individual case study series was analyzed to identify the most and least commonly reported leadership and management characteristics. There are significant limitations in this retrospective analysis of a case series. Leadership and management are not systematically or always explicitly reported in published articles, though it was possible to infer the presence of some characteristics. Quality and quantity of applied leadership and management characteristics were also hard to discern. The largest limitation is that most of these cases were not designed as prospective application of leadership and management interventions. The "control" was primarily limited to the health or program status prior to the programmatic changes described in each case study.

Despite study limitations, there appears to be a set of leadership and management characteristics that are most prominent among these very successful programs. Leadership and management have always been a present and critical component of successful global health programming. The strength and consistency of the association between leadership and management characteristics and the significant health improvements seen in these 57 case studies suggests, but can't prove, causality.

Specifically, this research can be used by the CDC to demonstrate the potential health returns on investments made in strengthening leadership and management in global health programs. Additionally, the results should be used to encourage CDC staff and public health officials to regularly report on leadership and management methods in their health programs. Establishing standards such as required leadership and management

characteristics to be included in peer review methodologies will be an essential step in continuing to strengthen the evidence base. This report also offers value for global health leaders and managers more broadly. CDC's clients, ministries of health, and other ministries such as education can utilize this research in teaching health management principles and providing related technical assistance.

Future research should (1) validate standard ways of measuring leadership and management, (as we have begun to do in this study), (2) do a more in-depth analysis of a few notable case studies through interviews and other methods to ascertain the intentionality of application of leadership and management not verifiable in this study's review of documents alone, and (3) conduct controlled and/ or prospective leadership and management program improvements and measure the impact on outcomes.

Recommendations:

- Establish L&M reporting as standard of practice. This study would have been enhanced significantly if leadership and management actions were regularly reported in peer review reports just as we currently require sampling methodology and M&E methods to be reported as part of program methodology. We recommend including reporting of L&M activities explicitly in all program reports and peer review articles so future research will better be able to analyze their contribution to success and program managers will better be able to replicate successful programs that utilize L&M principles
- Publish the methods, newly defined L&M characteristics and domains and conceptual framework in relevant business and health management peer reviewed journals, to disseminate this work and incite discussion and agreement on the definitions and validity of the methodology and results
- Pursue further analysis of relevant case studies to see if these results can be replicated or L&M associations can be further delineated.
- Conduct and publish in-depth case study analysis that link L&M actions with health outcomes
- Design and conduct prospective controlled case studies to test the relevance and impact of specific or grouped leadership and management characteristics on health and to investigate the causal associations between L&M and health outcome
- Replicate successful programs to ascertain if successes also can be replicated

Leadership and management are at the core of achieving global health results. Particularly in the current climate of stagnating funding, it is increasingly critical that global health programs become efficient, effective, adaptable, and sustainable. The overall goal is to identify best practices in global health leadership and management that can increase the efficiency and impact of ongoing global health programming. If leadership and management make the difference suggested by this case series, then additional investments in building such capacity could reap great improvements in global health outcomes. The hope is to help practitioners to involve leadership and management principles in their global health programs by design, not default. There will need to be a stronger evidence base to elicit sufficient funding for leadership and management strengthening. Global health research must continue to build the evidence base so that program planners, health officers and policy makers can appropriately and intentionally leverage leadership and management skills to improve the efficiency, effectiveness, adaptability, and sustainability of investments in global health.

Chapter One: Introduction & Purpose of Project

Global health is now a global priority. The past decade has seen unprecedented growth in resources for various disease-based initiatives (such as the United States President's Emergency plan for AIDS Relief, or The Global Fund to Fight AIDS, Tuberculosis and Malaria). Resource commitments to improve the world's health have more than quadrupled over the past twenty years (Ravishankar, et al., 2009). Despite more resources, it has been difficult for many organizations to scale-up and achieve their desired health impacts. A key limitation along the path towards universal attainment of the Millennium Development Goals and other global targets is not just resource availability but also a growing need to strengthen other determinants of global health programming success (Filerman, 2003) (Friedman, Katz, Williams, Chee, & Lion, 2010) (Egger, Travis, Dovlo, & Hawken, 2005). While there is a strong assertion that good leadership and management are important determinants of program success, the evidence base for this principle is sparse. The purpose of this project is to review the current evidence of the impact of good leadership and management on improving health, and to contribute to the evidence base through a case study series.

Despite increases in funding for global health, funds are still limited compared to the scope of global health needs. Donors and practitioners want—and often require—these scarce resources to be strategically allocated for achieving the maximum benefit. There is growing awareness that well lead and managed global health solutions are required to attain effective, efficient, and sustainable health programs, especially at the scale needed to accomplish high level goals and targets. Too often despite, good intentions, programs do not always reach the global health impact intended. This is driving increased emphasis for better performance measurement. As programs learn to measure progress better and use this information, they find that their achievement potential is still limited due to lacking or weak support structures (e.g., management and administrative capacity, human resource development, and information management systems) (Filerman, 2003). Renewed attention is being directed towards overarching programmatic contexts that influence how well programs perform. While there is not yet agreement or robust evidence of which associated determinants best facilitate implementation success, funding streams for health systems strengthening have emerged, which possibly signal increased political will and awareness of the need to improve the global health operating environment. This current study and set of cases contributes to better understanding of some determinants within health system strengthening that can enhance progress towards achievement of the Millennium Development Goals.

There has been growing consensus that a barrier to even greater success in increasing effective health outcomes is the lack of management skill among global health implementers (Wagstaff & Claeson, 2004) (United Nations, 2005) (Katzachkine, 2004). As former CDC director William H. Foege points out, there is a strong belief that good leadership and management are important, as a “lack of management skill appears to be the single most important barrier to improving health throughout the world.” Consideration should be given to the way an implementing organization's leadership and management capacities impact its effective production of desired health outcomes. Skilled management is largely about deliberately allocating efforts and resources through processes that maximize desired outcomes. This suggests that good management is an associated determinant that can greatly influence achievement of health outcomes. Identifying the quantifiable difference that good leadership and management make on global health achievement, and gathering the evidence base is complicated. As a result, this area of study is still developing and some would argue that it is still considered a “soft” science. At present, it is unknown what specific management initiatives are worth a possibly significant investment to increase global health outcomes. Evaluating direct impacts of management on health encounters

obstacles as “it is difficult to directly attribute health service outputs and outcomes to leadership and management strengthening inputs and processes” (WHO, 2007, p. 12).

Quantifiable differences that various management strategies make have only been documented on a case by case basis from various “best-practice” organizations including:

- An evaluation from the Lewin Group of the Management Academy for Public Health showed \$2 million invested in training resulted in \$6 million in benefits (Lewin Group, 2003).
- In 2004, the Institute for Healthcare Improvement launched the 100,000 Lives Campaign. Over 3000 hospitals (80% of total US hospital discharges) participated and saved over 84,000 lives (McCannon, Schall, Calkins, & Nazem, 2006).
- Motorola estimated for every \$1 that it invested in TQM training, the company gained a \$30 return (Motorola, 2010).
- In 1998, GE undertook a quality improvement initiative utilizing the Six Sigma strategy. GE invested \$400 million, mostly for training and was estimated to derive \$1.2 billion in benefits (General Electric, 2010).
- Ameritech established the Network Leadership Development Program (NLDP) with goals of improving leadership skills, ability to manage in a competitive environment, and increasing productivity and quality. Ameritech gained a 79% return on this investment (Day & Halpin, 2001).

Although these findings demonstrate great potential for the impact of good leadership and management on programming, there is a need to establish the state of evidence that documents how these practices impact health outcomes. Building this evidence base will help identify what the best practices are that key program planners and health officers can use to improve the effectiveness of investments in global health programs.

Objective

This study reviewed selected global health programs to identify the presence of leadership and management characteristics, and what achievements resulted, to further the evidence-base of leadership and management within global health programming.

Research Questions

This research attempts to answer the following four questions:

1. What is the state of the evidence for leadership and management in the global health setting?
2. Are leadership and management theories applicable to global health organizations and programs?
3. What are the aspects of good leadership and management that make a difference in achieving global health outcomes?
4. What hypotheses can be generated from this research?

Chapter Two: Methodology Overview

This project conducted a literature review for evidence of leadership and management's impact on global health outcomes. It also searched for theories and models on leadership and management relevant for global health. This review also led to a conceptual framework on the relationship of a consolidated set of 81 leadership and management characteristics and the program process cycle. The 81 characteristics were used to score identified successful global health cases. This was done to determine the presence of leadership and management principles that may be critical components for global health success. Abbreviated methods are described below and a detailed version of methods can be found in [Appendix I](#).

Literature Review for Existing Evidence of L&M Impact on Health

The initial literature review began with a search of the OvidSP global health database which drew from 226 books and 525 journals with publications from 1973 to 2010. The review used keyword identifiers combined in variation using the terms "leadership", "management", "impact", "evaluation", "global health" and "program." The results were less than ten and deemed not germane. The reviewers then decided to look more broadly in journals with known examples of leadership and management reports. Again results specific to global health programming were limited.

Defining Leadership and Management Characteristics

Given the lack of evidence in the literature, the reviewers decided to explore the existence of leadership and management approaches within global health via a retrospective review of successful global health programs. The study looked for use of leadership and management principles within those successful projects. In order to do that, specific and clearly defined leadership and management characteristics were needed. The literature review above and key informant interviews were used to gather the many differing and variably defined leadership and management characteristics. A large contribution to the leadership and management characteristics was borrowed from Management Sciences for Health's Leadership and Management for Results model (MSH, 2005). Eighty one leadership and management characteristics were defined and then grouped into three leadership and management domains. (See [Appendix II](#) for domain and characteristic definitions) These were used to score the presence of leadership and management in the case studies.

Design of a Conceptual Model

In a parallel and interdependent process, leadership and management theories and conceptual models from global health and business sector were reviewed for their application to global health. A conceptual model was designed that brought together elements of commonly used global health frameworks and incorporated the identified L&M characteristics (See [Chapter 3](#)). This conceptual model and the identified leadership and management characteristics were then used to guide the case study review.

Identifying Case Studies

Successful global health programs were identified through a review of program documentation for documented changes in processes, service delivery, or health effects. Reviewers also met with key informants deemed knowledgeable in topics relevant to global health management (Appendix I). Some programs under consideration were provided directly from key informants, but most were found through a review of public website based materials. Programs were included whether or not they explicitly identified their actions as leadership or management initiatives. There was purposeful diversification of the cases to draw from varying parts of the world and to represent different health programming areas. Over 400 potential case studies were

identified and 150 had sufficient documentation to profile. For most cases, four to six documents, peer review journal articles or program reports were used to extract the case study synopsis. Sixty-six cases were coded into the case study template. Nine cases were later omitted as weak either in leadership and management or in the evidence of success. This report consists of 57 programs identifying promising practice global health programs that display and document leadership and management characteristics.

Scoring Case Studies

For each case study, program documents were reviewed to identify the presence of 81 leadership and management characteristics. Each characteristic was scored on a range of 0-2. A score of 2 implied that the characteristic was explicitly present and easily identifiable to the reviewer. A score of 1 meant that the trait was somewhat present, but less than explicitly listed. In this situation, content analysis inferred presence based upon other case study information. A score of 0 signified that the characteristic's presence was unknown based upon review of available materials. The reviewed case study documents are program documents limited in length. This implies that the identification of a characteristic signifies a principal that the program thought was important enough to mention in their reporting and may therefore be a key contributing factor towards the program's achievements. In turn, the increased presence of a characteristic in documents across multiple programs may suggest that the characteristic is a key determinant of good leadership and management practices in global health.

Each case also recorded the program's measure of success; as well as the level and size of the impact. Program achievements were stratified into the following levels: health outcome (i.e., changes in mortality or disease rates), increased service outputs (i.e., provision, access, and coverage or utilization of program services or health interventions), or improved processes (e.g., cost reduction, decreased wait times, increased operational efficiency, health workers trained, facilities built,, etc.). The size of impact came directly from the reports and was usually reported as percentage change since onset of the program. Finally, the cases were scored for strength of performance assessment (i.e., high, average or low based on how well the case measured and assessed activities and achievements). Only cases that explained how they measured their reported improvements were included and this information was captured in the strength of performance assessment.

Data Analysis across Case Studies

Using Microsoft Excel, a pivot chart was created from the leadership and management characteristics. Several ranking procedures were used to display ordered list of the most present characteristics. Highlights from those ranking are presented in [Chapter 5: Findings](#).

Chapter Three: Global Health Leadership & Management – State of the Evidence

Identifying Leadership and Management Aspects Relevant to Global Health Programming – “The State of the Art”

The project began with an extensive search for leadership and management theories, principles, and approaches that would be relevant to global health. Information represented the private sector, public sector, academia, and organization-specific strategies. The review also considered a wide variety of reports from health service organizations to corporate domains and private industry. The literature review looked at the currently available evidence on how and to what extent leadership and management might impact health outcomes. The presently available literature has few studies that directly link leadership and management to improved health outcomes. Many authors cited the challenge of the direct attribution. There are a few case examples that do show the intentional application of leadership and management to improved efficiency or outcomes.

Evidence from Private Sector & Health Programs

Table 1: Estimated % Improvements Found in Literature Review

Return on Investment		
Entity/ Case	RESULTS	% Change
Motorola/ TQM trainings	ROI Each \$1 invested in quality training earns \$30 in benefits	3000%
Management Academy for Public Health/ Management Trainings	ROI Invested \$2 million to provide trainings and garnered \$6 million in returns	300%
CIGNA/ introduced business reengineering	ROI Each \$1 invested in reengineering ultimately returned \$2 to \$3 in benefits	200-300%
GE/ Six Sigma	ROI In 1997 invested \$380 million and received about \$700 million in documented benefits from increased productivity in one year In 1998 invested \$400 million and received about \$1,200 million in documented benefits from increased productivity in one year	184% 300%
Processes		
Entity/ Case	RESULTS	% Change
Globe Metallurgical/ TQM	cost reduction over three years reduced customer complaints increased manpower efficiency in certain areas	367% 91% 50%
IBM Rochester/ TQM	reduce new product development cycle time to eighteen months from the previous three to five years over a three year period	267%
The Annie E. Casey Foundation/ Leadership in Action Program – L&M training and support	Thirteen % increase in the number of young kids entering school healthy and ready to learn	50%
Cadillac/ TQM	increased customer satisfaction over four years	19%
Health		
Entity/ Case	RESULTS	% Change
The Institute for Healthcare Improvement/ 100 000 Lives Campaign – National Quality Standards for 3000 US hospitals	The campaign saved over 84 000 lives in sixteen months	

As seen in the Table 1 above, there are some very compelling examples of management principles applied to programming with ensuing dramatic improvements in outcomes. Most of these examples are in the private sector and were initiated with large investments in training and purposeful application of management theories, e.g. TQM, Six sigma and leadership training. The return on investment ranged from nineteen to 3000% in a relatively short period of time within one to five years. The singular health example measures its success in number of lives saved but doesn't give estimations of investments made or improved efficiency as measured by percentage improvement over baseline.

In the examples above there was prospective application of L&M principles but in most cases identified in the literature, authors noted that evaluating direct impacts of management on health encounters obstacles as "it is difficult to directly attribute health service outputs and outcomes to leadership and management strengthening inputs and processes" (WHO, 2007, p. 12). Similarly, the What Works Working Group, the body of thinkers that compiled *Millions Saved*, wrote that they were unable to include management and financing reforms cases in their compilation of best practices. These cases achieved comparatively great outcomes most likely as a result of changes in utilization, but the cases did not have a way to directly link those utilization changes to the observed changes in population level health status (What Works Working Group, 2004, p. 151). As a result, management and health financing model cases were not included in that case study review.

Current Management Theories Used in Global Health Programs

Leadership and management are multifaceted and complex concepts. Previous studies in this field use modeling to describe the interrelationship of leadership and management activity as it applies to a specific context (e.g., organizational structure, scope of work, industry sector, and market characteristics, among others). Such models are typically developed using a mix of management theory, research, and operational experience. Leadership and management cover a range of activities that can overlap, so few models attempt to describe these concepts in their entirety. Instead, models focus on explaining a particular leadership or management aspect, approach, or practice, such as a strategy for operating in a competitive market. In general, leadership and management models fall into—but are not limited to—the following four domains.

1. Tools for describing leadership and management as a whole
2. Tools for diagnosing an organization's capacity
3. Tools for strategically positioning an organization and its resources
4. Tools for accomplishing specific tasks

These domains are organized based upon how leadership and management actions are applied. The distinctions can be used by global health programmers to identify models that are relevant for their desired purpose. Several models, from both the traditional management discipline and the health care sector are applicable and valuable for global health programmers.

What follows are the key models and theories from the project's initial literature review.

Overarching Leadership and Management Fundamentals

Relationship of Leadership to and Distinction from Management

Leadership "creates the systems that managers manage and changes them in fundamental ways to take advantage of opportunities and to avoid hazards," whereas management is what "makes systems of people and technology work well day after day (Kotter International, 2010). The main function of leadership is to direct, which includes creating vision and strategy, communicating, motivating action, aligning people, and create

systems that managers can manage and transform them to allow for growth (Kotter International, 2010). In addition, leadership involves setting an organization's or program's priorities whereas management is ensuring those priorities are followed through. Management involves "taking complex systems of people and technology and making them run efficiently and effectively, hour after hour, day after day" (Kotter International, 2010) leadership and management practices together can lead to improved health outcomes. The exact distinction between leadership and management is less important than the recognition that leadership influences how successful management initiatives can be.

Essential Functions of Management

Management literature identifies six interrelated management functions: planning, organizing, staffing, directing, controlling and decision making. Planning involves deciding in advance what needs to be done. Organizing involves developing intentional patterns of relationships among people and other resources. Staffing involves acquiring, maintaining, and retaining human resources. Directing involves initiating work within the organization. Controlling involves regulating activities according to plans. Decision making is the act of choosing between or among alternatives. (Longest & Darr, 2008)

Influence of Organizational Structure

In addition to the influence of the external environment and the local context, management literature also addresses the effect of organizational structure on the articulation of management and the role of a manager. Hierarchical and centralized organizational structures are managed by clear divisions of labor, standardized procedures and tasks, and top-down decision-making where authority lies in the hands of a small group of individuals, as common in bureaucracies. In contrast, more horizontal, flat, or networked organizational structures are managed by decentralized decision-making, flexible procedures, and shared team tasks where individual managers are facilitators and problem solvers. The organizational structure helps to shape the culture of the organization through with leadership and management activities function.

Role of Behavior Change

Influencing individuals' behavior is often critical to achieving management goals, seen in Mary Parker Follett's definition of management as "the art of getting things done through people" (Follet, 1982). Therefore, many management schemas incorporate behavior change principles familiar to public health practitioners who have long applied similar concepts to impact health behavior in populations. In management, approaches exist for influencing behavior at a variety of levels including employees, supervisors, clients, and on the organization as a whole.

Specific Management Models and Theories

The models presented here are collected from a review of international organizations, non-governmental organizations, consulting firms, and academia.

Management Models Developed Specifically for Global Health

The World Health Organization (WHO) has built a conceptual framework (see Figure 1) for strengthening leadership and management in order to strengthen the health system and towards improving health services and sector goals, such as the Millennium Development Goals. WHO states that “an essential part of that strengthening process is the provision of appropriate management training and support for management development” (Conn, Jenkins, & Touray, 1996, p.64). There are four, interrelated, conditions that are necessary for good leadership and management according to this model: ensuring an adequate number of managers, ensuring managers have appropriate competencies, creating better critical management support systems and creating an enabling work environment (WHO: Management for health services delivery, 2007).

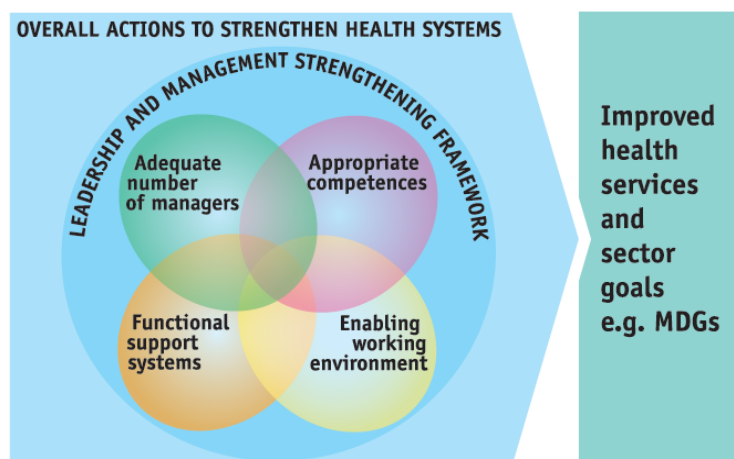


Figure 1: WHO Framework for building leadership and management capacity in health systems

This framework was used in The Gambia to strengthen health management. Competencies were improved by using data to identify problems, therefore enhancing problem analysis skills and changing team leadership to support an “ideas-oriented” environment. This led to increased motivation and commitment among team members (Conn, Jenkins, & Touray, 1996).

Management Sciences for Health (MSH) has developed a Results Model (see Figure 2) based on experience and research of successful managers. The model begins by building and applying knowledge about leading and managing in global health, identifying managers who lead, and improving processes that result in improved services and health outcomes. They define practices that enable a manager to lead and a manager to manage. For example, leading involves scanning, focusing, aligning or mobilizing and inspiring, while managing involves planning, organizing, implementing and monitoring and evaluating (Management Sciences for Health, 2002).

How do management and leadership contribute to improved service delivery?

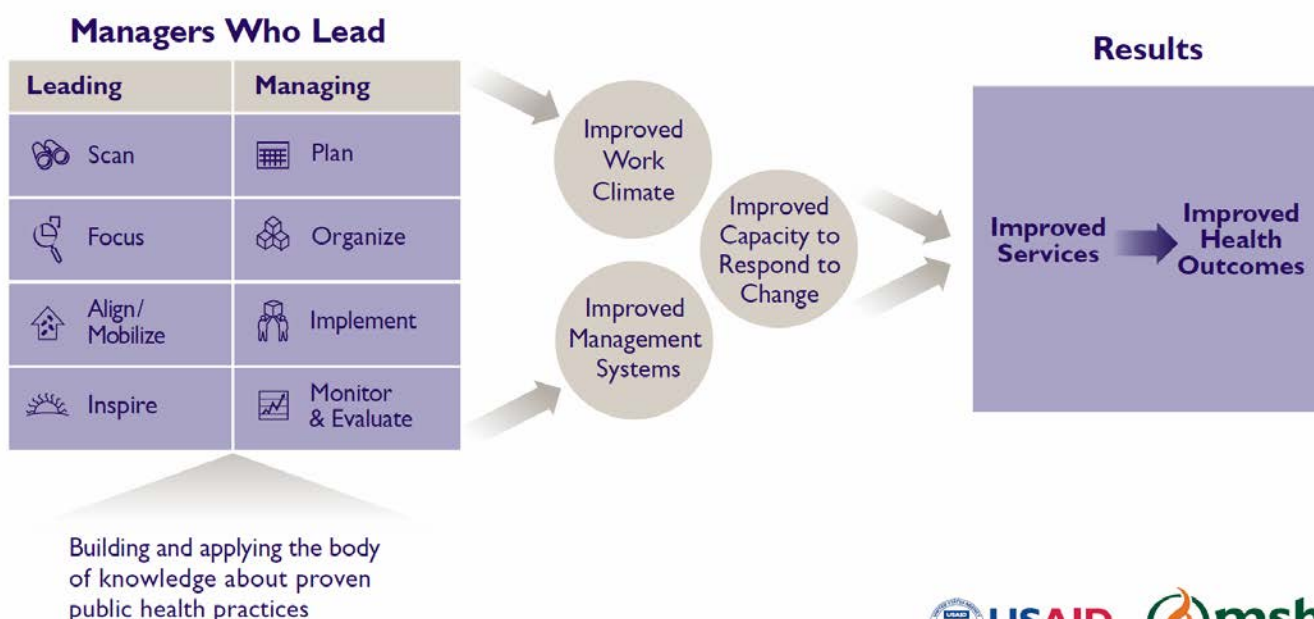


Figure 2: MSH Results Model for Leadership and Management

The MSH model has been implemented in over 40 countries during the past eight years, ranging from district level to national level application. One example is a leadership development program in the Aswan Governorate of Egypt. The health professionals, in Egypt, utilized applied learning strategies, developed team building strategies, expanded of the training. These activities were followed by significant observed health impact; maternal mortality decreased by 41% between 2003-2006 (Management Sciences for Health, 2006). The following case studies in this compendium discuss the application of this model in further detail: Kenya Leadership Development Program, Leadership Management and Sustainability Program CIES Brazil and Leadership Management and Sustainability Program DRC.

Management Models Developed for the Health Care Industry

There are several management schemas developed to specifically describe leadership and management in the health care industry. The National Center for Health Care Leadership (NCHL) provides a Health Leadership Competency Model (see Figure 3). This model focuses on three domains resulting in health leadership: transformation, execution, and people. Each domain contains a set of competencies, which then factor into health leadership. Transformation consists of envisioning a change process that unites communities, patients and professionals around new models of healthcare and wellness. Execution includes translating the vision and strategy into optimal

organizational performance. The People domain involves creating an organizational climate that values a diverse and energizing employee environment. The model places responsibility on the leader for understanding his or her impact (NCHL Health Leadership Competency Model, 2005-2010).

Other management models originating in the health care industry include the Center for Creative Leadership (CCL) model identifying essential organizational needs. This model states that an organization which develops a leadership strategy and culture addressing the identified needs will have a competitive advantage (see Figure 4). At the core of the CCL model is patient care, quality and safety; these are encircled by direction, alignment and commitment. The CCL model identifies

seven essential organizational needs:

human energy, patient care team integration, resource stewardship, leader capability, talent management, boundary spanning, and capacity for complexity and change (Center for Creative Leadership, 2010).

NCHL Health Leadership Competency Model



Figure 3: NCHL Health Leadership Competency Model



Figure 4: CCL Model 7 Essential Organizational Needs

Management Models Developed for the Business Sector

In addition to the leadership and management models directly from the health sector, many models and theories originating from the business sector have been applied and adapted to health services for managing people and organizations. One example of such adaptation includes the value chain model, developed by Michael E. Porter. It is an approach for creating value for an organization and increasing its competitive advantage. Value typically represents increased profitability in the business sector, but within the non-profit health sector, value can be

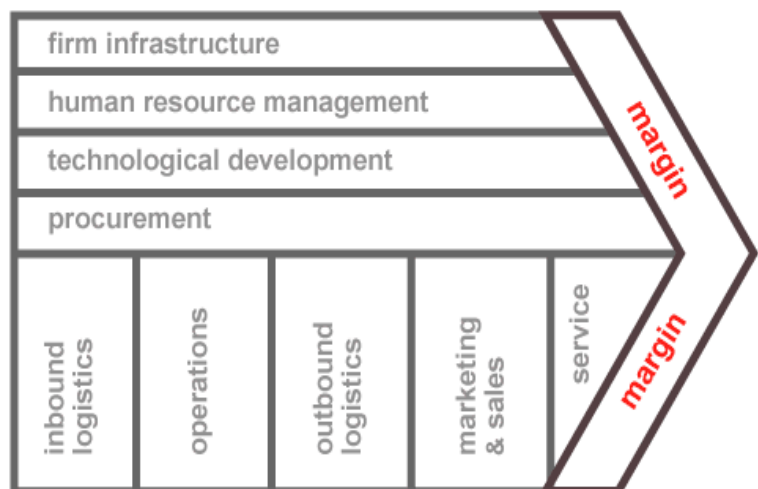


Figure 5: Value Chain Model

understood in terms of the health benefits achieved as a result of the resources expended. Similarly, social value is equivalent to the social benefits achieved as a result of the resources expended. This model takes into account service delivery at different points in service process, as well as support activities through the organizational culture, structure and strategic resources, all of which contribute to the value of the delivery system as a whole. (Swayen, Duncan, & Ginter, 2008). In essence, the value model seeks to do the most good through the use of time, relationships, money, and other resources (Swayen, Duncan, & Ginter, 2008).

The care delivery value chain (CDVC)—the value chain’s health-specific adaptation—has been employed in hospitals and health service organizations throughout the U.S. (Porter & Teisberg, 2006). Recently, Porter and colleagues have been applying the value chain concept to health service delivery in developing country settings (Rhatigan, Sachin, Mukherjee, & Porter, 2009). The CDVC model has been applied in HIV/AIDS programs and family planning to better manage coordination among activities (Rhatigan, Sachin, Mukherjee, & Porter, 2009).

Other management models and theories that originated in the business sector but have since been successfully applied to the health care industry include: the Boston Consulting Group’s growth-share matrix and portfolio analysis, six sigma, lean manufacturing, plan do study act (PDSA) cycle, continuous quality improvement (CQI), and total quality management (TQM). For example, the PDSA cycle was implemented in a clinic through the Smiling Sun Franchise Program in Bangladesh and resulted in decreased waiting times for patients (Smiling Sun Franchise Program, 2010). TQM was used by the CDC Sustainable Management Development Program in Vietnam to train health professionals in management activities and was adapted in-country for training TB Program directors (Center for Disease Control, 2010).

Leadership & Management Characteristics Developing Common Ground

The literature review was also the source for developing a list of leadership and management characteristics to be used in the review of the cases studies. These characteristics are also key elements in conceptual models of leadership and management (See [Chapter 3](#)) and represent basic principles of good leadership and management. Once common definition and distinct categories were defined the large set of characteristics were honed down to a final set of 81 which could be consolidated into twelve domains: five leadership domains, five management domains and two cross-cutting domains (See [Appendix II](#) for domain and characteristic definitions). These characteristics were used to standardize the leadership and management analysis in successful global health case studies. If agreed upon, these newly defined characteristics and domains would allow standardized reporting and analysis of L&M aspects of global health programs.

Leadership:

- Community Engagement
- Governance
- Scanning
- Setting Direction
- Staff and Work Climate Development

Management:

- Planning
- Staffing
- Structuring
- Management Systems
- Monitoring and Evaluation

Cross-cutting:

- External Commitment to Leadership and Management
- Leadership and Management Development

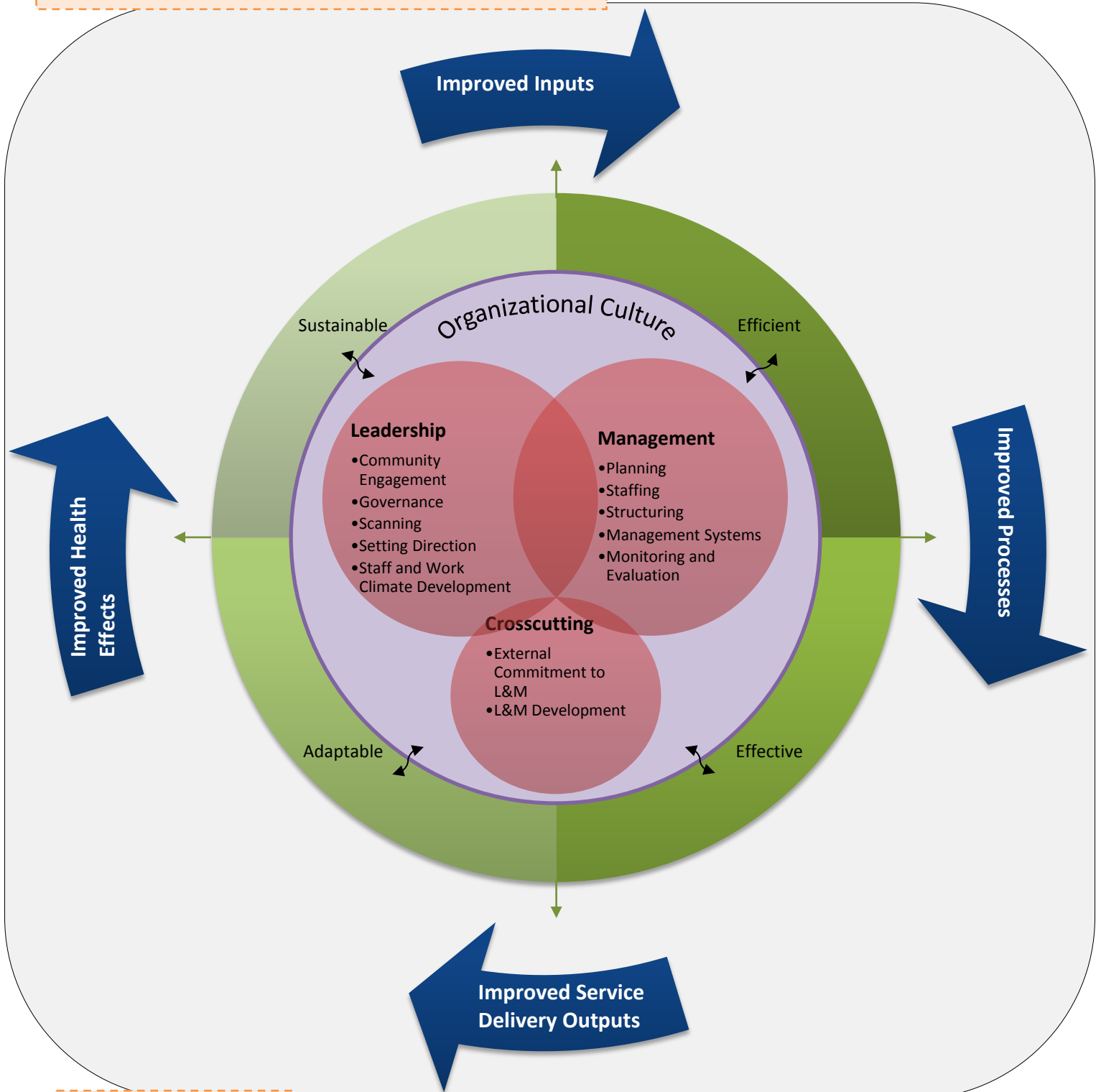
New Conceptual Framework: Impact of Leadership and Management on Health

The previously described management and leadership models guided the construction of a meta-model that became this study's conceptual framework. This conceptual framework seeks to explain the linkages between leadership and management principles within the traditional program cycle. The framework displayed on the following page aligns the identified leadership and management characteristics within an overarching model. This model explains how leadership and management could potentially impact the program cycle and ultimately contribute to improved health effects.

Conceptual Framework: Impact of Leadership and Management on Health

Market Forces

- Donor pressures
- Global economic shifts
- Global health trends
- Activities of other global health organizations
- Funding
- Advocacy trends
- Private sector involvement



Sociopolitical Forces

- Culture
- Local values
- Political structure
- Conflict/Instability

Environmental Conditions

- Geographic location
- Climate
- Natural disasters

In the model, the program cycle (represented by improved inputs, improved processes, improved service delivery outputs, and improved health effects) is influenced by two areas: (1) contextual forces in the external environment and (2) organizational intelligence. Contextual forces in the model are composed of sociopolitical forces, environmental conditions, and market forces. These forces produce changes in an organization's program cycle, but lie outside of the organization's direct control. Organizational intelligence consists of an organization's decision-making capacity. For this model, cultivating organizational intelligence leads to efficiency, effectiveness, adaptability, and sustainability. An organization's intelligence is impacted by its organizational culture, as well as its identification, selection, practice, and refinement of leadership and management characteristics. An organization's culture is important for this model and is considered, as Gareth Morgan described, "the set of beliefs, values, and norms, together with symbols like dramatized events and personalities that represents the unique character of an organization, and provides the context for action in it and by it." The above conceptual framework served as the lens through which the individual case studies in this compendium were developed. Review of this model will allow users of this compendium to better understand how researchers linked identified leadership and management characteristics to documented program impacts.

Chapter Four: Case Studies

How to Use This Compendium

This compendium is meant for Ministries of Health, program managers, researchers and donor entities. Like any series of case studies, it cannot show causation, but can contribute to the body of evidence that successful health programs contain many strong elements of Leadership and Management in their implementation. Many of the case studies included in this report address multiple leadership and management functions. You will see the breadth and variety of L&M characteristics in various case studies, as well as the interplay of these attributes. The cases are summarized from a leadership and management perspective. It is hoped that these short reviews of successful health programs will be models of “promising practices” that decision makers can use to guide the purposeful application of L&M principles, enhancing existing or planning new global health programs.

The case studies have health categories and geographic diversity highlighted in the headings and key words so that readers can find case studies in their area of interest. The quick reference table also displays the basic information for each case study including: management action, program successes, and strength of the program’s performance assessment. (See [Appendix III](#) for a full description of the template)

It should be understood though that the information in each case study is not a complete evaluation or review of a program. This compendium, the *Presence of Leadership and Management in Global Health Programs*, serves as a first step in collecting information on a wide variety of global health programs where effort is focused on highlighting common leadership and management characteristics among the selected cases.

Case Study Index

Organized by Health Topic and then Alphabetical by Case Study Name

Case Study Name	Health Topic
1. AGITA SAO PAULO PROGRAMME	Chronic Disease
2. COMMUNITY-BASED MENTORSHIP	Chronic Disease
3. MEND (MIND, EXERCISE, NUTRITION...DO IT!)	Chronic Disease
4. NARAYANA HRUDAYALAYA HEART HOSPITAL	Chronic Disease
5. RESPIRE	Chronic Disease
6. TOBACCO CONTROL POLAND	Chronic Disease
7. VERACRUZ INITIATIVE FOR DIABETES AWARENESS (VIDA) PROJECT	Chronic Disease
8. KENYA LEADERSHIP DEVELOPMENT PROGRAM	Health Leadership & Management Strengthening
9. LEADERSHIP, MANAGEMENT & SUSTAINABILITY PROGRAM CIES	Health Leadership & Management Strengthening
10. LEADERSHIP, MANAGEMENT & SUSTAINABILITY PROGRAM DRC	Health Leadership & Management Strengthening
11. MANAGEMENT EFFECTIVENESS PROGRAM EGYPT	Health Leadership & Management Strengthening
12. SESA LEADERSHIP DEVELOPMENT PROGRAM	Health Leadership & Management Strengthening
13. STRENGTHENING LOCAL GOVERNANCE FOR HEALTH PROJECT (HEALTHGOV)	Health Leadership & Management Strengthening
14. AFGHANISTAN BPHS	Health System Strengthening
15. ALBANIA PRIMARY HEALTH CARE HEALTH INFORMATION SYSTEM	Health System Strengthening
16. EQUITY PROJECT	Health System Strengthening
17. PARTNERSHIPS FOR TRANSFORMING HEALTH SYSTEMS (PATHS)	Health System Strengthening
18. QUALITY INFORMATION SYSTEM IN MEXICO	Health System Strengthening
19. REPRODUCTIVE HEALTH OUTPUT-BASED AID (OBA) VOUCHER PROGRAM	Health System Strengthening
20. SEGURO POPULAR	Health System Strengthening
21. TANZANIA ESSENTIAL HEALTH INTERVENTIONS PROJECT (TEHIP)	Health System Strengthening
22. IMAGE SOUTH AFRICA	Infectious Disease
23. LAO YOUTH HIV AND STI RESPONSE PROJECT	Infectious Disease
24. ONCHOCERCIASIS CONTROL PROGRAM	Infectious Disease
25. POLIO ELIMINATION IN LAC	Infectious Disease
26. TB CONTROL IN SOUTHERN MALAWI	Infectious Disease
27. UKRAINE MEDIA PARTNERSHIP TO COMBAT HIV/AIDS	Infectious Disease
28. VIETNAM PUBLIC HEALTH PRACTICE TRAINING PROGRAM	Infectious Disease
29. VILLAGE HEALTH WORKER PARTNERSHIPS	Infectious Disease

30. FORMATIVE SUPERVISION	Maternal and Child Health
31. GOLD STAR	Maternal and Child Health
32. GREENSTAR SOCIAL MARKETING PRIVATE SECTOR RH SOCIAL FRANCHISE NETWORK	Maternal and Child Health
33. HEALTHY WOMEN IN GEORGIA	Maternal and Child Health
34. MATERNAL HEALTH INITIATIVE	Maternal and Child Health
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36. QUALITY HEALTH PARTNERS	Maternal and Child Health
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39. YEMEN BASIC HEALTH SERVICES PROJECT	Maternal and Child Health
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Case Study Quick Reference Table

Name of Program	Implementing Entity	Country	WHO Region	Health Topic	Management Action	Score for Program Achievements	Strength of Performance Assessment
AGITA SAO PAULO PROGRAMME	Studies Center of the Physical Fitness Research Center in São Caetano do Sul (CELAFISCS)	Brazil	AMRO	Chronic Disease	Establish legislation, communications and build capacity for a comprehensive approach to address healthy diets and physical activity.	Increased Service Outputs	High
COMMUNITY-BASED MENTORSHIP	World Vision Rwanda (WVR), Tulane School of Public Health (TSPH) and the Rwandan School of Public Health (RSPH)	Rwanda	AFRO	Chronic Disease	Recruit and train local volunteers to mentor youth, utilizing a stepwise introduction of the mentorship program in order to evaluate program feasibility and value, and tailor activities to local context.	Increased Service Outputs	High
MEND (MIND, EXERCISE, NUTRITION...DO IT!)	MEND UK	UK	EURO	Chronic Disease	Develop an evidence-based service package that can be easily implemented and replicated, and train non-specialists to deliver the package through partner organizations to enable broad reach	Health Effect	High
NARAYANA HRUDAYALAYA HEART HOSPITAL	Narayana Hrudayalaya Private Ltd.	India	SEARO	Chronic Disease	“Focused factory” where a narrow range of services are offered with excellence, operational costs are minimized, and a high quality brand drives demand.	Health Effect	High
RESPIRE	UC Berkeley, University del Valle Guatemala, University of Liverpool, and University of Bergen	Guatemala	AMRO	Chronic Disease	Invest in and develop a comprehensive trial to test a promising cook stove solution	Health Effect	High
TOBACCO CONTROL POLAND	GoP & CSO/NGO partners (including Health Promotion Foundation)	Poland	EURO	Chronic Disease	Take a comprehensive approach involving legislation to limit supply, and institute taxation of tobacco products and evidence-based health education campaigns to reduce demand.	Health Effect	High

Name of Program	Implementing Entity	Country	WHO Region	Health Topic	Management Action	Score for Program Achievements	Strength of Performance Assessment
VERACRUZ INITIATIVE FOR DIABETES AWARENESS (VIDA) PROJECT	MOH	Mexico	AMRO	Chronic Disease	Integrated systems-based approach to improving quality of care	Health Effect	High
KENYA LEADERSHIP DEVELOPMENT PROGRAM	MSH	Kenya	AFRO	Health Leadership & Management Strengthening	Hold comprehensive and results driven training workshops to build leadership and management capacity among teams of health managers	Health Effect	High
LEADERSHIP, MANAGEMENT & SUSTAINABILITY PROGRAM CIES	MSH and Centro de Investigación, Educación, y Servicios (CIES)	Bolivia	AMRO	Health Leadership & Management Strengthening	strengthen key systems, such as human resources, financial management, marketing strategies, and organizational governance to increase providers' capacity to respond to change and prospects for sustainability.	Health Effect	High
LEADERSHIP, MANAGEMENT & SUSTAINABILITY PROGRAM DRC	MSH and DRC's MOH	Democratic Republic of Congo	AFRO	Health Leadership & Management Strengthening	Build the leadership and management capacity of teams of health managers to address their real workplace challenges and establish a standards-based tool to manage the quality of health service delivery.	Health Effect	Average
MANAGEMENT EFFECTIVENESS PROGRAM	The Egyptian Ministry of Health and Population (MOPH) and WHO	Egypt	EMRO	Health Leadership & Management Strengthening	WHO assisted MOPH in identifying the country's management needs, tailoring the global MEP program to the identified needs and context, and the implementing the MEP in-country.	Health Effect	High
SESA LEADERSHIP DEVELOPMENT PROGRAM	Ceara State Secretariat of Health (SESA), MSH	Brazil	AMRO	Health Leadership & Management Strengthening	Deputy Secretary of Health proposed a partnership among SESA, its school of Public Health (ESP), MSH and a local leadership consultant to implement a Leadership Development Program	Health Effect	High

Name of Program	Implementing Entity	Country	WHO Region	Health Topic	Management Action	Score for Program Achievements	Strength of Performance Assessment
STRENGTHENING LOCAL GOVERNANCE FOR HEALTH PROJECT (HEALTHGOV)	RTI International	Philippines	WPRO	Health Leadership & Management Strengthening	build health management and leadership capacity in local-level governance through a demand-driven approach	Improved Processes	Low
AFGHANISTAN BPHS	MoPH, USAID, MSH	Afghanistan	EMRO	Health System Strengthening	Implement national coordinated approach to HSS for PHC delivery	Health Effect	High
ALBANIA PRIMARY HEALTH CARE HEALTH INFORMATION SYSTEM	PHRplus and MOH	Albania	EURO	Health System Strengthening	Perform stakeholder and environmental analyses to inform scale up and tailor the HIS to local contexts	Improved Processes	Average
EQUITY PROJECT	South Africa's Department of Health (DOH) in partnership with MSH TBD	South Africa	AFRO	Health System Strengthening	restructure, strengthen coordination, and increase the efficiency and effectiveness of the public-sector delivery system.	Health Effect	High
PARTNERSHIPS FOR TRANSFORMING HEALTH SYSTEMS (PATHS)	DFID	Nigeria	AFRO	Health System Strengthening	Systems approach for addressing health sector weaknesses	Health Effect	High
QUALITY INFORMATION SYSTEM IN MEXICO	Secretariat of Health (Mexico)	Mexico	AMRO	Health System Strengthening	Redesign the existing routine HIS to integrate and standardize fragmented processes toward an explicit focus on quality improvement while building flexibility and adaptability for local use	Health Effect	Average
REPRODUCTIVE HEALTH OUTPUT-BASED AID (OBA) VOUCHER PROGRAM	Kenya's National Coordinating Agency for Population and Development (NCAPD)	Kenya	AFRO	Health System Strengthening	Demand-side approach to financing health care and incentivizing the poor to utilize health services by subsidizing health care clients directly and reimbursing both public and private providers for services.	Health Effect	Average

Name of Program	Implementing Entity	Country	WHO Region	Health Topic	Management Action	Score for Program Achievements	Strength of Performance Assessment
SEGURO POPULAR	Mexico MOH	Mexico	AMRO	Health System Strengthening	undertake major reform to reorganize the HS through the horizontal integration of 3 basic functions— stewardship, financing, and service delivery—and institute a comprehensive insurance scheme to control for the existing barriers and inequalities in financial protection for health service provision, especially for the poorest segments of the population.	Increased Service Outputs	High
TANZANIA ESSENTIAL HEALTH INTERVENTIONS PROJECT (TEHIP)	Tanzania MOH and IDRC	Tanzania	AFRO	Health System Strengthening	Increased technical efficiency of health system, increased allocative efficiency of health system, new incremental funding with decentralized control leading to higher quality and greater utilization of health services and better population health	Health Effect	Average
IMAGE SOUTH AFRICA	SEF and RADAR	South Africa	AFRO	Infectious Disease	Form a partnership to design and implement “Intervention with Microfinance for AIDS and Gender Equity” (IMAGE) program	Increased Service Outputs	High
LAO YOUTH HIV AND STI RESPONSE PROJECT	The Burnet Institute in collaboration with the Lao People’s Revolutionary Youth Union (LYU) and the National Committee for the Control of AIDS Bureau (NCCAB)	Laos	SEARO	Infectious Disease	Mobilize and train an active decentralized youth organization to plan, manage and implement HIV programs for their peers.	Increased Service Outputs	Average
ONCHOCERCIASIS CONTROL PROGRAM	WHO, World Bank , UNDP, UNFAO, Merck, and others	Sub-Saharan Africa	AFRO	Infectious Disease	Develop global partnership among donors, bilateral and multilateral organizations to control onchocerciasis.	Health Effect	High

Name of Program	Implementing Entity	Country	WHO Region	Health Topic	Management Action	Score for Program Achievements	Strength of Performance Assessment
POLIO ELIMINATION IN LAC	PAHO	LAC - 14 Countries	AMRO	Infectious Disease	Standardize surveillance and implement an aggressive eradication campaign focused on increasing HR capacity, inter-sectoral cooperation, technical innovation, decentralization of resources and social mobilization across the 14 polio-endemic countries in the region	Health Effect	High
TB CONTROL IN SOUTHERN MALAWI	Malawi National Tuberculosis Program and Project Hope	Malawi	AFRO	Infectious Disease	Training and supporting TB health workers, investing in laboratory support systems, and actively partnering with local communities, with an overall focus on quality improvement	Health Effect	Average*
UKRAINE MEDIA PARTNERSHIP TO COMBAT HIV/AIDS	Transatlantic Partners Against AIDS (TPAA) & IREX	Ukraine	EURO	Infectious Disease	Use a mass marketing approach through developing PPPs in order to provide incentives on reporting HIV/AIDS issues using an international best practice model for HIV prevention and campaigns	Improved Processes	Average
VIETNAM PUBLIC HEALTH PRACTICE TRAINING PROGRAM	Vietnam National Tuberculosis Program (NTP) and U.S. Centers for Disease Control	Vietnam	WPRO	Infectious Disease	Participate in management development program with training, supervision, and team-building	Health Effect	High
VILLAGE HEALTH WORKER PARTNERSHIPS	Karen Department of Health and Welfare and the Backpack Health Worker Team (BPHWT)	Burma	SEARO	Infectious Disease	Strategic training and use of Village Health Workers (VHWs)	Health Effect	High
FORMATIVE SUPERVISION	MOH, MSH, Maternal Health Family planning project	Senegal	AFRO	Maternal and Child Health	Use a formative supervision approach to improve the oversight and information management for the delivery of reproductive health services	Improved Processes	Average

Name of Program	Implementing Entity	Country	WHO Region	Health Topic	Management Action	Score for Program Achievements	Strength of Performance Assessment
GOLD STAR	Egypt's Ministry of Health and Population	Egypt	EMRO	Maternal and Child Health	Establish a quality assurance program through clinic certification under a common brand	Increased Service Outputs	High
GREENSTAR SOCIAL MARKETING PRIVATE SECTOR RH SOCIAL FRANCHISE NETWORK	Greenstar Social Marketing Program	Pakistan	EMRO	Maternal and Child Health	Created a fractional franchise network to give both the means and the incentives for private health providers to deliver high quality services.	Health Effect	High
HEALTH WOMEN IN GEORGIA	JSI Research & Training Institute, Save the Children, Fund Orthos, CLARITAS XXI, CSMA, HERA, CIF, McCann Erickson	Georgia	EURO	Maternal and Child Health	Build partnerships to design and deliver communication campaigns, and utilize local resources and community members to improve MCH service delivery	Health Effect	High
MATERNAL HEALTH INITIATIVE	McKinsey & Company, The Synergos Institute, and the Presencing Institute from MIT in partnership with Namibia's Ministry of Health and Social Services (MOHSS)	Namibia	AFRO	Maternal and Child Health	Build local leadership to improve supply and raise demand for maternal health services.	Increased Service Outputs	Average
PUBLIC HEALTH OUTREACH PROGRAM	Haitian Health Foundation (HHF)	Haiti	AMRO	Maternal and Child Health	Decentralize health service provision at the village level, where equitable coverage is tracked by a HIS, the existing workforce gap is filled through task-shifting to CHWs, and local participation enhances effectiveness.	Health Effect	High
QUALITY HEALTH PARTNERS	EngenderHealth	Ghana	AFRO	Maternal and Child Health	decentralized and comprehensive approach to quality assurance that builds human capacity at the facility level	Health Effect	High

Name of Program	Implementing Entity	Country	WHO Region	Health Topic	Management Action	Score for Program Achievements	Strength of Performance Assessment
SAFE DEMONSTRATION PROJECT OF COMMUNITY BASED DISTRIBUTION OF MISOPROSTOL FOR PREVENTION OF PPH	JHPIEGO in collaboration with Indonesia's MOH, WHO, and Indonesia Association of Obstetricians and Gynecologists (POGI)	Indonesia	SEARO	Maternal and Child Health	pair the programmatic change initiative with a change management process to counter resistance and promote acceptance and uptake of the alternative birthing practices.	Health Effect	High
URBAN HEALTH PROGRAM	Urban Health Resource Centre (UHRC)	India	SEARO	Maternal and Child Health	Gathering and using data to target resources allocation and programmatic efforts	Health Effect	Average
YEMEN BASIC HEALTH SERVICES PROJECT	Yemen MOPHP and local NGOs	Yemen	EMRO	Maternal and Child Health	Build capacity and training for health professionals and community workers through developing relationships with local partners	Health Effect	High
HAITI MYAP FOR FOOD SECURITY	Catholic Relief Services, World Vision, ACIDI/VOCA	Haiti	AMRO	Nutrition	Establish partnerships to provide a multi-sectoral response to food insecurity	Health Effect	High
LINKAGES	AED and various other partners	Multi-country	AFRO and SEARO	Nutrition	Leverage strategic partnerships to rapidly expand the delivery of evidence-based practices	Health Effect	High
NuLIFE UGANDA	URC, Save the Children, ACIDI/VOCA	Uganda	AFRO	Nutrition	Provide support and assistance to PLWHA by integrating nutrition into HIV/AIDS programs	Health Effect	High
ORAL THERAPY EXTENSION PROGRAM	BRAC	Bangladesh	SEARO	Nutrition	Begin with a cheaper, more readily available ORS alternative that rural mothers can produce and provide to children themselves, and expand adoption of the alternative through a focused mass campaign delivered face-to-face	Health Effect	High
SCHOOL FEEDING PROGRAM	Junta Nacional de Auxilio Escolar y Becas (NBSA)	Chile	AMRO	Nutrition	Contract out meal provision to minimize costs while strengthening quality and apply evidence-based methods to steer resources towards the program-specific target population	Increased Service Outputs	High

Name of Program	Implementing Entity	Country	WHO Region	Health Topic	Management Action	Score for Program Achievements	Strength of Performance Assessment
WHEAT FLOUR FORTIFICATION	MOH	Chile	AMRO	Nutrition	Choose an evidence-based and cost-effective solution of requiring the addition of folic acid to present wheat fortification systems	Health Effect	High
BANGLADESH SMILING SUN FRANCHISE PROGRAM	Chemonics International, Sibley International, Smiling Sun Health Franchise	Bangladesh	SEARO	Primary Health Care	Utilizing a quality management system for the establishment of an independent franchise network and developing strategic partnerships with businesses and local NGOs	Increased Service Outputs	Average
HEALTH EXTENSION PROGRAM	Ethiopia's Federal Ministry of Health	Ethiopia	AFRO	Primary Health Care	Decentralize health service provision, fill the workforce gap through task-shifting to a new cadre of health worker—Health Extension Workers (HEWs)—and use local participation to enhance effectiveness.	Health Effect	High
LIVING GOODS UGANDA	Living Goods and BRAC Uganda	Uganda	AFRO	Primary Health Care	Expanding access to basic health products and services at low-cost in villages that are currently underserved by the existing public and private health infrastructure.	Increased Service Outputs	Average
PRIMARY CARE NETWORKS	Alberta Health and Wellness, Alberta Medical Association, Alberta Health Services	Canada	AMRO	Primary Health Care	Establish joint ventures between private practices, creating networks of PHC providers who work collaboratively to increase access and quality, and control cost	Increased Service Outputs	Average
QUALITY ASSURANCE PROJECT (QAP) & BASIC SUPPORT FOR INSTITUTIONALIZING CHILD SURVIVAL PROJECT (BASICS)	USAID and MoH	Niger	AFRO	Primary Health Care	apply quality management (QM) principles to improve quality of care and facilitate the introduction of IMCI standards	Health Effect	High

Name of Program	Implementing Entity	Country	WHO Region	Health Topic	Management Action	Score for Program Achievements	Strength of Performance Assessment
THE PUENTES PROJECT: BUILDING BRIDGES FOR QUALITY	Population Communication Services (PCS)	Peru	AMRO	Primary Health Care	Comprehensive trust-building exercises involving open dialogue, socialization, and shared learning	Increased Service Outputs	Average
ABBOTT-TANZANIA: REGIONAL LAB MODERNIZATION PROJECT	Abbott Laboratories and GoT	Tanzania	AFRO	Specialty Care	Leveraging PPP to implement changes in lab support structures, HMIS, and personnel.	Health Effect	Average
ARAVIND EYE HOSPITAL	Aravind Eye Hospital	India	SEARO	Specialty Care	Establish a private, nonprofit eye hospital franchise anchored by a clearly articulated vision for service and high quality eye care, delivered within a highly efficient system.	Increased Service Outputs	Average
EMERGENCY DEPARTMENT IMPROVEMENT	Hamad Medical Corporation (HMC) Women's Hospital	Qatar	EMRO	Specialty Care	Establish multidisciplinary teams to use SIX SIGMA and LEAN management tools to improve patient flow processes	Improved Processes	Average
UGANDA SUSTAINABLE CLUBFOOT CARE PROJECT	University of British Columbia, MOH, Makerere University, CBM International	Uganda	AFRO	Specialty Care	Decentralize clubfoot care to permit easier access, addressing each step in value chain	Increased Service Outputs	High
VACCINE VIAL MONITORS	PATH; TEMPTIME Corporation; WHO	Global	Global	Specialty Care	Find a suitable technology to detect heat exposure and adapt it for vaccines	Increased Service Outputs	High
VISIONSPRING'S BUSINESS IN A BAG	VisionSpring India	India	SEARO	Specialty Care	Diversify product distribution channels to increase market access	Increased Service Outputs	Low

CHRONIC DISEASE CASES

AGITA SÃO PAULO PROGRAMME

1996-Present

IMPLEMENTING ENTITY:

Studies Center of the Physical Fitness Research Center in São Caetano do Sul (CELAFISCS)

Location: Brazil

AMRO/Upper-Middle Income

Health Topic: Chronic Disease/Obesity

Key Words: Strategic Partnership, Effective Policy, Systems-based, Innovation

PROGRAM OVERVIEW

Goal: To increase the population's knowledge (by 50%) of the benefits of physical activity for health and to increase participation in moderate physical activity (by 20%) in 10 years.

Objective: Develop a policy framework that would include six consecutive phases: vision, making the case, defining the problem, solutions, implementation, and evaluation.

Funding: Program costs \$152,000 a year. Health Secretariat of São Paulo covers most of the cost along with support from partnerships and local businesses.

Background of Agita:

- Educational program focused on increasing physical activity.
- Implements programs for children and adults of various ages.
- Based on a new public health recommendation for adults on the benefits from physical activity: to accumulate at least 30 minutes of moderate-intensity physical activity on most days of the week.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Lack of effective incentives to encourage healthy levels of physical activity, especially in low socio-economic and undernourished groups.

Management Action:

Establish effective legislation and health communication strategies. Build capacity for a comprehensive approach to address healthy diets and physical activity that will work synergistically with legislation and health messaging.

Principal L&M Characteristics Identified

Leadership:

- Scanning
- Setting Direction
- Community Engagement

Management:

- Planning
- Monitoring and Evaluation
- Structuring

Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- Increased physical activity and knowledge among population of São Paulo.

The diagram illustrates the three pillars of the 2030 Agenda, each represented by a large circle containing smaller sub-circles.

- Leadership:** A large grey circle containing four green sub-circles:
 - Scanning:** 1 2 3 4 5 6
 - Community:** 1 2 3 4
 - Setting Direction:** 1 2 3 4 5
 - Governance:** 1 2 3 4 5 7
 - Work Climate:** 4 5 7 8 9 10
- Cross-cutting:** A large orange circle containing:
 - Commitment to L&M:** 1 2 3 4
- Management:** A large grey circle containing three blue sub-circles:
 - Planning:** 1 2 3 4 5
 - M&E:** 1 2 3 4 5 6 7 8
 - Human Resources:** 1 2 4 5

Management Action in Detail

The Agita São Paulo Programme collaboratively developed a policy framework. Program planners identified steps necessary to progress through the framework's 6 phases. In addition, an ecologic model of influences on physical activity was developed. The program adopted a management scheme resembling a hanging nursery mobile. Agita applied this "mobile" management style to align its activities according to the ecological model. In the "mobile," the multileveled components of the Ecological Model are distributed three-dimensionally, hanging in a dynamic balance. The "mobile" arrangement requires that managers hold a systems-perspective when addressing program operations, recognizing that successful improvement in one level or section of the mobile must be matched with additional improvement initiatives in other sections in order to maintain balance.

The program adopted partnerships as a key strategy in carrying out its intervention, utilizing several government agencies and NGOs. Agita focused on three settings where physical activity can be reinforced: home, transport and leisure time. The program distributed educational materials stressing the benefits of mental and social health. These materials were chosen because evidence suggested they were most effective in changing behavior.

Agita developed specific messages for each target market. Nutrition pyramids were printed with corresponding physical activity pyramids to promote physical activity among teenagers. Large-audience events were organized and tailored for students, workers, and the elderly. These events resulted in strong supportive reports from the media. This media attention was especially significant as Agita could avoid paying for media exposure. Instead, Agita reserved financial resources for program activities. An annually held Agita Galera Day created the

opportunity to discuss the main messages of the program. The Galera Day was collaboratively prepared for through videoconferences and special meetings with education and health authorities.

Program Achievements

LEVEL: Increased Service Outputs

Evaluations directly linking the Agita program with population health outcomes have not been reported yet.

Service Outputs:

- Agita Galera Day (Move the Crowd Day), delivered in 6,000 public schools, involving over 6 million students.
- Over 12,000 persons per year started walking regularly and reached the CDC recommendation.

Process Improvements:

- People walking according to recommendation of at least 30 minutes/day, 5 or more days a week increased from 23% to 28% (1992-2002).
- Men reaching CDC recommendation of physical activity for health increased from 49% to 57% (1999-2002).
- Elderly women (in sample population) increased their participation in moderate-intensity activities from 3.4 to 5.0 times/week and from 86.2 to 192.3 minutes/week; walking increased from 2.9 to 5.8 times/week and from 40.8 to 102.3 min/week.
- Over 18,000 manuals, 6,000 posters, and 6 million flyers printed each year allowed each child to take home program messages, indirectly reaching the parents and relatives, another population of approximately 10 million persons.

Strength of Performance Assessment

SCORE: High

- 1999-2005, Multiple surveys and a retrospective analysis, 1999-2005: cost-effectiveness surveys, exercise monitoring and qualitative analysis through focus group discussions and KAPs
- Surveillance: physical activity levels, physical activity knowledge, barriers, attitudes, behavior stage, and knowledge of program

Comments

The Agita São Paulo case documented the importance of knowledge exchange to foster synergistic collaboration. Agita leveraged existing organizations—including public, private, and non-profit entities. It also used advice from expert consultants and local residents to produce tailored and intentional efforts.

COMMUNITY-BASED MENTORSHIP

2004-2006

IMPLEMENTING ENTITY:

World Vision Rwanda, Tulane School of Public Health, and the Rwandan School of Public Health

Location: Rwanda

AFRO/Low Income

Health Topic: Chronic Disease/Mental Health

Key Words: Quality Assurance, Psychosocial Support, Volunteer

PROGRAM OVERVIEW

Goal: Improve OVC well-being and assess value of community-based adult mentorship through home visitation.

Objectives:

- (1) Develop stable, caring relationships between youth and the adult mentors;
- (2) Strengthen the supportive environment for children's healthy growth and development; and
- (3) Mitigate the impacts of disrupted care-giving structures and marginalization.

Funding: World Vision US, Horizons (Population Council), and USAID.

Background of Community-based Mentorship program:

- Mentoring program with home visitation to complement existing services provided to orphans and vulnerable children by World Vision Rwanda.
- After a thorough screening process, World Vision trained adults as volunteer mentors.
- Mentors were assigned 2 or 3 youth-headed households located within their own community.
- Phased implementation strategy to incorporate lessons learned at each new site.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Developing scale-up strategy for a new health program.

Management Action: Recruit and train local volunteers to mentor youth. Utilize a stepwise introduction of the mentorship program in order to evaluate program feasibility and value. Apply these lessons to tailor activities to local context.

Principal L&M Characteristics Identified:

Leadership:

- Scanning
- Community Engagement
- Setting Direction
- Governance

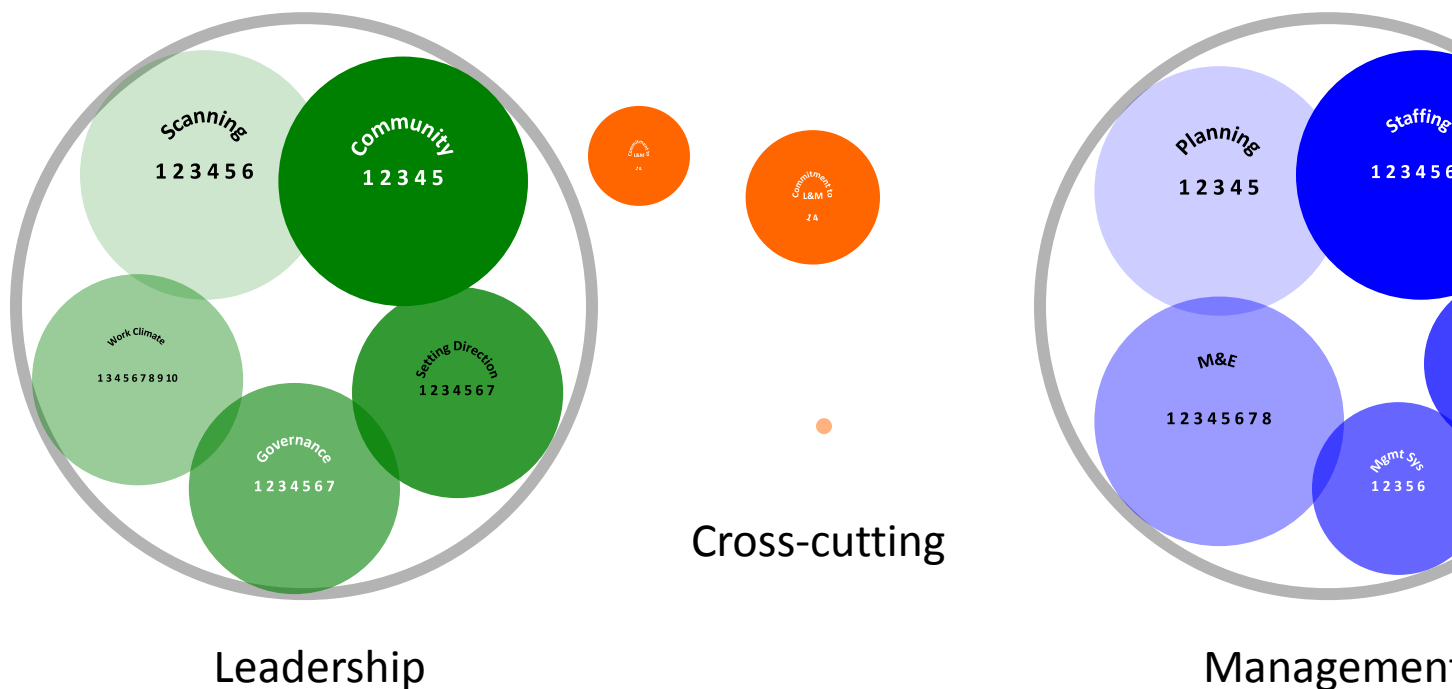
Management:

- Staffing
- Monitoring and Evaluation
- Planning

Results Achieved:

- Youth report increased feelings of value, happiness and confidence when with mentors. Mentors began home visits in October 2004 and within 1 year, the 156 mentors made 17,725 visits to 442 youth-headed households. The program value demonstrated in this initial phase led World Vision to decide to replicate the mentorship program in all other operational areas in Rwanda.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that Staffing was the most present domain from a review of case study materials (93% present). Other leadership domains were notable, including Scanning and Community Engagement (92% and 90% present respectively). The Leadership and Management Development domain was not detected in the review of case materials.

Management Action in Detail

Evidence-based Programming

Local input was sought throughout development of the program and design of the evaluation to ensure that the intervention activities were relevant in the local context. The findings of the baseline research conducted with youth were used to help the mentors and the wider community better understand the needs and problems facing youth-headed households. Barriers to community support and preconceived notions about orphans uncovered by the research became an integral part of mentor training and community sensitization activities. A simple pictorial monitoring form was developed as a checklist to guide mentors during home visits while doubling as a data collection tool which mentors supply to World Vision Rwanda during monthly meetings.

Phased Implementation to Build Capacity

The decision to phase-in a psychosocial support program allowed implementers to compare effects between the intervention and control group over time. Program managers were then able to modify and improve intervention components before delivering it on a broader scale. To ensure the success of the initial phase and the surrounding research, the program team collaborated with a technical committee. The committee was composed of both international and local professionals with experience in OVC and psychosocial programs.

Volunteer Mobilization

World Vision used a thorough screening process to recruit and select volunteer mentors. Volunteers were then provided with training and support. Training included principles of child well being and a range of psychosocial support skills. Mentors were assigned two or three youth-headed households located within their own community. Mentor supervision and support are integral for program effectiveness and high volunteer retention.

Program Achievements

LEVEL: Increased Service Outputs

Evaluations directly linking World Vision’s mentorship program with population health outcomes have not been reported.

Service Outputs:

- 97.7% overall retention rate of volunteers over two years.
- 98% of mentors indicated they would continue to visit households even if formal mentor program ended.
- Over 90% attendance rates at monthly mentor support meetings throughout the 18-month study period.

Process Improvements:

- 90% of youth said that they feel valued when they are with their mentor.
- 92% feel happy when they are with their mentor.
- 82% say that their mentors understand their feelings.
- 87% said they mentor helped them to feel more confident of their future.
- Significant improvement in parenting skills of household heads. Children reported a decrease in inappropriate behavior of head of household (harsh punishments; harboring all family resources) and improvement in responsiveness of head of household to children’s needs.
- 93% of mentors indicated that they helped one another solve problems and all the mentors interviewed at follow-up felt they were part of a “team.”
- 71% of youth agreed that their mentor helps protect them.
- Mentors reported that while youth were initially apprehensive and distant, after only a few visits, most youth became very excited about the mentor’s arrival.

Strength of Performance Assessment

SCORE: High

- Quasi-experimental study, qualitative; YHHs in 2 of the 4 districts in the province—Karaba and Nyamagabe—received the mentoring program in addition to the basic needs program during the study period. YHHs in the other 2 districts—Mudosomwa and Nyraguru—served as the comparison group. The basic needs program continued in all of the districts throughout the study, and the mentoring intervention was rolled out in the comparison districts after completion of the follow-up survey.
 - March 2004, Baseline survey and focus group discussions
 - March 2006, Follow-up survey and focus group discussions

Comments

The Community-based Mentorship case exemplifies well-management volunteer mobilization. Through structured screening and continuous support, the program recruited and retained committed volunteer mentors. Further, World Vision incrementally implemented its mentoring program. Lessons learned from each rollout site were incorporated into the next. This stepwise approach allowed World Vision Rwanda to build the organizational capacity required to deliver the program well at scale.

MEND (MIND, EXERCISE, NUTRITION...DO IT!)

2001-Present

IMPLEMENTING ENTITY:

MEND and various partners

Location: United Kingdom
EURO/High Income
Health Topic: Chronic
Disease/Childhood Obesity

Key Words: Strategic Partnership, Evidence-based Package, Replication by Non-specialists, HMIS

PROGRAM OVERVIEW

Goal: To enable a significant, measurable and sustainable reduction in global overweight and obesity levels

- Objectives:**
- (1) Provide effective and evidence-based obesity prevention and treatment programs, training and resources;
 - (2) Work alongside partners from the private, public, voluntary and academic sectors to make services available at a community level on the widest possible scale;
 - (3) Train people who come into contact with overweight and obese children so they can provide families with the best possible support; and
 - (4) Build one of the largest bodies of evidence, worldwide, on child obesity prevention and treatment.

Funding: Big Lottery Fund, Britvic, Bromley Mytime, FitPro, Legal and General, Nutricia, Sainsbury's, Sport England, Youth Sport Trust, and National Sports Foundation.

Background of MEND Program:

- Integrated, multi-component healthy lifestyle program.
- Social enterprise organization.
- Services delivered by local teams employed by local and national organizations.
- Engaged families in the process of weight management by addressing 3 components: (1) education, (2) skills training, and (3) motivational enhancement.
- Different programs for children of various ages and nutritional needs.
- Free to families because MEND secured local, regional, and national funding partners.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Insufficient number of specialists to adequately address burden of childhood obesity.

Management Action: Develop an evidence-based service package that can be easily implemented and replicated. Train non-specialists to deliver the package. Leverage partner organizations to enable broad reach.

Principal L&M Characteristics Identified:

Leadership:

- Community Engagement
- Setting Direction
- Scanning

Management:

- Monitoring and Evaluation
- Structuring
- Planning

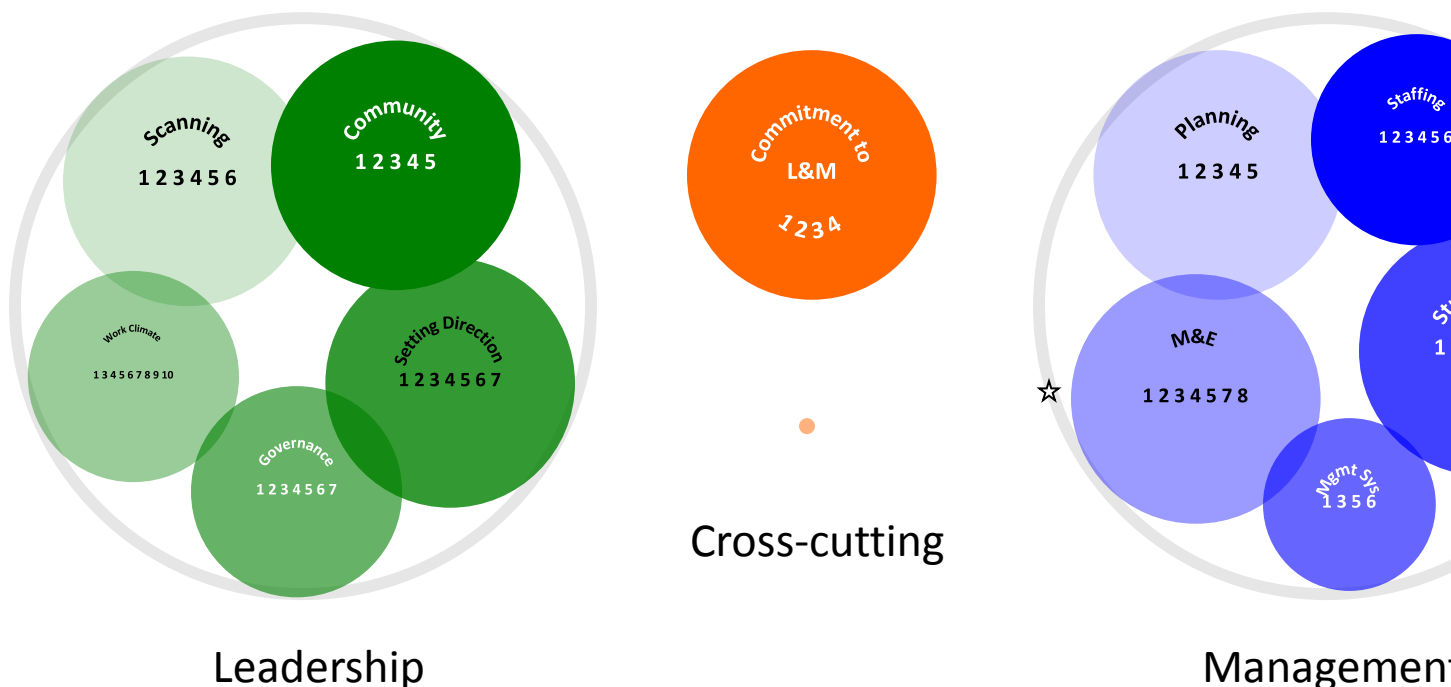
Cross-cutting:

- External commitment to Leadership and Management

Results Achieved:

- MEND Program helps children lose weight, increase their physical activity levels and self-esteem, and reduce their sedentary behaviors.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that Community Engagement was the most present L&M domain from a review of case study materials (100% presence). Multiple L&M domains in the figure are quite large in size, suggesting MEND documented a wide variety of leadership and management actions. The Leadership and Management Development domain was not detected in the review of case materials. The white star in the Management System domain denotes that a health management information system was identified for this case study.

Management Action in Detail

Evidence-based Management for Scalability and Replicability

Delivering evidenced-based services through strategic partnerships was central to MEND's success. MEND's distinctions from other common childhood obesity interventions included its multi-component nature, as well as the required attendance of both children and parents or care givers. MEND emphasized scalability and replicability by taking a 'solution in a box' approach. The program was designed by child health experts to be deliverable by non-specialists. The approach aimed to make implementation on the ground as easy as possible. Clear, standardized operating procedures created a shared vision across different settings. To ensure standardized delivery across sites, all implementers received training and were provided with identical materials: theory and exercise manuals, children's handouts, program resources, and teaching aids. The manuals contained detailed methods for the delivery of all sessions. MEND benefitted from an executive team and governing board with extensive management expertise. Executives and board members came from a variety of sectors, companies, and complex projects. The program prioritized monitoring its progress to inform decisions. Data was used in decision making for both individual children's support plans and larger organizational plans. The progress of each participant and the success of each program were tracked in a secure online system. This data informed continuous improvements and new program development.

Program Achievements

LEVEL: Health Effect

Health Effects:

- At 6 months, participants in the intervention group had a reduced waist circumference z-score (-0.37 ; $p < 0.0001$) and BMI z-score (-0.24 ; $p < 0.0001$) when compared to the controls.
- At 12 months, children in the intervention group had reduced their waist and BMI z-scores by 0.47 ($p < 0.0001$) and 0.23 ($p < 0.0001$), respectively.

Service Outputs:

- MEND works with local, regional and national partners to deliver over 400 MEND programs benefitting over 15,000 families.
- MEND has expanded to five countries (Australia, Canada, Denmark, New Zealand, and US).

Process Improvements:

- Significant between-group differences were observed in cardiovascular fitness, physical activity, sedentary behaviors, and self-esteem.
- At 12 months, benefits in cardiovascular fitness, physical activity levels, and self-esteem were sustained. The majority of these outcomes were not just maintained but continued to improve during the follow-up, suggesting that the program can be effective in the long term.
- Mean attendance for the MEND Program was 86%.

Strength of Performance Assessment

SCORE: High

- 2004, Pilot/feasibility trial of MEND program for ages 7-13
- 2005-2007, randomized control trial of MEND program for ages 7-13
- 2007, Pilot/feasibility trials of Mini-MEND
- MEND is currently conducting a second, larger randomized control trial at the Institute of Child Health to follow families for longer periods to see how they are faring two, five and ten years after starting the program.

Comments

MEND UK demonstrated that a structured package of services can be effectively delivered by a diverse set of non-specialists to reduce childhood obesity. The case showed the value of investing in performance monitoring, particularly when managing many partnerships.

NARAYANA HRUDAYALAYA HEART HOSPITAL

2001-Present

IMPLEMENTING ENTITY:

Narayana Hrudayalaya Private Ltd.

Location: India
SEARO/Lower-Middle Income
Health Topic: Specialty Services/
Cardiac Care

Key Words: Focused Factory, Economies
of Scale, HMIS

PROGRAM OVERVIEW

Goal: Provide the world's best heart care, with no one turned away for lack of funds.

Objective: Caring for cardiac patients with compassion.

Funding: Narayana Hrudayalaya Private Ltd. and Asia Heart Foundation plus user fees

Background of Narayana Hrudayalaya (NH) Heart Hospital:

- Treated patients from 73 countries with complex heart disease and performed the largest number of pediatric heart surgeries in the world.
- Used a tiered-fee strategy where the surplus gained from paying patients subsidized procedures performed at, or below, cost for patients who could not afford the full fee.
- NH Heart Hospital's charges for open heart surgery were the lowest in India (as of 2005).
- Patients could choose to stay in private wards for higher fees but the quality of care remained the same for all patients.
- Rapidly grew from 280 beds in 2001 to 500 beds by 2004 to 1000 beds 2009, and served as the foundation for the NH Health City—a conglomeration of hospitals over 25 acres with 5,000 beds.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Continually attracting a high enough volume of patients to reach the economy of scale necessary to provide affordable care to the poor and remain financially viable.

Management Action: Develop a “focused factory” where a narrow range of services are offered with excellence, operational costs are minimized, and a high quality brand drives demand.

Principal L&M Characteristics Identified:

Leadership:

- Setting Direction
- Governance
- Scanning

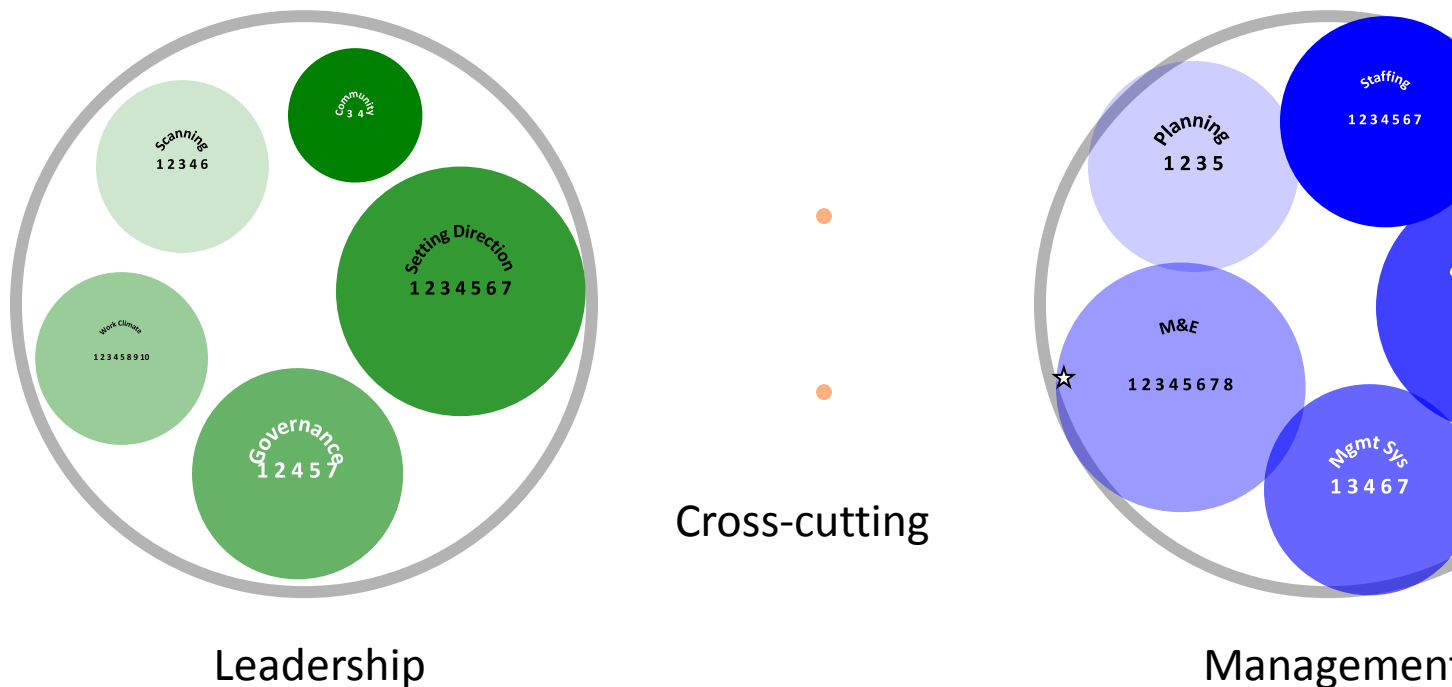
Management:

- Structuring
- Monitoring and Evaluation
- Staffing

Results Achieved:

- NH Heart Hospital was successful in delivering cardiac care that meets international quality standards at a price significantly lower than its competitors both within India and internationally.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



Setting Direction was the most present leadership and management domain measured at 93% presence based upon a review of case study materials. Another key leadership domain was Governance and this is comparably higher than most cases at 79% observed presence. Among management domains Structuring, Monitoring and Evaluation, and Staffing were notable at (83%, 81%, and 79% presence). Both the External Commitment to Leadership and Management and the Leadership and Management Development domains were not detected in the review of case materials. The white star in the Management System domain denotes that a health management information system was identified for this case study.

Management Action in Detail

Directional Strategy: Focused Factory

Narayana Hrudayalaya (NH) Heart Hospital used a hybrid strategy to attract paying patients by virtue of its reputation for high quality, combined with a relentless focus on lowering costs of operation. The Heart Hospital's rapid growth and success were possible due to a "focused factory" approach. By narrowing its focus to cardiac care services, the Hospital concentrated its resources on accomplishing a more targeted goal than general hospitals. The surgeons and physicians were highly specialized; each only performs a few variations of cardiac operations. Workforce focus led to simplicity, repetition, experience, and homogeneity of tasks which produces competence and in turn promotes quality care. High quality care and defined focus allowed NH Heart Hospital to build a strong marketable brand. This created a virtuous cycle where brand and quality increase patient volume and then patient volume increases provider competence and quality of care, further increasing brand strength. New physicians were attracted to this Hospital's work environment as it allows for rapidly building expertise. Reducing overhead costs added to their competitive advantage. High volumes allowed the hospital to negotiate better deals with their suppliers.

Comprehensive Management Systems

Using comprehensive hospital management software helped maintain minimum inventory and created other efficiencies. The finance department employed a unique accounting system where all revenue and costs are reported daily so decision-makers can measure performance, track profitability, and determine how much care NH Heart Hospital could subsidize in real-time.

Process Innovation

NH Heart Hospital also reduced costs for patients by capitalizing on technology. Over 50 telemedicine centers allowed physicians to conduct consultations remotely in addition to mobile cardiac care units which expanded access at a relatively low cost. The hospital adapted a business improvement process called LEAN that focuses on creating more value for patients while simultaneously utilizing fewer resources. The hospital also adopted other process innovations such as the use of digital X-rays which eliminated the recurrent costs of traditional machines.

Program Achievements

LEVEL: Health Effect

Health Effects:

- In 2008, the hospital reported a 1.4% mortality rate within 30 days of coronary artery bypass graft surgery compared with an average of 1.9% in the US, according to data gathered by the Chicago-based Society of Thoracic Surgeons. Comparison is difficult because this case does not use a risk-adjusted mortality rate and the US rate is adjusted. However, some suggest rates would look even better if adjusted for risk, because patients often lack access to basic health care and present with more advanced cardiac disease.

Service Outputs:

- Between 2001 and July 2004, the facility performed 9,591 tele-consultations and the mobile cardiac care units had 4,077 in-patients, many of whom would not have received treatment otherwise.
- In 2008, 42 cardiac surgeons performed 3,174 cardiac bypass graft surgeries, more than double the 1,367 the Cleveland Clinic, a US leader, did in the same year.
- In 2008, surgeons operated on 2,777 pediatric patients, more than double the 1,026 surgeries performed at Children's Hospital Boston.

Process Improvements:

- The average price charged for coronary artery bypass graft surgery in 2008 was \$2,000 compared to an average of \$5,000 for all private hospitals in India, and \$20,000-40,000 charged by US Medicare.
- Narayana Hrudayalaya Private Ltd. reports a 7.7% profit after taxes, or slightly above the 6.9% average for a US hospital, according to American Hospital Association data (2008).

Strength of Performance Assessment

SCORE: High

- Pre- and post- surveying of ongoing output monitoring and outcome assessments
- Quantitative analysis from regular reporting of clinical data and financial metrics

Comments

Narayana Hrudayalaya (NH) Heart Hospital's directional strategy focused exclusively on delivering high quality heart surgery. Through attracting high volumes of patients and expert health providers, the hospital built a strong marketable brand. Importantly, the Hospital leveraged its brand, expertise, and revenue streams to increase access to patients otherwise unable to afford quality care services. For its achievements, the NH Heart Hospital gained international attention, receiving recognition and accolades from Forbes, the Harvard Business School, and the World Economic Forum, among others.

RESPIRE

2002-2004

IMPLEMENTING ENTITY:

University of California Berkeley, University del Valle Guatemala, University of Liverpool and University of Bergen

Location: Guatemala
AMRO/Lower-Middle Income
Health Topic: Chronic Disease/Indoor Air Pollution

Key Words: Resource Targeting, Strategic Research

PROGRAM OVERVIEW

Goal: To evaluate the potential for improving health of an indigenous population in a low-income developing country by researching the consequences of reducing indoor air pollution through improved cook stoves.

Objective:

- (1) Conduct a randomized control trial to increase confidence in air pollution risk estimates; and
- (2) Extend the exposure response curve for particulate matter to higher chronic levels than has ever been done within a single population, thus assisting efforts to understand the physiological mechanisms of particulate matter impact.

Funding: US National Institute of Environmental Health Sciences (\$1.8 million grant); approximately \$150,000 from private foundations; resources obtained by WHO; and the Norwegian Research Council

The Randomized Exposure Study of Pollution Indoors (RESPIRE)

- First randomized intervention to reduce long-term indoor air pollution exposures.
- Introduced a previously proven exposure-reduction technology (chimney stoves) in a highly exposed population to study differences in the intervention versus control.
- Used the locally produced enclosed stove “*plancha*” which had been tested for effectiveness.
- Plancha was well-liked by the local community members, but the cost was prohibitive for most families to purchase one on their own.
- Regularly measured exposure through home visits.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Lack of sufficient evidence to attract investments for interventions.

Management Action: Recognizing that evidence drives funding and donor priority-setting, invest in and develop a comprehensive trial to demonstrate benefits from a promising cook stove intervention.

Principal L&M Characteristics Identified:

Leadership:

- Community Engagement
- Governance
- Scanning

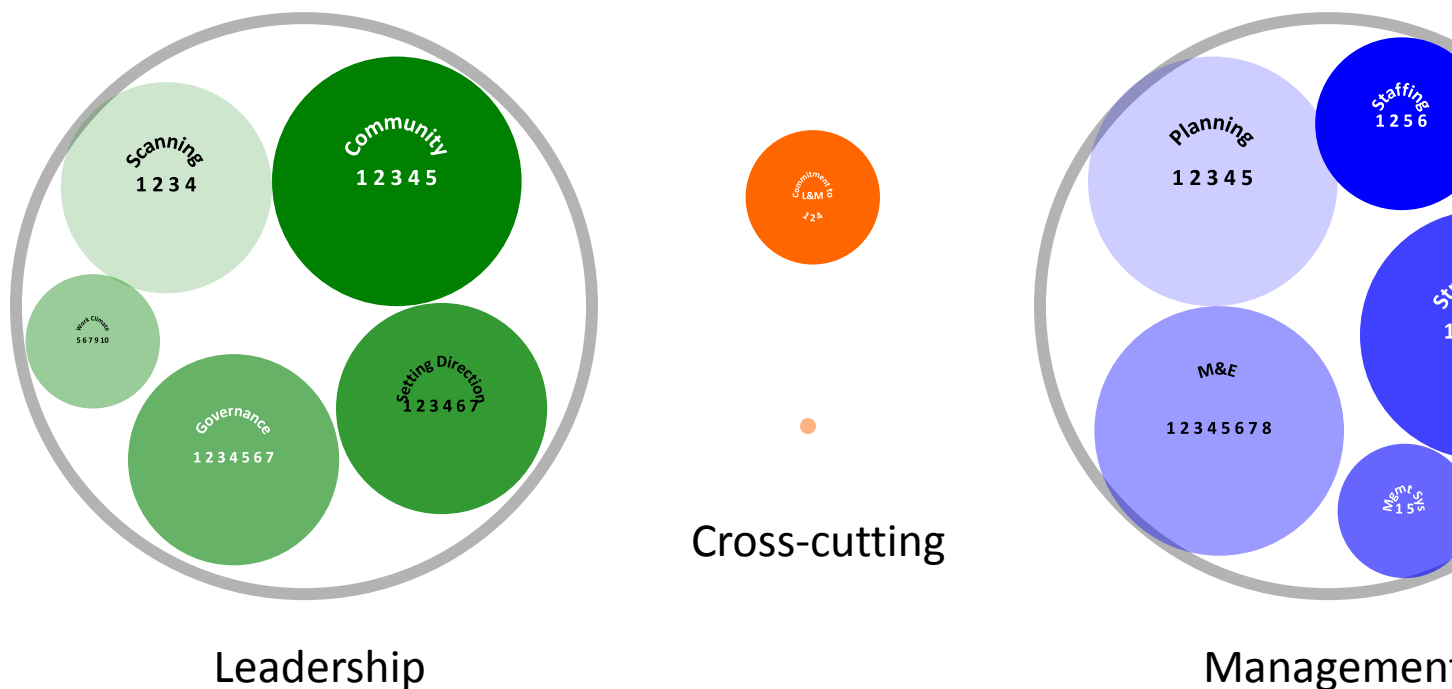
Management:

- Monitoring and Evaluation
- Structuring
- Planning

Results Achieved:

- Use of improved stoves significantly reduced participant exposure to IAP, as indicated by carbon monoxide in breath.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that Monitoring and Evaluation was the most present domain from a review of case study materials (94% presence). Structuring, Community Engagement, and Planning were also prominent in RESPIRE. The Leadership and Management Development domain was not detected in the review.

Management Action in Detail

Building an Evidence-base for Decision Making

Rural Guatemala was purposefully selected to conduct RESPIRE. A World Health Organization (WHO) expert committee scanned for possible locations and strategically chose the study site. The homes are generally enclosed with wooden doors and shutters, wood is the main household fuel and is burned indoors, and previous studies found that typical 24-hour average particulate matter concentrations were 15–20 times WHO guideline levels. Extensive pilot work was conducted to ensure feasibility and local acceptability of the intervention methods. The study's preparatory period lasted 1 year. Baseline information and further measurements were gathered by locally recruited fieldworkers who were trained to use standardized, evidence-based assessment guidelines. Fieldworkers received regular supervision and data collection was checked. The interview methods were piloted and modified as necessary to be understandable by the women participants.

Program Achievements

LEVEL: Health Effect

Health Effects:

- Prevalence of chronic respiratory symptoms, especially wheeze, was reduced among women in the enclosed stove group, but their lung function did not differ significantly from that of women who were still using open fires after a period of 12–18 months.
- Women participants that adopted the use of the enclosed stove had a significant reduction in carbon monoxide exposure during the 18-month period studied.
- Enclosed stove achieved a statistically significant 61.6% reduction in personal carbon monoxide exposure levels as measured by diffusion tubes.
- Overall child exposure reduction based on modeling of 48-hour carbon monoxide measurements was about 44%.

Strength of Performance Assessment

SCORE: High

- First randomized control trial on health effects of solid fuel use .
 - Baseline Household Survey, interviewer-led questionnaires
 - Regular follow-up measurements after 6, 12, and 18 months
- Weekly home visits by fieldworkers for acute lower respiratory infection case-finding.
- Other periodic assessments such as personal particulate matter exposure and blood pressure measurements.

Comments

RESPIRE realized that it could not move its agenda forward without an evidence-base to convince policymakers.

TOBACCO CONTROL

1990-Present

IMPLEMENTING ENTITY:

Government of Poland & Health Promotion Foundation

Location: Poland
EURO/High Income
Health Topic: Chronic Disease

Key Words: Systems Approach,
Evidence-based, Strategic Partnerships,
Effective Legislation

PROGRAM OVERVIEW

Goal: Reduce the mortality and morbidity associated with tobacco use in the Polish population.

Objective: Control consumption of tobacco, raise public awareness and change public opinion about smoking.

Funding: Unspecified

Background of Poland's Tobacco Control Program:

- Wide-ranging tobacco control legislation passed in November 1995.
 - Banned: smoking and the sale of cigarettes in health centers, schools, and enclosed workspaces; selling of tobacco products to minors under 18 years of age; producing and marketing smokeless tobacco; and advertising in electronic media (including radio and television), with restrictions on other media.
 - Required: free treatment for smoking dependence, and printing health warnings on all cigarette packs to occupy 30% of at least 2 of the largest sides of the packs—the largest health warnings on cigarette packs in the world at that time.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Difficulty promoting tobacco cessation in a market characterized by the highest cigarette consumption globally. Coupled with a population that was poorly informed about the dangers of smoking.

Management Action: Take a systematic approach involving legislation to limit supply, and institute taxation of tobacco products and evidence-based health education campaigns to reduce demand.

Principal L&M Characteristics Identified:

Leadership:

- Community Engagement
- Scanning
- Staff and Work Climate Development

Management:

- Monitoring and Evaluation
- Structuring
- Planning

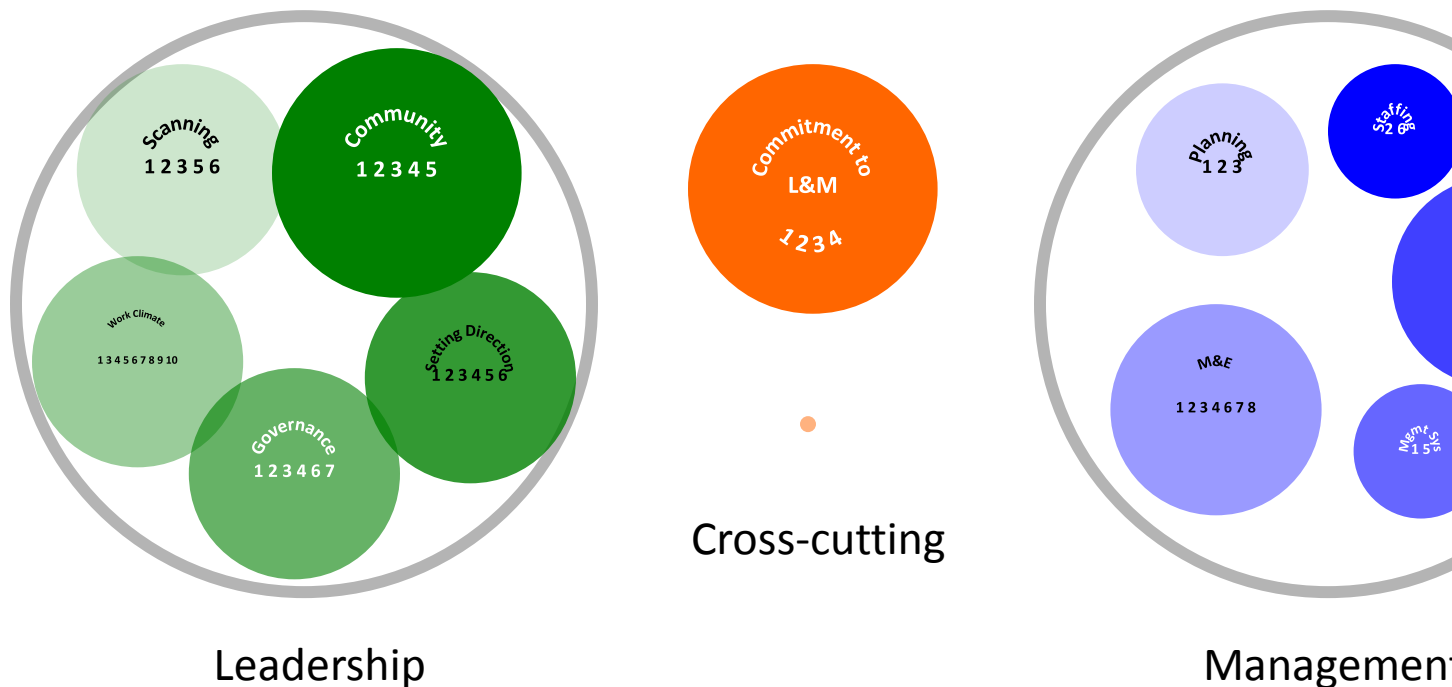
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- Poland's reduction in tobacco consumption has contributed to decreases in mortality, increases in life expectancy, and improved health outcomes.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



Community Engagement was the most present domain at 90% presence. Another prominent leadership domain was Scanning at 75% presence. The cross-cutting domain External Commitment to Leadership and Management was also noticeable at 88%. The Leadership and Management Development domain was not detected in the review of case materials.

Management Action in Detail

Building a Local Evidence-base

Poland's tobacco control movement was strengthened by building an in-country scientific evidence-base on the dangers of smoking. This helped to foster local ownership and engagement. Several international scientific and professional conferences were held in Poland to strengthen and reinforce the evidence. Success factors included strategic partnerships and collaboration between the science community, policy-makers, health advocates, and the media. Local evidence was applied in decision-making and policy formulation.

Social Marketing for Behavior Change

Key messages regarding smoking consequences were reinforced by the free media, providing a venue for public discourse, disseminating a shared vision, and influencing public opinion. Incentives were offered and campaigns created to build the public image of smoking cessation and counter the popularity image promoted by tobacco industry advertisements. An annual "Great Polish Smoke-Out" campaign, instituted by the Health Promotion Foundation, grew to be Poland's largest public health campaign and included a sweepstakes competition. The sweepstakes awarded someone who had quit smoking in the past year with a trip to Rome and a meeting with Polish-born Pope John Paul II. The media, community-based organization, faith-based organizations, and schools collaborated to promote the campaign.

Creating Revenue for Sustainability

Taxation of cigarettes allowed Government of Poland to leverage a new revenue stream while greatly increasing the cost by 30% in 1999 and another 30% in 2000 of tobacco products. All these efforts combined systematically to limit the supply and reduce the demand for tobacco consumption in Poland.

Program Achievements

LEVEL: Health Effect

Health Effects:

- Poland's total mortality rate (all causes) declined by 10% during the 1990s; 30% of which is credited to the decline in smoking, translating into 10,000 fewer deaths each year.
- By end of 1990s, lung cancer rates in men aged 20-44 had dropped 30% and 19% in men aged 45-64.
- Since 1991, the reduction in smoking has contributed to one-third of the 20% decrease in cardiovascular disease.
- Over a decade, low birth weight (LBW) decreased from over 8% in 1980 to less than 6%; about one-third of the decline in risk was attributed to reductions in smoking during pregnancy.
- During the 1990s, life expectancy increased by 4 years in men and over 3 years in women.

Process Improvements:

- Strong reach of anti-tobacco campaign: 80-90% of Poles had heard of the "Great Polish Smoke-Out."
- Each year, between 200,000 and 400,000 Poles credited the "Great Polish Smoke-Out" with their successful quitting; since 1991, more than 2.5 million Poles have quit smoking as a result if the campaign.
- Cigarette consumption dropped 10% between 1990 and 1998.
- Revenues from tobacco taxes served as a source of funding for tobacco control and other health promotion activities.

Strength of Performance Assessment

SCORE: High

- 1991, population case-control study of tobacco, alcohol, and diet in the etiology of laryngeal cancer
- 1998, ecological study of reasons for sharp decline in mortality from ischemic heart disease
- Ongoing analysis of mortality reporting

Comments

The Poland case demonstrated that strategic use of evidence and strong leadership can shift government policy to promote public health goals. The case applied a market approach in its intervention design. Poland's sweeping legislation, which was compatible with the World Health Organization's gold standard, has served as a model for tobacco control in other countries.

VERACRUZ INITIATIVE FOR DIABETES AWARENESS PROJECT

2000-Present

IMPLEMENTING ENTITY:

Mexico Ministry of Health and Diabetes Declaration of the Americas

Location: Mexico

AMRO/ Upper-Middle Income

Health Topic: Chronic Disease/Diabetes

Key Words: Quality Assurance, Systems Approach, Plan-Do-Study-Act Cycle

PROGRAM OVERVIEW

Goal: Increase the quality of life of people with diabetes through the improvement of quality of care.

Objectives:

- (1) Improve capacity and knowledge of diabetes care among health providers;
- (2) Introduce strategies to improve diabetes care; and
- (3) Evaluate and improve use of existing guidelines for diabetes care.

Funding: Unspecified

Background of the Veracruz Initiative for Diabetes Awareness Project:

- Part of Mexico's Ministry of Health's national campaign, *The Crusade for Quality Improvement*.
- One-year intervention included: in-service training of health workers, diabetes education, and a variety of initiatives led by primary care teams.
- Ten randomly selected health centers in Veracruz participated (five as intervention sites and five as controls).
- Intervention sites participated in project initiatives to improve diabetes training and education for health professionals and patients. Control sites continued treating diabetes with the existing model of care.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Mexico's Quality Information System indicated persons with diabetes were receiving inadequate quality of care.

Management Action: Integrated systems-based approach to improving quality of diabetes care.

Principal L&M Characteristics Identified:

Leadership:

- Scanning
- Setting Direction
- Community Engagement
- Staff and Work Climate Development

Management:

- Monitoring and Evaluation
- Management Systems
- Structuring

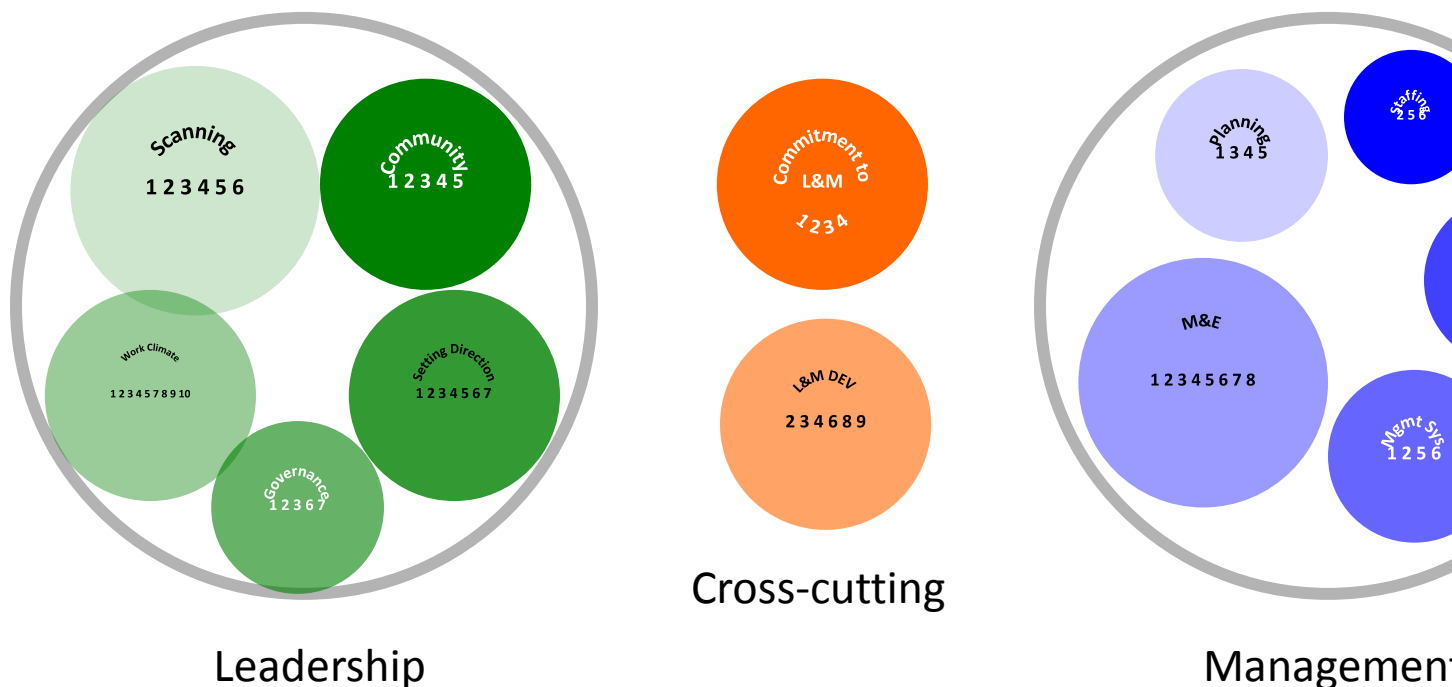
Cross-cutting:

- External Commitment to Leadership and Management
- Leadership and Management Development

Results Achieved:

- Clinical process indicators and health outcome indicators improved significantly more in the intervention group than in the control group.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that Scanning was the most present domain from a review of case study materials (83% present). Multiple other domains were also relatively large in size suggesting Veracruz Initiative for Diabetes Awareness Project documented a wide variety of leadership and management actions.

Management Action in Detail

Integrated Approach

The Diabetes Awareness Project set direction and planned activities to match the World Health Organization's Chronic Care Model components: self-management support, decision support, delivery systems design, and clinical information systems. The resulting intervention was a systems-based approach with in-service provider training, a structured diabetes education program, and a variety of process innovations created by the primary care teams.

Health Team-based Quality Improvement

Health workers were trained in how to apply the Plan-Do-Study-Act method for Continuous Quality Improvement. Plan-Do-Study-Act is a strategic management tool workers can use to scan for service gaps and areas for improvement, to generate and implement key priorities for action and to monitor and evaluate the effectiveness of organizational changes. The Diabetes Awareness Project used the Plan-Do-Study-Act training to encourage worker-initiated innovation and shared ownership of quality assurance. A range of team-generated solutions were developed and applied, most of which required little external resources. Some of the innovations that were put in practice by primary health care centers in the Diabetes Awareness Project included the organization of diabetes clinics, a collective medical visit for Diabetic clubs, and the use of health promoters to carry out diabetes education.

Patient Participation

The project engaged community members with diabetes to participate in the learning sessions. Patient involvement increased patient input when generating solutions for ensuring high quality care. All of the centers implemented a clinical information system.

Program Achievements

Health Effects:

- The proportion of diabetic patients with good blood sugar control increased from 28% to 39% in intervention group while the proportion increased from 21% to 28% in the usual care group.

Service Outputs:

- There were significant increases in recorded foot and eye examinations, education about foot care and nutritional counseling at the intervention sites. Documented foot care education increased to 76% of people in the intervention group, compared to 34% elsewhere.

Process Improvements:

- The proportion of patients achieving 3 or more quality improvement goals increased from 16.6% to 69.7% in intervention group while usual care group experienced a non-significant decrease from 12.4% to 5.9%.
- Building on the success of Veracruz, the project is now being extended to sites in Costa Rica, El Salvador, Guatemala, Honduras and Nicaragua.

Strength of Performance Assessment

SCORE: High

- Randomized control trial: five of the ten Veracruz Initiative for Diabetes Awareness project health centers were randomly selected to receive the intervention and patients at the other five health centers received usual care; HbA1C test (a long-term measure of diabetes control) data served as the baseline and end of project measurements

Comments

Veracruz Initiative for Diabetes Awareness's success was not due to a single intervention, but to a systemic approach based on a combination of factors, including in-service training for primary care teams. This case demonstrated that an integrated approach can improve the quality of diabetes care. Importantly, it showed that patient participation in the decision-making process contributed to successful outcomes and sustainability. Veracruz Initiative for Diabetes Awareness's results suggested that responsibility for service delivery does not lie exclusively with physician and nurse, but that a well-operating team is fundamental.

**HEALTH LEADERSHIP &
MANAGEMENT STRENGTHENING
CASES**

KENYA LEADERSHIP DEVELOPMENT PROGRAM

2008-Present

IMPLEMENTING ENTITY:

Management Sciences for Health (MSH)

Location: Kenya

AFRO/Low Income

Health Topic: Health Leadership & Management Strengthening

Key Words: Build Leadership & Management Capacity, Active Learning

PROGRAM OVERVIEW

Goal: To help Kenya's health sector develop managers who lead with a vision of a better future.

Objectives:

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

Funding: USAID

Background of Leadership Development Program:

- Conducted leadership and management gap analysis among Kenya's MOH managers.
- Developed coordinating framework to strengthen leadership and management among MOH and affiliated implementing partners.
- Tailored training program for leadership and management development

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Limited leadership and management capacity among health managers.

Management Action: Hold comprehensive and results-driven training workshops to build leadership and management capacity among teams of health managers.

Principal L&M Characteristics Identified:

Leadership:

- Setting Direction
- Staff and Work Climate Development
- Scanning

Management:

- Monitoring and Evaluation
- Planning
- Staffing

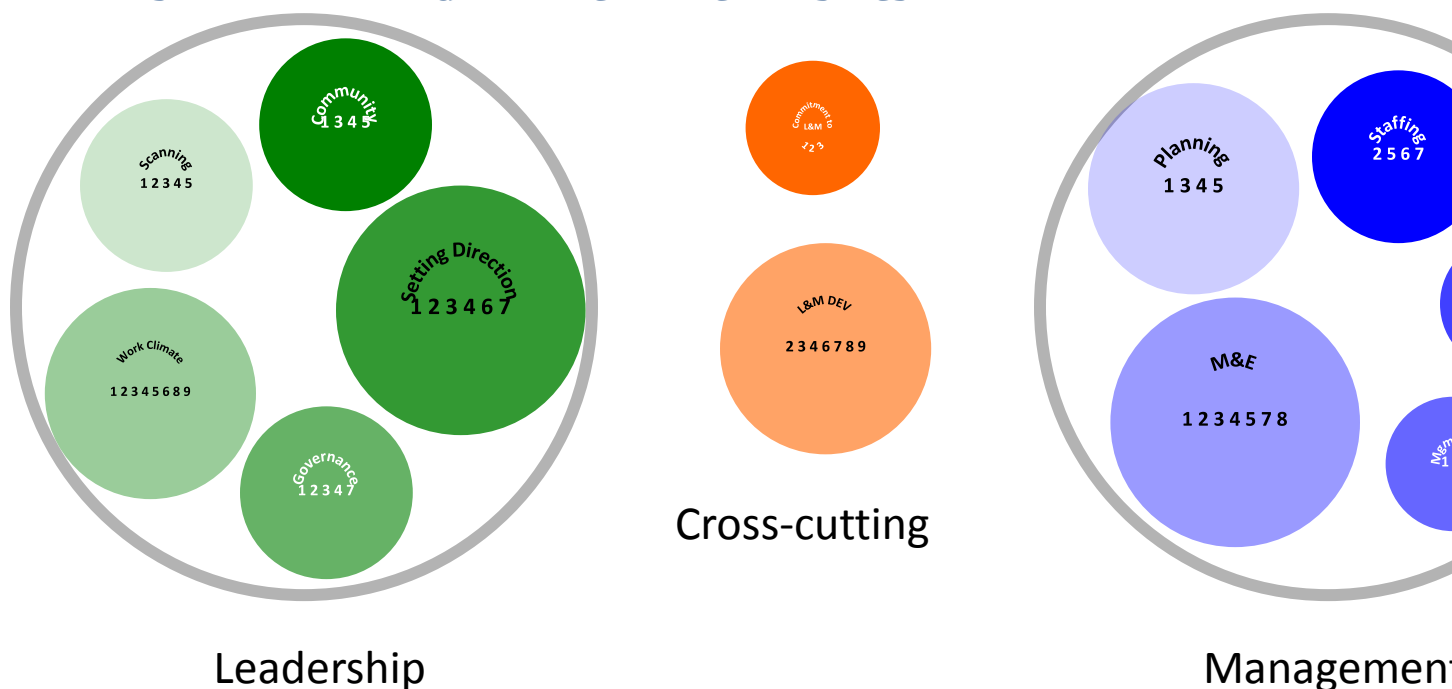
Cross-cutting:

- Leadership and Management Development

Results Achieved:

- Improved health outcomes among district and facility-level teams that participated in the LDP intervention. The majority of these improvements were sustained for at least two years after the end of LDP.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates broad implementation of leadership and management domains, with Monitoring and Evaluation and Setting Direction as the most present from a review of case study materials (88% and 80% presence, respectively). Leadership and Management Development was another prominent domain at 75% presence. This prominence likely results from the case's focus on training activities for managers.

Management Action in Detail

Leadership and Management Capacity Strengthening

The leadership development program takes a team-based approach. Teams engage in the program over a period of 4-6 months. Teams discuss strategies for—and actively address—their challenges through all program activities. LDP focuses on real challenges in the work place. Teams choose their challenge based on current problems they face on a daily basis that is preventing them from achieving results. Issues addressed were increasing coverage of fully immunized children under one year, birth delivery by a skilled attendant, four or more antenatal care visits and other health care challenges. To help organize and support their work, five kinds of program activities are held:

- **Senior Alignment Meeting**, an initial meeting which generates commitment and ownership of the Leadership Development Plan among key organizational stakeholders;
- **Leadership Development Plan Workshops**, a series of workshops comprised of twelve half to full day core sessions during which participants learn core leading and managing practices and concepts;
- **Local Team Meetings**, on-the-job meetings between workshops where participants transfer what they learned to their work team, discuss strategies to address their challenges, and apply leading and managing practices;
- **Regular Coaching**, in which local health managers support teams in implementing the tools of the Leadership Development Plan;
- **Stakeholder Meetings**, in which stakeholders are periodically updated and enlisted as resources to support the teams.

Program Achievements

LEVEL: Health Effect

Health Effects:

- 23 teams increased number of deliveries by skilled birth attendants.
- 25 teams increased immunization for children under 1 year.

Service Outputs:

- 11 teams increased the coverage of antenatal services where women received 4 or more consultations.
- 8 teams increased the coverage of services to address other health care challenges.
- For both district and facility level teams that received the Leadership Development Plan intervention, the aggregated coverage for all chosen service areas was 38% at baseline, 48% at endline. In the sustainability study conducted 6 months after the endline assessment, the aggregated coverage was 51%, showing that the teams, on average, improved their measureable results and sustained improvements between 2008 and 2010.
- At the district level, aggregated coverage rate for all chosen service areas increased from 54% at baseline to 65% at endline. The aggregated coverage rate was 67% in the sustainability study, showing that the plan produced and sustained positive results at district level. Comparison areas remained stable, with aggregated coverage rates of 46%, 46%, and 45%, respectively, for the 3 time periods (baseline, endline, and sustainability measures).
- At the facility level, results more than doubled in areas where Leadership Development Plan had been implemented, with Plan teams reporting an increase in results of 121% from baseline to endline, and 137% from baseline to the time of the sustainability study, an average of six months after the end of Leadership Development Plan. Comparison facilities showed a very modest increase of 9% (baseline to endline) and 26% (baseline to sustainability measure).

Process Improvements:

- Increased demand generated through social mobilization and health education.
- Increased access by providing more outreach sites or more service hours or days.
- Improved work climate due to renovated staff quarters, training, or supervision.

Strength of Performance Assessment

SCORE: High

- 2008, Baseline assessment
- 2010, Impact evaluation: retrospective quasi-experimental design, coverage rates at baseline, end-line and sustainability measures at district and facility levels, intervention group and comparison group

Comments

Kenya Leadership and Development Program demonstrated that leadership and management training can result in sustainable impacts that increase health outcomes.

LEADERSHIP, MANAGEMENT & SUSTAINABILITY PROGRAM 2005-Present

IMPLEMENTING ENTITY:

Management Sciences for Health (MSH)

Location: Bolivia

AMRO/Lower-Middle Income

Health Topic: Health Leadership & Management Strengthening

Key Words: Organizational Development, Action Learning, HMIS

PROGRAM OVERVIEW

Goal: To strengthen the institutional capacity of Centro de Investigación, Educación, y Servicios.

Objective:

- (1) Increase demand for reproductive health services;
- (2) Improve financial sustainability from 51% to 85%; and
- (3) Strengthen leadership practices and management systems, especially in human resources management

Funding: USAID/Bolivia

Background of Leadership, Management, and Sustainability Program:

- Carried out a needs assessment to identify and prioritize organizational management systems that required strengthening.
- Develop a long-term capacity building plan and strategy for financial sustainability.
- Assisted leadership team in implementing organizational restructuring plans.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Poor organizational management threatened the sustainability of programs.

Highlighted weaknesses included: lack of clear policies or planning, absence of a monitoring system, poor human resource management, stockouts and poor financial management.

Management Action: Strengthen key systems, such as human resources, financial management, marketing strategies, and organizational governance to increase capacity to respond to change, programmatic effectiveness, and prospects for sustainability.

Principal L&M Characteristics Identified:

Leadership:

- Scanning
- Setting Direction
- Community Engagement

Management:

- Monitoring and Evaluation
- Structuring
- Planning

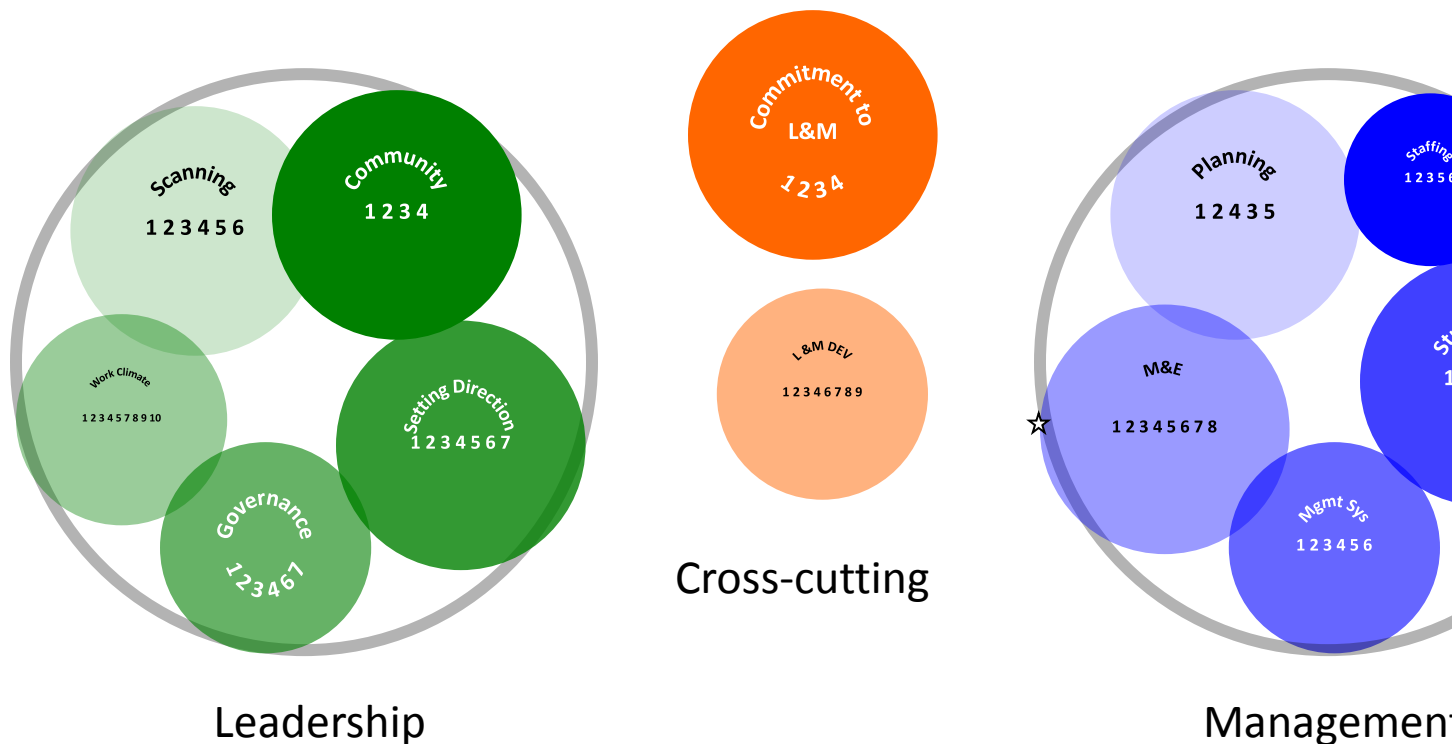
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- CIES met 97 different quality standards and was named an official International Planned Parenthood Federation (IPPF) Affiliate organization, and it succeeded in expanding the size of the population covered with key reproductive health services while simultaneously addressing the need to greatly improve its financial sustainability.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



Almost all characteristics in the figure are large in size suggesting this case documented a wide variety of leadership and management actions. In terms of greatest presence, Scanning was the most present domain from a review of case study materials at 100% presence. Of note, the white star in the Management System domain denotes that a health management information system was identified for this case study.

Management Action in Detail

Organizational Restructuring

The Leadership, Management, and Sustainability Program's technical assistance focused on the areas of strategic planning, marketing, business planning, proposal development, and human resource management. The program worked with a local NGO called Centro de Investigación, Educación, y Servicios to implement several tools to strengthen the organization and improve its financial sustainability. Tools included the Work Climate Assessment, Cost Revenue Analysis, the Business Planning for Health program, a human resource manual, and Leadership Development training program. The program supported a series of workshops for the NGO's staff to enhance leadership skills. The program incorporated areas of change management, negotiation, strategic thinking, and motivation into the training. These tools and workshops prompted the targeted organization to update its mission, structure, and strategies. The NGO then developed a new strategic plan for 2007–2011 and an ambitious operational plan. A management dashboard (management information system) was also created to monitor five key areas of the strategic plan: institutional image, financial sustainability, organizational capacity strengthening, replication of its health education model, and decentralized systems.

Program Achievements

LEVEL: Health Effect

Health Effect:

- Couple years of protection increased from 14,298 in 2007 to 26,751 in 2009. This will likely result in some level of decreased maternal mortality, but this has yet to be documented.

Service Outputs:

- As of late 2009, clinics and health centers attended to almost 400,000 reproductive health consultations per year and registered up to 236,000 clients using family planning methods.
- All facilities improved access to modern methods of family planning and offer the full range of methods including IUD, condom, pill, Depo-Provera, and male and female sterilization.
- Coverage and service delivery continuously improved.

Process Improvements:

- Improvements in organizational efficiency, sustainability, and work climate.
- Trained a total of 65 senior leaders in leadership and management practices.
- Introduced a web-based management dashboard to track key performance and financial indicators on a monthly basis by senior management.
- In January 2008, the organization received international quality certification as measured against 97 different quality standards.
- Financial sustainability increased from 51% to 60% with a solid trend towards achieving the target of 85% in 2010 and beyond.

Strength of Performance Assessment

SCORE: High

- 2006, Baseline assessment: interviews with key stakeholders, rapid assessments and “strengths-weaknesses-opportunities-threats” assessment
- 2008, Midline outcome evaluation
- 2010, Final program assessment: knowledge-attitudes and practices-based methodological assessment, structured interviews with managers and beneficiaries

Comments

Management Sciences for Health’s Leadership, Management, and Sustainability Program gave the Centro de Investigación, Educación y Servicios the leadership and management tools necessary to restructure the organization towards performance. Further, the program built staff capacity to maximize the utility of the leadership and management toolkit. These actions established a foundation for greater organizational sustainability over the long-term.

LEADERSHIP, MANAGEMENT & SUSTAINABILITY PROGRAM 2009-2010

IMPLEMENTING ENTITY:

Ministry of Health, Management Sciences for Health (MSH)

Location: Democratic Republic of Congo
AFRO/Low Income

Health Topic: Health Leadership & Management Strengthening

Key Words: Action learning, Build L&M capacity

PROGRAM OVERVIEW

Goal: To reduce infant, child, and maternal morbidity in 23 rural health zones in Kasai Oriental and Kasai Occidental, two provinces in west/central Democratic Republic of Congo.

Objectives:

- (1) Increase quantity and quality of health services;
- (2) Increase demand and service utilization; and
- (3) Strengthen the local capacity of MOH and NGO partners in management and delivery of health services.

Funding: USAID

Background of Leadership, Management & Sustainability Program:

- Two main components: the Leadership Development Program and the Fully Functional Service Delivery Point.
 - Leadership Development Plan built the leadership and management capabilities of teams of district and zonal health program staff
 - Service delivery point program was a standards-based whole systems tool that helped staff at hospitals and primary health care centers address service quality assurance, improvement, and expansion.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Health workers face challenges of high maternal mortality, poor working conditions, weak support structures, under-investments in management skills, and a lack of equipment, drugs and medical supplies. Programming tends to focus more on resource acquisition than on service quality or effectiveness.

Management Action: Build the leadership and management capacity of teams of health managers to address key workplace challenges and establish a standards-based tool to manage the quality of health service delivery.

Principal L&M Characteristics Identified

Leadership:

- Setting Direction
- Staff and Work
Climate Development
Scanning

Management:

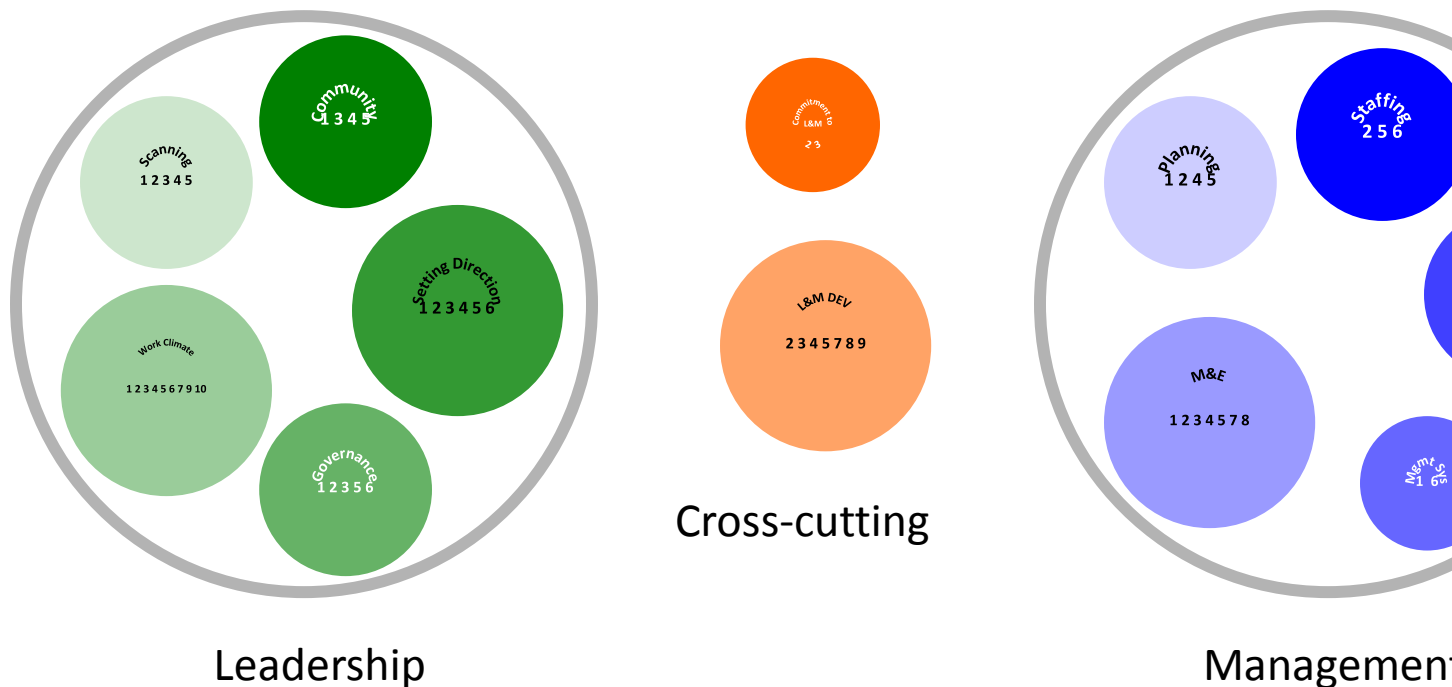
- Monitoring & Evaluation
- Structuring
- Planning

Cross-cutting:

- Leadership and Management Development

Results Achieved: The program helped health teams achieve improvements in quality, coverage, and management of health services.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that Monitoring and Evaluation and Leadership and Management Development were the most present L&M domains from a review of case study materials (both at 75% present). Multiple L&M domains in the figure are relatively similar in size, suggesting this case reported with equal attention on several areas. This is one of only a few case studies with very strong, proactive development of leadership & management in the cross-cutting area.

Management Action in Detail

Strategic Alignment

Before launching the program, the Leadership, Management, and Sustainability Program took time to gain buy-in and align local health officials to its goals. The program held a Senior Alignment Meeting to orient high-level stakeholders from the MOH and government administration in the project areas to the Leadership Development Program process. The program also supported the MOH at provincial, zonal and district levels through provision of pharmaceuticals, medical supplies and materials.

Action Learning to Build Workforce Competence

In the leadership development portion of the program, competency gaps in the health management workforce were addressed through teaching new skills. Training was based on principles of action learning including collaborating in teams, addressing real workplace challenges, systematic situational analyses, designing action plans, facilitative feedback, and ongoing coaching support. Health management teams worked together to ensure a common vision and clear understanding of roles and responsibilities. Participants identified shared priorities, planned for measurable results from the start, set timelines for reaching health objectives, and learned how to monitor. The active learning process built workforce capacities beyond the measurable health objectives. These capacities included improved communication, resource mobilization and team cohesion.

Performance Standards

The service delivery part of the program set standards and introduced a planning process at the facility level in tandem with the leadership development program. The service evaluation criteria were adapted to the local

context and aligned with the national strategy. Gradual introduction of the service delivery part of the program allowed time for health zones to build competence, derive lessons learned, and achieve success.

Results-Driven Activities

Both the leadership development and service delivery programs worked synergistically, both reinforcing performance improvement in health service delivery. Teams conducted preliminary assessments of pilot facilities and then secondary assessments at ten pilot facilities after six months. The pilot study was critical because data was needed to demonstrate potential impact to stakeholders in order to champion further investment and scale-up.

Program Achievements

LEVEL: Health Effect

Health Effect:

- The rate of births assisted by qualified personnel reached 94% (March 2010), up from 73% in the previous quarter, and 60% in the quarter prior to that.

Coverage and Service Outputs:

- 23,599 people were counseled in family planning and 87% accepted a method. The total number of people counseled increased 77% from the previous quarter (January-March 2010).
- The rate of coverage for prenatal care increased from 87% to 98% in one quarter (January-March 2010).
- Awareness-raising activities by Community Health Workers contributed to increasing the rate of postnatal consultations from 49% to 70% (January-March 2010).

Process Improvements:

- Across the nine areas measured by the service delivery part of the program (such as infrastructure and clinical quality), scores for the 10 health facilities increased by an average of 13% (from 32% to 45%).
- Improvements were most marked in health facilities with the lowest starting points (two of the lowest three improved over 30%).
- The range of scores across the 10 facilities was 41% to 62% (April 2010) as compared to the initial range of 22% to 45% (December/January 2010).

Strength of Performance Assessment

SCORE: Average

- Dec. 2009-Jan. 2010, service delivery preliminary assessment: pre-identified evaluation criteria and checklists
- April 2010, service delivery follow-up assessment: pre-identified evaluation criteria and checklists, and then compared to preliminary assessment findings

Comments

The Leadership, Management, and Sustainability Program established health service standards. Importantly, the program coupled this with training for health managers. Health managers actively learned to create action plans for meeting the service standards and then learned to monitor performance towards their service goals. The combination of standardization and training worked synergistically to improve health service outcomes through improved quality, coverage, and management in the participating facilities.

MANAGEMENT EFFECTIVENESS PROGRAM

2001-Present

IMPLEMENTING ENTITY:

Egyptian Ministry of Health and Population (MOPH) and World Health Organization (WHO)

Location: Egypt
EMRO/Lower-Middle Income
Health Topic: Health Systems Strengthening

Key Words: Build L&M Capacity, Training, HMIS

PROGRAM OVERVIEW

Goal: To develop the capacity of the health system in Egypt to respond to the needs of clients, improve the performance in achieving key health system objectives and introduce and sustain a culture of continuous improvement in management practices and processes

Objectives:

- (1) Build the managerial skills and competencies of individuals and teams through individual training, action-learning at the workplace, and sharing knowledge through learning networks;
- (2) Monitor and assess management performance; and
- (3) Review policies based on feedback of information and experiences.

Funding: Unspecified

Background of the Management Effectiveness Program:

- A global program lead by WHO but implemented with a country-specific focus.
- Intended to be an integral part of national health system strengthening efforts of a country and to improve management of both the public and private sector.
- Health leaders and their teams at selected sites identified system weaknesses and developed capacity to improve management processes and practices.
- Integrated the fundamental principles of quality management into national health system management.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Self-identified need for strengthening management expertise.

Management Action: Identify the country's management needs and tailor the global Management Effectiveness Program to the identified needs and context. Execute management capacity building in-country.

Principal L&M Characteristics Identified:

Leadership:

- Scanning
- Staff and Work Climate Development
- Setting Direction

Management:

- Monitoring and Evaluation
- Planning
- Structuring

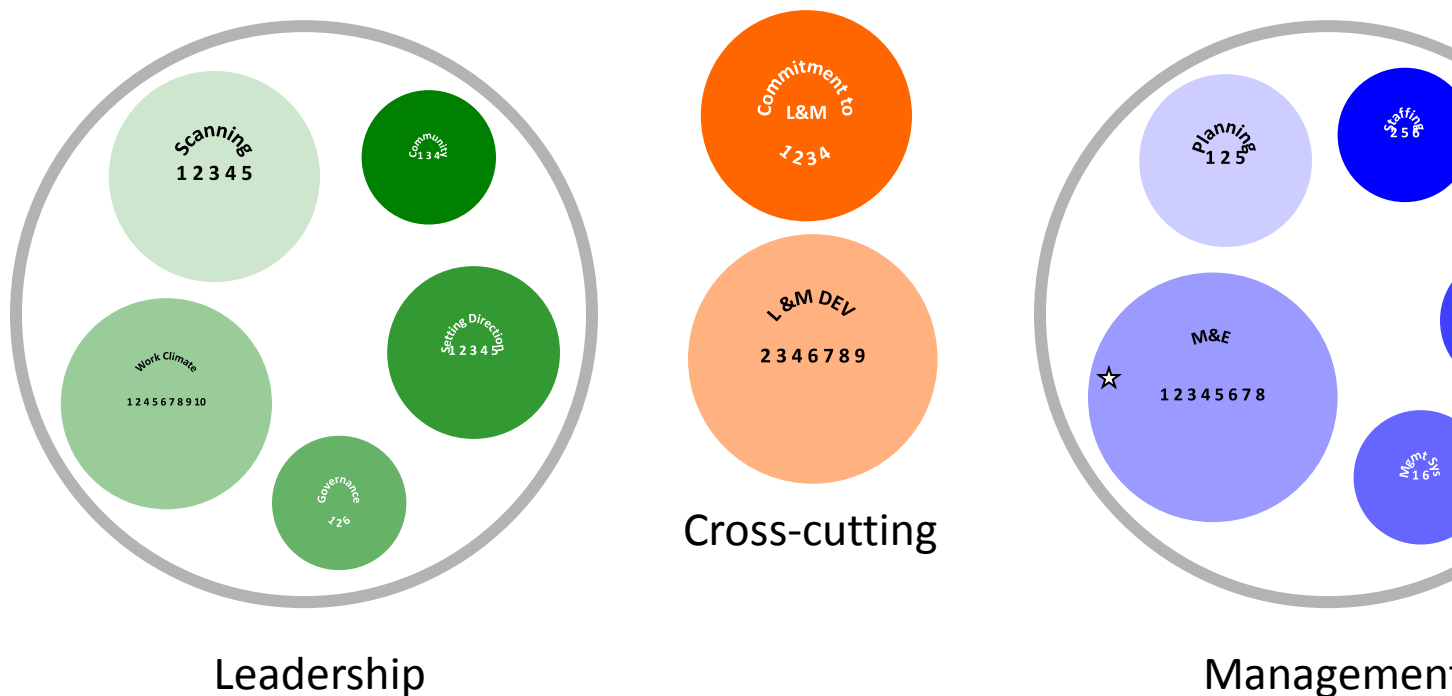
Cross-cutting:

- Leadership and Management Development
- External Commitment to Leadership and Management

Results Achieved:

- Substantial improvements made at program sites in leadership skills, teamwork and ability to target critical areas and use problem-solving techniques.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The cross-cutting domains External Commitment to Leadership and Management and Leadership and Management Development are unusually dominant in this case. Monitoring and Evaluation was the overall most present L&M domain reported in the case study materials (88% presence). Of note, the white star in the Management System domain denotes that a health management information system was identified for this case study.

Management Action in Detail

Prioritizing Leadership and Management Development

Egypt's Ministry of Health and Population designated a national Management Effectiveness Program director, a team of tutor-mentors, and a national center for the program. A central coordinating body was also established. Clearly designated roles and responsibilities facilitated information exchange and knowledge sharing among program implementing sites within and outside the country. This leadership structure also helped maintain strategic direction during program expansion.

Tailored Leadership and Management Strengthening

The Management Effectiveness Program's strategy for strengthening leadership and management capacity was tailored to the health system's context. The strategy combined learning core modules with a systems and roles development approach. Learning was sustained in two ways: (1) through providing continuous support by qualified mentors and tutors, and (2) through a feedback process that linked policy and operational levels of the health system. The strategy resulted in continual adjustment of structures and management. Institutionalizing adaptability maintained the health system's managerial effectiveness in achieving its goals. The program's complementary leadership and management strengthening activities included:

- Learning network: Linked sites together with partners, clients, and other stakeholders—both within a country and between countries. Facilitated the exchange of resources, knowledge, tools, and materials between participants. Provided a common administrative language in health system management.
- Open courses or seminars: Provided opportunity for managers throughout the health system to update their knowledge and awareness of new developments in the management field.

- Distance learning courses: Enrolled health system officials in degree or certificate courses on health management. Provided through partnerships with national and foreign universities, or advanced management training institutes.
- Executive development programs: Prepared selected individuals who demonstrated the potential and interest in achieving senior management and policy-making positions in the national health system.

Quality Improvement Through Management Training

The Management Effectiveness Program integrated the fundamental principles of quality management into the management of the national health system. It introduced and sustained a continuous process of measurable improvements. The program addressed quality through promoting patient-focused care and collaboration within health teams. Further, the program disseminated a common language regarding quality and shared quality improvement tools.

Action-Learning Addressing Self-Identified Problem

The Management Effectiveness Program carried out problem solving with the actual teams based at each facility. Teams worked together in a structured learning environment to apply leadership and management principles to their tailored issues at each facility. The environment provided teams an opportunity to develop and then later carry out standard operating procedures and training courses to inform managers of blood banks. This increased service utilization, coverage and reduced costs, in addition to other benefits.

Program Achievements

LEVEL: Health Effect

Health Effect:

- Increase in the number of deliveries at a hospital facility that were originally at home from 4 to 15 cases per month.

Service Outputs (2001-2004):

- 12% increase in service utilization (April 2003-March 2004).
- Initiated program to develop chest clinic and to screen target groups for TB.
- 50% increase in the utilization of family planning services in the catchment area (2001-2002).
- 25% increase in children under 5 years attending the lab to undertake test for anemia during 2004.
- 35% increase in the utilization rate of antenatal care in a 6-month period.
- Promoting thyroid screening services for neonates in new health service organizations increased screening coverage from 38% to 60% during 2004.

Process Improvements (2001 - 2004):

- Established of a health information management system for private medical services.
- 10% increase in revenue (April 2003-March 2004).
- Preparation and distribution of standard operating procedures.
- Utilization of existing equipments to provide new health services.
- Launching of health education program to raise awareness within the population for the complications and dangers of female circumcision.
- Shortened waiting time from 120 to 30 minutes.
- Reduction in the percentage of discarded outdated blood units in all 17 blood bank branches to World Health Organization standard of 2%.
- The Roda Center is now ranked as the best medical center in the health zone with respect to the provision of family planning and health services for homeless children.

Strength of Performance Assessment

SCORE: High

- Early 2002, Baseline assessment: collect data from the selected sites to identify initial capabilities, barriers and opportunities for management improvement.
- Mid-2003, Outcome assessment
- November/ December 2004, Final evaluation of the expansion phase scheduled

Comments

The Management Effectiveness Program strengthened Egypt's health system through creating a country-specific strategy on management development.

SESA LEADERSHIP DEVELOPMENT PROGRAM

1998-Present

IMPLEMENTING ENTITY:

Ceara State Secretariat of Health (SESA), Management Sciences for Health (MSH)

Location: Brazil

AMRO (Upper-Middle Income)

Health Topic: Health Leadership & Management Strengthening

Key Words: Build L&M Capacity, Action Learning

PROGRAM OVERVIEW

Goal: To strengthen leaders and managers of public health systems as a key strategy of the overall good governance initiative.

Objectives: Implement a Leadership Development Program for the entire Ceara State Secretariat of Health.

Funding: USAID [2001-2002; \$200,000], DFID, Ceara State Secretariat of Health and State School of Public Health [2003-present]

Background of Leadership Development Program (LDP):

- Focused on good governance and transparency.
- Established guidelines for hiring and promoting public sector employees based on qualifications.
- Formed educational partnership with Ceara State Secretariat of Health to strengthen health workforce using MSH's expertise in improving leadership and management competence. Provided MSH's Leadership Development Program model to all public health employees.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Public health practitioners lacked specific education and training in leadership and management.

Management Action: Deputy Secretary of Health proposed a partnership among the State Secretary of Health, its school of Public Health, MSH and a local leadership consultant to implement MSH's Leadership Development Program model.

Principal L&M Characteristics Identified

Leadership:

- Scanning
- Setting Direction
- Community Engagement

Management:

- Planning
- Structuring
- Staffing

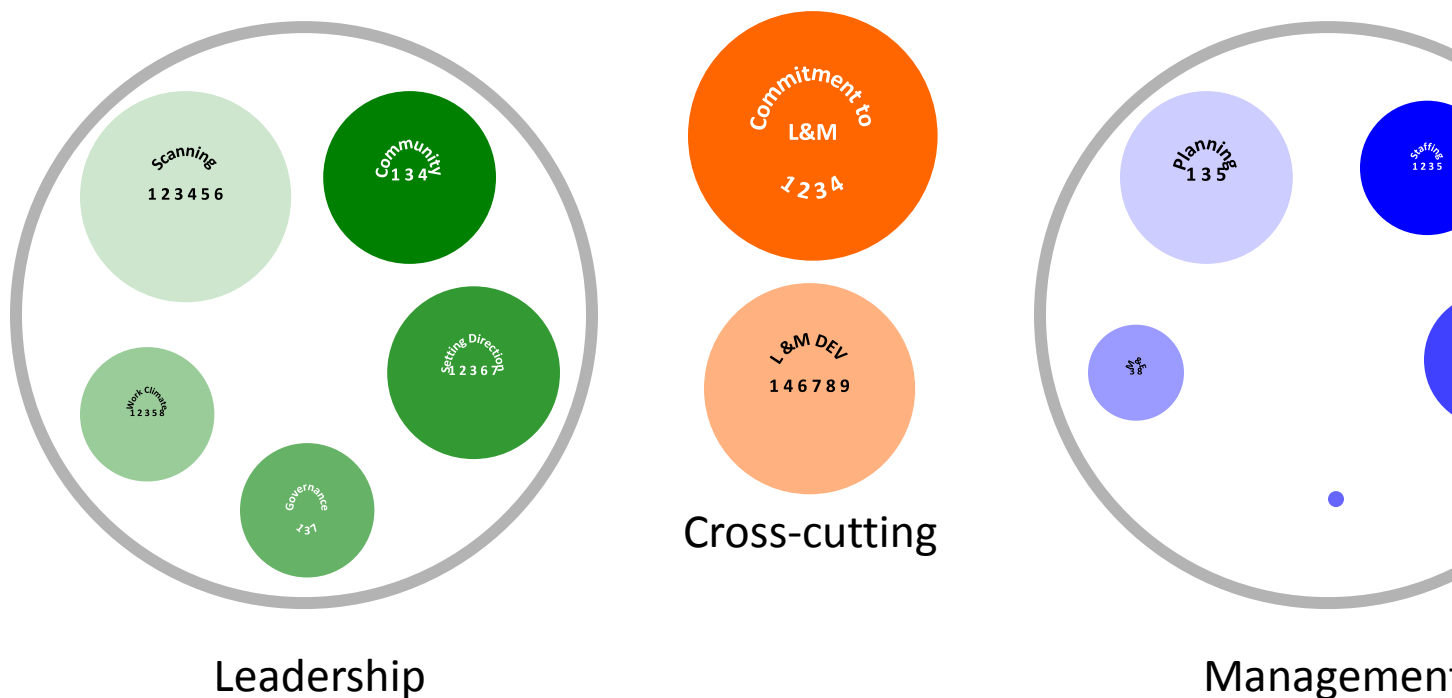
Cross-cutting:

- External Commitment to Leadership and Management
- Leadership and Management Development

Results Achieved:

- In the first year of the Leadership Development Program, 125 leaders were trained.
- Hospitals where staff participated in the Leadership Development Program demonstrated improvements in functioning and patient care.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



In this case the cross-cutting domains, Commitment to Leadership and Management, and Leadership and Management Development, were among the most present L&M domains from a review of case study materials (88% and 63% presence). This case is comparatively unique with notable presence in both cross-cutting areas. The leadership domain of Scanning was also apparent at 75% presence. The Management Systems domain was not detected in the review of case study materials.

Management Action in Detail

Strategic Recruitment

An extensive recruitment campaign was carried out by the State Secretary of Health. The Leadership Development Program was announced through major media outlets. The State Secretary of Health encouraged all public health employees in the state with university degrees to participate. Candidates were required to submit an application and recommendations from former and current supervisors. Senior managers in the Secretary reviewed the applications.

Innovative Approaches for Leadership and Management Training

With support from donors, the Secretary created LiderNet. LiderNet was a combination of face-to-face and web-based activities at the School of Public Health. This innovative method was chosen in order to expand access to low cost professional leadership development for current and future health managers. The Leadership Development Program and virtual leadership development within the School of Public Health continued to train public health leaders and managers, and leadership development spread to other sectors as well, within Ceara and to other Brazilian states.

Program Achievements

LEVEL: Health Effect

Health Effects:

- Up-to-date vaccinations for children under 1 year of age increased from 84% to nearly 100% in Ceara (2001-2005).
- 25 (75%) of the poorest municipalities of Aquiraz (small town within Ceara, pop. 69,000) reduced infant mortality by up to 50% (2000-2004).
- Children exclusively breastfed up to 4 months of age increased by 20% in Aquiraz (2001-2005).
- Proportion of children with low birth weight was cut in half in Aquiraz (2001-2005).

Service Outputs:

- Pregnant women enrolled in prenatal care in the 1st trimester rose from just over half to 80% in Aquiraz (2001-2005).

Process Improvements:

- 440 people applied for the first 75 places in the program, demonstrating demand for LDP to policymakers.
- LDP participants pursued multiple improvements and innovations with their new training. As an example, Senior staff from Sao Jose Hospital in Fortaleza made the following additions:
 - Increased strategic planning, established a strategic management committee, and instituted human resource development and staff relations programs
 - Launched a patient relations service: patient comments increased by 45%, but patient complaints decreased by more than 75% (2000-2005)

Strength of Performance Assessment

SCORE: High

- 2001, Baseline assessment
- 2005, Follow-up assessment: monitoring outcomes in coverage, functioning, and patient care known to be associated with improvements in health

Comments

The Ceara Leadership Development Program pursued a strategic and innovative approach to training public health professionals in leadership and management skills. The case demonstrates that strengthening the leadership and management capabilities of public health professionals can contribute to improved health outcomes.

STRENGTHENING LOCAL GOVERNANCE FOR HEALTH PROJECT (HEALTHGOV)

2006-2011

IMPLEMENTING ENTITY:

RTI International

Location: Philippines
WPRO/Lower-Middle Income
Health Topic: Health Systems Strengthening

Key Words: Decentralize L&M Development, HMIS, Training

PROGRAM OVERVIEW

Goal: To strengthen local government unit commitment to health and their capacity to sustainably provide, finance, and manage quality health services, particularly family planning, maternal and child health, TB, HIV/AIDS, and other infectious diseases such as avian influenza and Severe Acute Respiratory Syndrome (SARS).

Objective:

- (1) Strengthen health management systems;
- (2) Expand financing for essential health services;
- (3) Improve service provider performance; and
- (4) Enhance advocacy for service delivery and financing.

Funding: US Agency for International Development. Other key partners include: Jhpiego (a Johns Hopkins University Affiliated Organization), Centre for Development and Population Activities, Council for Population, Health and Welfare, and Orient Integrated Development Consultants, Inc.

Background of HealthGov:

- Service provision was decentralized in the Philippines.
- Supported more than 500 local governments in 23 provinces to strengthen their commitment and capacity to provide, finance, and manage quality health services.
- Mobilized a network of in-country government agencies, universities, and NGOs to secure institutional support.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Financing and delivering quality health services effectively and efficiently in a decentralizing health system.

Management Action: Build health management and leadership capacity in local-level governance through a demand-driven approach.

Principal L&M Characteristics Identified:

Leadership:

- Setting Direction
- Scanning
- Staff and Work Climate Development

Management:

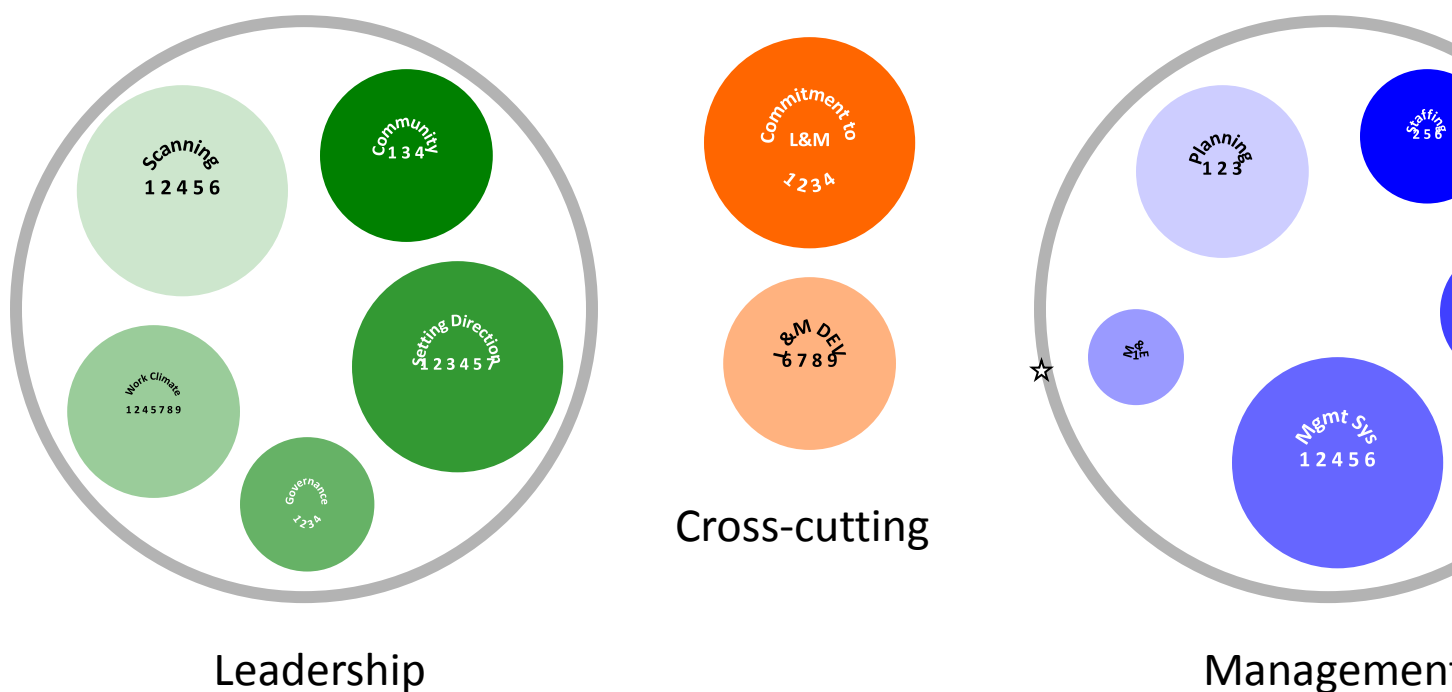
- Management Systems
- Planning
- Structuring

Cross-cutting:

- External Commitment to Leadership and Management
- Leadership and Management Development

Results Achieved: Increased advocacy on service delivery and financing, strengthened key local government unit systems to sustain delivery of key health services, improved and expanded local government unit financing for health, and improved service provider performance.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that Setting Direction was the most present domain from a review of case study materials (79% presence). Another prominent leadership domain was Scanning at 67% presence. Among management actions Management Systems was notable at 64% presence. The high presence in the cross-cutting category, with External Commitment to Leadership and Management at 63% presence, is noteworthy. The white star in the Management System domain denotes that a health management information system was identified for this case study.

Management Action in Detail

Strategic Planning

HealthGov promoted a demand-driven approach. In the program, local leaders defined a health governance development plan, including financial support for planned activities. HealthGov focused on strengthening elected and health officials' capacities in participatory planning. Planning was integrated between the national and the provincial level. Local government units formulated their health sector plans, programs, and activities into five-year investment plans.

Mobilizing the Community for Greater Accountability

Improving communication channels with the public, stakeholder participation, and the local HMIS accounts was a priority. Better communication was essential to increase access to information and awareness of client needs. To invigorate demand for improved services, HealthGov trained NGOs and civil society organizations in advocacy and policy issues, such as reading a budget. This was done to give NGOs and civil society tools to hold elected officials accountable. The project also trained Health Board members to advocate from within the local government.

Information Management for Evidence-based Decision Making

HealthGov promoted evidence-based decision making and problem-solving at the local level. Strengthening health management information systems included addressing data generation and analysis. Other information

management focused on long- and short-term planning, financial administration, quality assurance and supervision, human resource management, and performance monitoring and evaluation.

Strategic Financial Management

HealthGov assisted local government units in introducing performance-based budgeting to make better use of scarce resources, diversifying their financial base, and encouraging complete market segmentation. Market segmentation created a basis for introducing user fees, while protecting the poor.

Performance Improvement

To address provider performance, the program prioritized human resource management. The program ensured high quality service delivery. Training systems for health providers were strengthened. HealthGov improved the response capacity to specific infectious diseases. The program assisted some local government units in completing requirements for national accreditation for their health facilities. HealthGov modeled a client-focused Continuous Quality Improvement (CQI) approach.

Program Achievements

LEVEL: Improved Processes

Evaluations directly linking HealthGov with population health outcomes or increased service outputs have not been reported.

Process Improvements:

- Improved and expanded local government units financing for health through access to a grant facility and local resource mobilization
- The client-focused CQI approach, *Service Delivery Excellence in Health*, has been adopted by 41 health facilities in 21 municipalities, in 7 provinces
- Increased advocacy on service delivery and financing through a mechanism for community dialogues and feedback on health, civil society representation in functional local health boards, promotion of participatory policymaking, and collaboration with other partners
- Strengthened key local government units systems to sustain delivery of key health services through technical assistance for contraceptive self-reliance, local health management information system, and local health policy development
- Improved provider performance through service delivery implementation review; a family planning competency-based training manual; a public health nurse supervision manual; training and planning in informed choice and voluntarism, HIV/AIDS, Avian Influenza and TB

Strength of Performance Assessment

SCORE: High

- USAID Quarterly Program Reports with program outcome indicators from the first quarter of the first year (October 1- December 31, 2006) through first quarter of the third year (October 1 – December 31, 2008)

Comments

HealthGov worked with local government leaders to set strategic directions for their health systems. A hallmark of this program was data-driven decision-making. Information systems were used in budgeting, policy formation, and service performance improvement.

HEALTH SYSTEM STRENGTHENING CASES

AFGHANISTAN'S BASIC PACKAGE OF HEALTH SERVICES (BPHS) 2002-Present

IMPLEMENTING ENTITY:

Afghan Ministry of Public Health (MoPH), USAID, and Management Sciences for Health (MSH), Johns Hopkins Bloomberg School of Public health

Location: Afghanistan
EMRO/Low Income
Health Topic: HSS

Key Words: Systems Approach, Standardization, priority setting, HMIS

PROGRAM OVERVIEW

Goal: To provide a standardized package of basic services that would form the core of service delivery in all primary health care facilities.

Objectives:

- (1) Provide basic services that would have the greatest impact on the major health problems;
- (2) Ensure the quality of services provided;
- (3) Include services that would be cost-effective in addressing the problems faced by many people;
- (4) Extend coverage to these services in an equitable manner; and
- (5) Provide a foundation focused on community-based care for the reconstructed health system.

Funding: Approximate cost of delivering BPHS is US \$4 per capita, per year.

Background of Afghanistan's BPHS:

- Major national health program.
- Delivered a basic package of health services (BPHS) at a community level.
- Contracted service delivery to NGOs through a competitive bidding process. Assigned clear geographical responsibility to the NGOs (typically for whole provinces with populations from 150,000 to 1 million).
- Developed balanced score card to monitor standardized indicators for performance.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Reconstruct a health system after decades of neglect and conflict. Operate in a high-risk and volatile environment for a population with a high burden of illness.

Management Action: Institute a coordinated policy framework. Define a prioritized and standardized "Basic Package of Health Services". Compensate for lack of internal capacity for service delivery by contracting with NGOs. Prioritize monitoring and evaluation to inform progress of health sector development.

Principal L&M Characteristics Identified:

Leadership:

- Scanning
- Staff and Work Climate Development
- Setting Direction

Management:

- Management Systems
- Monitoring and Evaluation
- Planning

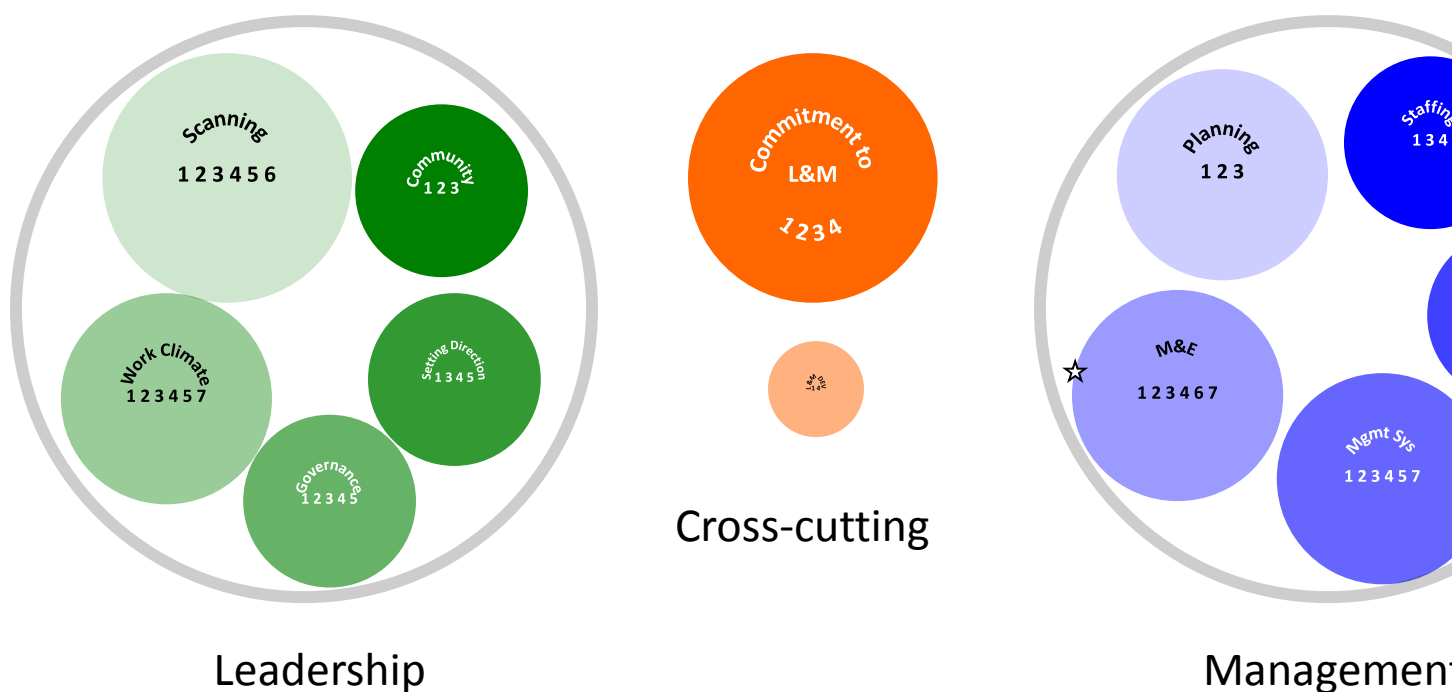
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- Brought coherence and unified the priorities of the Afghan health system; facilitated unambiguous decisions about the direction of the health system; standardized the classification of health facilities; increased the proportion of the population with basic access to BPHS services to nearly 82% (as of mid-2008).

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



Scanning was the most present domain from a review of case study materials (100% presence). Multiple L&M domains in the figure are relatively large in size suggesting the Afghanistan BPHS case documented a wide variety of leadership and management actions. Also, the cross-cutting domain of External Commitment to Leadership and Development is notably larger than most other cases at 88% presence. The white star in the Management System domain denotes that a health management information system was identified for this case study.

Management Action in Detail

Strategic and Coordinated Health System Strengthening

The basic package of health services (BPHS) introduced a new standardized classification of health facilities: health posts, basic health centers, comprehensive health centers and district hospitals.

Standardized Performance Monitoring

The Afghan Ministry of Public Health (MoPH) and other donors rehabilitated and reinforced key health information systems, including financial management and procurement systems. The improved systems enabled the MoPH to plan and manage activities, allocate resources, and monitor expenditures. As a result of its strong and continuous leadership in program and financial management, the MoPH is the first Afghan ministry certified by the U.S. Government as ready to receive and manage direct assistance.

Program Achievements

LEVEL: Health Effect

Health Effects: (Many of the main health indicators are up by a factor of 3 to 6 times since BPHS was launched.)

- 40% estimated reduction in maternal mortality from 2002 to 2008
- 38% reduction in under 5 mortality from 2002 to 2008
- 22% reduction in infant mortality from 2000 to 2006
- 317% increase in births with a skilled attendant from 2003 to 2006
- 248% increase in national immunization coverage (% children completed DPT)

Service Outputs:

- 84% of population with access to basic health services, up from 9% in 2000
- 320% increase in married women in rural areas using a modern family planning method
- 640% increase in pregnant women in rural areas receiving antenatal care
- 76% of health facilities with at least one skilled female health provider in 2006 up from 38% in 2003

Process:

- Increased from 53% to 70% across the 29 indicators from 2004 to 2007
- 19,000 community health workers (CHWs) trained and put in place
- Comprehensive health management information system was installed and tracked performance

Strength of Performance Assessment

SCORE: High

- Baseline survey to establish basic package of health services (BPHS) priorities.
- A score card was set up to benchmark BPHS's progress. The monitoring score card is an annual survey that looks at all aspects of care and delivery with 29 indicators across 6 domains. Child and maternal mortality data were updated from the development-focused 2008 national vulnerability and risk survey.
- 2006, Afghanistan Household Survey: 4 months of field surveys of rural households, focused on maternal and child health indicators; it addressed care-seeking behavior, expenditures and perceptions of health service.

Comments

Afghanistan's Basic Package of Health Services demonstrates that health system strengthening was possible in a highly volatile post-conflict environment. Early development of an agreed upon framework focused on a select set of achievable health services. Implementation proceeded quickly by leveraging already existing NGO networks. This case prioritized performance measurement to track progress and inform health system development.

ALBANIA PRIMARY HEALTH CARE HMIS

2002-2004

IMPLEMENTING ENTITY:

Albanian Ministry of Health (MOH),
Partners for Health ReformPlus (PHRplus)

Location: Albania
EURO/Upper-Middle Income
Health Topic: Health Systems
Strengthening

Key Words: HMIS

PROGRAM OVERVIEW

Goal: Design a Health Management Information System (HMIS) to inform and support interventions aimed at improving the quality of care and efficiency of primary health care in Albania.

Objective: To help facility, district, and regional managers to collect, analyze, and feed back the data necessary to make more informed clinical and managerial decisions.

Funding: Pilot funded by USAID (PHRplus), scaled up funded by Albanian local health authorities (with initial technical assistance from USAID/PHRplus)

Background of Albanian MOH's Health Management Information System (HMIS):

- An HMIS, adapted from an existing system in Egypt, was designed by the PHRplus Project to enable primary health care practitioners to make better-informed clinical decisions.
- Based on a simple one-page, scannable encounter form that captured data on every patient visit.
- HMIS proved effective in four pilot health centers—local health officials and facility staff produced and disseminated routine reports to target user groups for improved planning, monitoring, and quality improvement activities.
- The local government requested expansion of the pilot project from the facility level to the district level.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Planning for effective scale-up of pilot HMIS system.

Management Action: Perform stakeholder and environmental analyses to tailor the HMIS to the local context.

Principal L&M Characteristics Identified:

Leadership:

- Scanning
- Setting Direction
- Governance

Management:

- Planning
- Monitoring and Evaluation
- Structuring

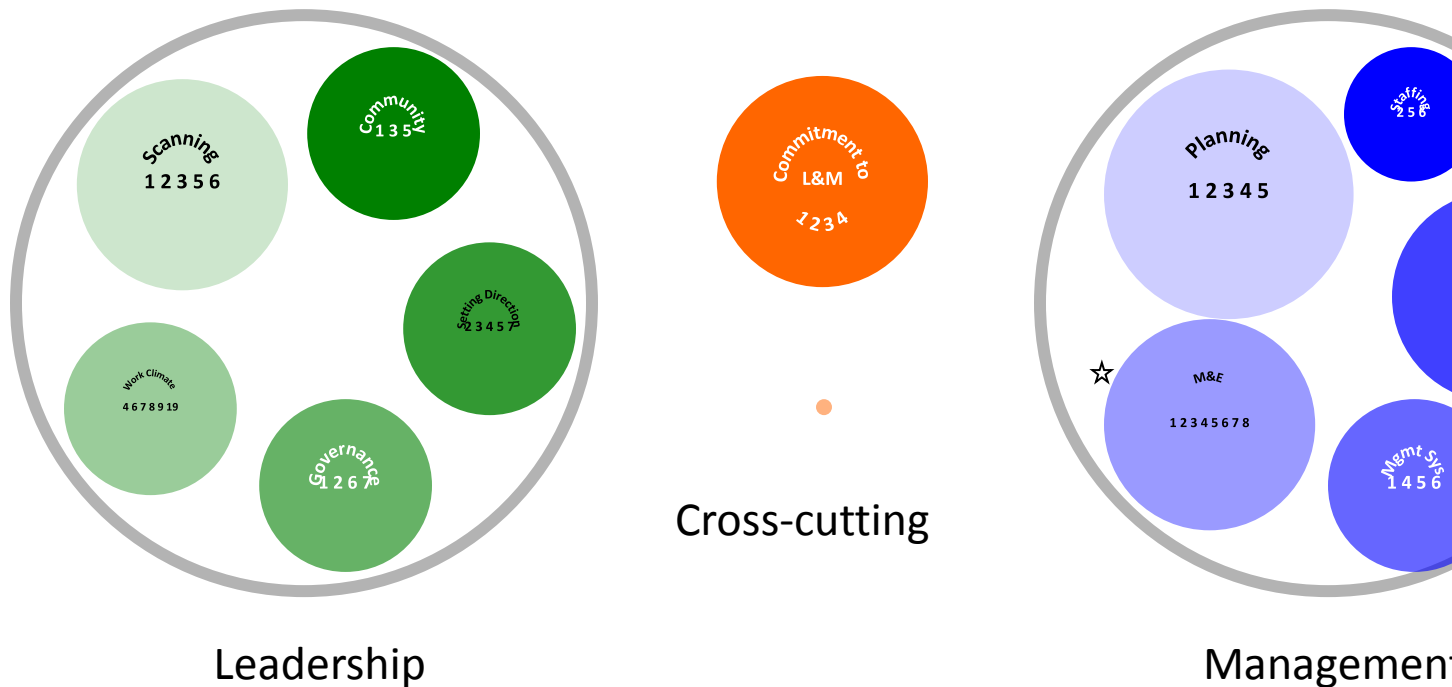
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- The HMIS has contributed to improved process measures and increased the availability of more timely and reliable health data.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that Planning was the most present domain from a review of case study materials (80% presence). Overall, the overarching management category appears to be more notable than the leadership or cross-cutting categories. The Leadership and Management Development domain was not detected in the review of case materials. The white star in the Management System domain denotes that a health management information system was identified for this case study.

Management Action in Detail

Streamlining for Scale Up

The PHR*plus* team recognized an opportunity to learn from the pilot experience (even though the pilot was successful) and improved the system before scaling it up. The PHR*plus* team performed a stakeholder analysis. The program used community participative decision-making to identify ways to reform the Health Management Information System (HMIS) for the new context. PHR*plus* sought input from staff of pilot health centers, information management experts, a diverse group of government representatives, and other key constituents. Group discussions led to an agreement on a set of principles for streamlining the HMIS and ensuring the system would be compatible with other health sector strategies and goals. To manage environmental risks, the HMIS infrastructure was flexible in design. The system did not require sophisticated technology. It ensured operation and data back-up given inconsistent electricity. The new reporting form allowed for costs to be assigned with procedures. By incorporating financial management capacity into the reformed HMIS, the system provided a means for future financial analyses. The new reforms were tested prior to full adoption. PHR*plus* addressed human resource capacity through training staff on the new system. Staff was provided with instruction manuals, toolkits, and ongoing technical assistance.

Program Achievements

LEVEL: Improved Processes

Evaluations directly linking Albania's PHC HMIS with population health outcomes or service outputs have not been reported.

Process Improvements:

- In the pilot, over 90,000 patient encounters were collected and analyzed (2002-2004).
- By 2004, the HMIS put in place by PHRplus in 2002 had begun to prompt behavior change among providers by the time of the follow-up provider survey; 29% of providers surveyed said that they had made changes in their practice based on information from the HMIS.
- In August 2004, after just 4 months of user experience the redesigned HMIS already indicated:
 - Costs for encounter forms had been reduced by 50%.
 - The time required for a provider to complete a form had been reduced by over 60%.
 - Data entry time decreased by 40% for getting forms entered into the HMIS.
 - Monthly reports were generated in less than 5 working days after month's end

Strength of Performance Assessment

SCORE: Average

- 2002, Baseline
- 2004, Pilot outcome assessment: natural experiment—household, facility, and provider level surveys
- August 2004, Testing the redesigned Health Management Information System: 18 health centers (46 physicians, 97 nurses) provided complete data (four months of user experience) for analysis at health center, district, and regional levels

Comments

PHRplus demonstrated strategic planning in its approach to scaling up Albania's health management information system. It conducted analyses to inform the expansion and built consensus on needed improvements. PHRplus selected and amplified successful components of the pilot system to improve quality and performance of Albania's health care system.

EQUITY PROJECT

1997-2003

IMPLEMENTING ENTITY:

South African Department of Health (DOH),
Management Sciences for Health (MSH)

Location: South Africa
AFRO/Upper-Middle Income
Health Topic: Health System
Strengthening

Key Words: Restructure Health System,
HMIS, Active Management

PROGRAM OVERVIEW

Goal: To provide integrated primary health services to all South Africans by rectifying the inequities in the provision of health services brought about and supported by apartheid.

Objectives:

- (1) Provision of equitable, comprehensive PHC for all citizens;
- (2) Improved functioning of the referral system through all levels of hospitals;
- (3) Improved management of resources allocated to health under the specific headings of planning, drug supply, finance, personnel and information systems;
- (4) Improved training of all staff in clinical PHC and emerging diseases, and management training with development of capable district management teams (DMTs); and
- (5) Effective attention to the emerging epidemics of STIs, TB and HIV/AIDS.

Funding: USAID [\$50 million]

Background of the EQUITY in Integrated Primary Health Care Project:

- Major health system operational restructuring program to shift priorities toward primary health care.
- Initial focus was in Eastern Cape Province (EC) with gradual nationwide replication.
- Involved new health district establishment, management decentralization, empowerment of health workers, and the dismantling of vertical and centrally-controlled health programs.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: A fragmented, uncoordinated, and inefficient health system that has historically placed strong emphasis on high-technology curative care, and relatively little attention to serving the majority of the population in the rural areas and the townships.

Management Action: Restructure, strengthen coordination, and increase the efficiency and effectiveness of the public-sector health delivery system.

Principal L&M Characteristics Identified:

Leadership:

- Scanning
- Staff and Work
Climate
Development
- Setting Direction
- Governance

Management:

- Structuring
- Monitoring and
Evaluation
- Staffing

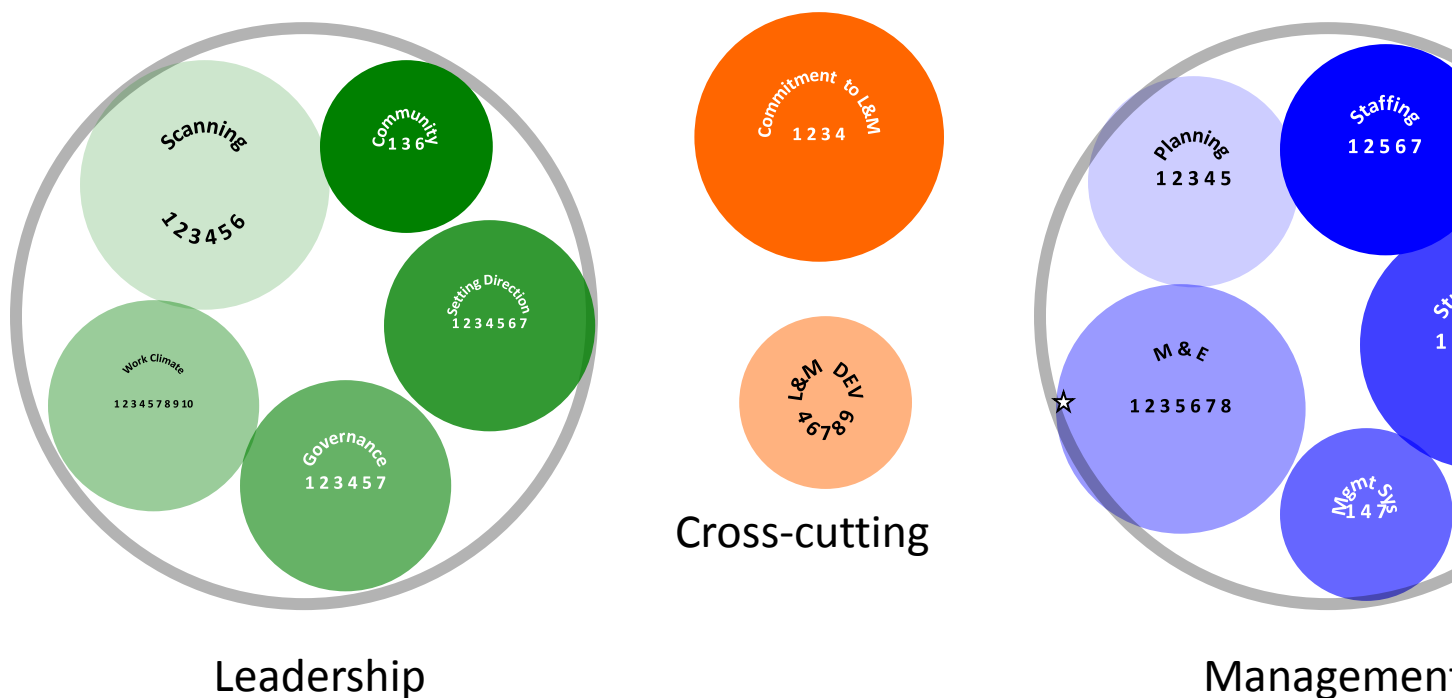
Cross-cutting:

- External Commitment to
Leadership and
Management

Results Achieved:

- By incorporating the systems improvements needed to effectively manage PHC, the EQUITY Project helped to redress some of the inequities of the past and impact health outcomes.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



Multiple L&M domains in the figure are relatively large in size suggesting the Equity project documented a wide variety of leadership and management actions. External Commitment to Leadership and Management was the most present L&M domain from a review of case study materials at 100% presence. Following that, the leadership domain Scanning was at 92% presence and in the management category, Staffing and Monitoring and Evaluation were at 83% and 81% presence, respectively. In particular, the white star in the Management System domain denotes that a health management information system was identified for this case study.

Management Action in Detail

Strengthening District Management Capacity

The Equity Project undertook comprehensive and wide-reaching restructuring interventions to achieve its broad objectives. District Management Teams were critical implementers of the Project. To build District Management Teams' capacity, a District Health Management and Leadership Program (DHM&L) was provided. 500+ managers participated in some portion of training and 30 district managers received the full DHM&L diploma. Managers were trained to improve budgeting and health planning and reporting, and were supported with manuals and toolkits for performance and expenditure reviews, financial analysis, and budget formatting. The relationships between government levels were better defined.

Strategic Information Management

To identify health needs and inform program plans, developing a health management information system (HMIS) was a key priority. The information needs were assessed at all levels: facility, region, district, provincial and national. The HMIS was field-tested. Managers and providers in all nine provinces were trained in data management and community mapping. Trainees were given support manuals to ensure usability and acceptance. The project reduced the set of primary health care indicators from 100s of indicators to a focused set of 25. This reduction allowed users to focus their scope and increase efficiency. Clinic and facility catchment areas were identified and carefully mapped to account for existing inequities. Mapping permitted targeting

services for effective resource use. HMIS was used for regular and routine monitoring of performance, as well as strategic problem solving.

Workforce Development and Supportive Supervision

Supervisor-facilitated on-the-job trainings were provided for 5000+ health providers and managers. Trainings established human resources infrastructure on district teams. Integrated curriculums and checklists were developed to guide providers in primary care management and patients' rights. Partnerships were strengthened between universities and the Eastern Cape Province Department of Health to address the project's training needs. Supervisors were trained and given manuals and checklists to clarify the purpose of their duties. Supervision policies were instituted which mandated regular supervisory visits. Supervisors used donated all-terrain vehicles to access rural areas.

Service Line Integration

The management of TB and HIV/AIDS were integrated into the primary health care system. Providers, counselors, supervisors, and laboratory staff were trained and supported with toolkits and manuals as with the other interventions (e.g. 10,000+ trained in opportunistic infection management). Indicators for TB and HIV/AIDS were incorporated into the health management information system (HMIS). Motorbike and taxi projects were launched to transport TB sputa to laboratories more efficiently.

Community Mobilization

The community and demand for services were mobilized through a communication and marketing campaign using pamphlets, posters, support groups, and the public-private Bambisanani Project. Hospital boards and clinic committees were established to involve the community in quality of care monitoring and provider accountability. Multi-disciplinary HIV and AIDS/STI/TB committees were formed at district level as well. Board and committee members were supported with training, handbooks, and checklists, both to explain specific governing duties and to strengthen members' leadership and management skills.

Modernized Pharmaceutical Management

Drug management improved through the use of a computerized HMIS present in twenty EC facilities with a data warehouse to monitor distribution and costs nationwide. Essential drug lists were promoted, 400+ existing pharmacists were trained in supply management, and 700+ facility staff was trained on a new stock card system. To address staff shortages, a pharmacist assistant program was created and the Eastern Cape Province Department of Health was assisted in developing recruitment and retention strategies. Documenting project phases and intervention results were a priority throughout, so that various toolkits and lessons-learned could be shared and spread to other districts and regions.

Program Achievements

LEVEL: Health Effect

Health Effects:

- In 2002, 69% of children were fully immunized, up from 58% in 1998
- Nurses have improved diagnosis and treatment of priority diseases:
 - 70% of child diarrhea treated with oral rehydration salts, up from 43% in 1997
 - 85% of respiratory tract infections treated according to protocol
 - 85% of sexually transmitted infection cases treated according to protocol, compared to 54% in 1997
- Monitoring and treatment of maternity patients improved at Mpumalanga's Delmas Hospital (a pilot facility site)
- Decreased maternal and neonatal mortality rates in hospitals—early neonatal mortality fell from 13.9/1000 in 2001 to 8/1000 in 2002, perinatal mortality fell from 42.6/1000 in 2001 to 34/1000 in 2002

Service Outputs:

- 85% of Eastern Cape Province clinics take TB sputa (2002), compared to 59% in 1998
- In motorbike communities (2002), the monthly average number of sputa collected at clinics more than doubled, sputa collection turnaround time reduced from weeks to less than 48 hours, and the collection of sputa specimens increased by 88%
- Rapid expansion of voluntary counseling and testing in Eastern Cape Province provided access to 55% of population (2002), up from 7% in 2001
- 92% of Eastern Cape Province clinics offer immunization, family planning, antenatal care and child curative services 5 days/week (2002)
- In 2002, 60% of Eastern Cape Province clinics offering rapid HIV tests had support groups

Process Improvements:

- The health management information system has been adopted nationwide and every district uses it to collect and report essential health data monthly. 8 countries worldwide also now use this system as model for their health management information system
- The Eastern Cape Province Dept of Health assumed full leadership and funding of the district level health leadership and management development and it is being modeled in other provinces
- Reduced stock outs of essential drugs and vaccinations
- Improved communication between all health system levels in the Eastern Cape Province
- Increased health human workforce positions
- 88% of patients in Eastern Cape Province clinics satisfied with their care
- The EQUITY project -designed nursing curriculum, guidelines for District Health Planning and Reporting, and the Service Level Agreement template have all been adopted nationwide
- One uniform supervision system promotes primary health care nationwide and the manual is incorporated into national quality improvement policy; improved supervision enhanced quality, particularly for priority disease management

Strength of Performance Assessment

SCORE: High

- Annually 1997-2002, EC Facility Surveys: set of 36 key indicators
- 1998 and again in 2002, EC Facility and Household Surveys: linked over 3,000 households with facilities to measure impact on the health of communities
- 2001-2002, EQUITY Clinical Training Assessment

Comments

The EQUITY Project sought to instill an entirely new public health approach using personnel and procedures designed for a fundamentally different model. Strategic leadership and management coupled with workforce development and facility modernization allowed EQUITY to increase health impacts. A health management information system was used actively for program improvements. The initiative strengthened management systems and enabled the government to respond more effectively to priority concerns of its population. The provincial level pilot project was so successful that the government of South Africa began expanding it nationally.

PARTNERSHIPS FOR TRANSFORMING HEALTH SYSTEMS (PATHS) 2002-2008

IMPLEMENTING ENTITY:

Life Sciences Partnership, Johns Hopkins University,
Liverpool Associates in Tropical Health,
Health Partners International

Location: Nigeria
AFRO/Low Income
Health Topic: Health System
Strengthening

Key Words: Systems Approach, Supply
and Demand, Facilitative Management,
HMIS

PROGRAM OVERVIEW

Goal: To improve the health status of poor Nigerians, measured in terms of progress towards the MDGs.

Objective: Improve the delivery and use of effective, replicable, pro-poor health services for the management of priority health conditions.

Funding: UK Department for International Development (DFID) [Cost \$78,760,000]

Background of the PATHS program:

- Systems-driven approach to improving quality and access to health services.
- Worked with Ministries/Departments of Health at federal, state, and local government levels.
- Focused on improving health outcomes by enhancing the governance of the health sector.
- Established partnerships with private sector, civil society, and other development organizations.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: The health system in Nigeria was fragmented, dysfunctional and unable to provide accessible, efficient and effective health services. Two-thirds of the population had no access to modern health care.

Management Action: Integrate a systems approach in the reconstruction of an expanding health system.

Principal L&M Characteristics Identified:

Leadership:

- Setting Direction
- Community Engagement
- Scanning

Management:

- Monitoring and Evaluation
- Management Systems
- Planning

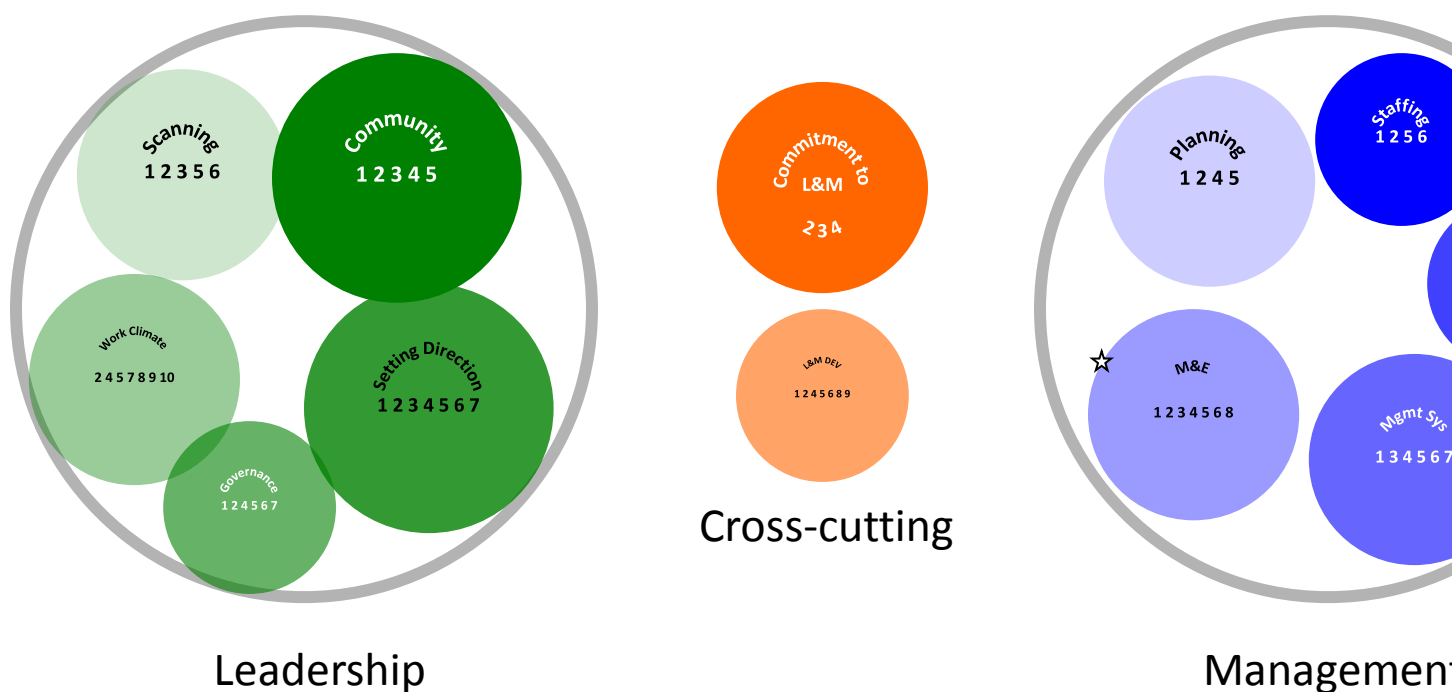
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- Increased progress towards MDGs, service coverage, utilization, and improved financial management.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



Multiple leadership and management domains in the figure are relatively large in size suggesting this case documented a wide variety of leadership and management actions. In terms of score, the figure above demonstrates that Setting Direction was the most present domain from a review of case study materials (86% presence). In particular, the white star in the Management System domain denotes that a health management information system was identified for this case study.

Management Action in Detail

Strengthening Government Stewardship

The partnership was a facilitative management program to strengthen capacity of Nigerian health officials. It was delivered through a consortium of five partners. Representatives of the consortium organizations met quarterly as the Technical Management Group to provide overall board-style direction. The operational management of the program was undertaken through a National Program Manager, State Team Leaders, and their teams. Implementation was integrated into existing health development and reform initiatives. The partnership assisted government health planners in establishing clear expected outputs. Clear direction setting allowed for consistent focus throughout. The program also trained officials to maintain effective oversight of progress.

Addressing Supply and Demand

The program included supply-side components (e.g., infrastructure, equipment, drugs and supplies, clinical and interpersonal skills and quality assurance systems) needed to deliver effective health services. Simultaneously, demand-side interventions increased community awareness of priority health conditions. Efforts were made to strengthen community understanding of rights and responsibilities around health. The program was stakeholder-driven which increased voice and accountability for health services. Other demand-side interventions increased local capacity to address priority health conditions within the community and household.

Management Support Systems

The partnership prioritized strengthening the drug supply chain and financial management systems. The program planned for state-wide rollout based on assessments that identified this as essential to achieving measurable program impact. Capacity was built by training in-state teams to operate the new systems and regularly monitor progress through producing monthly reports and debriefing stakeholders on findings.

Adaptable Operational Design

The available package of interventions was modular in design and could be adapted in a flexible manner. The packages were agreed upon in six-month work plans. Work plan design depended on emerging opportunities, the local context, and the donor's overall engagement with different states. Due to Nigeria's frequent instability, the partnership anticipated managing in a high risk environment. The project was designed to spread risks as broadly as possible with flexible funding controls.

Program Achievements

LEVEL: Health Effect

The impacts of all these on child mortality and maternal mortality are being analyzed, results forthcoming.

Health Effects:

- An increase in immunization across the country of 4%.
- An increase from 17.4% to 64% of Diphtheria Pertussis Tetanus 3 Vaccine (DPT3) in Jigawa.
- Demand for Emergency Obstetric Care in Jigawa improved with at least 50% increase of use.
- In Kano, TB case detection increased 14%.

Service Outputs:

- In Benue, primary health care level patient attendance increased by 360% and deliveries increased by 276% 1 year after program introduction.
- Utilization rates of renovated district hospitals increased 300% in Enugu and a 4-fold in Ekiti.

Process Improvements:

- In Kano, from 2005, 30% of surveyed facilities had at least 1 management system strengthened by 2007.
- In Jigawa, internally generated revenue at hospital level increased from under \$260,000 in 2005 to nearly \$640,000 in 2007.
- By the end of 2007, all states were able to produce consolidated financial reports for secondary level facilities that disaggregated the financial results of the services points, and the hospital.
- In Benue, internally generated revenue increased by over 440%.

Strength of Performance Assessment

SCORE: High

- 2005, Mid-term review
- 2007, Final program assessment: focus group discussions, HMIS pre- and post- program data comparison for health outcome changes in TB, CDR and birthing practices; some states conducted a KAP survey

Comments

The partnerships for transforming health systems strengthened government stewardship in health policy, planning, financing, and program implementation. It coupled the stewardship development with the installation of supportive management systems. Simultaneously, the program stimulated demand for improvement by engaging the community. Health service consumers became aware of their entitlement to good quality,

affordable health care—social accountability. Coverage of key health interventions was increased and improvements in health outcomes are expected to be measured in the future

QUALITY INFORMATION SYSTEM

1990s-Present

IMPLEMENTING ENTITY:

Secretariat of Health (Mexico)

Location: Mexico

AMRO/Upper-Middle Income

Health Topic: Health Systems
Strengthening

Key Words: Quality-focused, HMIS

PROGRAM OVERVIEW

Goal: To use data for effective decision-making in planning, monitoring and evaluation of services delivered by the national health system.

Objectives:

- (1) Flexible adaptation to local needs, while concurrently allowing for standardization of health care quality assurance indicators; and
- (2) Measurable quality performance of health facilities, comparable nationwide.

Funding: Unspecified

Background of Quality Information System:

- Comprehensive database for monitoring health care service delivery
- Decentralized strategy that relies on cooperation and collaboration from all levels of health care system.
- Focused on the development and interaction of state-wide quality councils.
- Quality improvement teams at the local level of the health care system.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: A lack of timely and appropriate information for decentralized decision-making.

Management Action: Redesign the existing routine information system to integrate and standardize fragmented processes. Focus on health management information system (HMIS) quality improvement while building flexibility and adaptability for local use.

Principal L&M Characteristics Identified:

Leadership:

- Setting Direction
- Scanning
- Community Engagement

Management:

- Structuring
- Monitoring and Evaluation
- Planning

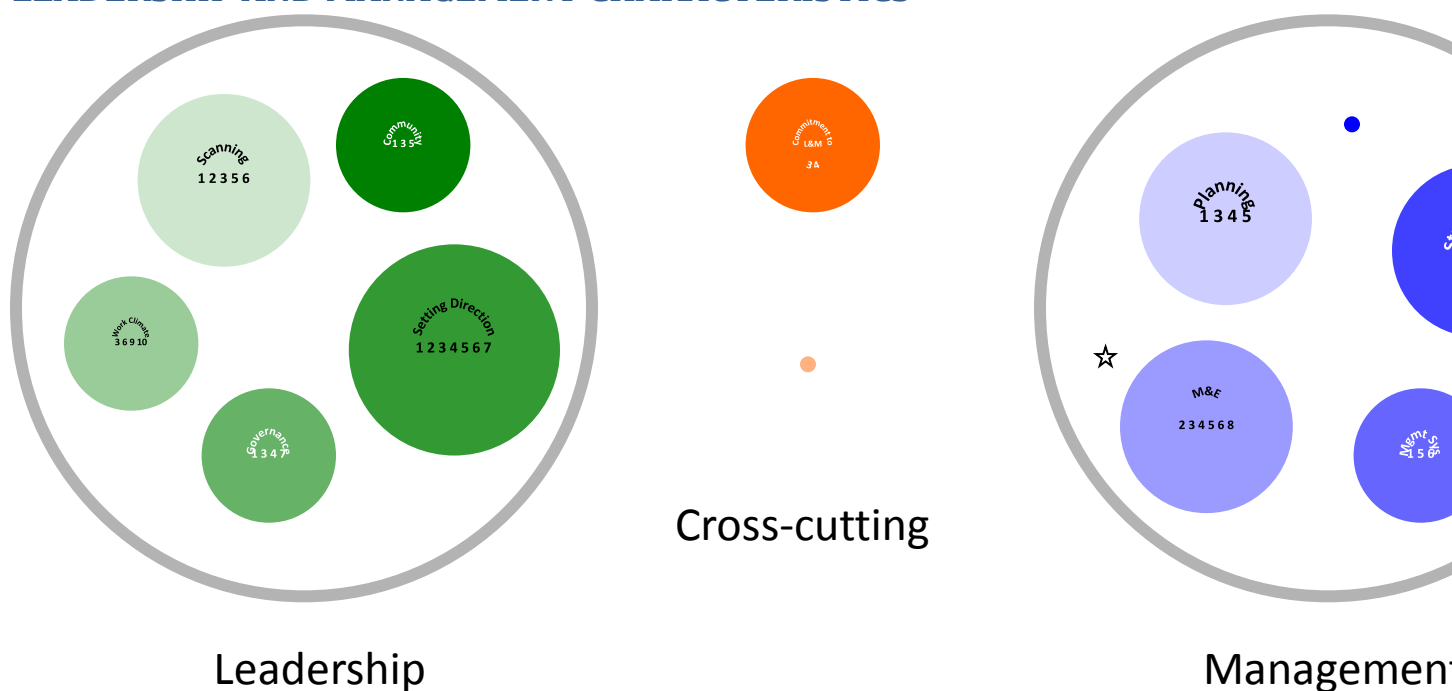
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- Mid-program review of hospitals documented improved comparative performance indicators across almost all states.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that this case focused on Setting Direction. This was the most present domain from a review of case study materials (64% presence). The next most present domain was Structuring at 50% presence. The presence of Staffing and Leadership Management Development was not reported or discernable within the reviewed materials. The white star in the Management System domain denotes that a health management information system was identified for this case study.

Management Action in Detail

Comprehensive Quality Improvement Strategy

Mexico employed a national strategy for health care quality improvement. It incorporated client and provider feedback on quality and satisfaction. It also utilized sentinel health events to identify quality gaps and further improvement. This synthesized feedback was used by the Secretariat of Health for Comparative Performance Evaluation (CPES).

Information Management

To manage the information from client exit interview surveys and provider surveys, a computer program was developed for data input and analysis. The computer program allowed jurisdictional managers to process local data and use it directly for decision making. Data was then sent by diskette to the state authority and then to Office of Statistics for centralized record keeping. This computer program allowed for timely and efficient information processing at all levels of the health system. The system also improved information sharing within and between health system levels.

Performance Management

Meetings were held every six weeks to plan, monitor and evaluate activities in the Secretariat of Health. Performance reports were presented. Approaches for performance improvement were discussed in the meetings as well. Lessons learned were shared between program offices. The Comparative Performance Evaluation was developed to identify how states rank in comparison to one another. This comparative evaluation was used to identify best practices.

Program Achievements

LEVEL: Health Effect

Health Effects:

- Comparative Performance indicators improved across almost all states for hospitals between the first trimester (January-March 1995) and third trimester (July-September 1995)
 - Tlaxcala: Percent of newborns vaccinated with BCG increased from 83.7% to 97.13%
 - Oaxaca: Percent of newborns vaccinated with oral polio vaccine(OPV) increased from 64.9% to 84.34%
 - Veracruz: Decreased adjusted hospital mortality rate from 21.1 to 17.94
 - Colima: Decreased maternal mortality rate from 1.8 to 0.763; adjusted mortality rate decreased from 17.0 to 15.02

Process Improvements:

- Response to quality monitoring through initiatives:
 - Problem-solving training for local health care teams (State of Campeche)
 - Improvement of supervisory and inventory systems (State of Guerrero)
 - Increased coordination in hospitals & primary health care centers for improved vaccination coverage (State of Aguascalientes)
- Response to client exit interviews and provider surveys
 - Diffusion and wider implementation of national clinical health care standards (State of Baja California)
 - Improvement in the clinical encounter experience (State of Durango)
 - Increased supervision by supervisory teams and health care managers (States of Puebla and Tlaxcala)

Strength of Performance Assessment

SCORE: Average

- Regular monitoring of CPES indicators: patient satisfaction, provider motivation and satisfaction, importance of the process selected within the facility, and value for money invested; adjusted length of stay for surgery, internal medicine, pediatrics, and OBGYN; percent of deliveries attended by C- section; percent of newborns vaccinated (with BCG and with Sabin); and hospital mortality (crude, adjusted, maternal).

Comments

This case successfully managed information to improve service delivery of an entire healthcare system.

REPRODUCTIVE HEALTH OBA VOUCHER PROGRAM

2005-2012

IMPLEMENTING ENTITY:

Kenya's National Coordinating Agency for Population and Development (NCAPD), Marie Stopes International (MSI)

Location: Kenya
AFRO/Low Income
Health Topic: Health System
Strengthening

Key Words: Output Based Aid, Financial
Protection

PROGRAM OVERVIEW

Goal: To contribute to a reduction of both maternal and infant mortality rates.

Objective: Improve use, responsiveness, and quality of family planning and safe motherhood services and give clients in economically disadvantaged populations a choice of providers by means of a voucher system.

Funding: German Development Bank and Kenyan Ministry of Public Health Services [Phase 1: \$9.5 million]

Background of the Output-Based Aid project:

- Performance-based reproductive health program.
- Incentivized access to and utilization of services.
- Consisted of a voucher scheme which covered a basic package of reproductive health services.
- Pilot carried out in Kisumu, Kiambu, and Kitui districts, and Korogocho and Viwandani slums in Nairobi (population of approximately 3 million).

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Providing health services to the poor was done through supply-side subsidies in the public sector, which were characterized by inefficiency, poor responsiveness, and questionable quality. Supply-side subsidies additionally overburdened public facilities and were unable to regulate private health services.

Management Action: Demand-side approach to financing health care and incentivizing the poor to utilize health services. Drive demand by subsidizing health care clients directly and reimbursing both public and private providers for services.

Principal L&M Characteristics Identified:

Leadership:

- Community Engagement
- Staff and Work Climate Development
- Scanning

Management:

- Planning
- Structuring
- Staffing
- Management Systems

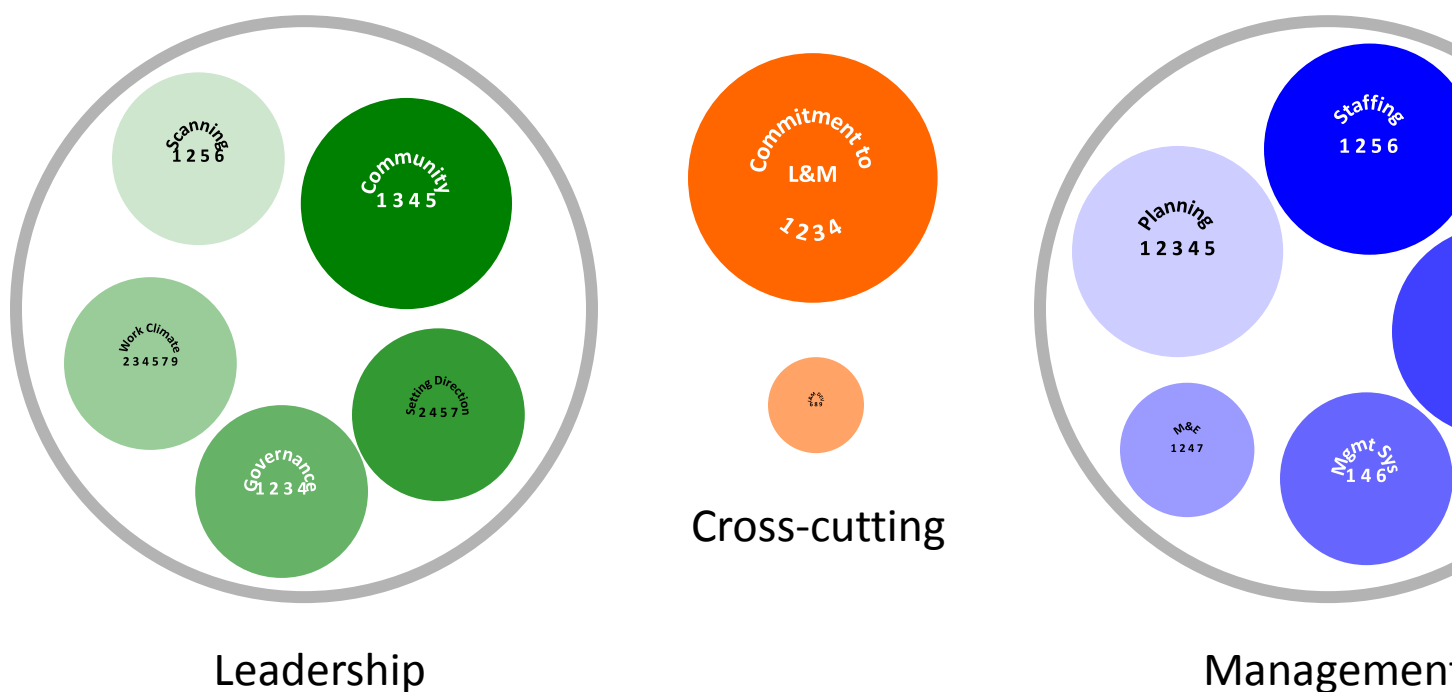
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- Early data suggests promising outcomes in processes and coverage.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates this case documented strong External Commitment to Leadership and Management (88% presence). It also had broad implementation of other leadership and management domains, as ascertained from a review of case study materials.

Management Action in Detail

Innovative Strategy for Cost-Effectiveness and Accountability

Unlike other voucher programs, both private and public sector facilities were contracted in Kenya. This allowed for greater competition and better service coverage. The program was in a position to strengthen accountability for provider performance and service quality in both public and private sectors. The government reimbursed facilities for specific services based on their service costs, rather than on an input basis or supply-side basis. Accreditation was required for providers to be selected to participate. To qualify for selection, providers were required to meet commercial, administrative, and technical criteria. Criteria included infrastructure, equipment, and staffing requirements. The OBA pilot separated oversight from program management. The National Coordinating Agency for Population and Development was responsible for oversight. A steering committee supported overseeing the program.

Institutional Strengthening

Providers were trained on quality management, reproductive health standards, and the voucher system process. After training, providers were incorporated into the program's referral network. The majority of participating providers' reimbursement revenues was spent on elements visible to patients. High-visibility investments, such as infrastructure and technology, could help facilities attract more patients. This may suggest that the voucher program stimulated provider competition.

Evidence-based Resource Targeting and Performance Monitoring

Participatory poverty grading tools were developed with district-specific indicators. The poverty grading tools were used to perform situational analyses and ensure the appropriate population was targeted. A computerized claims processing system monitored the program. The claims and fraud monitoring system used a database to

track technical and financial information from claims. The database linked claims data with reimbursement and voucher distribution data. Program planners incorporated experiences and lessons to redesign and strengthen the next phase. Further refinements would eventually contribute to the development of a National Social Health Insurance Scheme and become an integral part of Kenya's future health sector-wide approach.

Strategic Marketing

Marketing was a priority for the program's launch to stimulate demand for vouchers. Market and consumer research were conducted to create the program's brand, mobilize the target population, and establish the distribution network. An advertising agency ran a 1-month multimedia communication campaign to raise awareness.

Program Achievements

LEVEL: Health Effect

Health Effect:

- 12, 000 long acting family planning services that include births supervised by skilled attendants were provided between June 2006 and October 2008.

Service Outputs:

- Between June 2006 and February 2010, 82,523 safe motherhood claims, 12,643 family planning claims and 480 gender based violence recovery claims were submitted; 93% were reimbursed.
- 77% of vouchers were redeemed for the more comprehensive safe motherhood package compared to 41% of total distributed vouchers for family planning services.
- Voucher programs reduced economic barriers for poor pregnant women who previously did not deliver at facilities - even among non-voucher clients there was an increase in deliveries in facilities.

Process Improvements (2006-2008):

- Overall program costs were \$135 per safe delivery, including obstetric emergency cases.
- 85% of public, 89% of for-profit, and 67% of non-profit service providers used voucher revenue to improve infrastructure, buy equipment/drugs and supplies, hire new/pay existing staff, and create patient amenities.
- Women in Kitui purchased the vouchers as insurance against delivery complications rather than with obvious intentions to use for normal deliveries.

Strength of Performance Assessment

SCORE: Average*

- Ongoing monitoring: provider claims data, PWC field visits, and random client exit interviews at health facilities

** Impact assessment in progress, results forthcoming*

Comments

The voucher program was an innovative method of increasing access to reproductive health services while providing financial protection for the poor. By involving both the public and private sectors, and coupling facility participation with performance accreditation, the program took measures to ensure high quality care for vulnerable women.

SEGURO POPULAR

(Popular Health Insurance)

2008-2010

IMPLEMENTING ENTITY:

Secretariat of Health (Mexico)

Location: Mexico

AMRO/Upper-Middle Income

Health Topic: Financial Protection

Key Words: Integrate Health Services, Financial Protection, HMIS

PROGRAM OVERVIEW

Goal: To achieve universal health insurance coverage by 2010.

Objective:

- (1) State level: to reduce inequalities in public per capita health spending across states (as well as across public health insurance schemes); and
- (2) Household level: to achieve full coverage of the uninsured, minimizing vulnerability to catastrophic and impoverishing health expenditures, thus reducing inequalities of basic health opportunities.

Funding: Federal taxes with complimentary state contributions, as well as premiums prepaid by families (priced on a means-tested sliding scale to account for income levels).

Background of Seguro Popular:

- The subsidized insurance-based component of Mexico's financial health reform policy.
- Offered free access at the point of delivery to an essential package of primary, secondary and, tertiary level interventions.
- After federal and state funding, families prepay premium amounts such that the public subsidy is inversely proportional to family income. The poorest 20% are exempt from any fees.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Mexico's health system organization was vertically segmented. Economic burdens were unequally concentrated. 50% population lacked access to health insurance and annually two to four million households suffered catastrophic health expenditures.

Management Action: Undertake major health care reform (2003 General Health Law passed) to reorganize the health system through the horizontal integration of three basic functions—stewardship, financing, and service delivery—and institute a comprehensive insurance scheme to control for the existing barriers and inequalities in financial protection for health service provision, especially for the poorest segments of the population.

Principal L&M Characteristics Identified:

Leadership:

- Setting Direction
- Governance
- Scanning

Management:

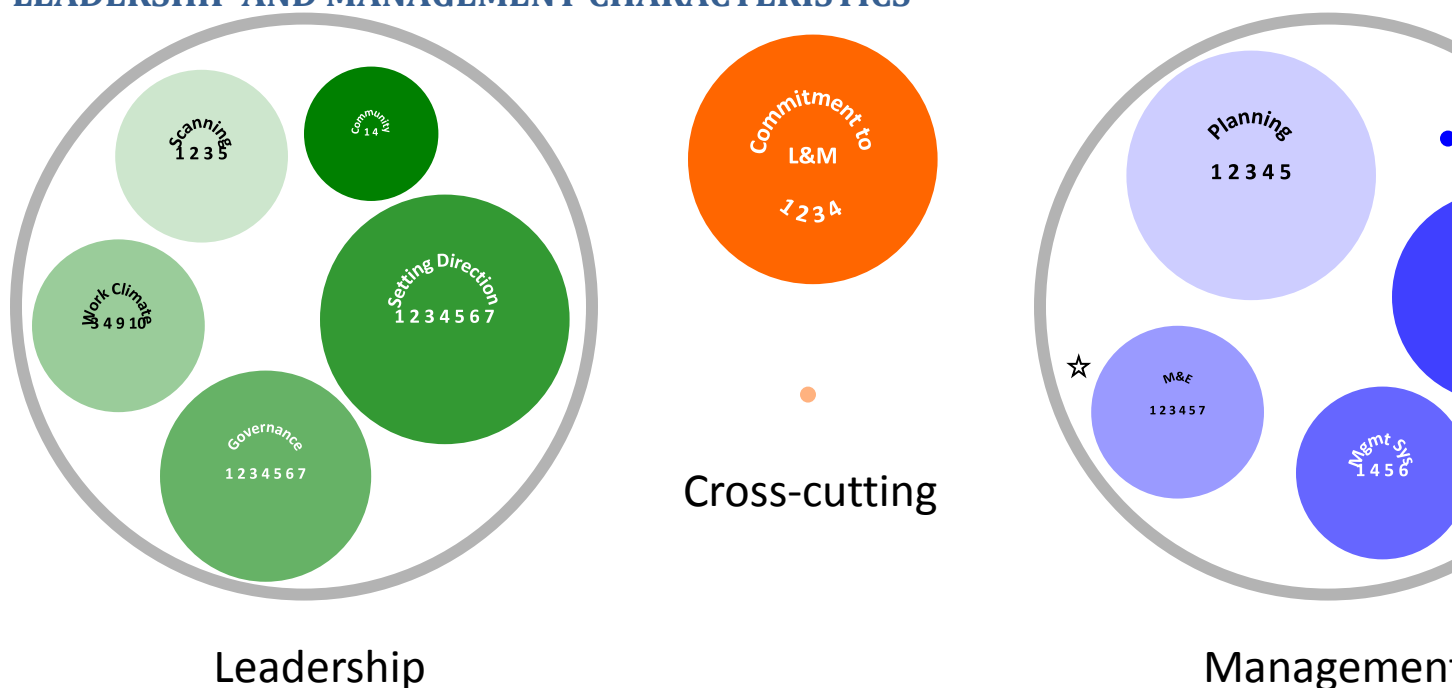
- Planning
- Structuring
- Monitoring and Evaluation

Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved: *Seguro Popular* expanded health services coverage to nearly one-third of the Mexican population and increased service utilization and financial protection.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



External Commitment to Leadership and Management was a notable cross-cutting domain for *Seguro Popular*. At 100% presence, this was the most present domain from a review of case study materials. The key leadership domain observed was Setting Direction and the key management domain was Planning. Those domains were found to be 86% and 90% present, respectively. The Leadership and Management Development and Staffing domain were not detected in the review of case materials. The white star in the Management System domain denotes that a health management information system was identified for this case study.

Management Action in Detail

Investing in Research

Evidence-based decision-making was the hallmark management method used in reforming Mexico's health system and creating Seguro Popular. This was possible due to two decades of significant investments in generating evidence and local research capacity prior to reform. The investment returns included an institutional base from which to generate surveys, undertake analysis, and train policymakers.

Strategic Advocacy and Resource Allocation

The use of evidence was reinforced by an explicit ethical framework which was advocated for by key leaders in the MOH, as well as other national policymakers and members of the international community. MOH leadership successfully argued that the pre-reform insurance system violated the democratic principle of equal rights. Funding of Seguro Popular was strategically designed to ensure equal allocation of federal resources, to account for the substantial differences in the level of development among states, and to uphold financial fairness in individual contributions. Financial management for the funds was decentralized at the state level, since these interventions were associated with low-risk, high-probability health events. Funds for high-cost tertiary-care interventions were managed at the federal level as they require a pooling of risk nationally. Under Seguro Popular, funding for the state is determined largely by the number of families affiliated and is thus driven by demand. Performance is also considered. In the past, federally allocated state budgets in health were largely determined by historical inertia and the size of the health sector payroll. Seguro Popular funding allotments shift focus to high-quality and efficient care that is responsive to patients. This shift influenced strategic investments in infrastructure, medical equipment, and human resources.

Information Management and Performance Monitoring

A comprehensive health management information system (HMIS) was created for capturing data from families affiliated to Seguro Popular. The HMIS was operated by the MOH. The system was used as a roster to identify the contribution level for every family. This was important for assuring transparency in the allocation of resources. The HMIS also served as a management tool that provides information on service utilization and outcomes. The basic package of health services served as the blueprint for developing accreditation criteria. To ensure quality services, an accreditation process was established and only certified providers were able to participate in Seguro Popular. Defining the basic package of health services and linking it to the certification of providers generated the conditions for the system to meet focused goals. Seguro Popular was able to deliver the specific interventions that were proven to produce maximum health gains for a given level of resources. To allow for future evidence-based decision-making, long-term, rigorous, external evaluation by use of an experimental design was planned and prioritized in the initial policy. Analysts measured Seguro Popular's effects on health conditions, effective coverage, health-system responsiveness, and financial protection.

Transformational Leadership

The transformational leadership of Dr. Julio Frenk, who served as Minister of Health of Mexico from 2000-2006, significantly influenced Seguro Popular. Prior to the MOH, Dr. Frenk held key positions in Mexican public health research organizations. Dr. Frenk's extensive research experience and personal understanding of the value of incorporating evidence into policymaking helped him champion for data-driven reform.

Program Achievements

LEVEL: Increased Service

Evaluations directly linking Seguro Popular with population health outcomes have not been reported.

Increased Coverage and Service Outputs:

- Enrollment in Seguro Popular associated with a mean increase in 1.65 prenatal visits during pregnancy (2002-2005)
- The odds of receiving antihypertensive treatment were 50% higher for those insured through Seguro Popular than those without insurance
- Research showed that those insured through the program had a 35% higher odds of receiving treatment with blood pressure control compared to the uninsured

Process Improvements:

- By 2009, there were close to 11 million families affiliated to the *Sistema de Protección Social en Salud*, which accounted to about 31 million beneficiaries (Informe de Resultado del Segundo Semestre de 2009, 2009), which is roughly about 28% of the entire Mexican population
- Over 10 months of study, Seguro Popular decreased the number of households suffering catastrophic health expenditures by 23% among all beneficiaries who intended to seek care
- Seguro Popular's effect was more pronounced among poorer households who intended to seek care; this group experienced a 30% reduction of households with catastrophic expenditures
- In the experimental group (those actively aided in enrolling in Seguro Popular) the reduction among poorer households was 59%

Strength of Performance Assessment

SCORE: High

- 2009, Formal program evaluation results released: matched-pair cluster-randomized experiment; treatment was randomly assigned to 74 clusters and consisted of encouragement to enroll in a health-insurance program and upgraded medical facilities; Pairs were matched for observations confounders
 - 2005, Baseline survey in 148 "health clusters," representing 7 states and 118,569 households
 - 10 months after baseline, Follow-up survey

Comments

Seguro Popular's successes resulted from a strong valuation of informed decision-making. This case created information management systems for use at programming and policy levels. This allowed the program to decentralize and increase affordability of health care in a transparent and planned manner.

TANZANIA ESSENTIAL HEALTH INTERVENTIONS PROJECT (TEHIP) 1996-Present

IMPLEMENTING ENTITY:

Tanzania Ministry of Health (MOH),
Canada's International Development Research Centre (IDRC)

Location: Tanzania
AFRO/Low Income
Health Topic: Health Systems
Strengthening

Key Words: Decentralize Services, Cost-Effective Resource Allocation, HMIS

PROGRAM OVERVIEW

Goal: To determine the feasibility of an "evidence-based" approach to health planning—an approach whereby decisions on how to allocate scarce health care resources are made based on information obtained locally rather than on unproven assumptions of a central agency—and measure its impact.

Objectives:

- (1) Strengthen district level capacity in Rufiji and Morogoro-Rural districts to effectively plan, set priorities and deliver health services using burden of disease and cost effectiveness analysis for resource allocation;
- (2) Increase and strengthen district level capacity to effectively deliver health interventions;
- (3) Assess and document overall lessons learned in district health planning and management information systems and processes; and
- (4) Measure impact of delivered health interventions in terms of burden of disease reduction.

Funding: IDRC [\$22,226,683], Canadian International Development Agency (CIDA) [\$16.0 million], and Tanzanian government [\$5,677,210] for the initial 4 years

Background of Tanzania Essential Health Interventions Project:

- Utilized simple and effective solutions for solving logistical problems.
- Supportive interventions and strategies included: district simulated basket funding, strengthening district health management and administration, Integrated Management Cascade, community ownership of health facilities, project operations committee meetings, and district research feedback meetings.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: World Development Report of 1993 identified factors leading to declining health status in developing countries. From these findings, the Tanzania MOH recognized the need to re-prioritize actions based on those factors.

Management Action: MOH decided to test innovations in planning, priority setting, and resource allocation at the district level in the midst of Tanzania's reform and decentralization of the health system.

Principal L&M Characteristics Identified

Leadership:

- Setting Direction
- Scanning
- Governance

Management:

- Planning
- Monitoring and Evaluation
- Management System

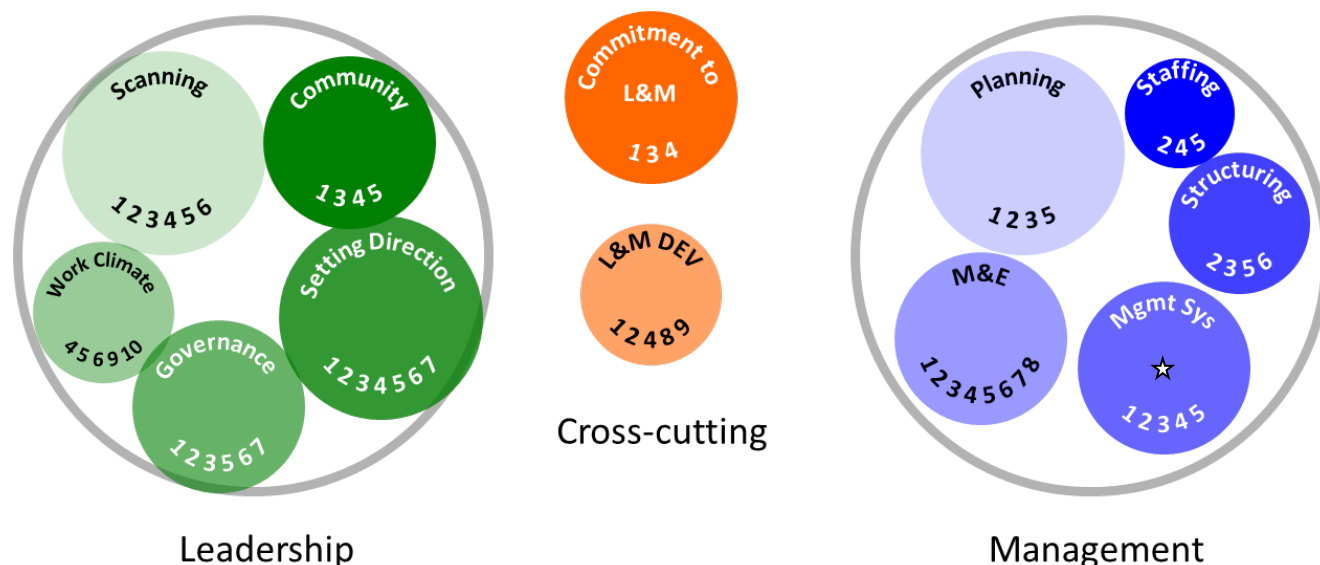
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- Improved allocation of funds based on burden of disease. Before TEHIP (1996/97), only about 11% of total health spending in Morogoro-Rural district was spent on malaria, which is the biggest cause of mortality in the district; after TEHIP (2000/01) funding increased to about 31% of total health spending.
- Health improved in Rufiji district due to use of health basket funding. Between 1999 and 2006, a 39% reduction in all-cause under 5 years-of-age mortality and a 54% reduction in infant mortality was observed.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that Setting Direction was the most present domain from a review of case study materials (93% present). Multiple domains in the figure are relatively large in size. Among leadership domains Scanning was 83% present and for management principles Planning and Monitoring and Evaluation were 80% and 75% present, respectively. This case documented a wide variety of leadership and management actions. The white star in the Management System domain denotes that a health management information system was identified for this case study.

Management Action in Detail

Collaborative Work Environment

Tanzania Essential Health Interventions Project (TEHIP) set up their management team in Dar es Salaam, with a new plan for office space. The office eliminated walls and doors to allow for more teamwork among staff and to facilitate “co-management.” In addition, regular exchange of information kept the managers up-to-date about the project and pertinent issues.

Information Management

A demographic surveillance system was instituted and information management tools were developed. Other tools developed included the burden of disease profile, district health accounts, district health services mapping, community voice, and a cost-effectiveness and cost information system tool.

Strengthening Management

District Health Management Teams carried out activities. Management and administrative skills were developed through the World Health Organization’s training course *Strengthening Health Management in Districts and Provinces* and *Ten Steps to a District Health Plan*. A significant portion of the work to improve management skills was combined into a common strategy: the Integrated Management Cascade. Part of the new Integrated Management Cascade strategy included improving transportation and communication between workers and supervisors. Health centers were equipped with solar-powered radios and a motorcycle to easily get through rough terrain between district headquarters and health facilities.

Research and Development

The project integrated research and development with decision-making. It looked at processes where evidence supported Tanzanian district health plans. Plans were studied for feasibility of implementation by decentralized district systems and cost effectiveness. Research was conducted on health systems planning processes, household health-seeking behaviors, and health impacts.

Program Achievements

LEVEL: Health Effect

Health Effects:

- Rufiji district
 - 39% reduction in all-cause U5 mortality and 54% reduction in infant mortality (1999-2006)
 - Infant mortality: 107.8 to 45.8/1000 live births (1999-2005)
 - U5 mortality: 135.5 to 81.8/1000 (1999-2006)
 - Maternal mortality: 5.2 to 4.6/1000 live births (1999-2006)

Process Improvements:

- Allocated funds based on burden of disease in Morogoro-Rural district (of total health spending) (1996/97 – 2000/01)
 - Malaria: funding increased from about 11% to 31%
 - IMCI: increase in funding from 19% to 24%
 - Sexually transmitted disease: increase in funding from 3% to 9%
 - Essential drugs program: increase in funding from 7% to 10%
 - EPI: Reallocation of funding from 30% to 7%
 - Tuberculosis DOTS: Reallocation of funding from 30% to 7%
- Supervision of peripheral facilities revised to include direct observation of patient care
- More coherent laboratory specimen collection and diagnostic laboratory reporting functions
- Timely delivery of drugs, equipment and supplies and improved maintenance
- Coordination of patient referrals to the district hospital
- Emergency epidemic support
- System for notification of staff salary payments
- Improved linkages and communication with communities
- Locally conducted capacity-building workshops, technical training, and refresher courses
- Posting of replacement health staff when regular personnel are ill or have died
- In Rufiji, the overall package was cost-effective, delivered at 80 cents per person per year

Strength of Performance Assessment

SCORE: Average

- February-April 1999, Mid-term evaluation: qualitative methods—focus group discussions, questionnaires, in-depth interviews, observation, document review and SWOT analysis

Comments

The Tanzania Essential Health Interventions Project engaged with the local community, used data for decision making and strengthened local management teams. The project resulted in strategic restructuring of interventions. Managers reallocated resources towards the largest burden of disease in the two profiled districts. Resources now targeted the actual population's needs and likely explain the increased health impacts.

INFECTIOUS DISEASES CASES

IMAGE SOUTH AFRICA

1999-2001

IMPLEMENTING ENTITY:

Small Enterprise Foundation (SEF), Rural AIDS & Development Action Research Programme (RADAR)

Location: South Africa

AFRO/Upper-Middle Income

Health Topic: Infectious Disease/
HIV/AIDS

Key Words: Microfinance, Gender-
Based Violence Prevention

PROGRAM OVERVIEW

Goal: To address issues of HIV prevention by focusing on roles of poverty and gender-based inequalities (and violence) that plays a role in fueling the HIV epidemic in South Africa.

- Objectives:**
- (1) Expand access to existing microfinance initiatives for women from poorest households in rural South Africa, and use this to facilitate improvements in welfare and empowerment;
 - (2) Develop participatory approach to gender awareness and HIV education for Small Enterprise Foundation clients and mainstream approach into existing microfinance activities;
 - (3) Investigate whether attitudes and skills gained through participation in the program, with social and economic benefits, can support decision-making that reduce vulnerability to both gender-based violence and HIV;
 - (4) Use quantitative, qualitative and participatory methods to describe and document related processes and outcomes at multiple levels; and
 - (5) Implement and evaluate intervention within framework and policy environment of the South African National Department of Health HIV and AIDS Pilot Initiative.

Funding: Anglo American Chairman's Educational Trust, AngloPlatinum, DFID, Ford Foundation, Henry J. Kaiser Family Foundation, HIVOS, South African Department of Health and Welfare, and SIDA

Background of IMAGE:

- Integrated gender and HIV education into the operations of an existing microfinance institution.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Establish a sustainable microfinance system by linking it with AIDS prevention education.

Management Action: Small Enterprise Foundation and RADAR formed a partnership to design and implement "Intervention with Microfinance for AIDS and Gender Equity" (IMAGE) program.

Principal L&M Characteristics Identified:

Leadership:

- Scanning
- Governance
- Community Engagement

Management:

- Monitoring and Evaluation
- Planning
- Structuring

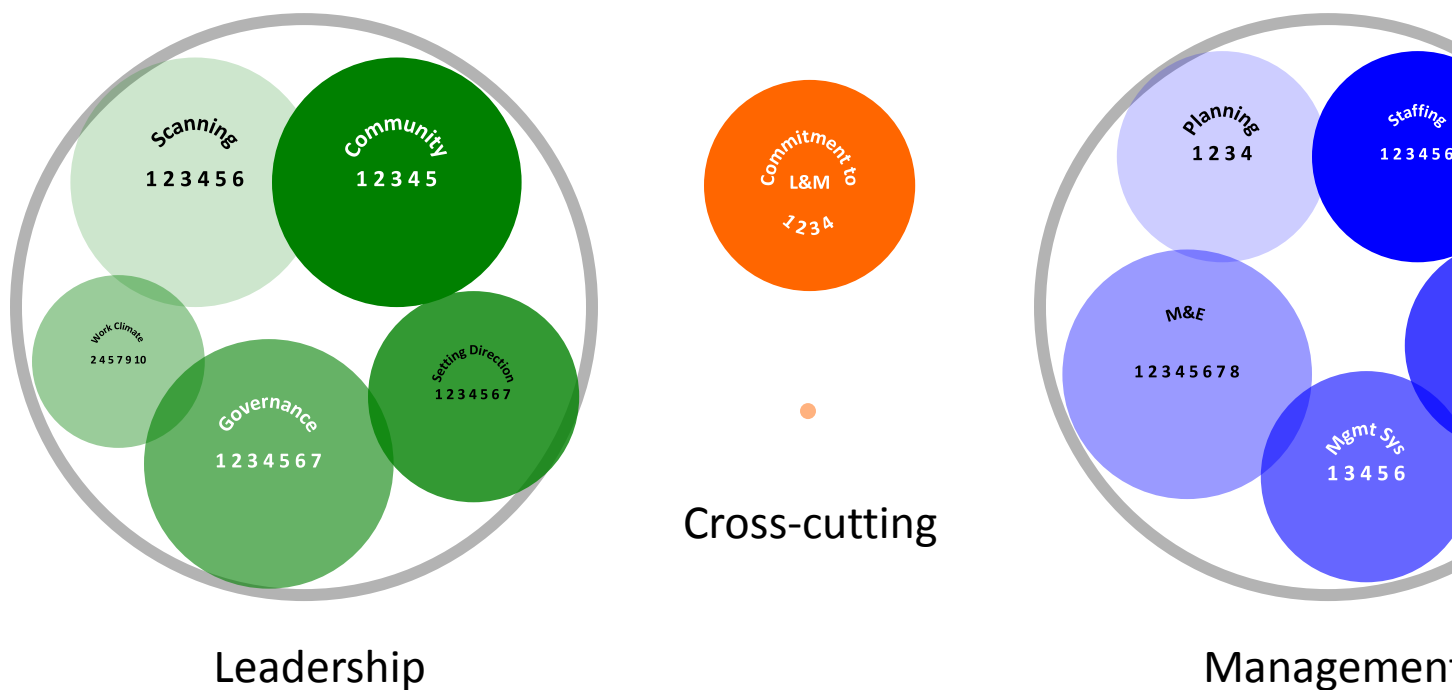
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- Successfully catalyzed women's advocacy action with microcredit and empowerment activities.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



Scanning was the most present domain from a review of case study materials (100% presence). This was followed by Governance and Community Engagement at 93% and 90% presence, respectively. The range of presence among management domains was 75% to 64%, so most appear full in size. On the whole, this case documented a wide variety of leadership and management actions.

Management Action in Detail

Structured Operations

IMAGE coordinated solidarity groups across the eight program villages by maintaining standardized operations for educational activities and structures for loan procurement. To introduce microfinance, the program used a “solidarity group lending” method and offered two microcredit programs to its clients. Four to ten solidarity groups formed a village center. The village center elected a management committee with a chairperson, secretary, and treasurer.

Ensuring Accountability

The project valued stewardship and accountability. The Tšhomišano Credit Program used motivational techniques, loan utilization checks, and ongoing follow-up processes in order to meet the clients’ needs. Sessions were marketed to clients as a mandatory part of an integrated package to ensure knowledge of loan terms and encourage compliance.

Community Integration

“Sisters for Life” was a series of participatory education sessions on gender awareness and HIV/AIDS into Small Enterprise Foundation operations. This program utilized participatory learning and community mobilization sessions in biweekly center meetings. To ensure local acceptability, staff incorporated topics of gender, domestic violence and HIV/AIDS issues as identified by the women.

Active Learning

IMAGE designed the curriculum to complement SEF values – mutual respect, personal responsibility, and group solidarity. Trained facilitators led the sessions during regular Tšhomišano Credit Program meetings. For program

continuity, homework activities were assigned and the women were asked to reflect on how the sessions relate to their experience. Another part of the training was open-ended and allowed women to develop and implement actions appropriate for their own communities.

Program Achievements

LEVEL: Increased Service

Evaluations directly linking IMAGE with population health outcomes have not been reported.

Service Outputs:

- Catalyzed women's advocacy activities: Women organized more than 60 village events and formed 2 new village committees to address rape and crime in the community. Women led many marches, including the first "16 Days of Activism" march to end domestic violence.

Process Improvements:

- After 2 years, the annual physical and/or sexual risk from an intimate partner was reduced by more than 50%.
- Intervention group had improvements in indicators of empowerment, including self-confidence, challenging gender norms, autonomy in decision-making, and communication with partners about sex and HIV.
- More than 1,750 loans were disbursed and repayment rates were high at 99.7%.
- Compared to controls, women in intervention group experienced improvements in assets, expenditures, and membership in informal savings groups.
- Participants identified higher levels of communication about HIV within households, significant increases in those going for counseling and testing for HIV, and higher levels of condom use in most recent sex with non-spousal partners. No change in HIV incidence.

Strength of Performance Assessment

SCORE: High

- Matched-community randomized trial; qualitative and quantitative data collection at baseline, midterm and post-intervention.

Comments

The IMAGE case synergistically made gains for both microfinance and AIDS prevention by integrating these services. The program was well managed to provide women with income generating opportunities with a structured accountability system. Community engagement established a social safety net. Income generation plus empowerment helped reduce women's risk of abuse.

LAO PDR YOUTH HIV AND STI RESPONSE PROJECT (I)1998-2001; (II)2001-2004

IMPLEMENTING ENTITY:

Burnet Institute, Lao People's Revolutionary Youth Union,
National Committee for the Control of AIDS Bureau (NCCAB)

Location: Laos
SEARO/Low Income
Health Topic: Infectious Disease/
HIV/AIDS

Key Words: Strategic Partnership,
Youth Mobilization

PROGRAM OVERVIEW

Goal: To reduce the spread and impact of HIV and other STIs among youth in Lao PDR.

- Objectives:**
- (1) Enhance the ability of young people in the Lao PDR to respond to the emerging risk of HIV and other STIs and to improve the capacity of the policy development, strategic planning, research, and program management in responding to the sexual health needs of young people; and
 - (2) Support effective implementation of national HIV and STI strategic plan and enhance the ability of young Lao PDR people to respond to the risk of HIV and STIs through increased access to locally appropriate prevention and care programs.

Funding: AusAID

Background of the Lao Youth HIV and STI Response Project:

- Five-year HIV strategic plan that stressed the role of youth in the national HIV/AIDS response.
- Partnership formed to implement strategic plan at community level.
 - Used a mass youth organization with over 245,000 members already active at all administrative levels and experienced in community mobilization.
- Aimed to enable young Lao people to protect themselves from HIV.
- Two phases: (I) build capacity and implemented local activities in six focus districts of four provinces, and (II) scaled up implementation to ten provinces and the Vientiane Capital.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Engaging target population and developing health human workforce capacity.

Management Action: Mobilize and train an active decentralized youth organization to plan, manage and implement HIV programs for their peers.

Principal L&M Characteristics Identified:

Leadership:

- Scanning
- Community Engagement
- Staff and Work Climate Development

Management:

- Monitoring and Evaluation
- Planning
- Staffing

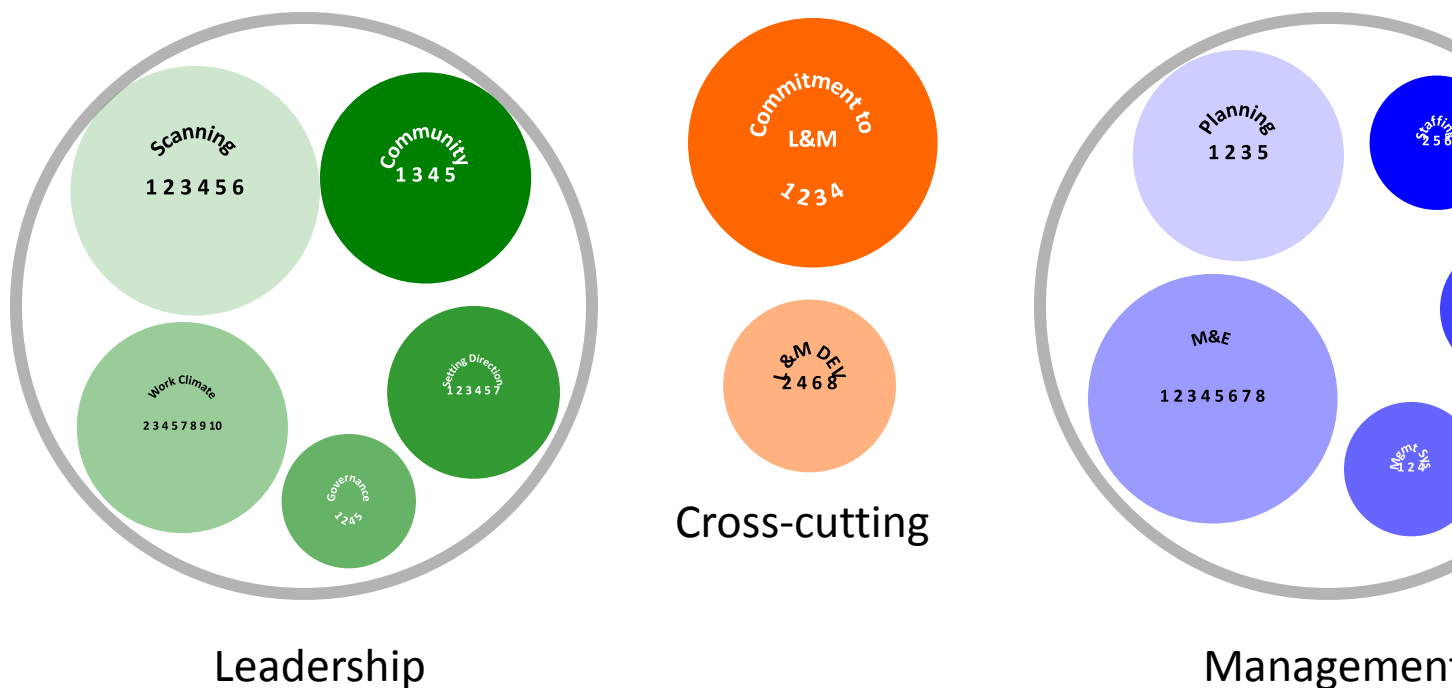
Cross-cutting:

- External Commitment to Leadership and Management
- Leadership and Management Development

Results Achieved:

- Significant capacity built within the government and enhanced the ability of young people to respond to the risk of HIV and STIs.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



External Commitment to Leadership and Management was the most present domain from a review of case study materials (100% presence). Within Management, Monitoring and Evaluation (81% presence) was reported more noticeably than the other management domains. Within Leadership, Scanning was also prominent at 92% presence.

Management Action in Detail

Leveraging Key Players

The project leveraged Lao People's Revolutionary Youth Union's network as a springboard for expanding the reach of locally delivered program activities. A critical success factor was the decision to involve the youth union and capitalize on the group's strengths. The project also engaged district officials early on in the program cycle. Involving district government leaders significantly improved the impact of the project because of their influence on other government staff, the wider community, and the allocation of resources.

Developing Management Capacity of Youth Workforce

Phase I focused on building capacity among the youth union and government members in management competencies including: situational analysis, strategic planning, proposal development, and program management. Efforts were made to train the volunteers in behavior change communication and implementation of prevention activities. Training workshops were participatory and emphasized team exercises. Workers were organized into district project working teams. The project also trained the village youth volunteers in participatory research and analysis. This research informed district action plans.

Youth-Driven Planning and Direction Setting

Provincial and district plans and targets were set by provinces and districts. This approach was different from the past when targets were set by the central level. Youth drove district-level planning of the project. The project involved the local communities in planning, decision-making, and skills-building to encourage sustainability. After training, youth staff conducted situational analyses and a systematic assessment of capacity. Data was then analyzed in participatory sessions where key problem areas were identified. Youth staff performed problem tree analyses to identify causal factors of the identified problems. Goals, objectives, outputs, and activities were derived to formulate village-specific action plans.

Gradual Scale Up for Sustainability

Initial focus on the central and provincial levels established project credibility and mutual trust, and promoted government ownership, before expanding to the district and village levels. Phase I established a native cadre of district project working team trainers and local ownership such that Phase II was able to use only native trainers in scaling up. Complex program components were introduced later, such as a financial management system in 2003.

Program Achievements

LEVEL: Increased Service

Evaluations directly linking the Lao People's Revolutionary Youth Union program with population health outcomes have not been reported.

Service Outputs:

- Young men reported using condoms more than before and often took condoms when they went out
- Most people reported they could get condoms at the village level, an improvement from the findings of initial village studies

Process Improvements:

- Increasing numbers of women asking village volunteers for condoms, although most women were still too shy or embarrassed to buy, carry, or suggest the use of condoms
- District authorities and project working team members reported that the project had significantly built their capacity in situation analysis, program planning, proposal writing, and the implementation of prevention activities
- District project working team members reported a much better understanding of the HIV situation in their districts

Strength of Performance Assessment

SCORE: Average

- 1998-2001, Situational analyses conducted during Phase 1
- 2004, Outcome assessment at district and village levels: qualitative participatory focus group discussion held in four of the original six focus districts, with district authorities, the district project working team, village volunteers, village youth and village authorities and older people

Comments

The Lao Youth HIV and STI Response Project demonstrated that it is not only possible to engage youth in HIV/AIDS programming, but—if given the right management tools—youth can successfully lead program activities towards achieving results.

ONCHOCERCIASIS CONTROL PROGRAM

1974-Present

IMPLEMENTING ENTITY:

Multiple Partners

Location: Sub-Saharan Africa
AMRO/Low- and Lower-Middle Income
Health Topic: Infectious Disease/
Onchocerciasis

Key Words: Strategic Partnership, HMIS

PROGRAM OVERVIEW

Goal: To control the disease as a public health problem – and build local capacity to ensure continued control – and boost socio-economic development through long-term increase in agricultural production.

Objectives:

- (1) Establish and sustain high treatment coverage in all rural areas where onchocerciasis is a public health problem; and
- (2) Stop disease transmission and eliminate the disease from sub-Saharan Africa.

Funding: Initial multi-donor investment of \$600 million. Total funding to date is now over \$3 billion

Background of Onchocerciasis Control Program (OCP):

- Began with seven countries, but grew to include more than a dozen countries in West Africa, expanded to nineteen African countries and became the African Programme for Onchocerciasis Control.
- Included more than 25 donors, 40 Non-Governmental Organizations (NGOs), and many rural community groups.
- Initially focused on vector control of black flies through weekly spraying of larvicides.
- Later established a sustainable community-managed treatment program.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Onchocerciasis (river blindness) affects about 42 million people worldwide and the threat of the disease led to people abandoning more than 250,000 km² of arable land in West Africa, not only disabling individuals but economic growth as well. Past efforts lacked long-term commitment to combat the disease and were insufficient as well as uncoordinated.

Management Action: Develop global partnership among donors, bilateral and multilateral organizations to control onchocerciasis.

Principal L&M Characteristics Identified

Leadership:

- Setting Direction
- Scanning
- Community Engagement

Management:

- Planning
- Management System
- Monitoring and Evaluation

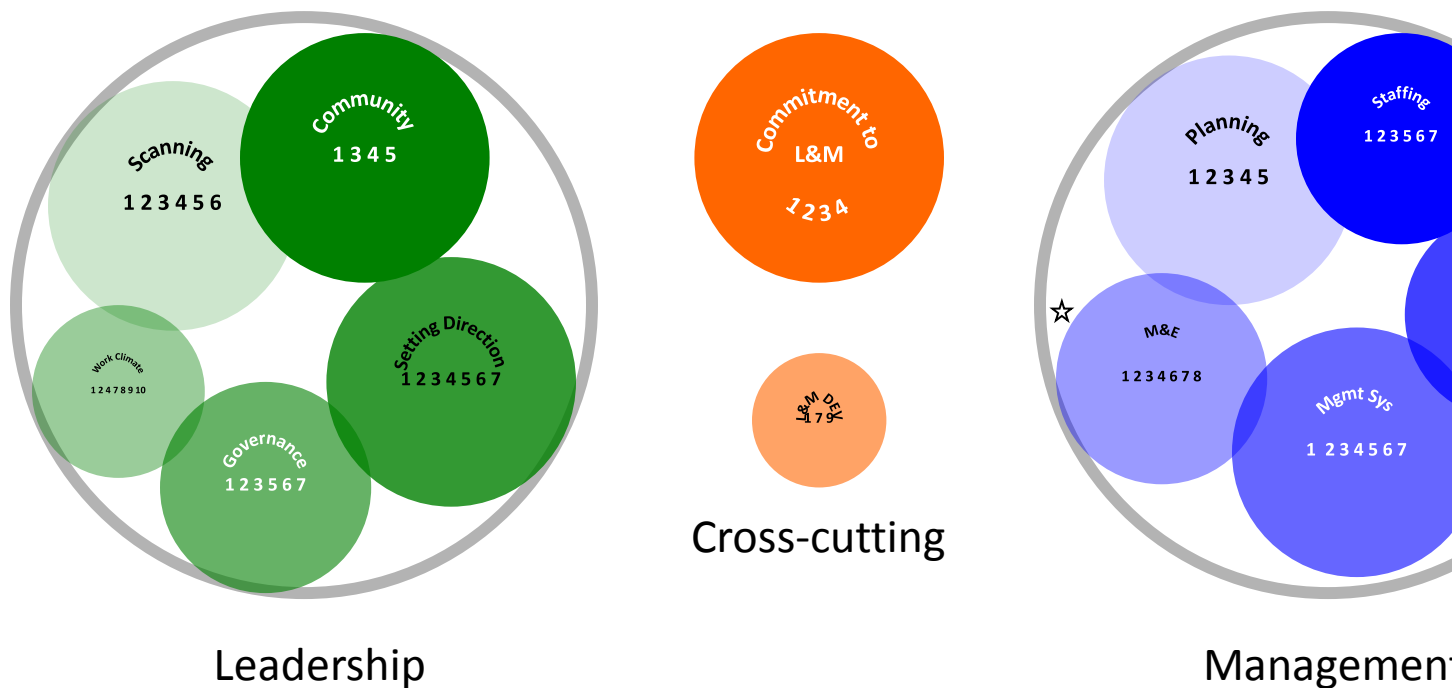
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- Transmission of the parasite was stopped in eleven West African countries and blindness was prevented.
- Children born in the program area were free from the risk of infection.
- Population could return to arable land, resulting in major agricultural and economic increases.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that Setting Direction, Planning, and External Commitment were equally the most present domains from a review of case study materials. All three traits were 100% present. In particular, the white star in the Management System domain denotes that a health management information system was identified for this case study.

Management Action in Detail

Coordinated Planning

The initiative involved more than 800 scientists, physicians, field staff and other personnel. Agreements, both administrative and financial, were split into six-year phases. Phases allowed for commitment and flexibility in planning cycles. Program duration was specifically planned to take into account the time necessary for the adult worms in the human population to die off (about 18 years). The program was expected to last twenty years. Therefore, planning partners recognized that the program would require long-term commitment.

Information Management

The program headquarters was comprised of four units: vector control, epidemiological evaluation, and biostatistical analysis and information systems. Current information was a key component of program implementation. Detailed mapping of onchocerciasis prevalence allowed for strategic program planning and decision-making. In addition, a research budget was built in to respond to challenges and explore effective prevention and treatment options.

Leadership and Commitment

Success was driven in part by the influence and commitment of key leaders. In 1988, Merck – a US based multinational pharmaceutical firm – offered to donate the medicine “to anyone who needed it, for as long as it was needed.” Influential leaders fueled the agenda on onchocerciasis control, encouraged global partnerships, and drove investments to solving the problem.

Multi-Sector Efforts

Many NGOs involved local people in various aspects. Training was provided for primary eye-health care workers, paramedics and specialists in using new technologies and techniques. Rehabilitation skills were taught to local people. Communities and local governments were mobilized to help in drug distribution activities. Tasks and authority were gradually delegated to lower levels, promoting ownership and commitment, and contracting technical services to private companies. Control efforts were incrementally transferring to affected countries.

Regional and Country Ownership

The program pioneered a system of community-directed treatment with Mectizan to develop a self-sustainable, fully African-owned and managed program. It used community volunteers to transfer, distribute and monitor Mectizan to community members. The program worked towards health and welfare promotion, disease prevention, and delivery of curative services and products. This case accomplished these while building capacity for equitable leadership and long term sustainability in the health sector, on a national and regional level.

Program Achievements

LEVEL: Health Effects

Health Effects (as of 2009):

- 1.5 million people who were once infected no longer experience symptoms.
- 600,000 cases of blindness have been prevented.
- 850,000 DALYs are being averted annually, at cost of \$7 each.
- Created potential for health improvement through increased economic development. 25 million hectares of arable land (enough to feed 17 million people/annum) were made safe for agricultural production and resettlement. This cumulatively created millions of years of additional productive work and boosted staple food production. 5 million years of productive labor have been added to economies of 11 program countries – using traditional farming techniques and existing technologies. Annual return on investment was calculated at 20% and an estimated \$3.7 billion will be generated from improved labor and agricultural productivity; yearly cost of less than \$1 per person protected.

Service Outputs (as of 2009):

- Community-managed treatment protected an at risk population of 120 million annually,
- 120,354 communities engaged.
- Rapid mapping of onchocerciasis completed in 19 countries.
- 1.29 billion Mectizan tablets donated to APOC (1997-2008).

Process Improvements:

- 22 million children born in the area are free from the risk of river blindness.
- 38,908 health workers trained/retrained; 250 manager level staff trained (APOC as of 2009).
- 418,000 Community Directed Distributors (CDDs) trained/retrained (APOC as of 2009).
- Training curricula introduced for medical schools in 12 countries (APOC as of 2009).
- 75% of projects evaluated deemed sustainable or making satisfactory progress (APOC as of 2009).

Strength of Performance Assessment

SCORE: High

External evaluations of APOC, monitoring and evaluation of community directed treatment with Mectizan projects; epidemiological evaluation, disease surveillance and assessment of health impact of APOC's operations are continuously being assessed. Information on each is available from

<http://www.who.int/apoc/evaluation/en/> .

Comments

The Onchocerciasis Control Program was a unique long-term and multi-partner initiative. Keys to successes in

health and non-health impacts were attributed to having sound management, capable and knowledgeable staff, effective and feasible control methods, and strong donor commitment.

POLIO ELIMINATION IN LAC

1985-1991

IMPLEMENTING ENTITY:

Pan American Health Organization (PAHO)

Location: Multi-country
AMRO/ Low, Lower-Middle, & Upper-Middle Income

Health Topic: Infectious Disease/Polio

Key Words: Region-Wide Collaborative Effort, Human Resource Capacity, HMIS

PROGRAM OVERVIEW

Goal: To eradicate polio from the region.

Objectives:

- (1) Achieve and maintain high immunization coverage with Oral Polio Vaccine (OPV);
- (2) Aggressive control of outbreaks through prompt identification of new cases;
- (3) Mobilize necessary political, financial and social commitment; and
- (4) Organize the managerial oversight to carry out immunization.

Funding: PAHO, UNICEF, USAID, IDB, Rotary International, Canadian Public Health Association [first 5 years cost \$120 million—\$74 million national sources, \$46 million international donors]

Background of Polio Elimination in LAC:

- Four-pronged strategy:
 - Achieve and maintain high coverage with at least three doses of OPV;
 - Provide supplementary doses of OPV to all children under 5 years old during national immunization days;
 - Surveillance of all cases of acute flaccid paralysis in children under 15 years with virological exam of stool specimens; and
 - House-to-house OPV mop-up campaigns.
- National vaccine days were implemented twice a year to increase coverage, and all children under 5 years old were vaccinated regardless of previous vaccination status.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Routine Expanded Program on Immunization alone was insufficient in eliminating polio in LAC.

Management Action: Standardize surveillance and implement an aggressive eradication campaign. Focus on increasing human resource capacity, inter-sectoral cooperation, technical innovation, decentralization of resources, and social mobilization across the fourteen polio-endemic countries in the region.

Principal L&M Characteristics Identified:

Leadership:

- Setting Direction
- Governance

- Scanning

Management:

- Planning

- Management System
- Monitoring and Evaluation

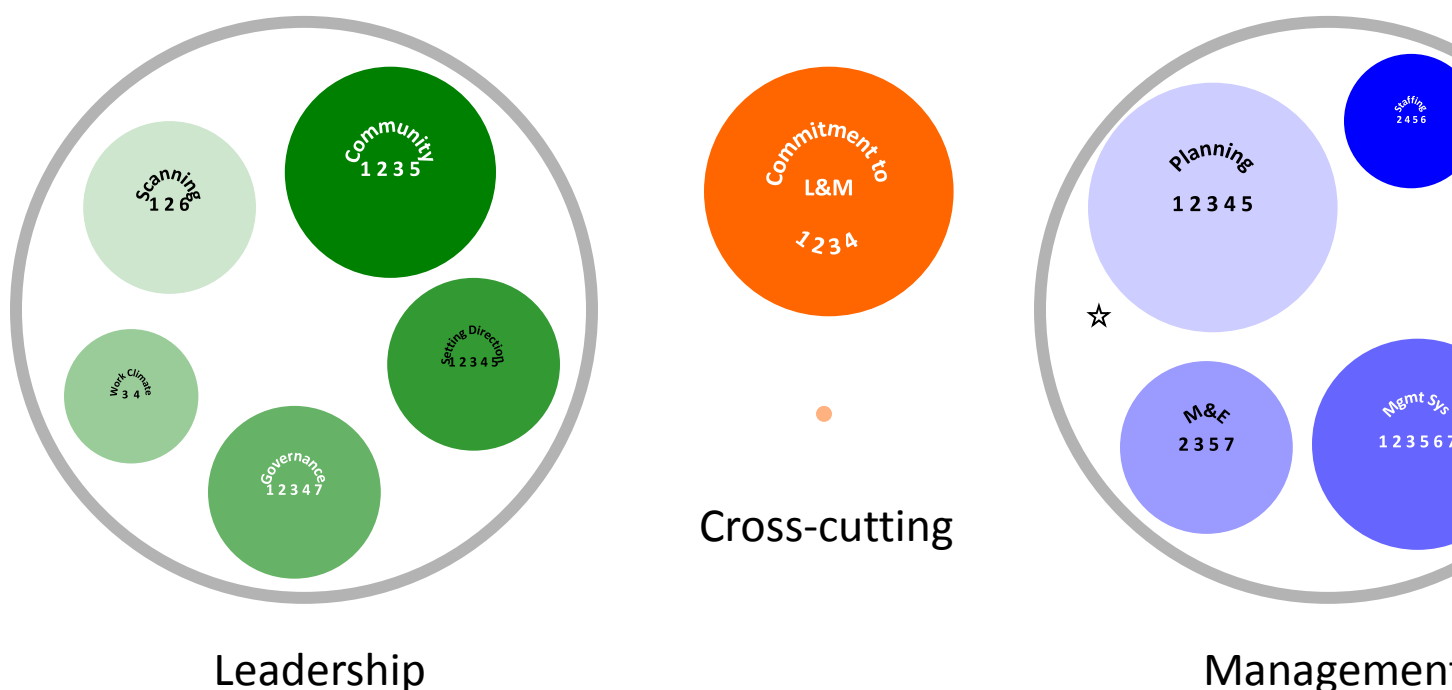
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- Polio was eliminated from Latin America and the Caribbean. The last wild case was detected in 1991.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



External Commitment to Leadership and Management was the most present L&M domain from a review of case study materials (88% presence). The Management domain of Planning followed with 80% presence. In particular, the white star in the Management System domain denotes that a health management information system was identified for this case study.

Management Action in Detail

Workforce Capacity Building

Thousands of managers, health workers, and technicians were trained in tasks such as cold chain management and surveillance. Non-monetary incentives were distributed along with reimbursement of personal costs, including transportation and communication costs. Cascade training and supervision were used to ensure basic guidelines were met. A standardized *Field Guide for Surveillance and Polio Eradication* was developed and distributed.

Information and Technology Management

Technical innovations such as the temperature-sensitive vaccine-vial monitor were attached to each oral polio vaccine vial and changed color if exposed to enough heat to inactivate the vaccine; using these technologies simplified monitoring and supervision. The Polio Elimination Campaign used simple spreadsheets for the calculation of human, physical, transport, social mobilization and financial resources required to immunize the target population. The spreadsheets were adopted into National Immunization Day guidelines and facilitated

central planning. Case definitions and indicators were standardized, and the system was computerized by 1989. Weekly reports were required from local clinics.

Monitoring and Evaluation

An Expanded Program on Immunization technical advisory group was created to review progress and set priorities for the program. Diagnostic laboratories were established. Surveillance indicators were robust and consistent, allowing for comparison of performance and impact between countries.

Decentralization of Resources

Resources were decentralized to strengthen response capabilities of the local health systems. Local resources were utilized for almost every task, including mapping, micro-planning, and vaccine transport. Central level resources were used to help lagging districts.

Program Achievements

LEVEL: Health Effect

Health Effect:

- LAC was declared a polio free region in 1994. The last wild case was detected in 1991.

Service Outputs:

- Vaccine coverage rates through routine immunization services peaked at 86% in the region in 1994.
- 9,000 stool specimens were examined and no poliovirus was found by the end of 1993.
- Established a network of diagnostic laboratories which hold trained epidemiologists and health workers experienced in cold chain management, surveillance, disease control and operational research that currently address new health challenges.

Process Improvements:

- All 14 countries in the polio-endemic category incorporated national vaccine to complement regular immunization by 1987. Diphtheria, tetanus, pertussis, and measles vaccines were also built in to the national vaccine days.
- Comparing savings from treatment costs with the cost of the 5-year program, the net benefit of eradication campaign (after discounting at 12%/year) in its first 5 years was \$271.2 million.

Strength of Performance Assessment

SCORE: High

- 1995, Multi-country assessment: interview data from communities, governments, NGOs, and health staff in six countries by the Taylor Commission.

Comments

The Polio Elimination Campaign was unique as it involved a multi-country collaborative approach with one vision. Successes were achieved through effective prioritization of a limited set of actions. The program also contributed to strengthening health systems in the LAC region.

TB CONTROL IN SOUTHERN MALAWI

2006-2011

IMPLEMENTING ENTITY:

Malawi National Tuberculosis Program, Project HOPE

Location: Malawi

AFRO/Low Income

Health Topic: TB/Infectious Disease

Key Words: Quality Assurance,
Community Engagement, Partnership
Building, Training

PROGRAM OVERVIEW

Goal: To reduce morbidity and mortality due to TB and TB-HIV co-infections in Mulanje and Phalombe Districts.

Objectives: (1) Improve treatment outcomes of TB and TB-HIV co-infection cases; and
(2) Increase case detection of TB, including among people with HIV co-infection.

Funding: USAID [\$1,500,000]; Cost-sharing [\$509,201] [Total: \$2,002,845]

Background of Project HOPE:

- Community-based programs
- Provides TB training to strengthen capacity of health care workers and health surveillance assistants.
- Community mobilization through education sessions, drama performances, and orientations for community leaders, traditional healers and shopkeepers.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Lack of human resources capacity, poor quality laboratory networks, and weak links with local communities created obstacles to improving National Tuberculosis Program implementation in districts.

Management Action: Train and support TB health workers, invest in laboratory support systems, and actively partner with local communities. Institute an overall focus on quality improvement.

Principal L&M Characteristics Identified

Leadership:

- Community Engagement
- Scanning
- Governance

Management:

- Management System
- Staffing
- Monitoring & Evaluation
- Planning

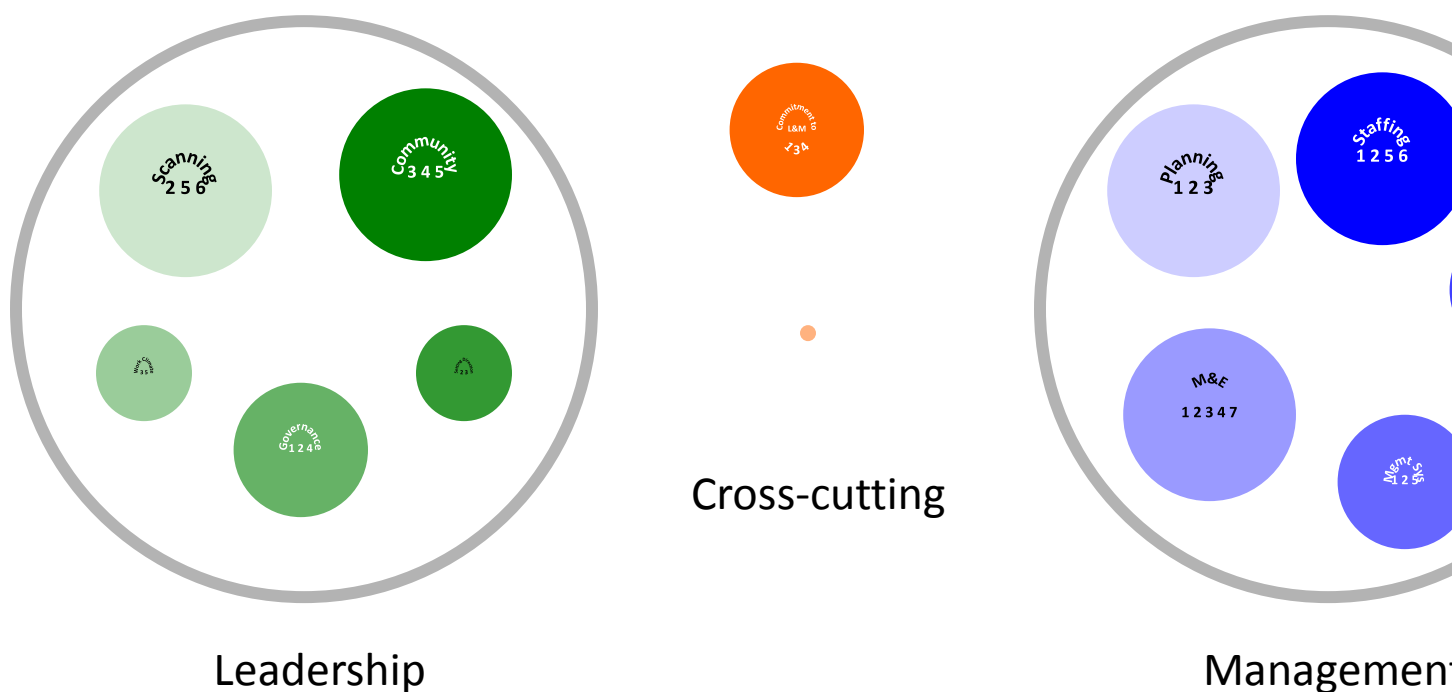
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- TB treatment success rate and case detection rates increased, while TB case fatality rate decreased.
- Project HOPE opened nine microscopy sites and facilitated the establishment of 30 community sputum collection sites.
- Increased and developed training of Health Surveillance Assistants, volunteers, shop owners, traditional healers, microscopists, counselors, and community leaders.
- Coordinated health education campaign events.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



This case is unusual with Community Engagement as singularly and considerably more present than other domains (80% presence). The Leadership and Management Development domain was not detected in the review of case materials.

Management Action in Detail

Strategic Partnerships

Project HOPE established partnerships with the District Health Offices for Mulanje and Phalombe districts, Christian Health Association of Malawi, and South-Eastern Zone staff. The program coordinated with the National Tuberculosis Program to develop TB guidelines and TB-HIV co-infection guidelines. Updating and improving training materials and curricula was a key priority in the partnerships.

Quality-Focused Capacity Building

Project HOPE improved the quality of the laboratory network by increasing the number of trained personnel (healthcare workers and Health Surveillance Assistants), increasing the number of laboratories in the districts, and providing regular supervision and mentoring visits to laboratories with National Tuberculosis Program. The project trained and supported health care workers, especially Health Surveillance Assistants to train, mentor, and supervise guardians in treatment adherence for TB and TB-HIV co-infection. Coordinating committees were established for TB case management. New laboratories were provided with support and equipment for sputum microscopy. The project also enhanced the quality assurance program in collaboration with local health authorities.

Community Driven Activities

Project HOPE introduced supervised Community Sputum Collection Points to increase access to TB diagnosis, with the support of community leaders and utilization of trained volunteers. The project emphasized client-friendly services, such as appropriate hours and confidentiality.

Program Achievements

LEVEL: Health Effect

Health Effects:

- TB case detection rate increased from 29% to 46% (2006-2009)
- TB treatment success rate increased from 60% to 85% (2006-2009)
- TB proven cure rate increased from 60% to 82% (2006-2009)
- TB case fatality rate decreased from 20% to 13% (2006-2009)
- TB patients given ART during TB treatment increased from 13% to 37% (2006-2009)
- TB patients tested for HIV increased from 49% to 87% (2006-2010)

Service Outputs:

- TB/HIV co-infection management shows increased accessibility to cotrimoxazole and ART provided during TB treatment

Process Improvements:

- Project HOPE has opened 9 microscopy sites, facilitated the establishment of 30 Community Sputum Collection Points, increased and developed the training of Health Surveillance Assistants, volunteers, shop owners, traditional healers, microscopists, HCT counselors and, TB-HIV case management for Health Surveillance Assistants, community leaders and health education campaign events.

Strength of Performance Assessment

SCORE: Average*

- 2005-2006, Baseline assessment
 - 2008-2009, Mid-term evaluation, plans to focus on facilities and service provision components
- *A final evaluation will be carried out with the participation of an external evaluator, with repetition of the baseline community cluster survey, the Health Facility Assessment and capacity assessments. Methods for evaluation will consist of a Knowledge, Attitude, and Practices survey, and a qualitative study. Monitoring will utilize the DOTS information system, HIV, TB-HIV, and ART Information System, routine reports, supervisory data, and through the project information system.*

Comments

Project HOPE established strong relationships with national and local partners, including local communities. Through training health care workers, improving the quality of the laboratory network, and mobilizing the community, the program improved case detection and treatment success rate of TB and TB-HIV.

UKRAINE MEDIA PARTNERSHIP TO COMBAT HIV/AIDS

2006-2008

IMPLEMENTING ENTITY:

Transatlantic Partners Against AIDS (TPAA) & IREX

Location: Ukraine
EURO/Lower-middle Income
Health Topic: Infectious Disease/
HIV/AIDS

Key Words: Public-Private Partnership,
Advocacy

PROGRAM OVERVIEW

Goal: To mobilize the communication power of mass media to improve awareness among the general population and specific target groups about HIV/AIDS.

Objectives:

- (1) Increase the level of private sector participation in public information and education efforts related to HIV/AIDS, specifically national and regional media outlets and commercial companies;
- (2) Develop and distribute targeted and coordinated HIV/AIDS messaging aimed at youth and high-risk groups (including youth and IDUs); and
- (3) Mobilize and train journalists and journalism students in Kyiv and at least four regions to improve the quality and quantity of HIV/AIDS-related reporting.

Funding: USAID [\$880,000]

Background of Ukraine Media Partnership (UMP):

- Adapted from the Russian Media Partnership to Combat HIV/AIDS.
- Developed environment of increased awareness, education, policy implementation, and behavior modification.
- Aimed to increase knowledge about HIV prevention and give a public voice to PLWHA.
- Encouraged the general population to identify, empathize, and build solidarity with PLWHA and members of other vulnerable groups.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Growing HIV/AIDS epidemic with high stigma and discrimination against People Living with HIV/AIDS (PLWHA).

Management Action: Use a mass marketing and product labeling approach through developing public-private partnerships. Provide incentives on reporting HIV/AIDS issues using an international best practice model for HIV prevention and campaigns.

Principal L&M Characteristics Identified

Leadership:

- Scanning
- Setting Direction
- Community Engagement

Management:

- Monitoring and Evaluation
- Management System
- Structuring
- Planning

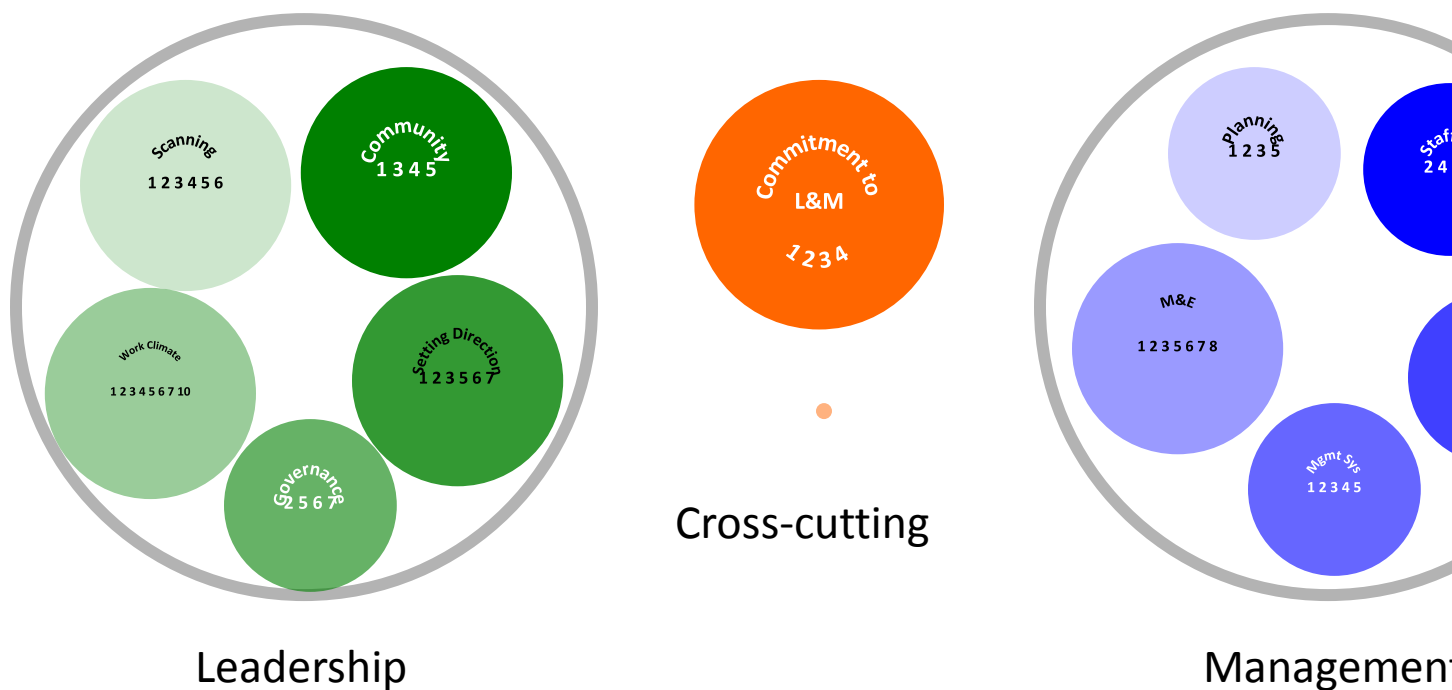
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- UMP projects ranged from public service announcements to special events and journalism briefings, and reached all 24 regions in Ukraine and the Republic of Crimea.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that External Commitment to Leadership and Management was the most present domain from a review of case study materials (88% presence). Multiple leadership domains in the figure are relatively large. Scanning, Setting Direction and Community Engagement were all considerably present at 75%, 71% and 70% presence, respectively. The management domain Monitoring and Evaluation was also apparent at 75% presence.

Management Action in Detail

Leverage Multi-sectoral Relationships

Ukraine Media Partnership collaborated with Ukraine's media companies, consumer products firms, advertising agencies and NGOs to develop a coordinated, cross-sector effort in its HIV/AIDS public awareness campaign. Through public-private partnerships with consumer product firms, Ukraine Media Partnership educated and held workshops for company trainers. The company trainers then trained other businesses about HIV and the Ukraine epidemic. The program partnered with L'Oreal and placed StopAIDS campaign logos and messages on L'Oreal products.

Advocacy and Awareness Tactics

Partnerships were initiated to reduce stigma and discrimination. The program partnered with magazines that printed personal stories of people affected by HIV. To capitalize on media coverage for HIV/AIDS, Ukraine Media Partnership strategically including HIV statistics in its event press releases. Events were organized with top Ukrainian celebrities as spokespersons, including a concert and a nationally broadcast telethon. These events raised awareness and support for People Living with HIV/AIDS (PLWHA). Mass marketing approaches included TV, radio, print, and outdoor materials linked to Ukraine's National hotline on HIV/AIDS and the campaign's website.

Build Media Competency

A training program educated journalists and editors about Ukrainians living with HIV. The program worked to establish dialogue between PLWHA and the media. To garner interest in the training, Ukraine Media Partnership invited Ukrainian and international public health and journalism experts. Journalism trainings were

comprehensive and incorporated action learning principles. Media fellowships were awarded to incentivize high quality products and increase HIV-related media coverage.

Program Achievements

LEVEL: Improved Processes

Evaluations directly linking Ukraine Media Partnership with population health outcomes or service outputs have not been reported.

Process Outcomes: (October 2006–December 2008)

- The campaign reached 43% or 15.9 million Ukrainians nationwide.
- 15 national and 20 regional media outlets that print or air ads as a result of campaign efforts.
- 2 commercial companies utilize consumer products or other public placed campaign messaging.
- 20 public service announcements for distribution among Ukrainian television media.
- 18 PSAs for Ukrainian radio.
- 15 PSAs for Ukrainian print publications and/or outdoor distribution.
- Journalism outcomes:
 - 182 journalists trained to be proficient in medical, social, economic and political aspects of HIV/AIDS, including issues related to vulnerable groups;
 - 6 meetings of Ukrainian Press Club on HIV/AIDS were held; and
 - 3 fellowships to journalists pursuing in-depth reporting projects on HIV/AIDS among vulnerable populations were awarded.

Strength of Performance Assessment

SCORE: Average

- 2008, survey of knowledge and familiarity with Ukraine Media Partnership campaign and its impact on the Ukrainian public: informal feedback solicited at all meetings with partners and UMP staff evaluated journalists' expectations and opinions about workshops

Comments

As in other cases, Ukraine Media Partnership was a prominent example of effective and innovative partnership building. The program strategically used social media to reach millions of people with HIV/AIDS messaging. Untraditional marketing outlets for HIV/AIDS were leveraged to increase awareness of prevention practices.

VIETNAM PUBLIC HEALTH PRACTICE TRAINING PROGRAM

1976-Present

IMPLEMENTING ENTITY:

Vietnam National Tuberculosis Program, CDC (USA)

Location: Vietnam

WPRO/Lower-middle Income

Health Topic: Infectious Disease/
Tuberculosis

Key Words: Management Development,
Supervision

PROGRAM OVERVIEW

Goal: To improve the National Tuberculosis Program's management capacity and implementation of DOTS.

Objectives: Provide management training for directors and senior TB staff.

Funding: Vietnam Public Health Practice Training Program

Background of Vietnam Public Health Practice Training Program:

- National Tuberculosis Program staff participated in CDC's Management for International Public Health (MIPH) and championed the development of the Vietnam Public Health Practice Training Program.
- Expanded leadership and management throughout MOHs, NGOs, and schools of public health.
- Utilized the train-the-trainer approach.
- Focused on six domains – leadership, team building, communication, priority setting and planning, performance assessment and problem-solving—applied at individual, interpersonal, managerial, organizational and contextual levels.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Vietnam NTP recognized weak management and lack of organization as barriers in TB programs.

Management Action: Participate in management development program with training, supervision, and team-building for NTP staff.

Principal L&M Characteristics Identified:

Leadership:

- Scanning
- Setting Direction
- Staff and Work
Climate
Development

Management:

- Monitoring and
Evaluation
- Staffing
- Planning

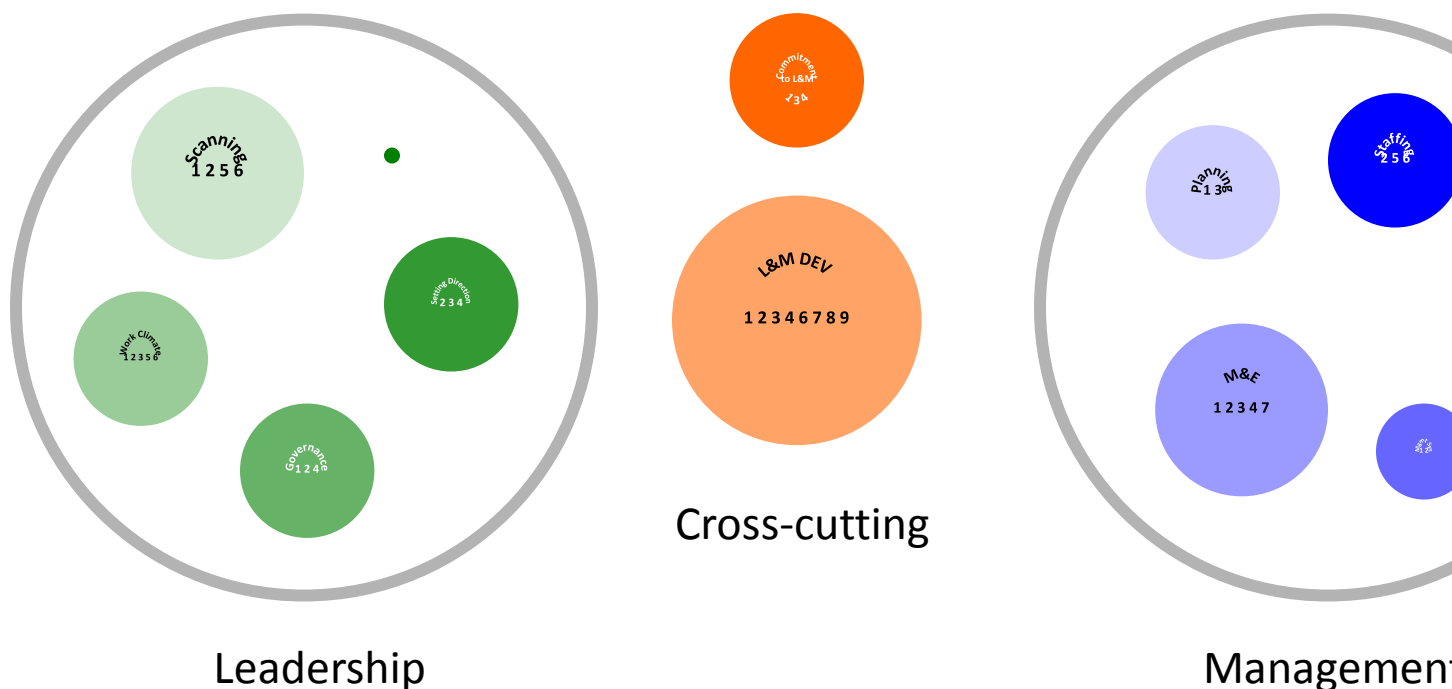
Cross-cutting:

- External Commitment to
Leadership and
Management
- Leadership and
Management Development

Results Achieved:

- Increased case detection rate for TB positive sputum samples in a district from 63 to 131/100,000 (3rd qtr of 2001 – 3rd qtr 2002).
- In a survey conducted post-training, learning and applying new skills related to evidence-based problem solving was mentioned by 30% of trainees and 47% of team members.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that Leadership and Management Development was the most present domain from a review of case study materials (75% present). All other domains were more than 20 percentage points away.

Management Action in Detail

Accelerating Gains through Train-the-Trainer Approach

Vietnam Public Health Practice Training Program utilized a train-the-trainer approach to expand staff familiarity with leadership and management skills. This value-added approach increased leadership and management capability at decreasing marginal cost. These gains improved National Tuberculosis Program quality.

Development of Management Skills

Vietnam Public Health Practice Training Program provided three weeks of courses on leadership, epidemiology, research, presentation skills, and health sector reform. Team building, planning, and Total Quality Management (TQM) were also included in the courses. TQM introduced concepts of teamwork and evidence-based problem solving. TQM provided teams with management tools to use for problem-solving, planning quality improvement actions, and measuring improvements.

Placing Coursework into Practice

After three weeks of coursework, the trainees returned to their organizations. Trainees worked on a project for six months with other staff members. The teams worked to improve a specific aspect of their program's performance. Trainees and teams were coached by National Tuberculosis Program staff during supervision visits. After six months, the trainees presented their project results to National Tuberculosis Program, faculty and each other. Outstanding projects are recognized.

Program Achievements

LEVEL: Health Effect

Health Effects: *(the study sites are labeled as pseudonyms as used in the original report)*

- Case detection rate for positive sputum samples in District XX increased from 63 to 131/100,000 (3rd qtr of 2001– 3rd qtr 2002).
- TB patients who completed 5-month follow-up exam in District Y increased from 27% to 67% (1st qtr 2002–3rd qtr 2002).

Service Outputs:

- TB suspects who receive smear exam increased from 51% to 76% (2nd qtr 2001–3rd qtr 2001) in District Z.

Process Improvements:

- Based on benefits of the program, NTP decided to include management training in its next 5-year plan
- Improved knowledge, skills, and on-the-job practices:
 - Sputum slides that met quality standards in District X increased from 45% to 89% (1st qtr 2002– 3rd qtr 2002)
 - Learning & applying new skills related to evidence-based problem-solving comprised 30% of trainee comments and 47% of team member comments; learning team building skills & valuing teamwork was the next most mentioned, followed by a commitment to continued use of these skills in their work. Team members in all 8 case study sites indicated they use total quality management regularly.
- Facilitators and barriers to success:
 - New positive patients late for their smear exam after 2 months of treatment decreased from 15% to 5% (3rd qtr 2000–3rd qtr 2001)
 - Error rate in national TB program paperwork decreased from 63% to 20% (2nd qtr 2001 –3rd qtr 2001)
 - District health centers unsatisfied with supply chain for drugs & equipment requests decreased from 66% to 33% (2nd–3rd qtrs 2001)

Strength of Performance Assessment

SCORE: High

- 2001, Baseline survey: qualitative
- 2004, Impact evaluation: case study design of eight provincial TB organizations selected by national TB program as sites, qualitative interviews, focus group discussions, and review of project reports

Comments

Vietnam Public Health Practice Training Program improved TB detection and case management through a quality initiative and leadership and management development. This led to higher numbers of TB case detected and improved treatment completion as measured by cure rates.

VILLAGE HEALTH WORKER PARTNERSHIPS

2003-Present

IMPLEMENTING ENTITY:

Karen Department of Health and Welfare (KDHV),
Backpack Health Worker Team (BPHWT)

Location: Burma
SEARO/Low Income
Health Topic: Infectious Disease/
Malaria

Key Words: Task-shifting, Training,
Standardization

PROGRAM OVERVIEW

Goal: To reduce the burden of malaria among Internally Displaced Persons (IDP) populations in eastern Burma.

Objective: Increase coverage of malaria control interventions and enhance the continuity of malaria programs.

Funding: Plant Care/Global Health Access Program

Background of Village Health Worker Partnerships:

- Local malaria program to fill the health service gap in the Karen State (To note: The Karen State is a government-in-exile. It represents the ethnic Karen people living in Burma).
- Care delivered at village level by partnering with village health workers.
- Program components included long-lasting insecticide treated bed nets, village screenings, early diagnosis and treatment, direct observation for treatment adherence, and malaria education.
- Pilot proved successful in four clinic areas.
- Followed by rapid scale up with extra safeguards to maintain quality care.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Shortage of health worker along with increased morbidity and mortality due to malaria, drug resistance, fake anti-malarial drugs, and remote village locations.

Management Action: Strategic training and use of village health workers. Adapted quality control measures for increased scale.

Principal L&M Characteristics Identified:

Leadership:

- Scanning
- Community Engagement
- Setting Direction

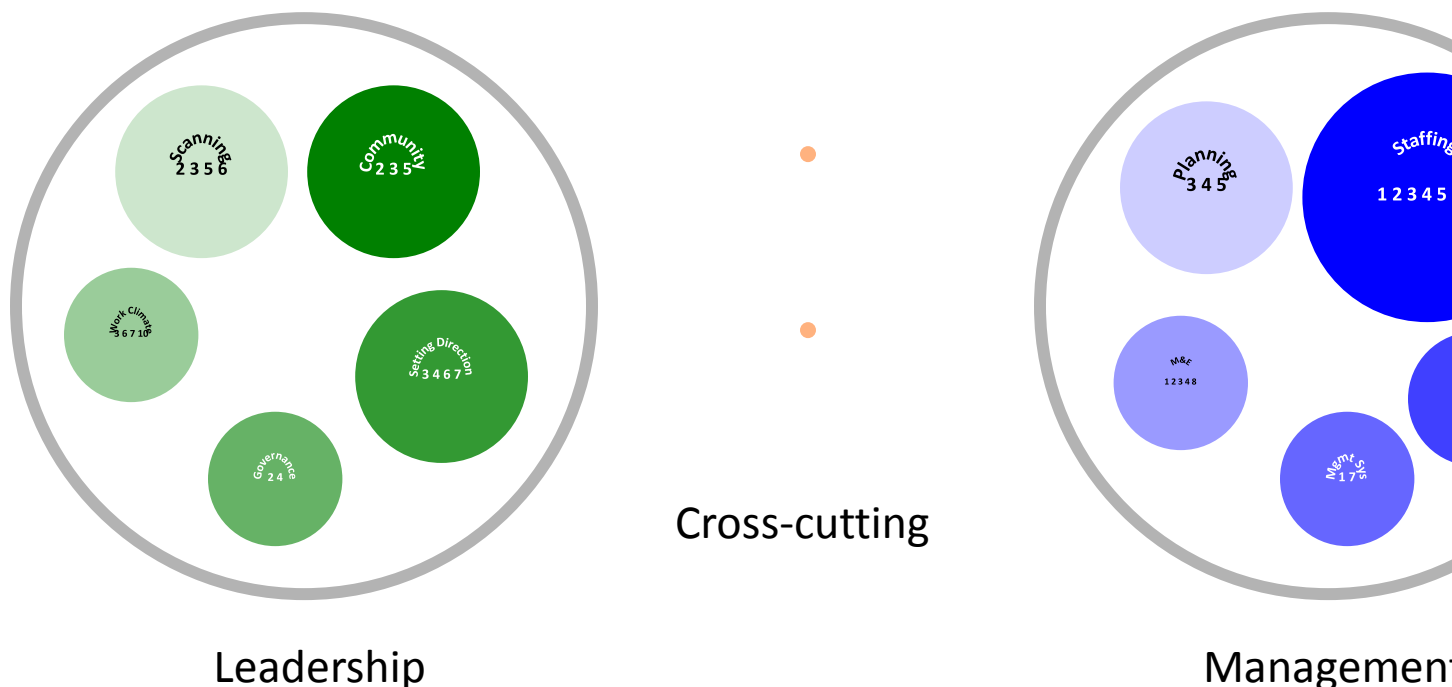
Management:

- Staffing
- Planning
- Monitoring and Evaluation

Results Achieved:

- Reduced malaria prevalence; built health workforce capacity; enhanced disease surveillance.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that Staffing was the most present domain from a review of case study materials. At 93% presence this domain was more than 20 percentage points away from others suggesting this was a key observed principle for the case. Both the External Commitment to Leadership and Management and the Leadership and Management Development domains were not detected in the review of case materials.

Management Action in Detail

Building Workforce Capacity

Clinic health workers trained a new group of workers recruited from the local villages. The program provided these health extension workers with official treatment manuals, and tailored their job responsibilities to the specific context of the village. For two months, this new cadre of staff worked alongside clinical health workers before being able to work more independently. Village workers continued to have regular meetings, supervision, and inventory monitoring from clinic health workers. The malaria program held a 'training-of-trainers' workshop for the program's clinic health workers every six months. This allowed for rapid expansion of education and training capacity. Workshops incorporated aspects of adult learning theory to refresh the skills of clinic health workers and enhance their ability to subsequently train and refresh village workers. The workshops also served as forums for discussion, feedback, and sharing of best practices and effective strategies among the clinic health workers. Training modules were revised based on input from clinic health worker discussions to improve confidence in delegating greater responsibility to village workers.

Meeting the Challenges to Scale Up

To increase efficiency and effectiveness with added malaria control responsibilities, clinic health workers had begun to informally enlist the help of local villagers. Karen Department of Health and Welfare recognized this as a potential advantage and chose to officially incorporate village workers in planning for the program's expansion. In the expanded program, village workers were formally recruited in accordance with established minimum qualifications. As was done in the pilot, village and district leadership participated in the planning process as a strategy to secure community buy-in. Village leaders helped select potential candidates. Time management trainings and tools were incorporated in the workshops to assist clinic health workers in balancing their responsibilities between overseeing village workers and clinic work. Small monthly stipends were instituted for village workers to improve staff retention and avoid frequent training of new individuals. The program

monitored inventory use and trained staff in supply management. Accurate therapy management was stressed to reduce over-treatment for individuals whose test results are negative.

LEVEL: Health Effect

Program Achievements

Health Effects:

- Pilot program:
 - *P. falciparum* prevalence among asymptomatic villagers decreased from over 8% to below 2%. There was approximately a 33% decline in incident cases (2003-2004).
 - Malaria prevalence decreased from 8-13% to between 1-4% depending on the area.
- Internally Displaced Person (IDP) settlement (2006):
 - An initial malaria screening demonstrated 28% prevalence of *P. falciparum* among recent arrivals.
 - Even as the IDP settlement's population grew follow-up screening showed that prevalence (18%) was still above levels normally recorded during the dry season. This implied an influx of the infected into the settlement thereby concentrating prevalence.
 - A year after the initial screening, an independent survey recorded *P. falciparum* prevalence of 5% among IDPs residing in the camp over 6 months. Population levels were roughly the same as during the initial screening.

Service/Coverage Outputs:

- Inclusion of village health workers increased overall health worker density from 13 to 53/10,000 persons in pilot areas (2003-2008).
- Increasing number of individuals in the community able to respond to disease outbreaks.

Process Improvements:

- Strengthened the continuity of the malaria program.
- The use of village health workers reduced the program's vulnerability to new Burmese military operations.
- Village health workers develop a basic skill set that is applicable for a variety of other public health issues.

Strength of Performance Assessment

SCORE: High

- 2003, Baseline measurement: community-wide screening, including biomarkers for malaria and Knowledge, Attitudes, and Practice (KAP) survey.
- 2004, Outcome assessment of pilot: natural experiment conducted from community-wide screening, including biomarkers for malaria and KAP survey, and then compared with baseline results.

Comments

The Village Health Worker Partnerships increased health workforce capacity by developing village health workers and ensured quality at expansion. The health department of the Karen National Union (government-in-exile of the ethnic Karen people) and Backpack Health Worker Team (community-based organization) took advantage of local resources and flexibly adapted as needed throughout scaling up services.

MATERNAL AND CHILD HEALTH CASES

FORMATIVE SUPERVISION

2003-2005

IMPLEMENTING ENTITY:

Maternal Health Family Planning Project, Management Sciences for Health (MSH), Division de la Sante' de la Reproducción, Health Districts of MOH

Location: Senegal
AFRO/Lower-Middle Income
Health Topic: MCH

Mgmt Act: Quality Assurance
Key Words: Training

PROGRAM OVERVIEW

Goal: Improve the quality and reinforce the technical competence of reproductive health providers.

Objective: Address the gap between information and reproductive health programming.

Funding: USAID

Background of Formative Supervision:

- Rights-based approach to service quality.
- Differed from other supportive supervision approaches by using a range of tools and activities to assess provider competence.
- Included the community in the supervision process.
- MSH implemented the program in 300 health facilities in six districts and conducted a study to evaluate changes resulting from reforms.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Senegal's MOH had developed protocols for reproductive healthcare that defined the objectives, tools, and frequency required for supervision. However, in practice, supervision was inconsistent and failed to result in the information necessary for tailoring priorities to improve quality.

Management Action: Reform the supervision policies with a formative supervision approach to improve the oversight and information management for the delivery of reproductive health services.

Principal L&M Characteristics Identified:

Leadership:

- Community Engagement
- Scanning
- Setting Direction

Management:

- Monitoring and Evaluation
- Structuring
- Staffing

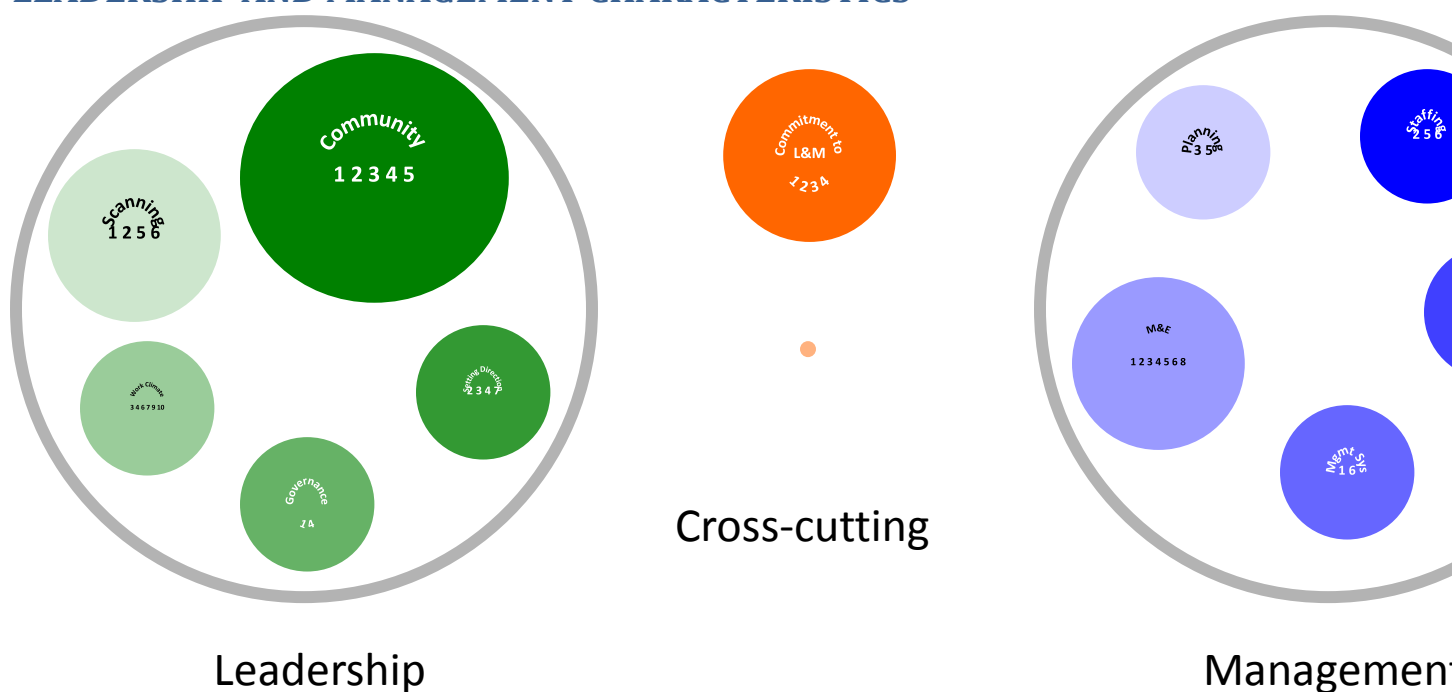
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- Formative supervision offered improved processes that lead to immediate benefits for health providers and communities. It collected critical data to inform program decisions.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that Community Engagement was the most present and was considerably more documented than any other domain at 90% presence. This suggests that Community Engagement was a major contributing leadership factor for this case's successes. The Leadership and Management Development domain was not detected in the review of case materials.

Management Action in Detail

Formative Supervision for Quality

The formative supervision program team recognized the multifaceted nature of provider performance and service quality. Program planners understood that a more systematic and complex approach to evaluation was required than Senegal's classical supervision allowed. The program broadened its scope to capture quality and provider competence. Checklists were created for assessments of quality in four areas of service delivery: infrastructure, staff and services management, recordkeeping, and technical competence. The checklists were developed in a participatory approach with input from multiple stakeholders and then were pretested for acceptance and usability. The checklist was designed to be adaptable to the range of health facilities in the national health care system: health posts, health centers, regional hospitals, and national hospitals. To stimulate demand for quality services, the program engaged the community in developing quality priorities. Engaging the community can also contribute to improving trust between providers and patients and fostering shared responsibility for improving population health status. During the first round of supervision, providers and community representatives developed action plans to improve the quality of service. In 2005, they initiated follow-up visits to assess progress in the execution of the action plans.

Program Achievements

LEVEL: Improved Processes

Evaluations directly linking the formative supervision program with population health outcomes or service outputs have not been reported.

Process Improvements:

- Thiès improved in management of staff and services by 23% and Louga improved by 16% (2003-2005).
- The smallest change observed in both regions was in infrastructure, with both Thiès and Louga improving by 4%.
- The most remarkable change across regions was in technical competence in infection prevention, with Thiès improving by 28% and Louga by 32%. This was a critical finding given performance in infection prevention was among the lowest in all areas of technical competence during the first round of supervision.
- Providers in the region of Thiès improved in technical competence by 26% (2003-2005).
- In Thiès, performance in logistics management improved by 29% (2003-2005).
- In Louga, technical competence in prenatal care consultation improved by 16% (2003-2005).
- Skills in family planning consultation improved in the region of Louga by 16%, and in the district of Tivaoune by 10% (2003-2005).

Strength of Performance Assessment

SCORE: Average

- 2003, Baseline assessment
- 2005, Preliminary outcome assessment: quantitative and qualitative tools including supervision checklists and completed action plans from four of the intervention districts; the sample accounted for 45 health facilities that received two rounds of supervision.

Comments

Formative Supervision highlighted the integral role supervision and workplace management play in service delivery. It also underscores the contribution communities and local users can make to improve quality services. The program established standardized supervision checklists that accounted for quality of care, provider competence, and facility services.

GOLD STAR

1992-2000

IMPLEMENTING ENTITY:

Egypt's Ministry of Health and Population (MOHP),
Population Project Consortium of Egypt

Location: Egypt
EMRO/Lower-Middle Income
Health Topic: Family Planning

Key Words: Quality Assurance,
Standardization, Branding, HMIS

PROGRAM OVERVIEW

Goal: Reduce maternal mortality.

Objectives: To upgrade the quality of family planning services, create new expectations for quality, and encourage the public to request better services.

Funding: USAID Population Family Planning III Project [Cost Analysis of Media Campaign Component: Cost per airing = \$7,450; Cost per person reached = \$0.28, Cost per single-client exposure = \$0.02]

Background of Egypt's Gold Star program:

- One of the largest public-sector quality assurance programs for family planning worldwide.
- MOHP partnered with the Ministry of Information to improve family planning services, publicize the improvements, and demonstrate what the public should expect from high quality care.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Poor utilization and quality of public sector family planning services.

Management Action: Establish a quality assurance program through clinic certification under a common brand.

Principal L&M Characteristics Identified:

Leadership:

- Community Engagement
- Scanning
- Setting Direction

Management:

- Monitoring and Evaluation
- Structuring
- Staffing

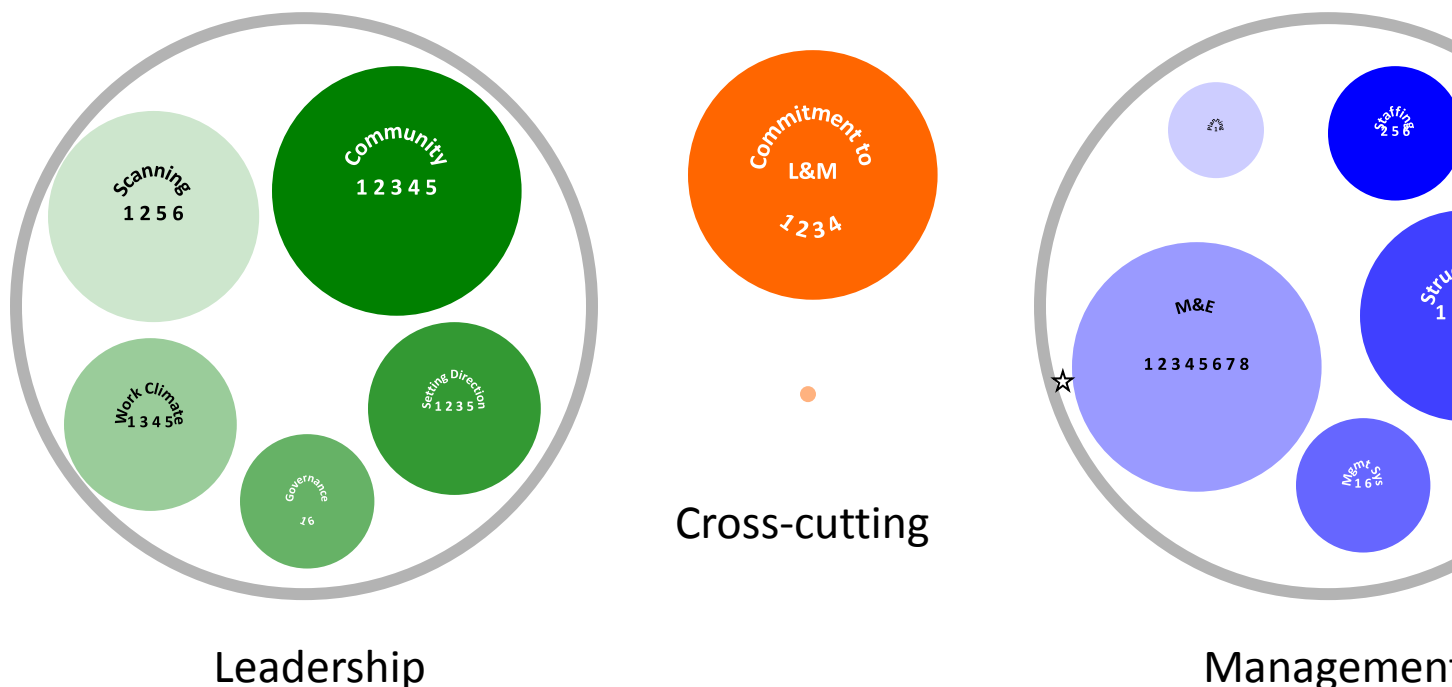
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- The Gold Star program provided more than 3,800 Ministry of Health and Population clinics with basic equipment and renovations, trained 7,710 physicians and 14,814 nurses, implemented national Clinical Standards of Practice in all units, and installed the quality management and supervision system. These activities contributed to increased coverage and demand for high quality family planning services and improved quality of care within public sector clinics.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that External Commitment to Leadership and Management was the most present L&M domain at 100% presence based upon a review of case study materials. The key leadership domain was Community Engagement found to be 90% present; for management, Monitoring and Evaluation was noticeable at 94% presence. The Leadership and Management Development domain was not detected in the review of case materials. The white star in the Management System domain denotes that a health management information system was identified for this case study.

Management Action in Detail

Standardizing High Quality Care

The Gold Star program oversaw the development of 101 minimum essential service requirements. The service requirements were used to standardize the provision of family planning services in the public sector. As a method for stakeholder analysis, the program administered focus-group discussions with women to gather information on their preferences and values with regard to service delivery. The 101 quality indicators were designed based on the input from these focus groups. The program identified and allocated resources to address the following needs: basic equipment and renovations for clinics, national Clinical Standards of Practice, and a management and supervision system.

Building Workforce Capacity and Accountability

To overcome health providers' initial reluctance to implement the new service standards, the project administered an extensive orientation and training plan to explain new procedures, develop a culture of teamwork, and improve technical skills. District supervision teams visited each facility four times a year and rated them on the list of 101 quality requirements. Supervisors worked with clinic staff to analyze reasons for substandard performance and develop solutions for problems.

Monitoring and Rewarding Quality

A computerized management information system was developed to track quarterly indicator scores for each clinic. If the facility met all standards for two consecutive quarters, it would receive Gold Star certification. Certified facilities could then display the Gold Star—a symbol of high quality—on clinic signs and staff badges. The Ministry built the ongoing cost of monitoring and certification into its regular budget and launched a

national multimedia communication campaign to advertise the locations of Gold Star accredited clinics and stimulate demand for Gold Star services.

Program Achievements

LEVEL: Increased Service Outputs

Evaluations directly linking the Gold Star program with population health outcomes have not been reported.

Service Outputs:

- Contraceptive prevalence increased from 47.9% to 54.5% (1995-1997); for the first time exceeding half of the eligible population
- 900,000 net new intrauterine device users, an increase from 30% to 35% of the population (1995-1997)
- Public sector market share for family planning services grew by 10% over 5 years (1995-2000)
- Private sector market share for intrauterine device provision declined from 56% to 34% (1988 -2000)
- The media campaign reached 81% of the target population for an estimated total 8.1 million

Process Improvements:

- The proportion of facilities meeting the quality standards rose from 29% to 46% (1995-1997)
- Regional disparities in the quality of care narrowed
- Disparities between primary and secondary care facilities narrowed
- The increase in patient flow was greatest at Gold Star Clinics
- 60% of facilities were able to maintain their Gold Star status for at least 18 months

Strength of Performance Assessment

SCORE: High

- 1995, Baseline assessment
- 1997, Midterm assessment: quantitative and qualitative, including the Service Provision Assessment Survey and ongoing monitoring of 101 quality indicators
- 2000, End-line assessment: quantitative and qualitative, including the Service Provision Assessment Survey and ongoing monitoring of 101 quality indicators

Comments

Gold Star standardized service delivery in public reproductive health clinics by developing 101 indicators of good-quality service. Gold Star combined this with regular monitoring and building a reputable brand, which institutionalized a culture of quality improvement among public family planning providers. Gold Star also developed a management culture that encouraged decentralized decision-making.

GREENSTAR SOCIAL MARKETING

Reproductive Health Social Franchise Network

1995-Present

Location: Pakistan

EMRO/Lower-Middle Income

Health Topic: Reproductive health

IMPLEMENTING ENTITY:

Greenstar Social Marketing Program [GSMP], Save the Children, Population Council, Pakistan Voluntary Health and Nutrition Association (PAVNHA)

Key Words: Franchise Network, Standardization, Quality

PROGRAM OVERVIEW

Goal: Improve reproductive health and family planning services in Pakistan.

Objective: To help increase the use of modern contraceptive methods.

Funding: Primary donor is USAID; other donors include the Global Fund, United Nations Organizations, DFID, Packard, German Development Bank (KfW), Population Services International, John Snow Inc, and Proctor & Gamble [\$31,700,000 for 1995-2002].

Background of Greenstar Social Marketing Program:

- Originally established as a condom social marketing campaign.
- Broadened to increase the choice of contraceptives to include methods dependent upon skilled providers.
- Pursued social franchising to ensure clients would have access to quality service delivery.
- Launched the Greenstar network of family planning franchises: privately owned and managed clinics and pharmacies in low-income urban areas that offered a focused package of services and products under the Green Star logo.
- Introduced on a pilot basis in 1995 and expanded in 1996.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Shortage of skilled providers and quality family planning services in Pakistan's private sector.

Management Action: Create a fractional franchise network to give both the means and the incentives for private health providers to deliver high quality services.

Principal L&M Characteristics Identified:

Leadership:

- Setting Direction
- Scanning
- Community Engagement

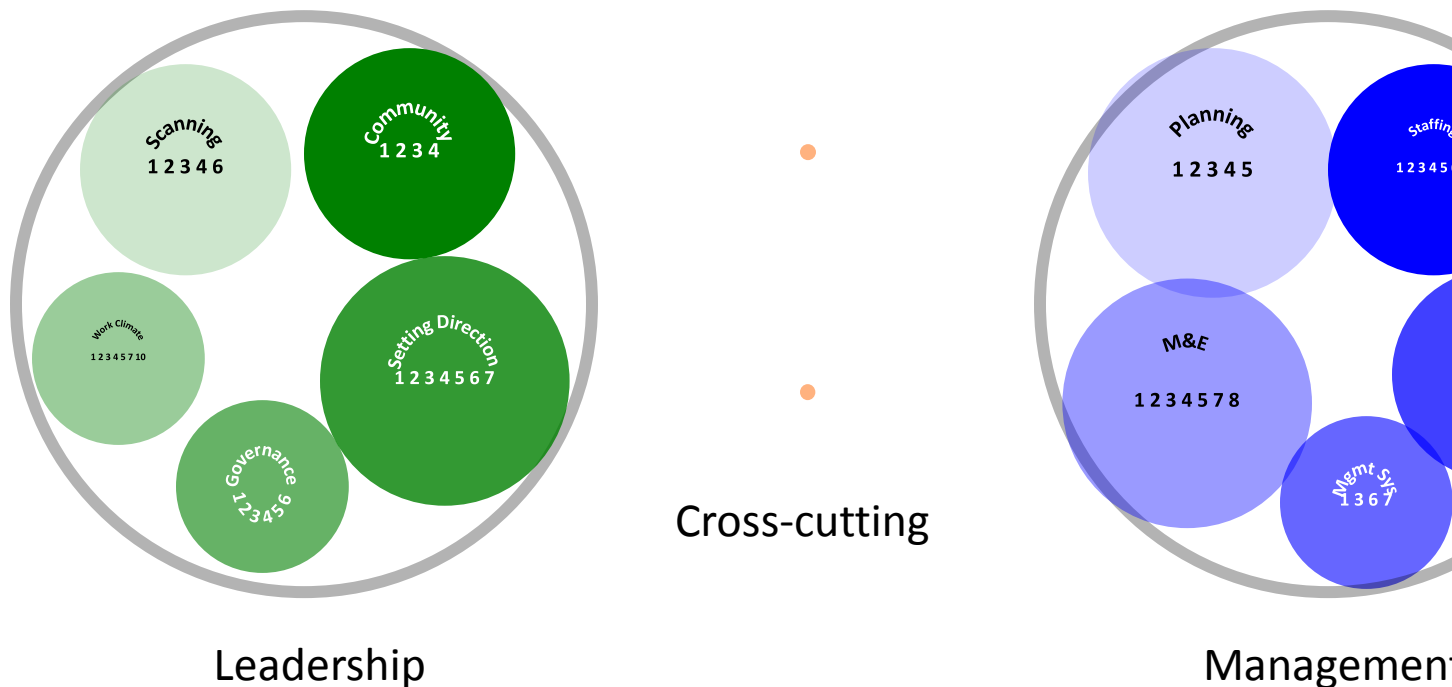
Management:

- Planning
- Monitoring and Evaluation
- Staffing

Results Achieved:

- Greenstar grew to 12,000 doctors, paramedics, and pharmacists operating in 40 cities and handled more than 10 million client visits per year. The program achieved over 15 million couple-years of protection, which contributed to averting approximately 9.3 million unintended pregnancies and approximately 16,500 maternal deaths (1995-2006).

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



Planning was the most present L&M domain at 90% presence as determined from a review of case study materials. Key leadership domains were Setting Direction (86% presence), Scanning (75% presence), and Community Engagement (70% presence). Notable management domains apart from Scanning were Monitoring and Evaluation and Staffing (88% and 79% presence, respectively). Both the External Commitment to Leadership and Management and the Leadership and Management Development domains were not detected in the review of case materials.

Management Action in Detail

Focused Franchise

The Greenstar case benefited from a strong organizational structure with established functional divisions, decision-making support structures, and a governing board to guide strategy and drive innovation. Service providers were selected to become franchisees through a transparent process based on defined criteria. Selection criteria were adjusted as the program matured to account for traits that had been demonstrated to better predict successful franchise relationships. An enforceable contract was established to govern franchiser–franchisee relations. Modifications made to the network’s comprehensive package of family planning services accommodated a broader range of service providers, in turn allowing for more rapid scale up of the network. To manage its supply chain and protect against stock-outs, the program used its own specialty sales force to bring products directly to providers each month. Products were priced in a total market approach where the price points change for different segments of the population (based on ability to pay), with the intention of ensuring both affordability and profitability. Greenstar collaborated with the public sector, other NGOs, and partners by sharing information and coordinating training programs to maximize coverage and impact, and including these organizations in their referral networks.

Strategic Planning through Stakeholder Engagement

Program planners conducted focus group discussions and surveyed the needs and preferences of their target population. Market testing and consumer research was done to ensure the logo and tag line would be well received by the public. An advertising campaign was developed based on the results, to generate awareness that the Greenstar brand symbolizes high quality and stimulate public demand for Greenstar services and products. To maximize market impact of the ads, a range of outlets were employed including television, radio, promotional materials, print, and outdoor. Community outreach was used to further engage the market. Outreach methods included pamphlet distribution (with maps and locations of nearby affiliated clinics), press-attended launch events that featured respected public speakers, Greenstar sponsorship for community activities, free medical camps, town-storming, trade promotions, and neighborhood meetings. Planners had health care providers participate in creating the service protocols and the training modules. Teamwork was fostered and provider input was given precedence.

Human Resource Management

A competency-based training approach was used where every trainee took the same test (appropriate to provider level). Tests were taken both prior to training and afterwards, which established a baseline and tested the trainee's competency at the end of training. The social marketing program provided further support through refresher trainings and a 24-hour telephone hotline. Rather than contract to an outside training group, Greenstar decided to hire doctors to direct the in-house training courses. Each doctor trainer was responsible for follow-up monitoring of their previous trainees which allowed for greater continuity and consistency, as well as social and technical support.

Performance Monitoring

In addition to the internal supervision, Greenstar monitored provider performance through Mystery Client Surveys. Program managers utilized a management information system to collect data and monitor clinic performance, patient data, sales data, and inventory overtime. Reports are generated to review performance against quality indicators. Strategic finance management was prioritized. Greenstar benefitted from a diversified funding base, employed cost containment strategies, and paid attention to revenue generation. Program managers planned for increasing cost recovery and decreasing operating costs with the objective of becoming less dependent on donor aid.

Program Achievements

LEVEL: Health Effect

Health Effects:

- Greenstar achieved 15 million couple years of protection since 1995, preventing 9.3 million unintended pregnancies and 16,500 maternal deaths.
- In 2008 alone, Greenstar achieved 2.5 million couple years of protection, or 492,000 DALYs.

Service Outputs:

- Prior to Greenstar, use of oral contraceptives and injectables in Pakistan remained virtually unchanged (1991-1995), but both methods experienced a dramatic rise in use after Greenstar expanded to include these products (1995-1997): oral contraceptive use increased by 29%, injectable use increased by 40%, and intrauterine device use increased 62%.
- Contraceptive prevalence rates among married women of reproductive age in Pakistan increased from 17.8% to 23.9% (1995-1997).
- A 2002 external evaluation identified Greenstar as the only organization in Pakistan to have successfully increased client flow for providers.

Process Improvements:

- Successful branding: Research in low-income urban areas in 1997 found 93% of respondents recognized the Greenstar logo and identified it as a symbol of high quality family planning at affordable prices.
- The cost of the program per CYP steadily decreased from approximately \$12 to \$4.5 (1996-2000).
- The Jhpiego study found notable accomplishments in Greenstar training including: an excellent use of adult learning techniques, trainers who are strong content experts, learning objectives clearly based on identified needs, good use of team training and competency-based training, and strong and effective participation by the learners.

Strength of Performance Assessment

SCORE: High

- Ongoing, Greenstar staff doctors measure franchisee performance and quality improvement progress through regular visits and all data is entered in HMIS system for quantitative analysis.
- 1997, Evaluation of the Greenstar pilot
- 1998, Jhpiego evaluated all four Greenstar training programs

Comments

Greenstar successfully used the social franchise business model to expand access to high quality family planning services in Pakistan.

HEALTHY WOMEN IN GEORGIA

2003-2009

IMPLEMENTING ENTITY:

JSI Research & Training Institute, Save the Children, Fund Orthos, CLARITAS XXI, CSMA, Women's Wellness Alliance, Curatio International Foundation, McCann Erickson

Location: Georgia

EURO/Lower-Middle Income

Health Topic: Maternal Child Health

Key Words: Strategic Partnership, Policy Change, HMIS

PROGRAM OVERVIEW

Goal: To improve the health and well-being of Georgian women and their families.

Objectives:

- (1) Modernize maternity care in Georgia through introduction and institutionalization of evidence-based and family-friendly effective perinatal care;
- (2) Promote access to and utilization of quality family planning services as a basic right of women and to decrease high abortion rates in Georgia; and
- (3) Improve both knowledge and health-seeking behavior of women of reproductive age, their families, and youth.

Funding: USAID [\$ 12.8million for 6 years]

Background of Healthy Women in Georgia Project:

- Women's health program supported by international and Georgian NGOs.
- Community level activities: youth peer education, breast cancer awareness, and parenting classes.
- Large-scale activities: provider training, clinical improvement, contraceptive logistics and distribution, supportive supervision, youth-friendly pharmacies, and medical education.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Georgia faced a number of policy and financial barriers in providing family planning, youth reproductive health education and modern maternity care.

Management Action: Established innovative partnerships, developed strategic marketing tools, and utilized local resources and community members to improve service delivery for maternal, child, and reproductive health.

Principal L&M Characteristics Identified

Leadership:

- Scanning
- Setting Direction
- Community Engagement

Management:

- Structuring
- Planning
- Monitoring and Evaluation

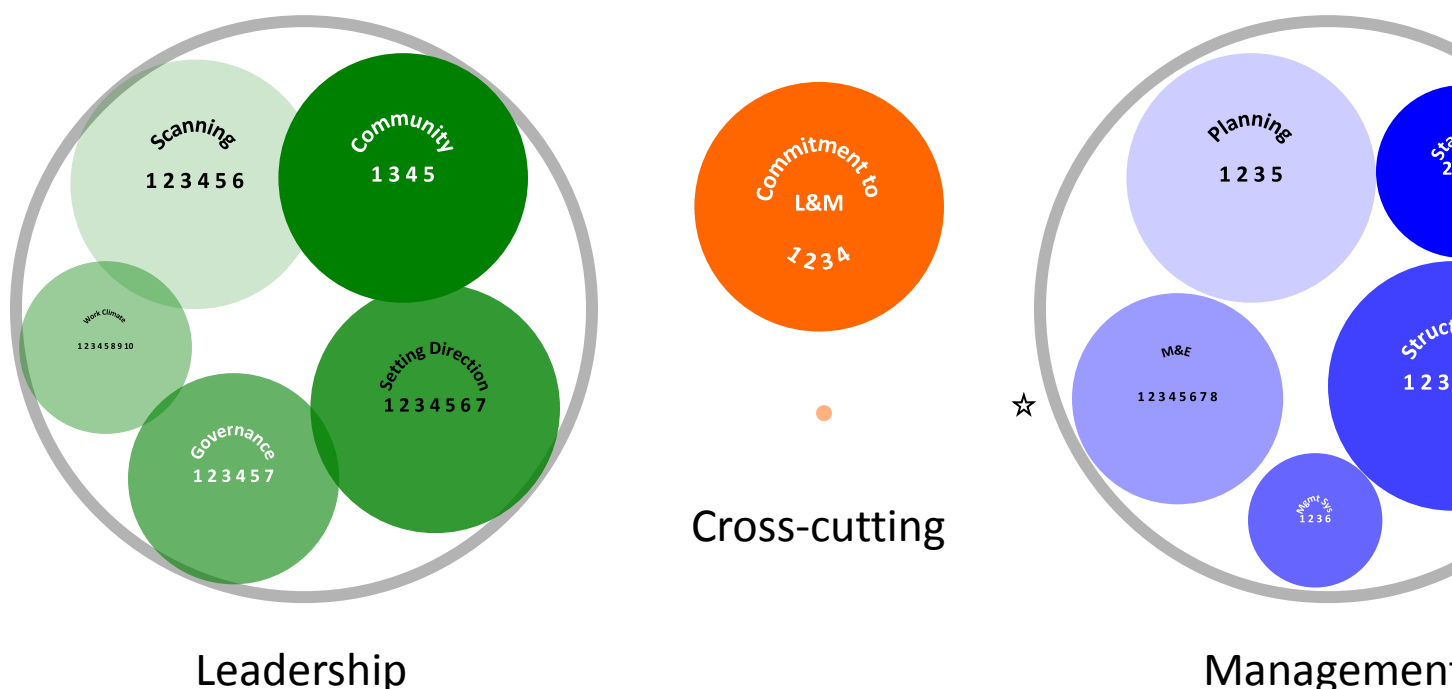
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- Increased use of modern contraceptive methods, awareness, and participation in maternal child health issues.
- Increased number of safer deliveries.
- Reduced maternal mortality and child mortality.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that Commitment to Leadership and Management was the most present domain from a review of case study materials (100% presence). Multiple L&M domains in the figure are relatively large in size. For management areas, Structuring and Planning were 83% and 80% present, respectively. For Leadership groupings, Scanning, Setting Direction and Community Engagement were present at 92%, 86%, and 80%, respectively. The considerable presence of a number of domains suggests that this case documented a wide variety of leadership and management actions. In particular, the white star in the Management System domain denotes that a health management information system was identified for this case study.

Management Action in Detail

Comprehensive Operational Strategy

Operations focused on improving client welfare (i.e., clinical outcomes, empowerment, and satisfaction). The case also emphasized improving skills, effectiveness, and morale of service line providers (i.e., doctors, nurses, pharmacists and teachers). All activities were based on a strong commitment to evidence-based programming, using worldwide best practices, and monitoring performance and outcome data. Cost-effective solutions, interactive learning, partnership leveraging, and sustained commitment among diverse implementers were priorities throughout planning, rollout, and delivery.

Ensuring Quality of Care through Active Labor Management

The program established facility-based quality assurance teams responsible for maintenance and refinement of obstetric and neonatal care practices. The Effective Perinatal Course included constant technical support, encouragement, and monitoring. The course provided small subsidies for minor renovations to maternity units. To complement the Effective Perinatal Course and clinical improvements, the program designed and delivered short courses. The short courses supplied providers in target sites with up-to-date information about clinical and epidemiologic characteristics of perinatal infections, modern diagnosis, management and prevention, and strategies to decrease infection risk factors. Short courses also provided “2 minute messages” to help pharmacists counsel clients effectively. Other courses introduced for beneficiaries included an expectant couples class. The class emphasized active and collective participation (i.e., by women, husbands, and families) in birthing and newborn care.

Strategic Marketing

To stimulate demand for services, media campaigns used multiple channels to reach large target markets, including: TV, print media, radio programs, billboards, website publications, social networking, and brochures. HWG made educational materials available online in the Georgian language to increase accessibility for medical students, health providers, and the general public.

Service Integration

The program used a comprehensive strategy aimed to strengthen Behavioral Change Communication service delivery by not only providing contraceptives, but also training for providers and pharmacists, a logistics and information management system, and ongoing supportive supervision. The program integrated postpartum and post-abortion care services to ensure post-abortion care clients receive counseling.

Strategic Partnerships and Policy Engagement

A public-private partnership was established with a NGO in Georgia. In partnership with this NGO, the program utilized unconventional groups such as hairdressers to educate community members about maternal child health and breast cancer. To reach goals, USAID and Georgia recognized free or subsidized contraceptives were needed for clients with limited or no ability to pay for them, and budgeted program funds accordingly. The program coordinated with the pharmaceutical sector so free commodities would not compete with commercial products. This case also successfully engaged the government to issue a “waiver” permitting the training of primary care doctors, pediatricians, and nurses in family planning counseling and services normally only done by licensed OB/GYNs.

Program Achievements

LEVEL: Health Effect

Health Effects:

- Active Management of Third Stage of Labor in 99% of vaginal deliveries, and as a result, reduced postpartum hemorrhage rate from 8% to 1%. This would show a reduction in maternal mortality as postpartum hemorrhages are a major cause of maternal mortality.
- Cumulative number of women giving birth who received Active Management of the Third Stage of Labor through USG-supported programs increased 14-fold over 3 years to 23,715 by 2009.
- Cumulative Couple Years of Protection in USG-supported programs increased 14-fold over 3 years to 60,555 by 2009. Increased contraceptive protection reduces potential for maternal mortality.

Service Outputs:

- Increased service delivery points 3-fold to provide family planning counseling/services at 575 locations by 2009.
- 200-times more newborns (247,331) received Essential Newborn Care in USG-supported programs than 3 years prior to 2009.
- As of September 2009, approximately 70% of deliveries in Georgia were at facilities using effective perinatal care technique.

Process Improvements:

- Effective infection prevention practices promoted in majority of facilities.
- Over 400 providers received on-the job training.
- Fewer wasted resources due to modernized techniques, compared to previous high costs due to over-medicalization, unnecessary interventions, and higher maternal and infant morbidity.

Strength of Performance Assessment

SCORE: High

- 2006, Baseline assessment followed up with quarterly quality monitoring for each HWG-assisted facility
- Cost study: Compared all costs of maternity and newborn services before and after implementation
- MCH study: Focus group discussion among providers and reproductive age women to assess changes in needs and health seeking behavior

Comments

Healthy Women in Georgia leveraged public-private partnerships to promote healthy practices in the community and effectively influence policy change. This project was successful in improving family planning and newborn care services, and led to a reduction in postpartum hemorrhage.

MATERNAL HEALTH INITIATIVE

2009-Present

IMPLEMENTING ENTITY:

McKinsey & Company, Synergos Institute, Presencing Institute from Massachusetts Institute of Technology (MIT), Ministry of Health and Social Services (MOHSS)

Location: Namibia
AFRO/ Upper-Middle Income
Health Topic: MCH

Key Words: Build L&M Capacity, Workforce Capacity, Quality Assurance

PROGRAM OVERVIEW

Goal: Stop Namibia's rising maternal mortality rate while improving productivity and health service delivery for maternal health; create a replicable model that can be applied in national health systems.

Objective: Promote locally developed maternal health improvement initiatives and build local leadership.

Funding: Bill and Melinda Gates Foundation

Background of Maternal Health Initiative:

- Program to enhance the quality and performance of the health leaders in pilot area.
- Empowered health leaders to design and test new approaches to problem-solving.
- Focused on developing a replicable approach for improving maternal health care across the country.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Namibia conducted a health sector assessment and found that leadership was weak, structures were dysfunctional, and there was a lack of strategic planning, proper data, clear targets, or progress toward MDG milestones. Findings were especially poor in maternal health.

Management Action: Build local leadership to improve supply and raise demand for maternal health services.

Principal L&M Characteristics Identified:

Leadership:

- Community Engagement
- Staff and Work Climate Development
- Scanning

Management:

- Structuring
- Staffing
- Management Systems

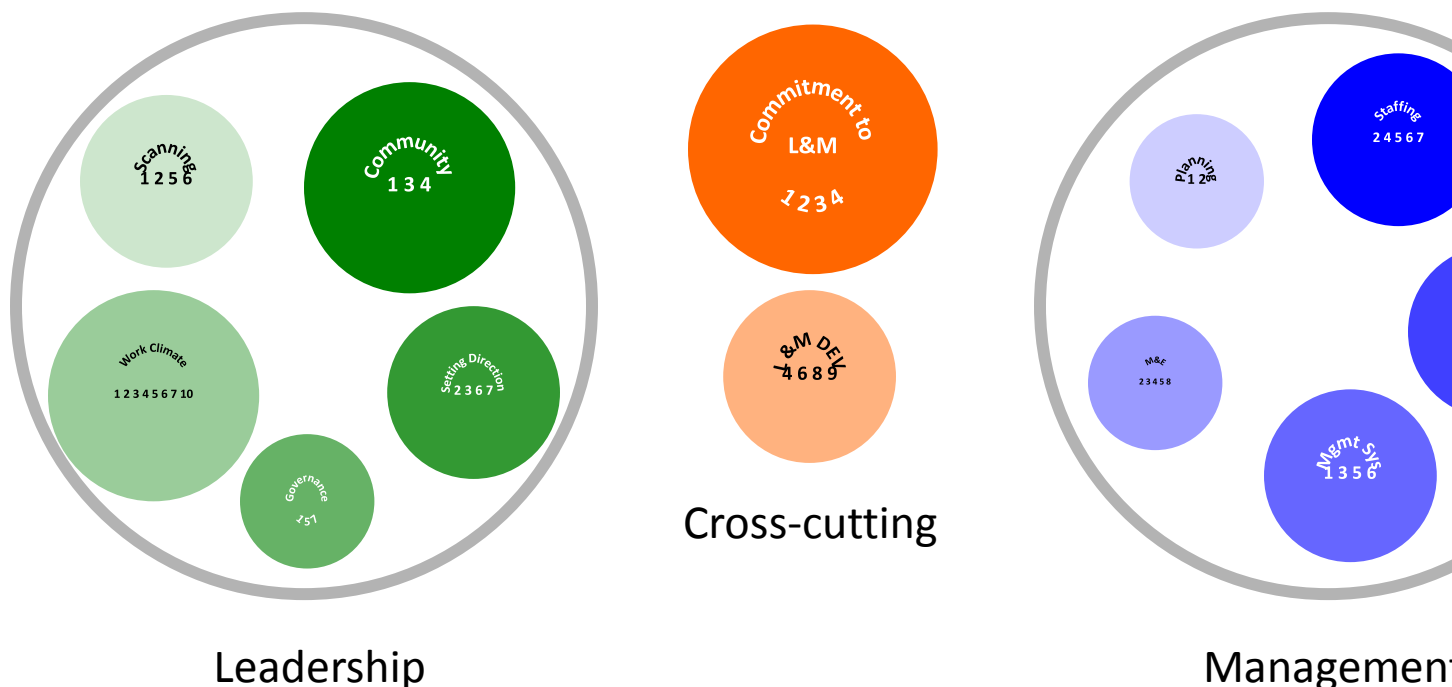
Cross-cutting:

- External Commitment to Leadership and Management
- Leadership and Management Development

Results Achieved:

- Pilot results suggest several significant process improvements contributing to the more accessible and efficient delivery of health services.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that External Commitment to Leadership and Management was the most present L&M domain from a review of case study materials (88% presence). Leadership domains are relatively more present as the Maternal Health Initiative set out to build local leaders.

Management Action in Detail

Leadership and Management Capacity Strengthening

Maternal Health Initiative formed three sub-teams (each consisting of local frontline health leaders and other stakeholders) to design and prototype maternal health solutions for problems associated with community mobilization, the capabilities of health workers, and health system operations (one sub-team per topic).

Interventions included:

- **Strengthening workforce capacity:** instituted a skill-building program for clinical personnel, created a mentoring role between senior nurses and nursing students which would offer in-service training, and developed a best practice curriculum and training manuals for midwives.
- **Information management:** introduced standard protocol for investigating maternal deaths and a system for measuring performance over time.
- **Quality control, efficiency, and access in service delivery:** introduced process changes to reduce wait times, created a patient satisfaction survey (results posted daily) to encourage staff to focus on customer service, designed a "Container Clinic" to expand access to rural areas, used LEAN management methodology to develop diagnostic tools aimed at freeing time for nurses who previously felt too busy to offer antenatal care.
- **Managing equipment, efficiency, and effectiveness for first responders:** helped ambulance drivers work with Ministry of Health and Social Service to prioritize repair of radio equipment, streamline requests for vehicle repairs, train a specialized dispatcher, develop dispatch protocol, institute performance management, and mobilize funding for a mini-bus to provide nonessential medical transport to increase ambulance capacity.
- **Consumer and market research-based initiatives to stimulate demand:** created a weekly reproductive health show for a local radio station which broadcast in six languages hosted by influential radio personalities. The initiative also introduced incentives to encourage earlier and greater participation in prenatal care.

A regional delivery unit was established in Khomas to ensure local ownership and accountability, provide managerial oversight, monitor the performance of the improvement in service delivery, and integrate the activities of the sub-teams with those of MOHSS's regional team.

LEVEL: Increased Service Outputs

Program Achievements

Evaluations directly linking the Maternal Health Initiative with population health outcomes have not been reported.

Increased Service Outputs (and Coverage):

- Within 4 weeks of using LEAN diagnostics, the nurses at the primary care clinic began treating antenatal care patients (the nurses did not have time for antenatal care before). These nurses became enthusiastic change agents and other clinics in the region began investigating similar changes. Within 5 months, all of the regions 11 primary care clinics were offering antenatal care.

Process Improvements:

- Within a month of the efforts to strengthen ambulance management, average response times had decreased by 60% and the proportion of emergencies handled within 30 minutes increased from 23% to 55%; average response times consistently remained below 30 minutes for more than 6 months.
- The pilot hospital in Khomas reduced antenatal care unit's waiting times by 30% in less than 1 month through process changes.
- The best practice curriculum and manuals for midwives led to efforts to standardize midwifery training in the region and to the development of a skills-accreditation system.
- Within 6 weeks the hospital had developed its own in-service training curriculum and concluded its first training program. Nurses reported feeling more confident in their ability to coach and mentor one another and provide care to patients. In-service training sessions are now held weekly and program coordinators continue to look for best practices and innovative training methods.
- The container clinic cost 25% less than a similarly sized permanent building. The Public Health Ministry planned to roll out such clinics across country and has submitted plans to the Finance Ministry to fund 16 additional clinics.

Strength of Performance Assessment

SCORE: Average

- Natural experiment: patient surveys, focus group discussions

Comments

The Maternal Health Initiative developed local leaders through a collaborative learning approach. The initiative demonstrated that better equipped health management teams could improve the health system and increase coverage of antenatal care without additional personnel.

PUBLIC HEALTH OUTREACH PROGRAM

1989-PRESENT

IMPLEMENTING ENTITY:

Haitian Health Foundation (HHF)

Location: Haiti
AMRO/Low Income
Health Topic: Child Health

Key Words: Decentralize Service
Provision, Task Shifting, HMIS

PROGRAM OVERVIEW

Goal: To improve the health and well-being of the poor so as to end the poverty cycle and improve child survival.

Objective: Reduce under-5 mortality by providing universal access to basic health care and referral at village level.

Funding: USAID/Haiti and private charitable donations to Haitian Health Foundation [\$3 USD per person per year]

Background of Public Health Outreach Program:

- Village-based health care delivery system in 104 villages surrounding **Jérémie**, Haiti.
- Care delivered through home visits and monthly village-based health clinics.
- Each village has a dedicated Health Agent (resident Community Health Worker).
- Conducted family registration, health education, immunizations, tracking for diarrheal disease reduction, nutrition interventions, village support groups, and maternal newborn care.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Haitian Health Foundation recognized an inability to deliver child health services to remote villages. Villages lacked permanent nurse-managed clinics due to health human workforce shortages. Further, lack of health knowledge and financial barriers dissuade families from seeking more distant care.

Management Action: Decentralize health service provision at the village level, where equitable coverage is tracked by a Health Management Information System (HMIS), the existing workforce gap is filled through task-shifting to Community Health Worker (CHWs), and local participation enhances effectiveness.

Principal L&M Characteristics Identified:

Leadership:

- Community Engagement
- Scanning
- Setting Direction

Management:

- Structuring
- Staffing
- Planning

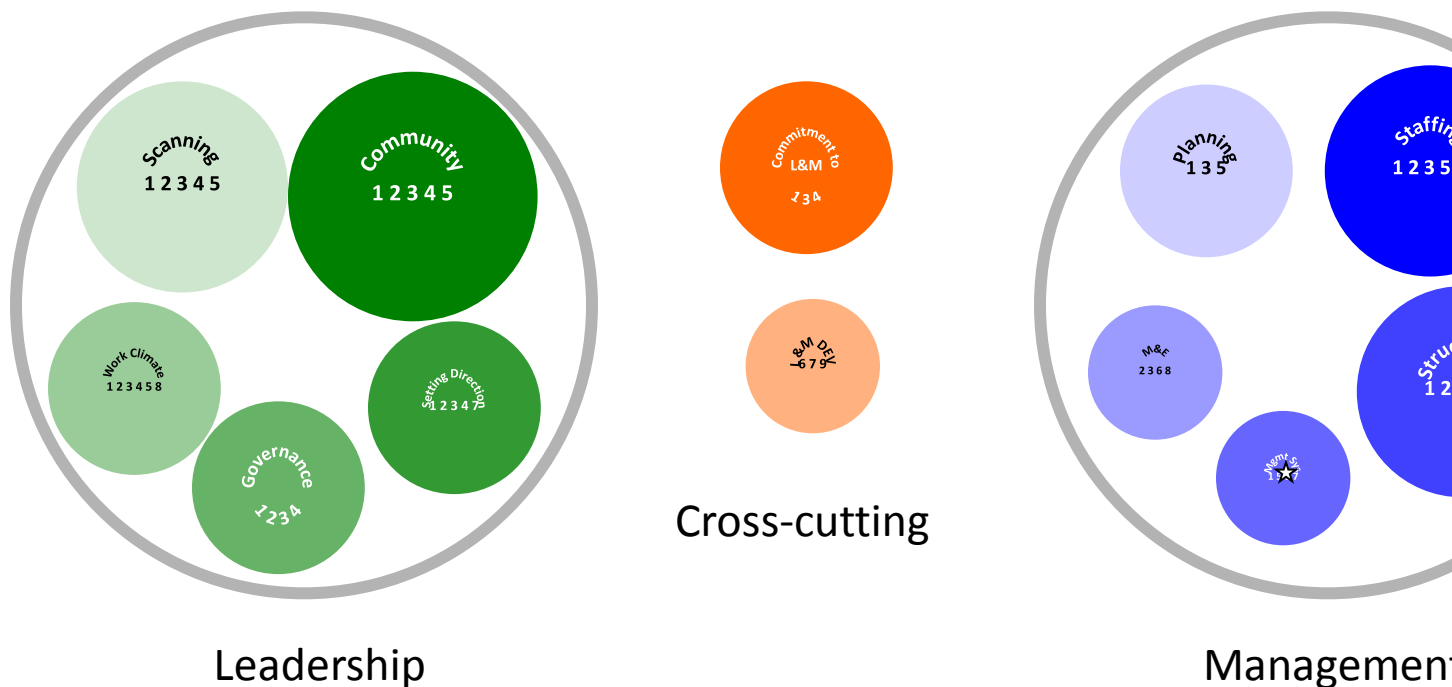
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- The program supplies health care to and tracks the medical status of more than 130,000 people in more than 100 villages, and provides access to medical services to an average of more than 225,000 people annually.
- Improved child health outcomes in rural Haiti: reduced under-5 mortality caused by acute respiratory illnesses, increased exclusive breastfeeding practices, high levels of immunization coverage, and more frequent utilization of health services.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that Community Engagement was the most present L&M domain from a review of case study materials (100% presence). All other domains were more than twenty percentage points away suggesting this was a major leadership component for this case. Of note, the white star in the Management System domain denotes that a health management information system was identified for this case study.

Management Action in Detail

Data-driven Service Delivery

The Public Health Outreach Program prioritized equitable service delivery informed by research. It is based on a census and registration system where all members of communities were identified and provided with care. The Haitian Health Foundation chose to manage this sizeable amount of data by investing in a computerized health management information system —“Health Track”. Health Track created a database of health information to track program progress over time. The HMIS allowed patient histories to be retrieved for subsequent health visits. Training was conducted to build information management capacity among the staff to maximize the value of the system. The registration system tracked socioeconomic indicators in addition to health information. Collecting a variety of data allowed for a more comprehensive market analysis. Service lines were tailored to the epidemiological profile of the population. Haitian Health Foundation regularly provides technical assistance to other Haitian organizations, as well as organizations in Africa, to help them adopt the same system.

Strengthening Workforce Capacity through Task-shifting

The Haitian Health Foundation took a task-shifting approach and trained a new workforce cadre of local Health Agents who are selected by their communities, trained in a government curriculum, and certified by the Haitian Ministry of Public Health and Sanitation (MSPP). This approach produces a dual benefit through expanded access to health services and job creation. To manage the quality of care, Health Agents are trained prior to taking their post, and provided with follow-up supervision and performance evaluations by Haitian Health Foundation nurses and doctors.

Community Mobilization

Haitian Health Foundation recognized the critical importance of active community engagement in its decentralized village-level health model. Haitian Health Foundation conducts stakeholder analyses and regular meetings with community leaders, healers, and village members. These meetings include general information, planning, feedback, and problem solving. To maintain patient satisfaction and trust, the foundation engages community members in new programs only when the service can be made routinely available, affordable, accessible, and acceptable.

LEVEL: Health Effect

Program Achievements

Health Effects:

- Reduction of baseline pneumonia-specific mortality from 6.2/1000/year to 3.1/1000/year. This illustrates that village health agents with brief formal training, intensive supervision, and regular continuing education can effectively diagnose and treat ARI in Haiti (1997).
- 66% of children under 6 months of age were exclusively breastfed. (In comparison, the 1994/5 Demographic and Health Survey found that nationally only 0.6% of children 4-6 months of age were exclusively breastfed).
- 98% of children aged 9-59 months had the level of measles vaccination appropriate for their age and 85% had all immunizations complete for age.
- 82% of pregnant women received three or more prenatal visits.

Service Outputs:

- 72% of children were weighed twice or more and in 90% of cases where a child had weight loss the caretaker received appropriate counseling.

Process Improvements:

- The reduction of pneumonia mortality, demonstrated by the Haitian Health Foundation's work, influenced policy change on the national level. Traditionally in Haiti, community health workers were not allowed to use antibiotics. When the Ministry of Health introduced the Integrated Management of Childhood Illness protocols (IMCI) at facilities across the country, community-based acute respiratory infection detection, treatment, and follow-up was included as an essential intervention and community health worker participation was approved.

Strength of Performance Assessment

SCORE: High

- Ongoing monitoring of program activities by the Health Track health management information system.
- 1997, Impact evaluation of community based program component for acute respiratory infection detection: team of CDC infectious disease physicians came to Jérémie to examine program records and death certificates, participate in village-level respiratory clinics, and interview community groups and caregivers

Comments

The Haiti Health Foundation dramatically scaled up healthcare in remote and hard-to-reach settings by training a new cadre of health workers. It utilized a health management information systems in a rural setting. The health management information system tracked not only program performance, but also patient progress, creating the foundations for electronic medical records.

QUALITY HEALTH PARTNERS

2004-2009

IMPLEMENTING ENTITY:

EngenderHealth with Jhpiego, Abt Associates, Initiatives, Inc.,
FHI

Location: Ghana

AFRO/Low Income

Health Topic: Maternal and Child Health

Key Words: Quality Assurance,
Supervision, Monitoring

PROGRAM OVERVIEW

Goal: Improve the quality of health care delivered in the Ghana Health System.

Objectives:

- (1) Strengthen institutional capacity of the Ghana Health System to provide high quality health services using approved standards and guidelines;
- (2) Improve systems for human resource capacity development;
- (3) Improve supervision, monitoring, problem identification and solving, and communication; and
- (4) Raise standard of quality in private and public health facilities and development of a franchising approach.

Funding: USAID

Background of Quality Health Partners (QHP):

- Supported MOH/Ghana Health System to improve quality and access in the 37 most deprived districts of southern Ghana.
- Focused on service delivery at the health center level and above, in the public and private sector.
- Delivered basic package of maternal and child health services including Safe Motherhood, Family Planning, Child Health, integrated management of childhood illnesses, malaria prevention, and treatment.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Maintaining quality in health service delivery in remote and deprived regions.

Management Action: Apply a decentralized approach to quality assurance that builds human capacity at the facility level.

Principal L&M Characteristics Identified:

Leadership:

- Staff and Work Climate Development
- Setting Direction
- Governance

Management:

- Structuring
- Planning
- Monitoring and Evaluation

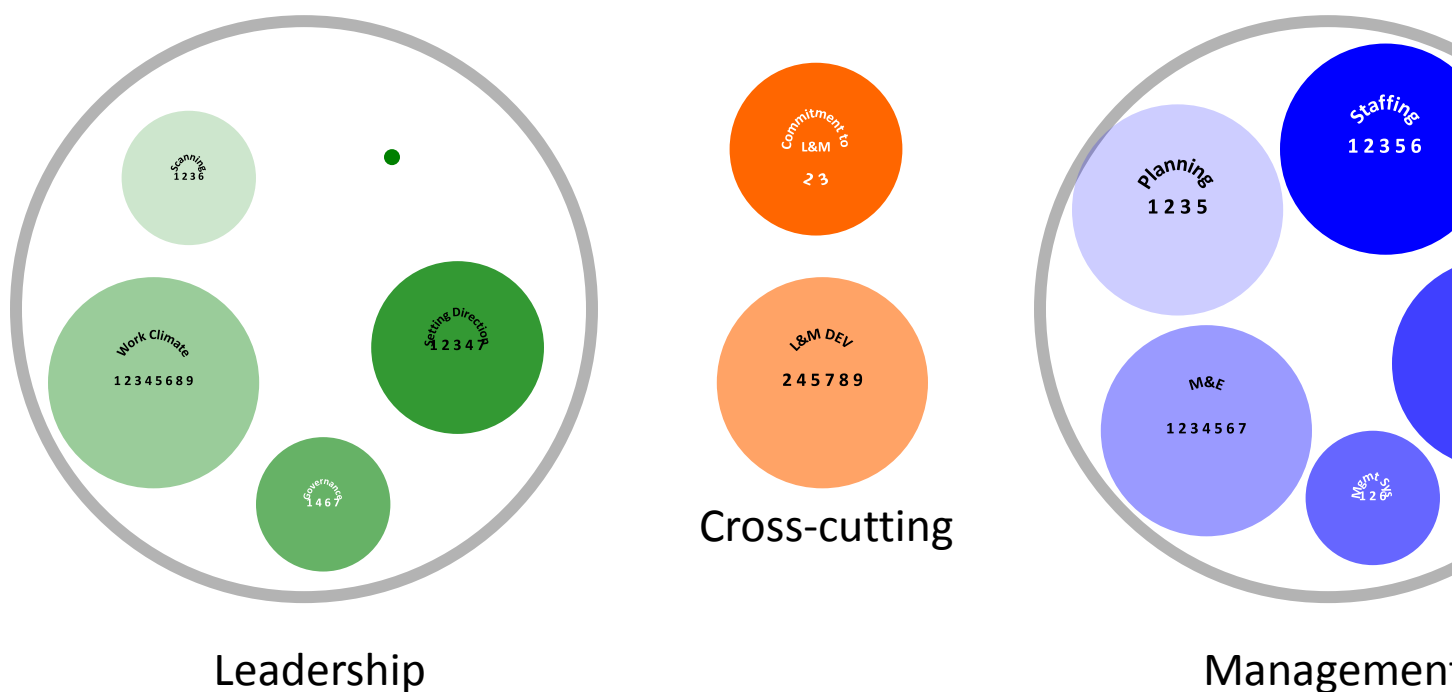
Cross-cutting:

- Leadership and Management Development
- External commitment to Leadership and Management

Results Achieved:

- Health and process gain were made in all maternal and child health program areas that Quality Health Partners supported.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that Structuring was the most present L&M domain from a review of case study materials (75% presence). There was also a strong presence of cross-cutting domains. Leadership and Management Development was 69% present. Community Engagement was not detected in the materials reviewed.

Management Action in Detail

Focused Performance Standards

Quality Health Partners' work with the Ghana Health System involved the development, dissemination, and implementation of standards and guidelines, as well as the provision of equipment and supplies. The scope was focused to delivering a standardized basic package of health services. Program activities were tailored to support the standard service package.

Human Resource Development

Quality Health Partners also involved building staff capacity through training and facilitative supervision. Emphasis was placed on human resource management and planning. In-service training incorporated managerial topics along with clinical and technical skills. Using a Whole-Site-Training Approach, EngenderHealth conducted infection prevention training for the entire facility, including housekeeping staff who previously never received training. Staff accountability was supported by developing job descriptions and an employee performance evaluation system. Continuous improvement was prioritized. Collaboration was fostered by establishing quality assurance teams within facilities, increasing the frequency and regularity of facility-level management meetings, and creating team-based action plans.

Evidence-based Organizational Learning

Various assessments were conducted to inform decision-making and planning throughout the implementation process. During the second half of 2007, Quality Health Partners modified its 4 core goals to reflect the evolution of program and account for newly identified needs such as incorporating HIV/AIDS activities into Quality Health

Partners' existing portfolio and improving monitoring and evaluation efforts by establishing Health Information Officers.

Program Achievements

LEVEL: Health Effect

Health Effect:

- Couple Years of Protection increased by over 50% from 80,077 (Oct. 2007-Sept. 2008) to 128,565 (Oct. 2008-Sept. 2009)

Process Improvements (2004-2009):

- Observation of providers who correctly managed diarrhea increased from 18% to 60% (2004-2009)
- Quality Health Partners trained over 6,500 staff members in different cadres; 80-92% of providers in target service areas had access to in-service training
- Facilities with quality assurances teams increased from 35.1% to 60% of facilities
- Proportion of providers with correct knowledge of Active Management of Third Stage of Labor increased from 66% to 81%
- The providers assessing all of the danger signs in children increased from 11.1% to 63% (2004-2009)
- Increase in provider assurance of patient confidentiality and privacy: from 21% to 61% in family planning and 58% to 92% in the delivery areas
- Improved provision of information to patients. Increased percentage of providers telling caregivers what their children are sick with from 33% to 70%. Also improved percentage of providers describing dosage of medicine to treat patient from 40% to 93%.
- Overall infection prevention measures improved in all service areas from 31% to 46%, in Child health (from 56-73%), Family planning (from 31-70%), Antenatal care (from 33 – 96%), and Delivery (from 51-80%)
- Proportion of providers who complete their weekly reports increased from 21% to 81%
- Proportion of providers who have case based surveillance forms increased from 49% to 55%
- Facilities increased with: essential equipment from 8% to 75%; IMCI chart booklet from 30% to 84%
- Periodic and regular meetings for addressing gaps increased from 45% to 63% of facilities
- Facilities that had at least half of their staff appraised rose from 29% to 56%
- Staff accountability efforts improved; the number of staff holding current job descriptions increased from 29% to 49%.

Strength of Performance Assessment

SCORE: High

- 2004, Baseline
- 2007, Mid-term
- 2009, End-line assessment: quantitative and qualitative—Facility audits, provider observation, and interviews with the Regional and District Health Management teams

Comments

Quality Health Partners successfully engaged health workers in taking ownership of their facilities' quality of care. Focused performance standards and shared accountability were hallmarks of the program. Importantly, quality teams remained committed to the continual nature of the quality improvement process. This established a foundation for evidence-based organizational learning.

SAFE DEMONSTRATION PROJECT OF COMMUNITY BASED DISTRIBUTION OF MISOPROSTOL FOR PREVENTION OF PPH

2002-2003

IMPLEMENTING ENTITY:

Jhpiego (a Johns Hopkins University Affiliated Organization),
Ministry of Health (MOH), World Health Organization (WHO)

Location: Indonesia
SEARO/Lower-Middle Income
Health Topic: Maternal Health

Key Words: Change Management,
Task-Shifting

PROGRAM OVERVIEW

Goal: To prevent postpartum hemorrhage (PPH) among women living in areas where a high proportion of births are not attended by skilled providers.

Objective: To demonstrate the safety, acceptability, feasibility, and program effectiveness (SAFE) of an intervention in which trained community volunteers provided women with information about preventing PPH, distributed misoprostol to pregnant women, and provided follow-up support.

Background of the SAFE Demonstration Study:

- Developed to assess the alternative strategy of using misoprostol instead of oxytocin to prevent PPH.
- Oxytocin was injected by a midwife or physician and required cold storage, whereas misoprostol could be administered orally, was equally safe and effective, less expensive, and did not require cold storage.
- Used the existing healthcare infrastructure and community resources, including a network of community volunteers (kaders).

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Introducing active management of third stage of labor (AMTSL) with misoprostol distribution as a change initiative to reduce PPH in places without access to sophisticated health services.

Management Action: Pair the programmatic change initiative with a change management process to counter resistance and promote acceptance and uptake of the alternative birthing practices.

Principal L&M Characteristics Identified:

Leadership:

- Setting Direction
- Community Engagement
- Scanning

Management:

- Staffing
- Monitoring and Evaluation
- Planning

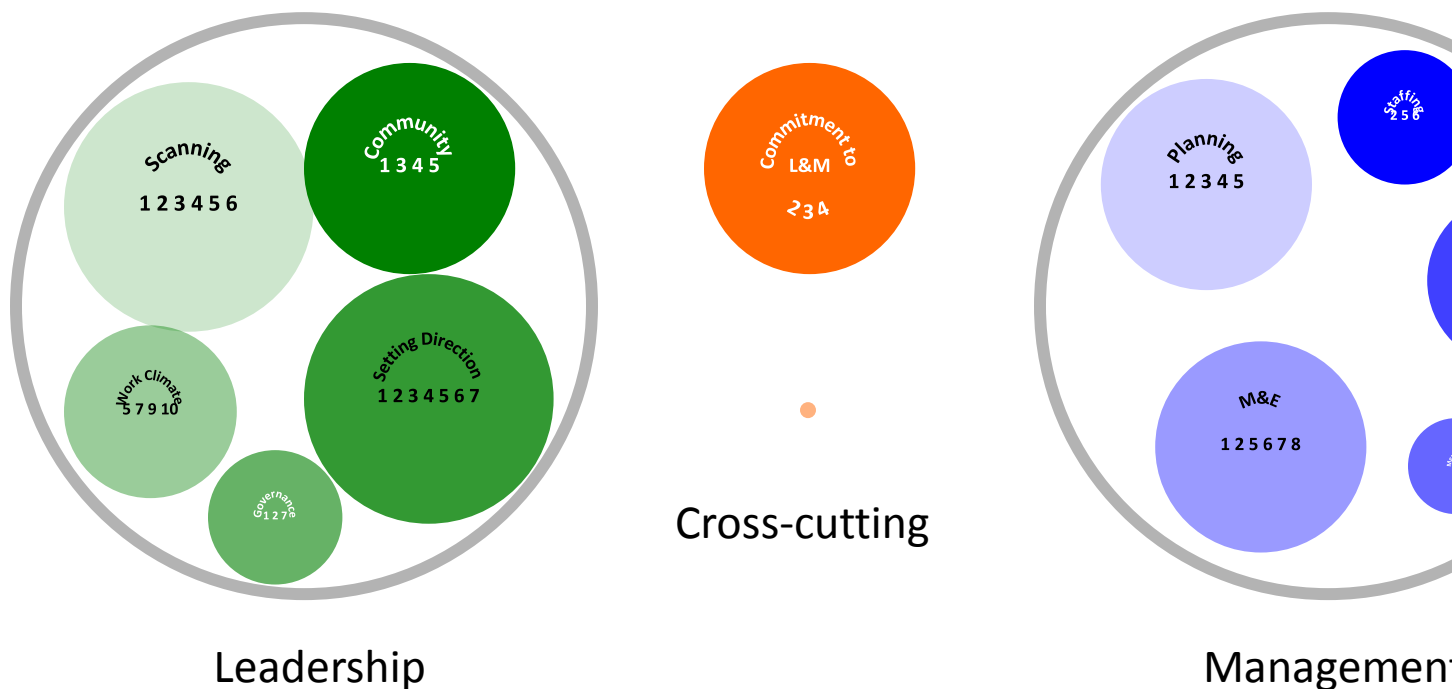
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- The study established the safety of home-based community distribution of misoprostol with decreased rates of postpartum hemorrhage and decreased rates of emergency obstetric referral. This prompted the MOH to issue a resolution incorporating the prevention of PPH into the national health strategy.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



Management Action in Detail

The figure above demonstrates that Setting Direction was the most present domain from a review of case study materials (93% present). Other notable domains were Scanning at 83% presence and Monitoring and Evaluation at 75% presence. The Leadership and Management Development domain was not detected in the review of case materials.

Building Consensus to Manage Change

The demonstration project planned to encounter resistance. Thus, change management principles were incorporated into planning, coordinating, implementing, and monitoring to prepare for challenges and promote acceptance of the new set of practices. There were extensive stakeholder discussions and consultations during study proposal and design. The field study team conducted interviews with physicians, nurses, midwives, women's groups, community and informal leaders, kaders, and government officials. Key informants reported on the safety, acceptability, and feasibility of taking misoprostol. As follow up, any serious complications that occurred during childbirth were investigated. A National Steering Committee was formed, made up of stakeholders with strong professional reputations and national influence, including the Director General of Public Health. This team obtained required reviews and MOH approvals at the national, provincial, and district levels.

Team Building

The team identified a principal investigator to play the role of change agent, to oversee and lead the implementation. An obstetrician/gynecologist with strong academic credentials and practical experience was selected. A change team—composed of a field epidemiologist, a study manager, and a technical assistant from Jhpiego—was formed to assist. The coordination team, change agent, and change team were fully informed of the goals, objectives, and active management of third stage of labor methods. Regular communication between these teams continued throughout implementation.

National Leadership Facilitating Program Expansion

At the conclusion of the study, the steering committee met and took steps to facilitate scale up. The committee presented key findings of the study to the MOH. They recommended an expansion of the PPH preventive health

strategy. The results of the study were disseminated widely. Measures were taken to advocate for commitment from regional health authorities and donors. The active participation of the National Steering Committee was important for the success of this study. National leadership facilitated rapid acceptance of study findings, financial commitment, and inclusion of a PPH program in the national health strategy.

Program Achievements

LEVEL: Health Effect

Health Effect:

- The number of emergency referrals due to birth complications was less than 10% (176 of 1,811); with only 47 emergency referrals suspected to be postpartum hemorrhage (PPH).
- Significantly fewer women in the demonstration area had emergency referrals for any birth complication, including PPH. Adjustment for differences in age, parity, education, economic status, and antepartum hemorrhage history showed that women in the demonstration area were:
 - 25% less likely to perceive excessive bleeding;
 - 30% less likely to need an emergency referral to a health facility; and
 - 45% less likely to need an emergency referral for PPH.
- None of the study participants who used misoprostol required referral for additional care because of increased symptoms or side effects following childbirth.

Service/Coverage Outputs:

- Coverage of the population with oxytocin or misoprostol (treatments to reduce PPH) was significantly higher in the demonstration area (93.7%) than the comparison area (76.8%).
- MOH implemented the program in 15 districts in 2007, and planned to identify new districts in different regions to roll out the intervention. Expansion will be done incrementally.

Process Improvements:

- Results found women taking misoprostol correctly, demonstrating trained and supervised community volunteers can successfully share health information with pregnant women who are unlikely to be reached by skilled providers, and that the women can understand this information and correctly use misoprostol to prevent PPH at a home birth.
- Having access to medication that prevents PPH did not make women more inclined toward giving birth at home.
- MOH issued an official resolution in July 2003 for incorporating dual options for PPH prevention (active management of third stage of labor and community-based distribution of misoprostol). MOH worked to order the drug in bulk and repackage it for PPH prevention.

Strength of Performance Assessment

SCORE: High

- 2002-2003, Natural experiment: in-depth interviews (pre- and post-interviews), focus group discussions

Comments

PPH Demonstration Study overcame the initial friction of change by building relationships with stakeholders, conducting a pilot to prove program validity, and coordinating with local decision-makers. By investing in performance monitoring, the study was able to build an evidence-base and gain acceptance for large-scale policy change. Dr. Harshad Sanghvi of Jhpiego was the 2009 Recipient of the Global Health Council's Best Practices in Global Health Award for his work on the SAFE Demonstration Project. Jhpiego has since assisted Nepal, Afghanistan, Gambia, Guinea Bissau, Tanzania, Pakistan, Kenya, and Uganda in integrating community distribution of misoprostol for PPH prevention into their national health policy and infrastructure.

URBAN HEALTH PROGRAM

2003-2007

IMPLEMENTING ENTITY:

Urban Health Resource Center (UHRC)

Location: India

SEARO/Lower-Middle Income

Health Topic: Maternal Child Health

Key Words: Resource Allocation,
Training

PROGRAM OVERVIEW

Goal: Improve maternal and child health (MCH) and nutrition among the slum dwellers in Indore, India.

Objective: (1) Increase coverage of services and adoption of key health behaviors in neonatal survival, diarrhea control, and other child health priorities;
(2) Improve the capacities of local stakeholders and slum-based groups in health behavior promotion; and
(3) Develop replicable models of urban MCH programs.

Funding: USAID

Background of the Indore Urban Health Program:

- Delivered services at the slum level.
- Trained health volunteers in health awareness and promotion in their slums.
- Slum community-based organizations instituted partnerships with public and private sector health providers.
- Activities to motivate slum dwellers to adopt appropriate health behaviors included individual and group counseling, street plays, puppet shows, video shows, healthy baby contests and healthy expectant mother competitions, and interactive health quizzes.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Allocating limited resources and program services for maximum effectiveness.

Management Action: Gathering and using data to target resources allocation and programmatic efforts.

Principal L&M Characteristics Identified:

Leadership:

- Community Engagement
- Scanning
- Setting Direction

Management:

- Monitoring and Evaluation
- Planning
- Staffing

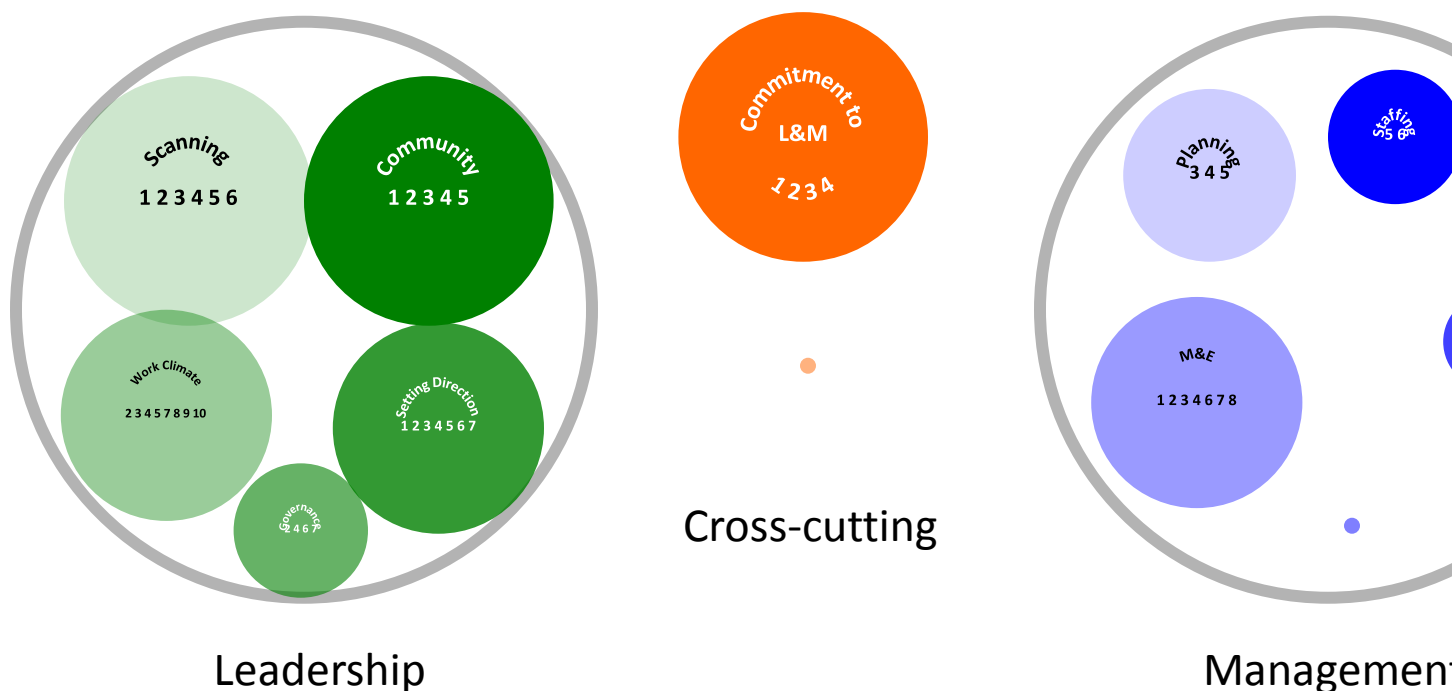
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- Increased institutional deliveries, exclusive breastfeeding, and immunization rates, for both pregnant women and children, and increased the supply of health care in the slums.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that Community Engagement was the most present domain from a review of case study materials (100% presence). Scanning and the cross-cutting domain External Commitment to Leadership and Management were both apparent at 83% and 88%, respectively. Both the Management Systems and the Leadership and Management Development domains were not detected in the review of case materials.

Management Action in Detail

Scanning to Inform Resource Allocation

To manage limited resources for maximum benefit, the urban health program team recognized the importance of identifying the most vulnerable slums to target in program activities. Information deficits were recognized and slum identification and plotting was undertaken to locate unlisted, hidden, and needy slums. A systematic situation analysis was conducted from July-December 2002 (consisting of key informant interviews, reviews of documents, and stakeholder meetings). Specific vulnerability criteria were developed in cooperation with various stakeholders. Based on the criteria, slums were categorized as extremely vulnerable, moderately vulnerable, and less vulnerable, and then program priorities were determined.

Fostering Interagency Coordination

Scanning showed that while the city boasted a tradition of community-level action through community-based organizations (CBOs) already engaged in the slums, there was little coordination between organizations. Rather than identifying the absence of coordination as an obstacle, Urban Health Program planners recognized an opportunity to leverage existing capacity of CBOs and build networks of interagency coordination to further stretch program resources and reach. They formed structures, synergistic relationships, and systems to assist CBOs in spreading health awareness, increasing demand for health services, providing logistical support, and mobilizing the community during health events. Examples of these activities included establishing Ward Coordination Committees composed of representatives from CBOs to share information, strategically allocate resources, and exercise collective action in advocating on the behalf of slum residents.

Program Achievements

LEVEL: Health Effect

Health Effect:

- Substantial increase in institutional deliveries, exclusive breastfeeding, and immunization rates, for both pregnant women and children in the slums where the demand supply and linkage approach was implemented.

Service Outputs:

- A total of 204 camps (primarily for childhood immunization) were organized, covering 28 underserved slums (population of 35,000) (2003-2006).

Process Improvements:

- Findings from the 2005 Maternal and Newborn Health study on the practice of the 'five cleans' (clean hands, clean blade, clean surface, clean tie, and clean cord stump) showed improvement among deliveries conducted at home.
- Strengthened social capital was evident from the improved health promotion and negotiation capacity of the community-based organizations (CBOs).
- Collectivized slum communities effectively influenced the Municipal Corporation to improve other services such as water, sanitation, and drainage in slums.
- Strengthened linkages between the community and health providers.

Strength of Performance Assessment

SCORE: Average

- 2002, Baseline situational analysis and vulnerability assessments
- 2003, Baseline health survey
- 2005, Maternal and Newborn Health study
- 2006, independent evaluation, conducted by MODE Services

Comments

Urban Health Program applied community mapping for increased stakeholder engagement and prioritization of target populations. Networks were established among local service providers. The program leveraged these networks along a coordinated work plan to achieve mutual goals.

YEMEN BASIC HEALTH SERVICES PROJECT

2006-Present

IMPLEMENTING ENTITY:

Yemen Ministry of Public Health and Population (MOPHP),
local NGOs

Location: Yemen

EMRO/Lower-Middle Income

Health Topic: Maternal and Child Health

Key Words: Systems Approach, High-Impact Interventions, Community Participation

PROGRAM OVERVIEW

Goal: To help the government increase access to quality health services in reproductive, maternal, and child health.

Objective: Help ensure better access to and utilization of reproductive health and maternal and child health services and improve health knowledge and behaviors.

Funding: USAID

Background of Yemen Basic Health Services (BHS) Project:

- Worked in five governorates that have poor health indicators and few donor-supported health activities.
- Project activities included increasing access to quality health services and community participation, increasing health knowledge, improving health behavior, and overall project management. Mobile teams provide basic obstetric and gynecological services, integrated management of childhood illness, vaccinations, ultrasound, electrocardiogram, first aid, and simple lab tests.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Yemen's population suffers from poor health and poverty, in large part due to minimal access to quality care and health related knowledge.

Management Action: Build capacity and training for health professionals and community workers through developing relationships with local partners.

Principal L&M Characteristics Identified

Leadership:

- Scanning
- Community Engagement
- Setting Direction

Management:

- Staffing
- Monitoring and Evaluation
- Structuring
- Planning

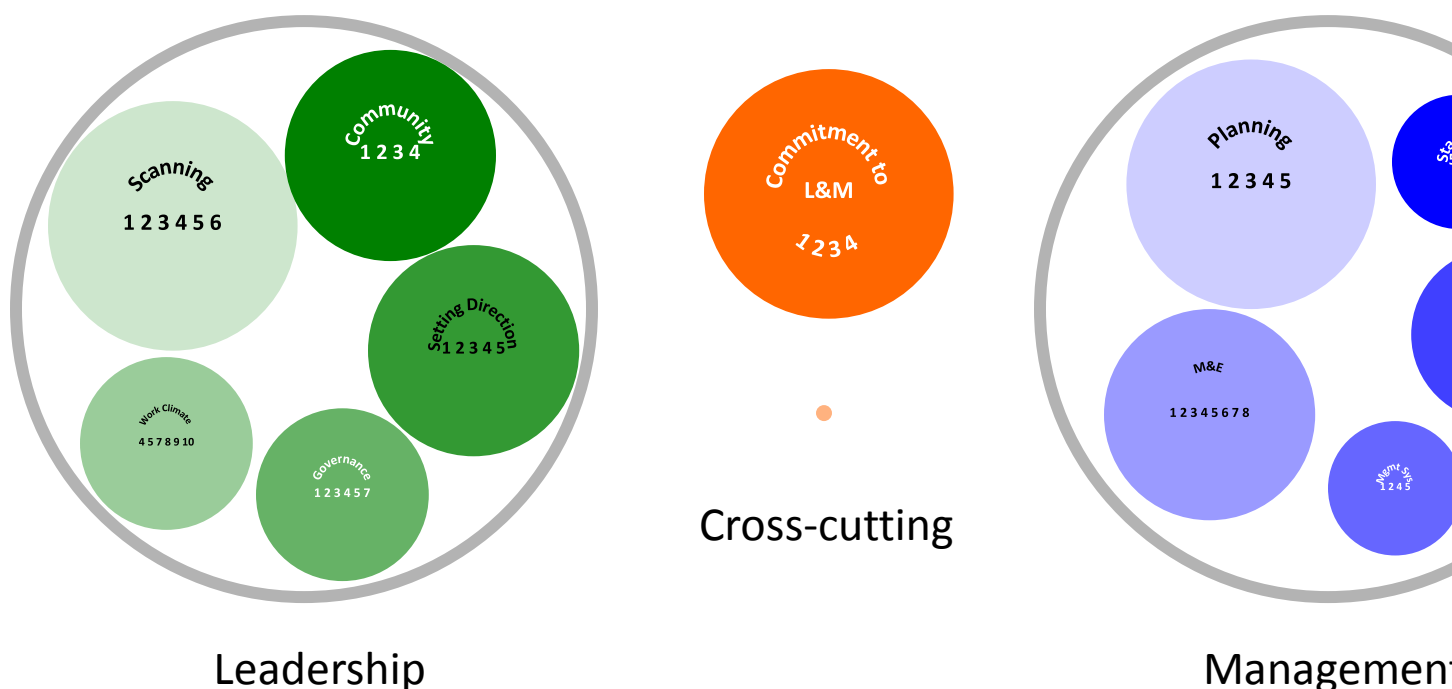
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- Basic Health Services improved health facilities and coverage of clients seeking health care in Yemen.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that External Commitment to Leadership and Management was the most present L&M domain from a review of case study materials (88% present). Multiple L&M domains in the figure are relatively large in size suggesting this case documented a wide variety of leadership and management actions. Among the management category, Staffing (86% present), Structuring, Monitoring and Evaluation (both 75% present), and Planning (70% present) were notable. For the leadership category, Scanning (83% present), Community Engagement (80% present), and Setting Direction (71% present) were the leading domains.

Management Action in Detail

Priority Setting

BHS worked with MOPHP to select facilities (e.g., reproductive health, antenatal care, emergency OB care, newborn and child care, postpartum care, and general areas such as lab, reception, administration, and pharmacy) based on a needs assessment and the commitment of permanent staff. In each facility, BHS coordinators were instructed to identify weaknesses regarding maintenance of facilities and equipment in monthly reports. Best were prioritized in courses for community health educators. BHS used data driven decision-making, based on a Knowledge, Attitude, and Practice pre-intervention survey. This led to the initiation of Safe Age of Marriage community awareness activities in two pilot districts of Amran governorate.

Comprehensive Training and Staff Development

To improve staff retention, BHS set strict selection criteria for pre-service training. The best instructors among the High Institute of Health Sciences staff were selected to ensure better skills development. BHS coordinators facilitated in-service training for providers to update clinical skills. In-service training also oriented supervisors and managers on clinical procedures. Training varied from clinical management guidelines to Training of Trainers (TOT) courses. Each course adopted a participatory approach, combining case studies with practical training, usually directly in the hospital-setting. Mobile teams were set up with a trained physician, two trained midwives, and a driver. A standard vehicle equipment list was developed to appropriately supply teams for providing basic and essential health services to men, women, and children. To ensure team members' skills were aligned with BHS prior to entering the field, new members received training and orientation with successfully operating

teams. Yemeni Midwives Association, with financial, administrative, and technical autonomy, led midwifery strengthening through upgrading business planning, hands-on training, and supervising skills.

Ensuring Quality of Care

To further ensure clinical competence and quality care, BHS conducted six-day clinical skills training for midwives. BHS health education and community mobilization activities operated at the governorate level. The activities focused on building capacity of MOPHP staff in communities, standardizing educational and promotional materials used by MOPHP and partners, training religious leaders, and forming Community Mobilization Groups.

Communications Strategy

To disseminate health messages in the community, BHS organized local volunteers in each governorate (90/governorate: adolescents and Religious Guidance Institute graduates). BHS strategically selected Yemeni Women's Union (YWU)—a national NGO actively involved in various women's issues—as the implementer for The Safe Age of Marriage Project. YWU was chosen because of its existing network, knowledge of the needs of Yemeni women, and capacity to conduct surveys.

Program Achievements

LEVEL: Health Effect

Health Effect (as of 2008):

- 17,403 couple years of protection achieved at behavioral change communication delivery points.
- 73,356 children less than 1 year old receiving PENTA vaccine 3rd dose.

Service Outputs (2006-2008):

- Increased number of clients served by mobile teams from 22,576 to 206,302.
- Increased number of clients in health facilities assisted by BHS (105,400 to 397,378).
- BHS increased the number of mobile teams in the 5 governorates from 3 to 12.

Process Improvements (2006-2008):

- BHS renovated 24 health units and centers, established 11 basic and emergency obstetric units in health facilities, built and furnished 17 housing units for health providers, and equipped 104 health facilities.
- The BHS project conducted 99 training courses; in the 5 governorates 1,173 providers were trained.
- Religious leaders implemented 4,437 activities that reached 419,147 people in the 5 governorates (by April 2009).
- Increased number of health education messages developed and disseminated in posters, health manuals, brochures, and a mothers' education booklet on best practices.

Strength of Performance Assessment

SCORE: High

- 2009, Mid-term evaluation: interviews, document review, and observations
- Quarterly and annual reports: reported to MOPHP, USAID, and shared with the director of each governorate

Comments

BHS improved maternal and child health through strategic planning and capacity building. BHS monitored records to increase performance quality and develop best practices.

NUTRITION CASES

HAITI MYAP FOR FOOD SECURITY

MYAP (MULTI YEAR ASSISTANCE PROGRAM) 2008-2012

IMPLEMENTING ENTITY:

Haiti Bureau de Nutrition et Developement, Catholic Relief Services, World Vision, ACDI/VOCA

Location: Haiti

AMRO/Lower-Middle Income

Health Topic: Nutrition/Food Security

Key Words: Multi-Sectoral, Strategic Partnership

PROGRAM OVERVIEW

Goal: To increase food security in the Southeast Department of Haiti.

Objectives:

- (1) Increase resiliency against future food insecurity through the protection and enhancement of livelihoods and the development of community capacities;
- (2) Protect vulnerable populations against immediate food insecurity and develop capacity to address long-term nutrition and health needs; and
- (3) Improve the ability of communities to identify and successfully respond to vulnerabilities and impending shocks.

Funding: USAID [\$191 million]

Background of Haiti MYAP:

- Addresses multi-sector causes of food insecurity in selected areas of rural Haiti.
- Integrated approach promoting sustainable livelihood strategies, health and nutrition, and the development of an early warning system.
- Agricultural programs include crop and soil fertility management, enhancement of market-based livelihoods, rehabilitation of natural resource resiliency and local response capacity, micro-watershed protection, and food for work components.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Lack of a coordinated multi-sector approach for food security in a highly volatile environment.

Management Action: Establish partnerships to provide a multi-sectoral response to food insecurity.

Principal L&M Characteristics Identified:

Leadership:

- Community Engagement
- Setting Direction
- Scanning

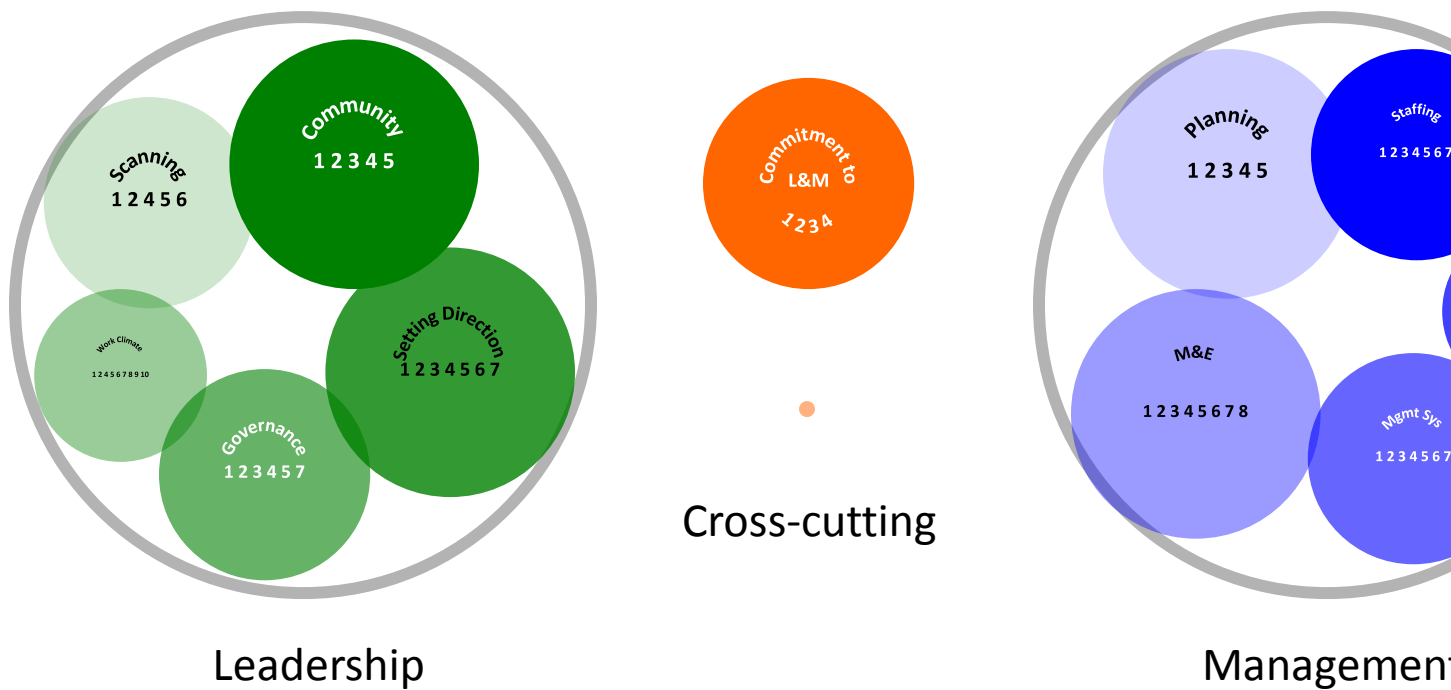
Management:

- Planning
- Monitoring and Evaluation
- Management System

Results Achieved:

- The program has reached thousands of households, delivered food and education programs, and established an early warning system.
- Established that blanket coverage with preventive food supplementation was cheaper and more effective for populations at high risk of malnutrition than previously implemented programs that diagnosed and treated malnutrition once it occurred.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that Community Engagement and Planning were the most present domains from a review of case study materials (both at 90% presence). Multiple L&M domains in the figure are relatively large in size suggesting Haiti MYAP documented a wide variety of leadership and management actions.

Management Action in Detail

Multi-sector Partnerships

Haiti MYAP leveraged partnerships and established accountability structures throughout the program. The program strategically targeted three main components: agricultural and off-farm livelihood improvements, MCH and nutrition enhancement, and the development of an Early Warning System for food-security related crises and increased emergency preparedness. The program also managed risks and reduced vulnerability to food insecurity.

Value Chain Analysis

The program partnered with the Ministry of Agriculture's leading yam specialist to conduct training on the mini-set technique, which allows production of many yams from a single tuber. MYAP applied a value chain approach to assisting a fisherman's association increase its yield of fish.

Performance Monitoring

To track MYAP performance, the health of beneficiaries was monitored. The project developed an Early Warning System. The Early Warning System fostered connections between local authorities, community leaders, and the Comité National de Sécurité Alimentaire. Haiti MYAP used impact and monitoring indicators in the educational components, building on Catholic Relief Services' experiences in food-assisted education activities.

Plans for Sustainability

The project collaborated with Haiti's Département de Protection Civile to strategically enhance its ability to effectively respond to crises. Haiti MYAP built sustainability by preparing and reviewing contingency plans with local authorities, key leaders, and other NGOs.

Program Achievements

LEVEL: Health Effect

Health Effects:

- At follow-up, stunting, underweight, and wasting were significantly lower, by 4-6 percentage points, in preventive than in recuperative communities.
- Mean indicators were also found to be of statistical significance. Height for age, weight for age, and weight for height all improved.
- Effect on indicators was greater in children that completed the preventive program from 6-23 months of age, than in children in it for shorter durations during this period.

Service Outputs:

- Livelihoods intervention has reached a total of 5,705 households (2010).
- 85 localities are currently covered by an early warning system that is linked to a response system.
- Over the life of the project, a total of approximately 16,740 households will receive health and nutrition training and 14,550 households will receive food aid for a limited period; approximately 24,000 direct beneficiaries from these households will receive agricultural support. The project anticipates reaching 72,750 individual beneficiaries in all.
- 3,827 families have received monthly food rations.

Process Improvements:

- 21% of assisted communities have a disaster early warning and response system in place (2008).
- 5,320 metric tons of commodities distributed (2009).
- 3,306 children and 521 pregnant and lactating women have benefitted from the nutrition program.
- WV conducted an evaluation study of the developmental and cost-effectiveness of preventive feeding vs. recuperative feeding and determined preventive feeding to be more effective and identified it as a key factor to improved results.

Strength of Performance Assessment

SCORE: High

- 2008, Qualitative Assessment: interviews, household surveys, focus group discussions, clinic records and biometric data analysis.
- 2008, Cost analysis and efficiency study.
- 2008, Participatory rural appraisal by ACDI/VOCA: established baseline for interventions; indicators and targets for percent of underweight and stunted children set.
- 2008 and 2009, Coordinating Sponsor Annual Results Report.
- 2009, Audit by USAID.

Comments

Through a coordinated multi-partner cross-sectoral effort, the MYAP project improved key indicators of nutrition and established new best practices in preventive nutrition, while making monitoring and sustainability a priority.

LINKAGES

1996-2006

IMPLEMENTING ENTITY:

AED and various other partners

Location: Multi-country
Low Income & Lower-Middle Income
Health Topic: Nutrition/Breastfeeding

Key Words: Strategic Partnership,
Standardization, Vertical Program
Integration, Multi-country Scale-up

PROGRAM OVERVIEW

Goal: To demonstrate in several countries an increase in optimal feeding practices among infants within a relatively short period of time (20-24 months) and at a scale that could achieve significant public health impact

Objectives:

- (1) Increase Timely Initiation of Breastfeeding rate (within the first hour of birth);
- (2) Increase exclusive breastfeeding rate of infants less than six months of age;
- (3) Expand the offering of lactational amenorrhea method; and
- (4) Increase Timely Complementary Feeding rate of infants 6-<10 months

Funding: USAID

Background of LINKAGES:

- Supported design and implementation of national-level advocacy, district-level programming, community-based counseling, and support groups.
- Focused on achieving measurable improvements in infant feeding behaviors.
- LINKAGES's approach was structured and oriented around a behavioral change framework.
- Long-term, large-scale country programs in Bolivia, Ethiopia, Ghana, Jordan, Madagascar, and Zambia.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Scale-up and wide adoption of breastfeeding practices was inadequate in developing countries.

Management Action: Leverage strategic partnerships to rapidly expand the delivery of evidence-based practices.

Principal L&M Characteristics Identified:

Leadership:

- Community Engagement
- Scanning
- Setting Direction

Management:

- Monitoring and Evaluation
- Planning
- Structuring

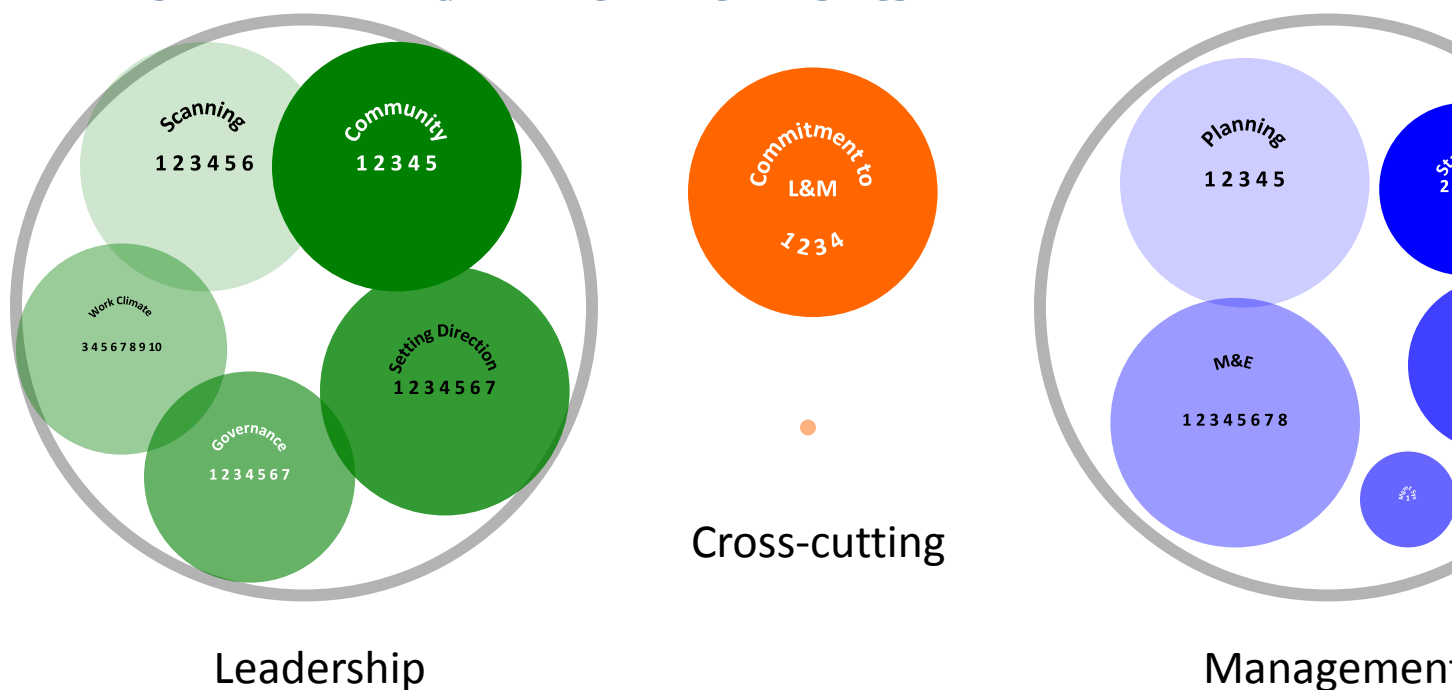
Cross-cutting:

- External commitment to Leadership and Management

Results Achieved:

- Using breastfeeding as its entry point, LINKAGES helped strengthen and expand infant and young child feeding components of other programs.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that Community Engagement was the most present domain (100% present) from a review of case study materials, but there were also large components of many other leadership and management domains reported. The Leadership and Management Development domain was not detected in the review of case materials.

Management Action in Detail

Strategic Planning for Sustainability

LINKAGES's mainstreaming process set a course for replication, scale-up, and sustainability. Program planners scanned the environment to identify needs in the local context, competitive advantages of partners, and location-specific opportunities. Country programs were implemented within a multi-year time frame. The first several months focused on securing funds, cultivating partners, building consensus through policy advocacy, and conducting needs assessments and baseline surveys. Toward the project end, a transition phase was initiated, where local partners mainstreamed coordination and continuation of key interventions at the initial program site and in expansion sites.

Performance Monitoring

LINKAGES's behavioral change communication program utilized evidence-based practices. Project planning and operations were anchored by systematic, results-driven performance management. Important program and results indicators were tracked through annual rapid assessment procedures. To monitor progress in achieving results, AED prioritized monitoring and evaluation, where clearly articulated indicators set the project's direction. All sites used standard indicators which were limited in number, fairly easy to both measure and interpret, and field tested prior to application.

Partnering for Results

Partnerships were a central success factor in LINKAGES. The project fostered "champions of change" at community, national and international levels. Community engagement allowed LINKAGES to leverage existing programs and networks. This provided locally accepted platforms for faster scale-up. Each country's MOH endorsed project activities. Where possible, MOH was involved as an implementing partner, which proved

valuable for linking community-based initiatives with national-level policy efforts. LINKAGES provided in-service training, revision of pre-service curriculums, and other learning tools to build local capacity. Innovation was encouraged throughout.

LEVEL: Health Effect

Program Achievements

Health Effect:

- Timely Initiation of Breastfeeding and exclusive breastfeeding rates had statistically significant increases in all 5 country programs.

Service Outputs:

- Lactational Amenorrhea Method user rates increased significantly in Madagascar (rate doubled in Bolivia but the increase was not statistically significant).
- Jordan: Lactational Amenorrhea Method user rate in MOH's MCH clinics increased from 0.1% to 13.3% (1999-2003).
- Timely Complementary Feeding rates increased in the 4 countries which measured this indicator but only Ethiopia's increase was statistically significant, 40% to 60% (2004-2006).

Process Improvements:

- Jordan: Lactational Amenorrhea Method counseling was mainstreamed as a regular component of family planning and added to family planning registry form and Demographic and Health Survey. MOH established a National Breastfeeding Center.

Strength of Performance Assessment

SCORE: High

- Baseline and endline surveys for the five country programs: Bolivia [2000/Stratified cluster sampling; 2003/Lot Quality Assurance Sampling (LQAS)]; Ethiopia (Oromia) [2004/Stratified cluster sampling; 2006/Purposive stratified cluster sampling]; Ghana [2000/Stratified cluster sampling; 2003/Stratified cluster sampling]; Madagascar [2000/Stratified cluster sampling; 2005/Stratified cluster sampling]; Zambia [2000; 2004]
 - Three indicators: Timely Initiation of Breastfeeding, exclusive breastfeeding, and TCF rates
 - Lactational Amenorrhea Method uptake rate included in Madagascar and Bolivia
 - Infant and Young Child Feeding indicator added in Madagascar in 2005 and Ethiopia in 2006
- Jordan [Routine data collection from service delivery statistics, focus on Lactational Amenorrhea Method user rate]
- Annual rapid assessments
- Stand alone assessments: media evaluations and cost-effectiveness studies

Comments

LINKAGES successfully established and maintained diverse partnerships across multiple countries. Further, the case managed for sustainability by cultivating local ownership and developing an exit strategy.

IMPLEMENTING ENTITY:

University Research Co, Save the Children, ACDI/VOCA

Location: Uganda
AFRO/Low Income
Health Topic: Nutrition

Key Words: Systems Approach, Service Integration, HMIS

PROGRAM OVERVIEW

Goal: To support the Ministry of Health (MOH) and US Government partners to integrate food and nutrition interventions in their programs for HIV/AIDS prevention, care, and treatment, with a focus on increasing the utilization, adherence to and efficacy of antiretroviral therapy and improving the nutritional and health status of people living with and affected by HIV/AIDS.

Objectives:

- (1) Provision of technical and financial support to the MoH, community-based organizations, people living with HIV/AIDS networks, and USG partners to integrate food and nutrition interventions into HIV/AIDS prevention, care, and treatment programs;
- (2) Development of a high quality, low-cost, nationally acceptable ready to use therapeutic food made from locally available ingredients; and
- (3) Establishment of supply chain system for ready to use therapeutic food delivery to health facilities.

Funding: USAID [~5.9million/year]

Background of NuLife:

- A technical assistance program that supported local institutions and communities.
- Provided comprehensive nutrition services to acutely malnourished individuals, people living with HIV/AIDS, or people affected by HIV/AIDS.
- Built capacity of health providers and health facilities to integrate nutrition into existing HIV care, support, and treatment services.
- Focused on improving linkages between health facilities and communities for case finding, referral, and follow-up care.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Lack of an integrated approach to manage the limited access to adequate nutrition, an important determinant of HIV progression and mortality.

Management Action: Provide support and assistance to people living with HIV/AIDS by linking two previously unlinked programs: nutrition programs and HIV/AIDS programs.

Principal L&M Characteristics Identified**Leadership:**

- Scanning
- Staff and Work Climate Development
- Community Engagement

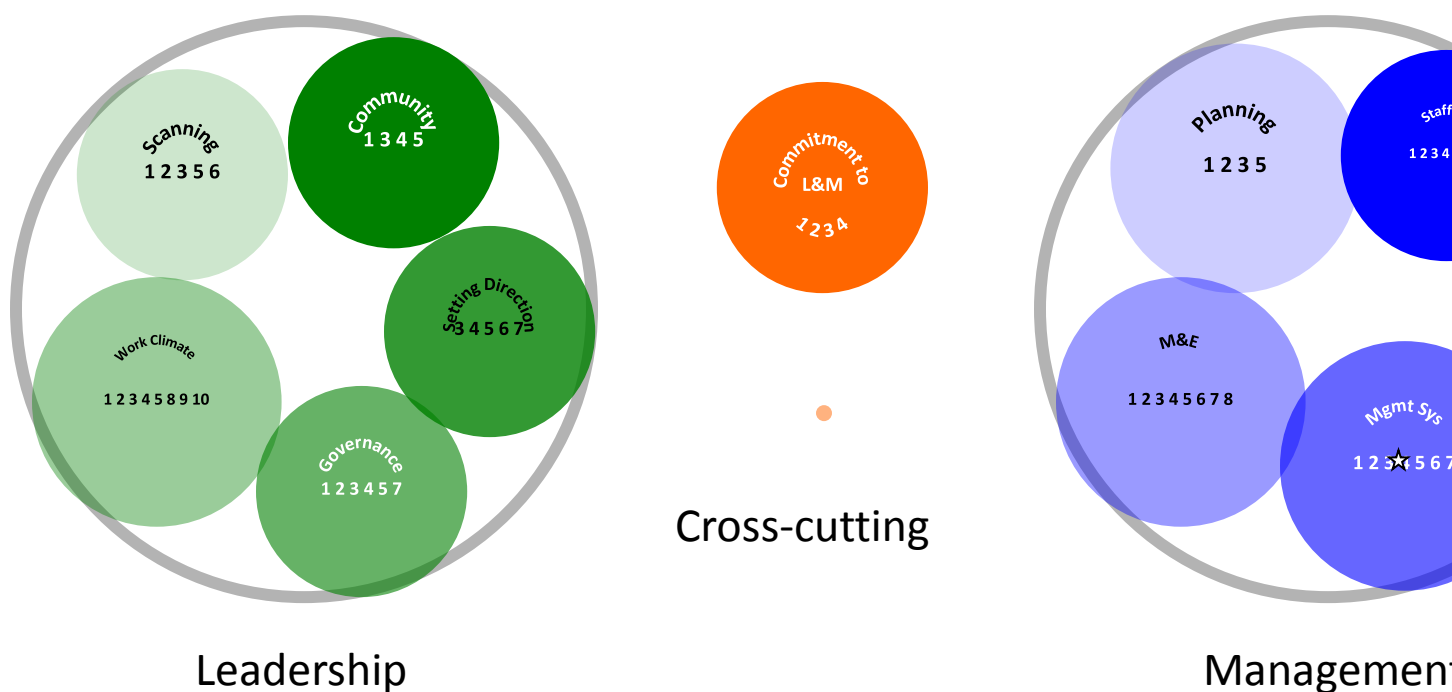
Management:

- Management System
- Monitoring and Evaluation
- Planning

Results Achieved:

- Policy guidelines were launched and the number of people living with HIV/AIDS receiving antiretroviral therapy and nutrition supplementation and counseling increased.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that Management System was the most present domain from a review of case study materials (100% presence). The two other most apparent domains were Monitoring and Evaluation and Planning at 81% and 80% presence, respectively. This suggests NuLife documented a wide variety of management actions that may support each other. The white star in the Management System domain denotes that a health management information system was identified for this case study.

Management Action in Detail

Building Public-Private Partnerships

On a national level, the program developed ready to use therapeutic food using locally available ingredients. NuLife supported efficient short and long term supply systems for delivering the nutritional products to implementing health facilities. A National Sub-Committee on Nutrition was established to build consensus among stakeholders. NuLife engaged a local manufacturer, Reco Industries, to produce ready to use therapeutic food. Reco developed a quality assurance strategy. Reco then implemented this strategy for capacity building by ensuring dispensers and nutritional focal persons at each site received the information, tools, and training needed to store and distribute the product appropriately.

District Planning

NuLife held orientation meetings to advocate for the inclusion of nutrition into district work plans and budgets. The program also reinforced the development of nutrition policy guidelines.

Technical Assistance and Training

NuLife established a team of trainers in comprehensive nutrition care and support. The program built capacity of the Ministry of Health's Quality of Care trainers, as well as coordinators and district officials. It also developed training curricula, job aids, and contributed to the revision of the antiretroviral therapy to include nutrition indicators. Technical assistance was also provided to implementing partners on a minimum package for nutrition interventions into HIV/AIDS care and support services. NuLife supported sites through the establishment of formal and informal agreements of collaboration. The program conducted field assessments to identify needs.

Quality Improvement

NuLife coordinated quality improvement with the Health Care Improvement project. This partnership established district quality improvement teams, and developed long term strategic plans. NuLife managed the performance of Health Care Improvement sites by compiling and analyzing quality improvement data.

Community Mobilization

NuLife identified key partners as part of its community mobilization efforts. The program developed a community outreach model and cascade model for training. A support mechanism was designed for trained volunteers to mobilize the community and build capacity for community workers and volunteers.

Information Management

To manage information, NuLife procured and installed an information technology server. The server allowed for secure data storage and information sharing. In addition, NuLife updated the Standard Operating Procedure to improve service delivery, efficiency, and cost effectiveness. NuLife prioritized monitoring and evaluation efforts. The program built health providers' capacity to gather and analyze data. Health providers were also trained to document the results of nutrition and HIV/AIDS integration, establish lessons learned, and identify best practices.

Program Achievements

LEVEL: Health Effect

Health Effects:

- Of HIV positive orphans and vulnerable children and adults who had previously defaulted on treatment, 42% were treated for acute malnutrition with ready to use therapeutic food.

Service Outputs:

- 583 HIV positive individuals on antiretroviral therapy with severe acute malnutrition received nutrition supplementation.
- 4,894 individuals – orphans and vulnerable children, pregnant and lactating women, and non-lactating women with children under 6 months – received ready to use therapeutic food (by September 2009).
- 34 health facilities supported to integrate nutrition into HIV services through quality improvement.
 - Increased assessment for malnutrition at all NuLife supported sites from 0% to 48%.
 - Percentage of people living with HIV receiving nutrition counseling increased to 20%.
- More than 20 USG partners incorporated nutrition into their HIV/AIDS care and support services.

Process Improvements:

- 20% of 3,142 individuals assessed for malnutrition by trained community volunteers were referred to health facilities for treatment of malnutrition.
- 31 HIV care and treatment facilities updated nutrition and HIV counseling materials.
- Developed and shared minimum package for integration of nutrition interventions into HIV/ AIDS care and support services with 26 USG implementing partners.
- Trained 662 providers from 77 health facilities and 660 community volunteers in integration of food and nutrition into HIV care and support services.
- 600 community leaders and other stakeholders oriented in integration of food and nutrition services.
- \$8,000 was financed by partners' contributions for training of community volunteers.
- Developed effective short delivery system and distributed 57.4 metric tons of ready to use therapeutic food and anthropometric equipment to 34 health facilities, 43.2 metric tons consumed by September 2009.

Strength of Performance Assessment

SCORE: High

- 2008, Baseline survey
- Qualitative analysis using client surveys, medical record reviews, interviews, inventory analysis, focus group discussions, KAP survey
- 2009-present, Data quality assessments: to review effectiveness of data collection systems, monitor indicators quarterly, and intermediate results are in line with organizational objectives.

Comments

Uganda NuLife demonstrated a comprehensive approach to procure nutrition services for people living with HIV/AIDS. The program had a strong emphasis on information management. Through effective leadership and management, the NuLife was successful in reducing the number of people who default on antiretroviral therapy.

ORAL THERAPY EXTENSION PROGRAM

1980-1990

IMPLEMENTING ENTITY:

BRAC (a Bangladeshi NGO)

Location: Bangladesh

SEARO/Low Income

Health Topic: Nutrition/Oral
Rehydration Therapy

Key Words: Focused Factory, National
Scale-up

PROGRAM OVERVIEW

Goal: To reduce infant mortality due to diarrhea in Bangladesh.

Objective:

- (1) Reduce diarrhea-related illness and deaths, particularly among children under 5 years old;
- (2) Teach at least one woman in each household to prepare the oral rehydration solution; and
- (3) Raise awareness in the community about diarrhea prevention.

Funding: BRAC and Oxfam funded the pilot project. Various other donors expanded the program for \$9.3 million. The cost of teaching each household was estimated at \$0.75; the cost of monitoring was estimated at 4% of project costs.

Background of the Oral Therapy Extension Program:

- Interactive program which restructured BRAC's approach to giving villagers tools to prevent dehydration in children with diarrhea.
- Developed the pinch-scoop method of oral therapy to maximize physical and financial access.
- Mothers were taught how to make the electrolyte-rich fluid themselves.
- Recruited and trained women as oral rehydration worker to teach households.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Existing program that promoted oral rehydration solution packets encountered many obstacles and suffered from inadequate supply, high cost, ineffective distribution, and poor uptake by illiterate rural mothers who were skeptical of untraditional products.

Management Action: Change strategy offering a cheaper, more readily available ORS-alternative. Develop new method with existing local goods. Train mothers to produce and provide ORS to their children at home. Expand adoption of the alternative through a focused mass campaign delivered face-to-face.

Principal L&M Characteristics Identified:

Leadership:

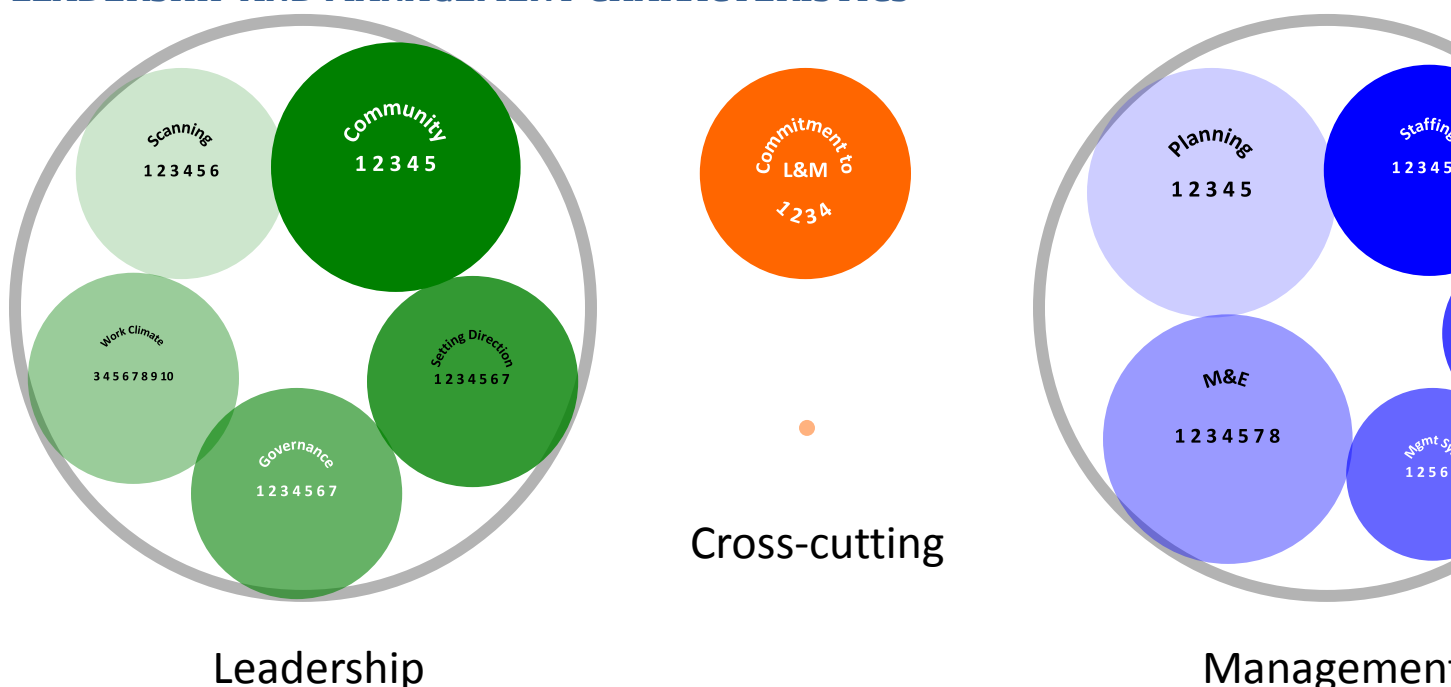
- Community Engagement
- Scanning
- Setting Direction
- Governance

Management:

- Planning
- Monitoring and Evaluation
- Staffing

Results Achieved: Greatly increased oral rehydration solution usage which contributed to dramatic reduction of child mortality.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that Planning and Community Engagement were the most present L&M domains from a review of case study materials (both at 90% presence). Multiple domains in the figure are relatively large in size suggesting this program documented a wide variety of leadership and management actions. The Leadership and Management Development domain was not detected in the review of case materials.

Management Action in Detail

Planning for Sustainable Scale Up

The program began as a pilot and then expanded in three phases over ten years. The pilot phase was a critical step as it allowed program planners and managers to test and refine operational design, procedures, and messaging. This sense of flexibility and continuous quality improvement was maintained throughout implementation and expansion. BRAC recognized characteristics of its program that fostered scale-up. It dealt with a problem common to all of Bangladesh. Further, the intervention was relatively simple and inexpensive for households to maintain as it utilized locally available goods. The program had a clear goal and specific outcome indicators. Despite the program's increased scale, its focused-approach allowed for an administrative structure of checks and balances and rigorous supervision.

Building Quality Improvement Capacity

Workers were given training prior to deployment and supported by quarterly refresher trainings. Proper teaching was crucial to ensure accurate, effective, and safe solutions. So the program took a two-pronged approach to quality control: (1) ongoing monitoring and supervision of Oral Rehydration Worker performance, and (2) operations research. Workers' performance could be measured through knowledge acquired by mothers. Supervisors would revisit 5-10% of the previously assigned households and monitor the mother's retention of lessons and skills. BRAC rewarded workers with a performance-based incentive system: the more each parent remembered, the higher the person's salary. Consistently poor-performing workers were removed.

Data-driven Decision-Making

BRAC used information revealed in its constant operations research practices to improve implementation and cost-effectiveness. For example, males, village doctors, schools, mosques, and bazaars were incorporated into various program activities as a result of M&E findings. Field initiatives were coupled with a media campaign to strengthen ORW's credibility and social perception. Training and messages built on existing skills and knowledge, such as cooking and childcare, and were culturally acceptable.

Adding Value through Organizational Learning

The way BRAC embraced success and discarded failure helped it manage for results. BRAC rigorously monitored and evaluated its work. An organizational learning culture promoted openness to acknowledging failure—not avoidance of objective data and evidence. Success often grew out of earlier failure.

Program Achievements

LEVEL: Health Effect

Health Effect:

- Mortality rates fell after the program was implemented, but it is hard to isolate the effects of the oral rehydration therapy from other factors. (Child and infant mortality declined from 285 per 1000 to 75 per 1000.)
- The program is widely believed by the public health community to have played a major role in halving the country's infant mortality rates, with government surveys showing that 70% of families in Bangladesh use BRAC's oral rehydration solution to treat diarrhea.

Service Outputs:

- The program reached 13 million households during the 10 years of operation.

Process Improvements:

- A study in 1993 found that over 70% of the mothers could prepare a chemically safe and effective oral rehydration solution; a significant number of these mothers were very young at the time of the mass campaigns which implied an intergenerational transfer of ORS knowledge.
- Bangladesh now has the highest rate of oral saline usage in the world.
- BRAC progressively lowered unit cost of this Oral Therapy Extension Plan implementation throughout the 10-year period by improving implementation process.

Strength of Performance Assessment

SCORE: High

- Internal assessments – Interviews, surveys
- Independent external assessments – observational studies, retrospective analysis, surveys
- Cost analysis

Comments

BRAC's Oral Therapy Extension Program dramatically expanded dehydration prevention education services in remote and hard-to-reach settings by training a new public health workforce cadre. This initial scale-up success fostered the rapid expansion of other BRAC initiatives.

SCHOOL FEEDING PROGRAM

1964-Present

IMPLEMENTING ENTITY:

Junta Nacional de Auxilio Escolar y Becas (NBSA)

Location: Chile

AMRO/Upper-Middle Income

Health Topic: Nutrition/School Feeding

Key Words: Resource Targeting

PROGRAM OVERVIEW

Goal: To promote school attendance by providing free meals to those children who might otherwise drop out from school.

Objective: Provide social and food assistance to low income children attending state-supported schools.

Funding: Government of Chile [Annual school feeding program budget: approximately \$145 million as of 2001] [Average cost of targeting process: \$36,772/year or less than 0.05% of annual SFP budget]

Background of School Feeding Program:

- Large scale food intervention program.
- Distributed meals of different nutritional contents to identified students approximately 180 days a year.
- Meals provided at primary, secondary, and kindergarten levels.
- Type of meal provided depended on the vulnerability index of the school (related to social, biomedical, and anthropometric variables of the children).

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Allocate limited resources in an efficient manner. Maximize the program's reach to those with most need.

Management Action: Contract out meal provision to increase competition and minimize costs. Also, strengthen quality and apply evidence-based methods to steer resources towards the program-specific target population.

Principal L&M Characteristics Identified:

Leadership:

- Scanning
- Setting Direction
- Community Engagement

Management:

- Planning
- Monitoring and Evaluation
- Staffing
- Structuring

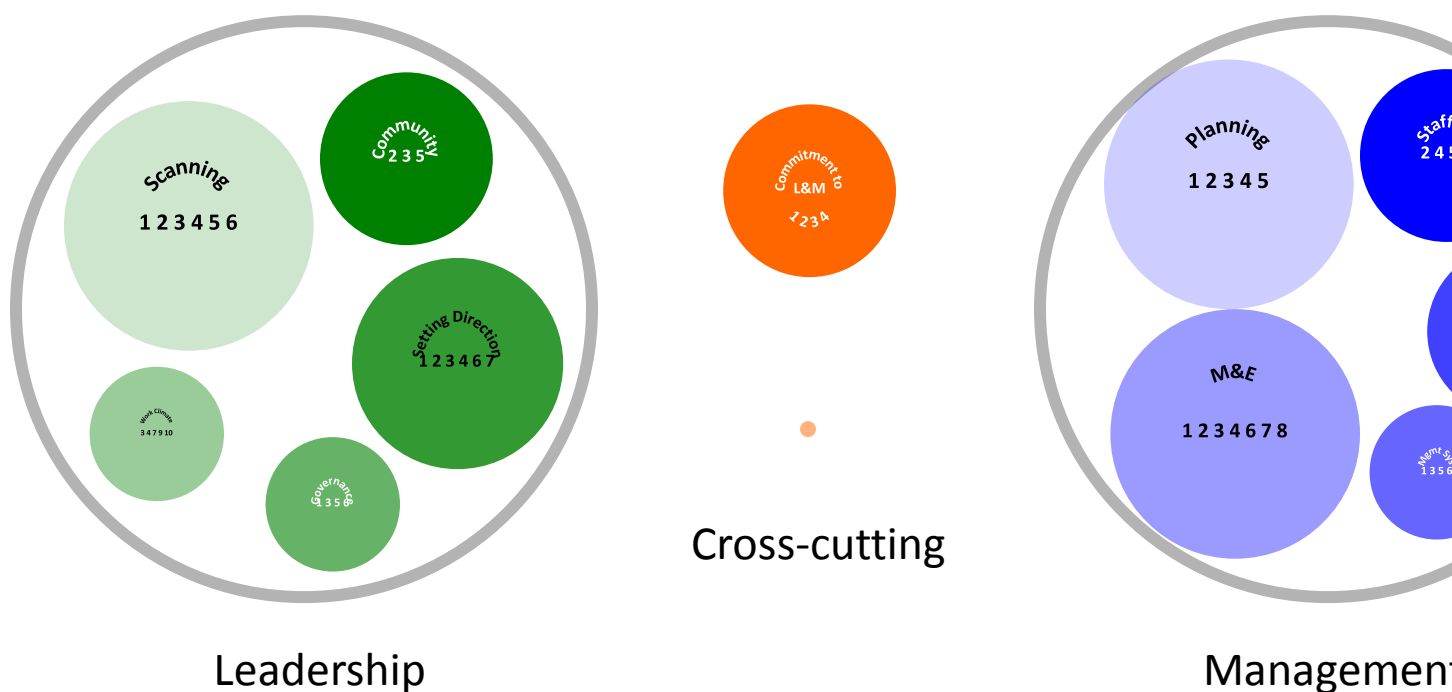
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- As of 2001, the school feeding program meals were distributed to 1.2 million children across 9,500 schools. The school feeding program reached the poor, improved its targeting over time, and served as a strong incentive for poor parents to send their children to school.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that Planning was the most present domain from a review of case study materials (90% present). Scanning and Monitoring and Evaluation were also especially prominent domains in the school feeding program case (83% and 81% presence, respectively). The Leadership and Management Development domain was not detected in the review of case materials.

Management Action in Detail

Strategic Restructuring

The local NGO was established in 1964 when Chile's Ministry of Education decided to centrally administer all school food assistance. The local entity was directly responsible for the purchase, storage, preparation, and distribution of food for the School Feeding Program. Studies conducted between 1965 and 1976 revealed deficiencies in the program's implementation despite high administrative costs incurred by the NGO. In light of the findings, School Feeding Program meal provision gradually shifted its approach to contracting out to private suppliers (1976-1980). Contracted companies took responsibility for full implementation, from the purchase of ingredients to distribution of meals to schools. As of 2000, 27 companies were contracted. The program benefited significantly from this shift. The implementing organization was able to focus on program oversight (e.g. development of technical norms, quality control, standards for nutritional content, and targeting criteria) and the contract bidding process.

Data-driven Resource Allocation

The School Feeding Program was characterized by the use of data to inform decision-making, owing in part to a well-managed targeting process. The targeting process allowed for regular review of program performance. The program recognized several necessary changes through constant monitoring. Multiple methodological adjustments over time helped the program to capitalize on its resources and reach students who were most in need. When assessments have revealed shortfalls, the School Feeding Program flexibly modified its approach to identifying needs and allocating meals. Teachers were trained to detect the basic food and health needs of their individual students. In the first semester of each year, targeting data was gradually collected with minimal pressure on school staff. In the second semester, the NGO analyzed the aggregated data, developed the

targeting model (logistical regression), and ranked schools by calculated vulnerability indexes. The program's targeting process was aligned with the budgeting process, which allowed the NGO to account for new funding allocations and define the number of meals per school prior to the start of the next school year.

Program Achievements

LEVEL: Increased Service Outputs

Evaluations directly linking School Feeding Program with population health outcomes have not been reported.

Service Outputs:

- As of 2000, 1.2 million children were served daily.
- More than 80% of the school feeding program's primary school beneficiaries belong to the lowest income quintiles.

Process Improvements:

- School desertion declined: 40% of children in rural areas completed primary education. In 1990 this improved to 58%, and improved further in 1999 to 70%.
- Competition between firms reduced costs (unit cost per meal declined by approximately 50% to \$0.60) and improved nutritional quality.
- Administrative costs declined from 40% to 5% of the total budget.
- Food acceptability and hygiene improved.

Strength of Performance Assessment

SCORE: High

- 1985, 1992, and 1998, Comparison of the results of the targeting model with surveys: conducted to verify if the School Feeding Program's model is actually reaching school children of poor families
- 1998-1999, Evaluation carried out by the Ministry of Planning, to determine how well the calculated vulnerability index for both primary and secondary schools correlated with the poverty level of beneficiaries' families
- 1999, Analysis conducted by Chile's Catholic University in Santiago, to confirm the association between the calculated index and the need identified directly by teachers

Comments

Chile's School Feeding Program leveraged the core competencies of partner organizations. By contracting out for program implementation, the program was able to focus on effective management and oversight. The case exemplifies data-driven decision-making. The School Feeding Program's scanning activities improved its resource allocation and reach of those most in need.

WHEAT FLOUR FORTIFICATION

2000-Present

IMPLEMENTING ENTITY:

Chilean Ministry of Health

Location: Chile

AMRO/Upper-Middle Income

Health Topic: Nutrition/Micronutrient Fortification

Key Words: Strategic Partnership, Service Integration, Quality Assurance

PROGRAM OVERVIEW

Goal: To reduce neural tube defects in Chile.

Objective: Add folic acid to wheat flour, by utilizing existing infrastructure and support mechanisms.

Funding: Chilean government

Background of Wheat Flour Fortification in Chile:

- Chile fortified wheat with micronutrients since the 1950s, but the addition of folic acid to wheat was not a national policy.
- Fortification with folic acid is an evidence-based intervention for mothers to prevent neural tube defects.
- Neural tube defects are a major physical and financial barrier to a productive and healthy life.
- From birth to 18 years of age in individuals with neural tube defects, medical expenses for surgery and clinical care are estimated to cost \$120,000 in Chile.
- The Chilean government issued a mandate in 2000 that indicated 2.2mg/kg of folic acid was to be added to the premix for wheat flour.
- Women of reproductive age that consumed wheat flour would then receive the recommended 400 µg/day dosage for preventing neural tube defects.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Engaging the non-health food production sector to enable preventive changes for a public health goal.

Management Action: Develop a public-private partnership and adopt a national policy to integrate folic acid (an evidence-based and cost-effective solution) into the existing wheat fortification system.

Principal L&M Characteristics Identified

Leadership:

- Governance
- Setting Direction
- Scanning

Management:

- Structuring
- Monitoring and Evaluation
- Planning

Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- Chile increased blood folate levels of women of reproductive age and subsequently reduced the incidence rate of neural tube defects by 40% over a decade.

The diagram illustrates the relationship between Leadership, Cross-cutting, and Management components. It features three main circular areas:

- Leadership (Left):** A large grey circle containing five smaller green circles. The circles are labeled: "Community" (1 2 3 4 5), "Setting Direction" (1 2 3 4 5), "Governance" (1 2 3 4 5 7), "Work Climate" (8 9 10), and "Scanning" (2 4 5 6).
- Cross-cutting (Center):** A large orange circle labeled "Commitment to L&M" (1 2 3 4). Below it is a small orange dot.
- Management (Right):** A large grey circle containing five smaller blue circles. The circles are labeled: "Planning" (1 2 3 5), "M&E" (1 2 3 4 5 6 7 8), "Stmnt Sys" (1 3 5 6), "Staffing" (2 5 6), and "Strategic" (1).

The Leadership and Management components are interconnected by a horizontal line, and the Cross-cutting component is positioned centrally between them.

Management Action in Detail

Wheat fortification proved to be a very cost-effective investment choice. Fortifying wheat with folic acid was estimated to reduce neural tube defects by more than 40% per year. This was a significant value-added in light of the minimal cost, 16 cents per woman (of reproductive age), receiving the target amount of folic acid. The added financial burden was minimal for Chilean mills already fortifying wheat flour with other micronutrients. Adding folic acid to the premix only increased costs by 15 cents per ton of wheat flour produced. These mills already had the necessary machines and quality control systems (through a laboratory), allowing the Chilean Government to leverage this existing system to target more health threats.

Donor agencies made valuable contributions to research, data collection and information sharing to support this intervention. Responsibility structures and protocols were established for the wheat fortification mandate. The food industry was responsible for production, distribution, and marketing of wheat flour, within government regulations.

The government's responsibilities consisted of regulation and monitoring wheat flour quality to ensure effectiveness. In addition, the government was able to track neural tube defects through a hospital-based surveillance system which had been established in 1999.

Program Achievements

LEVEL: Health Effect

Health Effect:

- Neural tube defect rate decreased from 17 to 10 per 10,000 births, a 40% decline (1999/2000-2001/2002)
- 3 to 4 fold increase in blood folate levels observed among women of reproductive age, 10 months post-fortification mandate

Process Improvements:

- Chile's health system was able to save about \$11 million per year based on preventing 110 cases of neural tube defects in one year
- Cost per DALY averted was \$89; 0.8% of Chile's GDP per capita
- Intervention cost per neural tube defect case and infant death averted were \$1,200 and \$11,000, respectively

Strength of Performance Assessment

SCORE: High

- 2000, 3 and 6 months post-mandate, random assessment of bread folate content
- 2000, Impact evaluation: indicators included folic acid content of bread, folic acid consumption from bread and changes in blood folate, and changes in neural tube defects frequency

Comments

Chile's wheat flour fortification was an effective intervention. The policy change demonstrated transformational leadership. Government mandates were aligned with achievable expectations. These aspects of successful management set a foundation for sustainable partnerships. This ongoing program continued to improve lives by reducing neural tube defects.

PRIMARY HEALTH CARE CASES

BANGLADESH SMILING SUN FRANCHISE PROGRAM

2007-2011

IMPLEMENTING ENTITY:

SSFP with Chemonics International & Sibley International

Location: Bangladesh
SEARO/Low Income
Health Topic: Primary Health Care

Key Words: Private Franchise Network,
Strategic Partnerships, Quality

PROGRAM OVERVIEW

Goal: To maintain and expand availability of sustainable NGO health services and products in a way that reduces reliance on USAID funding for recurrent costs while expanding availability to the poor.

Objectives:

- (1) Establish a network with a local Franchise Manager (FM) running it competently;
- (2) Deliver services and increase in efficiency; and
- (3) Expand the network.

Funding: USAID

Background of Bangladesh Smiling Sun Franchise Program (SSFP):

- Program activities addressed gender, youth, and corruption concerns and aimed to develop innovative strategies for implementation.
- Services included reproductive health, child health services, DOTS and microscopy for TB, and consultation of dispensing drugs and diagnostic lab services.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Initial stand alone services lacked orientation and capacity to attain financial sustainability. Operations are heavily dependent on donor funding to cover costs.

Management Action: Utilizing a quality management system for the establishment of an independent franchise network and developing strategic partnerships with businesses and local NGOs.

Principal L&M Characteristics Identified

Leadership:

- Community Engagement
- Scanning
- Staff and Work Climate Development

Management:

- Staffing
- Management System
- Monitoring and Evaluation

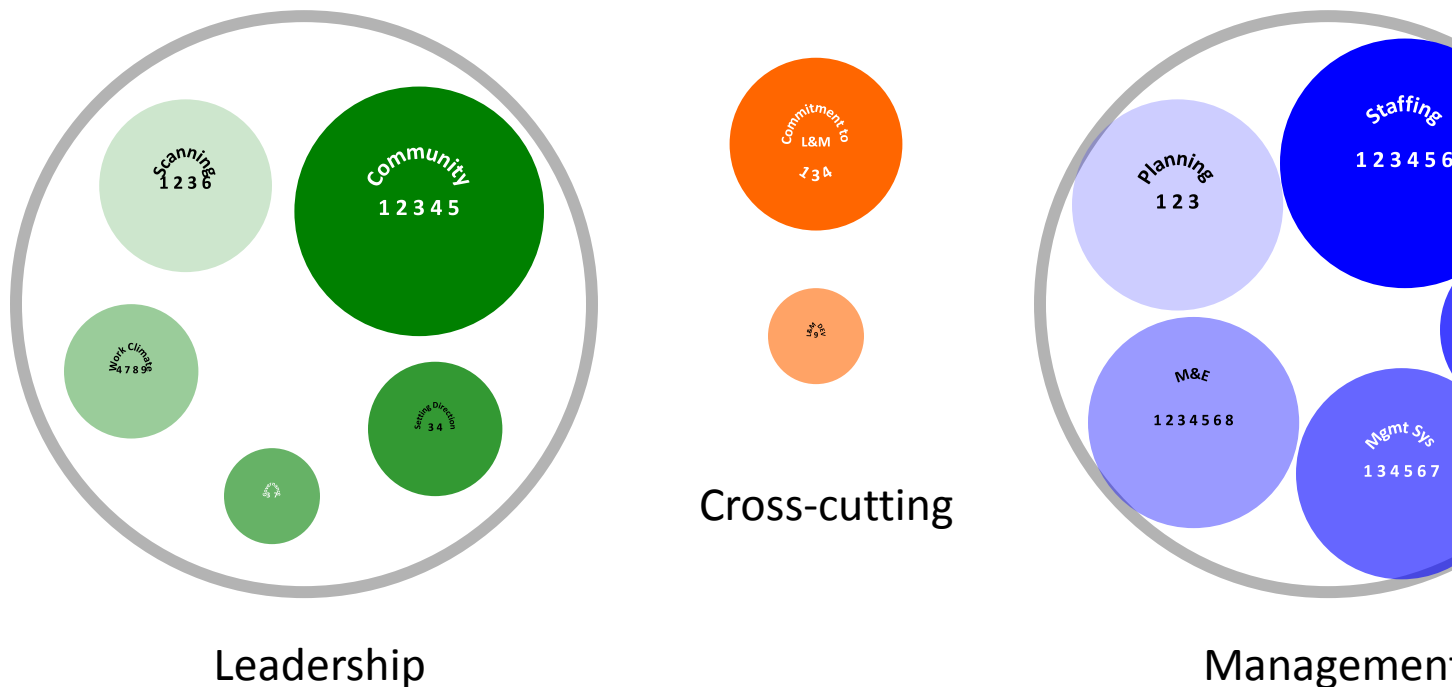
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- Smiling Sun succeeded in establishing the franchise network and a local Franchise Manager organization took ownership of management and operations.
- Smiling Sun NGOs and their clinics continue to provide quality health services with a reduction in grant money.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that Staffing was the most present L&M domain from a review of case study materials (86% present). The Leadership domain of Community Engagement was also highly present at 80%. The Management domains of Management Systems and Monitoring and Evaluation followed with 79% and 75% presence, respectively.

Management Action in Detail

Business Approach for Global Health Operations

Chemonics developed Smiling Sun Franchise Program's (SSFP) model based on researching McDonald's business model and other successful franchises. Chemonics then adapted those models to the local operational context. Chemonics used a project financing plan (Build-Operate-Transfer methodology). This plan gradually developed an external entity assuming the Franchise Manager role. By the end of the project, the Franchise Manager would transition into a fully independent and operational business. SSFP established revenue streams through strategic partnerships where the stakeholders had a vested interest in their client's health. Third-party payer arrangements were made with major local employers (Walmart and H&M Co). Garment employees of partnered companies received health care from SSFP clinics and SSFP recouped costs from the company.

Quality Management

SSFP used an interrelated quality management system. The system monitored quality among point of service, program management, and central level strategy to address efficiency and effectiveness. SSFP franchisee clinic managers used the Plan-Do-Study-Act (PDSA) cycle for problem solving. This was important as it used information to make action plans and then followed through on their execution. This multi-step approach generated more information to be reassessed cyclically.

Performance Monitoring

Mystery clients and independent quality audits were used for quality assurance accountability. Franchisees had designated staff members or teams responsible for measuring and reporting the clinic's performance indicators

into an HMIS which disseminates the data to Franchise Manager daily. Daily reporting allowed for real-time monitoring.

Staff Development

SSFP technical staff had titles and specific job descriptions. SSFP made market analysis and customer satisfaction a priority to ensure long-term success. To promote growth, staff and partners were allowed and encouraged to take the lead in defining strategies, activities, and outcomes.

Program Achievements

LEVEL: Increased Service

Evaluations directly linking the establishment of the Smiling Sun Franchise Program (SSFP) with population health outcomes have not been reported

Service Outputs:

- NGO clinics, satellites, and community workers continue to expand the volume of clientele, coverage of poor clients, range of services available, and quality of care.

Process Improvements:

- Smiling Sun Franchise network is in place and a local Franchise Management organization is competently managing the franchise operations.
- Smiling Sun NGOs and their clinics continue to provide quality health services with a reduction in grant money.
- West Bakalia Clinic: after implementation of the PDSA cycle, waiting time for customers reduced from 15 minutes to an average 7 minutes.
- Strengthened partnering organizations' quality of care while enhancing their financial sustainability.
- Expanded access to high quality health services and generated sufficient income to support approximately 70% of operational costs.

Strength of Performance Assessment

SCORE: Average*

- 2007, Baseline
- Outcome monitoring: quantitative and qualitative

**M&E plan in place, results forthcoming.*

Comments

Smiling Sun Franchise Program successfully improved access to quality health care by adopting a business approach towards global health programming. SSFP made gains through focused operations, quality improvement systems, and promotion of staff development.

HEALTH EXTENSION PROGRAM(HEP)

2002-2010

IMPLEMENTING ENTITY:

Ethiopia Federal MOH (FMOH)

Location: Ethiopia

AFRO/Low Income

Health Topic: Primary Health Care

Key Words: Task-shifting,
Decentralization, Resource
Management, HMIS

PROGRAM OVERVIEW

Goal: Create a healthy society and reduce rates of maternal and child morbidity and mortality.

Objectives:

- (1) Shift health care resources from predominantly urban to rural areas;
- (2) Improve access and equity of basic health services at village and household levels;
- (3) Ensure community ownership and participation by increasing health awareness, knowledge, and skills;
- (4) Promote gender equality;
- (5) Improve utilization of peripheral health services by bridging the gap between the communities and health facilities through Health Extension Workers;
- (6) Reduce maternal and child mortality, and promote healthy life styles.

Funding: Initiated as fully government-financed program; other funders include the Global Fund, Carter Foundation, Pathfinder International, USAID, and John Snow Inc.

Background of HEP:

- Major nationwide health program.
- Community-based health care delivery system.
- Focused on prevention, healthy living, and basic curative care.
- Customized services for pastoralist, agrarian, and urban populations.
- Care delivered through home visits by a newly created cadre of Health Extension Workers.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Reaching remote communities with health services in a centralized, facility-focused health system with a shortage of specialized health workers.

Management Action: Decentralize health service provision and use local participation to enhance effectiveness. Fill the workforce gap through task-shifting to a new cadre of providers—Health Extension Workers—who will function outside of facilities.

Principal L&M Characteristics Identified

Leadership:

- Community Engagement
- Staff and Work Climate Development Scanning

Management:

- Monitoring and Evaluation
- Staffing
- Planning

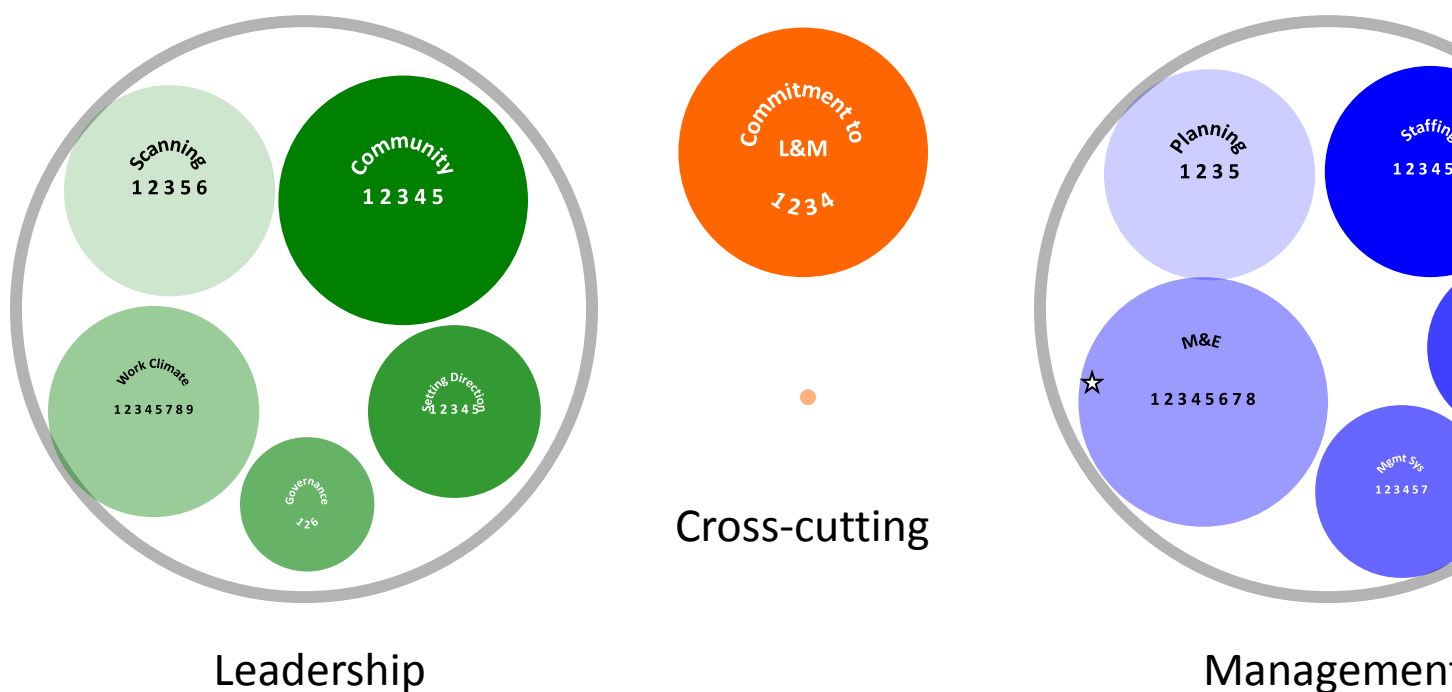
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- Improved Health Outcomes: immunization, contraceptive use, and personal and environmental hygiene.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that Community Engagement was the most present L&M domain from a review of case study materials. Multiple L&M domains in the figure are relatively large in size suggesting HEP documented a wide variety of leadership and management actions. The least reported domains were L&M development and governance. In particular, the white star in the Management System domain denotes that a health management information system was identified for this case study.

Management Action in Detail

Strategic Direction

The health extension program took a decentralized approach: districts received a block grant to cover expenditures to effect and manage services, and wards planned and implemented program activities. Clear identification of roles and responsibilities set strategic direction in planning, implementation, and monitoring and evaluation. Health service packages were community-driven.

Community Driven Activities

Health Extension Workers engaged the community from planning through evaluation of services (including leveraging existing networks through community-based organizations and organizing local events). Town hall meetings were held for community members to identify weaknesses and strengths, and provide ideas for improvement. As a government priority, the program benefited from top leadership commitment and resource support. This was crucial as HEP required substantial investments to achieve its operational scale.

Comprehensive Human Resource Management

Staffing was central to operations. The program established hiring guidelines for Health Extension Workers and formalized their inclusion as salaried government staff. Health Extension Workers were nominated by the community to gain local approval. Incentive packages, career ladders, and training were included in the budget. Each Health Extension Worker completed a training program entailing coursework and practical fieldwork in

cooperation with Ministry of Education. A Training of Trainers approach was used to rapidly expand education capacity. 30,000 Health Extension Workers received this one year training.

Intra-governmental Coordination

Regional authorities ensured sufficient health posts for Health Extension Workers entering the labor force. This was achieved through coordinating human resource management plans with simultaneous expansion of primary health care infrastructure. Where possible, health posts were located near other public institutions to enhance coordination among government services. If there were community health workers in a community, they worked together with Health Extension Workers. Weaknesses identified through program performance reviews and in logistic and supply management were addressed through national reforms.

Results-based Performance Management

Monitoring and evaluation were prioritized from the start for result-driven programming. Health Extension Workers collaborated with ward administrators to conduct baseline surveys. The survey data was used to identify and prioritize health problems. Plans of action were drafted and submitted to district and ward councils for approval. HEWs also collected information in standardized formats to keep accurate and timely records of their activities. The information was passed on to the ward council and district health office for review and action. The ward health committee, Health Extension Workers, and community health workers met weekly and provided a report to the ward cabinet. Data was captured in a health management information system (HMIS). The HMIS supported decision making at all levels, for both managerial and technical purposes.

Program Achievements

LEVEL: Health Effect

Coverage of Key Interventions & Health Effect:

- Improved immunization coverage – increase of $\approx 20\%$ in some regions for DPT3/Penta3 and measles
- Improved breastfeeding practices – in some regions early initiation increased almost 30% and exclusive breastfeeding increased $\approx 20\%$
- Improved nutrition – Vitamin A supplementation nearly doubled in some regions and protection from anemia increased through iron supplementation

Service Outputs:

- By mid-2008/09, the FMOH had successfully deployed over 30,000 HEWs throughout Ethiopia
- HEWs helped expand the distribution and use of insecticide-treated bed nets which contributed to a decrease in malaria deaths over a 3 year period
- Contraceptive utilization rates increased in some regions

Process Improvements:

- Early success in the rapid scale up of extension workers has made it easier to gain donor support for more costly plans to scale up doctors, nurses and midwives
- Many regions saw improvements in construction and utilization of latrines

Strength of Performance Assessment

SCORE: High

- 2007, Needs assessment: qualitative study on continuing education for extension workers; methods included review of literature, documents, and in-depth field study of all regions with already deployed extension workers
- 2008, Health impact evaluation survey: cross-sectional study in seven administrative zones

- Ongoing monitoring: qualitative surveys, including observations, in-depth interviews, focus group discussions; quantitative

Comments

This case dramatically scaled up health care in remote and hard-to-reach settings by training a new cadre of health workers. It appears that a variety of leadership and management actions went into training and deploying 30,000 new workers in seven years.

LIVING GOODS 2007-Present	Location: Uganda AFRO/Low Income Health Topic: Health Promotion Key Words: Micro-franchise Network, Branding
IMPLEMENTING ENTITY: Living Goods, BRAC Uganda	

PROGRAM OVERVIEW

Goal: Establish a fully financially sustainable, secure, and reliable system for delivering essential medical solutions to poor communities that can be easily adapted to other developing country contexts.

Objective:

- (1) Recruit and train Community Health Promoters to market health products and provide basic family planning and reproductive health services aiming;
- (2) Reduce mortality and morbidity rates by at least 25%, especially for children under 5; and
- (3) Create a fully sustainable program where community health promoters earn \$200-500 per year.

Funding: David Weekley Family Foundation, Draper Richards Foundation, Mulago Foundation, and Rockefeller Foundation (through BRAC Uganda) [2009 Program expenditure = \$1.6 million]

Background of Living Goods:

- Micro-franchise network of door-to-door Community Health Promoters who make a modest income selling health products at prices affordable to the poor.
- Adapted model from the US company Avon's highly successful micro-franchise experience.
- Focused on a short list of diseases that account for over two-thirds of mortality and can be prevented and/or treated at very low cost.
- Community health promoters market a diverse basket of goods anchored by essential items emphasizing prevention, and complimented with home and personal care items.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Expanding access to basic health products and services at low-cost in villages that are currently underserved by the existing public and private health infrastructure.

Management Action: Establishing a micro-franchise network of community-based health promoters.

Principal L&M Characteristics Identified:

Leadership:

- Community Engagement
- Setting Direction
- Scanning

Management:

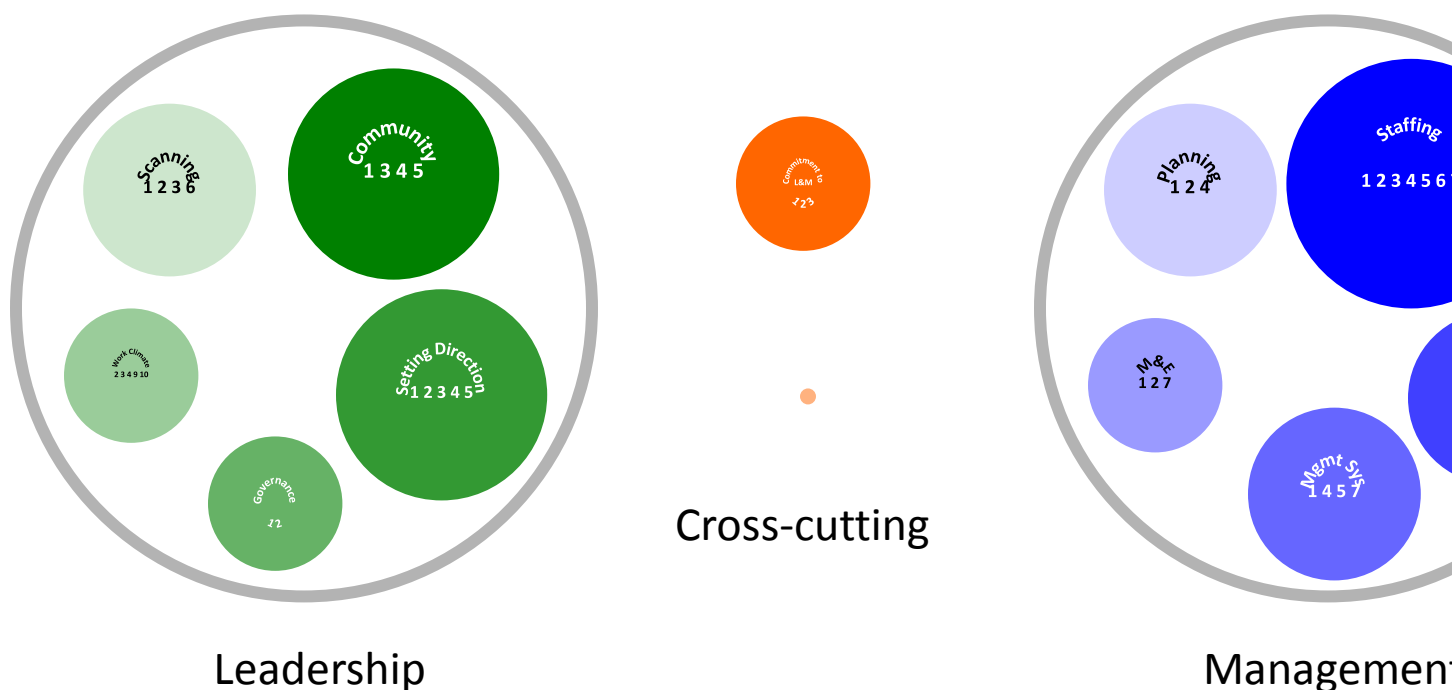
- Staffing
- Structuring

- Management Systems

Results Achieved:

- Increased service outputs – served 200 communities in 2007 and scaled to serve 900 communities by the end of 2009.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above shows Staffing as the most present L&M domain from a review of case study materials (86% presence). The Leadership and Management Development domain was not detected in the review of case materials.

Management Action in Detail

Focused Franchise

Program planners identified a target market and articulated clear objectives. A focused strategy was selected—the full franchise business model. Living Goods incorporated major characteristics of successful franchises: methodically screened agents, strict quality monitoring and follow-up training, uniform branding and product mix, effective promotions, low cost of goods achieved through scale, and stiff penalties for violating rules. Living Goods and BRAC set health behavior change targets, specific expected outcomes, and planned for evaluation, endorsed by the MOH.

Strategic Incentives

Living Goods' incentives target common human resource issues such as recruitment and retention. Incentives for community health promoters include: (1) A proven business-in-a-box system supported with training, marketing, and coaching, (2) Low start up costs of \$100-\$250 with simple low-cost financing, and (3) Flexible

hours and lifestyle- sellers work on their own schedule and in their own communities. Living Goods envisions that economic incentives create a virtuous circle. The more profitable the community health promoter is, the more time she will invest in her work, and thus the greater the health impact she is expected to have.

Leveraging Local Networks

To build a skilled workforce, community health promoters received three weeks of training plus monthly refreshers and regular coaching. Living Goods engaged and leveraged local partners; BRAC recruits community health promoters from its existing Village Organizations, so potential community health promoters are essentially pre-screened. Village Organizations provide natural customer bases as gatekeepers to the community. Existing BRAC branch offices serve as supply depots and Living Goods' bases in the field.

Adapting a Business Approach for Health

Living Goods has diversified its product mix to be broader than what typical community health workers in other programs have but still competitively priced, as a means of creating competitive advantage to increase sales and bolster financial sustainability. The program invested in building a strong brand. Living Goods prioritized an efficient supply chain for the purpose of becoming a distributor of choice for free goods from the public sector. Inventory and supply controls include a computer-based inventory management system, monthly physical stock counts, micro-warehouses, and stock reports by branch. Living Goods planned for a sustainable business model—at scale, profits should cover overhead costs for administration, training, transportation, and an adequate supervisor to franchisee ratio.

Program Achievements

LEVEL: Increased Service

Evaluations directly linking the Living Goods program with population health outcomes have not been reported.

Service Outputs:

- 2007 - Served 200 communities in Uganda, by the end of 2009-more than 900 communities [covering more than 20 districts]
- Served an estimated 460,000 clients in 2009;
- Strong sales of high impact health items: ACT (recommended malaria treatment), Oral rehydration solution (ORS), fortified foods, deworming

Process Improvements:

- Living Goods is able to set prices 10–30% below market, improving the consumer’s perceived value of the products
- The program increases referrals to the public health system for secondary care
- Steady increases in sales per agent
- Achieving 95%+ in-stock rates
- Living Goods expects to require no outside funding within 4-6 years.

Strength of Performance Assessment

SCORE: Average*

- Community health promoters collect data from every household at the start of their activities on: child ages, water source, latrine types, contraceptive method, bed net usage, health spending, and cases of malaria and diarrhea. Living Goods periodically re-measures these to track trends and inform strategy.

**Poverty Action Lab is currently working with Living Goods to assess the impact of the pilot; randomized control-based research; sample: 6,000 households in 200 clusters; results forthcoming*

Comments

Living Goods applied Avon’s business model in a development context to achieve scale, financial efficiency, and geographic reach in service of healthcare for the poor.

PRIMARY CARE NETWORKS

2005-Present

IMPLEMENTING ENTITY:

Alberta Health and Wellness, Alberta Medical Association, Alberta Health Services

Location: Canada

AMRO/High Income

Health Topic: Primary Health Care

Key Words: Strategic Partnership, Service Integration

PROGRAM OVERVIEW

Goal: To improve access to family physicians and other frontline health care providers in Alberta.

Objective: Increase the number of Albertans with access to primary care services.

Funding: Primary Care Initiative [Government]

Background of Primary Care Networks:

- Focused on health promotion, disease and injury prevention, care of patients with medically complex problems, and care of patients with chronic diseases.
- Oriented towards improving coordination of primary health services with other health care such as hospitals, long-term care and specialty care services and foster a team approach to providing primary care.
- A primary care network can be composed of one clinic with many physicians and support staff, or several clinics in a geographic area. These networks range from a group of three doctors to more than 200, but average at about 60.
- Participation in the group is completely voluntary for physicians, health professionals, and staff.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Family doctors felt concerned about the quality of care being delivered due to the lack of resources and lengthy wait times for patients.

Management Action: Primary care networks were formed in 2005 during the government's primary care transfer funding and supported through the Primary Care Initiative.

Principal L&M Characteristics Identified

Leadership:

- Community Engagement
- Scanning
- Governance
- Setting Direction

Management:

- Planning
- Staffing
- Monitoring and Evaluation

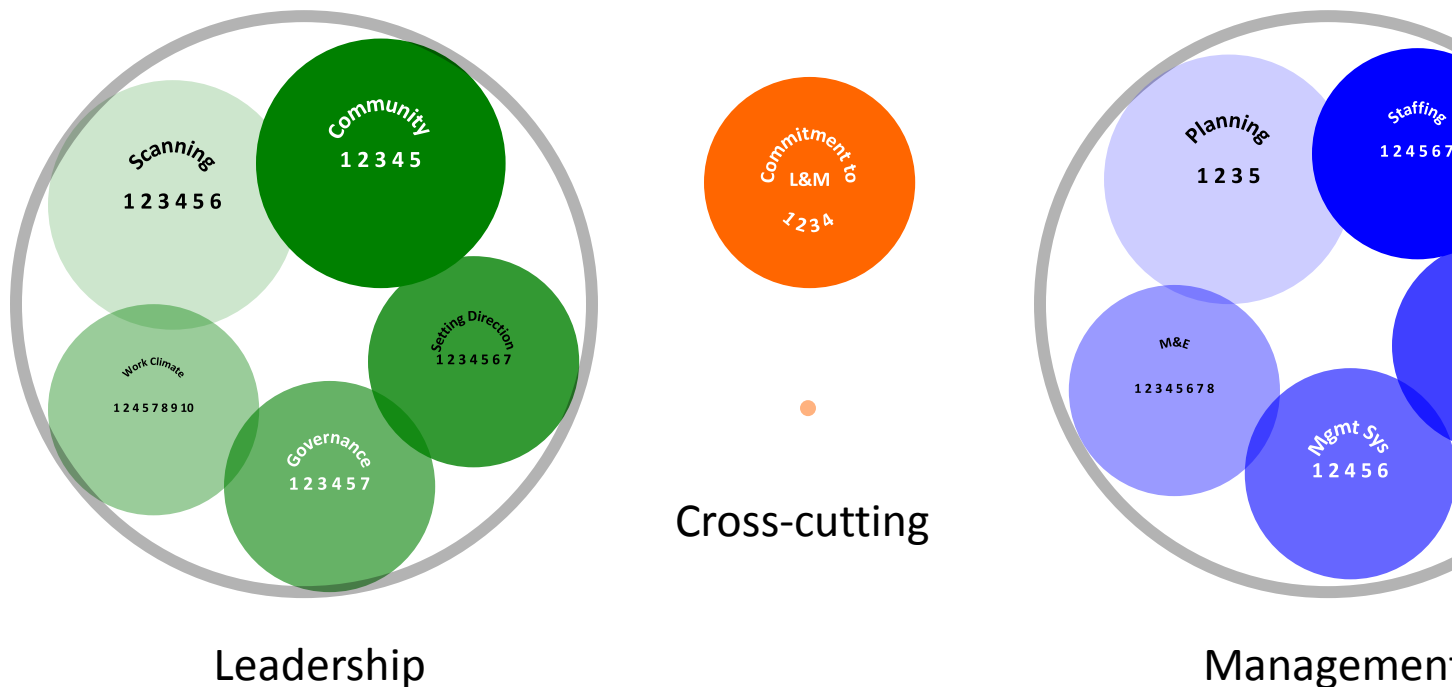
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- Many networks have been established, improving access to family doctors and wait times have been reduced.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that Community Engagement was the most present domain among reviewed materials (100% presence). This domain was followed by the leadership category of Scanning and the management domain Planning (83% and 80% presence, respectively). The figure has many relatively full domain in both leadership and management, suggesting that this case documented a wide variety of leadership and management actions.

Management Action in Detail

Engagement of Key Stakeholders

A joint venture agreement was created between Alberta Health Services and physician groups, to provide a full set of primary health care services to patient populations. A governance committee provided oversight for strategic direction and structure of daily operations.

Common Vision for Service Delivery

Networks strived to improve service delivery through various initiatives. Initiatives included hiring allied professionals to create multidisciplinary teams, improving chronic disease management, extending clinic hours, and improving coordination between clinic care, mental, and public health services.

Business Planning Model

A development structure existed for establishing primary care networks. Each stage of business planning was supported by a specific and relevant information package. Stakeholders were provided with early verification of proposals eligible for funding and the proposals were developed within established guidelines. Each group was required to submit a draft of their service delivery model to the Primary Care Initiative Program Office for review and approval. The Service Plan included an initial budget with planned programming and infrastructure. The structure was flexible in terms of network size, number of providers, and assortment of disciplines. The flexible structure allowed adoption of programs and services that matched its specific patient population.

Consistent Monitoring and Reporting

Once a primary care network completed the business planning process and was operational, it had to meet ongoing reporting and planning requirements. Requirements included submission of mid-year reports, annual reports, and an annual budget. Planning and reporting were consistent and each network received the same guidance from the Primary Care Initiative.

Program Achievements

LEVEL: Increased Service Outputs

Evaluations directly linking this case with population health outcomes have not been reported.

Service Outputs:

- 38 primary care networks involving over 2,000 family doctors provided care to 2.4 million Albertans. 64% of target reached – to have 80% of Albertans receiving care from networks by 2011 (as of August 2010).

Process Improvements:

- Clinical indicators including blood pressure, mammogram, and colorectal screening increased significantly at Chinook – 100 doctors caring for 200,000 patients in 17 different clinics.
- 75% of eligible family physicians in Alberta were working in the network.
- Over 90% of the network groups identified diabetes as a key health issue and developed programs.
- Over all participating physicians, average wait times decreased from 10 to 5 days to the next available appointment.
- Family physicians' work satisfaction increased: one rural clinic of 10 doctors reported a statistically significant improvement in sense of job autonomy – ability to influence patient behavior and communications between provider and community programs.

Strength of Performance Assessment

SCORE: Average*

- 2005 to present, ongoing surveying of providers knowledge and practices
- 2009, Began development of formative evaluation, surveying, visiting, and speaking with physicians and other staff to hear how the process of establishing a primary care group works and how it can be enhanced for future development.

**2011, Planned summative evaluation: surveys, outcomes and impact on patients, health professionals and other key stakeholders*

Comments

The Primary Care Networks in Canada were an important mechanism for increasing primary health care coverage among Albertans. The business approach model favored the development of services that would generate local demand. This required flexible decision making at the local level to integrate tailored programming aligned with the local population's needs. The standardized business approach improved service delivery and was supported by the government.

QAP & BASICS

1993-1998

IMPLEMENTING ENTITY:

USAID, Niger Ministry of Public Health (MPH)

Location: Niger

AFRO/Low Income

Health Topic: Primary Health Care/IMCI

Key Words: Quality Assurance, Standards, Monitoring, Cost Recovery

PROGRAM OVERVIEW

Goal: Strengthen newly decentralized regional and district management, improve the quality of primary health care in the regional Department of Tahoua, and support the introduction of Integrated Management of Childhood Illness (IMCI).

Objectives:

- (1) Strengthen district-level management capacity;
- (2) Train health workers in quality assurance;
- (3) Develop tools for supervision;
- (4) Adapt/impart standards;
- (5) Monitor progress; and
- (6) Implement cost-recovery systems.

Funding: USAID [Cost of basic quality assurance training session: \$230 per worker; and IMCI training session: \$430 per worker; Cost of supervision: \$20-35 per visit; Cost of coaching: \$15-20 per visit]

Background of Quality Assurance Project (QAP) & BASICS:

- The quality assurance project and BASICS (no longer a meaningful acronym but now the name for a child health program implementing IMCI guidelines) formed a joint program to determine if quality management strategies would facilitate the introduction of IMCI.
- The collaboration identified existing QAP districts and BASICS districts to pilot

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Introduce new clinical guidelines for managing childhood illnesses into existing health facilities and get providers to comply with and institutionalize the standards.

Management Action: Apply quality management principles to improve quality of care and facilitate the introduction of IMCI.

Principal L&M Characteristics Identified:

Leadership:

- Staff and Work Climate Development
- Setting Direction
- Governance

Management:

- Monitoring and Evaluation
- Planning
- Staffing

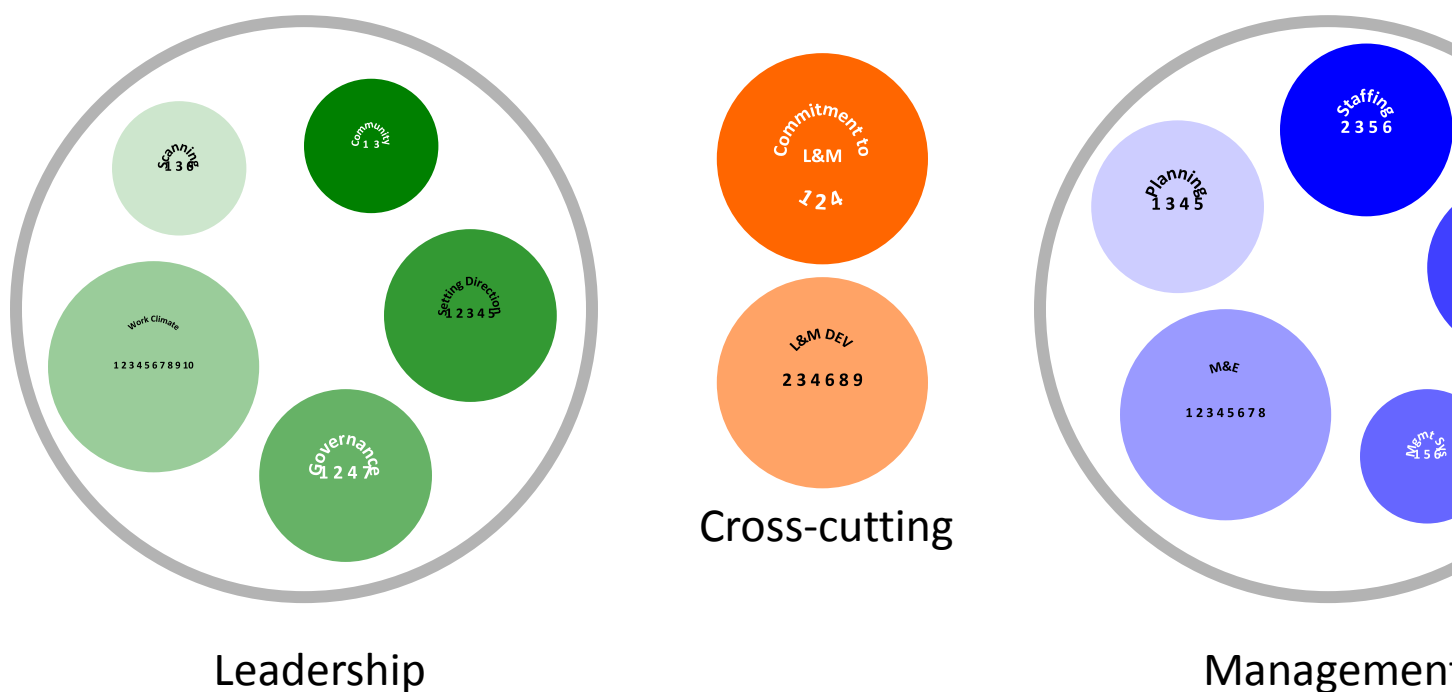
Cross-cutting:

- External commitment to Leadership and Management

Results Achieved:

- Quality management was effectively implemented in Tahoua with related improvements in health program indicators. The project met most of its objectives. Quality management was found to facilitate the introduction of IMCI.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that Monitoring and Evaluation, Staff and Work Climate Development, and Cross-cutting Leadership and Management characteristics were the most present domains from a review of case study materials (all at 75% presence).

Championing Quality

The Regional Health Director became a 'quality champion' after attending a one-week quality management training course at University Research, Co. (URC; Bethesda, MD, USA) and the George Washington University (Washington, DC, USA). Upon returning, department management was reorganized according to the following quality management principles: respect for clients and their needs, systems knowledge, quality measurement, and teamwork. The Regional Health Director trained staff members with QAP support. Quality councils were formed by executive teams at district and department levels. Teams were formed to apply the project's problem-solving approach: (1) problem identification; (2) problem analysis; (3) solution development; and (4) solution testing.

Empowering Provider Teams to Take Ownership of Quality Improvement

The quality assurance project encouraged health workers to solve problems using locally available resources. Teams measured improvements and communicated results to their district/departmental supervisors. Results were analyzed and posted on office bulletin boards for all staff to see. The supervision system was transformed from traditional authoritarian style inspection to a supportive problem-solving approach. Supervision was a continuous process of sharing information with staff, instructing them, and providing feedback on their performance. A checklist was created to guide supervisors during visits. Many supervisors performed the role of coach to quality improvement teams. Administrative standards were established and published in a manual. Quarterly two to three day meetings were attended by all district directors. The meetings served as forums to review progress, share experiences, set benchmarks, solve problems, and develop plans for the following quarter. The quality assurance management system was supported by training, communicating standards, and improving case management. A systems approach was used to identify, redesign, or improve essential components in the districts. The joint project's operations benefitted from several other management factors including teamwork, patient-focused organization, improved provider knowledge of quality assurance system

and processes, clarity of roles through standards, results monitoring, and synergy between quality assurance project and BASICS staff.

Program Achievements

LEVEL: Health Effect

Health Effect:

- Coverage rates for measles immunization rose from 24% to 83% (1993-1996).

Service Outputs:

- The utilization rate of curative services increased from 30% to 37% (1993-1995).

Process Improvements:

- As a result of the success of the pilot program (1993-1997), the MPH decided to replicate quality management in another 3 of its 7 departments with financial assistance from the World Bank.
- The average length of a problem-solving cycle was 6 months (ranging from 3 months to 1 year); regular coaching shortened this cycle.
- Tahoua trained 400 health workers in quality assurance skills and over 77 quality improvement teams in 42 districts worked on 120 problem-solving cycles (1993-December 1998).
- Staff motivation, participation, and performance improved as a result of team activities.
- The project succeeded in improving the supervision system and in creating trained supervision teams that provide technical support to health staff
- By the end of the project, 100% of senior staff at the Tahoua Regional Health Administration, 90% of the district health teams, and 85% of health workers were trained in basic quality assurance skills, and 92% of health centers in the project area had at least 1 operational quality improvement team; all supervisors in the department had been trained in facilitative supervision, and 70% of them received training in coaching skills.

Strength of Performance Assessment

SCORE: High

- 1998, Retrospective study: interviews with staff and managers, focus group discussion in community, and medical records; pre-project assessment used as baseline for comparison to assess quality assurance project since 1993, degree of quality assurance institutionalization in Tahoua, and lessons from introducing Integrated Management of Childhood Illness guidelines in a quality management environment.
- 2001 (two years after close of quality assurance project /BASICS), Retrospective, descriptive study: health worker interviews, document review, observations of health workers, and interviews with mothers, conducted at department, district, and health center levels; Maradi department used as comparison area.

Comments

This case formed a synergistic collaboration to leverage quality assurance project and BASIC's strengths. This case demonstrates that quality improvement can be done with local resource and implemented as a component of project start up.

THE PUENTES PROJECT: BUILDING BRIDGES FOR QUALITY

1998-2003

IMPLEMENTING ENTITY:

Ministry of Health (MOH), Population Communication Services, Save the Children

Location: Peru

AMRO/Upper-Middle Income

Health Topic: Primary Health Care

Key Words: Provider-Community

Partnership, Community Mobilization

PROGRAM OVERVIEW

Goal: To develop shared responsibility between communities and health service providers of public health services in selected project areas to contribute to the improvement of the population's reproductive health and general health.

Objectives:

- (1) Increase the utilization of public health services in selected project areas;
- (2) Improve client and service provider interpersonal interactions within health services; and
- (3) Establish mechanisms and/or systems to improve coordination and collaboration between health services and community organizations.

Funding: The Johns Hopkins University Bloomberg School of Public Health

Background of the 'Building Bridges for Quality' project:

- Community mobilization strategy to improve the quality of health services.
- Community members and service providers enter into an ongoing, respectful dialogue about what constitutes quality services and how they can improve their health and health services.
- Priorities are identified and strategies are developed collaboratively.
- Launched in three selected pilot areas from 1998-2000 and then scaled up by MOH to two new regions in 2003.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: A lack of trust between community members and health providers which serves as an obstacle to mobilizing the community to take ownership of public health services.

Management Action: Comprehensive trust-building exercises with open dialogue, socialization, and shared learning.

Principal L&M Characteristics Identified:

Leadership:

- Scanning
- Community Engagement
- Setting Direction

Management:

- Planning
- Monitoring and Evaluation
- Structuring

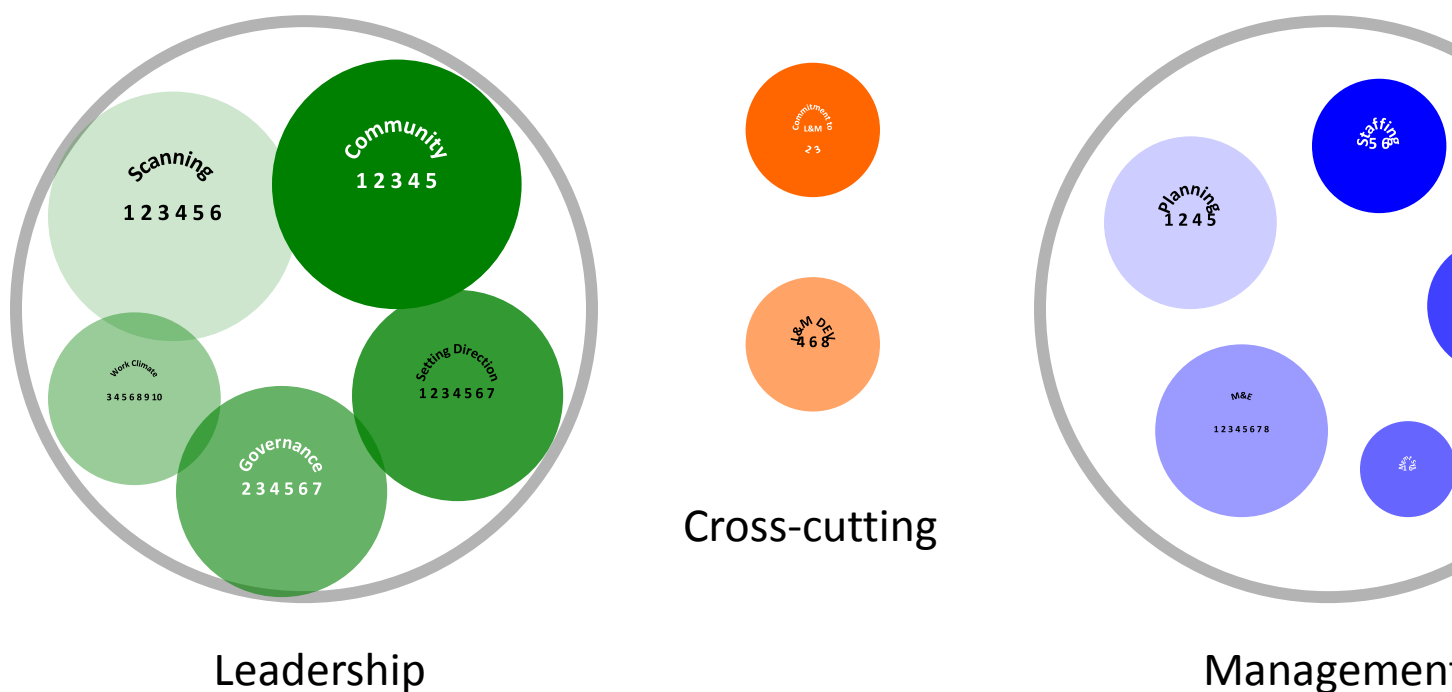
Cross-cutting:

- Leadership and Management Development

Results Achieved:

- Improvements in local health care services and client-provider interactions.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that both Scanning and Community Engagement were the most present domains from a review of case study materials. They were both found to be 100% present. Other domains were more than twenty percentage points away denoting this case likely focused on these leadership principles. Overall, documentation of the leadership category was more present in the Puentes project than management category.

Management Action in Detail

Mobilizing the Community for Quality Improvement

Recognizing that individuals make choices when seeking care, the Puentes Project prioritized community engagement. The program focused on factors that influence the community to choose to actively partner in health services. Mobilizing the community in this fashion stimulated demand for services and ensured the supply of services was appropriately matched with the needs of the community (or customers). Community members and health providers collaboratively created an action plan for improving quality. The action plan was based on shared goals and understandings of what quality encompasses in the local context. Project staff deliberately provided the space for open dialogue between the two groups. Open dialogue allowed for the shared vision to develop. This required learning about the local community culture, the organizational culture of health providers, and the perceived relationships between the two.

Innovative Approach to Collaboration

Planners recognized the need for a comprehensive and multi-faceted approach, understanding that bridging the gap of understanding and trust between community members and health providers would require a careful process with trained facilitators. For example, groups spent an entire day reciprocating hosting roles for sharing meals and socializing. Community members gave providers a map and tour of their village since most providers lived outside the community they serve. Providers hosted community members by giving them a tour of health facilities. The Ministry of Health field team was trained in community mobilization, facilitation, interpersonal communication, and participatory techniques. The training provided the field team with skills to lead the trust-

building process. To promote sustainability, the project formed joint committees to oversee action plan implementation, held general meetings to keep the communication channels open between community members and providers, and planned for an equally participatory evaluation process.

Program Achievements

LEVEL: Increased Service Outputs

Evaluations directly linking the Puentes Project with population health outcomes have not been reported.

Service Outputs:

- The MOH reported that process improvements resulted in measurable increases in the use of family planning and child survival services and attendance at health education sessions.

Process Improvements:

- Less than one year after implementation of the action plan, improvements in local health care services were visible, including the provision of:
 - 24-hour coverage at the health post
 - Complete drug stocks
 - An emergency fund
 - A complaint system for clients and providers
 - Publicly posted price lists
 - Walkways, lighted areas, fences, and general remodeling of the physical structures
- Resulted in a change in attitude between providers and community members.
- Built a sense of teamwork and greater accountability.
- Community members and health staff found many areas of common interest.
- Demonstrated improvement in client-provider interactions .

Strength of Performance Assessment

SCORE: Average

- Assessment activities included the monitoring of joint action plans, community and provider assessments, and service utilization monitoring. Quantitative and qualitative data was collected from focus group discussions, monthly clinic data, videotaped client-provider interactions, in-depth interviews with providers and Puentes community participants.

Comments

The Puentes Project successfully engaged the local community in health service delivery. The program built mutual trust and accountability by bringing providers and community members together.

SPECIALTY CARE CASES

ABBOTT FUND TANZANIA: LAB MODERNIZATION PROJECT 2001-Present

IMPLEMENTING ENTITY:

Abbott Laboratories, Tanzanian Government

Location: Tanzania
AFRO/Low Income
Health Topic: Specialty services/
Laboratory, HIV

Key Words: Public-Private Partnership,
Lab Development, HMIS

PROGRAM OVERVIEW

Goal: To turn Muhimbili National Hospital into a national laboratory referral facility and a center of excellence for disease management and HIV/AIDS in Tanzania and the region.

Objectives:

- (1) Build/renovate labs to a standard design focused on increasing efficiency, safety, and simplified construction;
- (2) Train and mentor lab staff to ensure sustainable improvements;
- (3) Support lab technology students to increase supply of quality lab professionals; and
- (4) Provide essential accessory equipment; Introduce preventative maintenance strategies.

Funding: Abbott Laboratories [over \$70 million in total][Muhimbili National Hospital: \$60 million; Renovation cost/lab: \$400,000 – 500,000; RLMP: \$10 million; Health Management Information System: \$2 million]

Background of Lab Modernization Project:

- Addresses system weaknesses at the Muhimbili National Hospital, as the hospital is at the top of the Tanzanian health infrastructure and is the most advanced medical institution and university medical center in the country.
- Three-year commitment from Abbott Fund to modernize all 23 regional-level laboratories implemented through collaborative partnership with Ministry of Health and Social Welfare, the Centers for Disease Control Tanzania, Design for Others, TOUCH Foundation, and a local construction firm.
- Abbott is responsible for funding, project management, training, and equipment.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Decaying infrastructure and poor management skills at Muhimbili National Hospital contributed to poor treatment for patients.

Management Action: Abbot leveraged public-private partnerships to implement changes in lab support structures, health management information system (HMIS), and personnel.

Principal L&M Characteristics Identified

Leadership:

- Scanning
- Community Engagement
- Setting Direction

Management:

- Structuring
- Planning
- Management System

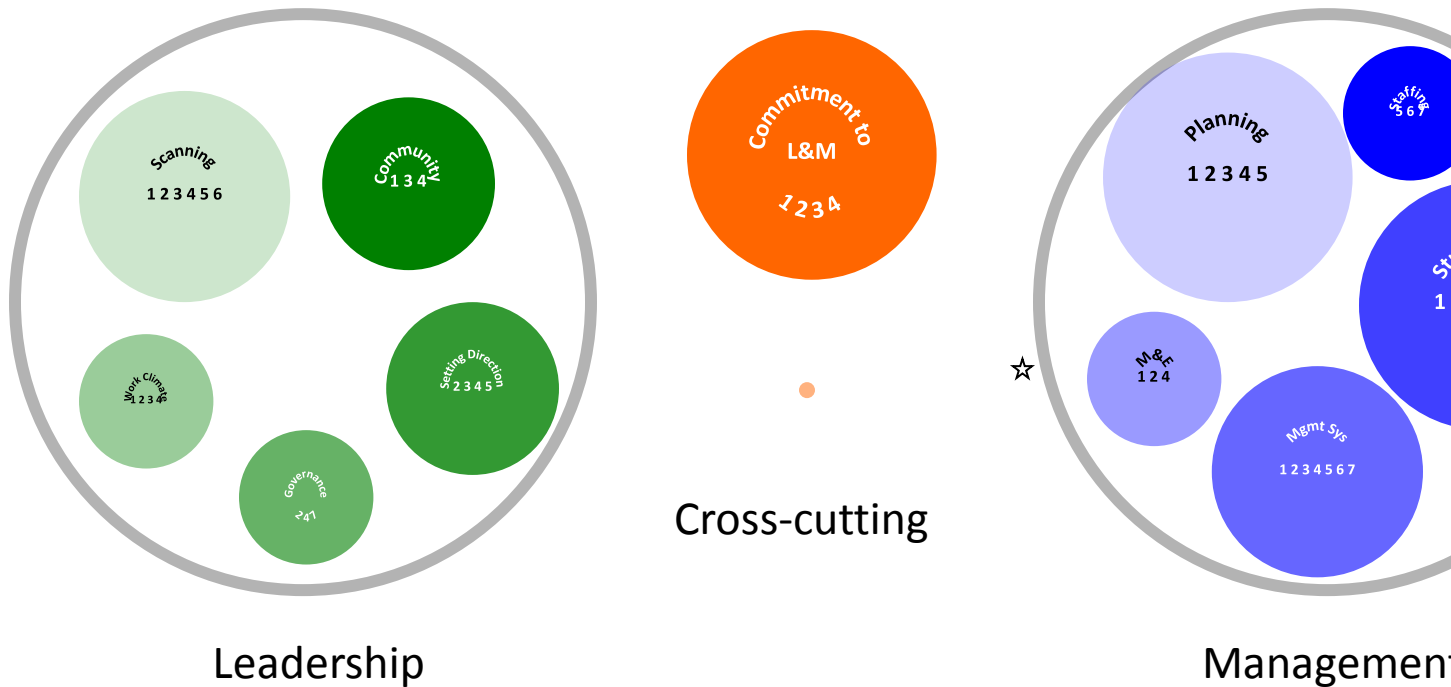
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- The program integrated services in the Outpatient Department, modernized the Central Pathology Lab and Emergency Medicine Department Center for Excellence at Muhimbili National Hospital, and established a HMIS. Improved both laboratory turnaround time and the quality of patient results.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that External Commitment to Leadership and Management was the most present L&M domain from a review of case study materials (100% presence). The dominance of this trait among cases is unique. Management domains also appear more notable than leadership domains. The domains of Structuring and Planning were considerably present at 92% and 80%, respectively. Of note, the white star in the Management System domain denotes that a health management information system was identified for this case study.

Management Action in Detail

Infrastructure Support

The first major intervention taken upon by Abbott was to rehabilitate the Central Pathology Lab. About 52,000 square feet of lab space was renovated, and Abbott donated the instruments, reagents, maintenance, and technical support personnel. The health ministry supplied lab equipment for the regional labs, and a service plan was put into place recently.

Health Management Information System

Abbott invested in a more sophisticated HMIS through electronic patient registration, electronic lab results, inventory management, health history tracking, referrals, lab results and prescriptions, human resources information, and financial management. The reagent ordering process has changed from a “push” system towards a “pull” system for reagent ordering.

Service Integration

HIV patients were integrated with others to minimize stigma, and private practice suites (to keep physicians on property at the Outpatient Department) and onsite pharmacy/health worker training facilities were set up.

Program Achievements

LEVEL: Increased Service Outputs

Evaluations directly linking The Lab Modernization Project with population health outcomes have not been reported.

Service Outputs:

- HIV testing has been provided for more than 300,000 people.
- A new outpatient center and state-of-the-art clinical labs are now serving hundreds of patients each day
- Trial project in Mt. Meru Hospital, Arusha
 - Number of tests rose from 15,000-134,000 per year
 - Number of clients using lab facilities increased from 5,000 to 38,000 per year (as of Oct. 2009)
- Testing and treatment have been expanded at more than 90 hospitals and health centers in country

Process Improvements:

- More than 15,000 health care workers have been trained or retrained in effective HIV care.
- Trial project in Mt. Meru Hospital, Arusha.
 - Turnaround time decreased from average of 3-14 days to less than 24 hours

Strength of Performance Assessment

SCORE: Average

- Pre- and post-intervention assessment tools developed to measure results.
- Weekly monitoring of number of patients served, number of test requests completed, instrument status, reagent inventory status, and turnaround time of results.

Comments

The Lab Modernization Project represents the strategic alignment of private industry with public health development. Abbott Industries public private partnership sustained quality through use of informed decision making. It is important to note that strong advocacy for a national lab service was initiated in the late 1990s and included active involvement in the health sector reform process that created an environment for the Lab Modernization Project to take place.

ARAVIND EYE HOSPITAL

1976-Present

IMPLEMENTING ENTITY:

Aravind Eye Hospital

Location: India

SEARO/Lower-Middle Income

Health Topic: Specialty Services/Vision

Key Words: Private Franchise, Scale, Efficiency, Replication, HMIS

PROGRAM OVERVIEW

Goal: To offer quality eye care at reasonable cost and eliminate needless blindness.

Objectives: Improve the quality of care and increase capacity to deliver eye care.

Funding: 10% of annual budget comes from outside sources; remaining 90% is self-generated

Background of Aravind Eye Hospital:

- Vision of a dedicated doctor who wanted to provide quality eye care.
- Based on highly efficient systems within McDonald's and other franchises in the U.S.
- Established hospital to provide the poor with free eye care.
- Today, Aravind Eye Care System consists of five hospitals with a combined total of 3,950 beds, three managed eye hospitals, a manufacturing center for ophthalmic products, an international research foundation, and an innovative training center.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: India lacked medical infrastructure to treat cataract cases and inefficiently used its existing resources.

Management Action: Establish a private, nonprofit eye hospital franchise with a clearly articulated vision for service and high quality eye care, delivered within a highly efficient system.

Principal L&M Characteristics Identified

Leadership:

- Scanning
- Setting Direction
- Community Engagement

Management:

- Planning
- Management System
- Structuring

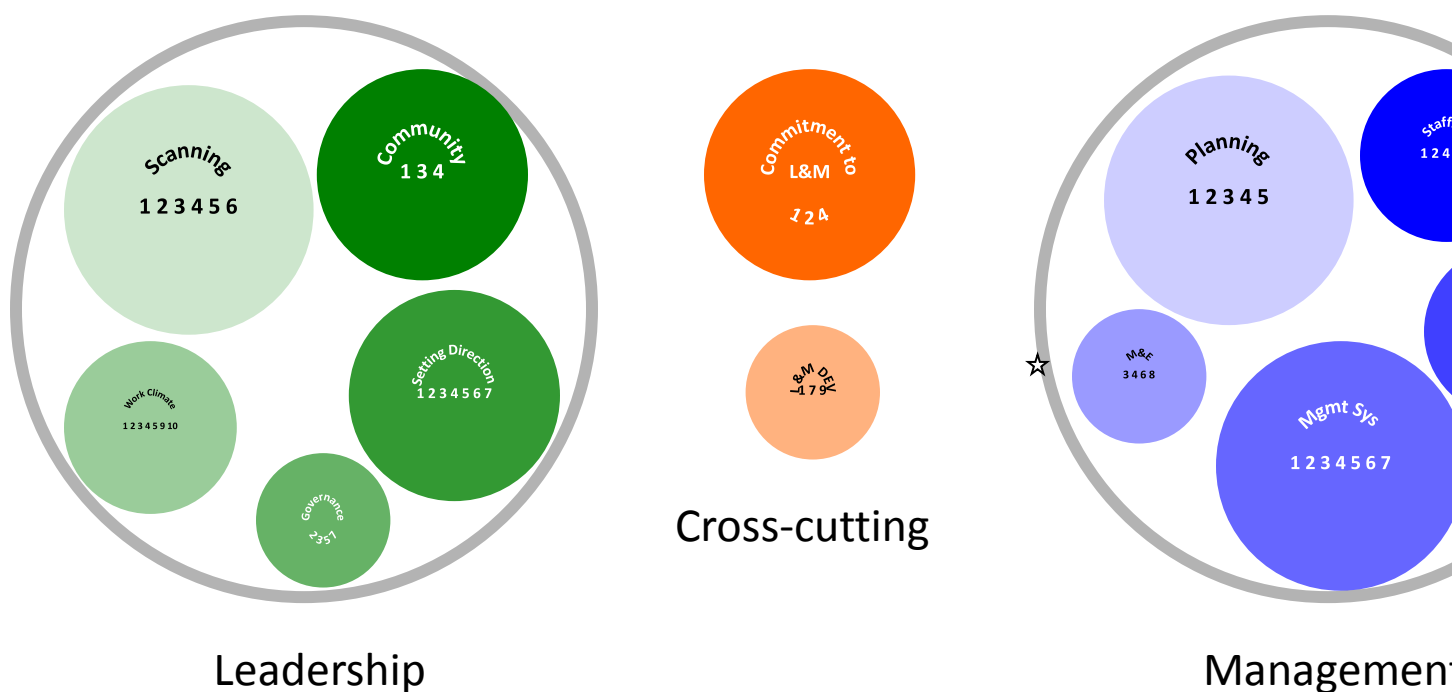
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- Increased number of outpatients served and surgeries performed, both free and paying.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



Planning was the most present domain (100% presence) from a review of case study materials. The figure depicts multiple large domain groupings. This suggests Aravind Eye Hospital documented a wide variety of leadership and management actions. For instance, the leadership domain of scanning and the management domain for management systems are within twenty percent presence of Planning (83% and 86%, respectively). In particular, the white star in the Management System domain denotes that a health management information system was identified for this case study.

Management Action in Detail

Efficient and Standardized Management

Aravind Eye Hospital implemented efficient models of care from the beginning, using a highly specialized workforce, and standardized management and clinical care processes. A “serial production” model was utilized in surgeries to increase efficiency. While one patient was operated on, the next was prepared for surgery on an adjacent table. An efficient patient registration system was established. It took only one minute to register each patient in the well-organized system.

Research and Development

In 1992, Aravind focused on operational efficiency by establishing Lions Aravind Institute of Community Ophthalmology (LAICO) to improve planning, efficiency, and effectiveness of all eye hospitals in India and beyond. This investment in research and development also allowed Aravind to benchmark its own progress and management its performance. Core activities of the established institute included training, consulting, research, and advocacy. Aravind reached out to the community by getting to patients, reducing costs and realizing economies of scale. Eye screening camps provided patient education and on-site surgeries to serve as many patients as possible. Technology development was a key component: to reduce their dependency on donations for intraocular lenses, Aravind built and operated its own manufacturing plant (now a global organization providing lenses for multiple countries).

Sustainable Approaches to Scale-up and Expansion

The “Aravind way”, which emphasized the goal of service (to humanity) and serving as many people as possible, was instilled through the organization’s mission and culture at all levels of training. Aravind’s mission was driven by the strategic leadership of the doctor and the organization continues to be a world leader in vision services. Aravind provided clinical and nonclinical training programs, including paramedical staff and a cost effective paramedical “sisters” program. Aravind exported its model through institutionalization. The core concepts of Aravind’s vision were: generating demand, quality, and sustainability. The Institute of Community Ophthalmology used multi-disciplinary teams to conduct a situation assessment, gap analysis, and strategic planning workshop. From these planning assessments, the teams helped a new facility derive an implementable business plan for its franchise. Aravind added programs for diagnostic and treatment services for Diabetic Retinopathy. Aravind provided technical support to Bangladesh and China for establishing community-oriented Diabetic Retinopathy services. Several management courses were offered by Aravind and included project management for eye care, hospital operations, management training and systems development, training for program managers, and others

Program Achievements

LEVEL: Increased Service Outputs

Evaluations directly linking Aravind with population health outcomes or have not been reported.

Service Outputs:

- Over 25 years to 2005
 - Increased outpatients 17-fold to 1.7 million.
 - Increased surgeries 30-fold to 246,007.
 - Increased free outpatients 11-fold to 792,000.
 - Increased free surgeries 27-fold to 153,000.

Process Improvements:

- Established Aurolab, Lions Aravind Institute of Community Ophthalmology, education and training programs, community outreach, eye bank, Aravind Tele-ophthalmology Network, specialty clinics, and management courses.
- 231 eye hospitals (188 in India and 43 elsewhere between 1997 and early 2008) worked with Aravind to adopt elements of their system.
- Institute of Community Ophthalmology capacity building process (2 year program): study of 65 hospitals found increased performance, improved resource use, and increased cost recovery.

Strength of Performance Assessment

SCORE: Average

- Annual reports: measure outreach performance based on number of camps for regular comprehensive eye care, diabetic retinopathy screening, refractive error, eye screening of school children, pediatric, vision centers, and community eye clinics

Comments

The Aravind Eye Hospital applied a franchise model to health service delivery that proved to be both cost-effective and efficient in improving vision services. The Aravind Eye Care System served as a model to “Project Impact” a hearing loss program in the United States and the “He Eye Care System” in China. In recent years, the Aravind Eye Care System received “The Gates Award for Global Health” and the “Conrad N. Hilton Humanitarian Prize.”

EMERGENCY DEPARTMENT IMPROVEMENT

2008-2010

IMPLEMENTING ENTITY:

Women's Hospital - Doha, Qatar

Location: Qatar

EMRO/High Income

Health Topic: Specialty Care/Emergency Care

Key Words: Quality Assurance, Value Chain, HMIS

PROGRAM OVERVIEW

Goal: Provide quality care and effectively manage the high volume of patients in the hospital, with a focus on high priority emergency cases.

Objective: Identify and implement process changes to improve the delivery of quality care in the emergency Department.

Funding: Hamad Medical Corporation (HMC) [Private health service organization]

Background of Emergency Department Improvement:

- The emergency department is in the only hospital for women and the primary obstetric and gynecologic hospital for all residents of Qatar. There are approximately 15,000 deliveries a year.
- To improve the emergency department, a multidisciplinary team met weekly.
- Used LEAN and SIX SIGMA quality management methods to develop plans and implement operational changes.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: The hospital's Emergency Department (ED) care delivery stream was unable to efficiently and effectively provide health services for the high volume of patients. The ED was characterized by long waits, over-crowding, long turnaround times, patient dissatisfaction and frustration among all healthcare providers where patients often left either in the midst of treatment or before being seen by a provider. There was no system to prioritize patients.

Management Action: Establish multidisciplinary teams to use SIX SIGMA and LEAN quality management methods and tools.

Principal L&M Characteristics Identified:

Leadership:

- Setting Direction
- Scanning
- Staff and Work Climate Development

Management:

- Planning
- Monitoring and Evaluation
- Structuring

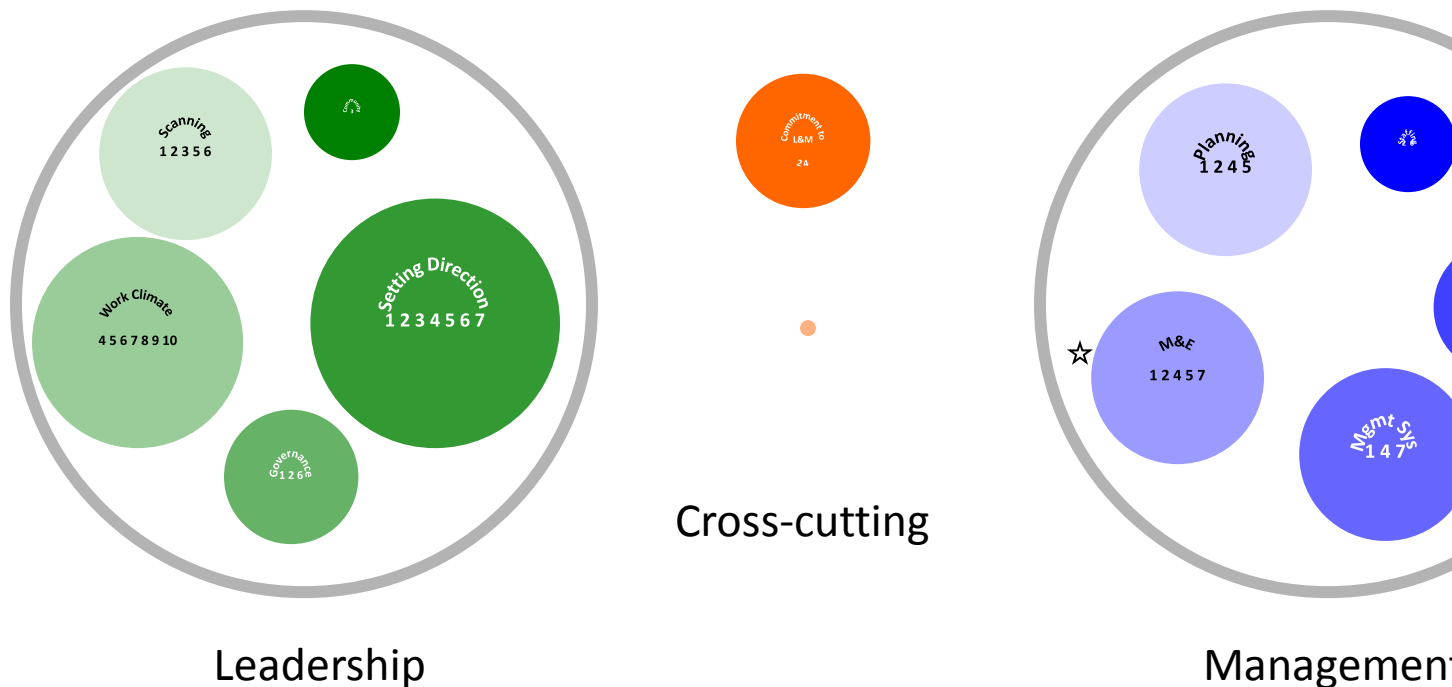
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- The initiatives developed and implemented through the quality improvement process resulted in improvements in: patient turnaround, percent of patients admitted and treated within two hours, percent of patients who left without being seen, number of lower priority patients referred to outpatient care, and the percent of high priority patients treated and discharged within two hours.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that Setting Direction was the most present L&M domain from a review of case study materials (86% present). The Leadership and Management Development domain was not detected in the review of case materials. The white star in the Management System domain denotes that a health management information system was identified for this case study.

Management Action in Detail

Value Chain Analysis

SIX SIGMA and LEAN are management models and theories with defined steps used to help an entity gain efficiency and create increased value. This case used these frameworks to review how patients were seen in the emergency department. From this, the team developed a new conceptual map to reflecting what the ideal process should be. A priority system was created when reflecting on what should be done and how this would increase efficiency and patient flow through the system. This process reduced the number of steps a patient had to take from 16 to 6 steps. A transition plan was created which outlined steps to be taken to move from the current process to the future state.

Focused Quality Improvement Initiatives

Improvement initiatives were proposed and then refined. Planners chose to focus on six core initiatives. Each initiative was addressed by a multidisciplinary task force. Each task force developed solutions for their task and worked in their teams to implement the plan. Stakeholder meetings were held to review the plans and collaborate for refinement of the plan and implementation. The larger group met weekly, all members of the team remained abreast of the actions being undertaken by others. The task forces collaborated with each other. All six initiatives were implemented. To measure progress, a 100-day improvement cycle was adopted as the timetable for change and indicators were selected to track effects.

Change Management

Gaining staff buy-in and having Physician Champions were critical to success. All the changes were new and innovative which at times created stress and resistance amongst various groups. Conflict resolution and consensus building approaches, including open dialogue and discussion, were used to dispel resistance.

Transformational Leadership

Mr. Nish Patel, Executive Director of Hamad Medical Corporation Women's Hospital and leader of the quality improvement process, has over 20 years of hospital administration experience. He held positions at Cleveland Clinic and Mayo Clinic, both of which have received accolades for management excellence. Patel's ability to apply this expertise in Qatar and prioritize investments towards administrative capacity was a critical factor in the program's success.

Program Achievements

LEVEL: Improved Processes

The program metrics are targeting towards measuring operations and process improvements. To date, no health outcomes or service outputs have been reported. However, it has been demonstrated in other facilities that long wait times for pregnant women is associated with increased death rates.

Process Improvements:

- Before implementation the total turnaround time average was 252 minutes, in the post-implementation, the average total turnaround time was 150 minutes. By July 2009, this was further reduced to 80 minutes
- Before implementation, only 27% of patients were seen and treated within 2 hours. After implementation 89% of the patients were seen and treated within 2 hours (as of November 2009)
- Within 100 days of implementation, the total number of patients reduced dramatically. More patients were referred to the outpatient clinic rather than using the emergency department for primary health care

Strength of Performance Assessment

SCORE: Average

- Ongoing progress monitoring as part of established quality improvement initiatives.

Comments

This case suggests that leadership and management tools and methodologies, such as Six Sigma and LEAN, that have proven successful in the US health industry can be transferred to development work.

UGANDA SUSTAINABLE CLUBFOOT CARE PROJECT

2004-2010

IMPLEMENTING ENTITY:

University of British Columbia, Ministry of Health (MOH),
Makerere University Medical School,
Makerere School of Public Health,
Christian Blind Mission (CBM) International

Location: Uganda
AFRO/Low Income
Health Topic: Specialty Care/Clubfoot

Key Words: Systems Approach,
Decentralization, Task-shifting

PROGRAM OVERVIEW

Goal: Make available a sustainable, universal, effective, and safe treatment of congenital clubfoot in Uganda.

Objectives:

- (1) Institutionalize the a non-surgical method throughout the Ugandan healthcare system;
- (2) Upgrade healthcare curricula of all Uganda's schools of higher education to include the treatment of clubfeet by a non-surgical method;
- (3) Raise awareness of the deformity with healthcare workers and the population; and
- (4) Train local healthcare personnel to provide a non-surgical clubfoot treatment.

Funding: Canadian International Development Agency

Background of Uganda Sustainable Clubfoot Care Project:

- Promoted Ponseti method, which is a non-surgical treatment for clubfoot.
- Established weekly clubfoot clinics.
- The clubfoot project provided in-service training for nurses, midwives, and community health workers on screening and referral procedures.
- Trained practicing orthopedic officers, medical officers, and surgeons to administer a non-surgical treatment for clubfoot and integrated the method into pre-service curricula.
- Raised awareness at healthcare centers, churches, schools, and via the radio.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Previous research concluded that the Ponseti method could substantially reduce the disability burden caused by clubfeet in Uganda. Despite its efficacy, the intervention was not reaching its target population.

Management Action: Decentralize clubfoot care to permit easier access, addressing each step in value chain. The value chain is a business approach that takes into consideration all parties necessary to provide a service to a patient. Each member of the value chain provides a distinct service or value which combined fulfills the health needs of the patient.

Principal L&M Characteristics Identified:

Leadership:

- Scanning
- Community Engagement
- Setting Direction

Management:

- Planning
- Structuring
- Monitoring and Evaluation

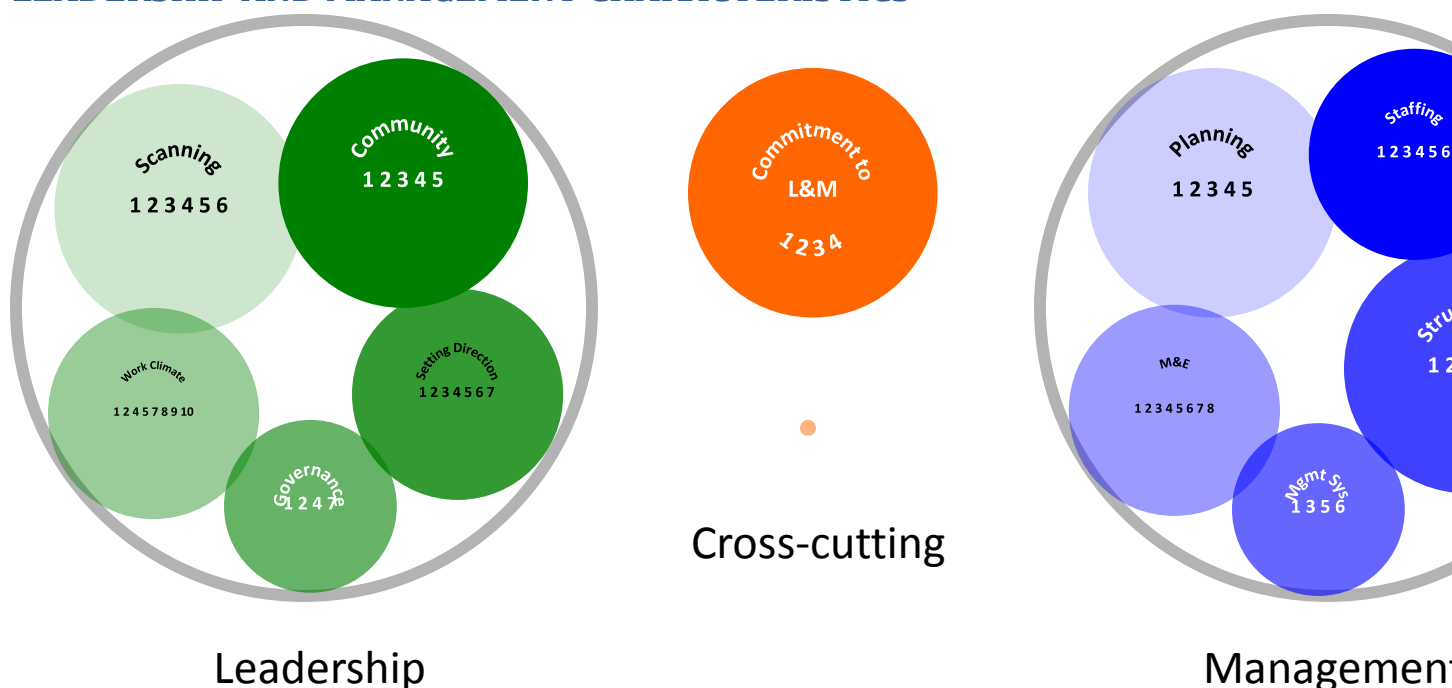
Cross-cutting:

- External commitment to Leadership and Management

Results Achieved:

- As of 2008, the clubfoot project increased coverage and access to clubfoot care.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



A review of case study materials identified Planning as the most present domain at 90%. Among leadership domains Scanning, Community Engagement and Setting Direction were all within twenty percentage points from the top characteristics. For management, Structuring and Monitoring and Evaluation were notable. Also, the cross-cutting domain of Commitment to Leadership and Management was unusually strong with an 88% presence score. This case appears to have documented a wide variety of leadership and management actions. The Leadership and Management Development domain was not detected in the review of case materials.

Management Action in Detail

Strategic Alignment and Coalition Building

Uganda Sustainable Clubfoot Care Project aligned its approach with the national health plan and strategy. This alignment prepared a foundation for sustainability and eventually full Ugandan ownership of project activities. The project conducted surveys to tailor project activities to local context and cultural understandings of foot deformity. It assisted MOH to sensitize district and sub district health administrators to change practice patterns regarding clubfoot treatment. Sensitizing health administrators was important as, when better informed, administrators could allocate resources appropriately. Uganda Sustainable Clubfoot Care Project used weekly clinics as a resource to provide communities of practice and forums for information exchange among both providers and patients.

Marketing to Stimulate Demand

The program's strategy coupled clinics with a communication campaign to stimulate local demand and discourage delayed seeking of care. Multiple media outlets reinforced messages and reached the target market.

Decentralized Service Delivery

Uganda Sustainable Clubfoot Care Project chose to train many provider levels to screen for foot deformities, not just facility-based specialists. This allowed for task-shifting and decentralization to increase detection efficiency. Screening and referral occurred at the first point of care (i.e., the community in Uganda). Hands-on training is given in foot screening to all providers. Clinical officers were trained in diagnosis and treatment application. Medical officers and surgeons were trained on the most advanced procedures in the treatment. The project

trained technicians to make the necessary foot abduction braces. This allowed Uganda to locally produce sufficient supplies for the national need.

Supervision and Performance Evaluation

Uganda Sustainable Clubfoot Care Project coordinated quality of care, availability of casting supplies and braces, and other logistics through regular onsite visits. Regular onsite visits served as a quality assurance mechanism. As the project matured, responsibility for quality supervision was incrementally passed to MOH. The evaluation component was critical for the project's performance management.

Program Achievements

LEVEL: Increased Service Outputs

Evaluations directly linking the clubfoot project with population health outcomes have not been reported.

Service Outputs:

- From 2006-2007, the clubfoot project provided care to 872 children with clubfeet, representing approximately 31% of the expected number of children born in Uganda with clubfeet during the same period.

Process Improvements:

- MOH approved Ponseti as the preferred treatment for congenital clubfoot in all its hospitals.
- 634 nurses and midwives were trained to screen for foot deformities.
- 39 surgeons and medical officers and 100 orthopedic officers were trained in the non-surgical method.
- 25 orthopedic technicians were trained in the making of foot abduction braces.
- 5 medical institutions approved and incorporated the clubfoot project training modules into their curricula.
- 1152 medical students benefitted from upgraded training.

Strength of Performance Assessment

SCORE: High

- 2006-2007, baseline survey of Incidence of Clubfoot in Uganda
- Ethnographic Knowledge, Attitudes and Practices survey: Cross-sectional descriptive study using qualitative methods including focus group discussions, interviews, and participant observation.
- Barriers to Adherence to Ponseti Clubfoot Treatment Protocols in Uganda: case-control study using qualitative methods including questionnaires and interviews.

Comments

Uganda Sustainable Clubfoot Care Project successfully expanded access to clubfoot care in Uganda. The program strategy accounted for each step of the value chain, from sourcing the foot braces necessary for treatment to coordinating screening, referral, and treatment, and providing critical support inputs throughout. This case managed for sustainability by aligning activities with the national health strategy and engaging key stakeholders from the start.

VACCINE VIAL MONITORS (VVM)

1985-1996 (Development); 1996-Present (Commercially Available)

IMPLEMENTING ENTITY:

PATH; TEMPTIME Corporation

Location: Global

Health Topic: Specialty Services/
Vaccine Technology

Key Words: Quality Assurance, Effective
Policy Change, Supply Chain
Management

PROGRAM OVERVIEW

Goal: To reduce wastage of vaccines while ensuring that only good vaccines are administered to beneficiaries.

Objective: Detect and indicate over-exposure of vaccines to heat.

Funding: Research and development was largely provided by USAID through the HealthTech program [each sticker added \$0.01 to cost of vial]

Background of Vaccine Vial Monitors (VVM):

- Small, circular indicator sticker printed directly on vial labels or adhered to the tops of vials.
- The sticker changed color irreversibly from light to dark with exposure to heat over time.
- Indicated how quickly the vaccine should be used or if the vaccine is no longer usable.
- Manufactured for a variety of heat-exposure specifications tailored to each specific vaccines.
- All Expanded Program on Immunization vaccines and all vaccines purchased through UNICEF and GAVI must be labeled with Vaccine Vial Monitors.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Many vaccines lose efficacy when exposed to heat or cold. Maintaining the “cold chain” is the major supply logistic challenge of vaccine programs. The inability to detect heat exposure of vaccine vials en route leads to questionable quality with either administration of ineffective vaccines (that then won’t prevent disease) or “wastage” and throwing away of potentially useful vaccine. Vaccine wastage is a major potentially avoidable cost in vaccine programs.

Management Action: Find a cost-effective technology to detect heat exposure and adapt it for vaccines. Build coalition support to gain global buy-in.

Principal L&M Characteristics Identified:

Leadership:

- Setting Direction
- Scanning
- Community Engagement

Management:

- Structuring
- Planning
- Monitoring and Evaluation

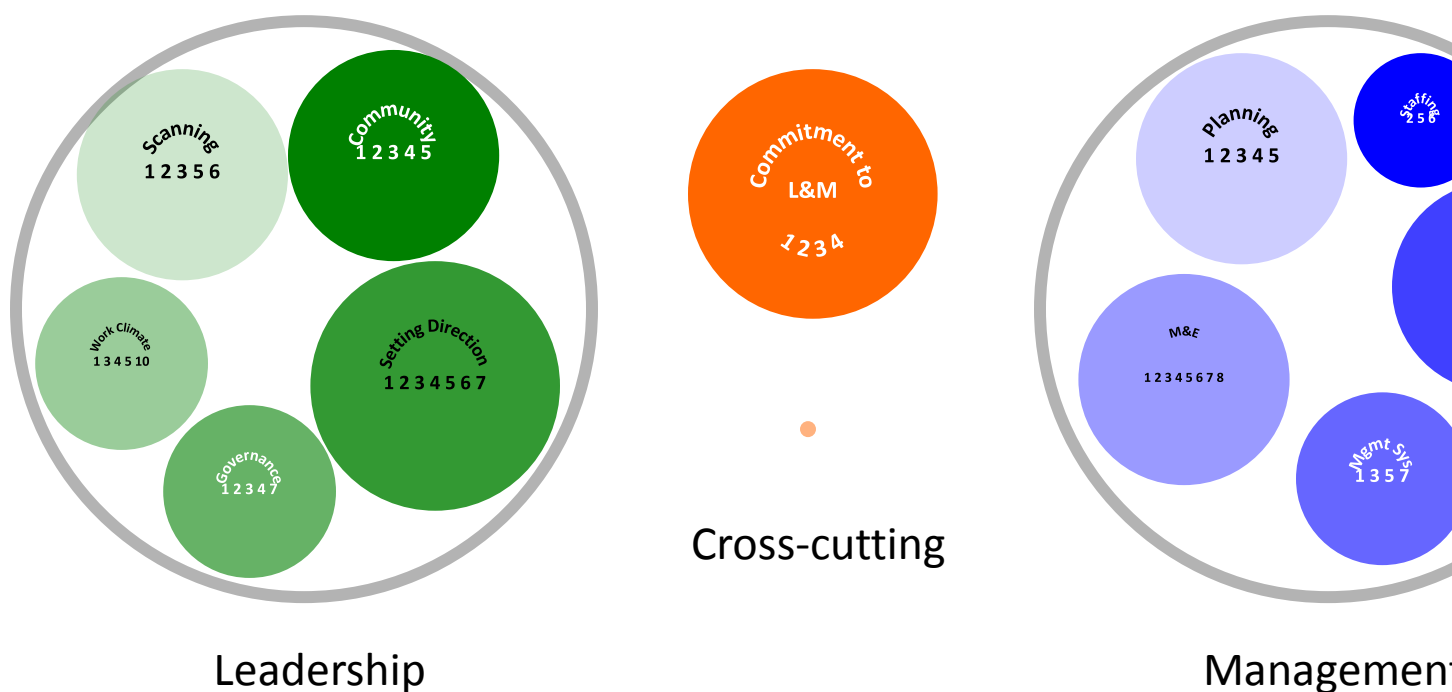
Cross-cutting:

- External Commitment to Leadership and Management

Results Achieved:

- Vaccine Vial Monitors increased operational effectiveness by allowing immunization programs to exploit the stability of each vaccine to the greatest possible extent, minimize distribution costs, and increase flexibility in managing vaccine supply in the field.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above demonstrates that External Commitment to Leadership and Management was the most present L&M domain (100% presence) from a review of case study materials. It also appears that Setting Direction was especially prominent (86% presence). The Leadership and Management Development domain was not detected in the review of case materials.

Management Action in Detail

Innovative Partnership

PATH, an NGO, tailored technology originally used by the food industry to save perishable products for use in Vaccine Vial Monitors. Recognizing a strategic opportunity, PATH established a partnership with TEMPTIME, the owners of technology. TEMPTIME worked with vaccine specialists to adapt the heat detecting stickers for use in vaccine delivery.

Coalition Building to Counter Resistance

The adoption of Vaccine Vial Monitors in global immunization campaigns was made possible through continued collaboration, leadership, and championing by PATH and the World Health Organization (WHO). PATH and WHO amassed the support of other influential donor agencies. The group collectively maintained a prolonged and consistent commitment to overcoming various hurdles (e.g., resistance from vaccine manufacturers and added cost of vital monitors) throughout the process towards large-scale uptake of Vaccine Vial Monitors.

Building User Capacity

In order to maximize the effectiveness of Vaccine Vial Monitors as an evidence-based decision making tool, it was critical to train users. WHO provided training to countries using labeled vaccines. A manual was developed to instruct health workers in interpreting Vaccine Vial Monitors colors. Guides were also developed to use the Vaccine Vial Monitors as management tools for more effective operations.

Program Achievements

LEVEL: Increased Service Outputs

Evaluations directly linking Vaccine Vial Monitors with population health outcomes have not been reported. Although, increased vaccination rates will likely lead to changes in child mortality.

Service Outputs:

- In Papua New Guinea, Vaccine Vial Monitor-labeled vaccines increased doses at birth of Hepatitis B vaccine from approximately 27% to 80%, and as high as 100% in some communities.
- More than 3 billion Vaccine Vial Monitors were used on vaccines for immunization campaigns sponsored by the WHO and GAVI, and the governments of India, Indonesia, and Pakistan.

Process Improvements:

- During the May 2006 earthquake in Yogyakarta, Indonesia, electricity went out for several days. Vaccine Vial Monitors showed most vaccines were undamaged, despite the heat, and still usable—saving 50,000 doses that otherwise would have been thrown away.
- Hepatitis B vaccine is heat stable as long as it remains no warmer than room temperature. Results from a joint study by PATH and National Expanded Program on Immunization in Vietnam where 3,000 neonates were provided with traditional cold chain vaccines and 7,000 were provided with out-of-cold-chain (non-refrigerated) but labeled vaccines.
- Before the project, only 45% of neonates received Hepatitis B vaccine within 72 hours of birth; after the study 83% received a dose within 24 hours, and 89% received it within 72 hours.
- Follow-up blood tests found the proportion of infants with protective levels of antibodies was comparable between both groups: 85.6% for cold chain and 91.7% for out-of-cold-chain with Vaccine Vial Monitors.
- In a joint study by the WHO and PATH, Vaccine Vial Monitors:
 - Identified more than 23 million doses of vaccine that were damaged by heat and therefore were not administered to patients.
 - Identified more than 31 million doses of vaccine that were exposed to potentially damaging heat, but were still effective for use – avoiding waste of those vaccines.
- In December 2010, labeling was used in the 1st nationwide MenAfriVac™ vaccination campaigns in Burkina Faso, Mali, and Niger to protect from meningococcal A meningitis, the most destructive strain in Africa's meningitis belt.

Strength of Performance Assessment

SCORE: High

- Various stand-alone assessments and quality control monitoring.
- 2009, Retrospective evaluation: interviews, site visits, rapid assessments, and focus group discussions.

Comments

The Vaccine Vial Monitor case exemplifies the importance of coalition building and sustained commitment to successfully change global policy. PATH and partners demonstrated creativity and adaptability when finding a proven technology from another industry and re-engineering it to address a common global health challenge. PATH estimates that from 2006 to 2016, "Vaccine Vial Monitors will allow health workers to recognize and replace more than 230 million doses of inactive vaccine and to deliver 1.4 billion more doses in remote settings—actions that could save more than 140,000 lives and reduce morbidity for countless others." UNICEF and WHO have estimated that the use of VVMs could save the global health community \$5 million per year. If applied to beyond basic vaccines, cost savings would be expected to be much greater.

VISIONSPRING'S BUSINESS IN A BAG

2001-Present

IMPLEMENTING ENTITY:

VisionSpring India

Location: India

SEARO/Lower-Middle Income

Health Topic: Specialty Services/Vision Services

Key Words: Franchise Network, Total Market Approach, Value Chain

PROGRAM OVERVIEW

Goal: Reduce poverty and generate economic opportunity through the sale of affordable reading glasses.

Objective: Focus on three points of leverage to enact a market shift and make reading glasses available to all who need them: access, awareness, and affordability.

Funding: The Open Society Institute provided seed capital to launch the pilot

Background of VisionSpring:

- Began as a micro-franchise approach to expanding access to affordable reading glasses through a network of direct salespersons referred to as Vision Entrepreneurs.
- Each entrepreneur started his/her own business as a franchisee, providing entrepreneurial opportunity without the barriers of high set up and operating costs.
- The target market consisted of 80% of India's population who live on less than \$2/day.
- The success and lessons of the pilot-led to program expansion where VisionSpring needed to reach a larger market to increase profitability and financial sustainability.
- Added two more service lines to the business model: Wholesale Channel and Franchise Partner Channel.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: Facilitate program scale-up while maintaining financial viability.

Management Action: Diversify product distribution channels to increase market access.

Principal L&M Characteristics Identified:

Leadership:

- Setting Direction
- Community Engagement
- Scanning

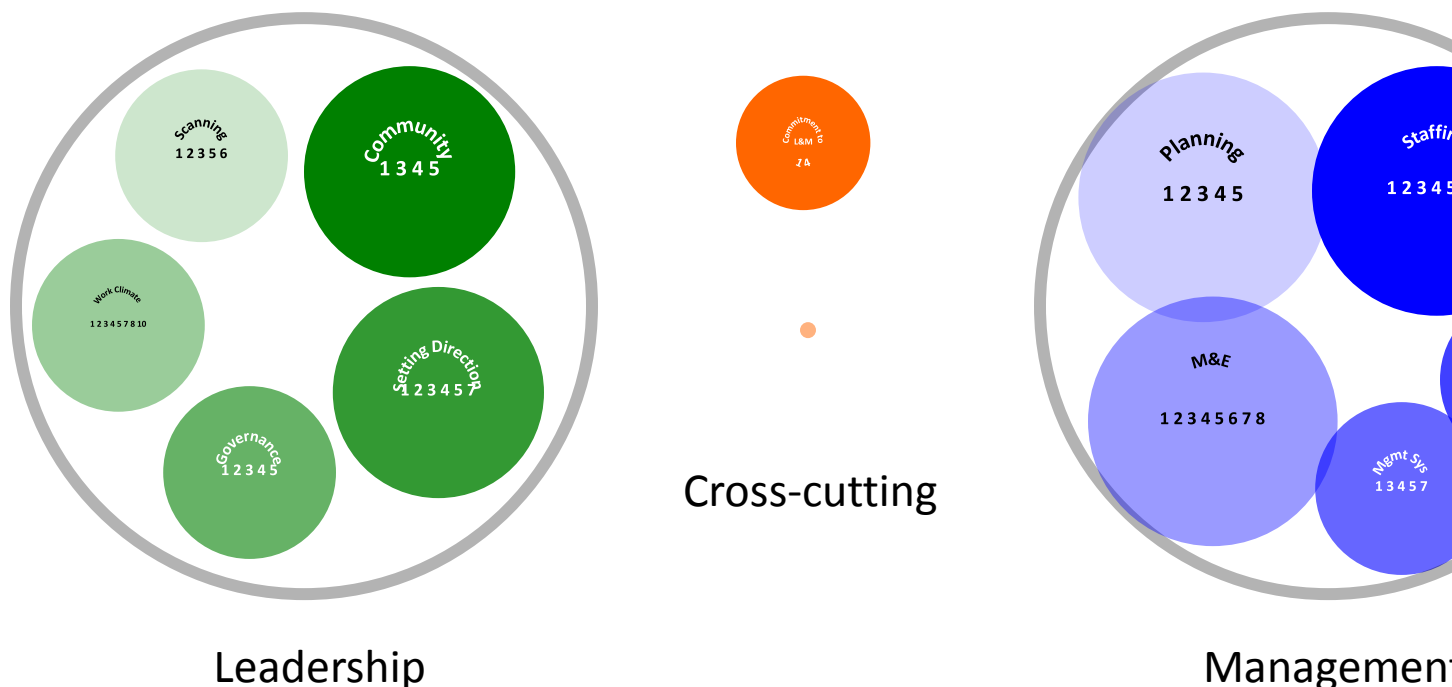
Management:

- Staffing
- Monitoring and Evaluation
- Planning

Results Achieved:

- Sold more than 50,000 pairs of glasses, trained 457 Vision Entrepreneurs, and established 20 strategic partnerships.

LEADERSHIP AND MANAGEMENT CHARACTERISTICS



The figure above shows Staffing as the highest measured presence of a domain at 86%, but the majority of notable domains were in the management category. A review of case study materials suggested that management domains were more prominent than leadership ones. The Leadership and Management Development domain was not detected in the review of case materials.

Management Action in Detail

Total-Market Approach

VisionSpring originally focused on direct sales, but it facilitated scale-up through a total-market approach. This approach identified ways to target more consumers in a greater range of locations and income levels—an estimated 250 million people. The program increased its marketability by creating two new markets. The first was the franchise partner channel that allowed entrepreneurs to open their own store. The second market was the wholesale channel that allowed the program to sell its product in bulk to distributors with established sales points. This expansion took all steps of the service delivery value chain into consideration. The approach incentivized the producer and distributors to improve product design and quality continuously. The business model was designed to be financially self-sustainable. Volume targets were set to ensure gross profits will cover overhead expenses. High volume coupled with production and distribution partners allowed larger margins compared to most retail products. The direct sales channel continued operating and began to serve as a “learning laboratory” for innovations.

Leveraging Strategic Partnerships

In the Franchise Partner Channel VisionSpring partnered with local organizations to leverage existing distribution networks of entrepreneurs (e.g., community health workers, computer kiosks owners, etc.). This reduced the burden of building new, costly infrastructure, and shortened the time it took to launch in a new location. VisionSpring provided training and the partner organization was responsible for the oversight of the new entrepreneurs and supply chain management. VisionSpring shared its sales and marketing expertise to build capacity in partner organizations. In the Wholesale Channel, VisionSpring partnered with local retail organizations to distribute low-cost glasses to underserved communities in urban and peri-urban areas.

Mechanisms for Cost-Sharing and Stimulating Demand

A variety of glasses and frames were made available which allowed for tiered pricing. Higher priced glasses were sold in wealthier urban markets with a portion of the profits used to subsidize glasses for the poor. This fueled demand by strengthening VisionSpring brand's association with quality, affordability, and social responsibility. VisionSpring informed its efforts with market research, collecting customer data, and the use of a web-based sales database to manage inventory, supply chain, and forecast future needs.

Program Achievements

LEVEL: Increased Service Outputs

Evaluations directly linking VisionSpring with population health outcomes or have not been reported.

Service Outputs:

- By June of 2007, VisionSpring had sold more than 50,000 pairs of glasses (2005-2007), and was targeting cumulative sales of 1 million pairs by 2010 and 10 million by 2016.

Process Improvements:

- On average, entrepreneurs earn more than twice their previous daily income on each pair of glasses sold.
- As of June 2007, the India program had trained 457 entrepreneurs through its proprietary network and 20 franchise partners.

Strength of Performance Assessment

SCORE: Low

- VisionSpring works with the William Davidson Institute at the University of Michigan to study the impact of its work on the lives of its customers and entrepreneurs.
- VisionSpring also collaborates with leading universities to measure its impact and document best practices, including Harvard University's Business School and School of Public Health.

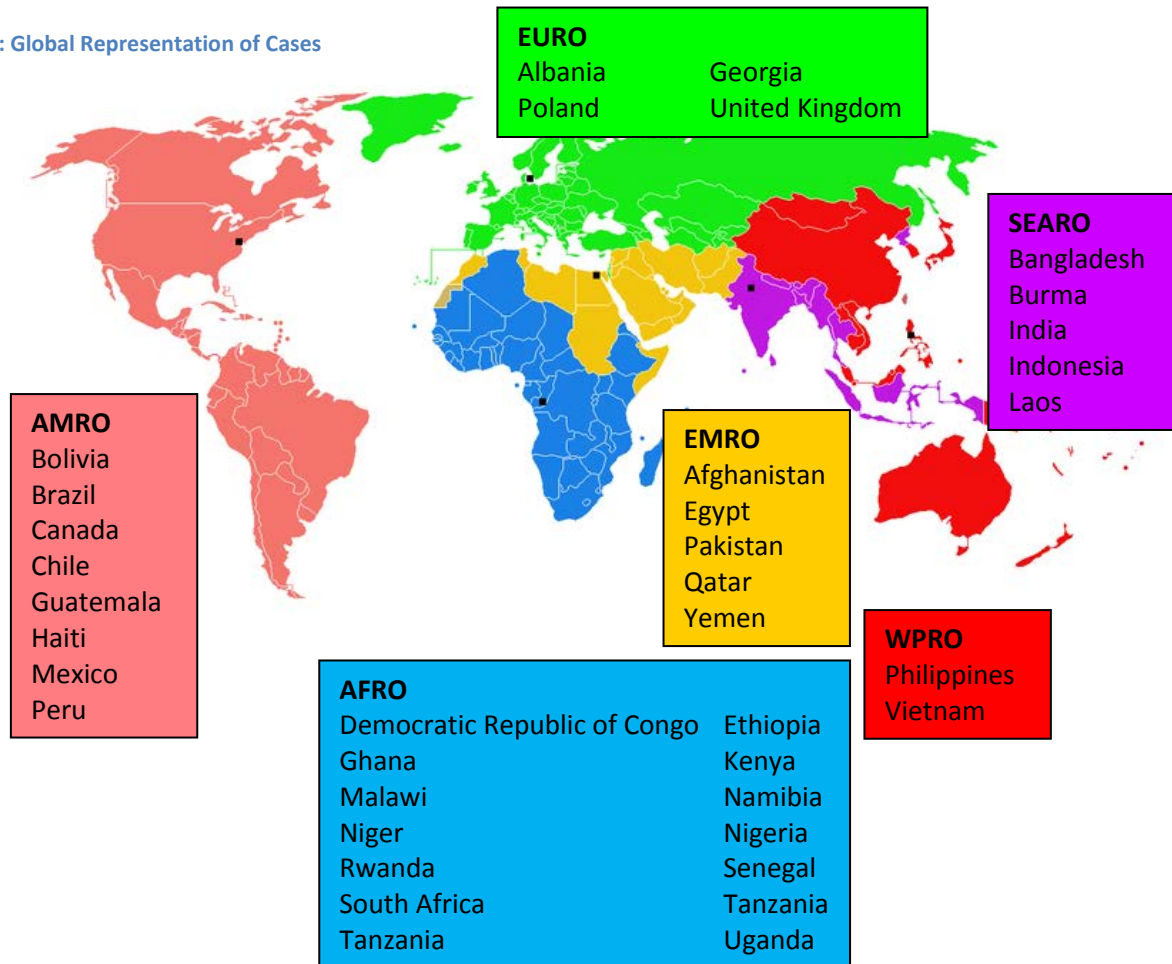
Comments

VisionSpring's case exemplifies adaption of social capitalism for health service delivery. By using a total market approach, VisionSpring expand services while creating jobs. Its rapid growth was possible since its product line was not limited by region-specific factors as everyone needs vision care. A multi-year winner of Fast Company's Social Capitalist Award, VisionSpring has been recognized for its innovative approach by The Economist, The International Herald Tribune, Foreign Affairs, and NBC Nightly News with Brian Williams.

Chapter Five: Findings

This section summarizes the findings when reviewing the whole set of case studies: similarities, differences and comparison between different groups of case studies. Cases represented 38 countries from six World Health Organization Regions. The geographic distribution is purposeful to ensure selection of programs from varying parts of the world but also represents where the bulk of global health programming is done.

Figure 6: Global Representation of Cases



Case Study Achievements

Below Table 2 shows the averaged % changes among case studies where comparable data was available. Specific achievements were extracted from the cases studies along the three different categories delineated from the template (Process, Service and Health). Achievements were analyzed for textual similarity and systematic classification of the outputs text converged into the following nineteen categories.

For example: For the cases that reported a change in waiting time, on average there was a 483% reduction in waiting time. This does not mean leadership or management was attributable to that change alone but it suggests some portion of causality.

Table 2: Estimated % Improvements of Case Study Achievements

Processes	
Brand recognition	81%
Cost Savings/recovery	68%
Decreased wait time	483%
Financial sustainability	203%
Improved Performance against standards	46%
Provider competency	65%
Quality Control	115%
Services	
Increase in services provided (available)	571%
Increased access	502%
Increased utilization of services	124%
Health Effects	
Reduction in Infant Mortality (includes Perinatal and Neonatal)	61%
Reduction in Maternal Mortality	63%
Improved Case Management	85%
Increased Immunization	97%
Increased Births with SBA	175%

Leadership and Management Findings across the Case Studies

In the individual case studies, the scores for each of the L&M characteristics were summed with the L&M domain and then represented visually by the proportional size of the bubble diagram. To similarly examine which L&M characteristics were most reported, the individual case study totals were summed across all cases for each characteristic. (See [Data Analysis](#) in [Appendix I: Detailed Methodology](#)) In the following five tables and figures the first four tables and Figure 2 represent data from all 57 cases. The next table and the subsequent three figures represent data from various groupings of cases arranged by level of program achievement or type of health topic.

Table 3 shows the number of L&M characteristics found in individual cases. Among all 57 cases, the Leadership Management Sustainability Program CIES had the highest number of leadership and management characteristics present (72 of a possible 81). Over all of the cases, the range of characteristics present ranged from 37 to 72. The average number of characteristics present in a case was 54. All of the top seven cases, had high performance strength. The evaluation strength could be expected in a program that has strong L&M characteristics. Most also had program achievements at the health outcome level. We had expected that more complex programs, that dealt with many factors and therefore needed a variety of L&M actions would be the programs rating higher in total number of characteristics. Three of the seven chronic disease cases and two out of eight of the health systems oriented cases were in our top seven list. This is suggestive but not conclusive of our expectations since several complex national level programs were not in this short list. The onchocerciasis program, while a narrower disease control program had very broad spectrum of partners and multiple avenues of approach and represents a very long term, multi country program and may therefore still fit our hypothesis that more complex programs require more L&M to be successful.

Table 3: Cases with the Highest Count of Characteristics (n=57 cases)

Case Study	Health Topic	Overall Score for Program Achievements	Strength of Performance Assessment	Count of 81 Characteristics
LEADERSHIP, MANAGEMENT & SUSTAINABILITY PROGRAM CIES	Health Leadership & Management Strengthening	Health Outcome	High	72
ONCHOCERCIASIS CONTROL PROGRAM	Infectious Disease	Health Outcome	High	68
HAITI MYAP FOR FOOD SECURITY	Nutrition	Health Outcome	High	68
MEND (MIND, EXERCISE, NUTRITION...DO IT!)	Chronic Disease	Health Outcome	High	67
EQUITY PROJECT	HSS	Health Outcome	High	67
COMMUNITY-BASED MENTORSHIP	Chronic Disease	Increased Service Outputs	High	65
VERACRUZ INITIATIVE FOR DIABETES AWARENESS (VIDA) PROJECT	Chronic Disease	Health Outcome	High	65

The alternate way of looking at the data is to look across all cases to see which characteristics were most and least present. The summed characteristics ranged from a low of four to a high of 103, out of a possible high score of 114 (57 cases * a max score of 2 per characteristic = 114) Table 4 shows that among the 57 cases, the characteristic “*determine key priorities for action*” in the Leadership: *Setting Direction* domain was the top most present characteristic. The other two most present characteristics were: Leadership - Scanning - *Identify stakeholders and their needs and priorities* and Management - Management Systems – *Information*. Table 5 shows the least commonly reported or present characteristics were all in the Leadership and Management Development domain: Action learning, Valuing skills learned and Reflection time. The work team addressing self identified problem was the very lowest, reported only four times. For all of these least reported characteristics, it may be that the definition encompassed too small an area of L&M practice or that they were important and/ or used but not reported.

Table 4: The 3 Most Present Characteristics among All Cases (n=57 cases)

Characteristic Name	Sum
Setting Direction - Determine key priorities for action	103
Scanning - Identify stakeholders their needs and priorities	101
Management Systems - Information	99

Table 5: The 3 Least Present Characteristics among All Cases (n=57 cases)

Characteristic Name	Sum
Leadership and Management Development - Training included reflection time	9
Leadership and Management Development - Skills learned were valued	7
Leadership and Management Development - Action learning using self-identified program problems	4

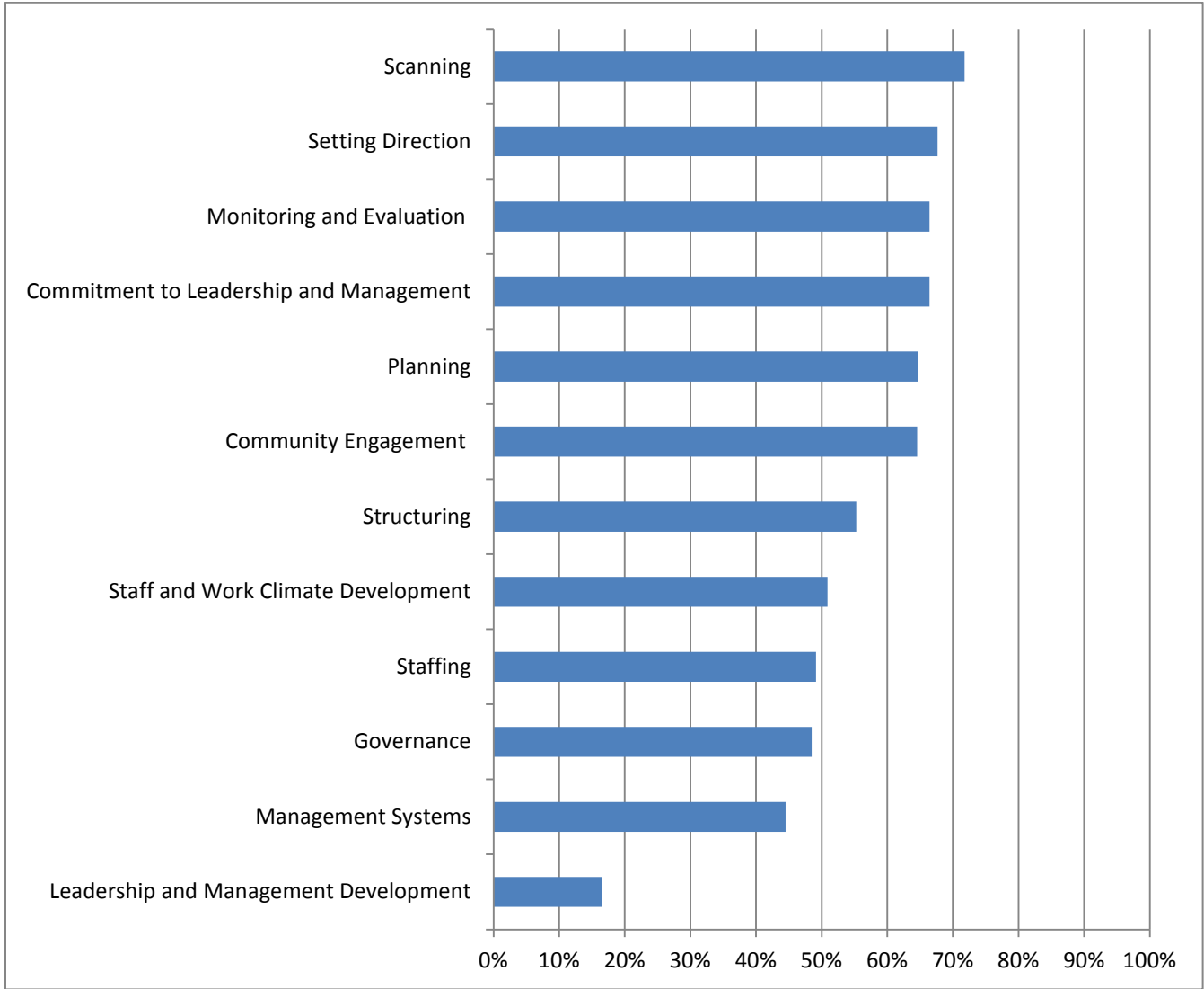
A similar analysis was done for the L&M domains; the five Leadership, five Management, and two Cross-cutting areas. Findings in Table 6 are presented in rank order according to percent of maximum possible presence. Results show that among all 57 cases, the Scanning domain was the most frequently present and Leadership and development significantly less frequently noted than all the others. Scores ranged from 16% to 72% with an average of 56%. Since the scoring differentiated between explicitly present with 2 points versus implicitly present with 1 point, some characteristics and domains were present more than half time but perhaps only implicitly reported.

Table 6: Ranked Presence of Twelve L&M Domains among All Cases (n=57 cases)

Characteristic Name	% of Maximum Possible Presence
Scanning	72%
Setting Direction	68%
Monitoring and Evaluation	66%
Commitment to Leadership and Management	66%
Planning	65%
Community Engagement	65%
Structuring	55%
Staff and Work Climate Development	51%
Staffing	49%
Governance	48%
Management Systems	44%
Leadership and Management Development	16%

The same data is represented visually in the bar graph on the next page.

Figure 7: Ranked Presence of Twelve L&M Domains among All Cases (n=57 cases)



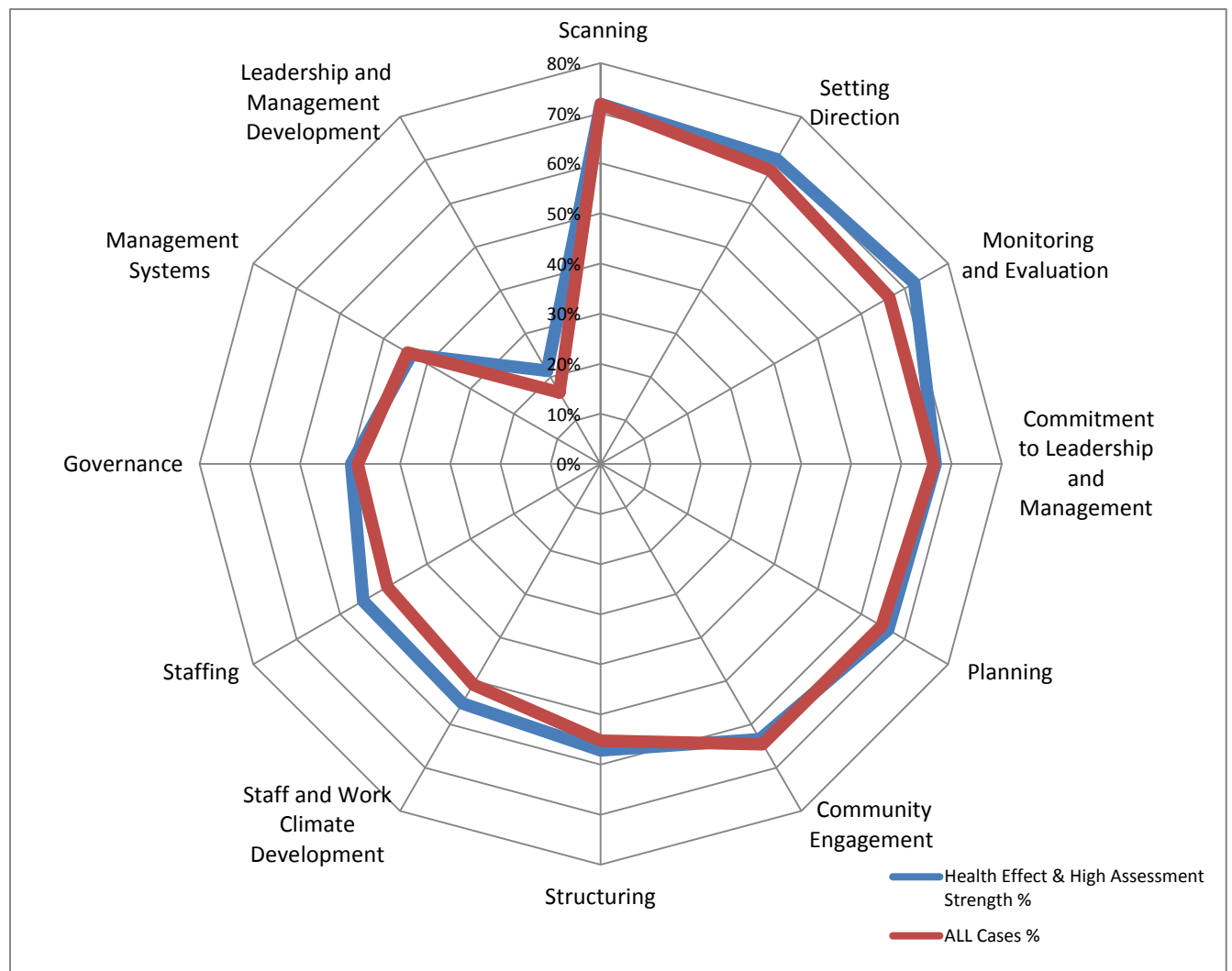
It was then possible to explore whether programs with different levels of health achievement and performance assessment had differing types or amounts of the L&M characteristics. The above findings were stratified along different levels of program achievement. Cases with documented health effects and which had a high strength of program assessment were classified as high performers. The ranking of major characteristic presence for these 29 “high performing” cases is presented in Table 7, showing the Monitoring and Evaluation domain was relatively more frequently present when compared to all cases. With this smaller number of cases, the presence scores ranged from 21% to 72%, with an average of 58%.

Table 7: Ranked Presence of Twelve L&M Domains among High Performers (n=28 cases)

Characteristic Name	% of Maximum Possible Presence
Monitoring and Evaluation	86.2%
Scanning	85.6%
Setting Direction	84.7%
Planning	82.1%
External Commitment to Leadership and Management	81.9%
Community Engagement	75.2%
Structuring	73.6%
Governance	73.4%
Staff and Work Climate Development	71.7%
Staffing	67.5%
Management Systems	54.2%
Leadership and Management Development	25.7%

In Figure 8, high performing cases were compared to all cases in a comparative array of the twelve L&M domains. The domains are ordered clockwise starting at 12:00 from most present to least present. High performers have more presence in all characteristics except Community Engagement.

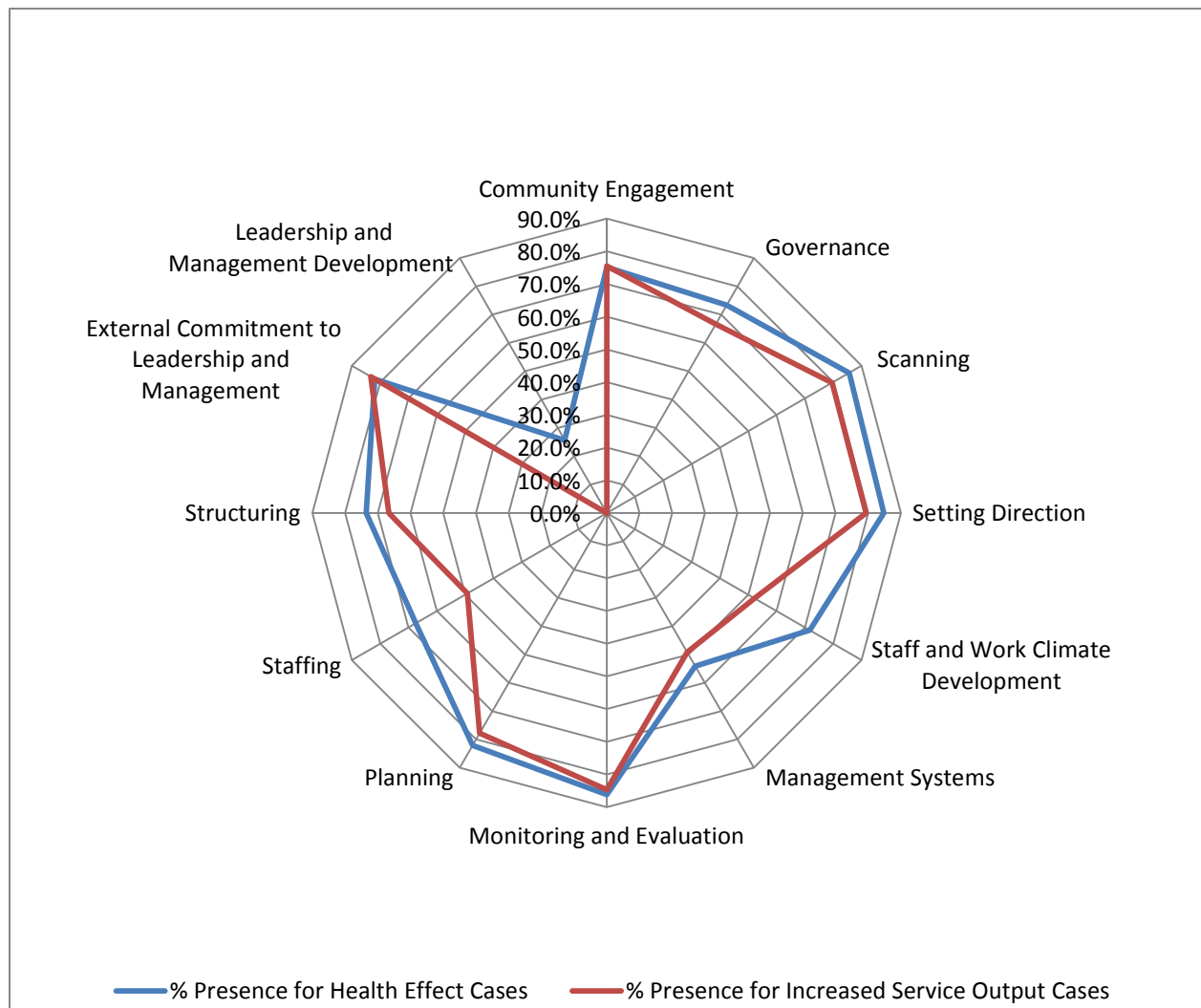
Figure 8: Comparative Array of L&M Domains for High Performing Cases 9 (n=28) vs. All Cases (n=57)



A number of cases had profound improvements at the service output level. Some of these cases had been going on for a relatively short period of time so that reaching measurable health outcomes would not yet have been expected. A few others performed very well but in areas or situations where impact on health outcomes might be difficult to ever measure. The India eye clinic example showed a 27 fold increase in services and eye surgeries over 25 years but there is no population based blindness rate to measure the improvement the program contributed to. These successful service level programs could in fact also be “high performers” so we did a comparison between the nine identified cases with program achievement at the increased service outputs level versus our original 28 “high performing” cases.

Figure 9 shows the twelve L&M domains comparing the 29 health outcome high performing cases with the eight service improvement high performing cases. Again, the twelve domains are ordered clockwise starting at 12:00 with the five Leadership Characteristics, five Management Characteristics, and then two Cross-cutting. The shape and level of the two groups are very similar. The service delivery cases have slightly less presence in about half the characteristics: Staff and Work Climate Development, Management Systems, Staffing, Structuring, and L&M Development and very slightly more presence reported in the seven domains with the structuring and management systems domains at the same level for both. Whether these differences reflect small number variation of essentially the same spectrum of L&M characteristics or are substantive in reality cannot be determined.

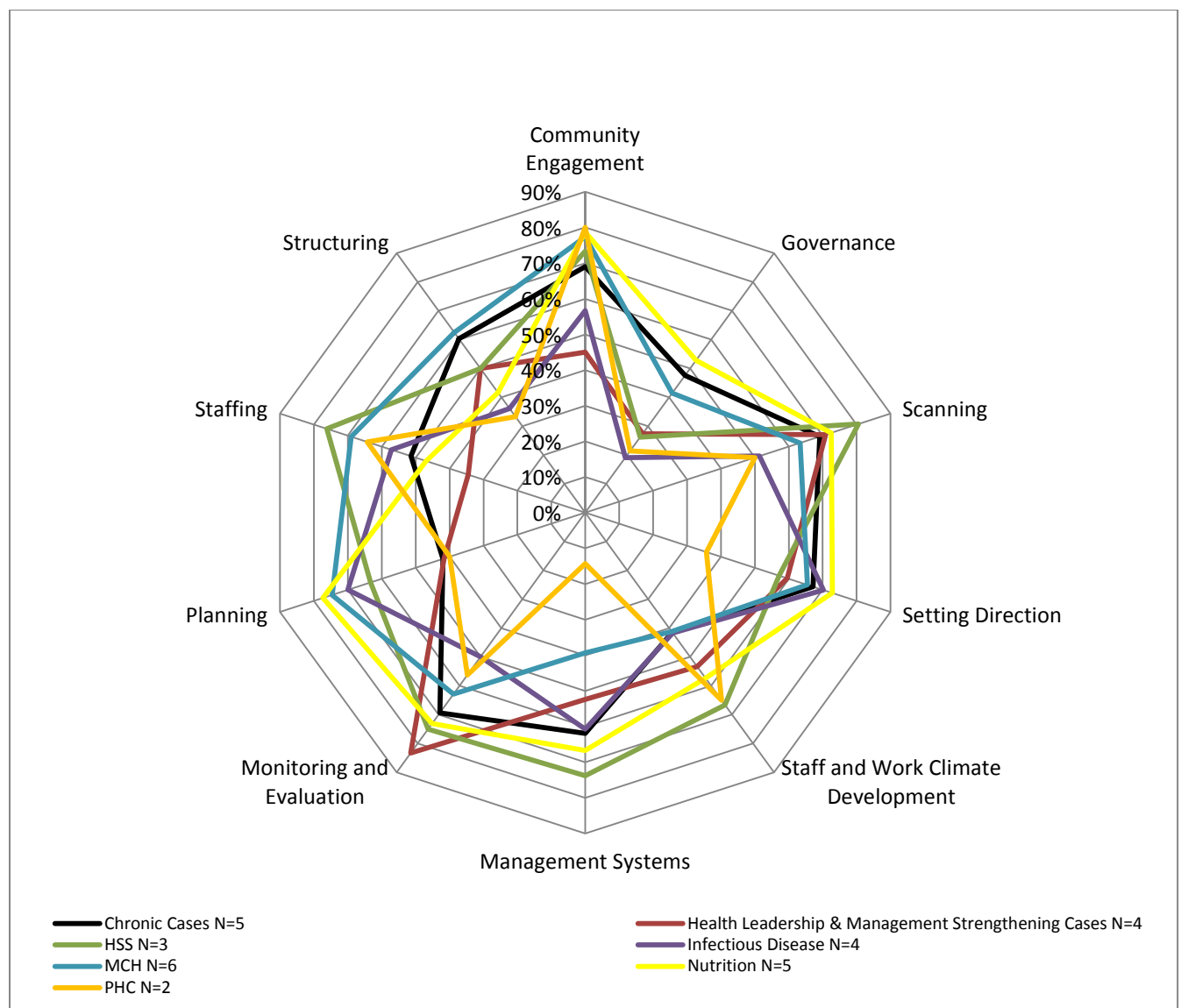
Figure 9: Comparative Array of L&M Domains for High Performing Cases 9 (n=29) vs. Increased Service Output Cases (n=8)



Leadership and management characteristics were then narrowed down by health topic for high performing cases. Figure 10 is a comparative array of characteristics presence among seven different health topics: Chronic Disease, Health Leadership & Management Strengthening, Health System Strengthening, Infectious Disease, Maternal and Child Health, Nutrition, and Primary Health Care. Specialty Services is not in this array as it did not have any cases that were high performers. Characteristics are ordered clockwise from 12:00 in the following manner: five Leadership Characteristics, and then five Management Characteristics.

The distribution of L&M domains by health topic shows some similarities and some distinct differences for the different health topics. It appears that for Maternal and Child Health cases Community Engagement and Planning are more present. Among Infection Disease cases Setting Direction and Planning are more present. Health System Strengthening cases reported on a variety of areas explicitly. Primary Health Care stands out with the most variability probably because of the low number of cases..

Figure 10: Comparative Array of L&M Domains among Different Health Topics



Limitations

Although this has been a thorough review of the available literature and program reports, the reviewers have identified several limitations that should be taken into account when interpreting the leadership and management implications of the case studies. Due to time and funding constraints, we were only able to include those initiatives and programs for which information was available in English, therefore somewhat limiting the diversity of case studies. Some case studies (i.e. quality information system in Mexico) may have more thorough descriptions on their respective ministry of health websites; however that information was not available in English. Variability in the availability of information may have affected the grading of the leadership and management characteristics, favoring some case studies over others. But the single greatest limitation is the likely under reporting, in publicly available document, of the kind of leadership and management actions these cases were trying to assess.

Additionally, the review used retrospective naturalistic analysis. The shortcoming of this form of analysis is that information presented is highly subject to the entity's perspective and motivation for providing the information. Implementer reports or donor reports may not contain the full picture of program activity. However this analysis also allows the inclusion of programs with newly released monitoring reports so that ongoing programming can be considered instead of only past projects that have long come to a close. The perspectives offered here are based upon multiple program documents (on average five per case), but case perspectives are not compared to other sources of data such as interviews with lead program managers.

Another limitation is this compilation of cases were gathered in a convenience sample, identified either by recommendation from key informants or through internet availability of program content. This may mean that the cases chosen are not necessarily representative of their geographic or health area. An underlying key concept in the vast majority of management schemas is that an organization's context—internally and often externally in the organization's environment—determines how the schema can and should be applied. Management initiatives and the successes noted in this compendium could be dependent on the local context. The variety of interventions, health topics and geographic areas considered is actually a strength of the approach. The evidence of so many similarities across diverse circumstances, make it much more likely that these case studies are in fact generalizable. Differences noted may indeed be real or may need to be studied with a larger number of representative cases.

Chapter Six: Conclusions and Recommendations

Leadership and management are at the core of achieving global health results. Particularly in the current climate of stagnating funding, it is increasingly critical that global health programs become efficient, effective, adaptable, and sustainable. Leadership and management practices create opportunities for improving program performance, strengthening workforce capacity, enhancing connections with target populations, and increasing the ability to respond effectively to change. Further, at a high level, leadership and management are essential to achieve country-ownership goals. The leadership and management capacity within national systems will be a key driver for effectively steering global health development into the future.

Case studies serves as a primary teaching method in acclaimed business, medical and public health schools worldwide and the case studies featured in this report offer 57 such education tools. These case examples can serve as launch pads for program designers and managers to think innovatively about the global health challenges they face. This study demonstrates the presence of key leadership and management characteristics within selected cases of successful global health programs. Overall, this review finds that leadership and management are not systematically reported in published articles, but many characteristics can be inferred or measured systematically within global health programming. Although there are significant limitations to the conclusions of the study, there appears to be a set of leadership and management characteristics that are most prominent among successful programs, and may be a causal factor for improved health effects. Identifying the most prominent leadership and management characteristics within selected successful programs is a significant step toward distinguishing promising practices and building lessons learned.

Currently, this study has demonstrated the most prominent leadership and management characteristics among selected cases in global health. The real world value of this research will be from global health practitioners reviewing the cases presented herein and identifying future opportunity for incorporating examples of good leadership and management within their own initiatives. It appears that successful health programs use many Leadership and Management characteristics. Additionally, cases that operate at a systems level dealing with multifactoral problems seem to use many more Leadership and Management principles than cases with a narrower scope of activity. These findings now allow researchers to test comparability of a management approach among very similar case studies that may have used different management characteristics and resulted in different levels of program success.

Specifically, this research can be used by CDC leadership and other staff members to demonstrate the potential health returns on investments made in strengthening leadership and management in global health programs. Further, the study results draw attention to the critical need to integrate leadership and management metrics into existing systematic reporting practices. The hope is to help practitioners to involve leadership and management principles in their global health programs by design, not default. The results should be used to encourage CDC staff and public health officials to regularly report on leadership and management methods occurring in their health programs. Establishing standards such as required leadership and management characteristics to be included in peer review methodologies will be an essential step in continuing to strengthen the evidence base. This report also offers value for global health leaders and managers more broadly. CDC's clients, ministries of health, and other ministries such as education can utilize this research in teaching health management principles and providing related technical assistance.

This study contributes to emerging hypotheses about leadership and management contribution to improved health outcomes by noting those characteristics that have the most notable presence in successful programming. These characteristics, especially prospectively applied warrant further investigation. Continued research is also needed to validate standard ways of measuring leadership and management processes (as we've begun to do in this study), and to determine the specific leadership and management actions that directly lead to health outcomes within a given context. Another next step would be to conduct a more in-depth analysis of a few of these or other case studies to ascertain the intentionality of application of leadership and management not verifiable in this study's review of documents alone. This could be done through interviews with program implementer, supplementing the document reviews.

Such analysis would also help to validate the specific definitions and groupings of leadership and management characteristics and further the evidence for causality. Prospective and semi- controlled application of the L&M principles in program design linked to measurable health outcomes could also be used to investigate causality. These endeavors would shed more light on the true measureable impact of leadership and management on global health outcomes. The overall goal is to identify best practices in global health leadership and management that can advance achievements already gained.

Recommendations:

- **Establish L&M reporting as standard of practice.** This study would have been enhanced significantly if leadership and management actions were regularly reported in peer review reports just as we currently require sampling methodology and M&E methods to be reported as part of program methodology. We recommend including reporting of L&M activities explicitly in all program reports and peer review articles so future research will better be able to analyze their contribution to success and program managers will better be able to replicate successful programs that utilize L&M principles
- **Publish the methods, newly defined L&M characteristics and domains and conceptual framework in relevant business and health management peer reviewed journals,** to disseminate this work and incite discussion and agreement on the definitions and validity of the methodology and results
- **Pursue further analysis of relevant case studies** to see if these results can be replicated or L&M associations can be further delineated.
- **Conduct and publish in-depth** case study analysis that link L&M actions with health outcomes
- **Design and conduct prospective controlled case studies** to test the relevance and impact of specific or grouped leadership and management characteristics on health and to investigate the causal associations between L&M and health outcomes
- **Replicate successful** programs to ascertain if successes also can be replicated

The overall goal is to identify best practices in global health leadership and management that can increase the efficiency and impact of ongoing global health programming. If leadership and management make the difference suggested by this case series, then additional investments in building leadership and management capacity could reap great improvements in global health outcomes. To elicit sufficient funding to strengthen leadership and management, there will need to be a stronger evidence base. Global health research must continue to build this evidence base so that program planners, health officers and policy makers can appropriately and intentionally use leadership and management skills to improve the effectiveness of investments in global health and achieve the improved health, we all work on so diligently.

Bibliography

- Board on Global Health. (2009). *The U.S. Commitment to Global Health: Recommendations for the Public and Private Sectors*. Institute of Medicine. Washington: The National Academies Press.
- Bhandari, A., Dratler, S., Raube, K., & Thulasiraj, R. (2008). Specialty care systems: A pioneering vision for global health. *Health Affairs*, 27 (4), 964-976.
- Bhattacharyya, O., Khor, S., McGahan, A., Dunne, D., Daar, A., & Singer, P. (2010). Innovative health service delivery models in low and middle income countries - what can we learn from the private sector? *Health Research Policy and Systems*, 8 (24).
- Center for Creative Leadership. (2010). *Addressing the Leadership Gap in Healthcare: What's needed when it comes to leader talent?* Retrieved from www.ccl.org
- Center for Disease Control. (2010). Retrieved from CDC Sustainable Management Development Program: www.cdc.gov/globalhealth/smdp/
- Conn, C., Jenkins, P., & Touray, S. (1996). Strengthening health management: experience of district teams in The Gambia. *Health Policy and Planning*, 11 (1), 64-71.
- Couto, J. (2008). Project management can help to reduce costs and improve quality in health care services. *Journal of Evaluation in Clinical Practice*, 14, 48-52.
- Daft, R. L., & Weick, K. E. (1984). Toward a Model of Organizations as Interpretive Systems. *Academy of Management Review*, 9 (2), 284-295.
- Day, D., & Halpin, S. (2001). *Leadership Development: A review of industry best practices*. Alexandria: U.S. Army Research Institute for the Behavioral and Social Sciences.
- Duran-Arenas, L., Rivero, C., Canton, S., Rodriguez, R., Franco, F., Luna, R., et al. (1998). The Development of a Quality Information System: A Case Study of Mexico. *Health Policy and Planning*, 13 (4), 446-58.
- Egger, D., Travis, P., Dovlo, D., & Hawken, L. (2005). *Strengthening Management in Low-income Countries*. Geneva, Switzerland: WHO.
- Filerman, G. (2003). Closing the management competence gap. *Human Resources for Health*, 1-7.
- Follet, M. (1982). *Dynamic Administration-The Collected Papers of Mary Parker Follet*. New York: Hippocrene Books.
- Friedman, E., Katz, I., Williams, E., Chee, G., & Lion, A. (2010). *Global Fund's Support for Cross-Cutting Health Systems Strengthening Interventions: A Reference Guide*. Bethesda, MD: Physicians for Human Rights, Health Systems 20/20 project, Abt Associates Inc.
- General Electric. (2010). Retrieved from www.ge.com
- Heerey, M., Merritt, A., & Kols, A. (2003, February). Build Partnerships Among Communities & Providers, Peru, The Puentes Project: Building Bridges for Quality. *Improving the Quality of Care: Quality Improvement Projects*

from *The Johns Hopkins University Bloomberg School of Public Health Center for Communication Programs* , pp. 3-4.

Huber, G. P. (1991). Organizational learning: the contributing processes and the literatures. . *Organization Science* , 2 (1), 88-115.

Katzachkine, M. (2004). *Lessons learned from the TRP, rounds 1–4*. Geneva, Switzerland: WHO.

Kaufman, K., & Tkach, S. (2007). Health care industry trends: Converting data to competitive advantage. *Trustee* , 60 (2), 24-28.

Kotter International. (2010). *Management vs Leadership*. Retrieved August 2010, from Kotter International: <http://www.kotterinternational.com/KotterPrinciples/ManagementVsLeadership.aspx>

Lewin Group. (2003). *Final Program Evaluation*. Falls Church: Lewin Group, Inc.

Longest, B., & Darr, K. (2008). *Managing Health Services Organizations and Systems*. Baltimore: Health Professions Press, Inc.

Lorenz, N. (2007). Effectiveness of global health partnerships: will the past repeat itself? *Bulletin of the World Health Organization* , 85 (7), 501-568.

Management & Leadership Program. (2002). Retrieved from Management Sciences for Health: <http://www.msh.org/projects/mandl/3.2.html>

Management Sciences for Health. (2006). An urgent call to professionalize leadership and management in health care worldwide. *Occasional Papers* (4).

Management Sciences for Health. (2002). *Management & Leadership Program*. Retrieved from Management Sciences for Health: <http://www.msh.org/projects/mandl/3.2.html>

Management Sciences for Health. (2005). *Managers Who Lead: A handbook for Improving Health Services*. Cambridge: Management Sciences for Health.

Management Sciences for Health. (2010, 4 6). *The Kenya Leadership Development Program: Linking Changes in Management and Leadership to Service Delivery Outcomes*. Retrieved 4 6, 2010, from Management Sciences for Health: <http://www.msh.org/projects/lms/Results/upload/2010-06-08-Strategic-Evaluation-Linkages-to-Service-Delivery.pdf>

Management vs Leadership. (2010). Retrieved August 2010, from Kotter International: <http://www.kotterinternational.com/KotterPrinciples/ManagementVsLeadership.aspx>

Marshall, J., Smith, S., & Buxton, S. (2009, August). Learning organizations and organizational learning. What have we learned? *Management Services* , 14-19.

McCannon, C., Schall, M., Calkins, D., & Nazem, A. (2006). Saving 100,000 Lives in US hospitals. *British Medical Journal* , 1328-1330.

Motorola. (2010). Retrieved from www.motorola.com

MSH. (2005). *Managers Who Lead: A handbook for Improving Health Services*. Cambridge: Management Sciences for Health.

NCHL Health Leadership Competency Model. (2005-2010). Retrieved from National Center for Healthcare Leadership: <http://www.nchl.org/static.asp?path=2852,3238>

Nonaka, I. (1994). A dynamic theory of organizational knowledge creation. *Organization Science* , 5 (1), 14-37.

PAHO/WHO. (2008). *The essential public health functions as a strategy for improving overall health systems performance: trends and challenges since the public health in the Americas initiative, 2000-2007, working document*. Washington, D.C.: PAHO/WHO.

Porter, M., & Teisberg, E. (2006). *Redefining Health Care: Creating Value Based Competition on Results*. Boston: Harvard Business School Press.

Porter, M., Farmer, P., & Kim, J. (2008). Redefining Global Health Care. *Harvard Business School's Centennial Global Business Summit Report 2008* (pp. 2-3). Cambridge: President and Fellows of Harvard College.

Ravishankar, N., Gubbins, P., Cooley, R., Leach-Kemon, K., Michaud, C., Jamison, D., et al. (2009). Financing of global health: tracking development assistance for health from 1990 to 2007. *The Lancet* , 373 (9681), 2113 - 2124.

Rhatigan, J., Sachin, J., Mukherjee, J., & Porter, M. (2009, February 22). Applying the Care Delivery Value Chain: HIV/AIDS Care in Resource Poor Settings. Harvard Business School.

Ruxin, J. (2008, Summer). *Doctors Without Orders: To improve global health, what we need isn't just Bill Gates' billions, but Microsoft's managers*. Retrieved August 30, 2010, from Democracy: A Journal of Ideas: <http://www.democracyjournal.org/article.php?ID=6618>

Schön, D. (1975). Deutero-learning in organizations: learning for increased effectiveness. *Organizational Dynamics* , 2-16.

Schwandt, D. R., & Marquardt, M. J. (2000). *Organizational Learning: From world-class theories to global best practices*. Boca Raton: CRC Press.

Smiling Sun Franchise Program. (2010). Retrieved October 01, 2010, from Smiling Sun Franchise Program: <http://www.smilingsunhealth.com/>

Swayen, L., Duncan, W., & Ginter, P. (2008). Strategies based on the value chain. In L. Swayen, W. Duncan, & P. Ginter, *Strategic Management of Health Care Organizations* (pp. 293-328). West Sussex: John Wiley & Sons Ltd.

Umble, K., Brooks, J., Lowman, A., Malison, M., Huong, N., Iademarco, M., et al. (2009). Management training in Vietnam's National Tuberculosis Program. *International Journal of Tuberculosis and Lung Disease* , 13 (2), 238-246.

United Nations. (2005). *In larger freedom: towards development, security and human rights for all Report of the Secretary-General*. New York, NY: United Nations (A/59/2005).

- Wagstaff, A., & Claeson, M. (2004). *The millennium development goals for health: Rising to the challenges*. Washington, DC: The World Bank.
- Walsh, J. P., & Ungson, G. R. (1991). Organizational Memory. *Academy of Management Review* , 15 (1), 57-91.
- Waring, J., & Currie, G. (2009). Managing expert knowledge: organizational challenges and managerial futures for the UK medical profession. *Organization Studies* , 30, 755-778.
- What Works Working Group. (2004). What Works Working Group Methods and Limitations. In R. Levine, *Millions saved: proven successes in global health* (pp. 151-152). Washington, D.C.: Center for Global Development.
- WHO. (2007). *Everybody's Business: strengthening health systems to improve health outcomes: WHO's framework for Action*. Geneva: World Health Organization.
- WHO. (2006). *The World Health Report: Working Together for Health* . Geneva: WHO.
- WHO. (2007). Towards better leadership and management in health: Report on an international consultation on strengthening leadership and management in low-income countries. 29 January - 1 February 2007. Accra, Ghana. Geneva: WHO.
- WHO. (2007). *WHO: Management for health services delivery*. Retrieved from WHO: <http://www.who.int/management/strengthen/en/index.html>

Appendix I: Detailed Methodology

Literature Review

Because of the dearth of global health specific leadership and management literature, evidence for positive impact through leadership and management was sought in almost 300 different journal and article ranging from traditional management to modern leadership and organizational development, and cover private sector, public sector, academia, and organization-specific strategies. The following journals were initially reviewed.

1. Gallup Management Journal
2. Global Health
3. Global Public Health
4. Human Resources for Health
5. International Journal of Health Planning & Management
6. Journal of Management in Medicine
7. Journal of Public Health Management & Practice
8. The Lancet

The review of a focused set of 8 books and 125 articles on leadership and management theory included a wide variety of reports from health service organizations to corporate domains and private industry. This literature review established the potential application of leadership and management principles to improve outcomes.

Defining Leadership and Management Characteristics

The leadership and management characteristics were then harmonized and defined by the following stepwise process:

1. Two methods of qualitative text analysis were used: content analysis and computer assisted free text analysis. In context analysis, reviewers organized the textual data into meaningful and manageable characteristics of leadership and management. 81 key and mostly distinct characteristics were identified
2. The 81 individual characteristics were then grouped into newly defined domains that represented key areas from Leadership and management conceptual frameworks (see conceptual framework methodology below). This resulted in a preliminary list of 12 leadership and management domains.
3. The individual characteristics, their definitions and the 12 domains were verified and validated through meetings with key informants. A description of the leadership and management characteristics used can be found in [Appendix II](#).

Methods to Create Case Studies

1. Qualitative analysis based on naturalistic inquiry method was used to select cases; approach allowed reviewers to use documented program materials of programming to retrospectively identify content pertaining to relevant L&M theories, initiatives and approaches.
2. Textual reduction to identify comparative health topics and management areas.
3. Template designed to capture information from the reviewed materials. (See [Appendix III](#) for full template details)
4. Selected cases coded along L&M characteristics and summary information entered in template.

Selection Criteria for Case Study Inclusion

Peer reviewed literature on global health program successes was limited. This required widening the search to all publically available grey literature directly from websites from International Organizations, Partnerships, NGOs, Think Tanks, and Academia. Due to limited time and funds, a focused list of areas to search was identified. A full list of entities reviewed is presented below.

International Organizations and Partnerships

DFID
GAVI
Global Fund
Global Health Workforce Alliance
Health Metrics Network
Health Systems Trust
IDB (Inter-American Development Bank)
Norad
PAHO
Roll Back Malaria Partnership
RTI International
The International Development Research Centre
USAID
WHO Health Systems Strengthening
World Bank

NGOs

Capacity Project
EngenderHealth
FHI
Global Health Action
HRH Global Resource Center
IntraHealth
JHPIEGO
JSI
MSH
PATH
PRIME
Public Health Foundation

Think Tanks, Academia, and Other Expertise

AIMS: Afghanistan Information Management Services
Center Creative Leadership
Center for Global Development
Creative Health Care Management
European Foundation for Quality Management
Gallup
Harvard
HLSP
National Bureau of Economic Research
John Hopkins University Bloomberg School of Public Health
Robert Wood Johnson Foundation
Turning Point

“Successful” global health programs were identified through a review of program documentation for documented changes in processes, service delivery, or health effects. Reviewers also met with key informants deemed knowledgeable in topics relevant to global health management. A list of key informants is presented below.

1. George Washington University Department of Global Health
2. George Washington University Department of Health Services Management and Leadership
3. George Washington University Department of Human and Organizational Learning and The Elliot School of International Affairs
4. Management Sciences for Health
5. Randolph Morgan Consulting LLC
6. United States Agency for International Development
7. United States Centers for Disease Control

Some programs under consideration were provided directly from key informants, but most were found through a review of public website based materials. Programs were included whether or not they explicitly identified their actions as leadership or management initiatives. There was purposeful diversification of the cases to draw from varying parts of the world and to represent different health programming areas. Some areas such as infectious disease had many successful programs to draw from and other newer areas of global health focus had relatively fewer (eg chronic disease) Therefore there is a relative oversampling of those newer areas compared to more established health disciplines.

Over 400 potential case studies were identified and 150 had sufficient documentation to fulfill the following criteria.

Programs were selected for further review based on the following criteria:

1. Program had publicly available documentation of activities implemented
2. Program implemented a health or health-related activity
3. Program was “successful” as determined by expert opinion and review with research team
4. Program conducted some level of review of accomplishments
5. Program had identifiable achievements in regard to health, coverage, and/or processes
6. Program described activities which included aspects of leadership and/or management
7. Reviewers searched for cases within previously identified Health Topics in attempt to have an equal distribution of cases within Health Topics represented

For most cases, 4-6 documents, peer review journal articles or program reports were used to extract the case study synopsis. Sixty-six cases were coded into the case study template. (See [Appendix III](#) for full template details) Nine cases were later omitted as weak either in L&M or in the evidence of success. Some of these were noted as promising practices to re-evaluate once they have had more time to show effect or do proper evaluation. The following program guide consists of 57 programs and is part of continuing process of identifying promising practice global health programs that display and document Leadership and Management Characteristics.

Management Assessment of the Case Studies

A case study template was designed that captures key words so readers can scan quickly to identify case studies of particular interest. A short programmatic overview with more traditional goals, objectives and activities begins each case study. Then each case was reviewed from a management perspective highlighting, management challenges, reported leadership and management specific activities. The documentation was reviewed for explicit or implicit presence of the standardized L&M characteristics described above. This is represented in both a narrative and visual format in the case template. The review also captured the level of program achievements, and strength of performance assessment. Every case had all documents reviewed and scored by at least 2-3 different individuals. Differences were brought up for discussion to build consensus among reviewers.

Coding of Case Studies

After review of the case study materials and extraction of information into the cases study template, researchers then coded identified programming documentation for the presence of 81 leadership and management characteristics. Each of the 12 L&M domains (i.e., *Scanning*) is made up of multiple of the standardized L&M characteristics.

Name of the Major Characteristic Name	Number of Sub-Characteristics within Associated Major Characteristic
Commitment to Leadership and Management	4
Community Engagement	5
Governance	7
Leadership and Management Development	9
Management Systems	7
Monitoring and Evaluation	8
Planning	5
Scanning	6
Setting Direction	7
Staff and Work Climate Development	10
Staffing	7
Structuring	6

Sample score card for a case study.

Legend

0 = Unknown/not explicitly present

1 = Somewhat present

2 = Explicitly present

Score 0,1,2	LEADERSHIP
	Scanning
	A. Actively seek information from the external environment, staff, internal databases, and other GH organizations and programs
	B. Identify stakeholders [community to public health professionals] and their needs and priorities
	C. Recognize trends and risks that affect the organization, identify best practices, identify staff capacities and constraints
	D. Know yourself, your staff, and your organization—values, strengths, and weaknesses
	E. Identify key challenges
	F. Recognize opportunities for partnership development and synergies
	Community Engagement
	A. Develop, utilize, and maintain systems of exchange with its external communities.
	B. External participatory decision making
	C. Accounts for what is expressed by the community by interacting with them when setting priorities/designs initiatives
	D. Stimulates demand in the community for the organization's services/products
	E. Utilizes the community as a player/resource to some extent (e.g. community health workers)
	Setting Direction
	A. Develop and articulate shared vision, mission
	B. Shared goal setting linked with the overall organizational mission, vision and strategy
	C. Determine key priorities for action
	D. Utilizes evidence-based decision making
	E. Create a common picture of desired results
	F. Willing/Openness to take informed risk(s)
	G. Willingness & mechanisms for adaption and changed direction (some measure of a learning organization)
	Governance
	A. Demonstrate a drive for results
	B. Build relationships
	C. Transparency
	D. Accountability and personal responsibility
	E. Respectful/Ethical in interactions
	F. Encourage questions and be responsive
	G. Active awareness and engagement with organizational culture
	Staff and Work Climate Development
	A. Professional enhancement opportunities
	B. Career development/promotion opportunities
	C. Incentivizing/Motivating
	D. Instilling and maintaining sense of program ownership among staff
	E. Team building and collaboration
	F. 360 degree feedback, open dialogue
	G. Internal participatory decision making
	H. Fosters trust and collaboration between managers and staff
	I. Develop, utilize and maintain systems of exchange among members of the organization
	J. Prioritizes/models learning, innovation, and creativity

	MANAGEMENT
	Planning
	A. Set short-term organizational goals and performance objectives
	B. Develop multi-year and annual plans
	C. Allocate adequate resources (money, people, and materials)
	D. Anticipate and reduce risks
	E. Readiness to modify to new info and changing environment (systems for regular self-correction)
	Staffing
	A. Hiring guidelines and procedures
	B. Supervising
	C. Job Descriptions
	D. Compensation
	E. Align staff capacities with planned activities
	F. Non-management position specific training
	G. Retention
	Structuring
	A. Standardization
	B. Authority/Accountability Structures and procedure
	C. Protocols
	D. Safe work environment
	E. Adequate facilities/equipment
	F. Technology management
	Management System
	A. Information
	B. Human Resources
	C. Logistics
	D. Finance
	E. Operations
	F. Quality assurance
	G. Supply chain
	Monitoring and Evaluation
	A. Clear objectives that match activities
	B. Monitor and reflect on progress against plans
	C. Identify needed changes
	D. Improve work processes, procedures, and tools
	E. Provide feedback
	F. Distributes program information to stakeholders in a timely fashion and an appropriate format
	G. Assess impact of program
	H. Utilization of Learning
	CROSS-CUTTING
	External Commitment to Leadership and Management
	A. Adequate funding for management initiative
	B. Leadership driven/supported
	C. Political capital
	D. Legitimization/value these important roles
	Leadership and Management Development
	A. Skills being learned were valued
	B. Participants received feedback
	C. Training included reflection time
	D. Team based training [equal distribution of power]
	E. Action learning – Work team or fraction thereof addresses self identified problem
	F. Action learning on-site – Work team addresses self identified problem
	G. Continuing education/career development/professional enhancement
	H. Training to specifically build leadership characteristics
	I. Training to build management ability

Several reviewers individually looked for and scored the presence of each characteristic in a each case. Scoring was on a scale of 0,1 or 2 as seen below:

Scoring Characteristics

- **Score of 2** = the subcategory was explicitly present/stated in research documents
- **Score of 1** = subcategory was somewhat present/its presence could be derived from available documents
- **Score of 0** = subcategory was not present or its presence is completely unknown

The L&M domain score then was the sum of the individual scores of the characteristics included in that domain. Since Scanning for example has 6 contributing characteristics, the total score if all were explicitly present would be 12. Staff and work climate domain has 10 contributing characteristics so could have a total score of 20. In comparing the domains visually the size of the colored circles varies with the summed domain score, but the maximum size represents 100% explicit presence of the L&M characteristics, 50% size means only 50% of the potential score were found in the case review, for scanning that would mean a sum of 6 points out of the potential 12, while to reach the same size the staff and work climate would need evidence of 10 of 20 possible points. This allows the domains to be visually comparable as readers scan the case studies.

Level of Program Achievement: Case's achievements in health status, coverage and processes.

Possible Scores: **health impact**, **increased coverage**, and **improved processes**.

- **Health Effect:** Changes in health status (e.g. mortality and morbidity)
Note: increased coverage of key interventions with established direct health impacts (e.g., immunization rates or contraceptive prevalence) were considered "health effects". Otherwise these measures were considered service increases in the below category.
- **Increased Service Outputs:** Coverage represents provision, access and utilization of program's services
- **Improved Processes:** (e.g., policy changes to support health outcomes, establishment of facilities, expansion, enrollment in health care services, curriculum and training development, cost reduction, increased operational efficiency, etc.)

Strength of Performance Assessment: Ranking of how well the case measured and assessed activities and achievements. Possible Scores: **high**, **average**, and **low**

- **High:** Multiple forms of systematic assessment are documented in reviewed materials, AND has a final or end-line analysis for outcomes of any sort
- **Average:** One form of systematic assessment is documented in reviewed materials. Includes such tools as: baseline surveys, situational analysis, rapid assessments, KAP surveys and vulnerability assessments
- **Low:** Cases with no documented methods of how outcomes were measured or anecdotal methods (e.g., business case studies, narrative reports, etc.)

Data Analysis across Case Studies

Data Analysis of Coded Leadership and Management Characteristics

Graphic Representation:

Leadership and management characteristics were scored as described above. The grading of subcategories for each characteristic was summed and a percentage of total possible points were calculated. For example in scanning, subcategories and their grading were present as follows: A(2), B(2), C(2), D(1), E(1), and F(2). The sum of these scores is 10 out of a possible 12 points, equaling 83% of subcategories represented within scanning. This calculation was done for each characteristic through the use of an Excel spreadsheet to reduce error and then rechecked among the reviewers. Each colored circle in the figure represents one of the twelve L&M

domains. The circles in the graphic are based on the proportion of subcategories present, with 20% incremental distributions.

Categorical Labels were derived from textual analysis and convergence. These comparison labels were used to stratify the cases into various categories to compare differences of major characteristics between groups.

- Textual analysis and convergence revealed the following comparison groups by Health Topic: Health Systems Strengthening, Health Leadership and Management Strengthening, Primary Health Care, Specialty Care, Women's Health, Infectious Disease
- Textual analysis and convergence revealed the following comparison groups by Management Area: Franchise Approach, Systems Approach, Leadership and Management Capacity Building, Quality Assurance Approach, Task-shifting/Service Delivery-shifting Approach, Strategic Partnership

Note: Financial Protection, Focused Factory, and Region-wide Collaboration were also identified as Management Areas but these groupings were included in the final set of options. Reviewers felt that these areas did not have enough cases in each to calculate meaningful averages.

Matrix: Using Microsoft Excel, a pivot chart was created from the leadership and management characteristics. Several ranking procedures were used to display ordered list of the most present characteristics. Highlights from those ranking are presented in the results section of this report.

Ranks were established using a few calculation procedures.

- Sums – the addition of recorded scores for a sub-characteristic across all cases that met the limiting factor combinations
- Counts – adding of the number of times a sub- characteristic was present across all cases that met the limiting factor combinations
- Percent Frequencies of Explicit Characteristics – the ratio of the number of times a characteristic was explicitly present compared to being present at any level of discrimination across all cases that met the limiting factor combinations

Ranks of the 12 domains were determined by using aggregations of the sub-characteristic scores within the major category.

- L&M domain aggregations were calculated by adding together the characteristic scores within a major domain and then dividing by the number of characteristics within that major domain category.
- For instance to determine the summation score for the domain of Planning, One had to add together the five summation scores from sub-characteristics within the major domain "Planning" (72,46,82,72,97). This sum (369) was divided by five to result in the average summation score of a characteristic within the major "Planning" domain (73.8).

Data was queried with the following limiting factor combinations

- Cases from any health topic, with any level of program achievement, and with any strength of performance assessment
- Cases from any health topic, with health outcomes for program achievements, and high strength of performance assessment
- Cases from any health topic, with service delivery for program achievements, and high strength of performance assessment
- Cases within the same health topic, with health outcomes for program achievements, and high strength of performance assessment

Comparison Graphs: Comparisons of major characteristic presence were graphed for the following

- Cases with any level of program achievement versus cases with health outcomes for program achievements and high strength of performance assessment
- Cases with a health outcome versus cases with service delivery level of program achievement
- Cases with different health topics

Appendix II: Descriptions of 12 Leadership and Management Domains and 81 Corresponding Characteristics

Leadership

Scanning: *Seeking out and identifying alternatives and options for the organization's work*

1. Actively seek information from the external environment, staff, internal databases, and other GH organizations and programs
2. Identify stakeholders [community to public health professionals] and their needs and priorities
3. Recognize trends and risks that affect the organization, identify best practices, identify staff capacities and constraints
4. Know yourself, your staff, and your organization—values, strengths, and weaknesses
5. Identify key challenges
6. Recognize opportunities for partnership development and synergies

Community Engagement: *Incorporating the community into program activities*

1. Develop, utilize, and maintain systems of exchange with its external communities.
2. External participatory decision making
3. Accounts for what is expressed by the community by interacting with them when setting priorities/designs initiatives
4. Stimulates demand in the community for the organization's services/products
5. Utilizes the community as a player/resource to some extent (e.g. community health workers)

Setting Direction: *Envisioning purpose, aspiration, and end for organization's work and mobilizing support*

1. Develop and articulate shared vision, mission
2. Shared goal setting linked with the overall organizational mission, vision and strategy
3. Determines key priorities for action
4. Utilizes evidence-based decision making
5. Creates a common picture of desired results
6. Willing/openness to take informed risk(s)
7. Willingness & mechanisms for adaptation and changed direction (some measure of a learned organization)

Governance: *Responsibly exercising control over an organization for mutual benefit*

1. Demonstrate a drive for results
2. Build relationships
3. Transparency
4. Accountability and personal responsibility
5. Respectful/Ethical in interactions
6. Encourage questions and be responsive
7. Active awareness and engagement with organizational culture

Staff and Work Climate Development: *investing in various opportunities and approaches toward improving the quality of employees' output*

1. Professional enhancement opportunities
2. Career development/promotion opportunities
3. Incentivizing/Motivating
4. Instilling and maintaining sense of program ownership among staff
5. Team building and collaboration
6. 360 degree feedback, open dialogue
7. Internal participatory decision making
8. Fosters trust and collaboration between managers and staff
9. Develop, utilize, and maintain systems of exchange among members of the organization
10. Prioritizes/models learning, innovation, and creativity

Management

Planning: *deciding in advance what is to be done*

1. Set short-term organizational goals and performance objectives
2. Develop multi-year and annual plans
3. Allocate adequate resources (money, people, and materials)
4. Anticipate and reduce risks
5. Readiness to modify to new information and changing environment (systems for regular self-correction)

Staffing: *acquiring, maintaining, and retaining human resources*

1. Hiring guidelines and procedures
2. Supervising
3. Job Descriptions
4. Compensation
5. Align staff capacities with planned activities
6. Non-management position specific training
7. Retention

Structuring: *developing intentional patterns of relationships among people and other resources*

1. Standardization
2. Authority/accountability structures and procedures
3. Protocols
4. Safe work environment
5. Adequate facilities/equipment
6. Technology management

Management System: *system(s) designed and utilized to identify, capture, structure, value, leverage, and share an organization's information/knowledge/ intellectual assets*

1. Information
2. Human Resources
3. Logistics
4. Finance
5. Operations
6. Quality assurance
7. Supply chain

Monitoring and Evaluation: *processes for tracking activities in accordance with plans and assessing the performance of those activities, and/or using assessment results to reassess program activities*

1. Clear objectives that match activities
2. Monitor and reflect on progress against plans
3. Identify needed changes
4. Improve work processes, procedures, and tools
5. Provide feedback
6. Distributes program information to stakeholders in a timely fashion and an appropriate format
7. Assess impact of program
8. Utilization of learning

Cross-Cutting

Commitment to Leadership and Management: *the readiness of outside governing and regulatory bodies/structures to invest in and value leadership and management*

1. Adequate funding for management initiative
2. Leadership driven/supported
3. Political capital
4. Legitimization

Leadership and Management Development: *training for the specific purpose of building the leadership and/or management competency of staff members*

1. Skills being learned were valued
2. Participants received feedback
3. Training included reflection time
4. Team based training [equal distribution of power]
5. Action learning – Work team or fraction thereof addresses self-identified problem
6. Action learning onsite – Work team addresses self-identified problem
7. Continuing education/career development/professional enhancement
8. Training to specifically build leadership characteristics
9. Training to build management ability

Appendix III: Description of Template

TITLE OF PROGRAM	OPERATIONAL PERIOD ¹
IMPLEMENTING ENTITY: The entity responsible for on the ground program implementation	
Location: Country WHO Region/World Bank Development ranking Health Topic: Identified health topic that the program addressed Key Words: Descriptors of management action and/or key activities	

PROGRAM OVERVIEW

Goal: Identified goals of the program.

Objectives: Identified objectives that the program sought to achieve.

Funding: Source of funding for program start-up and continuation, if applicable. [Cost information for key program activities, if available]

Background of HEP:

- Brief summary of the program to provide context.

LEADERSHIP AND MANAGEMENT OVERVIEW

Management Challenge: The challenge(s) identified at first that instigated the need for leadership/management action.

Management Action: In brief, the management initiatives undertaken by the program to address the management challenge and achieve its goals and objective.

Principal L&M Characteristics Identified

Leadership:

Management:

Cross-cutting:

Results Achieved:

- The process, coverage, and/or health effect achieved.

¹ Program start date to conclusion date, or to present if applicable

The diagram illustrates the relationship between three main components: Leadership, Cross-cutting, and Management.

- Leadership:** A large grey circle containing five smaller green circles. The circles are labeled:
 - Scanning (1 2 3 5 6)
 - Community (1 2 3 4 5)
 - Work Climate (1 2 3 4 5 7 8 9)
 - Setting Direction (1 2 3 4 5)
 - Governance (1 2 3 4 5)
- Cross-cutting:** A large orange circle containing a smaller orange circle. The text inside the large circle is:
 - Commitment to L&M (1 2 3 4)
- Management:** A large grey circle containing five smaller blue circles. The circles are labeled:
 - Planning (1 2 3 5)
 - Staffing (1 2 3 4 5)
 - M&E (1 2 3 4 5 6 7 8)
 - Memt Sys (1 2 3 4 5 7)
 - (Unlabeled circle with 1 2 3 4 5 6 7 8 9)

Management Action in Detail

Program Achievements

- Health Effect: Any reported achievement of improvement in health
- Service Outputs: Any reported information on the program's achievements in coverage, such as personnel at facilities, population reached, etc.
- Process: Any other measurable outcomes identified such as process improvement, a change in community perception, policies developed, etc.

SCORE: Low/Average/High

- ## Comments

If applicable: notable awards, current news or contextual information pertinent to the program.

Appendix IV: Compiled List of Quotations

"Because of these improved management skills, I am getting better results and solutions to problems....Whenever any hospital issue is raised now, I introduce it to the management team and we use brainstorming, theme selection, finding root causes, and standardizing the changes. Good team building helps us to solve problems more effectively." – Trainee from Vietnam team building program for TB. [Umble, K.E., Brooks, J., Lowman, A., Malison, M., Huong, N.T., Iademarco, M. and Laserson, K. (2009). Management training in Vietnam's National Tuberculosis Program: an impact evaluation. International Journal of Tuberculosis and Lung Disease, 13(2):238-246.] p.241-242

"The knowledge acquired from the PDSA cycle was instrumental in managing customer flow. Following the initiative the customer flow has been increased and we are now in a better position to handle huge number of customers in our clinic," - Mr. Nath, Clinic Manager of West Bakalia Clinic in Bangladesh, part of SSFP. USAID. Success Stories: Management Tools help Smiling Sun clinics to improve service quality. Available at <http://www.smilingunhealth.com/SuccessStory5.aspx>, Accessed 20 September 2010]. P.1

"The same way you train somebody for the Olympics - a leader must train everybody. Everyday you coach him, guide him, play with him so you can develop him quickly as a top player. And then there must be an internal motivation also-he must develop a physical stamina, a mental capacity and a vision. This our doctors feel, and they carry this all their lives. The whole society has the potential to change when one institution shows positive change. It becomes a sort of a benchmark for other people to do it also." – Dr. V, Founder of Aravind Eye Hospital [Aravind Eye Care System. Activity report 2009-2010. <http://www.aravind.org/publications/reports.asp>]

"People don't get it. I'm always trying to convince people that hospital administration should be the highest priority. Because you can't have good services without good management." and *"Managers must feel themselves to be part of the change. What motivates people is when they see that they can really do something about their challenges."* - Humberto Vitorina Dantas, career in directing finances of the state of Ceara's health secretariat and unified health system [MSH: Stories from the Field. <http://www.msh.org/projects/mandl/6.3.html>]

"A lot of programs give lip service to 'sustainability' - this is the real deal. Living Goods is one of few models with the potential for game-changing scale." - Holly Wise, Former Secretariat Director of USAID's Global Development Alliance [Living Goods website <http://www.livinggoods.org/> [accessed 9 November 2010]

"Narayana Hrudayalaya demonstrates it is possible to fulfill a great social need without compromising on the profitability." - Shishir Jain, NH shareholder and executive director at JP Morgan

[No author. 1 July 2010. "Narayana Hrudayalaya: A Model for Accessible, Affordable Health Care?" India Knowledge@Wharton. Online: <http://knowledge.wharton.upenn.edu/india/article.cfm?articleid=4493> [accessed 1 October 2010]

"Narayana Hrudayalaya will change the way healthcare is delivered across the world." -Santosh Senapathy, NH shareholder and managing director of PineBridge Investments

[No author. 1 July 2010. "Narayana Hrudayalaya: A Model for Accessible, Affordable Health Care?" India Knowledge@Wharton. Online: <http://knowledge.wharton.upenn.edu/india/article.cfm?articleid=4493> [accessed 1 October 2010]

"[VisionSpring] will help hundreds of thousands of people and in the process create a whole new sector of the economy." -President Bill Clinton

[VisionSpring's website: <http://www.visionspring.org/about/our-story.php> [accessed 25 September 2010].