10. LEADERSHIP AND MANAGEMENT TO EMPOWER THE HEALTH WORKFORCE

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A broken health system is a silent killer. It results in more illness and death despite the fact that the public health and medical knowledge exists to greatly reduce illness and save millions of lives every year, especially in developing countries. What is missing is the leadership capacity to ensure that the management systems are in place to apply and scale up this knowledge. More simply put, global health initiatives mus t invest in the leadership of those running health systems, especially in low-resource settings where every dollar counts and every health worker is indispensable. Doing so is essential if governments are to meet the health needs of their own populations (Dwyer, Johnson, and Vriesendorp 2006).

The goal of this paper is to present voices from Africa affirming how strengthened leadership and management contributed to improvements in health workforce performance in Kenya, Tanzania, and Ghana. Time after time, they echo the feeling of empowerment and motivation they have, as nurses, doctors, pharmacists, community health workers, and health providers, when they work together in teams to lead a plan to improve health services.

LEADERSHIP: A MISSING INGREDIENT IN HEALTH SERVICES

Health care in developing countries is a multibillion-dollar endeavor. Yet, the people charged with leading and managing this work often have little formal preparation. Senior health care managers around the world express the urgent need to professionalize the leadership and management of health care services. Their argument for better preparation of these crucial leader-managers comes from their own experience.

The head of a major health program in Kenya remembers: "I was appointed a district medical officer in 1993, straight from a surgery ward and within a week I had to manage an entire district. It was a totally different world. Doctors definitely need training in leadership and management and it should not be short term" (MSH unpublished data, Director of the Malaria Control Program, Kenya, 2006).

It is common practice to promote good clinicians into leadership positions, but this often has the unfortunate consequence that the system loses a good clinician and gains a mediocre or weak leader. The management of the health workforce calls for better health management practice guided by competencies in leadership and management.

Conversations with health leaders across the continent have revealed many reasons why health leadership and management have traditionally not been high on the agenda of institutions that produce health professionals, or the governments that employ them:

- Role of health care managers is not well understood and thus cannot be fully valued.
- Curricula of medical, nursing, public health, and allied health professions are already very crowded, making it hard to find a space for management and leadership modules.

- Human resource managers who play a key role in the performance of the health workforce generally have little influence over how health personnel are prepared for promotions into leadership and management positions.
- Cost of poor leadership and management is not known.
- There is an assumption that good doctors and nurses will also be good leaders and managers.

As a result, service providers who are advanced into new management positions encounter challenges of a different nature from the ones they prepared for in school (box 1).

BOX 1. MANAGEMENT CHALLENGES FACED BY HEALTH MANAGERS

- How to scale up services to reach more people as populations grow
- How to motivate workers who are poorly paid and work in difficult circumstances when there are no financial incentives
- How to assure consistent delivery of high-quality services with limited staff and weak capacity
- How to develop (and then maintain) systems and capacity to accommodate new funding streams
- How to use data for decision making when the data may be of poor quality, incomplete, or not timely
- How to move from donor-influenced management to institutional models of management
- How to rationally deploy health workers
- How to change the mind-sets of individuals who are used to focusing on activities to paying greater attention to results
- How to decentralize decision making to managerial levels closer to the communities
- How to maintain transparency in the face of corruption and misuse of funds

These challenges are exacerbated by the constant urgency to save lives and demonstrate results for the influx of megafunding organizations such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria; the Bill & Melinda Gates Foundation; the US President's Emergency Plan for AIDS Relief (PEPFAR); and many other European and foundation donors.

The Management Sciences for Health (MSH) Leadership Development Program (LDP)

illustrates what can be done to meet these leadership challenges and improve the management of health systems and the performance of the health workforce.

Origins of the MSH Leadership Development Approach

In 2002, the Egypt Ministry of Health and Population faced the challenge of improving access to and quality of services in rural Upper Egypt in the face of low morale among health workers and managers. From 1992 to 2000, the ministry, with donor support, had succeeded in reducing the nationwide maternal mortality rate by 52 percent. Nevertheless, a gap remained between urban and rural areas (Mansour, Mansour, and EL Swesy 2010).

In 2002, Egypt's Ministry of Health, with funding from the United States Agency for International Development (USAID) and assistance from MSH, introduced a leadership development program. The program aimed to improve health services in three districts of the Aswan Governorate by increasing managers' ability to create high-performing teams and lead them to achieve results. The program introduced leadership and management practices and a methodology for identifying and addressing service delivery challenges. Ten teams of health workers participated.

Results. After participation in the LDP, the districts of Aswan, Daraw, and Kom Ombo increased the number of new family planning visits by 36 percent, 68 percent, and 30 percent, respectively (ibid.). The results in Egypt indicated that attention to management and leadership skills could contribute to improvements in health workforce performance and service delivery.

This was the prototype of what came to be known as the Leadership Development Program (LDP). The hypothesis tested in Egypt proposed positive links among the manager's behavior, the work environment, and service improvements. A last link, between service improvements and health outcomes, would be a contributing rather than a causal factor.

After the US funding ended, local doctors and nurses independently scaled up the program to 184 health care facilities and trained more than 1,000 health workers. From 2005 to 2007, the LDP participants focused on reducing the maternal mortality rate as their annual goal. They succeeded in reducing it from 85.0 per 100,000 live births to 35.5 per 100,000. The reduction in the maternal mortality rate in the governorates implementing the LDP was much greater than reductions in similar governorates in Egypt (ibid.). Managers and teams across Aswan demonstrated their ability to scale up effective public health interventions through their increased commitment and ownership of service challenges.

In subsequent years and the next generation training, the district teams reported improved morale, work climate, attitudes, and skills of health workers in Aswan District (ibid.). Service results such as an increased number of prenatal visits per woman (from 1.3 to 3.7 per woman) and child care visits (from 1.1 to 3.5 per child) suggest that attention

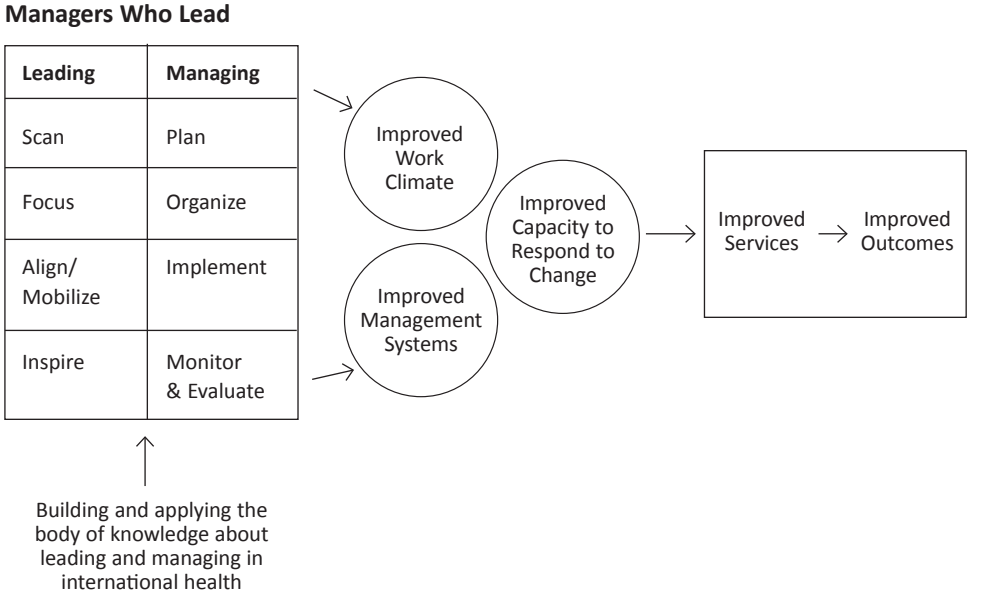
to management and leadership skills can spill over into workforce morale, empowerment, responsibility, and productivity. The relationship between clients and health workers also changed with a positive effect on other health practices. Later iterations of the program produced a better medical information system and an increase in the use of various contraceptive methods (ibid.).

Key Factors and Model

Two key factors that make the LDP model successful are that it is team-based and it is results-focused. The Leadership Development Program is a four- to six-month process that includes four modules based on the Leadership and Management Framework (figure 1).

FIGURE 1. LEADING AND MANAGING FOR RESULTS MODEL

How do management and leadership contribute to improved service delivery?



Source: MSH (Management Sciences for Health). 2005. *Managers Who Lead: A Handbook for Improving Health Services*. Cambridge, MA: Management Sciences for Health. Reprinted with permission.

In the process, teams choose a challenge that they are facing and work to solve it. Their action plans are based on measureable results. At the end of the program, teams present their challenge and progress to date in implementing their action plans.

Themes

A number of themes have emerged from a decade of MSH's interventions in strengthening leadership and management in Africa. The LDP has been conducted in forty-five countries with more than a thousand teams and five thousand participants. Often assisted by local LDP facilitators, it has produced positive results, which have been documented in formal and informal reports and in internal and external evaluations (Jamanka 2009; Jamda et al. 2009; Khalil and Topçuoğlu 2005; MSH 2010, 2012; Perry 2008; Seims 2012; Seims et al. 2012; Sherk 2004; Shrestha 2007; Topçuoğlu 2003; Topçuoğlu and Nawar 2004). In reviewing these reports and the comments people have made about their experience in these programs, several themes emerge that are of particular importance to their success. These themes are consistent with the literature (Block 1987; Bragar 1990; Covey 1989; Daloz Parks 2005; Heifetz 1994; Kotter 2001; Kouzes and Posner 1987; MSH 2002, 2005; Senge 1990; Wheatley 1992):

- **Connection**: Because the LDP is team-based, it has enabled people to feel connected and become more aware of the larger environment in which they work. In the process, they become more empowered to take on challenges that impede their vision of healing the sick.
- **Work climate**: Managers often sense when the work climate is affecting staff's performance, which can be seen in absenteeism, unmet performance objectives, lack of initiative, and reduced interest in their work. Managers and leaders can often turn their work groups around by applying leadership and management practices that promote on-the-job clarity, support, and challenge.
- **Focus**: Developing a focus for action provides the team with a common sense of purpose and a specific challenge they feel is important to achieve their goals. With a focus on a specific challenge, the team is able to develop a plan to guide their activities, identify the resources they need, track their progress, and align with other key stakeholders.
- **Vision**: A shared vision is a powerful element in improving the motivation and performance of the health workforce. Through improved leadership practices, health workers regain the common sense of purpose and vision they share. This is inspiring, not only to them but also to others around them.
- **Sustainability**: Practical leadership, or the concept that people can lead at any level and, in the process, learn to take on a challenge and mobilize resources to produce change, is a powerful antidote to low morale. By itself, the practice of team leadership is sustainable because people would rather feel empowered and take action than not.

COUNTRY CASE SELECTION

Case studies from Kenya, Tanzania, and Ghana are presented here because each of these programs has been rigorously evaluated for its impact on health service delivery. Each of these programs was funded by USAID through the Center for Leadership and Management at MSH. Also, in each of these countries, the Leadership Development Program was a key intervention by MSH, whereas in other African countries, the LDP was one of multiple interventions carried out by MSH as a package of technical assistance, capacity building of community service organizations (CSOs), business planning, human resource management, and policy development.

In each of these countries, the evaluation was designed to examine the processes through which leadership and management development can lead to improved health workforce performance and health service delivery. The evaluation studies on which this paper is based were first reported in a variety of published papers and internal reports.

It is worth noting that the projects reviewed in this study differ along many variables, including (1) the period of implementation, from as little as one year to up to four years; (2) the point of intervention, such as regional, provincial, district, or health facility levels; (3) budget; and (4) number of participants.

The methods used to collect data on the results of the Leadership Development Program and the specific study questions also differed. The study in Kenya was largely quantitative, using a quasi-experimental design to compare LDP team performance with performance in comparison areas. The study in Tanzania was also quantitative but used a before-and-after design without comparison groups. The study in Ghana, however, was largely qualitative and used in-depth interviews to identify factors that influenced LDP team performance and the sustainability of outcomes. What was common about all three studies, however, was that they examined the service delivery outcomes of programs implemented by teams trained in management and leadership and they identified factors that contributed to successful and sustained outcomes

Kenya: Linking Changes in Management and Leadership to Service Delivery Outcomes (2008–2010)

Challenge. During the 1990s, there was a decline in Kenya's national health indicators, which the government attributed to the failure of management systems and coordination (Ministry of Health, Republic of Kenya 2005). In response, the Kenyan government developed the National Health Sector Strategic Plan (NHSSP I) to improve coordination, planning, and implementation of health services.

The challenge for the Ministry of Medical Services (MOMS) and the Ministry of Public Health and Sanitation (MOPHS) was to "reverse the decline of health indicators," and in response, they initiated an unofficial call to action, which included a series of health reforms to decentralize

operations. To be successful, implementation of these reforms required a higher level of competence in management and leadership at the provincial and district levels.

Intervention. MSH and the Ministries of Health in Kenya developed a National Assessment of the Management and Leadership Competencies of Health Managers (hereafter called the National Assessment), which was conducted in 2007 (Ministry of Medical Services and Ministry of Public Health & Sanitation, Republic of Kenya 2008). The National Assessment and the resulting draft National Strategy for Leadership and Management formed the foundation for the leadership program in Kenya that began in July 2008.

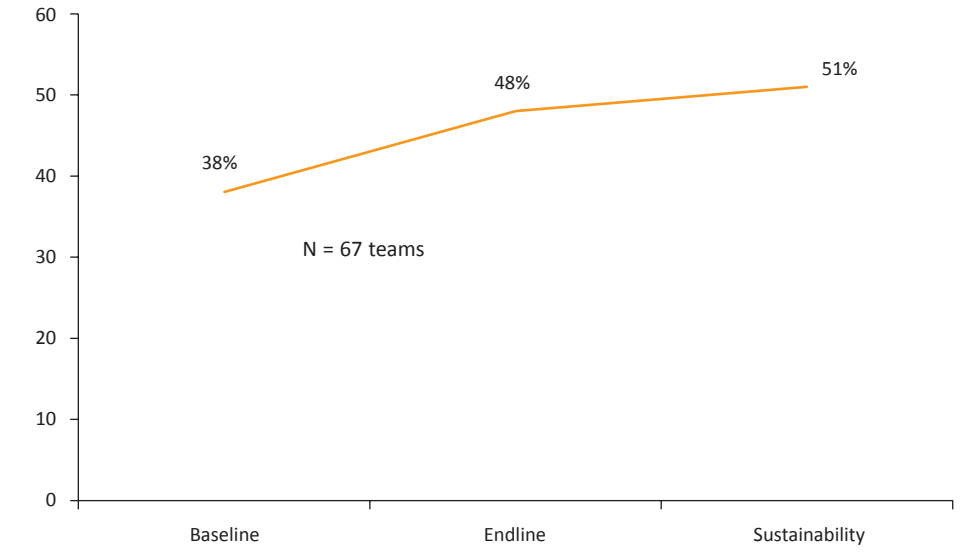
From February to April 2010 a study was conducted of sixty-seven teams that had participated in the LDP up to that point and had implemented interventions focusing on service delivery outcomes. The assessment included data on quantifiable service delivery indicators for the sixty-seven teams along with data from a matched sample of districts and facilities that served as comparison groups (Seims 2012). The teams focused on the following challenges, the first three of which relate to the Millennium Development Goals health indicators:

- Increasing coverage of fully immunized children under age one (twenty-five teams)
- Increasing delivery by a skilled birth attendant (twenty-three teams)
- Increasing the proportion of pregnant women receiving four or more antenatal care visits (ten teams)
- Increasing coverage of another service delivery intervention (nine teams)

Results. As depicted in figure 2, aggregated data for all sixty-seven teams indicate that coverage for the teams' key outcome indicator was at 38 percent before implementation of the LDP. At the end of the program, approximately six months later, coverage had increased to 48 percent. These results were sustained at 51 percent six months after the end of the LDP.

Data were examined for the same indicators and same time periods for comparison districts and facilities. The LDP team and comparison districts and facilities were matched for a number of criteria to increase the closeness of the match. (Districts were matched on size and location; facilities were matched on type, location, number of beds, and family planning service statistics.) Data from the comparison sites remained relatively stable throughout the same time period, with differences between intervention and comparison groups statistically significant (t test, p value = ≤ .05). The data indicate that following exposure to the LDP, the health indicator coverage associated with the teams improved.

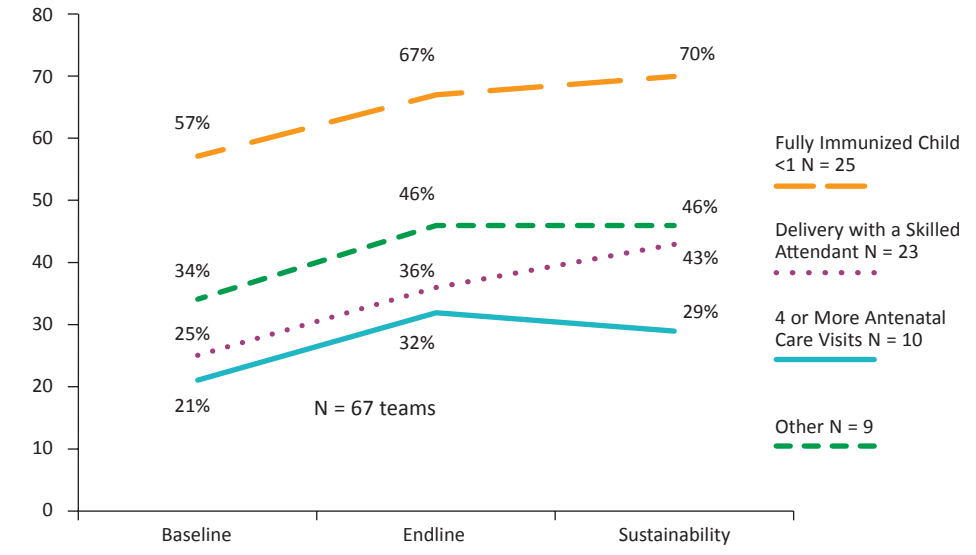
FIGURE 2. AVERAGE COVERAGE RATES FOR AGGREGATED HEALTH SERVICE DELIVERY INDICATORS FOR INTERVENTION TEAMS, KENYA, 2008–2010



Source: MSH, unpublished data, 2012.

Although the focus of the assessment was on team results, and because the results by specific interventions have relatively small sample sizes, the data also suggest that coverage increased for each of the interventions, as illustrated in figure 3.

FIGURE 3. AVERAGE COVERAGE RATES FOR AGGREGATED HEALTH SERVICE DELIVERY INDICATORS FOR INTERVENTION TEAMS, DISAGGREGATED BY INDICATOR, KENYA, 2008–2010



Source: MSH, unpublished data, 2012.

The teams were comprised of leaders and managers. Nearly two-thirds of the sixty-seven teams interviewed cited that they supervised staff. Their duties included approving staff leaves, handling disciplinary issues, performing medical supervision, coordinating community health workers, setting work climate, conducting staff appraisals and making salary recommendations, and managing support staff. The remainder reported that they were in charge of deployment of staff throughout the district.

For the forty-three teams (64 percent) where health indicator coverage was sustained at the same or higher level six months after the end of the LDP, factors cited as contributing to sustainability were (1) redeployment of staff to generate demand through social mobilization and health education, (2) increasing access by providing more outreach sites or more service hours or days, (3) an improving work climate, and (4) training a new cadre of workers. These factors were outside of the LDP, but the participants felt they helped to maintain health coverage.

Legacy. Since the results of the Ministries of Health National Assessment and Strategy on the need for leadership and management strengthening in the health sector were first published in 2008 there has been a dramatic increase in the understanding of the critical role that leadership,

management, and also governance play in improving the quality of health workforce performance and health service delivery in Kenya. To highlight this progress and build on the accomplishments of the past few years, the Ministries of Health in Kenya, in partnership with MSH, held a National Conference on Health Leadership, Management, and Governance in January 2013. The conference included a wide range of ministries, donors, and key stakeholders who underscored the critical role that leadership and management play in improving the quality of health service delivery in Kenya.

Tanzania: Leadership Development for Family Planning Services

Challenge. Access to family planning services is one of the key pillars to improve maternal health outcomes in Tanzania (Ministry of Health and Social Welfare, United Republic of Tanzania, Reproductive and Child Health Section 2008). As part of a major initiative of the Ministry of Health and Social Welfare to revitalize family planning, increased access to family planning services is a key strategy to address the health needs of women of reproductive age and to improve maternal and child health.

Access to family planning services, as a key priority, requires the effective delivery of family planning interventions, including the availability of quality services; adequate stocks of contraceptive supplies at service delivery points, particularly in remote areas of the country; and educational programs on family planning methods for women of reproductive age. Yet, at the same time, the Ministry of Health was faced with serious challenges. Health centers were underperforming, poor coordination existed between district activities and those of the health centers, and health centers were feeling isolated and unsupported.

Intervention. In January 2006, staff from MSH's Leadership, Management, and Sustainability Program, in collaboration with staff from the USAID-funded ACQUIRE Project and the Tanzania Ministry of Health and Social Welfare, initiated a six-month Leadership Development Program in Kigoma, a remote rural province in western Tanzania. The aim of the collaboration was to integrate leadership and management development into ongoing technical assistance in the ACQUIRE-led family planning program to revitalize family planning in the region and ultimately improve maternal and child health through improved health workforce performance at the service delivery level.

Six health facility teams and three district teams participated in the program. With the assistance of Eastern and Southern Africa Management Institute staff—located in Arusha, Tanzania—and a local consultant, all three LDP workshops were delivered in Swahili. Between the initial workshop and additional workshops in March and June 2006, Kigoma-based ACQUIRE staff and district-level Ministry of Health staff provided follow-up coaching to the teams to help them refine their action plans and apply the leadership skills they learned in the program.

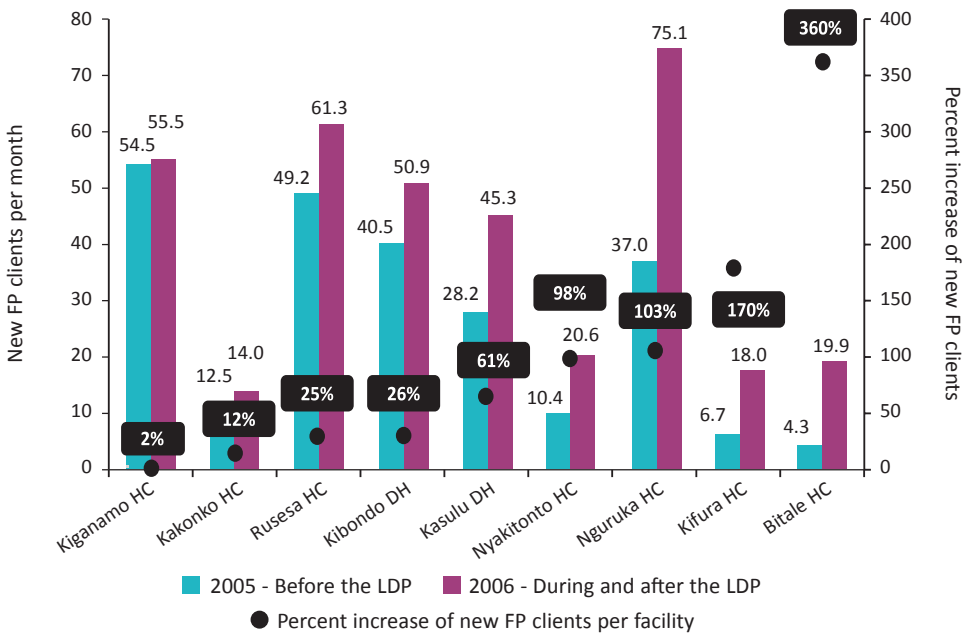
Early in the LDP, teams were asked to consider how they were doing in addressing family planning and to assess weaknesses and strengths. All were originally of the opinion that they

were doing relatively well, but the scanning exercise revealed very modest results vis-à-vis family planning utilization. District teams acknowledged that health centers were underperforming, in part due to poor coordination of district activities and those of the health centers within their jurisdiction, resulting in situations where health centers felt isolated and unsupported.

The participating teams successfully used the tools introduced in the LDP program to identify priority activities, action planning, resource mobilization, and monitoring and evaluation. As a direct result of their data analyses, teams reallocated health personnel to ensure adequate numbers of health workers were available for family planning counseling and service delivery, provided training and refresher training for providers of family planning, and raised awareness in the communities served by the facilities about the importance of family planning for the health of women and children.

Results. As depicted in figure 4, all the participating health facilities (health centers and district hospitals) were able to increase the number of new family planning clients per month from a low of a 2 percent increase in Kiganamo Health Center to a high of a 360 percent increase in Bitale Health Center.

FIGURE 4. AVERAGE NUMBER OF NEW FAMILY PLANNING (FP) CLIENTS PER MONTH IN HEALTH CENTERS AND DISTRICT HOSPITALS, KIGOMA, TANZANIA, 2005–2006



Source: MSH, unpublished data, 2012.

Legacy. The leadership development work carried out in Tanzania left an impressive imprint in terms of family planning service delivery results. The achievement of such results motivated the Kigoma LDP facilitators from ACQUIRE and the Ministry of Health to scale up the program to twenty more dispensaries and health centers in two districts on their own without technical assistance from the MSH Program staff.

Short-term interventions like the LDP can result in service delivery improvements as documented in the Kigoma experience. However, after this promising beginning, a national shortage of family planning commodities in Tanzania in 2008 impacted the program, and the LDP could no longer continue to be scaled up. One of the key lessons that the participating teams learned was that sustaining service delivery improvements in family planning requires the availability of essential commodities, such as contraceptive supplies, and an effective system for their distribution at service delivery points. Otherwise, the lack of such commodities becomes a major barrier to sustaining those initial improvements. The purpose of the LDP is to empower managers to address obstacles that are in their control. Unfortunately, not all constraints are in their control.

Ghana: Scaling up the LDP

Challenge. The Ghana Health Service (GHS) was created in 1996 with the responsibility to manage the provision of health care services to the people of Ghana. The GHS employs more than forty-two thousand staff. But the distribution of health workers is skewed toward more affluent regions, largely in the southern half of the country. Highly skilled health professionals are concentrated in the greater Accra Region as well as in the Korle Bu and Komfo-Anokye teaching hospitals, in the greater Accra and Ashanti Regions respectively. These two teaching hospitals employ more than 45 percent of the country's doctors; however, less than 15 percent of Ghana's doctors practice in the district hospitals. Human resource managers are assigned at the regional level and at teaching hospitals; training coordinators are responsible for in-service training at the regional levels and at the teaching hospitals. The limited health personnel in the regions where the health needs are greatest justify the need for optimal management of available resources (Ghana Health Workforce Observatory 2011).

Intervention. USAID supports interventions to improve family planning and maternal, neonatal, and child health in Ghana. As a component of USAID's effort to improve health results, MSH introduced the Leadership Development Program in 2007.

In a May 2012 interview for a study conducted by MSH about why the LDP was first introduced, one of the coordinators of the LDP since the beginning of the program in Ghana, who is a deputy director in the GHS, explained: "There have been a lot of concerns raised about productivity and outputs in the health sector. Looking at the amount of monies that are pumped

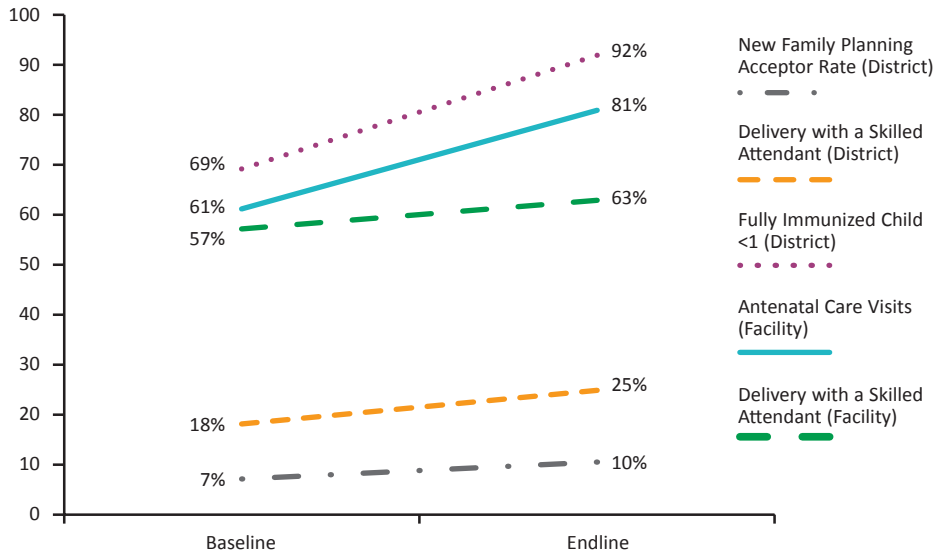
into health services, the indicators are still where they are—maternal mortality, low coverage and so on. . . . We know we have all the technical know-how, and fairly adequate resource allocation funding from agencies and donors, but still we are not getting anywhere. . . . So, these discussions . . . really crystallized the issue. . . . Let's focus on developing managers who lead to show results" (Seims et al. 2012).

A pilot program was first conducted in Cape Coast in the Central Region in 2008 with funding under the Leadership, Management, and Sustainability (LMS) program. The program began with eight facilitators, four of whom were still facilitating the LDP four years later. In 2009, the LDP was implemented in Kumasi for regional, district, and facility teams from Ashanti Region, which spurred a locally driven, region-wide rollout of the LDP. The LDP training is continuing in the Ashanti Region with funding from the regular regional budget of the GHS. Also in 2009, a Training of Trainers was offered to potential LDP facilitators to assist in the scale-up of the LDP.

The LDP was next rolled out to the Volta Region in August 2010, using GAVI Alliance support for health systems strengthening in the GHS. The program also expanded to the greater Accra, Western, and Central Regions in 2010. As of July 2011, 295 staff in fifty teams had been trained in the LDP. In 2012, with funding from UNICEF, the LDP was rolled out in three regions in the northern part of the country, namely, the Northern, Upper West, and Upper East Regions.

Results. In May 2012, MSH conducted an evaluation of the LDP in Ghana that included key informant interviews with twenty individuals who had key roles as LDP participants. The purpose of the study was to identify the changes that followed the LDP and to determine which changes, behaviors, practices, and outcomes were sustained and why. Interviews were conducted in greater Accra, Ashanti, Central, and Volta Regions; all interviews were digitally recorded and transcribed. Five of those interviewed cited data for their team's health indicators for both before and after the LDP. These data were cited from internal health management information system reports and are not available externally. One participant reported a district-wide increase in fully immunized children under one year old from 69 percent to 92 percent, exceeding their target of 90 percent (MSH unpublished data, District Director, GHS, May 23, 2012). Other district teams reported an increase in the family planning acceptor rate, from 7 percent to 10 percent (MSH unpublished data, LDP Facilitator, May 18, 2012), and in the proportion of births with a skilled birth attendant from 18 percent to 25 percent (MSH unpublished data, District Director, GHS, May 18, 2012). One large facility reported an increase in the proportion of pregnant women who received antenatal visits, from 61 percent to 81 percent; another reported an increase in the proportion of births with a skilled birth attendant, from 57 percent to 63 percent (MSH unpublished data, Acting District Director, GHS, May 23, 2012). These improvements are illustrative of the magnitude of the change that teams in Ghana were achieving (figure 5).

FIGURE 5. SELECT TEAM RESULTS BEFORE AND AFTER LDP INTERVENTION, GHANA



Source: Seims, L. 2012. *Sustainability of the Leadership Development Program in Ghana: A Eureka Experience*. Unpublished internal report. Arlington, VA: Management Sciences for Health. Reprinted with permission.

Other findings are more difficult to quantify. For example, in the Volta Region, the mechanical workshop of the Regional Health Directorate had approximately one hundred vehicles for transporting patients as well as staff for supervision. At any point in time, however, a large proportion of their fleet was out of use awaiting repair or not roadworthy. The Regional Health Directorate selected revamping the mechanical workshop and improving the transport as their LDP challenge. No funds were expended for new vehicles. Instead, they invested in new tools, parts, supplies, and training for mechanics. At present, most vehicles can now be repaired within twenty-four hours. Having vehicles in good working order improved patient access to health services and improved management and supervision of staff throughout the region.

The mechanical workshop also became a source of income generation. The region now offers fee-based vehicle repair services for GHS vehicles outside the region and for United Nations vehicles.

Legacy. The LDP has become integrated with Ghana's policy process, which has helped to institutionalize the method and support its rollout. LDP tools are now routinely used in the

development of new public health sector projects; every level of the GHS "must be introduced to the LDP" (MSH unpublished data, Training Director, GHS, May 18, 2012).

A former director general of the GHS views the LDP as his legacy. As noted in a testimonial given by an LDP facilitator, "Their Director General said that that is the legacy he wanted to leave with the Ghana Health Service. He said on two or three occasions that—I was there—that the LDP is the legacy he wants to leave" (MSH unpublished data, LDP Facilitator, May 22, 2012). Many of those interviewed view part of the legacy of the LDP as the expansion of LDP team training within the GHS to more sites and to regions not previously covered. LDPs have involved public sector health staff at all levels, from national to regional, district, and subdistrict, especially from hospitals. At the national level, the Human Resources Division rolled out the LDP to its own staff. One regional director emphasized that LDP fostered a culture of teamwork that has been institutionalized as regional policy and that this policy is reinforced during field supervision visits.

COST AND SUSTAINABILITY

As long as the real costs of poor management and leadership remain hidden, the cost of management and leadership skills training will typically be considered merely an additional expense. It is only when the payoff (better services, more lives saved) becomes visible that the cost of investing in leadership and management will likely be seen as a positive investment.

It is difficult to identify a common cost for the process of strengthening leadership and management through LDP. The core operational cost of implementing one LDP ranges from US$120,000 to US$180,000, but there are many parts to the process that imply variables. In some cases, there is a request for expatriate staff; in many other cases, local facilitators manage the process. Other variables include venue, travel costs, and the degree of coaching and mentoring required. As more and more local facilitators are trained, the costs diminish.

Sustainability

For the purposes of leadership development, sustainability is defined as having adequate numbers of trainers within the country to continue to implement the program as well as the commitment of the organization to support it on a continuing basis. In the three countries discussed here, local trainers were an essential part of the implementation process, and the Ministries of Health were committed to its mission. A true measure of sustainability of the resulting changes in leadership and management practices lies in the institutionalization of the LDP methodology, tools, and concepts within organizations that have seen improved service

delivery as a result of the program. The following are illustrative of this evidence:

1. In Ghana, there are influential champions in the Ghana Health Services and the Ministry of Health as well as a pool of experienced facilitators. This is also true for Kenya.
2. In South Sudan, Tanzania, South Africa, Namibia, and Lesotho, the LDP has become an integral part of USAID-funded health systems support.
3. Universities have included elements of the LDP in their pre-service curricula; these include the College of Health Sciences, Makerere University, Uganda; Mbarara University of Science and Technology, Uganda; Ghana Institute of Management and Public Administration (GIMPA); Medical Education Department, Suez Canal University, Egypt; Kenya Medical Training College (KMTC), Nairobi.
4. As previously mentioned, the Ministries of Health in Kenya hosted a National Conference on Health Leadership, Management, and Governance in January 2013.
5. While not part of the cases described here, MSH is aware that following the LDP the Ministry of Public Health in Afghanistan now has a department that is exclusively focused on management and leadership development, called the Management and Leadership Development Department, housed in the Ministry of Public Health's General Directorate for Human Resources. Created in 2011, following five years of the LDP program being implemented in-country, this department sees its mission as the following: "The Management and Leadership Department of the Ministry of Public Health is committed to enable health care human resource facilitators and strengthen the health system through development and scaling up of management and leadership practices" (MSH 2012).
6. In South Africa, the pharmaceutical leadership development program is looking for accreditation with the South Africa Pharmaceutical Council, a statutory body.
7. In Egypt, the LDP continued under its own steam once the project funding ended.
8. Due to the highly positive impact of the LDP in Ghana, the GHS, USAID, and the UN, through a variety of programs, continue to support the scale-up of the LDP in the Central and Western regions of Ghana.

Limitations of Case Studies

The key limitation of these case studies lies in the difficulty of collecting data on an ongoing basis. As demonstrated, a monitoring and evaluation procedure requires additional budget and the support of specialists in monitoring and evaluation. This is frequently beyond the scope of the budget and capacity of the country to implement.

A further limitation is attributing causality. In recent years, donors, global organizations, and national governments have increasingly acknowledged the importance of leadership, management, human resources for health, and health system strengthening in addressing their

health challenges. As a result, other initiatives in these areas would have likely also been a part of the landscape in these countries.

LESSONS LEARNED

Lessons learned from strengthening management and leadership practices of health staff can be summarized as follows:

1. Following short-term leadership development interventions, improved service delivery outcomes can be realized and sustained despite the complex environment that low-income settings present for the effective delivery of public health interventions.
2. Leadership development interventions appear to play an important role in strengthening health systems, including service delivery improvements at any level of the system in low-income settings.
3. Both integrating leadership development into existing structures and coordinating with Ministries of Health, other USAID collaborating agencies, and donors help to ensure sustained attention to leadership development in low-income countries.
4. Programs that target the district level often do not cascade down to lower-level facilities, so it may be important to implement facility-based leadership development programs to achieve desirable effects. Lower-level leaders should be part of the planning and start-up phases.
5. It is critical to attach the LDP to health indicators so that it is not a stand-alone leadership program without any associated work performance targets.
6. The LDP creates an improved work climate that promotes better health service delivery and workforce performance.
7. There is a need to institutionalize leadership development in pre-service and in-service health training programs.

CONCLUSION

Management and leadership development are often confused with management and leadership training. The two are not the same. The MSH approach to strengthening these skill sets is anchored in addressing current challenges faced by program participants and the operationalization of management and leadership as a set of practices that anyone, at any level, can learn to do better.

The cases presented here show some of the diversity of applications—yet the approach remains the same: (1) work with members of existing professional teams to identify a

challenge in their work that they are committed to address; (2) teach them the practices and how to be systematic about using them; (3) strengthen the ability of team members to use metrics and measurements to monitor progress; and (4) encourage them to make course corrections.

The LDP provided leaders in the health systems with a practical method to take responsibility, ownership, and action rather than waiting for superiors to step in and solve problems. It is a scalable process that, once planted, enables participants to continue to harvest the benefits of the investment by transferring the tools to their local colleagues. Most critically, the LDP is being used to contribute solutions to some of our most stubborn, persistent, and deadly health problems.

One participant noted: "When I occupied this office . . . the LDP gave me a 'can do.' It placed in me a 'can do' spirit. This is exactly what we need in our health workforce today" (MSH unpublished data, Regional Deputy Director, Clinical Care, May 31, 2012).

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