

Scaling Up Access to Effective Management and Leadership Practices for Health Organizations through the Use of Virtual Approaches



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

MEC implemented the strategic evaluations in two phases with a preliminary report released in January 2009 and a final report completed in May 2010. The two-phased reporting allowed for an early assessment of results achieved and lessons learned to be shared with USAID and its external evaluation team, as well as for adjustments to be made in technical approaches to improve LMS performance during the remaining months of the program and for future programs supported by various USAID Missions. All strategic evaluation reports and their abridged summaries will be shared with interested stakeholders, including the larger international health community.

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

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GLOSSARY OF ACRONYMS

ACQUIRE Project	Access, Quality, and Use in Reproductive Health
ADS	Asociación Demográfica Salvadoreña
AIDS	Acquired Immunodeficiency Syndrome
APROPO	Apoyo a Programas de Población, Peru
ART	Antiretroviral therapy (ART)
ARV	Antiretroviral
CEPEP	Centro Paraguayo de Estudios de Población
CHAM	Christian Health Association of Malawi
CIRD	Centro de Información y Recursos para el Desarrollo, Paraguay
CRTU	Contraceptive and Reproductive Health Technologies Research and Utilization program
CS	Contraceptive security
CSO	Civil society organization
CYP	Couple Years of Protection
DAIA	Comites de Disponibilidad Asegurada de Insumos Anticonceptivos
DMPA	Depo-Provera
ESAMI	Eastern and Southern Africa Management Institute
FBO	Faith-based organization
FHI	Family Health International
FP	Family planning
GEN	Global Exchange Network for Reproductive Health
GTZ	German aid agency
HIV	Human Immunodeficiency Virus
HPI	Health Policy Initiative
HR	Human resources
HRH	Human resources for health
HRM	Human resource management
IBP	Implementing Best Practices (Consortium)
IUD	Intrauterine device
JSI	John Snow, International
LAC	Latin America/Caribbean
LMS	Leadership, Management and Sustainability Program
M&L	Management and Leadership Program
MC	Male circumcision
MCH	Maternal and child health
MOH	Ministry of Health
MSH	Management Sciences for Health
NGO	Non-governmental organization
OECS	Organization of Eastern Caribbean States

OHA	Office of HIV/AIDS
OPD	Outpatient department
OPRH	USAID Office of Population and Reproductive Health
PAC	Post-abortion care
PY	Project year
RFMH	Raleigh Fitkin Memorial Hospital
RFP	Repositioning Family Planning
RH	Reproductive health
SFH	Society for Family Health
SHOPS	Strengthening Health Outcomes through the Private Sector
SPARHCS	USAID's Strategic Pathway to Reproductive Health Commodity Security
TB	Tuberculosis
USAID	U.S. Agency for International Development
VBPH	Virtual Business Planning for Health (Program)
VCT	Voluntary Counseling and Testing
VFCP	Virtual Fostering Change Program
VHRM	Virtual Human Resources Management Program
VLDP	Virtual Leadership Development Program
VCGP	Virtual CSO Board Governance Program
VSPP	Virtual Strategic Planning Program
WHO	World Health Organization

EXECUTIVE SUMMARY

Around the world, health professionals, doctors, nurses, nutritionists, pharmacists, social workers, laboratory specialists and other clinicians and public health practitioners are managing and leading programs with little or no formal management and leadership education or training. In addition, even staff in purely administrative positions report that their preparation lacks practical management skills. To improve population health by improving the delivery of health services, these widespread management and leadership gaps must be addressed.

A key mandate of the Management Sciences for Health Leadership, Management, and Sustainability (LMS) Program is to mainstream and scale-up the use and institutionalization of effective leadership and management practices in health institutions and programs in developing countries. LMS defines scale-up as expanding the number of people and organizations who are effectively applying leadership and management approaches to achieve improved results in health. With funding from USAID, MSH has developed Web-based distance learning programs, networks, and resources to address gaps in health professionals' management and leadership skills and education. USAID supported this important effort in partnership with the Management and Leadership Program (2000-2005), and subsequently with LMS (2005-2010). This support provided the opportunity to experiment with ways to reach people virtually, build skills, and change management, leadership, and governance behaviors as a pathway to improving health services. Through the process of "after action review" following all new virtual deliveries, lessons learned were continuously folded back into the development of the next programs, and used to expand offerings in new areas, such as business planning for health and human resource management.

LMS's Collection of Virtual Approaches



First launched in 2002, these virtual offerings focus on leadership development, business and strategic planning, human resource management, board governance, and other organizational needs. Through one or more of these Web-based learning activities, more than 8,000 health professionals from 140 countries have gained leadership and management skills. Virtual Programs are delivered to teams of health professionals working in civil society organizations (CSOs) and in the public sector. Seminar and conference facilitators from both LeaderNet and Global Exchange Network for Reproductive Health employ individual learning, peer-to-peer discussion, and team focused teaching approaches. LMS virtual programs and seminars are consistently highly rated by participants. In a 2007 LeaderNet survey, 68% of 133 survey respondents reported using resources and applying knowledge or practices from a LeaderNet seminar in their work. Of those, 43% reported that teamwork was strengthened, 32% reported that they had improved

their capacity to respond to change, 30% reported improved work climate, and 26% reported improved management systems. In a 2008 Global Exchange Network for Reproductive Health survey, 70% of 264 survey respondents reported using resources, knowledge, or practices from seminars in their work; 52% reported making organizational improvements as a result of participating in a seminar; and 84% would like to continue to receive updated information on reproductive health and management skills.

Program and seminar participants apply the skills they learn during virtual programs and seminars to achieve public health results. Teams from Family Planning organizations in Latin America have secured funding to increase contraceptive security and post-abortion care services. Teams in Francophone Africa have improved their monitoring and evaluation systems so they are better able to anticipate challenges and come up with clear plans to address them.

During the eight years that MSH has been delivering leadership, management, and governance content virtually to teams across the globe, we have learned seven primary lessons:

Successful programs are responsive to the needs and interests of participants: LMS online programs and seminars are designed around priority management and leadership topics that are identified by LMS client organizations and partners.

The potential for using virtual approaches is growing: Virtual approaches are cost-efficient and an increasingly viable and accepted way of extending learning opportunities to teams in many health organizations and countries. Virtual approaches increase access to learning opportunities for people who would not otherwise receive them, such as mid- and lower-level managers, women in low resource settings, people working in rural areas, and other marginalized populations. With access to the internet increasing every day and electronic technology constantly improving around the world, the potential for the use of virtual approaches is enormous.

Balance standardized and customized program content: It is important to standardize programs to ensure quality and easy replication, while at the same time allowing enough flexibility so that programs can be adapted to the context and needs of client organizations.

Partnering extends LMS' reach: Partnering with other USAID projects, cooperating agencies, and other organizations maximizes USAID's investment in our virtual approaches by enabling us to reach a greater number of teams and organizations, and cover a broader range of technical areas.

Dynamic facilitation is a key to success: LMS trains facilitators in key technical areas who develop relationships with teams, recognize their progress, and provide interactive feedback and support. Interactive and supportive facilitators keep participants engaged and are a key factor in keeping attrition rates low.

Intact teams that have self-selected for the program are the most engaged: Teams that self-select for program participation experience lower attrition, fewer challenges implementing action plans, and higher engagement than teams who are directed to participate. Teams who have previously worked together and will continue to do so in the future have better success applying and sustaining the skills they have learned than teams who do not regularly work together.

Measuring and reporting results motivates teams: When teams set goals and achieve them, they are inspired to share their results and skills with others, and to continue applying what they have learned. Obtaining quality follow-up data is also vital to demonstrating the links between investments in management and leadership capacity building, improved organizational and program functioning, and improved services and health outcomes.

The need for capacity development in management, leadership, and governance is large, and using virtual technologies is a way to meet this demand. Virtual approaches provide ongoing learning opportunities to people who would not otherwise receive them, and at a reasonable cost. Significant opportunity exists to expand these virtual approaches as internet connectivity increases, and mobilization and financial support for strengthening health systems grows. We are in a new era of international development that requires a long-term view. Increasingly, donors will need to pursue long-term health strengthening strategies while continuing to address the pressing immediacy and demands of vertical health programs. The overarching aim should be to help countries achieve independence, and to leave a legacy of countries who are able to plan, lead, manage, finance, and deliver basic health services on a sustained basis. Strengthening leadership, management, and governance innovatively, and with the most effective technologies, is a central means to these important ends.

I. INTRODUCTION

Around the world, health professionals, doctors, nurses, nutritionists, pharmacists, social workers, laboratory specialists as well as other clinicians and public health practitioners are managing and leading programs with little or no formal management and leadership education or training. Developing management and leadership skills and competencies are rarely part of the curriculum in pre-service institutions such as schools of medicine or nursing. Strong management and leadership skills and sound organizational management systems are critical to successfully functioning health programs, organizations, and institutions, and are critical to efficient and effective delivery of health services. To improve global health by improving the delivery of health services, these widespread management and leadership gaps must be addressed.

A key mandate of the Leadership, Management and Sustainability (LMS) Program is to mainstream and scale-up the use and institutionalization of effective leadership and management practices in health institutions and programs in developing countries, including Ministries of Health; Civil Society Organizations; National Family Planning Programs; National AIDS Commissions; Global Fund Country Coordinating Mechanisms and Principal Recipients; and other health service organizations and programs. LMS defines scale-up as expanding the number of people and organizations who are effectively applying leadership and management approaches to achieve improved results in health. To scale-up, LMS employs direct technical assistance approaches through LMS country-based offices.

With funding from USAID under the Management and Leadership (M&L) and LMS programs, MSH has expanded the use of virtual approaches to reach a greater number of organizations, especially those in low resource settings. This support provided the opportunity to experiment with ways to reach people virtually, build skills, and change management, leadership, and governance behaviors as a pathway to improving health services. Through the process of "after action review" following all new virtual deliveries, lessons learned were continuously folded back into the development of the next programs, and used to expand offerings in new areas, such as Business Planning for Health and Human Resource Management.

LMS's Collection of Virtual Approaches



LMS' virtual approaches include management and leadership development learning programs, forums on Web-based platforms such as LeaderNet and the Global Exchange Network for Reproductive Health, conferences, and the electronic Health Manager's Toolkit, all of which have significantly contributed to the total number of managers, health professionals, organizations, programs and countries reached during LMS.

LMS virtual learning programs and networks have significantly expanded access to management, leadership and governance capacity building practices for health managers and their teams in public and private sector health organizations in developing countries. Our experience since 2002, under both the Management & Leadership Program (2002-2005) and the LMS Program (2005-2010), has shown that it is possible to strengthen the leadership, management, and governance capacity of thousands of health professionals via

facilitated, Web-based programs and seminars in a cost effective manner. As of March 2010, LMS has received Field Support earmarks and Associate Awards from USAID Missions in 23 countries. Through the use of virtual approaches, LMS has expanded this reach to teams in 62 countries with virtual learning programs, and to individuals in over 140 countries through LeaderNet and the Global Exchange Network for Reproductive Health. Since the launch of the first virtual programs in 2002, 3,000 health professionals have been reached through virtual programs, more than 6,000 people have access to virtual seminars, and hundreds of people have participated in conferences on

management, leadership and governance. Seven thousand people also access the online resource the Health Manager's Toolkit every month. LMS has shown that virtual approaches:

- Strengthen the leadership, management, and governance capacity of teams to achieve public health results;
- Cost-efficiently broaden access to much needed competencies for thousands of health professionals at all levels of the health care system in low- and middle-income countries;
- Allow individuals and teams to share information and learn from each other on internet platforms, despite physical distance;
- Allow several technical experts to effectively work with each participating team at reduced cost.

This document provides information on virtual approaches that have been used under LMS to reach an ever increasing number of people and organizations to scale-up best practices in leadership and management for improved health outcomes. We provide descriptions of our virtual approaches, information on their application, and results. Strategies for successful virtual approach implementation are discussed, including offering field-tested approaches that can be readily applied, offering engaging content that is responsive to the needs of health professionals, using multi-lingual blended learning approaches, and making continual improvements based on feedback. We highlight the use of virtual approaches in the areas of family planning and reproductive health, contraceptive security, post-abortion care, and the integration of family planning and HIV/AIDS/TB services. Finally, we discuss the main lessons we have learned while scaling up leadership and management skills virtually, and the significant opportunity that exists to expand these methods as internet connectivity increases, and mobilization and support for strengthening health systems increases.

The programs sampled here allow us to explore an association between management and leadership inputs and improved health system performance. LMS' client organizations are deliberately selected, and the strategies used are the best adaptation of standardized management and leadership tools to local contexts. We do not control for external variables that may also have an influence on improved health systems performance, so we do not claim a strict cause and effect relationship. We can and do build a case for a strong association to improved performance based on the strength of the evidence collected and elucidate the success factors and the barriers to strengthening the health sector in a variety of settings.

2. VIRTUAL APPROACHES AND IMPLEMENTATION UNDER LMS

With funding from USAID, Management Sciences for Health has developed Web-based distance learning programs, networks, and resources to address gaps in health professionals’ management and leadership education. First launched in 2002, these virtual offerings focus on leadership development, business and strategic planning, human resource management, board governance, and other organizational needs. Through one or more of these Web-based learning activities, more than 8,000 health professionals from 140 countries have developed their management and leadership skills.

At MSH, we believe that to truly impact family planning and reproductive health, to reduce child mortality, and to advance the battle against HIV/AIDS, we need to consider leadership and management development as important as clinical training for people working at all levels of the health system. MSH delivers accessible programs, networks, and tools for learning that provide a pathway for health professionals to learn new skills. The LMS Program has successfully developed a virtual suite that includes:

- **Virtual Programs:** Eight- to 20-week programs available in multiple languages for health teams to develop and implement a focused action plan. Facilitation and follow-up is provided by MSH organizational development specialists.
- **Virtual Networks:** Multilingual online networks that host periodic seminars and conferences, allowing for cost-effective worldwide knowledge exchange in priority health management and leadership issues.
- **Virtual Resources:** The Health Manager’s Toolkit is a comprehensive, multilingual electronic library of tools from MSH and other organizations that help build knowledge and skills in leadership, management, and governance. We are also launching a new resource, *Health Systems in Action: An eHandbook for Leaders and Managers*, on May 17, 2010 at the LMS End of Project Conference.

Virtual approaches have expanded significantly since the conclusion of the M&L Program and the end of LMS. Participation in Virtual Programs has more than doubled since these programs were first launched under the M&L Program between 2002 and 2005. Membership in LeaderNet and the Global Exchange Network for Reproductive Health has increased more than 13-fold, with the average number of participants per seminar steadily increasing over time. Rapidly growing participation in these programs, networks, and conferences is compelling evidence of a growing demand on the part of international health professionals for online learning in the areas of leadership, management, and governance.

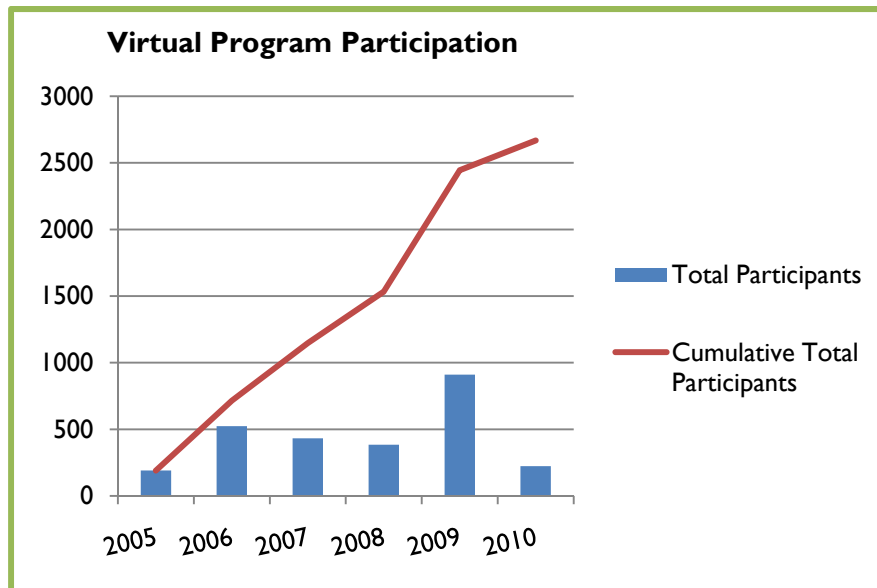
Table 1. Growth in reach of virtual programs and networks between 2002 and 2010

Virtual Programs and networks	M&L (2002-2005)	LMS (2005-2010)
Virtual Programs	149 teams, 950+ individuals from 29 countries	300+ teams, 2,400+ individuals from 46 countries
Virtual Networks (LeaderNet and the Global Exchange Network for Reproductive Health)	424 individuals from 30+ countries	6,000+ individuals from 140+ countries
Virtual Conferences (iCoherence website)	263 participants in 2 conferences	548 participants in 2 conferences

2.1 Virtual Programs

The development and delivery of virtual learning programs have contributed significantly to the scale-up of leadership and management approaches and tools under LMS. As currently structured, a single offering of a virtual management or leadership learning program can reach up to 120 people from 12 different countries.

Figure 1. Virtual Programs under LMS from January 2005 to Quarter 2 of PY5 in 2010



Demand for virtual programs during LMS has been high and continues to grow, with participation increasing approximately ten-fold since 2005.

Often, face-to-face capacity building approaches are not available to mid- and lower-level managers, women, marginalized populations, or in rural areas, and involve sending an individual health professional to off-site workshops and programs from 1 day to 2-3 weeks. This can be slow and costly, and may disrupt health service delivery. When participants return from workshops to their workplaces, it is often difficult to transfer their newly acquired skills and knowledge to their colleagues and generate support for change. Other disadvantages of traditional approaches include a theoretical rather than practical focus, the participation of too few staff from the same organization, and the cost of these events.

If the cost per participant of implementing a 16-week VLDP is compared with the hypothetical cost of one participant coming to the United States for a 3-week long university course, including the cost of travel, room, board, and tuition, the VLDP is far less expensive per participant as shown in the chart below.

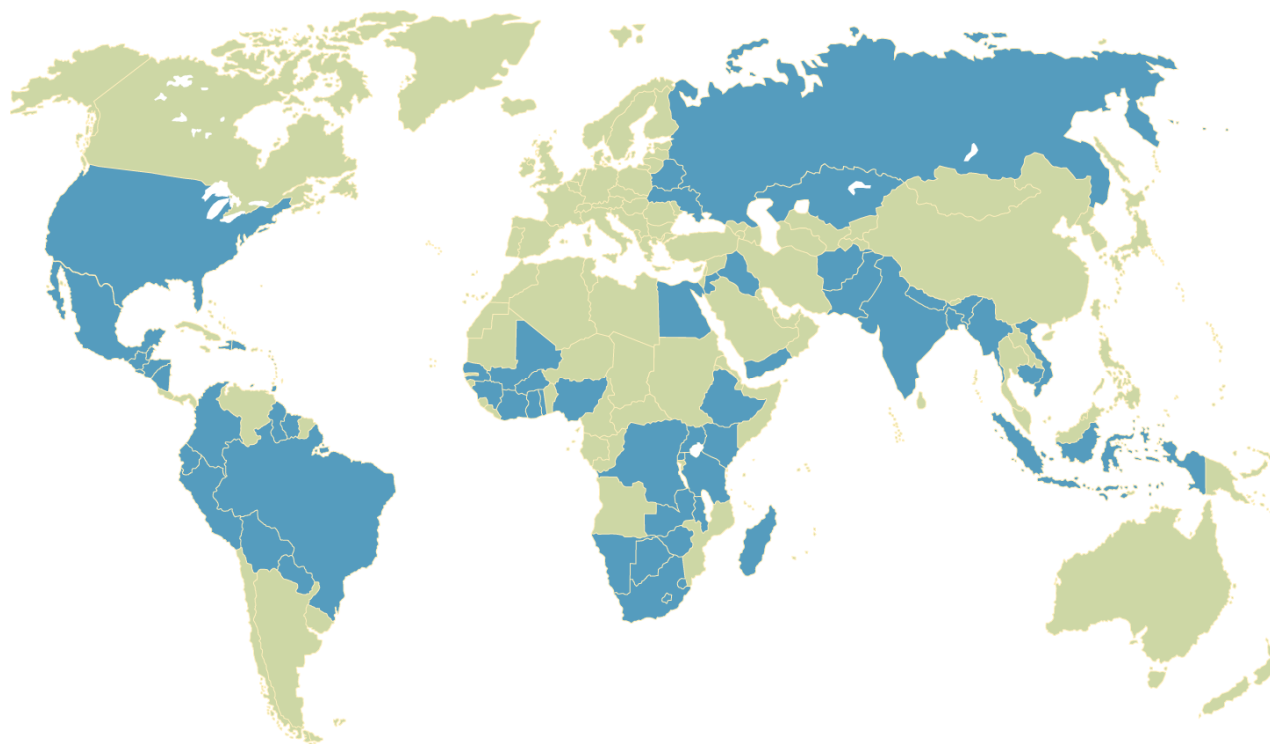
Learning Program	Description	Price per Participant
Virtual	16-week VLDP for 92 participants from 4 countries	\$1,256 (\$78 per week)
Face-to-Face	Fee for one student to attend a 3-week course in an East African country	\$4,300 including travel, lodging, and food. (\$1,433 per week)

When the price per participant for a virtual conference is compared to the cost of one person attending a hypothetical face-to-face conference including the cost of travel and per diem, a virtual conference is far less costly per participant, as shown in the chart below:

Conference	Description	Price per Participant
Virtual	RFP conference for 254 francophone African participants for 3 days	\$216
Face-to-Face	Hypothetical international conference in Bangkok for 3 days	\$1,981

LMS would be unable to reach the numbers of health professionals, health teams and health organizations that it does for the budget available without virtual approaches to capacity-building.

VLDP Participant Country Representation: August 2005 – March 2010



LMS' portfolio of Web-based distance learning programs is facilitated by organizational development specialists and experts in key health and technical areas. Facilitators provide teams with technical assistance, feedback, and support via website postings, email, and telephone throughout the program. Programs enroll up to 12 organizational teams that consist of 4 to 10 people who work together on a regular basis. These programs strengthen the leadership and management capacity of health teams and their organizations to improve health service delivery and organizational performance. Rather than giving a few senior-level managers off-site leadership and management training, virtual learning programs train intact, organizational teams of four to 10 individuals on-site in their organizations over the course of eight weeks to one year.

Table 2. LMS's Portfolio of Virtual Programs

Program	Length	Languages	Purpose
Virtual Leadership Development Program (VLDP)	13 weeks	English, Spanish, French, Portuguese, Arabic, and Russian	To strengthen the leadership of teams by supporting them to identify and address an organizational challenge they are currently facing.
Virtual Strategic Planning Program (VSPP)	17 weeks	English and Spanish	To support teams as they develop an organizational strategic plan.
Virtual Business Planning for Health Program (VBPH)	20 weeks	English and Spanish	To assist teams in the development of a business plan for a new or expanded product or service.
Virtual Human Resource Management Program (VHRM)	8 weeks	English	To support teams in the process of assessing their human resource system and developing an action plan to improve priority areas.
Virtual Civil Society Organization Board Governance Program (VCGP)	8 weeks	English and Spanish	To support teams in the development of a plan to improve governance of their board.
Virtual Fostering Change Program (VFCP), developed in collaboration with Implementing Best Practices Consortium	1 year	English and French	To support teams in the identification of a proven health practice and apply effective change practices for implementation and scale-up.

LMS's virtual programs require that participating teams develop an action plan, a strategic plan, or a business plan during the course of the program. Team members work independently on the program web site with additional support from the program workbook. During the program, they also take part in on-site team meetings in their organizations. Participants are not required to leave their work sites in order to benefit from these programs, eliminating travel costs and associated absenteeism. Teams carry out their action plan after the virtual program ends. Facilitators follow up with teams six months post-program to check in on the progress they have made implementing their action plans and the results they have achieved.

Program Requirements for participants include:

- Reliable access to a computer and the internet (a minimum 56.6 Kb/s modem connection speed and a version of Internet Explorer 5.1 or higher).
- A team of health professionals that works together on a regular basis on a common objective or goal.
- Organizational commitment to the time requirements of the program (generally four to six hours per individual per week for the duration of the program).

MSH's virtual programs are practical and focus on improving performance in health organizations. They require that participating teams implement a plan developed during the program, such as an action plan, a strategic plan, or a business plan. Teams have produced concrete achievements in service delivery and organizational outcomes as a result of their participation in MSH virtual programs.

Table 3. Examples of LMS Virtual Program Results

Team Challenge	Results
CEMOPLAF— Ecuador Strengthen small basic pharmacies	All pharmacies completed financial analysis and developed Standard Operating Procedures. 8% increase in sales 7% increase in sustainability
Joint Clinical Research Centre— Uganda Increase regional access to antiretroviral (ARV) drugs in 26 antiretroviral therapy (ART) clinics	Opened six more ART sites.
Society for Family Health — Zambia Increase HIV/AIDS Prevention	Provided 250 male circumcisions within six months.
Apoyo a Programas de Población — Peru Improve access to Family Planning	Secured more than \$47,000 from Peruvian government to make spermicidal latex condoms available for low-income young adults.

Detailed descriptions of each LMS virtual learning program are in Appendix I, along with Table 2, a list of all virtual programs that have been implemented under LMS.

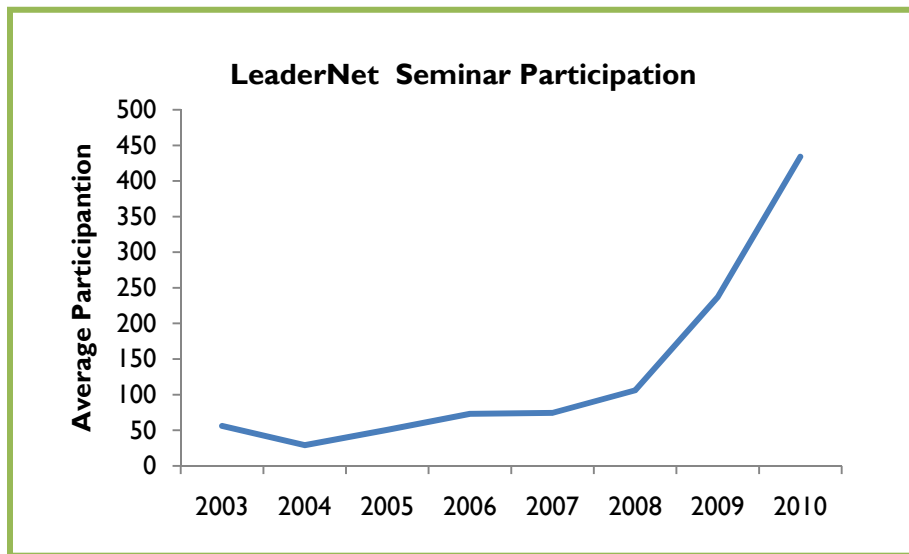
2.2 Virtual Networks

2.2.1 LeaderNet

Developed under the M&L Program, and enhanced and scaled up under LMS, LeaderNet is an online community of health professionals, managers, facilitators, and technical experts who are interested in improving their leadership and management skills and the management and leadership capacity in their health organizations and programs.

LeaderNet is an online community for continuous learning, ongoing support and worldwide peer exchange on priority health management and leadership topics. LeaderNet seminars are multi-lingual, and are offered in English, Spanish, Portuguese, and French.

Figure 2. Average Number of LeaderNet Participants per Seminar



LeaderNet has seen rapid expansion since the close of M&L. Attendance in seminars has increased from an average of 74 participants from 35 countries per seminar in 2007, to an average of 181 participants from 68 countries per seminar in 2010.

The LeaderNet online community offers:

- Multilingual online seminars designed and delivered by top management and leadership experts.
- Networking opportunities and resources for the professionalization of leadership and management in pre- and in-service programs.
- Blogs by individual members used to share experiences, challenges, and best practices.
- An annual Leadership and Management Award where team success in achieving results is celebrated.
- Periodic “challenges of the month” where current challenges from the field are discussed and solutions proposed from colleagues worldwide.
- Resources, tools and online seminars for Leadership Development facilitators and other interested members.

LeaderNet’s virtual seminars are consistently highly rated by program participants. A 2007 Web-based survey garnered responses from 133 members across a diverse sample of public and not-for profit organizations. Sixty-eight percent of respondents reported using resources and applying knowledge or practices from a LeaderNet seminar in their work. Of those, 43% reported that teamwork was strengthened, 32% reported that they had improved their capacity to respond to change, 30% reported improved work climate, and 26% reported improved management systems.

A second survey conducted in 2009 documented leadership, management, and governance skills members learned during seminars and applied afterwards in their day to day work. Key findings from the 113 survey responses analyzed included:

- Of the 31 respondents who participated in the seminar on the importance of periodic organizational management assessment and the Management and Organizational Sustainability Tool (MOST) from February 23-27, 2009, 75% said they had used the tool after the seminar.
- Seventy-one percent (71%) of those who participated in the seminar “Performance-Based Financing of Health Services: Paying for Results not Processes” (May 5-9, 2008), used the resources after the seminar. Of those, 30% met with stakeholders to discuss performance problems and desired results and 20% set performance targets to motivate staff to achieve results.
- Of those respondents who participated in the seminar “Moving up the Leadership Ladder,” 79% of respondents utilized the resources to identify their own strengths and weaknesses as a manager and improve their managerial skills.

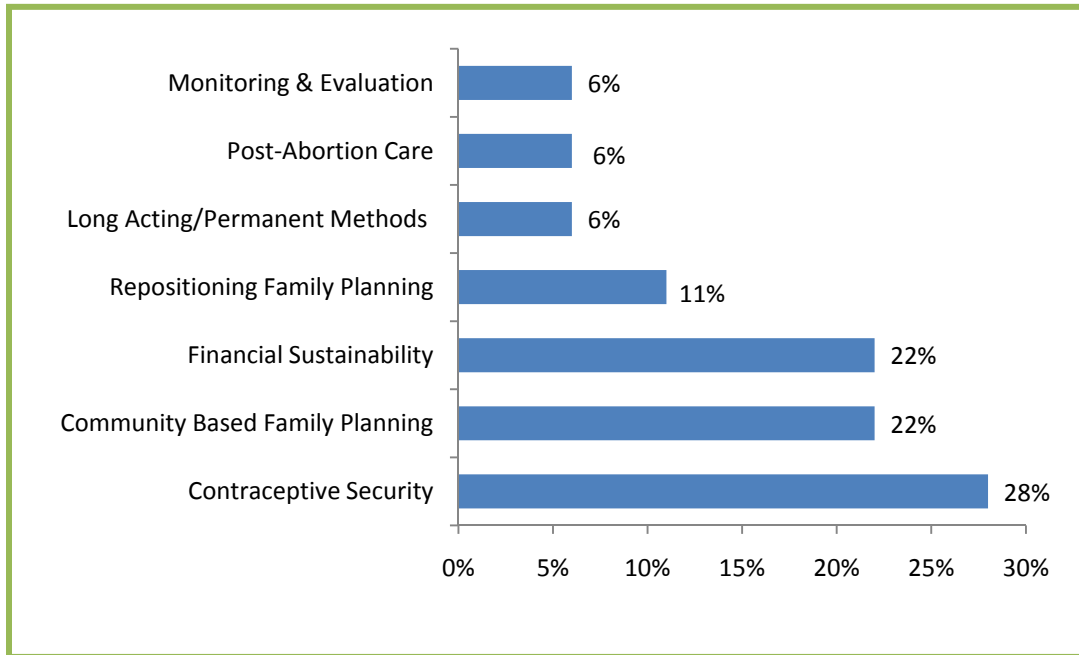
LeaderNet has become an important vehicle for scaling up and mainstreaming leadership and management tools and approaches worldwide. These survey findings and the application of Google Analytics to analyze use patterns help to guide future programming and enhancements to the website.

Table 8 in Appendix II shows all of the LeaderNet forums, seminars, and other learning exchanges carried out to date during LMS.

2.2.2 Global Exchange Network for Reproductive Health

Developed under the M&L Program, the Global Exchange Network for Reproductive Health is an online global network that allows for exchange and learning about leadership and management in the context of family planning (FP) and reproductive health (RH). Network offerings include periodic, one-week online forums to promote the exchange of information and proven practices on priority management, leadership, and governance issues in reproductive health and family planning. The Global Exchange Network for Reproductive Health also covers other USAID Global Leadership Priorities such as repositioning family planning, contraceptive security, and HIV and family planning services integration.

Figure 3. Global Exchange Network for Reproductive Health Seminar Themes



At the beginning of LMS in 2005, the Global Exchange Network for Reproductive Health had 294 members. As of March 2010, the Global Exchange Network for Reproductive Health had a total of 2,871 members from 133 countries in North and South America, Africa, Europe, and Asia. Like LeaderNet, the Global Exchange Network for Reproductive Health’s seminars are multi-lingual, and are offered in English, Spanish, and French.

To improve the quality of virtual program and networks offerings and activities, the LMS team regularly conducts evaluations after every online forum and seminar. To supplement the routinely gathered information, LMS carried out a full survey of all Global Exchange Network for Reproductive Health members in December 2008. Of the 1,726 eligible members, 264 completed the survey, for a response rate of 15%. The goal of the survey was to collect information to assist LMS in providing Global Exchange Network for Reproductive Health members with better opportunities for learning and sharing. Specifically:

- To document members’ use of the resources and tools available on the Global Exchange Network for Reproductive Health website.
- To assess the current needs of members in order to improve future Global Exchange Network for Reproductive Health offerings.

Of the 264 respondents:

- 70% reported using resources, knowledge, or practices from the Global Exchange Network for Reproductive Health in their work;
- 52% reported making organizational improvements as a result of participating in the Global Exchange Network for Reproductive Health;
- 84% reported reading/downloading forum resources;
- 47% participated in Global Exchange Network for Reproductive Health events by posting to the forum/seminar;
- 84% and 74%, respectively, would like to continue to receive updated information on reproductive health and management skills from the Global Exchange Network for Reproductive Health;
- 86% would recommend the Global Exchange Network for Reproductive Health to a colleague.

Resources, knowledge, and practices members reported using in their work:

- Leadership and Management skills
- Coaching and Mentoring
- Staff development
- Effective models for long-acting and permanent methods
- Strategic planning
- MSH Health Manager's Toolkit
- Assessment and Quality Assurance tools

Over 70% of survey respondents applied their learning from the Global Exchange Network for Reproductive Health to their daily work. This indicates that low cost virtual experiences such as those provided by the Global Exchange Network for Reproductive Health can play an important role in building the leadership and management skills of professionals, and strengthening the quality and sustainability of reproductive health and family planning services and programs.

Only 25 survey respondents (11%) reported facing challenges and barriers to accessing the Global Exchange Network for Reproductive Health resources. The most common challenges or barriers reported were the lack of time during their regular work to devote to the Global Exchange Network for Reproductive Health (60%) and poor internet connectivity or computer/technology skills (52%). Respondents had a variety of ideas to facilitate further learning and sharing, including providing access to journals/research articles, providing an email list to encourage participants to continue discussions after the end of a forum, and supplementing online seminars with face-to-face activities.

See Table 9 in Appendix II for a complete list of seminars delivered on the Global Exchange Network for Reproductive Health during LMS.

In December 2008, the LeaderNet and Global Exchange Network for Reproductive Health teams cross referenced their membership databases to see how much membership overlap existed. Despite LeaderNet and Global Exchange Network for Reproductive Health members receiving invitations to seminars and other events on both sites, only 250 members were shared between the two networks, indicating that the two networks are serving distinct needs. In March 2010, this analysis was repeated. Between the Global Exchange Network for Reproductive Health and LeaderNet membership lists, there are a total of 6,089 members. There are 416 duplicates, indicating that there is only a 6.8% overlap, and that LeaderNet and Global Exchange Network for Reproductive Health continue to serve distinct needs.

2.2.3 Virtual Conferences

In addition to virtual learning programs and virtual seminars, LMS also used virtual conferences as a way to reach large numbers of people with pertinent information on RH/FP and management and leadership practices. Similar to the LeaderNet and Global Exchange Network for Reproductive Health websites, the virtual conference website consists of a “directory” of participants with profile information, a “café” or informal discussion area where participants can introduce themselves and post pictures, a “library” with resources on reproductive health and family planning, and a “conference hall” where the presentations can be viewed. On each presentation page there is a discussion section where participants can post comments and ask questions. Presenters and other participants are able to respond directly within this discussion section.

In 2007, LMS implemented two USAID-funded virtual conferences on Repositioning Family Planning, with the objective of fostering the exchange of successful RFP experiences and mentoring relationships in francophone African countries among government, non-government organizations, the private sector, and other participants. USAID engaged its partners to select presenters from key countries that have had successful experiences and varied strategies in RFP within their countries. The presenters included representatives from Ministries of Health and international organizations working locally and supporting RH and FP programs.

In total, 647 individuals (196 women, 222 men, and 9 unidentified) registered for these virtual conferences. Participants were active in the discussions; there were 315 comments, questions, and responses posted in discussion sections, including the presenters’ comments and responses.

2.3 Virtual Resources

2.3.1 The Health Manager’s Toolkit

The Health Manager’s Toolkit is a multilingual online library of tools provided by MSH and partner organizations that health professionals can use to build their knowledge and skills in leadership, management, and governance. Tools are available in English, French, Spanish, and Portuguese and can be used by health managers at all levels of an organization to improve organizational performance. MSH is always searching for appropriate new or updated management tools to add to the Toolkit.

The Toolkit includes spreadsheet templates, forms for gathering and analyzing data, checklists, guidelines for improving organizational performance, and self-assessment tools for evaluating underlying problems management systems. The Tools in the Toolkit are organized alphabetically and by the following technical categories:

- Clinical Services and Quality Management
- Community Health Services
- Drug and Supply Management
- Financial Management
- General Management and Operations
- Governance
- Health Policy and Reform
- Human Resources Management
- Information Management
- Leadership Development
- Monitoring and Evaluation
- Organizational Planning

In addition to a link to the tool itself, information on each tool is provided, including the purpose of the tool, recommendations for applying the tool, advantages and limitations of the tool, countries where the tool has been applied, and the contact information of the tool developer. At present, the Health Manager's Toolkit contains 73 tools. Since the beginning of LMS, 24 new tools have been added to the Toolkit. On average, the Toolkit is accessed by 7,000 unique users per month. Users most frequently accessing the Health Manager's Toolkit come from the following countries: Mexico, United States, Colombia, Brazil, Venezuela, France, Peru, Canada, Ecuador, Spain, Morocco, Argentina, Guatemala, Chile, India, Dominican Republic, United Kingdom, Kenya, Nigeria, Costa Rica, Bolivia, Philippines, El Salvador, United Arab Emirates, and Nicaragua. The Health Manager's Toolkit can be accessed at <http://erc.msh.org/toolkit/>.

3. APPROACHES AND IMPLEMENTATION UNDER LMS

The LMS Scale-Up team has relied on eight primary strategies to scale-up virtual management and leadership learning programs, virtual forums and virtual conferences during LMS. These strategies have been developed based on needs identified by participants, on successful methods we have used in the field and adapted for use in virtual contexts, and on challenges we have faced and feedback we have received along the way.

3.1 Offer what health professionals want and need

A primary strategy has been to shape content around the requests of health professionals from around the world. LMS continuously gathers information from program participants, MSH field offices, local organizations and USAID missions on requests for leadership, management, and governance technical assistance. Content can also be adapted to particular technical areas such as Family Planning, Contraceptive Commodity Security, HIV/TB Co-Infection, public-private partnerships, human resource management, and pre-service management and leadership programs.

3.2 Base virtual content on successful, field tested approaches

LMS' virtual learning programs in the areas of Leadership Development, Strategic Planning, Business Planning, Human Resources Management, and CSO Board Governance are all based on field applications. The field tested approaches, programs, and tools have been adapted for virtual delivery. This shortens the development time of products and assures use of tested, quality materials.

3.3 Deliver engaging, relevant content that can be readily applied

Any organization can produce Web-based content. What makes LMS virtual approaches successful is not the fact that they are online. They are successful because LMS uses field-tested, well-designed materials, and experiential learning approaches with support and feedback from experienced organizational development facilitators. Virtual programs and seminars are practical and action oriented so participants leave with skills and tools they can apply to enhance the performance of their organizations. In addition to organizational advantages, individuals and teams also benefit. The dynamic facilitation of our learning programs and networks is also a key factor in their success. Facilitators keep individuals and teams engaged and motivated, and acknowledge their progress toward completing program requirements.

3.4 Train new facilitators and develop the skills of existing facilitators

To deliver 14 virtual programs and 12 seminars and forums in one year, as LMS did in 2009, the LMS Scale-Up team trained 43 new facilitators for virtual learning programs, bringing the total of qualified virtual facilitators in multiple languages to 49. Additional program managers and administrative coordinators have also been trained to support these programs. Resources, tools and online seminars are available through LeaderNet to further the development of virtual program and seminar facilitators.

3.5 Make improvements based on feedback

The virtual program and seminar management teams conduct After Action Reviews (AARs) following the delivery of each program and seminar. These have proved valuable for identifying performance gaps and improvements to be made from the perspective of both participants and facilitators. Based on feedback, continual improvements are made to website functionality, instructions, and program and seminar content.

3.6 Offer seminars in multiple languages simultaneously

By offering seminar resources in multiple languages, and providing almost real-time translation of discussion posts throughout virtual seminar events, health professionals can talk to each other asynchronously across time zones. This important strategy allows a participant from Bolivia to communicate in a discussion with someone from Afghanistan, and is one of the most highly rated aspects of network seminars. One participant noted that the challenges being discussed were so similar, it felt as if everyone was from the same country. Through this style of communication, participants realize the “answer is in the room,” meaning that instead of relying on experts to give advice, people learn from each other and develop confidence that their own solutions are good ones.

3.7 Use a Blended Learning Approach

Virtual programs employ a blended learning approach. Blended learning is defined as the use of various learning methodologies and approaches. In LMS virtual programs, participants complete individual work on the website such as reading case studies, completing module exercises and self-assessments, and participating in online discussion threads. Participants also take part in face-to-face group meetings with their team members from their organizations to discuss what has occurred in the module and conduct assigned group work. Group meeting summaries are posted on the website for discussion among the facilitators and organizational teams, and team products are sent to the facilitators for review and feedback. This blended learning approach is advantageous for LMS virtual programs and approaches given that many of the participating individuals and teams do not always have reliable access to the internet or computers, and this way, they can participate in the programs both on and off line. This approach also strengthens teams by having them learn skills and solve challenges together.

3.8 Partner with USAID projects, cooperating agencies, and other organizations

By developing partnerships with cooperating agencies and other USAID-funded initiatives, LMS has been able to maximize the USAID investment by combining LMS’ strengths with the strengths of our partners to deliver more programs and seminars to teams and individuals. By working together with partners, we cover a greater number of program and seminar topic areas and reach additional participants in a cost-efficient way.

Examples of partnerships with USAID projects include:

Capacity Project

Two VLDPs for HRH teams were offered in partnership with the Capacity Project in 2006 and 2007. The programs were funded through LMS and the Capacity Project. For each program, the facilitation team included staff from MSH, ESAMI, and the Capacity Project. In the first VLDP HRH, LMS and Capacity reached 10 teams, representing 60 participants and the countries of Kenya, Ghana, Tanzania, Lesotho, Uganda, Namibia, and Nigeria. In the second program, eight teams participated, representing 50 participants and the countries of Madagascar, Uganda, Rwanda, Ethiopia, South Africa, Nigeria, and Malawi.

From March to June 2008, the Capacity Project fully-funded, and MSH implemented, a VLDP for teams working on FP/RH challenges. Sixty participants from nine teams participated from Uganda, Ethiopia, Malawi, Kenya, and Tanzania.

DELIVER and HPI

LMS partnered with the DELIVER and HPI Projects to offer two VLDPs for teams working on contraceptive commodity security (CS) challenges. Staff from these projects served as valuable support to the VLDP facilitators, reviewing and commenting on the action plans produced by the teams throughout the program. In the VLDP CS

LAC, 92 participants from 12 teams and four countries (Honduras, El Salvador, Paraguay, and the Dominican Republic) participated, and in the second VLDP CS for Francophone countries, 98 participants from 11 teams participated from Mali, Madagascar, Rwanda, and Senegal.

Additionally, between December 10th and 14th, 2007, a virtual forum was carried out entitled Virtual Forum on Options for Contraceptive Procurement in Latin America and the Caribbean, which drew from the results of various studies produced by the USAID | DELIVER PROJECT and the USAID | Health Policy Initiative in 2006 and 2007. The forum featured 93 comments from 133 participants, representing 21 countries.

HPI

MSH and USAID | Health Policy Initiative (HPI) collaborated to highlight USAID's Contraceptive Ready Lessons II, 6: "Mobilizing Financial Resources for Contraceptive Security." This global virtual event was held July 20-24, 2009, and 155 members from 45 countries discussed existing systems for financing family planning (FP) and key components of resource mobilization for FP commodities.

PSP-One Project

A VLDP for teams working on Public-Private Partnership challenges in RH/FP was held in 2008. LMS partnered with the USAID-funded PSP-One Project to offer a VLDP as a follow-up to a face-to-face workshop on public-private partnerships. This VLDP ended in December 2008. Eleven teams, with a total of 61 participants, participated in this program, representing Ethiopia, Nigeria, Ghana, Kenya, and Swaziland.

DELIVER and SHOPS

The Global Exchange Network for Reproductive Health collaborated with the USAID | DELIVER PROJECT and Strengthening Health Outcomes through the Private Sector (SHOPS) to highlight the USAID publication Contraceptive Security Ready Lessons II, 7: Fostering Public-Private Collaboration for Improved Access from December 9-11, 2009. During the three-day event, 137 people from 45 countries logged into the forum a total of 239 times. Discussions focused on the role of contraceptive security committees, advances in implementing a policy framework to guarantee and regulate the provision of family planning services, challenges in guaranteeing the stewardship role of the public sector, and concerns about the quality of medicines in the commercial sector as an impetus for better regulation and public/private partnership. The event was lightly facilitated, with partners from the USAID | DELIVER PROJECT and SHOPS contributing opening and closing messages while monitoring discussions daily.

CRTU

LMS partnered with the USAID-funded Contraceptive and Reproductive Health Technologies Research and Utilization (CRTU) program, implemented by Family Health International (FHI), on two seminars offered through the Global Exchange Network for Reproductive Health. The first was held in 2007 on "Addressing Unmet Need for Family Planning in Rural Areas: Introducing Community-Based Distribution of Injectable Contraception," fully-funded by CRTU. LMS staff trained CRTU staff to facilitate the forum. One hundred and eighty-eight participants from 19 countries participated in English. One result stood out; Nigerian officials who participated in the seminar expressed interest in establishing a community-based distribution of injectable contraceptives program in Nigeria, and in February, 2008 Nigerian officials participated in a study tour of the Uganda FHI/Save the Children program. Future activities will include convening national stakeholders meeting, and supporting a local champion who will promote and educate others about safe delivery of Depo-Provera in community-based distribution programs.

LMS partnered again in 2008 on a Global Exchange Network for Reproductive Health forum focused on "Effective Programming for Long-Acting and Permanent Methods: A Forum for Family Planning Program Managers and Policymakers." The USAID-funded ACQUIRE project also partnered on this event, which was jointly funded by LMS, CRTU, and ACQUIRE. Ninety-four participants representing 34 countries participated in this English-language forum.

New donor: Organization of Eastern Caribbean States

In March 2010, a VLDP for teams from National HIV/AIDS Programs, Ministries of Health, and the Organization of Eastern Caribbean States (OECS) in the Caribbean was launched. Funded by the OECS, a Global Fund Principal Recipient, this is the first non-USAID funded virtual program. The program will continue through June 18, 2010 with 11 teams from Anguilla, Antigua, the British Virgin Islands, Dominica, Grenada, Montserrat, Nevis, St. Vincent and the Grenadines, St. Kitts, and St. Lucia.

Inclusion of virtual programs in other USAID-funded projects

The USAID-funded MEASURE Evaluation III has conducted three VLDPs and one VSPP for teams working on challenges related to monitoring and evaluation.

4. USING VIRTUAL APPROACHES TO ACHIEVE POPULATION AND REPRODUCTIVE HEALTH GOALS

Many LMS virtual learning programs and seminars have furthered family planning and reproductive health (FP/RH) goals and supported specific Global Leadership Priorities, including Repositioning Family Planning, Contraceptive Commodity Security, and Post Abortion Care. In addition to the FP/RH programs and seminars described below, all Global Exchange Network for Reproductive Health virtual seminars have focused on priority FP/RH management and leadership topics (refer to Table 9 in Annex II). As of March 2010, the Global Exchange Network for Reproductive Health has reached 2,871 members from 133 countries.

4.1 General Family Planning and Reproductive Health

4.1.1 Virtual Business Planning for Health Program for FP teams in LAC

A 20-week Virtual Business Planning for Health Program (VBPH) program was successfully delivered from April to August 2008 to 10 teams and a total of 67 participants from family planning and reproductive health non-governmental organizations in Latin America. By the conclusion of the VBPH, seven organizations had prepared business plans addressing family planning and organizational priorities.

The non-profit organization CIRD in Paraguay focused their business plan on scaling up existing consulting services to family planning and reproductive health organizations in the areas of organizational development, financial administration and management. Their immediate goal was to increase demand for these services to 10 new municipalities and 4 departments in the country. The organization surpassed their US\$28,500 fundraising goal, securing US\$70,000 after 4 months from the German aid agency GTZ.

A Peruvian family planning NGO, Apoyo a Programas de Población (APROPO), developed a business plan for a new product, a low-priced latex condom that includes a spermicide for low-income young adults. The team secured funds from the government to make the condoms available to young adults at various local hotels in the country.

As of March 2010, a second 20-week offering of the VBPH, integrating program improvements identified during the first offering, is currently ongoing for seven teams of FP/RH professionals in Latin America.

4.1.2 Virtual Fostering Change Program for FP and MNCH teams in ANE

LMS delivered the first offering of the Virtual Fostering Change Program (VFPC) to eight teams from Asia and the Middle East working on family planning and maternal, newborn, and child health (MNCH) programs between April 2009 and March 2010. The 56 team members who participated were from Afghanistan, Indonesia, Jordan and Nepal. During the program, teams developed action plans to introduce FP/MNCH best practices and then implemented these action plans. The Prince Faisal Hospital team in Jordan used the program to develop a counseling and treatment program for pregnant women with anemia.

4.2 Repositioning Family Planning

Joining other concerned donors, civil society organizations, advocacy groups and international health organizations, USAID has made Repositioning Family Planning (RFP) a key technical priority. LMS contributes to RFP by strengthening the leadership and management of public and private stakeholders in FP at the national, regional and local level.

In 2007 LMS worked closely with Office of Population and Reproductive Health technical leaders and with local USAID Missions in select Francophone African countries to plan and implement two virtual conferences on repositioning family planning. The centerpiece of the conferences was USAID's Strategic Pathway to Reproductive Health Commodity Security (SPARHCS).

Key themes that emerged during discussions at the two conferences were:

- Advocacy, media and communication campaigns
- Socio-cultural barriers, religious leaders, and education
- Integration of family planning into the health system
- Diversion of funds to HIV/AIDS
- Contraceptive security, long-acting and permanent methods
- Family planning in conflict and post-conflict contexts
- Human resource capacity
- Public-private partnerships
- Community involvement and male involvement in family planning
- Leadership and management practices essential to RFP

Nearly all of the respondents (96%) indicated they would attend a similar virtual conference, and 84% reported that they acquired skills or knowledge useful for their work. The use of electronic technology provided an efficient, cost-effective way for participants to interact, share materials and ideas across and within countries and continue their commitment to getting family planning back on the public health agenda in their respective countries.

“In light of the relocation of health facility service providers, using the information provided in the presentations, I will assist the health facilities under my supervision to retain their personnel. The concept of leadership will help me to improve my coordination of activities and to achieve the work objectives of my unit.”

“The community distribution of DMPA, I will bring this up at a technical group meeting composed of health and political leaders to see how we can apply this strategy in our country, the Democratic Republic of Congo, and specifically in my province, Bas-Congo.”

–Comments from two participants

4.3 Contraceptive Security

Contraceptive Security is also a key technical priority for USAID. CS exists when every person is able to choose, obtain, and use quality contraceptives and condoms for FP and HIV/AIDS prevention. LMS has worked closely with the OPRH CS team to strengthen the leadership and management capacity of FP professionals, organizations and institutions dedicated to improving contraceptive security. LMS activities in CS are clustered in two areas: (1) Leadership strengthening of CS teams, organizations and national committees; and (2) CS Regional Institution

strengthening. LMS technical assistance experts provide face-to-face technical assistance to ESAMI in Tanzania and PRISMA in Peru under this Regional Initiative.

VLDP for Contraceptive Security in Latin America/Caribbean: LMS has worked closely with the OPRH CS team in planning and implementing leadership development programs for teams working on CS in Latin America and Francophone Africa. USAID funded a VLDP for CS in Spanish for 12 teams (92 individuals) from the Dominican Republic, El Salvador, Paraguay and Honduras.

Teams came from organizations that are members of their countries' national CS committees. The VLDP was conducted in collaboration with JSI/DELIVER and the Futures/Health Policy Initiative (HPI) Project. DELIVER and HPI brought extensive regional and CS technical expertise to the collaborative effort and provided technical assistance during the action planning process. LMS leadership development specialists facilitated the program. LMS, HPI, DELIVER and USAID collaborated to adapt the VLDP for contraceptive security in Latin America and Francophone Africa, supported teams during the program, and met post-program to evaluate the offering.

The participating teams developed high-quality action plans. Follow-up was completed with the LAC teams at six months post-program. Examples of challenges identified by the teams in the LAC VLDP and the results achieved six months post-program are described in Table 4.

Table 4. Results from Latin America VLDP for Contraceptive Security, 2007

Team	Challenge	Measurable Result	Indicators	Achieved by December 2007															
Asociación Demográfica Salvadoreña (ADS)	How can we secure funding that will ensure access to education and to sexual and reproductive health services (including contraceptive supplies) for El Salvador's rural population, emphasizing teenagers and youth with limited purchasing power?	In December 2007, we will have \$640,000 to ensure family planning services and commodities for the population of fertile age in 640 rural communities in areas that ADS works in, an average of \$1,000 per community.	1) Percentage of financing obtained, with respect to the total amount desired (\$640,000) 2) Number of communities for which we have obtained financing, considering the average of \$1,000 per community.	The budget of the \$640,000 was approved in December 2007.															
Centro Paraguayo de Estudios de Población (CEPEP)	How can we maintain the CYP produced by the PAC Program during 2006, taking into account the new tax status, declining donations, and increase in the population with limited resources?	Maintain the 7,490 CYP produced during the PAC program in 2006.	Number of CYP produced from January - December 2007 in the PAC program.	7,337 (98%)															
Paraguay MOH	How can we ensure the availability and accessibility of the four contraceptives in the basic basket for groups of women and men from the country's 46 poorest districts, according to the IPG index?	By December 2008, 85% of the service points of the Ministry of Health in the 46 selected districts have the basic four contraceptives accessible and available.	% of stockout by method 100% of Human Resources leaders trained in CYP Dec. 2007	% of stockout by method <table border="1"> <thead> <tr> <th></th> <th>Mar07</th> <th>Dec07</th> </tr> </thead> <tbody> <tr> <td>IUD</td> <td>9.5%</td> <td>3.9%</td> </tr> <tr> <td>Oral</td> <td>7%</td> <td>5.5%</td> </tr> <tr> <td>Depo</td> <td>15%</td> <td>7.9%</td> </tr> <tr> <td>Condom</td> <td>11%</td> <td>4%</td> </tr> </tbody> </table> 100% of Family planning Human Resources leaders trained in CYP Dec. 2007		Mar07	Dec07	IUD	9.5%	3.9%	Oral	7%	5.5%	Depo	15%	7.9%	Condom	11%	4%
	Mar07	Dec07																	
IUD	9.5%	3.9%																	
Oral	7%	5.5%																	
Depo	15%	7.9%																	
Condom	11%	4%																	

4.3.1 VLDP for Contraceptive Security in Francophone Countries

USAID funded a VLDP for CS in French for 11 teams (65 participants) from both the public and private sector in the Francophone Africa countries of Madagascar, Mali, Rwanda and Senegal. This VLDP focused on teams from organizations that are key stakeholders in reproductive health commodity security - including Ministry of Health reproductive health programs, international and local family planning NGOs, and organizations focused on the pharmaceutical sector. The VLDP was conducted in collaboration with HPI/ Futures and DELIVER/JSI, whose staff brought extensive regional and CS technical expertise and provided important technical assistance throughout the action planning process.

Table 5. Examples of results from VLDP for Contraceptive Security

Team	Challenge	Measurable Result	Results as of July 2009
MAHAVITA, Madagascar	Given the fragility of the information system and inability of the management to generate reliable data in a timely manner, how can we improve the management of the supply of contraceptive products so that the districts and health facilities have an adequate level of stock?	By the end of the first quarter of 2009, 75% of the health districts are compliant with the supply process at the SALAMA procurement center.	76.6% of the districts were compliant with performance criteria for monitoring the management of the supply of contraceptives.
Equipe Malienne non-gouvernementale, Mali	How we can convince the Malian State to include a budget line for the purchase of contraceptive commodities and to reinforce the information system for the logistical management in light of the fact there is insufficient political will and socio-cultural constraints for the implementation of a national commodity security plan in Mali?	By May 2009, the Malian national budget ensures the purchase of 10% of the contraceptive commodities and cost of reinforcing the information system for the logistical management.	The budget line exists since the state took over 10.1% of the purchase of contraceptives in 2009.

4.4 Post-Abortion Care

From January 26, 2009 to March 19, 2010, LMS conducted a Virtual Fostering Change Program (VFCP) for teams working in post-abortion care (PAC) in five Francophone African countries: Burkina Faso, Guinea, Rwanda, Senegal, and Togo. The fostering change methodology helps teams to introduce and scale up a best practice using a systematic pathway for leading change in order to improve the health of the populations they serve. Teams often underestimate what is required to make change sustainable. This methodology provides clear principles as well as phases and stages of the change process to enable them to implement sustainable change.

The teams from Guinea, Rwanda, and Togo finalized their action plans for implementing their selected best practice in one to four sites and gathered and analyzed data from these selected intervention sites. The team in Rwanda conducted a day-long training at their one site for all service providers in the maternity ward as well as any available doctors, 13 participants in total, on providing PAC and the integration of family planning and PAC services. This training provided an introduction to PAC in Rwanda, a presentation of the action plan of the VFCP PAC Rwanda team to improve PAC in Rwanda, training on data collection tools, training on a method of pregnancy evacuation, and next steps to implement and improve the integration of family planning and PAC services. The team from Togo also successfully implemented their selected best practice in three of their four sites and the team from Guinea successfully started implementation.

Remaining funds from the VFPC PAC will be used to conduct a face-to-face workshop for teams from four health service sites in Togo. Offered in collaboration with the VFPC PAC team for Togo as part of their implementation plan, the workshop will build capacity in change management and leadership to integrate PAC and FP services in the four selected health sites. This workshop will be offered at the end of April 2010.

4.5 HIV/AIDS

With funding from the Office of HIV/AIDS (OHA), LMS has delivered virtual learning programs to both HRM managers and their teams as well as to teams from HIV/AIDS public and private sector organizations. Additionally, LMS has received Field Support from USAID Brazil and the USAID Europe and Eurasia (E&E) Bureau for HIV/AIDS-focused virtual programs. Examples of these programs follow.

4.5.1 VLDP for HIV/AIDS teams in Southern Africa

To strengthen leadership to promote HRH and improve Human Resource Management (HRM) within health organizations and institutions, LMS conducted an OHA funded VLDP. This VLDP was delivered from April 30, 2007 and July 27, 2007 to thirteen teams in five African countries¹.

Teams identified a real organizational challenge that they were facing and developed an action plan to address this challenge, achievable within six months. The challenges selected and associated action plans were of high quality and showed a firm understanding of the concepts and competencies discussed in the program. Some examples of challenges identified and results achieved by teams in this VLDP are displayed in Table 6.

Table 6. Results of VLDP in Human Resource Management for South African Teams

Team	Challenge identified	Progress as of April 2008
Society for Family Health(SFH) Zambia	How we can offer male circumcision services to clients at voluntary counseling and testing (VCT) centers given limited space, inadequate supplies, few trained medical providers and fear of work overload on available staff?	The team completed all the activities in the action plan: 250 male circumcisions (MC) were provided at 1 SFH site. In addition, 60 MC have been provided at a private clinic.
Raleigh Fitkin Memorial Hospital (RFMH) Swaziland	How can we reduce the average waiting time of clients at the outpatient department (OPD) by 30% of the current waiting time given the existing obstacles (many queues, insufficient pay point, delay of doctors to attend to patients, high staff patient ratio and discontinuity of care)?	The team obtained a baseline measurement of OPD patient waiting time (approximately four hours). Empirical observations indicate waiting time has been reduced to three hours.
Christian Health Association of Malawi (CHAM)	With inadequate VCT counselors, how can we provide quality and sustainable VCT services in the rural areas within the catchment areas of CHAM units?	The team has implemented VCT in “approximately 25 static sites.” (Target was 25 mobile and static sites.)

¹ Malawi, Tanzania, Botswana, South Africa and Zambia. Seven (50 people) of these 13 teams completed the program successfully: Christian Health Association of Malawi (CHAM), Hubert Kairuki Memorial University (Tanzania), Institute of Development Management (IDM) (Botswana), Ministry of Health Botswana, Swaziland Nursing Association, Raleigh Fitkin Memorial Hospital (Swaziland), and Society for Family Health (Zambia).

4.5.2 Virtual Human Resource Management Programs for HIV/AIDS organizations

A Virtual Human Resource Management (VHRM) Program for Human Resource (HR) teams in Government and Civil Society Organizations working in HIV/AIDS in Anglophone Africa was offered from October 27 to December 19, 2008 to teams from both the public and private sector. Ten teams enrolled in this first offering of the VHRM, coming from the Anglophone African countries of Ethiopia, Namibia, Tanzania, and Uganda.

The second offering of the VHRM Program for Human Resource teams in Government and Civil Society Organizations working to address HIV/AIDS was launched on May 25, 2009. The eight-week program, which culminated on July 17, 2009, featured teams from both the public and private sector, encompassing international and local CSOs, as well as central and regional government entities. Nine teams were enrolled in the program, including three from Asia (Afghanistan, Bangladesh, and Ukraine) and six from Africa (Ghana, Kenya, Nigeria, and Uganda).

Both offerings of the VHRM focused on HR teams from organizations that work to address HIV/AIDS and sought to improve the understanding of the role of Human Resource Management (HRM) in an organization and develop the capacity to strengthen HRM systems in order to improve staff satisfaction and performance.

Select program results from both offerings include:

Family Guidance Association of Ethiopia

Priority Area: Job descriptions

Desired Result: By March 2009, 71 staff will have updated and accurate job descriptions.

Result: As of January 1, 2009, every employee received a revised and clear job description, in line with the updated and revised Human Resource Management Manual.

Kumasi Metropolitan Health Services, Ghana

Priority Area: HR Planning

Desired Result: Provide needed focus and direction for HRM activities within the institution with an HR plan that will also serve as a tool to measure the performance of their HRM system, and ultimately serve as a springboard for developing a broader institutional plan.

Result: HR plan developed with HR committee. Management has improved and stopped shipping positions of trained staff and developed a plan for in-service training.

Straight Talk Foundation (STF), Uganda

Priority Area: HR Planning

Desired Results: To incorporate HR planning into all stages of intervention design and to have an actual HR plan document.

Result: HR plan produced and disseminated

4.5.3 Virtual Strategic Planning Program for HIV/AIDS teams in Asia and Africa

Funded by OHA, the Virtual Strategic Planning Program (VSPP) Asia and Africa was offered to teams from organizations that provide HIV/AIDS services in Asia and Africa. The VSPP supports teams to complete an initial design or update of an existing strategic plan of the participating health organizations; it also facilitates the exchange of strategic planning experiences, perspectives and practices among all participants. This program was launched on January 26, 2009 and completed on May 22, 2009. A total of 10 teams participated in the program and seven of them finished the program. The seven teams that completed the program were from three Asian countries (India, Vietnam, and Bangladesh) and three Anglophone African countries (Kenya, Uganda, and Nigeria).

Example VSSP result:

Kenya Ports Authority (KPA)

Priority Area: HR Planning

Desired Results:

- By 2014, the Kenya Ports Authority Medical department will be recognized as a quality comprehensive HIV service delivery point and will be the preferred service provider of the KPA employees and dependents.
- Reduce stigma of our target population and infection rate nationally by the year 2014 through peer education, behavior change communication (BCC), and voluntary counseling and testing (VCT) activities.

Result as of Spring 2010: The team reports that there has been a significant increase in uptake in VCT, preventing mother-to-child transmission of HIV (PMTCT), and comprehensive clinical care (CCC) services. The team attributes the increase in uptake to more positive attitudes of KPA employees about HIV and better attitude on the part of KPA medical department that provide HIV services.

There was a significant increase in VCT and a modest increase in PMTCT services, comparing the seven months before the end of the VSPP (November 2008 to May 2009) and the seven months after the VSPP ended (June 2009 to December 2009). For example, comparing these two periods:

- The number of men and women tested and the number of men and women counseled increased over 70% (73% and 74% , respectively)
- The number of women tested and the number of women counseled increased more than 1.5 times (177% and 179%, respectively)
- The number of pregnant women tested for HIV increased 5%

There were also increases in CCC services when the two periods are compared:

- The number of men and women currently on prophylaxis increased 16%
- The number of men and women on ART increased 1%, while the percent of women on ART increased 5%

4.5.4 Virtual Leadership Development Program for HIV/AIDS/TB teams in Eastern Europe and Eurasia

Despite needing an integrated, holistic approach to yield positive health results, many national TB/HIV co-infection programs in Eastern Europe and Eurasia are managed as separate, vertical programs. To strengthen the capacity of government and non-government agencies to work together in the areas of TB and HIV, Management Sciences for Health, with funding from the USAID E&E Bureau, offered a 13-week Virtual Leadership Development Program (VLDP) in Russian in 2007.

Ten organizational teams of 66 senior managers from Belarus, Kazakhstan, Russia, and Ukraine participated, each representing national TB and HIV/AIDS programs. Team identified a challenge they were facing and developed an action plan to address it, with the challenges falling broadly into two categories: alignment of agencies and organizations working in TB/HIV co-infection and service delivery.

At the time of follow-up, teams had achieved significant results. Among the teams reporting significant improvements in service delivery resulting from their action plans were the HIV/AIDS and TB teams from Belarus. The HIV/AIDS team's challenge centered on testing of HIV-infected patients in order to ensure delivery of antiretroviral treatments. Their initial target was to provide ARV treatments to 900 patients; they exceeded this result with 1,200 patients having received treatment by December 2008. Likewise, the TB team sought to improve patient care, and wanted to increase the number of patients receiving adequate individualized treatment for Multi-Drug Resistant TB by 10%. They, too, surpassed their goal with a 21% increase in the number of patients receiving treatment.

An NGO coalition team from the Ukraine sought to increase the number of signatories on the resolution from the Second Conference on the National Response to the TB Epidemic, which numbered 15 at baseline. At follow-up, 75 nongovernmental and public sector organizations had signed.

4.5.5 Virtual Leadership Development Program for HIV/AIDS teams in Brazil

This VLDP was delivered from July 20 to October 16, 2009 to 12 teams from non-governmental organizations and Civil Society Organizations working on HIV/AIDS challenges from 10 different states in Brazil: Amapá, Brasília/Distrito Federal, Espírito Santo, Paraná, Paraíba, Sergipe, Rio de Janeiro, Rio Grande do Sul, Santa Catarina, and Tocantins. One Brazil-based MSH staff member and one MSH consultant from Brazil facilitated the program with the assistance of an MSH Monitoring and Evaluation (M&E) specialist who aided in the review of the teams' action plans.

Eight of the 12 teams (AEM, ASMMST, Casa de Maria, GAPA Chapecó, Gesto-GESC, GVP, MDS, and Unidas) successfully completed action plans with feedback from the two facilitators and the M&E specialist (Casa Servo de Deus, CASSMA, Departamento de DST e Aids, and MAB did not complete action plans). Team challenges were largely concerned with increasing the use of services provided by participating organizations. Challenges teams chose to address include the following:

ASMMST: How do we get the government to sponsor social and educational initiatives for the prevention of STDs/AIDS in the municipality of Monte Santo do Tocantins-TO, since the municipal budget does not prioritize these actions?

Gapa Chapecó SC: How can we motivate People Living with HIV/AIDS in the city of Chapecó to participate in the activities of the Positive Attitude Project and make them realize that quality of life is more than receiving medical and pharmaceutical care?

The teams who participated in the VLDP Brazil faced a unique set of challenges to participating in the program, as many were small, grassroots, and volunteer-based organizations. Despite these challenges, based on the participation of the teams, results of the program, and participant feedback, the VLDP Brazil was a success. Eight teams completed the program requirements, developed action plans, and earned program certificates. A follow-up six months post-program will also be conducted in April 2010 with all teams who successfully completed the program.

5. LESSONS LEARNED ABOUT USING VIRTUAL APPROACHES TO SCALE-UP MANAGEMENT AND LEADERSHIP

In the course of scaling-up proven practices and approaches through virtual approaches, LMS has learned several important lessons about scale-up.

5.1 Successful programs are responsive to the needs and interests of participants

LMS online programs and seminars are designed around priority management and leadership topics that are identified through field-based work, the needs expressed by LMS client organizations and partners, and the feedback of participants from earlier programs and seminars. Virtual learning programs, seminars and conferences provide asynchronous discussions and so are available online 24-hours a day during delivery, allowing participants to engage in the program when it is convenient for them.

Virtual approaches are only a vehicle to achieve results. What makes LMS virtual approaches successful is not the fact that they are online. They are successful because LMS uses field-tested, well-designed materials, and experiential learning approaches. Virtual programs and seminars are practical and action oriented so participants leave with skills

and tools they can apply to enhance the performance of their organizations (e.g., a leadership challenge identified and addressed; a strategic or business plan produced and applied, etc.).

5.2 Measuring and reporting results motivates teams

When teams set goals and achieve them, they are inspired to share their results and skills with others, and to continue applying what they have learned. From end-of-program surveys and follow-up data collection, we know that our programs improve how teams work together on their objectives and goals. Quality follow-up data is also vital to demonstrating the links between investments in management and leadership capacity building, improved organizational and program functioning, and improved services and health outcomes.

5.3 The potential for using virtual approaches is growing

An exciting lesson learned is that virtual approaches are an extremely important vehicle for scaling up management and leadership approaches and tools to public and private sector health organizations in the developing world. While these approaches are still not viable in some low resource settings with poor internet access, teams in health organizations in dozens of African, Latin American, Asian, and Middle Eastern countries have accessed these programs, participated in them actively and productively, and rated them very positively. Attrition has been low and participation high. Virtual approaches as demonstrated by LMS are a cost-efficient and increasingly viable and accepted way of extending learning opportunities to many teams in many health organizations and countries. With access to the internet increasing every day and electronic technology constantly improving, the potential for the use of virtual approaches is enormous. Virtual approaches do not substitute face-to face, hands on technical assistance at the country level, but they are a powerful complement and allow us to reach more people and teams than ever before imagined. Virtual approaches can be used in even the most challenging environments, such as post-conflict areas.

5.4 Balance standardized and customized program content

When scaling-up virtual programs, it is important to standardize programs to ensure quality and allow for easy replication. At the same time, it is important to be able to adapt these programs to the context and needs of client organizations. Each time the VLDP was offered in a new content area under M&L, and even at the beginning of LMS, much of the content of the program was revised to reflect the new program focus. However, given the time and resources spent on each program adaptation, and recognizing that LMS virtual programs focus on developing priority management and leadership skills applicable to all areas of health, the programs are now more standardized, but retain enough flexibility to be meaningful in different country contexts. For example, if a VLDP is offered to meet a client need in a new health area, the introduction to the program and one key case study in the program are adapted. The rest of the program remains standardized. In this way, LMS is able to offer flexible and adaptable programs that are standardize and easy to replicate, making scale-up less costly.

5.5 Partnering extends LMS' reach

Partnering with USAID programs, cooperating agencies, and other organizations is an important way to maximize USAID's investment in our virtual approaches. It is also an excellent way to add content and value to our programs in the areas that our partners specialize in, such as contraceptive security and public-private partnerships. Partnering was a particularly successful strategy for the VLDP and the Global Exchange Network for Reproductive Health. Organizations working in family planning and reproductive health could see the benefits of expanding their reach through the use of LMS' virtual media, and saw the added value of incorporating management and leadership skills to strengthen clinical approaches.

5.6 Dynamic facilitation is a key to success

Participants will not stay engaged in a program or online discussion if the program is not dynamically facilitated by qualified facilitators. LMS has 49 trained facilitators in key technical areas that develop relationships with teams, recognize their progress, and provide interactive feedback and support. For example, facilitators and other technical experts provide timely technical feedback on the teams' action plans as they are developing them, enabling participants to develop high-quality plans with the input of several organizational development specialists (something that is very difficult to do face-to-face with several technical staff given the costs of travel).

Additionally, opportunities for teaching about leading and managing arise constantly, whether the facilitator is composing his or her daily announcement, responding to a query from a team or an individual, or posting a response or new thread in the Café. Virtual facilitators always use real-life occurrences as examples to illustrate a point. For example, when a team is struggling with a team member who is not participating, the facilitator helps the team see this as a leadership challenge and encourages members to practice what they are learning. LMS developed 'A Guide to Virtual Facilitation' that walks facilitators through the process of online program facilitation. The guide has supported the scale-up of the number of experienced facilitators by enabling face-to-face facilitators, who may have no virtual facilitation experience, to take on this new role.

5.7 Teams that have self-selected for the program are the most engaged

Under LMS, we have offered open-enrollment programs to a wide array of organizations that learned of the program via e-mail announcements, LISTSERVs, the MSH website, colleagues or contacts, or word of mouth. Interested teams applied to participate in the program, and LMS selects the teams. In other cases, LMS has worked with outside organizations to recruit participating teams, or participating teams were asked to enroll by USAID missions and field offices. These teams came to the program with less of an understanding of the program than self-selected teams do, and perhaps this is one of the reasons these programs had higher than normal attrition rates, more challenges in program implementation, and teams that were less engaged in the program overall. Participants in virtual programs and seminars are most engaged when they have self-selected.

6. CONCLUSION

Around the world, health professionals, doctors, nurses, nutritionists, pharmacists, social workers, laboratory specialists, managers, and administrators are applying skills they have learned in LMS's virtual programs and seminars to reduce illness and save lives. Demand for LMS' virtual approaches continues to increase as recognition and evidence grows that using virtual approaches to build capacity is effective and affordable. LMS has shown that these virtual approaches:

- Strengthen the leadership, management, and governance capacity of teams to achieve public health results;
- Cost-efficiently broaden access to much needed competencies for thousands of health professionals at all levels of the health care system in low- and middle-income countries;
- Allow individuals and teams to share information and learn from each other on Web-based platforms, despite physical distance;
- Allow several technical experts to effectively work with each participating team at reduced cost.

Opportunity exists to innovate and expand virtual approaches using new methods as internet connectivity increases, and mobilization and support for strengthening health systems grows.

6.1 The Next Frontier for Knowledge Exchange

To be on the cutting edge of knowledge exchange, we need to remain strategic about the adoption and integration of innovations while never losing sight of marginalized and harder-to-reach health professionals. This means understanding that what worked best yesterday might not be the best approach today. It means remaining open to advances, open to improvements, and open to an ever-changing landscape.

6.1.1 Multi-format delivery

Reaching greater numbers of people more effectively requires disentangling content and learning approaches from a single delivery strategy. Content and learning approaches should be adapted to multiple delivery formats like print, CD, Web, and mobile phones in order to increase the reach and impact of learning opportunities, and by making them more easily transferrable and replicable by local partners and organizations. Mobile phones and CD-ROMs can help support new facilitators by giving them the information they need to implement high-quality face-to-face and blended virtual capacity-building programs. Health professionals can use mobile phones for asking questions via SMS which can be answered in real-time by local partners. These new approaches could be offered in synergy with Secretary Clinton's Civil Society 2.0 Initiative to Build Capacity of Grassroots Organizations, a plan for building local civil society organizations' capacity to connect, exchange information, network, and develop skills via various forms of technology.

6.1.2 Less custom programming, and more open-source platforms and applications

In the early days, MSH's Center for Leadership and Management (CLM) had to custom-code its platforms because no one else was producing the kinds of learning platforms needed for reaching our large audiences. These days, however, the Web-based service sector has exploded, and there is much less reason to spend as much time and effort on internally-produced and maintained platforms. Opening up current and future program offerings to a wider audience by using open-source rather than custom-built proprietary platforms requires research and development into appropriate approaches that are easily transferrable.

6.1.3 Suite of integrated, social learning products

LMS's virtual offerings could build upon each other more seamlessly, and better leverage the social learning components of the virtual offerings. By taking a modular approach to content, tailored and integrated learning packages can be created for learners and organizations that dramatically expand their capacity building opportunities.

All of CLM's virtual programs utilize aspects of social learning where participants teach and learn from one another. LeaderNet was designed in response to learners having no way to continue their learning exchanges after their seminar ended. While LeaderNet has made some very innovative strides in continuous learning, there are additional methodologies that could be explored to deepen the use of social learning approaches, and support ongoing knowledge exchange among health professionals that does not rely so heavily and continuously on US-mediated material.

6.1.4 Appropriate technology and hybrid approaches

Access to the internet and development of software has grown tremendously in the past two decades. However, access remains variable and uneven, particularly in the developing world and especially in areas outside the capital cities. This means that health professionals in a single country span those able to access and meaningfully engage with cutting edge technology and approaches while other health professionals in the same country are minimally literate and have little or no access to the internet. To offset this variability, we need to identify, develop and support appropriate local partnerships with educational institutions or other local capacity-building organizations. This requires having an informed understanding and criteria for what the ideal partner organizations offer, their organizational culture, and their capacity in both capacity-building and using technology to support education.

When MSH's Center for Leadership and Management (CLM) first launched its virtual programs, there was very little like it. With USAID's support, CLM took a well-calculated risk to pursue its strategic vision in the face of a lot of naysayers. Some of the opinions were so strongly against virtual programs that even midway through a successful delivery of the VLDP in Africa, a number of people continued to opine that virtual programs in Africa could never work. CLM then went on to institutionalize and scale-up delivery of virtual programs and seminars under the M&L and LMS programs. MSH hopes to continue providing strategy, direction, and vision in the areas of leadership, management, and governance capacity-building, to set standards and ensure quality, ensure cross-fertilization amongst local partners and geographic regions, provide funding, and provide encouragement and support.

We are in a new era of international development that requires a long-term view. Increasingly, donors will need to pursue long-term health strengthening strategies while continuing to address the pressing immediacy and demands of vertical health programs. The overarching aim should be to help countries achieve independence, and to leave a legacy of countries who are able to plan, lead, manage, finance, and deliver basic health services on a sustained basis. Strengthening leadership, management, and governance innovatively, and with the most effective technologies, is a central means to these important ends.

“In our country we face many challenges; life is so difficult. To me the workshop is the only window through which I can see and take fresh air. It is so good to see the other people in the world. I feel that all the people in the world want to help me and my country.”

– LeaderNet member from Baghdad, Iraq

APPENDIX I. VIRTUAL PROGRAMS

1. The Virtual Leadership Development Program (VLDP)

Languages available: Arabic, English, French, Spanish, Portuguese, Russian

Length of Program: 13 weeks

Developed under the USIAD-funded Management and Leadership (M&L) Program (2000-2005), the Virtual Leadership Development Program (VLDP), is MSH's farthest-reaching virtual program to date. The VLDP is a 13-week program available in English, French, Spanish, Portuguese, Arabic and Russian, strengthens the capacity of health teams to identify and address organizational and service delivery challenges. During the VLDP, each team plans and develops an action plan that addresses a real organizational or programmatic challenge facing them.

The VLDP is designed in seven modules, one introductory, five content modules, and one conclusion module. The five content modules of the VLDP cover the following topics:

- Introduction to leadership in health institutions
- Facing leadership challenges
- Competencies in leadership
- Communication
- Change management

Leadership and organizational development experts facilitate the program, providing support and feedback to participants via email, telephone and Web site postings throughout the program. Experts in monitoring and evaluation assist the facilitation team when the participants are working on their leadership action plans.

The VLDP results in improved health outcomes through the implementation of a leadership action plan as well as improved teamwork and workgroup climate. The VLDP has been successfully adapted and implemented, helping teams of health professionals around the world to address health management challenges related to Reproductive Health and Family Planning, HIV/AIDS, and tuberculosis, among others.

2. The Virtual Strategic Planning Program (VSPP)

Languages available: English, Spanish

Length of Program: 17 weeks

The Virtual Strategic Planning Program is a blended learning program that guides senior teams through the four basic questions of the planning process in order to produce strategic plans for their organizations. The VSPP is structured in six modules, and delivered over a period of 17 weeks. The program's team of facilitators supports teams from public health organizations in the creation of strategic plans. Each module is structured with a theoretical framework, individual readings, exercises, group work, and exchange between participants and the facilitators through the website's asynchronous chat board and email. During the program, the organizations' missions and visions are reviewed. Teams also analyze their current situation and define strategic objectives and strategies in order to achieve their organizational vision. Throughout the program, teams determine the mechanisms necessary to meet their objectives and implement new strategies and the participants strengthen their ability to plan and to think strategically.

3. Virtual Business Planning for Health Program (VBPH)

Languages available: Spanish, (CD-Rom version available English, French, Spanish)

Length of Program: approximately 20 weeks

The Virtual Business Planning for Health program (VBPH) helps organizations build expertise in business planning. The VBPH covers topics such as capturing and packaging breakthrough ideas, identifying target markets and marketing strategies, and determining the best complement of staff to design and launch the new product or service. The VBPH helps NGOs navigate the financial aspects of a business plan, projecting both social and financial return on investment. The tools, techniques, and worksheets supplied during the learning experience simplify the complexities of business planning, while helping participants balance their enthusiasm with market realities. In the past, many of the ideas carried out by NGOs have been shaped by the donors and external parties that provide the funding. The VBPH program encourages organizations to identify and offer innovative products and services based on market research and client needs instead of adapting ideas to correspond to donor priorities.

The VBPH was first offered in 2008 under the LMS Program, based on the CD-Rom version that had been developed under the M&L Program and offered 18 times in that form.

4. Virtual Human Resource Management Program (VHRM)

Languages available: English

Length of Program: 8 weeks

The Virtual HRM Program is an eight week program designed for teams of HR managers, health program and operations managers responsible for HR who want to improve HRM in their organizations. The purpose of this program is to help health managers better understand the role of HRM in their organization, learn how they can strengthen it in order to improve staff satisfaction and performance, and develop an action plan to strengthen organizational outcomes and personnel performance.

5. Virtual CSO Board Governance Program (VCGP)

Languages available: English, Spanish

Length of Program: 8 weeks

The Virtual CSO Board Governance Program is an eight week program designed for teams consisting of Board of Directors members, the Executive Director and senior management of a Civil Society Organization. The purpose of this program is to understand the board's roles, responsibilities, and main activities; ensure board accountability and transparency; and prevent conflict-of-interest situations.

6. Virtual Fostering Change Program (VFCP)

Languages available: English, French

Length of Program: 1 year

The Virtual Fostering Change Program is an extension of A Guide to Fostering Change to Scale-up Effective Health Services. As the Guide was, the VFCP will be a collaboration of the Implementing Best Practices (IBP) Initiative that will be led by Management Sciences for Health. The purpose of the Virtual Fostering Change Program is to guide teams through the change planning process for scaling up proven health interventions using a blended learning virtual approach. The target audience is Ministry of Health National, Regional/Provincial or District Technical Program Teams (those in charge of introducing new policies and practices) and Technical Program Teams from FBOs and NGOs working at the district, regional/provincial or national level. The program is offered in 3 phases:

Phase 1: Identifying the need for change and preparing for demonstration (8 to 10 weeks)

Phase 2: Supporting the demonstration (6 to 8 months)

Phase 3: Preparing for Scale (4 weeks)

Table 7. LMS Virtual Program Deliveries (August 2005-March 2010)

Program Title	Language	Focus	Country(ies)	Types of Organizations	Funding Source
2005					
VLDP Haiti	French	Leadership Strengthening for HIV/AIDS organizations	Haiti	MOHs, NGOs	HS -2007, Haiti bilateral
VLDP Iraq	English	Leadership Strengthening for MOH priorities: child health, environmental health, etc.	Iraq	MOH	BASICS Project
2006					
VLDP HRM	English	Leadership Strengthening for HRM	Uganda, Nigeria, Namibia, Kenya, Tanzania, Lesotho	MOHs, NGOs	1/2 LMS Pop Core; 1/2 Capacity Project
VLDP Haiti II	French	Leadership Strengthening for HIV/AIDS organizations	Haiti	MOHs, NGOs	HS-2007, Haiti bilateral
VLDP Iraq II	Arabic	Leadership Strengthening for MOH priorities: child health, environmental health, etc.	Iraq	MOHs	BASICS Project
VLDP Peru	Spanish	Leadership Strengthening for Family Planning organizations	Peru	CAs	LMS Peru Field Support
VLDP Rwanda	French	Leadership Strengthening for HIV/AIDS organizations	Rwanda	MOHs	BPF-HIV Project, Rwanda bilateral
VSPPI LAC	Spanish	Strategic Planning	Peru, Guatemala, Nicaragua, Bolivia, Ecuador	NGOs	LMS: Pop Core

Program Title	Language	Focus	Country(ies)	Types of Organizations	Funding Source
2007					
VLDP HRM II	English	Leadership Strengthening for HRM	Nigeria, Malawi, Ethiopia, Madagascar, Rwanda, Uganda, South Africa	MOHs, NGOs	1/2 LMS Pop Core; 1/2 Capacity Project
VLDP CS (LAC)	Spanish	Leadership Strengthening for Contraceptive Commodities Security	Honduras, El Salvador, Paraguay, Dominican Republic	MOHs, NGOs, Social Security Institute, Etc.	LMS: Pop Core-CS
VLDP OHA	English	Leadership Strengthening for HIV/AIDS organizations	Tanzania, Botswana, Swaziland, Zambia, Malawi	MOHs, NGOs	LMS: OHA Core
VLDP Rwanda II	French	Leadership Strengthening for HIV/AIDS organizations	Rwanda	MOH	BPF-HIV Project, Rwanda bilateral
VLDP EE	Russian	Leadership Strengthening for HIV/AIDS and TB co-infection	Kazakhstan, Russia, Ukraine, Belarus	MOHs, NGOs	LMS: E&E Bureau Field Support
VSPP II Africa	English	Strategic Planning	Nigeria, Malawi, Namibia, Afghanistan, Kenya, Uganda	NGOs, Academic Institutes, Public Sector	LMS: Pop Core
2008					
VLDP Pre-service	English	Pre-service integration of leadership & management curricula	Egypt, Kenya, Uganda, Mexico, Tanzania, South Africa, Yemen	Academic Institutes	LMS: Pop Core
VLDP for Family Planning	English	Leadership Strengthening for Family Planning organizations	Tanzania, Ethiopia, Malawi, Uganda, Kenya	MOHs, NGOs	Capacity Project
VLDP CS	French	Leadership Strengthening for Contraceptive Commodities Security organizations	Mali, Madagascar, Rwanda, Senegal	MOHs, NGOs, Pharmacy Task Force	LMS: Pop Core
VLDP Public-Private Partnerships	English	Leadership Strengthening for Public-Private Partnerships in FP/RH	Nigeria, Ethiopia, Swaziland, Ghana, Kenya	MOHs, NGOs	LMS: Pop Core; PSP-One
VBPH	Spanish	Business Planning	Peru, Paraguay, Honduras, El Salvador	NGOs	LMS: Pop Core
VHRM	English	Human Resource Management	Tanzania, Ethiopia, Namibia, Uganda	MOHs, NGOs	LMS: OHA Core

Program Title	Language	Focus	Country(ies)	Types of Organizations	Funding Source
2009					
VLDP M&E I	English	Monitoring & Evaluation, HIV/AIDS	Botswana, Ghana, Guyana, India, Kenya, Nigeria, Swaziland, Uganda, Zambia	NGO, FBO, public sector	MEASURE Evaluation
VLDP M&E II	English	Monitoring & Evaluation, Family Planning	Ethiopia, Kenya, Malawi, Myanmar, Nigeria, Uganda, Zimbabwe	NGO, FBO, public sector	MEASURE Evaluation
VLDP M&E III	English	HIV/AIDS	Ethiopia, Kenya, Nigeria, Tanzania, Uganda	CAs, MOH, NGO, FBO	MEASURE Evaluation
BLDP Rwanda	French	HIV/AIDS	Rwanda	MOHs	Rwanda MSH Bilateral
VSPP	English	HIV/AIDS	Bangladesh, Kenya, India, Uganda, Vietnam, Nigeria	Public sector, NGOs, academic, FBO	LMS: OHA Core
VCGP	English	Family Planning	Afghanistan, Ethiopia, Kenya, Nigeria	NGOs	LMS: Pop Core
VCGP 2	Spanish	Family Planning	Guatemala, Nicaragua, Honduras	NGOs	LMS: Pop Core
VCGP 3	English	HIV/AIDS	Ethiopia, Ghana, Kenya, Uganda	NGOs	LMS: OHA Core
VLDP OHA	English	HIV	Kenya, Ethiopia, Zambia, Tanzania, Uganda, Lesotho, Zimbabwe, South Africa	MOHs, NGOs	LMS: OHA Core
VHRM 2	English	Human Resource Management	Afghanistan, Bangladesh, Ghana, Kenya, Nigeria, Uganda, Ukraine	MOH, NGOs, FBOs	LMS: OHA Core
VLDP Brazil	Portuguese	HIV/AIDS	Brazil	NGOs (CSOs)	LMS: Brazil Field Support
VLDP Peru	Spanish	Health Promotion	Peru	MOHs	LMS: Peru Field Support
VFCP PAC (Ongoing)	French	Post Abortion Care	Burkina Faso, Guinea, Rwanda, Senegal, Togo	MOHs, CAs, NGOs	LMS: Pop Core

Program Title	Language	Focus	Country(ies)	Types of Organizations	Funding Source
VFPC ANE	English	Maternal and Child Health	Afghanistan, Indonesia, Jordan, Nepal	NGOs	LMS: Pop Core
2010					
VBPH 2 (Ongoing)	Spanish	Family Planning	Bolivia, Honduras, El Salvador, Dominican Republic, Peru	NGOs	LMS: Pop Core
VSPP M&E (Ongoing)	English	HIV/AIDS	Botswana, Cambodia, Ghana, India, Nigeria, Ukraine, Uganda, Sudan, Zambia	CAs, FBOs, public sector	MEASURE Evaluation
VLDP OECS (Ongoing)	English	HIV/AIDS	Eastern Caribbean states	MOHs, Global Fund Project teams	Organisation of Eastern Caribbean States (OECS, a Global Fund Principal Recipient)
VLDP FP Africa (Ongoing)	English	Family Planning	Cameroon, Kenya, Ghana, Liberia, Tanzania, Namibia, Nigeria, Sierra Leone, Ethiopia, Zimbabwe	NGOs (IPPF Affiliates)	LMS Pop Core

APPENDIX II. VIRTUAL NETWORKS

Table 8. LeaderNet Events (May 2006-March 2010)

Date	Topic	Total Participants	Total Countries Represented	Funding Source	Language
May, 2006	Confronting health challenges in the world's most difficult environments	81	22	LMS Pop/ RH Core	E, P, S, F
Oct, 2006	An urgent call to professionalize leadership and management	65	24	LMS Pop/ RH Core	E, S
Apr, 2007	Global Fund proposals: how to create, support, and participate in multi-sectoral grant partnerships	84	30	LMS Pop/ RH Core	E, S, F
Nov, 2007	Developing an effective advocacy campaign for professionalizing leadership and management	65	35	LMS Pop/ RH Core	E, S
Jan, 2008	Improving Employee Satisfaction and Performance through HRM	132	36	LMS Pop/ RH Core	E, P, S, F
March, 2008	Challenge of the Month - Employee motivation	28	15	LMS Pop/ RH Core	E, S
Mar-Apr, 2008	Coaching for professional development and organizational results	158	33	LMS Pop/ RH Core	E, S
April, 2008	Challenge of the Month - Competing priorities	22	13	LMS Pop/ RH Core	E, S
May, 2008	Performance-based financing of health services: Paying results not processes	177	39	LMS Pop/ RH Core	E, S, F
June, 2008	Challenge of the Month - Monitoring and Evaluation of programs	19	11	LMS Pop/ RH Core	E, S
Aug, 2008	From Vision to Action (VLDP Pre-service follow up)	47	11	LMS Pop/ RH Core	E
Aug, 2008	The Changing Face of Human Resource Management	373	68	LMS Pop/ RH Core	E, S, F
Sept-Oct, 2008	Challenge of the Month - Building capacity of recipient and sub-recipient organizations	10	6	LMS Pop/ RH Core	E, S
Oct, 2008	Leadership and Management by Design, Not by Default: Creating Career Paths for Health Managers (Global Leadership Team)	230	48	LMS Pop/ RH Core	E, S
Nov-Dec, 2008	Challenge of the Month - Task shifting as a policy level decision	22	13	LMS Pop/ RH Core	E, S
Feb, 2009	Management and Organizational Sustainability Tool	313	65	LMS Pop/ RH Core	E, S, F
Mar, 2009	Leadership Facilitators, "Road Map to Results: Making Monitoring and Evaluation (M&E) Work for Facilitators of Leadership Development Programs"	278	57	LMS Pop/ RH Core	E

Date	Topic	Total Participants	Total Countries Represented	Funding Source	Language
Apr-Jun, 2009	Challenge of the Month: Intersectoral collaboration for health reform	5	4	LMS Pop/ RH Core	E, S, F
Jun, 2009	Seminar: Strengthening Finance and Office Operations Systems in Your Health Services Organization	351	58	LMS Pop/ RH Core	E, S, F
Aug, 2009	Moving up the Leadership Ladder	390	58	LMS Pop/ RH Core	E, S
Oct 13-16, 2009	Finding Our Voices: Strategies to Promote LM by Design	274	54	LMS Pop/ RH Core	E, S
Mar, 2010	Good Governance of Civil Society Organizations	434	58	LMS Pop/ RH Core	E, S

Language Key:

E = English

S = Spanish

F = French

P = Portuguese

**Table 9. Global Exchange Network for Reproductive Health Seminars
(June 2006-March 2010)**

Date	Topic	Total Participants	Total Countries Represented	Funding Source	Language
June, 2006	The Financial Sustainability of Reproductive Health Programs and Organizations	161	15	LMS Pop/RH Core	S
Sept, 2006	Financial Sustainability of Community Networks for Reproductive Health	196	15	LMS Pop/RH Core	S
Dec, 2006	Financial Sustainability of Reproductive Health Programs for Adolescents	193	15	LMS Pop/RH Core	S
May, 2007	Addressing Unmet Need for Family Planning in Rural Areas: Introducing Community-Based Distribution of Injectable Contraception	188	34	CRTU	E
Sept, 2007	National CS committees in LAC VLDP CS countries (DAIA)	40	5	LMS CS Core	S
Dec, 2007	Procurement Options in Latin America and the Caribbean	133	21	LMS Pop/RH Core, JSI/Constella Futures	S
April, 2008	Effective Programming for Long-Acting and Permanent Methods: A Forum for Family Planning Program Managers and Policymakers	94	33	50% MSH, 50% FHI and Engender	E
June, 2008	Using Leadership to Reposition Reproductive Health on the Public Health Agenda	212	55	LMS Pop/RH Core	E, S, F
Sept, 2008	Market segmentation strategy and its contribution to our organizations' missions	170	50	LMS Pop/RH Core	E, S, F
Nov, 2008	Strategies to Reposition and Strengthen the Demand for Reproductive Health Services	110	39	LMS Pop/RH Core	E, S, F
Dec, 2008	“ De la conférence de soins après avortement (SAA) tenue au Sénégal au Programme virtuel de promotion du changement : Utiliser le Dossier Mondial d'Information sur les Soins Après Avortement afin de renforcer nos programmes « (Follow-up seminar to Virtual Fostering Change Program for Post-abortion Care)	48	10	LMS Pop/RH Core	F

Date	Topic	Total Participants	Total Countries Represented	Funding Source	Language
Feb, 2009	Effective Models for Delivering Family Planning to Groups with Limited Access	227	53	LMS Pop/RH Core	E, S, F
April, 2009	Results-Based Operational Planning in Family Planning and Reproductive Health Organizations	208	47	LMS Pop/RH Core	E, S, F
June, 2009	Using Performance Dashboards to Monitor Results in Reproductive Health	245	51	LMS Pop/RH Core	E, S, F
July, 2009	USAID's Contraceptive Security Ready Lessons II, 6: Mobilizing Financial Resources for Contraceptive Security	155	45	LMS Pop/RH Core; Partnered with Futures Group	E, S, F (without translation)
Sept, 2009	Family Planning in the Context of Decentralization: Successes, Challenges, and the Role of Leadership and Negotiation	193	54	LMS Pop/RH Core	E, S, F
Dec, 2009	USAID's Contraceptive Security Ready Lessons II, 7: Fostering Public-Private Collaboration for Improved Access	137	45	LMS Pop/RH Core; Partnered with USAID/DELIVER and SHOPS	E, S, F (without translation)
Mar, 2010	Using Leadership and Management to Collaborate with Contraceptive Security Committees	190	53	LMS Pop/RH Core	E, S, F

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