Leadership and Management Intervention Assessment Report

September 2015
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## List of Abbreviations and Acronyms

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<th>Abbreviation</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>ADRA</td>
<td>Adventist Development and Relief Agency</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<tr>
<td>BLC</td>
<td>Southern Africa Building Local Capacity Project</td>
</tr>
<tr>
<td>CDRA</td>
<td>Community Development and Relief Agency</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
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<tr>
<td>CRS</td>
<td>Contraceptive Retail Sales</td>
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<tr>
<td>CSO</td>
<td>Civil Society Organization</td>
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<tr>
<td>EML</td>
<td>Essential Medicines List</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HR</td>
<td>Human Resource(s)</td>
</tr>
<tr>
<td>HRH</td>
<td>Human Resources for Health</td>
</tr>
<tr>
<td>ICA</td>
<td>Institute of Cultural Affairs/Nepal</td>
</tr>
<tr>
<td>ISP</td>
<td>Institutional Strengthening Program</td>
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<tr>
<td>KZN</td>
<td>KwaZulu-Natal</td>
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<tr>
<td>L+M</td>
<td>Leadership and Management</td>
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<tr>
<td>LDP</td>
<td>Leadership Development Program</td>
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<td>LOISNET</td>
<td>Local Institutional Strengthening Network</td>
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<tr>
<td>LMG</td>
<td>Leadership, Management and Governance Project</td>
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<td>LMS</td>
<td>Leadership, Management and Sustainability Project</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>MSH</td>
<td>Management Sciences for Health</td>
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<td>MTOT</td>
<td>Master Training of Trainers</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<tr>
<td>NSAID</td>
<td>Non-Steroidal Anti-Inflammatory Drugs</td>
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<tr>
<td>OCAT</td>
<td>Organizational Capacity Assessment</td>
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<tr>
<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
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<tr>
<td>PHC</td>
<td>Primary Health Center</td>
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<tr>
<td>PLDP</td>
<td>Pharmaceutical Leadership Development Program</td>
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<tr>
<td>ROLDP</td>
<td>Results-Oriented Leadership Development Program</td>
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<tr>
<td>SIAPS</td>
<td>Systems for Improved Access to Pharmaceuticals and Services Project</td>
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<tr>
<td>SOP</td>
<td>Standard Operating Procedures</td>
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<tr>
<td>STG</td>
<td>Standard Treatment Guidelines</td>
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<tr>
<td>TA</td>
<td>Technical Assistance</td>
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<td>USAID</td>
<td>US Agency for International Development</td>
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1. BACKGROUND


At the core of this work around the world is a suite of leadership and management interventions that are adopted and/or adapted and applied through carefully facilitated processes by trained facilitators and experts in organizational development, leadership and management\(^1\). These interventions have been applied with teams across organizations (government and non-government), levels (health facility, hospitals, Ministry of Health and Country Coordinating Mechanisms [CCMs]) and countries. The interventions are usually applied over six months to one year, and are usually, if not always, accompanied by technical assistance, mentoring and coaching during the implementation period.

The LMG Project commissioned an external assessment of two leadership and management interventions that support institutional strengthening and team-based approaches: the Leadership Development Program (LDP) and the Institutional Strengthening Program (ISP). ISP is a term we developed for this paper that refers to the application of the Organizational and Capacity Assessment Tool (OCAT) and the tailored package of technical assistance that follows. The assessment of these two interventions was meant to ascertain their benefits to participants and consequent results for various stakeholders. The assessment questions were:

1. What results have the LDP\(^2\) and the ISP– and the accompanying technical assistance including coaching and mentoring – enabled the client organizations to produce in both the short and intermediate terms after their application?
2. Have these results been sustained or scaled up over time? If so, what factors have enabled these results to be sustained? If not, what barriers have prevented these results from being sustained?
3. Have the tools or processes imparted through the LDP and the ISP been institutionalized, replicated, or adapted by organizations? What factors have enabled or prevented organizations from doing so?

This assessment found evidence that both the LDP and the ISP as implemented in Nepal and Southern Africa for the former, and Kenya and Southern Africa for the latter – through facilitated capacity

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\(^1\) The LMG Project developed and implemented the LDP+, which does not always need a facilitator trained in organizational development.

\(^2\) This assessment looks at the application and adaptations of the LDP because we wanted to look at the sustainability of this program over 2-5 years.
development, accompanying TA, and mentoring and coaching – have strengthened the institutional capacity of non-governmental organizations (NGOs), civil society organizations (CSOs), community based organizations (CBOs), and local government agencies. Beneficiaries shared with us that the interventions have resulted in a wide range of individual, organizational, and health service delivery outcomes including improving the reach and quality of services, achieved time savings, and increased revenue.

This assessment report describes these findings in detail. LMG and other projects at MSH will use the findings in the following ways: to support internal efforts to learn what is working and what is not in leadership and management (L+M) strengthening to improve health results and outcomes; to offer recommendations and insights into ways that the ISP, the LDP and its subsequent versions, the process of applying them and the measurement of results can be modified for maximum effectiveness and to contribute to external reviews of LMG to examine the sustainability of the ISP and the LDP. The findings will also inform technical “legacy” publications planned by the LMG Project in PY5.
2. INTRODUCTION

This is a report of an assessment of the ISP and the LDP, two legacy interventions designed by MSH to strengthen L+M practices within teams and institutions. The LDP and the ISP have been utilized under the M&L (2000-2005), LMS (2005-2010), and LMG (2010-2015) Projects and subsequently adapted and applied under other USAID-funded MSH projects. The assessment investigated their continued use and their short- and long-term benefits for various stakeholders.

**Intervention 1. Leadership Development Program (LDP)**

MSH created the Leadership Development Program (LDP) in 2002 under the USAID-funded Management and Leadership (M&L) Project. It is a team-based, results-oriented, participatory leadership development process that enables teams to address challenges and achieve results through experiential learning. Individuals from the same workplace form teams to learn and apply leadership and management practices. Teams complete the Challenge Model, a core LDP tool, to define their goal and the challenges they will need to overcome to achieve it. Working on real workplace challenges over time, they receive feedback and support from facilitators and local managers to achieve measurable results. This approach to leadership development differs from traditional leadership training programs. The LDP does not introduce leadership theories, values, and behaviors in a structured classroom setting. Rather, it offers a process for teams to use this learning to produce measurable organizational results to achieve better health results and outcomes.

The LDP has been applied in more than 40 countries and adapted in various projects and contexts. The LMG Assessment Team looked at two different examples of LDP adaptations.

The Systems for Improved Access to Pharmaceuticals and Services (SIAPS) Project implemented the Pharmaceutical Leadership Development Program (PLDP) between 2011 and 2015 in the KwaZulu-Natal (KZN) province of South Africa. The LDP was adapted specifically for pharmacists, and sections were added on legislation, ethics, governance, financial management, and human resources. The PLDP combines pharmaceutical management knowledge and sound leadership practices to better equip pharmacy managers to respond to challenges in their workplaces. The PLDP is structured into five workshops held at monthly intervals. Working in teams, participants tackle one of their own workplace issues by applying the Challenge Model and other supporting tools to one challenge at a time. In working through the model, participants:

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3 More recent adaptations of the LDP include the LDP+ and the Essential Management Package (EMP) developed and implemented by the LMG Project. The LDP+ adds a focus on gender, governance, and service delivery improvement by ensuring that all teams within an LDP+ are working toward a jointly identified, service delivery indicator. The LDP+ is also designed so that it can be self-paced and self-administered. The EMP is a self-paced, shorter, modular version of the LDP+ developed and tailored to the needs of the International Committee of the Red Cross (ICRC).
- Create a shared vision and define one measurable result
- Assess the current situation and identify opportunities
- Define their challenge and select priority actions
- Develop an action plan
- Implement their plan
- Monitor and evaluate their progress towards achieving their desired result

The second adaptation of the LDP reviewed by the assessment team was the Results-Oriented Leadership Development Program (ROLDP) in Nepal. The LMS Project and its partners, the National Health Training Center, the Adventist Development and Relief Agency (ADRA), and the Institute of Cultural Affairs (ICA), adapted the LDP for the Nepali context, and used the name Results Oriented LDP (ROLDP) for the adapted program. The ROLDP was implemented at both the national and district levels under LMS, and a Training of Trainers (ToT) was conducted to support the continued roll out of the ROLDP down to the community level beyond the life of the project.

**Intervention 2. Institutional Strengthening Program (ISP)**

For the purposes of this assessment, we developed the term ISP to encompass the implementation of a capacity assessment tool and the tailored package of technical assistance which is subsequently provided to address identified weaknesses. The ISP comprises a facilitated process by which an organization can identify organizational sub-system strengths and weaknesses, and stimulates discussion among staff about the findings. Analyzing an organization’s abilities and needs helps determine priorities for tailored technical assistance and support to improve operations and organizational performance. The priorities are documented in an organization-specific capacity development plan.

The initial assessment is done using an Organizational Capacity Assessment Tool (OCAT). The OCAT was designed to:

- Measure an organization’s capabilities before a capacity development program is implemented
- Provide evidence-based qualitative and quantitative data on specific areas that can be improved
- Reassess and quantify the effects of capacity development efforts over time.

The OCAT is used to assess an organization’s capacity in nine different sub-systems or areas: 1) Leadership and Governance; 2) Systems and Structures; 3) Human Resource Management; 4) Financial Management; 5) Grants Management; 6) Program Management; 7) Planning, Monitoring and Evaluation; 8) Partnerships, External Relations and Networking; and 9) Knowledge Management. These nine areas are broken down into 52 sub-components. It is implemented through a highly participatory process that takes place over a two- to three-day period in a workshop setting with a facilitator. Each area is scored and priority areas are selected for strengthening jointly with the organization. The OCAT is followed by tailored capacity development efforts including on-site technical assistance, mentoring, coaching and repeat assessments to track progress.
This assessment included two projects that implemented the ISP for organizational development: the FANIKISHA Project in Kenya (2011-2015), and the Building Local Capacity (BLC) for Delivery of HIV Services in Southern Africa project (2010-2015).

FANIKISHA worked to build the organizational capacity of national-level CSOs and NGOs in leadership, (financial and human resource) management and governance and advocacy to play a more strategic role in working with the Government of Kenya and other stakeholders to deliver effective health services at the community level.

FANIKISHA was designed and implemented during a time when a clear need existed to strengthen Kenyan CSOs’ capacity to play substantial roles in Kenya’s health sector. Global and national priorities focused on making investments in local capacity development and increasingly using local ownership and country-led initiatives to solve health problems. Kenyan CSOs were recognized as key actors in the local health system. However, their weak organizational capacity prevented them from playing key roles in health development. Within this context, FANIKISHA articulated a clear vision of Kenyan national CSOs that were strong, efficient and sustainable and would have a lasting impact on the health of all Kenyans as integral parts of a functional Kenyan health system.

More specifically, the project’s strategic objective was to build the capacity of four to eight national-level CSOs and NGOs to become sustainable recipients of large subagreements or contracts from USAID and other large donors to deliver effective health services at the community level. The OCAT was used to assess the capacity of these CSOs.

FANIKISHA adopted a three-pronged approach based on 1) strengthening the organizational capacity of national-level CSOs and their affiliates, 2) mentoring grants to smaller CSOs to support institutional strengthening activities, and 3) encouraging stakeholder engagement aimed at building sustainable partnerships. The project focused on three result areas:

1. Strengthened leadership, management, and governance of local CSOs
2. Increased access to and use of high-quality data for CSO decision making
3. Improved quality of institutional strengthening for CSOs

In Southern Africa, the five-year (2010-2015) Building Local Capacity for Delivery of HIV Services in Southern Africa (BLC) Project contributed to the USAID/Regional HIV/AIDS Program (RHAP) goal of strengthening the overall sustainability, quality, and reach of HIV and AIDS interventions in the region. The BLC Project worked with local and regional organizations in Angola, Botswana, Lesotho, Namibia, South Africa, and Swaziland at the community, national, and regional levels to:

- Build the capacity of government agencies at district and national levels to improve, coordinate, and deliver services to their citizens
- Build the capacity of local CSOs to improve the coordination of HIV-related services for communities, orphans and vulnerable children (OVC), and migrants
- Improve the skills of hospital and clinic-based health workers to continuously improve the quality of services they provide
• Develop the capacity of the Southern African Development Community (SADC) to coordinate the development and implementation of HIV prevention policies and programs for SADC Member-States

A strong focus area of the BLC Project was to provide technical assistance in organizational development, including leadership, management, and governance for organizations providing services in three key program areas: 1) OVC care and support; 2) HIV prevention; and 3) community-based care. The OCAT was the basis for the institutional assessments and the resulting capacity development plans that were implemented.

3. METHODS AND DATA

A targeted review of the literature was undertaken to understand existing conceptualizations of sustainability (see Appendix) and to specify the scope of the assessment. The review informed the creation of an a priori conceptual framework that formed the basis for inquiry for this assessment (see Figure 1). Based on the literature, the factors that contribute to sustainability can be grouped into four broad categories (see Appendix 1 for more details):

1. Interaction between the intervention and recipient organization including stakeholder alignment, presence of internal champions and organizational buy-in)
2. Intervention characteristics related to the delivery of governance, finance, and service delivery intervention content
3. Broader organizational characteristics
4. Broader environmental characteristics

In this assessment, we focus in Sections 1 and 2 on the first category and the second category, respectively. Section 3 presents evidence on how the ISP and LDP tools and processes have led to sustainable outcomes for the participating organizations, and on broader organizational sustainability factors such as resource mobilization and delivery of high-quality products and services. Environmental factors are beyond the scope of this assessment. The report concludes with recommendations and next steps.
Figure 1. “What makes an intervention sustainable?”: Proposed conceptual framework for assessment (based on literature review)

**Environmental Factors**
- Nature and stability of the socioeconomic and political environment
- Community participation and the existence of partnership that lead to non-monetary support of the focal organization

**Organizational Factors**
- Capacity of an organization to consistently adapt its governance practices, structure, and systems to remain mission driven and market adjusted, allowing the organization to respond to the shifting priorities of its supporters and to new responsibilities towards its clients, while creating a positive work climate for its staff.
- Capacity of an organization to consistently secure, manage, and report on the use of revenue from various sources to support its ongoing programs and undertake new initiatives.
- Capacity of an organization to deliver quality products and services that respond to its clients' needs and to anticipate new areas of need, supported by a strong knowledge management system.

**Organizational Buy-In/ Stakeholder Alignment**
- Fit and alignment of program with organizational mission and operating routines
- Integration with existing programs
- Identification of internal champion to advocate for the program
- Building buy-in from other staff on the benefits of the intervention

**MSH’s Intervention foci [L+M+G behaviors and practices]**
- Leading
  - Scan, Focus, Align/Mobilize, Inspire Managing
  - Plan, Organize, Implement, Monitor/Evaluate Governing
- Cultivate accountability, engage stakeholders, set shared direction, steward resources

**L+M Intervention Characteristics**
- Governance, financial and service delivery mechanisms addressed
- Appropriate level, quality, and duration of training and capacity development provided
- Program is flexible and adaptable from its original form
- Level of evidence to support program effectiveness exists

**Sustained L+M Intervention (including Institutional, Financial and Programmatic Sustainability)**
- Institutionalization/routinization/standardization of elements of intervention in the organization
- Mobilization and allocation of resources to maintain intervention activities and benefits
- Continued benefits of intervention activities
- Increased/continued awareness of target problem and post-intervention investments to address these
- Diffusion/ replication of elements of intervention to other sites
- Networks or coalitions maintained over time
The assessment was conducted in two countries – Kenya and South Africa. Key informants from a third country, Nepal, were interviewed remotely. These countries were selected based on the following inclusion criteria and in consultation with an MSH-wide Advisory Group:

- Countries where MSH has multiple projects applying L+M tools
- Countries where longer-term L+M tools and interventions have been used under one MSH project
- Countries where MSH has ongoing projects/presence to support in-country logistics and coordination with partners and stakeholders

The following tables show the organizations included in both parts of the assessment and the distribution of the 43 interviews conducted.

**Table 1: LDP Interviews**

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>PROGRAM</th>
<th>IMPLEMENTATION PERIOD</th>
<th>ORGANIZATION</th>
<th>NUMBER OF INTERVIEWS</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Africa</td>
<td>PLDP</td>
<td>2011-2015</td>
<td>KwaZulu-Natal District Pharmacy Managers</td>
<td>11</td>
</tr>
<tr>
<td>Nepal</td>
<td>LMS</td>
<td>2006-present</td>
<td>Multiple</td>
<td>8</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>19</strong></td>
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</table>

**Table 2: ISP Interviews**

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>PROGRAM</th>
<th>IMPLEMENTATION PERIOD</th>
<th>ORGANIZATION</th>
<th>NUMBER OF INTERVIEWS</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Africa</td>
<td>BLC</td>
<td>2010-2013</td>
<td>Thembalethu Development</td>
<td>5</td>
</tr>
<tr>
<td>South Africa</td>
<td>BLC</td>
<td>2010-2013</td>
<td>Inerela</td>
<td>4</td>
</tr>
<tr>
<td>Kenya</td>
<td>FANIKISHA</td>
<td>2011-2015</td>
<td>NOPE</td>
<td>5</td>
</tr>
<tr>
<td>Kenya</td>
<td>FANIKISHA</td>
<td>2011-2015</td>
<td>KANCO</td>
<td>5</td>
</tr>
<tr>
<td>Kenya</td>
<td>FANIKISHA</td>
<td>2011-2015</td>
<td>ICL – Africa</td>
<td>5</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>24</strong></td>
</tr>
</tbody>
</table>
The assessment team reviewed multiple project documents and reports. The interviews were recorded with permission from the interviewees and selectively transcribed. Interviewee perceptions and responses were analyzed for convergence with or divergence from the a priori organizational factors and intervention characteristics identified through the targeted literature review.

Given the time and resources available, this assessment has some limitations. With the exploratory nature of the questions and the sample size of selected organizations, these findings cannot be interpreted as generalizable to other L+M tools and programs under the LMG Project.

4. FINDINGS

These assessment findings are presented in three sections:

1. Interaction between the recipient organization and intervention in terms of stakeholder alignment, the presence of internal champions, and achieving organizational buy-in
2. Intervention characteristics related to the delivery of governance, finance, and service delivery intervention content
3. Sustainability of the intervention characteristics and links to broader organizational sustainability.

4.1. Interaction between Recipient Organization and Intervention

Stakeholder Alignment

The likelihood of sustainability of a given intervention increases when there is alignment, compatibility, or convergence between the recipient organization’s mission and operating routines, and the intervention’s mandate (Trasi, Seims and Grenier 2012). Both the LDP and ISP tools and processes aligned closely with the needs, organizational mission, and regular routines of the participating organizations.

LDP

The PLDP, in South Africa, aligned with the recipient organization’s mission because it addressed an already identified need: providing management training to pharmacy managers.

“The majority of pharmacy managers do not have the capacity to manage. PLDP was exciting for us because it was the first time we had a program designed just for pharmacy managers”. [M&E officer, KZN Pharmaceutical Services, South Africa]

“At university, we do basic management but many are made managers without any experience. Pharmacy managers feel this is not what they studied for. PLDP teaches them how to approach problems, resolve problems, especially in team-based settings ... that is why we welcomed this program.” [Head, KZN Pharmaceutical Services, South Africa]

“I was very excited because I had not had formal training to be a pharmacy manager. Just learning as you go. It would be good to get some training.” [PLDP Participant, South Africa]
Running the PLDP through existing administrative or management channels ensured that participants understood that there was a convergence between the intervention and their regular work routines. Participant applications were submitted through the district pharmaceutical services head office, and all communication, presentations, and workshops were under the banner of the head office. This was important for buy-in and to position the program, from the beginning, as an initiative owned and implemented by the district authorities.

Finally, each Challenge Model completed by the PLDP teams aligned with the existing organizational mission and staff work routines. Every team picked a challenge that built on district-specific gaps identified through data generated by their results framework for monitoring performance, and every district team’s progress became part of regular reporting practice at the provincial headquarters:

“The challenges taken up by the teams are all linked to our performance as a district and these are the issues that we report to our principals … the PLDP projects became part of our regular reports. This was not seen as something on the side. It was integrated with our work … complemented our work … it got positive acceptance from the principals....” [Head Pharmaceutical Services, KZN, South Africa]

Challenges were evidence-based; some teams took input from all district-level managers (including those managers who did not participate in the PLDP) on which challenge to pick:

“We [participant’s team] decided our Challenge Model at the quarterly meeting of the district pharmacy managers where we look at the district’s overall performance. The decision on which challenge to choose was made by all managers, not just those who participated in the PLDP program.” [PLDP Participant, KZN, South Africa]

While the literature on sustainability emphasizes the importance of congruency of an intervention with organizational operating routines (Gruen et al. 2008; Scheirer and Dearing 2011), an example from the ROLDP Nepal shows that sometimes it is necessary to go beyond an organization’s regular routines.

“When you work with projects that are run by organizations that have more of a corporate culture - set work plans, project deliverables, where staff time is rationed - I learned that taking up a new challenge for the staff becomes very difficult because they can’t think beyond deliverables. But if you take up an action that is already in your work plan, that is not a challenge. What I had to do is to have teams stretch the deliverables. There was a lot of resistance at first. But here too the ROLDP and Challenge Model is very powerful. You have to make them realize that leadership is about not just doing what is expected, but going beyond ... the only way to change targets without increasing resources is to optimize leadership and management. That is the power of the tool ...” [ROLDP Trainer, Nepal]

ISP
Recipient organizations reported that the ISP aligned with their existing organizational mission and goals. A FANIKISHA-supported partner shared an example of the project’s opportune timing and content.
“FANIKISHA fit into one of our strategic areas of focus, which was institutional system strengthening ... so when we saw the call for proposals we thought, “yes, this is one of the projects we definitely would want to participate in.” FANIKISHA came at a time when we wanted to review and update our organization’s procedures and manuals and we thought this was a great opportunity.” [FANIKISHA-supported CSO participant, Kenya]

An example from South Africa’s BLC program highlights the alignment of the project’s objectives with their own development phase. When Thembalethu Development applied to the BLC program, they were in the process of a major organizational change, from being a corporate social responsibility wing of a large mining corporation to becoming an independent entity. The respondents at Thembalethu Development credit BLC with helping the nascent organization stand on its own:

“When MSH [BLC] came, we were a fairly new organization that had just separated from the mother company. We did not even have an organogram ... staff did a little of everything ... so I can say that MSH helped us become an organization ... a professional organization ...” [BLC-supported CSO participant, South Africa]

Participants, in Kenya, felt that the project did not create additional work for their staff. The ISP activities aligned well with existing staff work plans and routines.

“The gaps identified by the ISP were on those aspects where our work was not being done at an optimal level, there was no task assigned to me that was somehow an added responsibility ...” [FANIKISHA-supported CSO participant, Kenya]

Respondents who had participated in the FANIKISHA program highlighted that by involving all staff, MSH’s intervention distinguished itself from other similar institutional strengthening programs. The ISP necessitated the involvement of all staff, thereby ensuring that the existing work routines of the entire organization were simultaneously taken into account. Participants’ responses reflect MSH’s approach to institutional strengthening as an organization-wide effort recognizing the interconnectedness of work routines and processes that affect one another and people that must work together to move an organization in any given direction.

“We had participated in another institutional strengthening program before FANIKISHA ... that program’s tools had almost the same components but there was a heavy emphasis on programmatic areas and mostly involved the leadership and program staff ... ISP involved the whole of our organization ... the whole office staff was part of this program” [FANIKISHA-supported CSO participant, Kenya]

Internal Champions
The presence of an internal champion ensures that an intervention’s effectiveness is understood and appreciated, allowing the replication or adaptability of the intervention (Trasi, Seims and Grenier 2012). A strong internal champion is an important factor for organizational buy-in and stakeholder alignment and can play an important role in the sustainability of an intervention by replicating it, or mobilizing organizational resources for it to continue. The success of an internal champion advocating for the continued use of the intervention and its subsequent results is discussed in Section 4.3 of this report.
**LDP**

The ROLDP provides an excellent example of how the intervention’s success has spread organically, creating internal champions who advocate for the tool and the process that goes along with the tool.

After receiving the LDP Master Training of Trainers (MTOT) at the inception of the MSH program in Nepal in 2006-2007, the trainer successfully advocated for the ROLDP when he moved to FHI360. FHI360 agreed with the trainer’s suggestion to use the ROLDP in a contraceptive and reproductive health services program, and one of the companies that underwent the ROLDP training was Nepal Contraceptive Retail Sales (CRS), a social marketing company. One of the CRS participants in the ROLDP stated that achieving the goals of the challenge that his team undertook resulted in a historical achievement for Nepal CRS. This participant has since moved from Nepal CRS to another organization, where he now urges his new boss to use the ROLDP.

> "The vision for Nepal CRS at the time was to become a sustainable social marketing organization. Achieving the measurable result through the Challenge Model was a major achievement in CRS’ history.” [Participant, ROLDP, CRS Nepal]

The following are comments from three different respondents familiar with the ROLDP: the first from a master trainer; the second from one of the earliest participants in the program; and a third from a participant, who had recently used the tool but was unfamiliar with the antecedents of the tool and MSH. Each quote points to a different strength or advantage of the ROLDP from individuals, who continue to champion and use the ROLDP.

> "I am very passionate about the LDP tool. Even after the project closed, I continued using it wherever I needed to build the capacity of local organizations and communities. I took a course on “appreciative inquiry”, it was nice, for one week you are a great leader and then you forget everything ... In LDP participants are involved, they have a tool to work with, they can measure their achievements, can reflect back on what went wrong ... process itself is learning oriented ... LDP gives you tools, actions, and it makes clear that leadership is not only for people at the top ...” [ROLDP Trainer, Nepal]

> "I am now a PhD candidate and want to write my dissertation on the ROLDP model. This is an established model that works. If I get a chance to use it with any government agency or any organization, I will use it. This is a diamond that should be shared with everybody.” [ROLDP Participant, Nepal]

> “The models and tools are so organized that it fits into every community...there is no project in which I cannot use ROLDP...” [ROLDP participant, Nepal]

At times, despite the internal champions, a project is unable to sustain institutional strengthening efforts – indicating that champions are necessary, but not sufficient to make interventions sustainable.
Internal champions are important to identify and cultivate from the onset of an intervention, and nurture and maintain over the course of the project. FANIKISHA (and BLC) project start-up included an application and selection process that was meant to identify organizations which prioritized institutional strengthening and already had champions. From this early stage, identifying and cultivating internal champions was part of the approach and engagement process for institutional strengthening. One CEO of a FANIKISHA-supported CSO was quoted as saying, “We certainly have grown and are ready to take our place as leaders of the civil society movement in Kenya.” Several of the graduated CSOs continued to build on their FANIKISHA experience to become direct recipients of USAID funding a year after the project closed. These reflections suggest that FANIKISHA’s work in developing internal champions early in the project may have fostered continued improvements in institutional capacity – enough to warrant direct funding from USAID.

In the case of FANIKISHA, the project ended abruptly. This was a topic of discussion in the interviews. The unanticipated ending of the project prevented some institutional building plans from being implemented completely. This sudden closure points to the potential influence external factors (in this case, donor support of the project) can have on the implementation of the program interventions and its sustainability.

The sudden closure of FANIKISHA was a result of the pivot by the Office of the Global AIDS Coordinator (OGAC) to PEPFAR 3.0, under which such health systems activities are considered non-core4. The reasons for the early closure of FANIKISHA were communicated to all partners and sub-grantees. Still, some participants communicated confusion and disappointment from the sudden closing of the project.

“We still do not know why FANIKISHA had a premature end ... that remains a mystery ... the manner in which it happened was haphazard ... we had just sub-granted, just done an assessment ... and remember that it is a negotiated entry ... and then you end it abruptly ... I can say for free that the close-out was shambolic ... it was crazy ... we had to tell people in the middle of a workshop to end it ...” [FANIKISHA-supported CSO participant, Kenya]

It is not clear if the participant was expressing that he had not received communication from FANIKISHA or if he was expressing confusion at the donor decision to end the project. Regardless, it is clear that the PEPFAR pivot by OGAC had an immediate downstream impact on the beneficiaries of FANIKISHA as an institutional strengthening project. Another participant noted the irony in the sudden decision and the focus of the project, perhaps also noting MSH’s inability to contest donor decisions in the face of policy decisions and programmatic changes at the global level.

“They [FANIKISHA] told us to have risk management strategies but they did not have one in place for themselves ... when you have done so much to build us, why would you risk ending on such a negative note?” [FANIKISHA-supported CSO participant, Kenya]

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The premature end of project support presents a difficult challenge for internal champions to continue to mobilize resources, or replicate project interventions, and influence the continued benefits of the project. The assumption that projects will have committed support from the donor and the time necessary to complete the institutional development process is one to consider when designing future institutional development programs.

**Organizational Buy-In**

Whether an organization’s key staff and clients believe an intervention is effective is one of the key factors in the sustainability of the intervention.

**LDP**

The ROLDP program began with introducing the intervention to numerous stakeholders, and highlights the importance of taking time to build buy-in.

> "Initially we started a dialogue with expected stakeholders – ministry of health, ministry of local development, National Health Training centers – because leadership and management is a cross-cutting issue ... It took many months to finish conducting all the meetings even before we started the implementation." [ROLDP Trainer, Nepal]

The PLDP program illustrates how organizational buy-in can take time and patience. The PLDP was stopped mid-way because the leadership was not convinced of the intervention’s benefits. However, after seeing the results produced by the intervention, the leadership not only came on board, but became an internal champion and the intervention continued.

> My Chief Director wasn’t too sure about PLDP because there are so many trainings that waste time, with people sitting in conference rooms instead of doing service delivery, and with no target or results. So we had to stop the program mid-way. Then the first group presented their work and my boss also attended. She told the entire conference openly that she had initial reservations. But after seeing the team presentations she said, “I have changed my mind. I endorse it. I am fully behind it.” She saw the evidence. [Head, KZN Pharmaceutical Services, South Africa]

An example from a PLDP team challenge illustrates that the success of an intervention depends on learning the lessons of organizational buy-in. The challenge involved reducing the numbers of uncollected pre-dispensed chronic medication packs from a Primary Health Center (PHC) clinic. The pharmacy managers who undertook the challenge were based at the regional hospital. To achieve results, they had to work with multiple stakeholders outside the pharmacy department: nurses, who dispensed medicines at PHCs; and transport staff, who carried the medicines from the regional hospital to the PHC. The Senior Nurse at the regional hospital described how organizational buy-in done by the pharmacist team was the key to success:

> “I learned the importance of management buy-in from this program. The challenge was introduced to the hospital management – CEO, medical manager, systems manager, nurse manager, HR manager, transport manager ... everybody knew what was going on ... once there
is buy-in, then lower levels all come together ... the nurses who participated did not complain because they felt part of the team ... then you also need buy-in from the community ... it took time to convince ... so I have learned persistence and participative management from this PLDP project ... never give up ...” [Nursing staff whose support was needed for the pharmacists’ participating in the PLDP, South Africa]

With organizational buy-in came results. The challenge was: How can the team reduce the high rate of uncollected pre-dispensed chronic medicine packs, given the lack of processes, systems, and sustainable supervision and support visits at the PHC Clinic? Figure 2 below shows the results achieved between November 2012 and March 2013.
ISP
In contrast to the LDP approach discussed above, the FANIKISHA and BLC programs implemented a proposal mechanism to generate buy-in from organizations interested to build their capacity through the interventions offered by FANIKISHA and BLC. The ISP was one of the interventions used. Only those organizations that thought the intervention would benefit them applied for these programs.

4.2. Intervention Characteristics

Intervention Content: Governance, Finance, and Service Delivery
Interventions that address three critical organizational issues – governance, finance, and service delivery mechanisms – are best placed to produce sustainable changes in health service delivery.

LDP
Participants expressed immense satisfaction that the L+M training they received through the PLDP not only pushed participants to achieve measurable results in service delivery outcomes, but also provided training on governance and finance issues.

“I had participated earlier in the supervisors’ course, and emerging managers’ course but I found this very different. The program was extremely well-organized and comprehensive. There was a workshop on governance; there was a workshop on HR just on dealing with staff issues related specifically to pharmacists; there was a workshop on finance ... there is a Public Finance Management Act of which we only know the name, they told each group to read a different section of the Act and come back to present and when we presented, there was someone from National Treasury who went over the Act in detail so we could understand how it relates to pharmacy, how we get the medicines budget ... things we were never exposed to before ... then it was all tied up to our challenge projects ...” [PLDP Participant, Kwa-Zulu Natal, South Africa]
Several challenge projects taken up by teams were directly linked to increasing service delivery. For example, one team’s challenge was: “How can we reduce the time taken to complete a main order from 27 to 10 days considering the lack of a workload management system, and weak governance related to human resources and management?” What is interesting about this challenge is that this team was at the provincial headquarters and was led by a staff person who was initially meant to oversee the program, not participate in it. However, she felt that to truly understand the program, the staff at the province level should themselves work on a challenge. Thus, the reduction in time-to-completion of orders occurred at the main provincial depot (Figure 3).

**Figure 3: Average time to complete an order**

The PLDP saw a **14 day reduction** in the average time to complete an order.

IPSP

The ISP helped organizations understand the necessity of linking the areas of finance with program management. The technical assistance inputs helped them to identify systems that would allow them to link finance and program systems.

“We used to have costs and codes in the budget which were not reflected in the program data. So it was difficult to relate finance data with program data. It was time consuming to produce the financial report. There was a lot of discussion on what we needed and finally we were advised by FANIKISHA mentors to switch from Quick Books to Sage Pastel where there is one code throughout the finance and program systems so it is all seamless. Now we work faster.”

[FANIKISHA-supported CSO participant, Kenya]

Participants who implemented the OCAT explained a distinguishing feature of the tool. Compared to similar tools implemented by other organizations, the OCAT went one step beyond a focus on the important areas of governance, finance, and service delivery (program management). For example, the OCAT brought attention to areas such as knowledge management and HR, as seen in the statements below:
“The OCAT was very comprehensive ... in fact, it made us aware of the other issues we should be looking at. Sometimes if you don’t have a holistic view of the operations of an NGO, you are more likely to focus on obvious issues like programs, finance, but things like knowledge management, you may not have a framework for what to do with the program reports coming from the ground ... we have implemented programs but are not good at documenting that ... we didn’t even have a website or an intranet of repository of documents ... now we are sharing within and with our partners ... it is one of the key things we did with BLC...” [BLC-supported CSO participant, Southern Africa]

“[OCAT] was very comprehensive. It captured all components. Other assessments did not look at HR ... this tool and program showed the other staff the importance of HR and how it connects to the rest of the organization ...” [FANIKISHA- supported CSO participant, Kenya]

**Intervention Content Delivery: Level, Quality, and Duration**

**LDP**

Participants in the PLDP said that this program was different from other courses, programs, or trainings largely because of the level, quality, and duration of the program. First, the workshop presenters were considered experts in their field. Second, the mentors provided very in-depth feedback and support, including on-site visits which bolstered the efforts of the teams to complete their challenges and trouble-shoot issues as they emerged. And third, the relationship between the teams and the PLDP program staff was described as “highly professional”, “participatory”, “helpful”, and “engaged” (i.e., “they were one of us”). Several respondents said that one of the biggest benefits they gained from the mentorship from MSH was improving their presentation and public-speaking skills.

The engaged nature of the mentorship helped teams specify their challenges and produce effective, evidence-based solutions to service delivery issues.

“The PLDP program helped us to dig deeper. Our challenge was to reduce the defaulter rate of pre-dispensed chronic medications at PHC clinics. We thought the solution was to increase collection points for patients. But early on, because of root cause analysis, when we did the baseline, we found out that patients are actually comfortable coming to the PHC, so there is no need to increase collection points. Their problem was waiting time. So the problem was with the systems. As a result, we developed Standard Operating Procedures [SOPs] to improve delivery outcomes.” [PLDP Participant, Kwa-Zulu Natal, South Africa]

Under the supervision of the PLDP staff, the team analyzed the data and devised an appropriate solution. Figure 4 shows the modest, but often hard-to-achieve improvement in defaulter rates post-intervention.

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Note that although this challenge (with results shown in Tables 3 and 4) is similar to the one whose results are shown in Table 1, these challenges were undertaken by different teams. Each team picked the challenge independently of the other. This also shows that pharmacists across the province are facing similar problems, and were able to learn from each other’s projects.
ISP

One FANIKISHA-supported CSO participant contrasted FANIKISHA favorably against other institutional strengthening and capacity development programs in terms of the depth of its engagement.

“FANIKISHA went a level deeper than other programs. The other program would help us develop a Board policy, give us a template, review our policy ... MSH would say, ‘ok, you did a Board policy, let’s go to the next level of implementing that policy’ ... they would send their focal person to the next Board meeting ... a big one was how our Board used to operate ... the other program would say, ‘you have the right Board composition, you should have regular meetings, minutes should be signed, policies should be in place’ ... but MSH and FANIKISHA would sit in the actual meetings to see the conduct of the meetings.”

This participant cited how FANIKISHA mentors were immediately available over a long period.

“The mentorship period was over several months. The other program was run out of an office in Uganda. The FANIKISHA mentors were just a phone call away and come to our office anytime. That made a huge difference.” [FANIKISHA-supported CSO participant, Kenya]

The same CSO participant attributed to FANIKISHA positive changes in Board governance and oversight.

“It is because of FANIKISHA that we changed the way the Board actually ran ... it now has actual oversight capabilities ... to monitor even the CEO, to manage the strategic plan ... now they say concretely, ‘we recommend you hire a resource mobilization person. We want to sit in the interview of hiring the new finance manager’
4.3. Intervention Sustainability

New or institutionalized norms and behaviors

An output of both the LDP and ISP is an implementable action plan that organizations—supported by their mentors—follow up on. Interviewees’ reflections on the implementation of these action plans provide clear evidence of organizational practices becoming standardized, and new norms and behaviors becoming institutionalized.

**LDP**

Figure 6 below is an example of a Challenge Model undertaken by a PLDP team that contributed to standardization of practice and routinization of behaviors. The team was concerned with the over-prescription of Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), which have serious side-effects, out of accordance with the Standard Treatment Guidelines (STGs) and Essential Medicines List (EML) issued by the government. Increased compliance is evidence of a shift in prescriber practice. As a result of the team’s efforts to improve awareness on, and knowledge of, the STG and EML, the PLDP contributed to prescriber compliance with standards (see Figure 5, below) over time.

**Figure 5: Compliance with Standard Treatment Guides for NSAIDs**

_The PLDP team saw increased compliance and shifts in provider practices._

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**ISP**

The FANIKISHA and BLC programs applied the OCAT with organizations to determine priorities for improving each organization’s operations and performance. The output of the OCAT is a tailored action plan for each organization that uses the OCAT findings to prioritize the technical assistance provided. FANIKISHA and BLC supported recipient organizations to implement tailored action plans and provided periodic targeted technical assistance, mentoring and coaching. Specifically, the FANIKISHA and BLC
programs provided technical assistance to these organizations to create policies, frameworks, manuals, and guidelines on various organizational components related to governance (e.g., Board policy), finance, human resources, monitoring and evaluation (M&E), knowledge management, and other areas. The quote below highlights how the guidelines have led to standardization in organizational practices:

“Earlier, for our personnel files, we would put whatever came our way. But our mentor gave us the checklist to know whether we had everybody’s CVs, qualifications, criminal check, background check, a complete package for all staff ... earlier one personnel file had one document, another file had another thing ... we didn’t know how to do qualifications checks ... the MSH team advised us to outsource and use a placement company to do the checks ... this is required for USAID funding ... so all this is now standardized across all staff ...” [BLC-supported CSO Participant, Southern Africa]

Resource Mobilization

LDP

The success of the ROLDP in Nepal in resource mobilization is evidenced by the fact that ADRA Nepal (a partner in the LMS project that rolled out the ROLDP) now mentions the use of the ROLDP in every funding proposal. Moreover, the ROLDP gave the participants the idea of increasing their resource base.

“We learned of a simple idea from MSH about how to find the appropriate support. It’s called aligning and mobilizing resources. We learned who our concerned people are – list all donors and supporters to whom we can approach, and also the interests of the donors and supporters...Earlier, we only approached those people who know us. After training, we approached those people who we did not know.” [ROLDP Trainer, Nepal]

ISP

Respondents mentioned several ways in which participation in the FANIKISHA and BLC programs had increased resources for their organizations, thereby increasing sustainability. First, graduating to USAID funding (a critical element of both programs) is viewed as a vote of confidence in the organization by the biggest bilateral donor. In fact, as stated by one respondent, “the OCAT assessment report is a capacity report that we can take to funders to show that we have the

Figure 6: Choose Life- Africa Growth in Financial Resources

Note: Units are in USD
“capability to manage large funds.” As an example, Figure 6 shows the increase in donor contributions at one participating CSO (source: FANKISHA final report).

Second, some organizations mentioned that FANKISHA has provided organizations with “new areas and tools” to work with. CSOs that received institutional strengthening technical assistance from FANKISHA have now included “institutional strengthening” as their own strategic areas, thereby broadening their resource base. One FANKISHA-supported CSO shared a success story: one of their affiliate CSOs under the FANKISHA mentored grant program has now sub-contracted to them on another USAID grant to provide technical assistance on an institutional strengthening program.

Third, one FANKISHA-supported organization, through discussions generated by the ISP, has started a consultancy with existing staff so that staff time can be “loaned out” as technical assistance providers to other organizations. This has led to increased revenue for the CSO.

Finally, increasing the capacity of staff it itself a path to increased resources:

> “Previously we did not know the difference between behavior change and advocacy. Now I can tell you what the advocacy component is in all our programs. My capacity has been raised. So we can apply to more donor funding because even though we have been doing advocacy for a long time, we did not know we were doing it.” [FANKISHA-supported CSO participant, Kenya]

**Replication of Intervention at Other Sites**

**LDP**

The ROLDP has been used in numerous projects across Nepal, not just in health but a wide variety of development projects. After 2008 and following the close-out of the LMS Project, multiple other organizations have used the ROLDP on their own, including: ADRA Nepal, the Community Development and Relief Agency (CDRA), FHI360, ICA Nepal, Rotaract Clubs, the Rotary Clubs of Dhulikhel and Rudramati, Sidda Samaj, and the Small Farmer Agricultural Cooperative Federation (SFACF) in Dhading, and the Women Awareness Forum in Nala. Much of this happened as people moved from one organization to another and continued to champion the benefits of the ROLDP and found ways to apply it.

The success of the PLDP is highlighted in the quote below:

> “I was motivated to such an extent that when we got back, I started a mini PLDP with my own staff who did not attend the program ...” [PLDP Participant, South Africa]

**ISP**

CSOs who participated in the FANKISHA program are using the OCAT within new projects as they get funding to provide technical assistance for strengthening other CSOs in Kenya.

> “We are using the OCAT in our current project. We added a component because the project [focus area] is on conflict resolution but otherwise, all the components are the same.” [FANKISHA-supported CSO participant, Kenya]
Maintained Networks and Coalitions

There are several examples from respondents of how networks, created under the LDP and ISP, have flourished.

- Coaches and mentors have remained a resource:
  
  “I had lunch with my mentor just yesterday” [FANIKISHA-supported CSO participant, Kenya]

  “Even now after FANIKISHA closed, if there is a problem, I call my mentor. They still help us.” [FANIKISHA-supported CSO participant, Kenya]

- From the workshops organized by the intervention, other smaller groups have formed. For example, the HR managers supported under FANIKISHA now have a regular round table meeting, even after the closing of the FANIKISHA program.

- The Local Institutional Strengthening Network (LOISNET) created under FANIKISHA remains active.

- The PLDP groups continue to learn from each other’s challenges and results achieved. One group has adopted the SOPs created by another.

5. CONCLUSION

This assessment set out to answer the following questions:

- What results have L+M interventions and the accompanying technical assistance, coaching, and mentoring produced in both the short and intermediate terms after its application?

- Have these results been sustained over time? If yes, which results and what factors have enabled these results to be sustained? If not, what barriers have prevented these results from being sustained?

- Which L+M interventions have been institutionalized, replicated or adapted by organizations? What factors have enabled or prevented organizations from doing so?

The assessment found evidence that both the LDP and ISP interventions implemented in Nepal, Kenya, and Southern Africa – through facilitated capacity development, accompanying TA, and mentoring and coaching – have helped build institutional capacity at health service-delivery NGOs, CSOs and CBOs, and have strengthened local government agencies. The assessment revealed that these L+M interventions resulted in a wide range of individual, organizational, and health service delivery outcomes including improving the reach and quality of services, time savings, and resource mobilization. Interviewees attributed many of these results to factors related to interactions between their organizations and the intervention, and how the program content was delivered (e.g., early stakeholder buy-in, creation of internal champions, alignment of program with organization’s mission and goals, ongoing and high quality capacity development and mentorship).
Respondents across countries and programs were able to share how their participation and experience has led to sustained outcomes for their organizations. For the organizations and projects included in this assessment, interviewees reported distinct examples of sustained interventions, which included standardization of practices, routinization of behaviors, institutionalization and replication of programs, resource mobilization, and maintenance of networks for continued support and learning.

Our findings illustrate that these L+M interventions were designed and implemented in ways that either embody the characteristics of sustainable interventions or demonstrate outcomes that can continue to be sustained over time. Indeed, there was significant convergence between the a priori conceptual framework and the findings of this assessment.

The findings were presented to the MSH Advisory Group, which has recommended that these findings and this report be shared with the MSH Leadership Team, in-country project leadership, and a wider internal audience to inform an organization-wide dissemination and discussion about MSH’s L+M interventions. We believe that these findings can also be used to develop metrics to measure intermediate outcomes for the ISP and the LDP. Finally, we recommend that the findings be shared with USAID to highlight the success of these interventions, inform the external evaluation, and provide recommendations for the design of future interventions and projects addressing leadership and management.
APPENDIX

Conceptual Framework for Sustainability of Leadership and Management Processes and Practices as part of Organizational Development

LMG Tools Assessment Team

July 29, 2015

BACKGROUND

LMG is conducting an assessment of key legacy programs and associated tools and processes designed by MSH to strengthen leadership and management (L+M) practices. These programs and tools are at the core of the LMS (2005-2010) and LMG projects and subsequently have been adapted and applied for other MSH projects funded by USAID. The assessment is investigating the continued use of these tools, and the short- and long-term benefits and results for various stakeholders. The focus is therefore on the sustainability of the MSH L+M tools and/or the processes imparted by these tools to improve leadership and management practices. The assessment does not focus on the sustainability of an organization as an entity but rather the select components or functions within an organization that were targeted for strengthening leadership and management practices to achieve program results. LMG hopes that the findings of the assessment will support internal efforts to learn what is working and what is not in leadership and management strengthening; and offer recommendations and insights into ways that the tools, the process of application of the tool, and the measurement of results can be adjusted for maximum effectiveness. The findings will also contribute to any external reviews to examine the sustainability of L+M tools and approaches at scale. The assessment includes the Leadership Development Program (LDP) and associated tools and the Organizational Capacity Assessment Tool (Table 1). These are leadership, management and governance tools that are often applied through carefully facilitated processes by trained facilitators and experts in organizational development, leadership and management. Most of these tools champion a team-based, experiential learning approach; and have all been applied with teams across both government and non-governmental organizations and at different levels and health domains. Organizations in Kenya, Nepal, and South Africa will be included in the assessment. Table 2 provides a summary of which tools were implemented in organizations in each country.

Having a clear understanding of what sustainability means in the context of organizational development is a key step for the assessment. A limited review of the literature was undertaken to understand existing conceptualizations of sustainability and approaches for measurement in this context. We used insight from the literature, including a previously completed literature review (Trasi et al. 2012), to develop a conceptual framework to guide our assessment.
Methodology

LMG staff shared key background documents on the LMG conceptual model and the tools to be assessed. Internal staff had also conducted a literature review (Trasi et al. 2012). This conceptual framework is based on a review of that earlier literature review and other shared background documents. The information was supplemented by a limited search of the literature on organizational development and implementation science for articles post-2011 focused on program sustainability in health systems.

Table 1. Overview of leadership and management tools to be assessed

<table>
<thead>
<tr>
<th>Tool</th>
<th>Description</th>
<th>Intervention/Method</th>
<th>Components Assessed</th>
<th>Expected Outcomes/Benefits</th>
</tr>
</thead>
</table>
| LDP  | A team-based, results-oriented, participatory leadership development process that enables teams to face challenges and achieve results through action-based learning. | Usually a 12-week process involving experiential learning in which teams complete the challenge model while getting feedback and support from facilitators, coaches and colleagues in a series of workshops and meetings. Specific steps in the process:  
• Selection of a priority health area relevant to the organization.  
• Identification of measurable service delivery results.  
• Agreement on specific results as a goal.  
• Development and implementation of action plan.  
• M&E (emphasis on quantitative indicators). | N/A | Leaders and decision makers of an organization (or facility) in the health system apply leading, managing, and governing practices to:  
• Oversee performance improvement processes and the use of proven public health interventions to address specific priority health areas.  
• Ensure strong technical leadership of their health programs for which they are responsible. Sustain and scale up performance improvements and the LDP process.  
Local Improvement Teams apply leading, managing, and governing practices to:  
• Carry out proven interventions to achieve measurable results in the priority health areas.  
• Build a productive workgroup climate. |
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<tr>
<th>Tool</th>
<th>Description</th>
<th>Intervention/Method</th>
<th>Components Assessed</th>
<th>Expected Outcomes/Benefits</th>
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</table>
| OCAT | Measures an organization’s capabilities before a capacity development program is implemented; provide evidence-based qualitative and quantitative data on specific areas that can be improved; and over the long-term, quantify the effects of capacity development efforts. | A participatory assessment process that takes place in a 2/3-day workshop. Tool used to collect data from 8-10 participants who represent all levels of the organization. The tool identifies organizational strengths and weaknesses, and stimulates discussion among staff about the findings. Analyzing an organization’s abilities and needs helps determine priorities for support to improve operations and performance. The priorities are documented in an organization-specific capacity development plan. | 52 sub-components spanning 9 areas:  
- Leadership and Governance  
- Systems and Structures  
- Human Resource Management  
- Financial Management  
- Grants Management  
- Program Management  
- Planning, Monitoring and Evaluation  
- Partnerships, External Relations and Networking  
- Knowledge Management | Provides a baseline and identified areas for improvement in the organization. Allows assessment of the contribution of technical assistance to the organization’s capacity. Institutional strengthening program (ISP) includes an OCAT, development of tailored capacity development plans, onsite technical assistance, coaching and mentoring, and periodic assessments of capacity and performance improvements. |
Table 2. The tools implemented in each of the countries included in the assessment

<table>
<thead>
<tr>
<th>Country</th>
<th>Project/ Program</th>
<th>Implementation Period</th>
<th>Tool</th>
<th>Organizations Included in the Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Africa</td>
<td>BLC</td>
<td>August 2010 – December 2013</td>
<td>ISP</td>
<td>AMSHeR and Thembalethu Development</td>
</tr>
<tr>
<td>Kenya</td>
<td>FANIKISHA</td>
<td>July 2011 – March 2015</td>
<td>ISP</td>
<td>3 of 9 CSOs:</td>
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<td>• I Choose Life – Africa (ICL – Africa)</td>
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<td>• Kenya AIDS NGOs Consortium (KANCO)</td>
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<td></td>
<td>• National Organisation of Peer Educators (NOPE)</td>
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<tr>
<td>Nepal</td>
<td>LMS</td>
<td>2006 – 2015</td>
<td>ROLDP</td>
<td>ADRA</td>
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<tr>
<td>South Africa</td>
<td>SIAPS</td>
<td>2011- 2015</td>
<td>PLDP</td>
<td>Kwazulu-Natal Pharmaceutical Staff</td>
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</tbody>
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**FINDINGS**

In deriving a conceptual framework to guide our assessment, there are 3 key questions:

- What is sustainability in the context of organizational development? This includes an understanding of ‘what is being sustained’ and who are the key stakeholders and beneficiaries.
- What factors affect/facilitate intervention sustainability?
- What serves as evidence of a sustained intervention?

We summarize below the findings from the literature with respect to these three questions.

**What is sustainability in the context of organizational development?**

MSH defines the sustainability of an organization along three dimensions: institutional, financial and programmatic sustainability. An institutionally sustainable organization is able to consistently adapt its governance practices, structure and systems to remain mission driven and market adjusted, allowing the organization to respond to the shifting priorities of its supporters and to new responsibilities towards its clients, while creating a positive work climate for its staff. A financially sustainable organization is able to consistently secure, manage, and report on the use of revenue from various sources to support its ongoing programs and undertake new initiatives. A programmatically sustainable organization is able to deliver quality products and services that respond to its clients' needs and to anticipate new areas of need, and is supported by a strong knowledge management system (AIDSTAR-Two undated draft).

The preceding definitions refer to the sustainability of an organization. With respect to the sustainability of an organizational development program or intervention, more relevant definitions culled from the literature include:

- The continuation of programs and maintenance of benefits to stakeholders over time (Shediac-Rizkallah & Bone, 1998; Pluye et al 2004).
To what extent an evidence-based intervention can deliver its intended benefits over an extended period of time after external support from the donor agency is terminated (Rabin et al. 2008).

- Durability of activities and resources aimed at program-related objectives (Scheirer 2005).
- The continued use of program components and activities for the continued achievement of desirable program and population outcomes (Scheirer and Dearing 2011).
- Continued effectiveness of intervention/program and capacity to adapt or replace intervention/program within a context that constantly changes (Bowman et al. 2008).
- Institutionalization of programs within organizational systems (sources cited in Gruen et al. 2008).
- Routinization—“an innovation has become a stable and regular part of organizational procedures and behavior” (Yin 1979 as cited in Pluye et al. 2004, p.123).
- Standardization—even more formalized than routines, institutionalized through higher-level (regional, state) rules and policies, which may influence (constrain) organizational routines (Pluye et al. 2004).
- The process of managing and supporting the evolution of an intervention within a changing context (Chambers et al. 2013).

Answering the question of ‘what is being sustained’ in the organization, ‘what’ may refer to intervention (program) activities or benefits (e.g. establishing and maintaining an advisory board to assist in developing relevant program for the organization’s beneficiaries), resources aimed at intervention-related objectives (e.g. periodic purchasing/updating of software to strengthen financial management capacity) or some combination thereof. An important insight from the literature is that a given intervention may not continue in its original configuration and this does not mean that the intervention has not been sustained. For example, the intervention could be adapted and integrated into the organizational operations or routines in such a way that only parts of the original intervention continue or are recognizable. However, it remains unclear what amount of adaptation or change of the components of the intervention can occur while still defining the intervention as sustained, and what components must be present for an intervention to be counted as sustained (Scheirer and Dearing 2011).

**Factors that Facilitate Intervention Sustainability**

According to Scheirer and Dearing (2011), the likelihood of sustainability of a given intervention increases when there is “an alignment, compatibility, or convergence of (1) problem recognition in the external organizational environment or community, (2) the program in question, and (3) internal organizational objectives and capacities” (p. 2060). These factors are centered on a notion of fit or alignment. Fit will vary over time because it is determined not only by the characteristics of the intervention, but also by contextual factors of the organization and its broader environment, where change is a constant. Chambers and colleagues (2013) note that the sustainability of an intervention over time is dependent on the measured, negotiated, and reciprocal fit of an intervention within a practice setting and the practice setting within the broader environment. Further ongoing assessment of this fit and quality improvement efforts will improve sustainability of the intervention and identify opportunities for intervention improvement.
As Trasi et al. note, it is unclear the extent to which the factors that affect or facilitate the sustainability of an intervention are necessary precursors for sustainability or result from the interventions. Sustainability of a given intervention is dependent on the ongoing improvements of the intervention (Chambers et al. 2013; Scheirer and Dearing 2011). This implies that sustainability is a dynamic process and that change is a constant. We can therefore expect that the factors that facilitate sustainability are dynamic, changing over time, and simultaneously affecting and being affected by a given intervention. As such, planning and implementing for sustainability is not about controlling contextual factors but learning about the optimal fit of an intervention in a given setting.

We can think of the factors that facilitate or affect the sustainability of an intervention as potential independent variables for the purposes of our assessment. Based on the literature, we can group these factors into four broad categories:

1. Organizational Buy-in/Stakeholder Alignment
   - Congruency of program with organizational mission, leadership and operating routines (Gruen et al. 2008; Scheirer and Dearing 2011)
   - Integration with existing programs (Gruen et al. 2008)
   - Presence of internal champion to advISPe for the program (Gruen et al. 2008; Scheirer and Dearing 2011)
   - Whether the organization’s key staff or clients believe the intervention to be beneficial (Scheirer and Dearing 2011).
   - The existing capacity and leadership of the organization (Scheirer and Dearing 2011).

2. Intervention Characteristics
   - Level, quality and duration of training and capacity building provided (Gruen et al. 2008; Pluye et al. 2004; Scheirer and Dearing 2011; Shigayeva & Coker 2014).
   - Flexibility and adaptability of program from its original form (Pluye et al. 2004; Scheirer and Dearing 2011; Shigayeva & Coker 2014).
   - Level of evidence to support program effectiveness (Scheirer & Dearing 2011).
   - Governance, financial and delivery arrangements (Gruen et al. 2008; Pluye et al. 2004; Scheirer and Dearing 2011).

3. Broader Organizational Factors (from AIDSTAR Two-Undated Draft)
   - Capacity of an organization to consistently adapt its governance practices, structures and systems to remain mission driven and market adjusted, allowing the organization to respond to the shifting priorities of its supporters and to new responsibilities towards its clients, while creating a positive work climate for its staff.
   - Ability to consistently secure, manage, and report on the use of revenue from various sources to support its ongoing programs and undertake new initiatives.
   - Ability to deliver quality products and services that respond to its clients’ needs and to anticipate new areas of need, and is supported by a strong knowledge management system

4. Broader Environmental factors
   - Nature and stability of the socioeconomic and political environment (Gruen et al. 2008; Scheirer and Dearing 2011; Shigayeva & Coker 2014).
   - Community participation and the existence of partnerships that lead to non-monetary support of the focal organization (Scheirer and Dearing 2011).
   - Potential availability of other funders or funding in the environment (Scheirer and Dearing 2011)
Evidence of a Sustained Intervention

Given the discussion of what sustainability is and the factors that influence it, how do we identify a sustainable intervention? Trasi et al. (2012) proposed the following as evidence of sustainability:

- Continuation of some or all intervention activities for the benefit of stakeholders;
- Continued demonstration of benefits or outcomes as intended by the intervention at the individual, institutional, community or environmental level—service provision, behavior change of clients or service providers, change in organizational practices and operational procedures, etc.;
- Integration of any activity/component of the intervention into the institution’s ‘routine’ (e.g. training curriculum);
- Replication of the intervention or some component thereof at other sites;
- Maintained networks and coalitions;
- Continued funding through one or more sources for implementation of some or all intervention activities;
- Post-intervention investments in human resource development for health;
- Contributions to changes in human resources for health (HRH) strategy at the national level.

Trasi and colleagues’ list shares some similarities with the characteristics of program sustainability proposed by Scheirer and Dearing (2011):

- Whether benefits or outcomes for consumers, clients, or patients are continued.
- Continuation of the intervention activities or components of the original intervention.
- Maintaining community-level partnerships, coalitions or other networks that developed during the funded intervention.
- Maintenance of new organizational practices, procedures, and policies that were started during intervention implementation.
- Issue salience—whether there is continued heightened attention to the issue or problem originally addressed by the intervention.
- Intervention diffusion and replication in other sites—to what extent have the underlying concepts or interventions of the program spread throughout the organization or to others.

These two lists are a useful starting point for identifying the characteristics of sustainability to be measured in our assessment.

PROPOSED CONCEPTUAL FRAMEWORK

Given our findings from the literature and our discussion above, we can assemble a conceptual model to guide our assessment of the sustainability of the LMG tools [see Figure 1 on page 11 of this report]. For LMG’s purposes, we are interested in whether both the tools and processes engendered of the use of the tools, and the associated benefits, are being sustained. The key stakeholders are the organizations in which the tools have been implemented and where applicable, the populations they serve.

For our purposes and given the definitions culled from the literature we can conceptualize a sustained intervention as one which, in its entirety or a part thereof, has been adapted and integrated into an organizational routine or behavior, institutionalized as rules or policies and/or has been adapted or
replicated at other sites. We would also expect that the target organization continues to mobilize and allocate resources for the intervention, which continues to demonstrate effectiveness, maintains networks and coalitions built through the interventions and results in continued benefits for the organization and the population it serves (Figure 1).

The factors that affect intervention sustainability can be broadly classified into four categories: (1) the alignment of the intervention with the organization’s mission alongside stakeholder buy-in; (2) characteristics of the intervention itself; (3) the broader organizational factors; and finally, (4) the broader environmental context of the organization.

The broken lines around each category of factors illustrated in Figure 1 suggests that the sustainability of a given intervention will not be independently determined by these separate categories of factors. Rather, intervention sustainability will be dependent on the interactions and feedback between the factors at the three different levels. So while we would expect the sustainability of an intervention to be heavily dependent on the intervention’s characteristics, we would also expect the organizational setting, the level and quality of stakeholder buy-in and alignment of the intervention with the organization’s stated needs, and the organization’s external environment to affect intervention sustainability and vice versa. Further, we can expect these effects to be non-linear and dynamic, changing over time.

There are two key related insights from the literature that should be considered in developing our assessment approach. First, assessing the sustainability of an intervention should be predicated on the acceptance of change as a constant. Second, ‘quality improvement’ to ensure intervention optimization, rather than ‘quality assurance’ to ensure adherence to the original protocol of the intervention, is key to sustainability (Chambers et al. 2013). These two ideas suggest that in the identification of what is being sustained we are not looking for a simple dichotomy of whether an intervention or its benefits have continued (Scheirer and Dearing 2011). So we would expect that the more an intervention has been adapted or optimized into an organization’s routine and processes, the more likely it is to be sustained (Chambers et al. 2013; Pluye et al. 2004; Scheirer and Dearing 2011). Therefore, assessing the sustainability of an intervention involves an enumeration of the elements of the intervention (underlying concepts, processes, skills and/or expected benefits and outcomes) and determining the extent to which each element has continued.

The importance of change and optimization in the sustainability of a given intervention raises a measurement challenge. As noted earlier, how much change can an intervention undergo and still be considered as sustained? There are two possible approaches to get at this question. First, we can consider the existence of continued benefits and expected outcomes of the intervention and where possible, trace these back to the specific elements of the original intervention. This requires a careful analysis of the stakeholders and beneficiaries of the intervention. Attribution will be impossible, especially if the immediate consumer/beneficiary of the intervention is beyond the boundaries of the organization and is instead part of the service population. However, some of this difficulty can be mitigated if considered in combination with the second approach, which is assessing the continued salience of the issue originally targeted by the intervention. Scheirer and Dearing (2011) originally proposed issue salience as a variable to mean the extent to which there is continued attention to the
issue or problem. Continued attention to the issue or problem targeted by the intervention could imply that the problem still exists and that the intervention has not been effective or sustainable. Further, the intervention may be routinized to the extent that staff are unaware of the explicit intervention and its elements. However, we can reasonably expect that if a given intervention is sustained, our assessment can measure it by considering one or more of the following:

- How much staff and leadership are aware of the original target problem/issue, its impact on organizational operations and/or the need to avoid recurrence?
- How much are staff and leadership aware of the benefits of some element of the intervention?
- What priority has the organization explicitly given to ensuring that the target problem does not recur or is effectively addressed if it does?
- What organizational practices, procedures, and policies are in place to address the problem (regardless whether the staff is aware of the source of these processes) and can any of these be traced back to any elements of the original intervention?
- Does the organization continue to mobilize and allocate resources to address the target issue or to maintain some element of the original intervention?
- Has the intervention or part thereof been diffused and replicated at other sites?

Implicit in this approach is acceptance of the notion that the original intervention may change substantially from the original protocol or be routinized to the extent that the problem and the associated intervention may not be obvious to the staff using it. As such, the assessment needs to focus on the elements (underlying concepts, skills, etc.) of the intervention more so than the intervention itself.

REFERENCES

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