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REPORT ON THE LEADERSHIP DEVELOPMENT PROGRAMME IN INTERNATIONAL HEALTH (FIRST SESSION, 1989)

Contents

REPORT ON THE LEADERSHIP DEVELOPMENT PROGRAMME IN INTERNATIONAL HEALTH (FIRST SESSION, 1989)

1. Background

The Thirty-sixth Session of the Regional Committee (RC) in 1989 discussed an Interim Report, including an Addendum, on the Leadership Development Programme in International Health (LDP) and adopted resolution EM/RC36/R.15, which noted the report "with satisfaction" and demanded a full report on the First (1989) Session (LDP/1) "based on a thorough evaluation and giving details on the preparatory work of the Second (1991) Session" (Annex 1).

This report is intended to meet the above request of RC/36, but it does not cover the preparation of the first two phases of LDP/1 (as that was contained in the Interim Report and its Addendum). This report covers Phases 2 and 3, then describes evaluation efforts and their results and ends with a discussion of the preparatory work for the Second (1991) Session of the LDP (LDP/2). In addition, there is a detailed report on LDP/1, including 50 appendices, which is available to members of the Regional Committee upon request.[1/]

2. Further Remarks on LDP/1

2.1. Phase 2

As was reported to RC/36, while Phase 1 was a problem-based three-month learning experience in EMRO, with a modular approach and learning objectives clearly defined by participants, based on the general aims and objectives of LDP/1, Phase 2 was a three-month work experience in a country of the Region other than the participant's own. While the aim of Phase 1 was to let participants improve their self-learning and problem-solving capabilities, the aims of Phase 2 were two-pronged:

i) To let participants learn about the health system of a particular country, its structure and functioning, its leadership in the context of health-for-all/primary health care philosophy, and learn in practice, using this as a case study, how to analyse and evaluate a health system so as to make valid recommendations to improve it; and

ii) To let participants learn about how international health activities promote national health development, and the role and activities of organizations concerned with international health, first and foremost WHO, at national level.

Thus, Phase 2 is a logical continuation of Phase 1, assuring the application of all that was learned in that latter phase, and, at the same time, a preparation for Phase 3, during which participants are assumed to look at country problems from the regional level, and see the same problems at the country level, but from another angle.

1/ Two examples of the full report, including appendices, are available for your perusal in this conference room. If you would like to receive your own copy, please sign the appropriate sheet near the display copies and one will be mailed to you shortly.

Phase 2, as was reported to the Regional Committee in 1989, started after a briefing week (28 May - 1 June), on 11 June and ended on 7 September 1989, after a debriefing week in EMRO, exactly as planned. Participants spent 12 weeks in the countries (two participants each in Somalia, the Syrian Arab Republic and Yemen and one in Egypt), 11 June to 31 August 1989. They worked, as planned, at district, governorate, regional and national levels, and with WHO representatives' offices and other international agencies in the country concerned. Each participant defined his own learning objectives, based on his country's needs and taking into account the objectives proposed by the organizers.

The original plans foresaw that participants would participate in the daily work at all levels. This proved to be difficult everywhere, and often, specially in ministries of health, unfeasible. At the district level in Somalia, and, to a certain extent, in the Syrian Arab Republic (in health centres), at the provincial level in Egypt and Yemen, this happened, but elsewhere, participants visited, interviewed, observed, studied documents and statistics and undertook situation analysis, which proved to be, on final account, as beneficial as participation in actual work would have been.

2.2. Phase 3

Because of the timing of last year's report, no account could be given on Phase 3; therefore, it is described here in more detail.

Phase 3 of LDP was planned as an apprenticeship-type of learning experience whereby participants of the programme would work for three months in EMRO, each with a Regional Adviser (preceptor) of his choice, as a kind of "junior adviser". The aim of this experience was to let participants continue to learn about international health and WHO (its policies, plans, priority setting and finances, modes of operation and leadership), in view of the aims and objectives of LDP.

The aims included that LDP participants should develop a "detailed knowledge of international health organizations, first and foremost of WHO, and that they be able to ... use most effectively and efficiently international collaboration for enhancing national health development towards health for all", that is, the participants have to develop their skills for optimal use of international health resources (human, financial, technical and material) to promote national health development. This phase is a logical continuation of, and builds on the results of, Phases 1 and 2.

After proper preparation, Phase 3 started on 24 September and ended on 28 December (i.e., with a two-week delay compared with the original plan), owing to a two-week computer assignment that was requested by participants and agreed to by the Regional Director. During the implementation process of Phase 3, the following activities, *inter alia*, took place:

i) At the start of Phase 3 (24 September 1989), participants were asked to work out their learning objectives, in collaboration with their respective preceptors, and then, based on those objectives, to elaborate their work programmes. Participants then worked with their preceptors in close collaboration on the implementation of their work plans, to achieve their respective objectives. They regularly met with their preceptors on a daily basis and were involved in three kinds of activities: (a) participation in the daily work (routine) and life of the unit; (b) missions to Member States to serve on the secretariat of

technical meetings and participate in WHO/Member States' cooperative activities; and (c) studying WHO policies and work procedures, including those of support services, based on documents and daily work. According to participants' reports, activities consisted of responding to correspondence, reviewing the progress of projects in Member States, rephasing of budgets, preparatory work of and writing reports on meetings, revision of curricula of training for various categories of health workers, briefing and debriefing of consultants, studying files, pursuing issues with support services such as finance, personnel, budget, supply units, etc. The seven (male) participants went on 14 missions in nine countries and participated in nine technical meetings.

ii) In addition to individual work programmes with their respective units, participants also had to write a programme (course) paper (approximately 30 pages) on a technical subject chosen by them. On 26-27 December, each participant had 1 1/2 hours for introducing his paper, which was introduced by one of his peers, who volunteered to be designated "opponent", and by his preceptor. Each discussion period was chaired by another participant. The discussions were excellent learning opportunities, due to the active and positive participation of EMRO technical staff, and reflected how much the participants had matured during the LDP: gaining self-confidence, practice in public speaking, handling meetings and, in general, relating to others in an international context.

iii) There was also a "side" (fringe) programme for the participants, which included:

- Meeting with experienced leaders, who were invited as role models. In the up to one-day interaction with each of them, a number of questions were raised in which participants prepared a "checklist" for these encounters. The leaders who met the participants (H.E. Dr T. Bencheikh, Minister of Health, Morocco; H.E. Dr A. Fakhro, Minister of Education, Bahrain; Dr Hussein A. Gezairy, Regional Director, EMRO; Dr A. Khogali, Director, Programme Management (DPM), EMRO; Dr Maureen Law-Weiler, Deputy Minister (Health), Canada; and Dr H. El Sayed, Member of the Egyptian Parliament (cardiologist, former President of the Egyptian Medical Association) received the question list in advance, and then the discussion was guided by those questions, as well as by other ones.

- In addition to the four participants' seminars, organized in Phase 1, three further ones were organized, which gave an opportunity to each one of the seven participants to play the roles of secretary, chairman, rapporteur and consultant (background paper writing), and learn about meeting preparation and implementation by actually doing it.

LDP/1 ended on 28 December 1989 with a small ceremony during which Dr A. Khogali, DPM, on behalf of the Regional Director, distributed the diplomas to the participants, all of whom finished the programme with "distinction".

2.3. Programme cost

At the preparatory stage of the LDP in November 1988, the preliminary cost of the programme was prepared, amounting to $319 000 (Table 1). The total budget, which came from 10% of the country general fellowship allocation, was $587 700 for the biennium. Total expenditure for the LDP was $424 470; this was more than was originally foreseen in November 1988, but considerably less than the available budget (72.2%) assured for the LDP by the Regional Committee.

Table 1. LDP Cost, Budget and Expenditure

Budget line description	LDP cost November 1988 (US$)	EMRO budget 1988/89 (US$)	Expenditure	
			(US$)	(%)
Participants (remuneration, travel, etc.)	141 000	410 255	226 171	53.3
Consultants, temporary advisers	130 000	132 000	134 948	31.8
Temporary staff	--	28 060	31 200	7.3
All miscellaneous expenses (mainly learning materials)	23 000	17 385	32 151	7.6
Unforeseen expenses	25 000	--	--	--
Total	319 000	587 700	424 470	100.0

The breakdown of the original costing, of what was budgeted and of actual spending, is shown in Table 1. More than half of the expenditure (53.3%) went direct to the participants (remuneration, travel, per diem, etc.), and with learning materials they received, this went up to three-fifths (60.9%). The remaining funds went for personal costs (39.1%), the External Review Committee (ERC) and facilitator meetings.

Thus, this first LDP cost approximately $60 000 per participant, which is approximately double what it would cost to send a fellow for a Master of Public Health degree to a developed country. However, it is expected that programme costs may be somewhat less for future LDP sessions.

As was mentioned earlier, there are, as yet, no comparable programmes anywhere in the world. However, in Washington, the Pan American Health Organization/Regional Office of the Americas (PAHO/AMRO) operates a programme called "Residency in International Health", which is similar to Phase 3 of the LDP. The total cost of the programme there, as here, was not calculated, but direct expenses (monthly remuneration, roundtrip ticket, health insurance, etc.) for the 12-month programme totalled about $24 000 per person. The World Bank also has a similar residency programme that costs between $28 000 to $43 000 per person (in 1988). The LDP participant costs considerably less, direct expenses not more than $15 000 (the rest is mainly travel and per diem, which PAHO and World Bank residents also have, but that are not included in their figures).

The External Review Committee (ERC), at its second session, stated in its report that it "was not in a position to study the cost-effectiveness of the LDP in any detail". It noted, however, "the innovative nature of the

programme and endorsed the need to invest in the development of this model which has a great potential for application; not only at national and subregional, but also at interregional levels".

2.4. Some considerations concerning LDP/1

Even a brief overview of LDP/1, of what actually happened and how, shows how truly innovative the programme is, taking into account experiences all over the world, but not following any prior model, not imitating any existing pattern.

The basic concept--to let future health leaders learn on their own, and in a rather independent way, about national health development for HFA/PHC, and how international health can most effectively and efficiently promote this development--was served by a three-stage programme in which each stage was logically built on previous ones. But how far can LDP/1 go in approaching the ideal, that is, creating an environment conducive for creative independent learning that fosters growth and development of leadership and management capabilities and skills of the participants?

3. First Attempt to Evaluate LDP/1

3.1. Introduction

Final evaluation of LDP/1 can only truly take place when its participants are followed upon their return home in their future work, which will show how useful the programme was, in retrospect, for the Member States concerned. However, very serious and continuous efforts have been exerted to evaluate the programme in its entirety.

3.2. Evaluation methods and mechanisms

In the preparatory phase of the LDP, an "evaluation protocol" was prepared by Professor A. Rotem, from Australia, and then discussed and endorsed by the first meeting of the External Review Committee (ERC). This protocol proposed 12 key areas to be evaluated, and then, for each of those areas concerned, indicators, methods and sources were recommended. The 45 indicators and the model questionnaires attached to the protocol served as a basis and/or inspiration to create those questionnaires, which were used to ask participants' opinions about each step of the programme, and also preceptors' opinions of Phase 3. Altogether, each participant completed ten questionnaires, not counting the 13 weekly questionnaires in Phase 1. In addition, each participant wrote reports on Phases 2 and 3, his duty travel, computer assignment, and the seminar in which he was the rapporteur. Each participant also wrote one background paper for one of the seminars and a maximum 30-page programme paper. There were also reports from each facilitator of Phase 1, from WHO representatives and visitors (ERC members, consultant) to Phase 2 countries and from Phase 3 preceptors.

The decision that there would be no formal examination was taken after careful consideration. In the large amount of literature on "evaluation", it is clearly stated that examinees learn from examinations what they feel is needed to pass those examinations. The intention is to let participants learn what they feel they need to know in order to be able to solve their national problems that they identified, free from any stress of examinations. Experience shows, and the experience of LDP/1 validated this, that students

under such circumstances (a) learn much more than under the pressure of exams; (b) learn things that they feel are relevant to their needs; and (c) the retention rate and duration of the newly acquired knowledge and skills is incomparably better than is the case where students learn under the threat and pressure of exams.

However, in addition to internal mechanisms of evaluation, external mechanisms are also used. As was explained above, the Regional Director established an External Review Committee (ERC), which has had two meetings: the first (ERC/1) during 26-29 March 1989 and the second (ERC/2), 10-13 December 1989 (their reports are annexed to the full report, as appendices 37 and 38).

3.3. Phase 1 results

It appears that the objectives of Phase 1 were largely achieved. Conclusions that can be made include: (i) all seven participants gained new knowledge and skills that will assist them in achieving learning objectives they had defined for themselves based on LDP aims and objectives; (ii) they all looked forward to applying their new and enhanced capabilities to make changes at home and to make their colleagues learn from their experiences; (iii) they were all satisfied and would recommend the LDP to others, but offered some comments for improvement; (iv) they learned "how to learn", how to study literature to solve problems, instead of by rote learning; (v) they developed a new thirst for further learning; (vi) their problem-solving capability was considerably enhanced; and (vii) altogether, they experienced rather rapid human growth and development.

All participants expressed their satisfaction, and all felt that Phase 1 helped them "very much" to progress towards their overall objectives. As one of them stated, "I was exposed in learning to eminent experts' experiences and a very well-organized programme". One participant summed up the group's feelings saying, "I now see a difference between teaching and learning. I enjoy the learning and learned in this Programme how to enjoy it....I see the change not only in myself, but I see it in all the other participants.... I now feel a great self-confidence that I will be able to do a lot in my country to change others".

Having been the first LDP, there were some inevitable shortcomings. A great number of recommendations made by participants and facilitators show that there were problems that will need attention when organizing LDP/2. There was the problem of the time element, for example: for most modules the time was felt to have been too short, with not a clear enough priority setting. There is the need to strengthen further the leadership character of the programme and problem-orientation aspects, taking into account language, personal concerns, and the lack of any academic credit gained at the end of a 10-month programme.

It remains to be seen how far the undoubted gains of Phase 1 will or will not yield dividends on the return home of the participants.

3.4. Phase 2 results

All the participants said that they had achieved all, or practically all, the objectives they had defined for Phase 2.

The general impressions about the LDP, up till the end of Phase 2, can be summed up by what the participants replied to the question, "Based on your

experience so far, would you recommend the LDP to others?" One participant, for instance, said, "Yes, because it is a great experience: a unique opportunity to learn, to acquire skills and knowledge most needed; it widens the person's horizon and changes views for the better. This programme gives the opportunity to develop people who can take [an] active part in leadership development in their own countries". Another one said, "Yes, because he gains good knowledge, information to develop leadership qualities; it is a very good programme, better than an academic course, well organized and with objectives that a leader and a health planner should pursue".

The long list of things they felt they had learned starts almost in each case with the application of a systematic approach to the study and evaluation of a health system. Then the following items are mentioned repeatedly: leadership; planning and management of health systems; contribution of international health to national health development; communication skills; community participation; intersectoral cooperation; collection of information from various sources, the role of motivation of health personnel; and working methods of WHO at country level. The growth of their self-confidence was also mentioned and that they could use the skills they had learned in Phase 1. They also mentioned that they could now consider shortcomings in the health system as "opportunities" for learning and for change. Phase 1 seemed to have been even more appreciated in the light of Phase 2. This was emphasized by all the participants. As one of them said, Phase 2 enabled them "to put in practice in real life all what we have learned theoretically in Phase 1".

The participants were also seriously contemplating how they could use the skills learned in Phase 2 on their return home. The fields listed above, where participants felt they had acquired new knowledge and skills, were first and foremost those where they felt they would be able to apply and/or introduce changes at home.

It was indeed heartening to obtain feedback from many sources about the participants' behaviour and performance in their four respective countries, which has been unequivocally positive and often enthusiastic. All four countries seemed to have agreed with the statement that H.E. the Minister of Health of the Syrian Arab Republic made: "WHO has been at its best organizing this programme...it has been beneficial for both countries: for the one that sent the participants and for the one that received them in Phase 2". He thought that the LDP should continue, and in Phase 2, participants should be used by the host country as "unbiased observers". He was the one who organized a debriefing for the participants on their return to Damascus from field work, with his ministry present, and who then said that he would like to have such reports in the future as well.

In participants' reports there were a great number of useful proposals, which were discussed in the ministries of health concerned. Recommendations touched upon a whole gamut of problems in the health system, from policy, planning, leadership, the managerial process for national health development (MPNHD), health systems research, to international cooperation. It was proposed that if in the future, LDP participants go to one of the four countries, they should monitor the implementation of these recommendations.

There were difficulties as well, as one would certainly expect with a new programme. The unavoidable "teething difficulties", and more, were present in country selection, preparation of Phase 2 in the countries,

implementation, logistics, sometimes in the availability of WHO representatives, and there were, in certain cases, difficulties for the nationals, especially for those who were part-timers, but sometimes also for others. However, in spite of these difficulties, Phase 2 was deemed by all those concerned as an unequivocal success, thanks to the devotion and hard work of all those involved--nationals, WHO staff and, last but not least, the LDP participants. The difficulties are certainly not insurmountable. A very great number of proposals were made for LDP/2.

3.5. Phase 3 results

The participants all felt that they had profited from Phase 3, although there were some difficulties, mainly linked to the often frequent absence of some of the preceptors. The preceptors felt that Phase 3 was a "good experience", they "learned mutually". Both preceptors and participants enjoyed Phase 3 "very much", and participants thought that the organization was "very good". Participants felt that their expectations were met and they made good progress towards their LDP objectives. Also, the "side programmes" were considered to have been very useful, and the participants were truly impressed by the leaders whom they met and felt that they provided excellent role models. They welcomed the opportunity to learn from the experiences of eminent health leaders.

At the start of the programme, the participants all developed their learning objectives in concertation with their respective preceptors and their workplans based on those objectives. Thus, they were very clear about what they wanted to learn and about how to do that. They were equally clear in listing what they felt they had learned, and their preceptors were, in general, in accordance with them. They felt that they had gotten a "fair idea" about how WHO operates and collaborates with its Member States. The long list of things they felt they had learned starts with WHO policies, strategies and work procedures. The following items were mentioned repeatedly: promoting collaboration between WHO and its Member States; ways of coordination among WHO and its Member States and nongovernmental organizations (NGOs); projecting national HFA/PHC policies in coordination with WHO; writing of reports and technical papers; organization and conduct of meetings; project monitoring and evaluation; work of support programmes; etc. Preceptors and participants agreed that practically all the participants' objectives had been achieved.

In conclusion, it can be said that Phase 3 was an apprenticeship-type of learning experience that allowed participants to learn about WHO concepts and practices "by doing". The experience was two-pronged: it aimed, on the one hand, to give an opportunity to learn about the technical aspects of one programme in some detail and, on the other, to use this technical area as a "case study", to learn more about the practicalities of international health to be used on return to the home country. It seems that Phase 3, despite some recognized teething difficulties, achieved its stated objectives, and as one of the participants wrote, "it was very useful because I got the replies to all my questions regarding WHO". The participants had very clear ideas what objectives they wanted to achieve, and their respective preceptors knew those objectives very well. All felt that practically all their objectives had been achieved. They all acquired the appropriate skills, based on proper insight, as to how to collaborate with WHO in a more efficient way, in particular, how to strengthen cooperation with EMRO, and how to provide leadership in harnessing optimally international health resources to speed up and promote

national health development towards health for all. All participants felt that, on return home, they would be able, if given the chance, to put to use their newly acquired skills. The human growth and development process that started in Phase 1, continued in Phase 2 and Phase 3 undisturbed. The difficulties contributed, in a way, to stimulate that process. The participants' self-confidence also continued to be strengthened during this phase as well. Phase 3 was considered by the External Review Committee, preceptors and participants as an absolutely necessary, integral part of the LDP, and numerous proposals were made as to how to improve it for LDP/2.

3.6. Overall evaluation of LDP/1

At the end of LDP/1, participants completed another questionnaire. Based on an analysis of these questionnaires, participants, looking back at LDP/1, felt that they had achieved most of their objectives, some entirely and a few partially; and said that they would want more in the programme rather than less, in which they unanimously said, nothing was superfluous: all phases, the seminars, participation at meetings and workshops, writing of programme papers, meeting with eminent leaders, planning, management, leadership modules, problem-based learning, in short, "most of the LDP" was most useful, beneficial and very enjoyable. The LDP will help them to solve problems, to apply/use things and introduce changes, facilitate learning of others at home, especially in the field of collaboration with international organizations, and in planning and management. The overall organization of the LDP was "very good"; the programme allowed as much flexibility as they needed to accommodate their personal learning needs. One participant said that "there were many opportunities to discuss what we want to learn and what are our objectives and we always found positive reactions". Another one said that "... we were free to learn whatever we wanted. Lots of materials were at our disposal".

Comparing participants' statements with LDP aims and objectives, it was felt that they had been strengthened precisely in the fields that the LDP aimed at: leadership, international health collaboration, planning and management. These were precisely the points that appeared most often in the replies to different questions. The proposals made for improvement also pointed in that direction.

Finally, in regard to LDP/1, several participants said, "It is an essential programme for our Region"; "The LDP was very useful, I learned more about management and leadership, HFA/PHC and WHO"; "I feel that I gained new knowledge and skills during this programme in management and leadership that will enable me to strengthen the national movement for HFA"; "I didn't expect really to gain as much as I gained. It was a very useful programme, it opened the horizon of new knowledge"; "I will now be able to use international health collaboration to its fullest extent to promote national health development for HFA". These are, after all, precisely the aims that the LDP is all about. We may therefore conclude that it seems, from what the participants said, that the LDP was a success, as it achieved what it had planned originally to achieve. The question remains now whether the follow-up will prove the same.

The External Review Committee (ERC), that has three active cabinet ministers from the Region among its seven members, also gave overall evaluation of the LDP at both its sessions. At ERC/1 it stated that "in addition to the development of national health leadership and the strengthening of international cooperation, the LDP would also stimulate the

professional development of WHO staff members through their active involvement in the conduct of the programme". It was further noted that, "in the light of the innovative and experimental nature of the LDP, it had an excellent potential to provide a model for leadership development which can be replicated in different settings", and "the Committee felt that the mounting of the LDP was timely and well justified in the light of its innovative nature, its sound design and its emphasis on issues and capabilities which are of high priority to national and international initiatives in health development. The Committee stressed the importance of maintaining the delicate balance of the programme between development of national capabilities, international cooperation and WHO requirements". After discussing the programme in some detail, and making proposals as to its improvement, ERC/1 concluded that "on balance, the ERC found the LDP to be a worthwhile and well-designed programme. The programme is experimental and innovative and may provide a useful model for leadership development in health. The Committee endorses the directions and methods of the programme".

ERC/2 "recognized that the programme cannot and should not be expected to create leaders. The LDP has been designed to cultivate and enhance the leadership qualities and capabilities of those individuals selected by their countries to participate in this unique programme". ERC/2 also "recognized that the uniqueness of the LDP is derived from the integration of its three main concerns, i.e., (a) leadership attributes, (b) managerial skills and (c) cooperation in international health...The Committee wishes to have this uniqueness retained and strengthened"...[It] considered the three components (phases) of the programme as the right ones". ERC/2 reiterated the Committee's endorsement of the main LDP objectives and devoted much attention to sustaining the programme in the future.

ERC/2 "recommended to continue to evaluate the outcome and impact of LDP/1 at least over the next two years". The follow-up of participants, in a way, had started already during LDP/1. Ministers of health of the seven participants' countries were kept informed continuously about the progress of their respective participants. The Regional Director also decided that in August 1990 all former participants of LDP/1 will be visited by a consultant to find out (a) in what way the countries had put to use their skills and capabilities; and (b) how they see, in retrospect, LDP/1, and, having returned to the "reality" of their respective countries, what would they propose to change in LDP/2, to make future participants better able to cope with problems of national health development? Results of these follow-up visits will be reported to the Regional Committee.

3.7. Concluding remarks

There seems to be a consensus emerging among the participants of LDP/1, different external observers, reviewers and organizers, concerning a few basic statements (with special regard also to the "tracer concerns" and "indicators" listed in the "Evaluation Protocol"):

a) The LDP is a unique, innovative and most creative programme of regional and even interregional importance;

b) The aims and objectives have been found valid and endorsed by all concerned as being consistent with national and regional health development priorities;

c) Overall LDP objectives and programme organization left ample space for participants' imagination regarding priority setting and definition of own objectives;

d) The problem-based approach, the learning by doing and the continuous evaluation used throughout the whole programme fostered development of capability to confront and solve problems that arise in national health development and in harnessing international health collaboration in an optimal way to speed up the achievement of health for all;

e) The objectives set by the participants, based on LDP aims and objectives, have been largely achieved;

f) Participants throughout the programme continued reflecting on what, and how, to apply from their newly acquired skills and enhanced leadership capabilities on their return home, to speed up national health development;

g) The process of human growth and development continued throughout all of LDP/1, not only for the participants, but also for those countries and WHO staff who participated in the programme in one way or another, thus

h) Member States and WHO have started to profit from this programme, even before the return home of LDP/1 participants; and

i) The LDP should be continued on the basis of present precepts, and a great number of proposals and recommendations were made by all those concerned to improve LDP/2.

4. Preparatory Work for LDP/2 (1991)

Work started in 1989.

4.1. Aims and objectives

ERC/2 recommended "to sharpen further the definition of the scope and purposes of the programme in order to maximize understanding concerning the selection of participants, the expected outcomes and the potential benefit to the participating countries". According to these recommendations, the aims and objectives, whose content has been endorsed, are being revised in order to make them clearer.

4.2. LDP/2 schedule

Based on the aims, objectives and recommendations prepared by ERC/2 and others, taking into account the great number of proposals made by LDP/1 participants, facilitators, preceptors, WHO representatives, Phase 2 national staff, etc., a programme schedule has been designed for LDP/2 (Annex 2). According to this, the programme would start 3 March 1991 and end on 16 January 1992. The duration is about the same (44 weeks) that it was for LDP/1 (43 weeks), plus a 2-week vacation (which was not granted for LDP/1). Shifts have also been operated among phases, as proposed by ERC/2: five weeks have been added to Phase 1, one week to Phase 2, and 5 weeks taken from Phase 3 (i.e., Phase 3 has been shortened by one-third: from 15 to 10 weeks). Shifts have been made also within the phases.

4.3. Invitation to Member States for designation of candidates

A letter has been sent to all governments in the Eastern Mediterranean Region requesting them to designate candidates for ERC/2 who fulfil the seven criteria listed in the letter (health-related university degree; proficiency in English language; 30-40 years of age; minimum five-years health development experience; recognized leadership qualities; firm government commitment for appropriate employment on return; designation of high-level "mentor" to follow up development and then placement).

4.4. Preparatory work for LDP/2 (Phase 1)

Facilitators of LDP/1 (Phase 1) were invited to a facilitator meeting (FM/1) in parallel with ERC/2. The facilitators met several times with ERC/2, but also worked on their own to meet the ERC/2 request "for better integration of the modules through a series of problem-solving activities leading to a concrete product demonstrating mastery of the required skills". FM/1 agreed on ways and means to "re-package" the modules around "problem-situations". The revised modules will be ready by 15 July 1990 and, after mutual review, they will be revised and further integrated at the second meeting of Phase 1 facilitators (FM/2) in September 1990. Coordination among module writers during the preparatory work is ensured.

4.5. University diploma for participants

From the beginning of LDP/1, negotiations are continuing in regard to ensuring a university-level diploma for participants of this one full academic year (10-month) programme. Negotiations may succeed for LDP/2 participants, but difficulties remain.

4.6. Plans for institutionalization and decentralization

ERC/2, in its report, said that "another major concern of the ERC has been the further institutionalization of the programme", and it also wanted to see this programme established "later at the national level in order to make it more relevant to local needs". Discussions about different options for institutionalization and decentralization have started. The next ERC meeting (ERC/3) in late 1991, or early 1992, will discuss these options and advise the Regional Director about how to continue the LDP beyond LDP/2.

Annex 1

INTERIM REPORT ON LEADERSHIP DEVELOPMENT PROGRAMME IN INTERNATIONAL HEALTH

The Regional Committee in Resolution EM/RC.33/R5 in 1986 approved the recommendations of the Regional Consultative Committee, including the proposal that 10% of the country general fellowship allocation "be used to recruit nationals for the purpose of providing them with on-the-job training in international health work and in the planning and implementation of various technical programmes" (EM/RC33/18-B, p. 17, para 5).

The rationale of the programme proposed by the Regional Committee has been to train and develop mid-career, potential leaders of the national health systems so that they have detailed knowledge of international health organizations, first and foremost of WHO, and that they be able to develop nationally appropriate and relevant cooperative programmes and, in general, use most effectively and efficiently international collaboration for enhancing national health development towards Health for All.

In the wake of the Regional Committee resolution, a working group has been formed in EMRO; it elaborated a first proposal which then served as a basis for further discussions. All Member States of the Region were then approached to designate candidates for the programme. Seven participants, from seven countries of the Region, were finally selected by the Regional Director for the 1989 session of the programme.

The detailed preparation of the programme, now called Leadership Development Programme for International Health (LDP), started in 1988. Five general objectives have been elaborated and also a number of "intermediate objectives" related to each of them. These objectives deal with the broad fields of:

- information;
- planning;
- management;
- leadership; and
- human resource development.

On the basis of these objectives a programme has been worked out according to which the LDP consists of three phases of three months each:

- Phase 1 - a core course in the Regional Office;
- Phase 2 - field work in a country of the Eastern Mediterranean Region (but not in the participant's own country);
- Phase 3 - apprenticeship-type work in the Regional Office.

In Phase 1 all the seven participants follow a problem-based programme in the Regional Office, using a modular approach.

In Phase 2 participants will become acquainted with the functioning, planning and management of a health system other than their own. They will start work at district level, then "climb up" to provincial/governorate and then to national level where they will work not only with national but also with international agencies present in the country and relevant to health. In

this "ladder" part of the programme, in addition to studying the health system in general, participants will "major" in one particular programme of their choice (in agreement with the Director of the LDP).

In Phase 3 participants will work in the Regional Office. They will become acquainted with the operation of the whole Office but their main task will be to work with one particular Regional Adviser as a sort of "junior adviser", or "apprentice".

It has been decided that there would be no formal examinations in whatever form during this first, unavoidably experimental, session of the LDP. However, informal, (so-called "formative") evaluation will be used such as auto-evaluation, peer-review, tutor/coordinator assessment, course-paper, etc. Professor A. Rotem from Australia has prepared an evaluation protocol for programme evaluation and for testing the modules which, because of shortage of time, in this case cannot be pre-tested. The protocol is already being used.

The LDP started, as planned, on 5 March 1989 with seven participants, from Republic of Afghanistan, Democratic Yemen, Iraq, Jordan, Pakistan, Somalia, and Sudan. The participants have been carefully selected from those candidates proposed by the Governments of the Member States in the EMR. They are all mid-career public health administrators who are deemed to be potential health leaders in their countries. Their ages are between 32 and 45; their level of responsibility ranges from that of a director of a health centre to that of an assistant deputy minister of health.

Before the LDP started, there was a three-day briefing session (28 February - 2 March 1989) in EMRO for all professional staff of the Office. This consisted of a leadership "mini-workshop"; a discussion of LDP's goals, objectives and structure and EMRO staff's role in the LDP with special regard also to problem-based learning. WRs have also been informed in detail about LDP and one day during their annual meeting in June 1989 was devoted to that subject. Preceptors in the countries concerned with Phase 2 and in the programmes concerned in EMRO (Phase 3) also have had special briefing.

The first, introductory week of the LDP, 5-9 March 1989, had a varied programme: getting acquainted with one another, with WHO and EMRO; learning about what leadership is; developing ideas about self-directed and problem-based learning, were all elements of that week's agenda. On the first day, each participant was individually interviewed and they made decisions, in concert with the Director of the LDP (who is also the Director of Health Manpower Development, EMRO) as to in which country they would spend Phase 2 (two participants each in Somalia, Syrian Arab Republic and Yemen, and one in Egypt), with which programme in EMRO they would work in Phase 3 (two participants each with PHC and EPI, and one each with HMD, CDS and MCH). They also selected the topics of their course papers.

After the introductory week, the first module, on information, occupied the next three weeks. The participants learned, in a problem-based mode, about using existing information, planning and implementing surveys, collecting, processing and analysing data, using computers, epidemiological and demographic analysis, health systems research and, first and foremost, how to request and use information for planning and management and, in general, for decision-making. They also learned how to define problems in their home environment and how to use those problems to elicit data which

they can then use in the solution of such problems and also in monitoring and evaluating the solution.

At the end of each week the participants are polled and at the end of module 1 (Information) they completed a ten-page questionnaire. The analysis of these feedback instruments is then used to improve the programme; it will also be used to plan the next session of the LDP which is now foreseen for 1991. The reaction to the LDP is, so far, unanimously favourable. The participants have, of course, critical comments but the overall reaction is overwhelmingly positive and appreciative.

The modules 2 and 3 (Planning and Management) started on 2 April 1989, with a new team of facilitators. They lasted six weeks. In this way the programme is running according to schedule. However, it would be too early yet to evaluate.

The preparation of Phases 2 and 3 with the countries and WHO programmes concerned is also on schedule.

The Regional Director decided to establish an External Review Committee (ERC) to advise him on the improvement of the planning and implementation of the LDP, both concerning the 1989 session and with special regard to the one planned for 1991. Relevance of the LDP to the needs of the Member States of the Eastern Mediterranean Region will evidently be the first concern of the ERC which will be a most important and powerful body to help to steer the LDP in the direction in which the Regional Committee intended it to go.

The first meeting of the ERC took place 26-29 March 1989. In its report it recognized the importance of the Programme and stated, *inter alia*, that the LDP is "a worthwhile and well-designed programme. The programme is experimental and innovative and may provide a useful model for leadership development in health. The Committee endorses the directions and methods of the programme ...". The ERC then made eight recommendations, among them those concerning the preparation of the 1991 session of the LDP. The next meeting of the ERC will take place 10-13 December 1989 and will provide guidelines for the detailed evaluation of the 1989 session to take place in 1990, as well as for the further preparation of the 1991 session of the LDP.

Addendum to EM/RC36/19

INTERIM REPORT ON LEADERSHIP DEVELOPMENT PROGRAMME IN INTERNATIONAL HEALTH

Since the writing of the Interim Report, the modules 4 and 5 (Leadership and Human Resources Development) and, with that, Phase 1 of the LDP have ended, as planned, on 8 June 1989. Throughout the whole Phase 1, participants kept being polled at the end of each week and at the end of each module. Finally, they completed a 12 question questionnaire at the end of Phase 1, evaluating their own progress. In addition, each facilitator prepared a report on his module and on the progress of each participant in it. The evaluation summary of Phase 1 of the LDP states, among other things, that "there is not the slightest doubt that the participants have gained new knowledge and developed new skills as to the objectives of the LDP", and that "they see now things in a different way than before Phase 1". It is also said that "all participants seriously look forward to application of newly acquired knowledge and skills, to make changes and to let colleagues learn from their experiences at home". As one participant has summed up the feeling of the whole group after Phase 1: "I now feel a great self-confidence that I will be able to do a lot in my country to change others" and this may be one of the most important traits of a successful leader.

After the successful completion of Phase 1 and in a one-week briefing for Phase 2, participants started the Phase 2 of the LDP, on 11 June 1989. Two participants each went to Somalia, Syrian Arab Republic and Yemen and one to Egypt. They finished their work there on 31 August 1989, according to schedule. In the countries they have worked as planned at district, regional (governorate), and national level, the latter including international health as well.

The Regional Office has solicited the services of a consultant to visit all the four countries and meet those with whom the participants have worked and thus collect first hand information about the Phase 2. He reported back that Phase 2 of the LDP has been organized with great care and due attention has been given to all aspects of the work in all the four countries. Both the nationals and the participants as well as the international staff in the countries concerned considered the programme to have achieved its objectives and to have been, by all standards, very successful and enjoyable. In addition, all felt that the process has been beneficial for all parties, i.e., not only for the participants but also for those with whom they have worked. Two members of the ERC also have visited the participants in Syrian Arab Republic and Yemen respectively. Phase 2 will be evaluated based on their forthcoming reports and on the reports that the participants, the WHO representatives concerned will prepare as well as on the reports the consultant has prepared.

The experience of Phases 1 and 2 have yielded a very rich source of ideas and proposals for improving the LDP at its next (1991) session.

After Phase 2, participants returned to EMRO and a debriefing week starts on 3 September 1989 after which they will spend 2 weeks to acquire a basic computer literacy skill. Then on 24 September 1989 will start Phase 3, by now thoroughly prepared, and last till 28 December 1989. Those participants who successfully finish the whole 10-month programme will be awarded by WHO a Diploma.

It is planned that in 1990 a detailed evaluation will be carried out and, as a part of this, in August-September 1990 the countries of the present LDP participants would be visited. It is fully realized that the success of the whole Programme depends on how far the countries of the participants can use their newly developed leadership capabilities, how far the former participants will have an opportunity to practise their new skills and how far the Member States concerned profit from that to enhance the achievement of Health for All.

The experiences of the evaluation will be used in the planning of the 1991 Session of the LDP that will have to be prepared in 1990. Invitations to designate candidates will be sent soon to all Member States in the Region hoping that there will be many good candidates proposed, in view of the criteria stated.

Annex 2

LEADERSHIP DEVELOPMENT PROGRAMME IN INTERNATIONAL HEALTH (LDP)

SECOND SESSION (LDP/2)
1991

Time Schedule

Second Draft

	Number of weeks	% within the		Dates
		Phase	Programme	
Phase 1. Core Programme				
Introduction to WHO, LDP, HFA/PHC, basic skills, settling down	2	11	5	3-14 March 1991
Module 1.1 Leadership	2	11	5	17-28 March
2.0 Information	3	17	7	31 March - 18 April
3-4 Planning and Management, Organization Dynamics	6	34	13	22 April - 30 May
5.0 Human Resource Development	3	17	7	2-20 June
1.2 Leadership	1	5	2	23-27 June
Review situation paper; briefing for Phase 2	1	5	2	30 June - 4 July
Total Phase 1	18	100	41	
Phase 2. Field Work				
2.1 Work in a country of the Region				
Briefing; Ministry of Health	2	13	5	7-18 July 1991
District	3	20	7	21 July - 8 August
Governorate/Region	2	13	5	11-22 August
Ministry of Health and other central health-related agencies	2	13	5	25 August - 5 September
WR; health-related international agencies	2	13	5	8-19 September
Leave	—	—	—	22 September - 3 October
2.2 Work in own country	3	20	6	6-24 October
Debriefing in EMRO	1	8	2	27-31 October
Total Phase 2	15	100	35	
Phase 3. RO attachment				
Regional Office	10	—	22	3 November 1991 to 9 January 1992
Evaluation closure				
Regional Office	1	—	2	12-16 January 1992
Grand Total	44	—	100	
Leave after Phase 2.1	2	—	—	

REGIONAL COMMITEE FOR THE
EASTERN MEDITERRANEAN

EM/RC37/9
June 1990

Thirty-Seventh Session

ORIGINAL: ENGLISH

Agenda item 11

REPORT ON THE LEADERSHIP DEVELOPMENT PROGRAMME IN INTERNATIONAL HEALTH (First Session, 1989)

Summary of Recommendations

1. The Leadership Development Programme in International Health (LDP) is a unique, innovative and most creative Programme that successfully meets important, earlier unmet, needs of the Eastern Mediterranean Region. It is therefore recommended to continue it at least during the present WHO Medium-Term Programme period (1990-995).

2. The aims and objectives of the LDP being consistent with national and regional health development priorities in the Eastern Mediterranean Region, it is recommended that they continue to serve as the basis of programme organization after further sharpening and clarification, as proposed by the LDP External Review Committee.

3. All Member States of the Region should benefit from the LDP both by proposing appropriate participants and by working with them in Phase 2 of the Programme.

4. Participants, on return to their countries after completing the Programme, should be given full opportunity to exercise, and develop further, their leadership capabilities and newly acquired skills in

international health planning and management. The Regional Director should inform the Regional Committee on the extent that Member States could profit from the considerable human and financial investment that the LDP represents.

5. The 10 percent of general fellowship allocations seems to be both necessary and sufficient for financing the LDP. Therefore this budget level should be maintained as a minimum and earmarked for LDP, at least up to and including the 1994-1995 biennium.

6. The Regional Director should report to the Regional Committee on the progress on the LDP in 1991, in an interim report, and to the Thirty-ninth Session in 1992, in a full report, on the Second Session of the LDP (LDP.2) and on the future plans concerning the LDP.