

The generation and implementation of the concept of health leadership development

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Need for leadership development

Since the Declaration of Alma-Ata in 1978, countries throughout the world have restructured their national health systems based on primary health care. These developments have resulted in great changes for health workers. Community health workers at various levels of professional qualification and in various functions have been recruited and trained to meet the requirements of the primary health care system. They have worked at differing levels within the health care system and with different categories of health workers at professional, technical and auxiliary levels.

The training, functions, job description and management of these teams working at the primary health care level has been one of the major preoccupations of health and human resource planners. However, the performance of health workers operating as a team fell below the expectations of the original planners of primary health care. This led the planners to think about the managerial defects which might have led to such a situation. The general consensus was that the problem lay in a deficiency in leadership at higher levels of the health system. Team leaders capable of effective leadership, and supervision with transparency and sensitivity to personal relationships, organizational

knowledge and managerial skills were badly needed. These factors, among others, led WHO to think of ways and means to develop leadership. Training in leadership was considered an important contributor to leadership development. Although the statement that "leaders are born and not made" has a lot of truth to it, there is also enough evidence that training, organization and supervision contribute much to leadership development.

The beginning

Recognizing that a problem existed, the Director-General of WHO launched a new initiative in January 1985, called health-for-all leadership development. This initiative was based on the premise that the implementation gap could be substantially narrowed if individuals in leadership positions understood more fully the processes involved in developing and implementing the strategy of health for all, pursued its values and developed within themselves the appropriate qualities and abilities to lead the process. The principal aim of the initiative has been to establish and mobilize a critical mass of people in each country who are in a position to motivate others and direct their national health development processes towards the goal of health for all. Strategically located throughout the entire spectrum of the national structure, not only in health systems but also in

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related institutions, universities, research establishments, health profession associations, political organizations, nongovernmental organizations, and, last but not least, the community. A network of these people can provide material support in fostering and exploiting the conditions required for necessary changes.

The initiative of health-for-all leadership development has been pursued rigorously from the beginning in the Eastern Mediterranean Region. Leadership conferences were organized and travelling seminars were arranged in Thailand and Indonesia to observe the experiences of these countries. Brainstorming sessions for parliamentarians, consultations for religious leaders and tours for women leaders were also implemented.

A major event in progress towards leadership development was the adoption of a resolution by the Regional Committee in 1986 which approved the recommendations of the Regional Consultative Committee, including a proposal that 10% of a country's 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.

Based on this resolution, the WHO Regional Director for the Eastern Mediterranean launched a regional Leadership Training Programme in International Health (LTP), the title of which was changed in April 1989 to EMRO Leadership Development Programme in International Health (LDP).

Objective

The objective of the leadership development programme in the Region is to develop a critical mass of mature, mid-career potential leaders for the national health system who will have detailed knowledge of international

health matters and are able to develop nationally appropriate and effective cooperative health programmes. Individuals who can use effectively and efficiently resources obtained by international collaboration, facilitating national health development towards achieving health for all.

The anticipated outcome from the above objective will be to:

- develop nationals in EMR countries with leadership potential and qualities who are capable of formulating policies, planning and managing their national health systems, including all technical programmes;
- provide leadership in harnessing international health collaboration which can speed up national health development towards health for all;
- enhance and improve collaboration on health issues amongst countries of the Region.

Planning stage

Based on the objectives set, the Regional Director decided to launch the first session of the LDP during the period May to December 1989. It was decided that the first session should be held at the Regional Office in Alexandria in English in order that all countries of the Region could have an equal chance of nominating candidates for the first session. The following criteria were set for the selection of eligible candidates:

- graduates from medical schools or university graduates from other fields related to health;
- preferably 25–35 years of age;
- involved in health and development activities in the community at district health level or below;

- expected to be in influential management positions within the national health system or in health-related work in their countries where they can work as a change agent;
- recognized by their peers and seniors as having leadership qualities, aptitudes and potential; and
- extra language proficiency: should have a working knowledge of English.

Financial resources were secured through deductions made from the general fellowship allocations in the WHO regular budget of all countries, as endorsed by the Regional Committee and became a regular contribution every biennium for the LDP. Suitable persons were identified and approached to participate in the training.

The training programme, which lasts for one year, is divided into three phases which complement each other. The initial phase includes problem-based learning modules to stimulate competence in obtaining and using information on policy formulation, planning and management, leadership development, and the development of human resources. Each module includes activities which expose participants to concepts, techniques and literature resources. Each module is based on self-directed learning, problem solving approaches, skills and the application of theoretical knowledge to real working situations.

During the second phase of the programme, participants are sent to a country of their choice in the Region where they are attached to different levels of the health system. In these countries the participants are required to work in the actual service provider setting and to try and solve all the problems they meet under supervision by the local health authorities. They also work for a period in their own countries.

In the third phase of the programme the participants work in the Regional Office of

WHO with a Regional Adviser of their own choice. During this phase they get acquainted with the operation of the Regional Office. They are required to examine problems and requests received from Member States and propose solutions for them under the guidance of the Regional Adviser concerned.

All participants prepare a 30-page technical paper by the end of the programme on a subject of interest to themselves which they select during the first week of the course. The aim of this paper is for participants to identify a problem, collect relevant data, analyse the data and propose a solution for the problem.

No formal examination is undertaken by the participants in the LDP programme. They are evaluated on progress achieved and through reporting carried out by their teachers and supervisors at field level.

Implementation stage

Since its inception in early 1989, five sessions of the Leadership Development Programme have taken place. The first two sessions were in English and were conducted at the Regional Office.

After these two regional sessions the Regional Director felt that the programme should be decentralized to Member States for the purpose of providing a critical mass of nationals trained in leadership in all countries of the Region. This would be achieved by including in the intake a large number of candidates from the country hosting the session. The first decentralized session was held in Pakistan in English in 1993. The first decentralized session in Arabic was held at the High Institute of Public Health, Alexandria, in 1996. The third session, in French, is running in Morocco. Table 1 gives a current summary of sessions completed or planned.

Decentralization of LDP

Since the third session, held in Pakistan, the selection of candidates has differed in that the host country is privileged in being able to nominate half the total number of candidates, the other half coming from other countries in the Region. The host country in addition to its usual contribution from the general fel-

lowships allocations, finances the cost of training for the additional number of candidates it sends on the programme from its country allocations of WHO regular budget. It is hoped that in this manner a large number of local candidates will be trained by any country which opts to host a session of the LDP, thus speeding the creation of a critical mass of persons trained in leadership. The

Table 1 Distribution of LDP candidates

Location	Session 1	Session 2	Session 3	Session 4	Session 5	Total
Language	EMRO English	EMRO English	Pakistan English	Egypt Arabic	Morocco French	
Total participants	7	10	18	15	14	64
Date	5.3.89	18.8.91	15.8.93	3.3.96	3.11.97	
	to	to	to	to	to	
	28.12.89	2.7.92	22.6.94	4.12.96	14.8.98	
<i>Nationals participating</i>						
Afghanistan	1	1	1			3
Bahrain			1	1		2
Djibouti					4	4
Egypt		1	1	8		10
Iran, Islamic Republic of		1				1
Iraq	1		1			2
Jordan	1	1		1		3
Lebanon					1	1
Libyan Arab Jamahiriya		1			1	
Morocco					8	8
Oman				2		2
Pakistan	1	1	8			10
Saudi Arabia		1	1	1		3
Somalia	1	1				2
Sudan	1	1	1			3
Syrian Arab Republic			1	1		2
Tunisia				1		1
Yemen, Republic of	1	2	2			5
Mauritania					1	1

same procedure was applied to programmes run in Egypt and Morocco.

Problems and constraints

The main problems encountered by participants in LDP sessions have been:

- language difficulties, particularly during the English sessions;
- inadequate supervision and guidance in some countries during phase two of the programme (country experiences);
- absence of regional programme directors from the office during phase three of the programme, resulting in inadequate supervision and guidance of participants during the Regional Office attachments.

Evaluation

To assess the impact of graduates of the LDP in improving health care and quality of life in

their home countries it may be necessary to develop a specific evaluation tool. At present the number of graduates in any country is so small that it may not yet be appropriate to undertake such an evaluation. With the decentralization of the LDP and when more countries opt to have regular decentralized sessions, resulting in larger numbers of graduates, it may then be possible to carry out an assessment of the impact of the programme.

To date the outcome of the programme, from the observation of graduates of the LDP sessions working in their own countries, is that they have effectively and positively influenced the development of health care in their countries. All graduates already hold key positions in the health systems of their countries, such as deans of medical faculties, directors-general in their ministries of health, undersecretaries of ministries of health, etc. Those met personally by the author and other WHO staff have been well satisfied by the experience they have gained and have expressed gratitude and appreciation to WHO for the initiative.

With the increasing number of institutes conducting LDP courses a critical mass is being developed in the Region which will allow for exchange of experience and networking. An example of such collaboration was witnessed between the Instituts nationaux de l'Administration sanitaire in Morocco and the High Institute of Public Health in Alexandria.

Source: The work of WHO in the Eastern Mediterranean Region. Annual report of the Regional Director, 1 January–31 December 1997. Page 45.