

PROLEAD:
WHO Health Promotion
Leadership Development Program

EVALUATION REPORT FOR THE WHO KOBE CENTRE

By

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July 2006

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Abbreviations

6 th GCHP	6 th Global Conference on Health Promotion
HP	Health promotion
HPF	Health promotion foundation
HULC	Healthy Urbanisation Learning Circles
MOH	Ministry of Health
SDOH	Social determinants of health
SEAMEO-TROPMED Network	South East Asian Ministers of Education Organization, Tropical Medicine Network
SPH-LTU	School of Public Health, La Trobe University, Australia
WHO	World Health Organisation
WKC	WHO Kobe Centre
WHO-WPRO	World Health Organisation Regional Office for the Western Pacific

Section 1. Executive Summary

1.1 Background to Prolead

Following extensive preparatory work, the first program of Prolead (Prolead I) was piloted over nine months from July 2004 in six Western Pacific countries, in partnership with the Southeast Asian Ministers of Education Organization, Tropical Medicine Network (SEAMEO-TROPMED Network); the La Trobe University School of Public Health; and the Field Epidemiology Training Programme Alumni Association Inc., with the support of the Government of Japan. The strategic intent of Prolead was to identify teams of leaders who promote health in countries, develop a critical mass of such leaders in countries, create and sustain a learning and mentoring environment and to support the scaling up of health promotion in order to make an impact on health.

In November 2004 WHO regional advisors and focal points for health promotion agreed that Prolead would expand to include teams from Africa, Eastern Mediterranean and South East Asian regions. Following a modification of the curriculum, Prolead II was rolled out on an inter-regional basis in 2005 to five countries from three regions and SEAMEO-TROPMED Network.

1.2 Evaluation of Prolead

This evaluation of Prolead sought to respond to three questions. Firstly, what lessons have been learned that have informed changes in Prolead since its inception? Secondly, what have been the impacts of Prolead? Thirdly, what should Prolead III look like, given its aims, the experience of implementing previous forms of Prolead, the changing social and political contexts and new thinking about leadership development programs?

Evidential enquiry was undertaken by reviewing program documentation and interviewing fellows to identify facts concerning the planning, implementation and outcomes (short, medium and longer term) of Prolead I and II. Evocative enquiry was undertaken by interviewing a majority of Prolead I participants and Prolead stakeholders, and discussing Prolead II fellows' experiences in a facilitated forum. These results were combined with a re-consideration of the broader context for the implementation of Prolead and recent literature on leadership and leadership development in order to identify issues to consider for further developing Prolead and a research agenda to support and accompany Prolead.

1.2.1 What lessons have been learned that have informed changes in Prolead since its inception?

Strategic intent and Focus. Prolead's strategic intent was preserved because it had continuing relevance for countries and WHO. The focus of Prolead shifted to pro-health governance, reflecting the need to focus on the fundamental processes underpinning system dynamics.

Structure and coursework. The structure of three modules, delivered over a nine-month period, was generally regarded as appropriate given that Prolead is concerned with applied learning and the testing in country of new information, ideas and skills. There may be a case for developing the learning and networking potential of the third (two-day) module. While the structure worked well, some fellows thought that the program could be expanded to four modules, although it was not clear what strategic objectives or content this might have.

The content of the coursework was also generally regarded as appropriate to achieving the objectives of the program, offering substantial information, concepts, skills, ideas, tools and learning experiences. Topics such as financing and governance were appreciated, reflecting in part the background of the two cohorts of Prolead fellows.

Country-based team projects and mentoring. Developing team projects during the course was regarded by fellows as a critical learning experience, although opportunities exist for some preparatory work (such as priority setting) to be done prior to the start of coursework. Projects required teamwork and involved identification of priority issues and examination of factors associated with these issues, thus reflecting in-country processes that may need to be fostered in order to elevate health promotion on the policy agenda. Twinning international organisations to team projects for project mentoring proved to be popular and useful, and was felt to have made a difference to the quality of project outcomes.

Based on feedback from Prolead I fellows and mentors, individual mentoring moved from being a core component to an optional component of Prolead. Fellows who took up the option generally regarded personal mentoring as valuable. The challenges inherent in making mentoring work effectively were identified as communicating across countries and across geographical, cultural and interpersonal barriers. Opportunities for face to face communication were seen as critical to building qualities of a relationship that are central to mentoring: trust, rapport and understanding.

Other activities. Group activities such as field visits and participation in international meetings were highly regarded for their ability to extend fellows' personal and professional learning.

1.2.2 What have been the impacts of Prolead?

Evaluation results to date indicate that Prolead has proven to be a critical ingredient in stimulating the development of infrastructure, financing and governance that are likely to sustain health promotion in countries. It has:

- Trained 37 health promotion leaders across three regions, enabling them to acquire skills, attitudes, personal attributes, networks and insights required to initiate and drive systemic change in their respective countries, with the goal of securing health promotion as a priority strategy to improve population health.
- Stimulated capacity-building for health promotion in countries
- Assisted fellows in a number of countries to create or fast-track legislation to earmark taxes on tobacco or alcohol products (or both) for health promotion and introduce health promotion foundations as a strategy to create continuous financing of health promotion.
- Produced tangible benefits for fellows' countries such as setting national agendas for pro-health governance in order to tackle the social determinants of health through health promotion, and mobilising action to create new and autonomous structures and sustainable financing for health promotion
- Created bridges between international organisations (such as health promotion foundations, universities, SEAMEO-TROPED Network) around the task of health promotion leadership development
- Established the basis for a Prolead alumni network that has an ongoing role to play in training leaders as well as engaging in international efforts associated with the Prolead agenda for change.

1.2.3 What should Prolead III look like?

The following model is recommended as a basis for future Prolead programs, given Prolead's aims, the experience of implementing previous forms of Prolead, the changing social and political contexts and new thinking about leadership development programs.

Strategic intent and Focus

The strategic intent for the program should remain the same, although the focus should be adjusted depending on whether the fellows are working at the city or at the national level.

Fellows

The selection of fellows should continue to focus on fostering teams of individuals who can play key roles in facilitating change and promoting health.

Structure and Coursework

The structure and coursework of Prolead should be retained and monitored for their relevance.

- Individuals to complete three full modules of one-week each implemented over nine months that enhance knowledge, promote skill development and teamwork and model strategic thinking so that fellows develop the capacity to navigate through complex organizational and environmental issues.

Country-based team projects and mentoring

Country-based team projects should be complemented by project mentoring, and individual mentoring should be offered to all fellows as an option.

- Teams to undertake rapid assessment and prioritisation of local issues that will be addressed in projects *before* Module 1 starts
- Mentoring organizations to be recruited to support teams and the design and implementation phases of their projects
- Individual mentors to be organised for fellows who wish to have one.

Mentors (individual and project) supported to make in-country visits in an early stage of Prolead to become familiar with fellows and the professional context in which they work, for fellows to become familiar with their background and what they can offer in the way of guidance and support and to establish reliable ways of communicating.

Other activities

A range of other activities should be offered to fellows to consolidate and extend their personal and professional attributes, learning and networks.

- Encouragement of teams to build links beyond projects, especially with Prolead teams in other countries/cities, assist with other policy developments, debates and capacity building needs in their countries and regions
- Participation in field visits
- Implementation of a Prolead Alumni that is cultivated as a formal, active entity with contributions to make to international debates, research, workforce development and in-country and international professional education and training.

1.3 Research agenda

Prolead offers a rich opportunity for targeted research along several lines.

The work of Prolead teams offers an opportunity for action research. This research agenda could cover topics associated with the logical framework of the program (ie investing in health promotion infrastructure and capacity, developing pro-health governance, and optimising social determinants of health).

In addition, the program offers an opportunity for research into leadership development processes and evaluation of changes in aspects of leadership over time. As such, continued monitoring of the Prolead cohorts may be valuable. The research agenda could also cover the evaluation framework used to assess the short, medium and long term impacts of Prolead. One of the challenges that arose from this evaluation was how to attribute changes occurring in health systems to the impact of Prolead. Associated with this was the difficulty of identifying indicators and measures for evaluating changes in complex systems, such as health systems.

Section 2. Introduction

2.1 Background to the genesis of Prolead

In support of the Regional Framework for Health Promotion 2002-2005¹, the WHO Regional Office for the Western Pacific (WHO-WPRO) convened a workshop on capacity building for health promotion in Manila on 5-8 November 2002. To inform this workshop, WHO WPRO commissioned a report on strategies to improve health promotion effectiveness in developing country contexts.² The report concluded that successful efforts in health promotion at all levels require, amongst other elements, leadership that facilitates decision-making, inter-sectoral action and sustainability of program effects. One of the critical interventions proposed to develop leadership was a *regional health promotion leadership development program*.

Workshop participants agreed that such a program should recognise contemporary challenges for health promotion leaders within Ministries of Health in developing countries in particular, such as integration of health promotion with health care delivery, changing people's health seeking behaviour, health financing and health sector reform and intersectoral action for health. The program was envisaged as a key part of a broader regional strategy to mobilise resources and bring together suitable institutional linkages for ongoing training and support. The role of the program would be to engage individuals with leadership potential in a transformative process: 'changing mindsets in order to take risks'³ would be one of the key challenges. Individuals would ultimately be expected to play a key role in bringing about changes in support of health promotion in local, national and international systems, through public policies, health programs and organisational change. The magnitude of these tasks and high level of difficulty needed to be explicitly considered in the design of the leadership development program.⁴

The workshop provided important starting points for the further development of a program model. It concluded that new skills and competencies were needed in the following areas: research, politics, strategic/scenario planning, community mobilisation, networking for advocacy and influence, problem-solving, legislation and law enforcement, resource allocation, and emotional quotient /courage. Key principles enunciated for the program included:

- Develop a critical mass of trained people within each country
- Train 'in place'
- Apply knowledge and skills in practice
- Focus around team projects
- Maintain relevance to local systems and issues
- Use regional networks and institutional links to support capacity-building
- Prioritise the training of existing leaders.

¹ WHO Regional Office for the Western Pacific (2002). The Regional Agenda for Capacity Building in Health Promotion 2002-2005. WHO: Manila, Philippines.

² Lin V & Fawkes S. (2002) Effectiveness of health promotion in changing environment and lifestyles in developing countries of the Western Pacific Region: A review and a proposed framework. La Trobe University School of Public Health.

³ *ibid*

⁴ Moodie R, Borthwick C, Phongphit S, Galbally R, Hsu-Hage BH-H. (2000) Health promotion in South-East Asia: Indonesia, DPR Korea, Thailand, the Maldives and Myanmar. Health Promotion International, Oxford University Press. 15 (3): 249-257.

In addition, the program should build on existing training resources, work through training centres in the region, and be delivered through a combination of learning strategies, such as mentoring, formal training in universities and institutes, training of trainers, continuing education, distance learning, tailored overseas short courses, and higher degree training. The outcome of such an approach to health promotion leadership development should include the development of a critical mass of stakeholders, shared vision, and implementation of health promotion strategies and actions.

In 2003, in response to the workshop's recommendations and to support an evidence-based approach, WHO WPRO commissioned a report on models for a health promotion leadership development program.⁵ The report incorporated a review of the models used in a number of existing and relevant international leadership development programs for public health, mostly from developed countries where such programs have been in operation in both private and public sectors for some years. The health promotion infrastructure and financing study group met in Bangkok on 29 September – 3 October 2003 to develop a regional template for health promotion leadership training, with health promotion infrastructure and financing as its central focus. On the basis of these activities, and drawing on the CDC FMTP Program⁶, the curriculum for health promotion leadership development program, Prolead, was prepared based on a consultative group convened in Manila in November 2003.

Prolead was piloted over nine months from July 2004 in six Western Pacific countries, in partnership with the Southeast Asian Ministers of Education Organization, Tropical Medicine Network (SEAMEO-TROPMED Network); the La Trobe University School of Public Health; and the Field Epidemiology Training Programme Alumni Association Inc., with the support of the Government of Japan.

In September 2004, WPRO initiated discussions with WHO Kobe Centre (WKC) to support Prolead participants' participation in the 6th Global Conference on Health Promotion (6th GCHP). In a meeting of regional advisors and focal points for health promotion in November 2004, it was agreed that Prolead would expand to include teams from Africa, Eastern Mediterranean and South East Asian regions. A workplan for Prolead II was submitted to WKC, and was approved in January 2005. Following a modification of the curriculum, Prolead was rolled out on an inter-regional basis to five countries from three regions and SEAMEO-TROPMED Network (based in Thailand).

2.2 Aim of this report

This report aims to present findings from an evaluation of Prolead and respond to three key questions:

1. What lessons have been learned that have informed changes in Prolead since its inception?
2. What have been the impacts of Prolead?
3. What should Prolead III look like, given its aims, the experience of implementing previous forms of Prolead, the changing social and political contexts and new thinking about leadership development programs?

⁵ Lin V and Fawkes S (2003). Health promotion leadership development: program model options for Western Pacific Region. A working paper prepared for the Regional Workshop on Health Promotion Infrastructure and Financing, Bangkok, Thailand, 29 September – 2 October 2003. La Trobe University School of Public Health.

⁶ CDC FMTP Program is the Centres for Disease Control Field Management Training Program

Section 3. Evaluating Prolead

3.1 Approach

Whatever outcomes Prolead is able to produce will reflect the nature and quality of planning and implementation. Process evaluation is therefore an important activity because it assesses aspects such as curriculum design and program content and delivery, providing critical information for program development.

Assessing the outcomes of Prolead is the complementary activity that indicates whether the program has achieved its objectives and what other impacts it has made. Drawing on the work of Grove, Kibel and Haas (2005)⁷, the approach taken to evaluating the short, medium and longer term outcomes of Prolead was based on three main considerations.

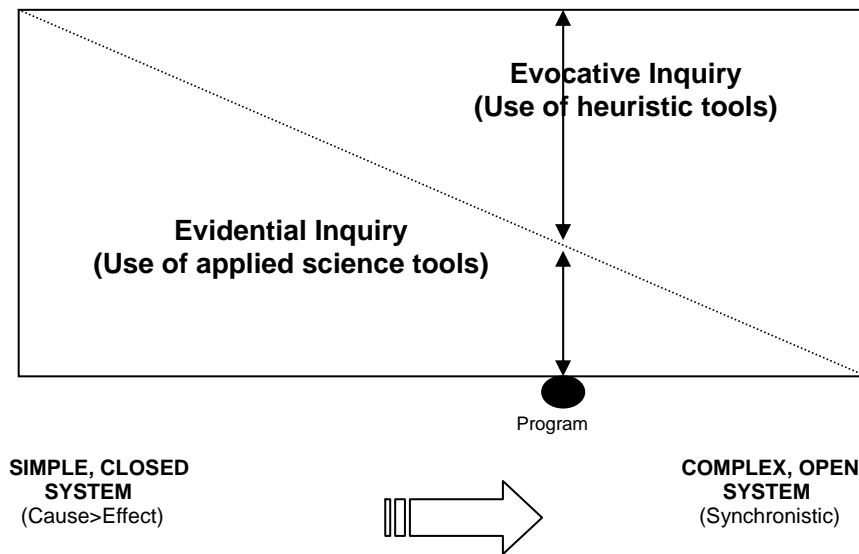
Firstly, Prolead operates within an open system. This means that learning occurs in an environment where various factors other than exposure to the program can influence what attitudes, knowledge and skills are acquired by fellows. Also, changes across a *range of domains* (such as partners and networks, public policy, health systems) may result from numerous influences, not just the enhancement of leadership (through Prolead) in the system. The implications of this are that care needs to be exercised in interpreting data that attempts to measure the impact of Prolead on fellows and the wider environment: attribution of change to the effects of Prolead can be problematic.

Secondly, three *types of change* may occur as a result of fellows' participation in Prolead. Grove, Kibel and Haas (2005) term these changes 'episodic', 'developmental' and 'transformative' but for this evaluation, these terms have been adapted to 'direct results', 'developmental changes' and 'transformative changes'. Essentially, these changes occur in the short term (such as knowledge gained by fellows), medium term (such as a sustained change in work-related behaviour of fellows and their teams such as patterns of decision-making) and longer term (such as shifts in worldview of government teams in which fellows are members or social attitudes to health promotion).

Thirdly, the nature of Prolead is that it provides experiences and frameworks for gaining and testing knowledge, skills and attributes. While certain facts can indicate the program's outcomes, fellows' experience in undertaking Prolead is also an integral dimension to evaluate. Hence, two *forms of inquiry* were used to evaluate Prolead: evidential and evocative inquiry (see **Figure 1**). Evidential inquiry supports an analysis of Prolead by establishing the facts, markers and indicators relevant to the program such as the content and design of its components or how many people participated and completed the program. Evocative inquiry complements this and seeks to establish the opinions, stories and reflections of people influenced by Prolead (such as participants and stakeholders associated with participants).

⁷ Grove J, Kibel BM and Haas T. (2005) EvalUlead Guide. Public Health Institute: Oakland, California. Accessed at <http://www.evalulead.net/docs/EvaluLEADGuidebook.pdf>

Figure 1. Forms of enquiry: Evidential and Evocative enquiry⁸



As a consequence of these three sets of considerations, results from data collection were reported against an evaluation results map (see **Figure 2**). This map depicts the key domains where results were expected and the nature of evidence that needs to be gathered to evaluate the impact of Prolead in these domains (as far as is practicable and sensible given the problems of attribution described above).

⁸ *ibid*, Adapted

Figure 2. Prolead Evaluation Results Map ⁹

KEY:

Type of result: Direct results [I₁, N₁, P₁]

Description: An intervention leads to predictable results.

Direct results are well-defined, short term results stimulated through components of the program (including fellow participants, instructors, mentors, others associated with the program, country-based team project).

Examples: specific knowledge gained, specific program proposals written, convening of a meeting or conference, a change to a policy or organisation.

Type of result: Developmental changes [I₂, N₂, P₂]

Description: Changes that occur across time.

Developmental changes are achievements or even setbacks in making progress on a matter. Results are open-ended, and less controllable and predictable than for direct results due to factors such as the influence of external influences and capacity to change. Developmental changes are those that involve steps taken by an individual, country-based team, organisation or government that strives to and may achieve some outcomes. Unanticipated or uncontrollable conditions and events may determine the pace of change and achievement of outcomes.

Examples: sustained changes in specific aspects of individual behaviour, the a new network or set of partnerships to progress an aspect of government policy, a new organizational strategy that is used to guide priorities and organisational activities, implementation of a health financing reform program.

Type of result: Transformative changes [I₃, N₃, P₃]

Description: Fundamental shifts in individual, organizational or community beliefs, attitudes, values and perspectives which form the basis of fundamental shifts in behaviour or performance.

Transformative changes represent significant changes or conversions among individuals or groups, the ways in which matters are pursued or the behaviour or property of systems. Transformative changes tend to be unexpected and can represent some quite complex changes that ultimately emerge from changes in individual, organizational or community beliefs, attitudes, values and perspectives.

Examples: substantive shifts in points of view/worldview, vision or paradigms; shifts in career trajectories; new directions for policy or organisations; and fundamental reforms in social and political matters.

⁹ *ibid*, Adapted

MAP:

Evidence base/ Data source	Short-term Outcomes		
	INDIVIDUAL Direct results (I₁)	NETWORKS and PARTNERS Direct results (N₁)	PUBLIC POLICY AND HEALTH SYSTEMS Direct results (P₁)
Facts Interviews Program and country documentation	Number of fellows starting and completing Prolead I Demonstrated acquisition of knowledge and skills	Networks and partners associated with Prolead I Mentors matched to fellows	Events and changes occurring in relation to public policy and health systems
Opinions Interviews	Skills and attributes gained during Prolead Contribution of aspects of Prolead to the development of skills and attributes	New networks and partners established or joined during Prolead Contribution of aspects of Prolead to the development of skills and attributes	Events and changes in relation to public policy and health systems that occurred during Prolead Contribution of aspects of Prolead to the development of skills and attributes
Evidence base	Medium-term Outcomes		
	INDIVIDUAL Developmental changes (I₂)	NETWORKS and PARTNERS Developmental changes (N₂)	PUBLIC POLICY AND HEALTH SYSTEMS Developmental changes (P₂)
Markers Interviews Program and country documentation	Changes that have occurred over the medium-term in skills and attributes	Changes that have occurred over the medium term in networks and partners	Changes that have occurred over the medium-term in public policy and health systems
Stories Interviews	Changes that have occurred over the medium-term in skills and attributes Contribution of aspects of Prolead to the development of skills and attributes	Changes that have occurred over the medium term in networks and partners Contribution of aspects of Prolead to the development of networks and partners	Changes that have occurred over the medium-term in public policy and health systems Contribution of aspects of Prolead to changes in public policy and health systems
Evidence base	Longer-term Outcomes		
	INDIVIDUAL Transformative changes (I₃)	NETWORKS and PARTNERS Transformative changes (N₃)	PUBLIC POLICY AND HEALTH SYSTEMS Transformative changes (P₃)
Indicators Interviews Program and country documentation	Changes that have occurred over the longer- term in skills and attributes	Changes that have occurred over the longer- term in networks and partners	Changes that have occurred over the longer- term in public policy and health systems
Reflection Interviews	Changes that have occurred over the longer- term in skills and attributes Contribution of aspects of Prolead to the development of skills and attributes	Changes that have occurred over the longer- term in networks and partners Contribution of aspects of Prolead to the development of networks and partners	Changes that have occurred over the longer- term in public policy and health systems Contribution of aspects of Prolead to changes in public policy and health systems

3.2 Method

Approach

Evidential enquiry was undertaken by reviewing program documentation and interviewing fellows to identify facts concerning the implementation and outcomes (short, medium and longer term) of Prolead I and II. Evocative enquiry was undertaken by interviewing Prolead I fellows¹⁰ and Prolead stakeholders, discussing Prolead II fellows' experiences in a facilitated forum held at WKC in May 2006, and obtaining written responses to a questionnaire from Prolead II fellows. These results are presented in Section 6. Outcomes identified by Prolead fellows primarily related to the short and medium term as not enough time has passed for long term outcomes to emerge.

These results were combined with a re-consideration of the broader context for the implementation of Prolead and recent literature on leadership and leadership development in order to identify issues to consider for further developing Prolead (See Section 7) and a research agenda to support and accompany Prolead (Section 8).

Limitations

Results from the evaluation of Prolead need to be considered in the light of methodological limitations.

- While direct results were obtainable from both Prolead cohorts, only the first cohort (Prolead I fellows) could provide opinions on developmental changes (and transformative changes to a lesser extent, because of the time required for such changes to occur).
- A limited range of data sources were available and accessed for this evaluation. This range could be broadened and deepened, in line with the evaluation results map (Figure 2). For example, tools such as reflective journals could strengthen the data used to identify personal and professional development of fellows; focus groups could be undertaken with stakeholders to identify changes that they associate with Prolead; and types of evidence could be identified and analysed that would show developmental changes and transformative changes at all levels.
- The experience and views of Prolead I and II fellows were captured in different ways. This raises issues for comparability of data from each cohort.
- Formal process evaluation was not undertaken during Prolead (although there were opportunities for continuous feedback between presenters and fellows). The gap in time between the program and the evaluation may have affected fellows' quality of recall.
- Formal stakeholder evaluation was not undertaken, although there were a range of opportunities for continued dialogue between stakeholders, program presenters and fellows.

Prolead I cohort:

- Just over half of all fellows (8 out of 14) responded to the invitation to take part in interviews. All but two of these interviews were conducted by telephone – the others were undertaken through an email exchange that involved the fellows writing answers to questions in the interview schedule. Despite the response rate being just over 50%, some degree of saturation of responses was observed.
- To record fellows' responses from telephone interviews, notes were taken by the same evaluator in order to provide a measure of consistency. However, calls were not audio-taped and data quality was not verified.

¹⁰ See Appendix 1 for schedule of questions used for interviewing Prolead fellows

- Interviews were conducted in English, which was not the first language of some fellows. This may have produced some errors, resulting from misinterpretation by the evaluator of fellows' views for example.

Prolead II cohort:

- Prolead II fellows wrote answers to questions on the interview schedule. 16 out of a total of 22 fellows (72%) provided written responses.
- Fellows responded in English to the interview schedule, which was not the first language of some fellows. This may have affected the ability of the data collection tool to collect reliable data.

Given the ongoing nature of Prolead, and the importance of measuring medium and longer term outcomes, further work is warranted on the evaluation strategy, in particular the identification of indicators of change, data sources and data collection methods needed to indicate change at multiple levels. Methodological limitations can be addressed through further development of the evaluation strategy for Prolead III.

Section 4. Foundations of Prolead

4.1 Context

The Global Institute for Responsible Leadership¹¹ described the context for leadership in the following way: ‘At the opening of the 21st century, we face increasing tensions and clashing forces throughout the world. This rising tide of critical issues includes:

- A *social and economic divide* between the rich and the poor;
- An *ecological divide* between global economic development and nature;
- A *cultural divide* between a materialistic world view and a world view that embraces the more subtle dimensions of human perception and experience; and
- An *ideological divide* between the proponents of financial capitalism and advocates for a broader capitalism that also values human, social, and natural capital.’

The context for leadership is also characterised by new opportunities brought about by technological developments in fields such as telecommunications, and social developments such as increasing attention to governance and recognition of the contribution of civil society in effecting change. These sets of issues point to the complexity of the task for health promotion leaders and pose important challenges for leadership development. It is in this context that Prolead was conceptualised and designed by WHO-WPRO.

4.2 Concepts of leaders, leadership and leadership development programs

To inform the design of Prolead and with a view to learning from lessons and insights gained from practice, recent literature (1990-2002) on leaders, leadership and leadership development was examined by SPH-LTU in 2002. This analysis identified a number of themes:

- There are distinctions between *leaders* and *managers*, as well as *leadership development* and *management development*, that need to be considered in designing leadership development programs
- The *concept of leadership* and *philosophy of leadership development* underpinning leadership development programs are often poorly defined and nebulous yet directly influence the nature of outcomes a program is expected to achieve. They should be explicitly considered when designing a leadership development program
- A number of *specific components* or *elements* are commonly found in leadership development programs (such as formal curriculum delivered through a group learning process, action research-type project, mentoring). However, no one model satisfies the requirements of all situations and all cultural contexts.

The literature also pointed to a shift that has been observed in recent decades concerning who are the leaders in any organisational system. There is general agreement that leadership no longer solely arises from individuals who occupy designated leadership positions in formal organisations, such as executive directors or

¹¹ The Global Institute for Responsible Leadership. About the Institute. Accessed at http://www.theglobalinstitute.org/L2_theinst.html#prem

chief executive officers. Rather, individuals in positions throughout a system, community or organization who have leadership qualities and skills can also exercise considerable sway by bringing people together, coordinating activities and influencing the ways work is accomplished. In emphasising this point, a group of leading international researchers in leadership have concluded that: “While it is not valid,... to associate leadership with managerial rank, it is valid to associate leadership with spirit, energy, patience, perseverance and imagination” and “these are the mark of effective leadership at all levels.”¹²

A concomitant shift has been observed in thinking about the nature of leadership, from what some term as an ‘industrial paradigm’ (where designated leaders use a top-down approach to making decisions, are a model of efficiency and exercise a command-and-control approach) to a ‘post-industrial paradigm’ (leaders throughout a system promote collaboration and consensus, facilitate the achievement of goals and empower others).¹³ The following definition represented common thinking in the literature about the concept of leadership:

*‘interpersonal influence over and above the influence that stems from a person’s positional authority or legitimate power’ and ‘has the effect of influencing the activities of others toward some defined goal’.*¹⁴

Leadership is thus widely regarded as a social process that employs interpersonal skills and occurs through a team approach. While leadership involves defining what needs to be done, working out how to get it done and most importantly, getting people to do it, carrying out these activities is no longer the sole domain of one conspicuous individual at the top of a system or organisation.

In exerting their interpersonal influence, people assuming leadership roles have commonly been found to demonstrate a range of behaviours and approaches to their tasks¹⁵: motivating and coordinating others towards a set of objectives; influencing or persuading others by example (modelling) or persuasion to bring about change; appreciating and learning from the past but willing to explore new pathways; working in circumstances that have ambiguity or paradox, yet discerning and communicating clear ways forward; sensing and actualising emerging opportunities. Leadership development programs have pursued approaches to developing the skills and attributes that enable these behaviours and approaches to thrive. See **Table 1**.

¹² Arthur WB, Day J, Jaworski J, et al. Illuminating the Blind Spot: Leadership in the Context of Emerging Worlds: 20 Propositions Based on Conversations Among the Authors and Dialogue-Interviews with Thought Leaders on Knowledge and Leadership. Summary Paper on an Ongoing Research Project. Accessed at <http://www.dialogonleadership.org/WhitePapertoc.html>

¹³ Rost, JC (1993) Leadership for the twenty-first century. Westport, CT: Praeger

¹⁴ Campbell DJ, Dardis G, Campbell KM. Enhancing incremental influence: a focused approach to leadership development. *Journal of Leadership and Organisational Studies*, 2003; 10 (1)

¹⁵ Arthur WB, Day J, Jaworski J, et al. Illuminating the Blind Spot: Leadership in the Context of Emerging Worlds: 20 Propositions Based on Conversations Among the Authors and Dialogue-Interviews with Thought Leaders on Knowledge and Leadership. Summary Paper on an Ongoing Research Project. Accessed at <http://www.dialogonleadership.org/WhitePapertoc.html>

Table 1: Typical leadership skills and attributes

Category	Generic Leadership Qualities and Skills ^{16 17}
Intra-personal qualities	Self-awareness; self-regulation; self-motivation; "appropriate" set of beliefs, values and ethics; moral character and integrity; loyalty
Inter-personal qualities	Build and maintain teams; establish trust; demonstrate respect (re gender, culture, nationality, religion etc); listen empathetically and show sensitivity to others; provide helpful feedback; take initiative; motivate others; empower others; manage conflict
Cognitive skills	Detect, analyse and solve problems; see and generate alternative problem solutions; explore and resolve ambiguity; question assumptions
Communication skills	Articulate and express a vision; communicate with influence
Task-specific skills	Expertise to carry out certain tasks; knowledge of particular specialised content areas that enables structuring of tasks and clarification of objectives, resolution of ambiguities about how to proceed, provide direction

Distinctions between leadership development and management development can be subtle, but are important to make in order to focus a leadership development model. Leaders and managers have been described as differing in terms of their motivations and behaviours, in their perspectives and approach to change, and in the processes they emphasise. ⁹ Distinctions between these two roles (which might often be fulfilled by the same person) are represented in **Table 2**. ¹⁸

Table 2: Distinctions between management and leadership ¹⁹

Activity	Management	Leadership
Agenda creation	Planning/ budgeting: Developing detailed strategic plans Allocating resources	Establishing direction: Developing future vision Articulating the vision in a way to inspire others
Human resource development for achievement	Organising/staffing: Developing planning and staffing structures, aims and objectives Providing policies and procedures for guidance, and monitoring systems	Aligning people: Enthusiasing others to join in achieving the vision Creating teams that understand and are engaged in developing the vision and means to achieve it
Execution	Controlling/problem solving: Detailed monitoring of results Identifying deviations, organising corrections	Motivating/inspiring: Energising staff to overcome barriers by inspiring, maintaining positive expectations, valuing and developing
Outcomes	Tends to produce: Order/predictability, efficiency Results expected by stakeholders	Tends to produce: Change, often dramatic, and potential for effective change

To achieve the influence expected from leadership, certain skills and attributes are necessary and it is the primary role of leadership development programs to offer exposure to concepts, ideas and information, methods of learning and opportunities for experience that initiate or hasten the development of these characteristics.

¹⁶ Australian Public Service Commission. Senior Executive leadership development - Programs and Services. World Wide Web accessed 20 June, 2003: <http://www.apsc.gov.au>

¹⁷ Reinelt C, Foster P, Sullivan S. Evaluating Outcomes and Impacts: A Scan of 55 Leadership Development Programs. World Wide Web accessed 3 June, 2003: <http://www.developmentguild.com/customers/10-02WKKFLeadershipScan.pdf>

¹⁸ Queensland Health. Leadership Development Framework. Accessed 1 July, 2003: http://www.health.qld.gov.au/about_qhealth/ldf/default.asp

¹⁹ Boaden RJ (2006). Leadership and Organisation Development Journal. 27 (1): 5-27

Health promotion leadership has much in common with other forms of leadership, requiring individuals to apply personal and professional skills and attributes to conceptualise problems, build teams and pursue strategies to bring about change at multiple levels. However, some important distinctions can also be drawn.

Health promotion leadership may involve operating across more than one *jurisdiction*. In the current era, where globalisation is re-shaping almost every aspect of our lives and environments, unprecedented cooperation is required to act on the determinants of health and use the social technology provided by health promotion to bring about changes in favour of health. Cooperation across programs and sectors at the local and national levels will be insufficient to make sustainable change however: governments and other players operating at supra-national, regional and global levels are also critical to achieving improvements in population health.

As a consequence, health promotion leadership entails bold and creative work at *multiple interfaces* involving numerous stakeholders and within the ‘messiness’ of complex systems. Those involved in health promotion leadership may find that they are substantially involved in ‘interface management’, working at the boundaries of government, statutory authorities, communities and other stakeholders. For instance, efforts to improve population health require action not only by the health sector, but by other public sectors whose activities are associated with health determinants such as social welfare, agriculture, labour market regulation, education and urban planning. While leadership is about the person not the position, in some countries, particularly in Asian cultures, the word ‘leader’ is used to point to those who occupy senior political or high-level administrative offices. In these countries, a particular leadership challenge for individuals working in health promotion is to motivate senior-level, officially designated leaders in health and non-health sectors to sign on as “champions”, and to develop leadership qualities in others across relevant organisations who can assist in this process.

Health promotion leadership requires individuals to have a particularly sophisticated *toolkit of skills* that comprise a broad range of knowledge and know-how associated with public policy and programs - governance, financing, program development and delivery and stakeholder management. Complementing such skills is the *repertoire of personal attributes* associated with high performance, working in teams and as ‘boundary spanners’²⁰ such as good judgement, honesty, persuasion, diplomacy, and confidence to resolve ambiguous situation and conflict.

²⁰ Stern R and Green J (2005). Boundary workers and the management of frustration: a case study of two Healthy City partnerships. *Health Promotion International*. 20 (3): 269-276.

Section 5. From Prolead I to Prolead II

5.1 Scope of changes

Prolead's pilot program model reflected the program's strategic intent: to develop health promotion leadership in countries in the Western Pacific region by drawing potential leaders in health into a learning environment for problem-solving and strategic decision-making. The *program focus* was based around current and future strategic challenges for health promotion leaders. The *program model* featured a nine-month formal program (*coursework and country-based team projects*), *individual mentoring* and informal activities (such as participation in international meetings).

Assessment by fellows, course facilitators and other stakeholders of the implementation and short term impacts of Prolead I enabled modifications to be made to enhance the relevance and effectiveness of Prolead II. The shifts from Prolead I to Prolead II are summarised (see **Table 3**) and further described below.

Table 3: Summary of changes in Prolead features and components

	Prolead I	Prolead II
Program features		
Strategic intent	Develop applied team leadership and management in countries across the Western Pacific region	Develop applied team leadership and management in countries globally
Focus	Securing infrastructure and financing for health promotion	Governance for health
Fellows	15 fellows from 6 countries in Western Pacific region: Fiji, Tonga, Malaysia, Philippines, China (Shanghai), Mongolia	Participation expanded; 18 fellows from six countries in three regions (Western Pacific – Japan (Kobe), Korea, Vietnam (Hue); Eastern Mediterranean – Oman, Lebanon; South East Asia – India (Bangalore) plus 4 fellows from SEAMEO-TROPED Network
Structure	9 month program	Duration of program maintained
Program components		
Coursework	Delivered in three modules; spanned technical, political and personal skills required for leadership in health promotion	Same structure; content sequencing changed
Country-based team projects	Country teams comprising 2-3 individuals; Projects focused on securing infrastructure and financing for health promotion in countries	Same structure; Projects were more diverse in focus but all related to the core process of governance for health
Mentoring	All fellows matched to individual mentors based on a defined matching process during Module 2 Team mentoring by health promotion foundations, organised during Module 2 via International Network of HP Foundations	Fellows matched to mentors on request; Country teams matched with appropriate mentoring organisations in Module 1; mentoring organisations attended Module 2
Other activities	Module 2 coincided with Regional workshop on economic gains of promoting health Fellows attended the 6th GCHP, Bangkok, Thailand (August 2005)	Fellows attended the 6th GCHP, Bangkok, Thailand (August 2005)

5.2 Changes in program characteristics

5.2.1 *Strategic intent and Focus*

The strategic intent of Prolead I reflected WHO-WPRO capacity-building priorities: to develop applied team leadership and management in countries across the Western Pacific region in order to secure infrastructure and sustainable financing for health promotion (specifically the use of tobacco taxes for health promotion foundations).

Two factors combined to shift the strategic intent for Prolead II. Reflecting feedback from Prolead I fellows, there was a re-focusing on the more fundamental process underpinning system dynamics - governance for health. As Burris²¹ states, governance refers to the management of the course of multiple events within a system and is a crucial factor for health promotion because it influences health and what health promotion activities will proceed. Pursuit of this agenda was considered to be central to the task of improving the health of populations and would need considerable leadership within and across countries to carry it forward. Also, interest in Prolead had emerged from other regions as well as at the city level during the pilot program, so the program was rolled out globally for Prolead II.

5.2.2 *Fellows*

Appendix 2 provides details about Prolead fellows. The goal was for fellows to be individuals who are recognised as leaders in health promotion, who currently work in professional areas and demonstrate potential in influencing the complex policy environment that affects health promotion outcomes. Thus, the Prolead teams comprised key health promotion personnel, working in a team with fellows who represented key partners for health promotion work. The focus was, therefore, not solely on individual training, but on team building for strategic thinking and practical problem-solving within countries.

5.2.3 *Structure and Coursework*

An important role played by Prolead is to expose fellows to the most up-to-date thinking, debates, evidence and research in content areas central to leadership development (such as the challenges of leadership, drivers of change in systems, public health systems, reform processes and health promotion) as well as provide opportunities to discuss these matters in relation to their own and other countries. Prolead also provides an opportunity for skills in using key practical tools for situation assessment, planning and evaluation to be gained and practised.

In Prolead I coursework was offered in three modules over nine-months and this approach was sustained for Prolead II. However, the timing and sequencing of the delivery of coursework content changed to suit the needs of each group. (See **Table 4**)

²¹ Burris S (2005). Nodal governance and the economic gains of promoting health. Presentation at prolead II, 25 July-August 2005, Bangkok Thailand. Accessible at <http://www.who.jp/CHP/papers.html>

Table 4: Changes in structure and coursework

Coursework		
	Prolead I	Prolead II: A Health Governance Initiative
Objective	To enhance practical skills among teams across five categories (intrapersonal qualities, interpersonal qualities, cognitive skills, communication skills and task-specific skills) that are required for leadership to secure sustainable health promotion infrastructure and financing.	To enhance practical skills among teams across five categories (intrapersonal qualities, interpersonal qualities, cognitive skills, communication skills and task-specific skills) that may be needed to improve governance for health promotion, with a sub-focus on new and autonomous structures and sustainable financing to address challenges brought about by glocalisation.
Module 1	<p>26 July – 6 August 2004 Manila, Philippines Course overview Health promotion infrastructure and financing Country team reports Personality Insights Profile Team building Effective leadership Health sector reform Health care financing Health promotion and Governance Public-Private partnerships for health Total quality management Presentation of health promotion infrastructure and financing project proposals Effective communication Social mobilisation and advocacy Media relations Negotiation Tobacco taxes Other financing arrangements for health promotion Health promotion foundations Health promotion legislation Field visits Synthesis and processing</p>	<p>25 July – 3 August 2005 Bangkok, Thailand Course overview Health promotion leadership challenges and issues Globalization and health Nodal governance Defining health promotion issues at the <i>glocal</i> interphase Country team reports Behavior style analysis Effective leadership Team building Health sector reform and health promotion financing <ul style="list-style-type: none"> ➤ Tobacco taxation and health promotion ➤ Public private partnerships for the promotion of health ➤ Social health insurance for health promotion ➤ Local government funding for health promotion Introduction to total quality management and governance <ul style="list-style-type: none"> ✓ <i>Theme selection</i> ✓ <i>Reasons to improve</i> ✓ <i>Customer values assessment</i> ✓ <i>Analysis</i> ✓ <i>Countermeasure and practical methods</i> ✓ <i>Results, standardization and future plans</i> Effective communication, social mobilization and advocacy Field visit to ThaiHealth Participation in <i>Leaders Forum on capacity building for the promotion of health and 6th Global Conference on Health Promotion</i> Presentation of project proposals</p>
Module 2	<p>15 – 26 November 2004 Manila, Philippines Change management and organisational development Special topics: governance; economic arguments for promoting health Participation in the <i>Regional meeting on the economic gains of promoting health (22-25 November)</i> Project updates</p>	<p>5–9 December 2005 Kobe, Japan Change management and organisational development Case studies of health promotion foundations, Healthy Cities and public private partnerships for health Negotiation skills Project Updates Assessment on mentoring Discussion on country-based team projects</p>
Module 3	<p>28-29 March 2005 Manila, Philippines Project presentations Poster presentations Course graduation ceremony</p>	<p>20–22 April 2006 Kobe, Japan Project presentations Course evaluation Course graduation ceremony</p>

5.2.4 Country-based team projects and Mentoring

Country-based team projects are a core feature of Prolead, designed to nurture a core of in-country expertise and to offer fellows the opportunity to work with colleagues on relevant, practical projects that advance countries' health promotion capacity- building agendas.

One of the prerequisites for completing Prolead and obtaining a certificate of training is the development by each team of an applied project on health promotion that should:

- Contribute to knowledge on bridging gaps between local and national health promotion action;
- Address policies related to sustainability of health promotion at the global interface;
- Result in improved governance and/or organizational practice;
- Demonstrate how individual and team leadership skills are applied to specific situations; and
- Include "leverage" of counterpart funding and cost-sharing at project inception.

In Prolead I, projects undertaken by country-based teams (two to three individuals) were concerned with enhancing an area of general weakness in the Western Pacific region - mobilising partnerships and autonomous, sustainable financing to build health promotion infrastructure. Using specific tools introduced during coursework, the teams undertook strategic analysis of the problems they faced, and developed action plans for implementation during the course of the program.

Prolead II fellows took on the expanded scope of governance as their starting point, and projects were thus more diverse in nature. Each Prolead team was linked to a mentor institution to assist them in developing and implementing their projects. (See **Table 5** below for projects and mentoring organisations)

Mentoring was offered as an integral component of Prolead from its inception, as a means for fellows to gain guidance and support, to be challenged and extended. In Prolead I, mentoring commenced in Module 2 and comprised two tiers: individual mentoring and organisational mentoring of country teams (or 'project twinning'). First tier mentoring focused on individual fellows and involved matching a Prolead fellow with a senior professional with relevant background and experiences. Mentoring included a variety of activities designed to support the fellow in developing confidence, skills and know-how: informal and formal support, sharing of information and experiences, extension of networks and opportunities for learning and practice and guided learning about issues of relevance to the fellow. Second tier mentoring involved supporting fellows as a group, by offering project and policy guidance as they developed and implemented country-based team projects. Project mentoring or 'twinning' was made available from several leading health promotion bodies.

In Prolead II, as a result of piloting the dual mentoring components, mentoring began in Module 1 and was conducted primarily through a single tier; country-based teams were linked with leading health institutions from around the world. Resources were made available for optional face-to-face mentoring as desired by individual fellows.

Table 5: Changes in country-based team projects and project mentoring

	Country	Project title	Project Mentoring/ Organisational Twinning
Prolead I: Mentoring commenced in Module 2			
Western Pacific Region	China	<i>Academics and implementers</i>	ThaiHealth
	Fiji	<i>National and local levels of governance</i>	VicHealth
	Malaysia	<i>State and private sector partnership</i>	Australian Centre for Health Promotion
	Mongolia	<i>Health educators and health policy advocates</i>	ThaiHealth
	Philippines	<i>Legislative and executive branches of government</i>	Swiss Health Promotion Foundation
	Tonga	<i>Political leaders and career civil servants</i>	VicHealth
Prolead II: Mentoring commenced in Module 1			
Western Pacific Region	Japan	<i>Mental health promotion for emergency room staff in Kobe and Promoting food safety in disaster management plans in Hyogo Prefecture</i>	WHO Kobe Centre – Japan; visit to St Vincent's Hospital, Melbourne, Australia
	Vietnam	<i>Involving stakeholders in health promotion</i>	City of Kuching, Malaysia
	Republic of Korea	<i>Building consensus on the strategic vision for the health promotion fund</i>	Mr Joe Hafey and the Public Health Institute, California - USA
Eastern Mediterranean Region	Lebanon	<i>Creating a mechanism to coordinate media coverage of health issues</i>	Dr Bushra Jabre and the Johns Hopkins Centre for Communication Programs – USA
	Oman	<i>Revitalising health promotion in Oman</i>	Dr Bertino Somaini and Swiss Health Promotion Foundation – Switzerland
South East Asian Region	India	<i>Advocacy and development of partnership for a health promotion foundation in Bangalore</i>	Initial advice from Ms Addy Carroll; visit to City of Kuching
	SEAMEO-TROPED Network	<i>Enhancing human resource development in health promotion</i>	Assistance from La Trobe University, Deakin University – Australia; University of Minnesota, USA

Section 6. Evaluation outcomes: the Prolead difference

6.1 Process evaluation of Prolead

Fellows' opinions about the design and implementation of Prolead played an important role in process evaluation of Prolead and were complemented by feedback at various points from other stakeholders (such as mentors and course facilitators). Fellows all stated that they enjoyed the program very much, particularly as it introduced them to colleagues from a number of other countries in the region and international experts on areas such as health promotion, communications, governance and financing. This international dimension seemed to inspire fellows and in itself provided significant learnings because it offered continuous opportunities to gain insights through comparing and contrasting. Fellows' experience of Prolead was satisfying and very positive overall. They regarded highly the relevant focus of the program, its design and the quality of its implementation.

Feedback about Prolead's design and implementation from fellows and stakeholders are presented below in terms of four aspects of Prolead: strategic intent and focus, structure and coursework, country-based team projects and mentoring, and other activities. Suggestions for changes to Prolead overall and in specific components are included in the later section of this report: 'Suggestions for program enhancement'.

6.1.1 Strategic intent and Focus

With regard to the process and content of Prolead, one set of stakeholders remarked that a number of Prolead objectives have ongoing relevance to them, namely: to develop new skills and knowledge to be shared among health promotion experts to intensify health promotion actions in various country settings; to discuss health promotion programmes from new perspectives e.g health infrastructure and financing; and to exchange health promotion experiences and best practices across different countries.

6.1.2 Structure and Coursework

The structure of three modules, delivered over a nine-month period, was stated by a number of fellows to be useful because it allowed for applied learning and the testing of new information, ideas and skills to take place in-country. The third module was considered by some to have some unrealised potential: fellows are brought together for only two days and, given the distance fellows travelled to be present, this could be extended and further opportunities organised for learning and networking. While the structure worked well, some fellows thought that consideration could be given to expanding the program to four modules, although it was not clear what strategic objectives or content this might have.

All coursework sessions were held at a common base. For Prolead I, this was at WHO in Manila and for Prolead II, this was at WKC. As a result of mixing with fellows from another cohort, one fellow commented that their learning could be enriched even more if Prolead could be delivered in a variety of locations other than the base location, in order to expose them to the issues and activities of other countries and enable them to access the depth of resources that are distributed through the region.

In Prolead I, there was a tendency for fellows to see the program as comprising the three modules, that is, with the program concluding at the end of the third module.

Yet, neither the individual mentoring nor project twinning were finalised until the second module, resulting in a lack of synchronicity to some extent. This was addressed in the implementation of Prolead II.

Fellows regarded coursework as offering substantial information, concepts, skills, ideas and tools in important and relevant areas of knowledge and competency. Coursework on financing and governance were noted as particularly valuable because they related to things that are needed to make health promotion happen, such as money and authority. Coursework also enabled fellows to develop some skills in teaching and research and develop useful networks and partners for curriculum development and research.

The introduction of tools (such as total quality management tools and health report cards) was appreciated because they expanded fellows' repertoire of tools for effective planning and implementation.

Developing team project proposals during the coursework was felt to be a critical learning experience for some fellows because it required teamwork and the identification of which issue was significant for fellows' countries and then the collaborative formulation of a way of tackling it.

6.1.3 Country-based team projects and mentoring

In Prolead I, team projects responded to current and emergent policy challenges relevant to fellows' countries but associated with securing health promotion infrastructure and capacity. For Prolead II, enhancing systems of governance to support health promotion was emphasised in team projects. Projects were seen as a creative way of applying the concepts learned in the coursework while strengthening health promotion in the region.

Country-based teams rather than lone individuals were recruited for Prolead. Fellows viewed country-based teams as a critical feature of Prolead; it helped them to forge working relationships with in-country health promotion partners and provided teams with opportunities to fine-tune their own projects by sharing ideas and information with other teams. Useful networks and partners were introduced.

Most fellows reflected on the extent to which they enjoyed their team project and its value as an applied professional and personal learning exercise. It was considered a creative way of applying the concepts and strengthening health promotion in the region. Specific skills and confidence were identified as gains by a number of fellows. The projects also challenged fellows to consider others' views more deeply and work with others to optimise their strengths rather than struggle to make others change.

Support provided within teams and to teams by the Prolead faculty were both appreciated by fellows. They recognised that the support from external parties, provided through individual mentoring and organisational twinning of country-based team projects, was potentially useful for their professional development and to achieve project objectives.

Mentoring was evaluated following the conclusion of Prolead I through discussion with mentors and fellows²². As well, mentoring was discussed in interviews with fellows for this evaluation process. One of the key challenges of Prolead relates to the challenges of communicating across countries (with or without additional resources)

²² Lin V and Fawkes S (2005). Final report. WHO reference: Project ICP/HSE/2.3/001. School of Public Health, La Trobe University

and across geographical, cultural and interpersonal barriers. This was an issue for both tiers of mentoring (individual and organisational). The additional resources invested in the organisational mentoring/ project twinning component of Prolead I enabled face-to-face communication between mentors and fellows. This demonstrated that direct, informal communication between people is needed to build quality communication and in turn, to build understanding and cooperation and realise the benefits of mentoring.

The essential prerequisites for satisfying experiences of individual and organisational mentoring were identified as a good matching of and introductions among participants; adequate preparation and planning around aims, objectives, processes; time; commitment by both parties; and resources. Establishing trust and ways of communicating effectively cannot be forced and require time. Identifying and addressing any geographical, cultural, and interpersonal barriers also require time, commitment and resources. The earlier in the program that contact with individual or organisational mentors can be established, the more support and guidance fellows can receive in their experience of leadership development and the more team projects can benefit from the expertise and insights of mentors. Making contact initially through a face-to-face meeting was generally considered to be essential to a high quality, satisfying and productive mentoring experience. This was demonstrated by the proactive involvement of ThaiHealth with fellows from Mongolia: two visits by the ThaiHealth colleagues enabled 'old ways' of thinking to be challenged, such as it is the role of the government or the country to look after the population, and brought experts to Mongolia, including from WHO, to consider healthy public policy and health system reforms.

It was suggested that fellows who have completed Prolead could be involved as mentors in future Prolead programs.

6.1.4 Other activities

Prolead I fellows were able to attend a number of field visits and, after the conclusion of Prolead I, the 6th GCHP. Fellows valued their participation in these activities for different reasons, referring to these experiences as 'uplifting', 'energising', 'motivating'.

The field visit to the Philippines Senate ²³ was timely for some fellows who were engaged in developing bills for tobacco tax for their own country. This visit included meeting with ministers and top management, which provided fellows with critical insights into the processes of advocating for, and carrying through, a tobacco tax.

The regional meeting on the economic gains of promoting health ²⁴ was organised by WHO-WPRO and attended by Prolead fellows, health promotion foundations/funds from Australia, Thailand, Korea and Switzerland), UNDP, World Bank and various technical advisors and representatives/observers. Fellows valued this meeting for the relevance of its specific foci: making the economic case for health promotion at the highest levels of government, financing options to secure health promotion and coverage of political and technical challenges in advocating for, initiating and leading financing institutions.

The field visit to ThaiHealth occurred just prior to the 6th GCHP and several months after Prolead I was formally completed. It was regarded as important because it

²³ Manila - Module 1: July/August 2004

²⁴ Manila - Module 2: 22-25 November 2004

renewed contact between fellows and CEOs from other health promotion foundations and helped some teams to discuss issues and resolve dilemmas associated with their projects. It also introduced Prolead I fellows to Prolead II fellows (who were undertaking Module I) which helped to expand the professional networks of both groups.

Participation in the 6th GCHP extended fellows' knowledge in some important areas. As well, the conference exposed fellows to leaders in key areas of health promotion and colleagues from other countries who were working on similar challenges. The chance to move from room to room and gain insight into a wide range of research, debates and strategies was considered very valuable. Fellows were able to present their projects at the conference, which helped them gain confidence in what they are doing and their own presentation performance, as well as expanding their networks for further discussion.

Some fellows had the opportunity to take part in a radio interview in Manila on Prolead. This experience was beneficial for the fellows involved (boosting their confidence and testing their presentation skills) and also Prolead (by exposing it to a broader audience).

6.2 Impact evaluation of Prolead

As well as offering opinions about the goals and conduct of Prolead itself, fellows identified some of the direct results and developmental and transformative changes resulting from their participation in Prolead. Stakeholders including WHO-WPRO provided insights into the impact of Prolead at the country and regional levels. Their remarks, and other information indicating impact, are summarised below.

Many of the same direct results were achieved from Prolead II as were achieved from Prolead I. This is not surprising, given that both programs were similar in terms of objectives, coursework and country-based team projects. The focus on governance in Prolead II however, led to qualitatively different types of networks and partnerships being called on and formed. The final module of Prolead II had been just completed when this evaluation process was undertaken, so further changes (developmental and transformative) will need to be explored in future evaluations.

6.2.1 Direct results from Prolead

Direct results fellows attributed to Prolead appear in Appendices 4 and 5.

Individuals (I₁)

Fellows observed they had changed personally as a result of the program. They believed that experiences in Prolead had increased their self-knowledge (such as patterns of thinking and working, styles of communicating) and enhanced confidence in their own self-management and 'internal reserves'. Prolead prompted changes in their personal behaviour, such as demonstrating patience and determination, more acceptance and tolerance and increased assertiveness with colleagues, being persistent when problems seem insurmountable and developing a proactive mindset.

Fellows also identified changes at a professional level. They were: using new ways to solve problems and achieve consensus; open to and pursuing more collaborative ways of working such as in networks and with other sectors; working for change; maintaining composure in interactions; seeking out their own sources of first hand information to support decision-making; feeling more confident in making

presentations. Some fellows noted that their approach to decision-making was less rushed and had taken on a more strategic and systemic focus because of their exposure to the 'bigger picture' associated with their work.

Prolead was also identified as playing an instrumental role in enhancing fellows' knowledge about how other people think, problem-solve and become motivated, and raised awareness of the significance of fellows' personal roles as health promoters. One fellow expressed this as having 'developed a deeper understanding of how important negotiation and interpersonal relations are in what we do as people who promote health.' Valued friendships formed as a result of cooperative learning and socialising during Prolead.

Prolead provided the means for fellows to gain concepts and skills that they applied in their work settings. Many were able to apply techniques to investigate the root cause of problems, and this underpinned thinking that was more strategic and reflected a systems perspective. Approaches to CQI / TQM (continuous quality improvement/ total quality management) were able to be transferred to other activities. Skills in nodal governance mapping enabled some fellows to become more aware of non-traditional partners in health promotion and encouraged them to more routinely seek and engage colleagues outside their normal set of relationships.

Some fellows remarked that they had taken on a more educative function. Some fellows were keen to educate colleagues about health promotion while others had assumed responsibilities and become a reference point for developing and reviewing educational activities and health promotion curricula

Some fellows remarked that during Prolead, they gained confidence and comfort in their role as health promoters. In particular, Prolead enabled some fellows to feel part of a group that works on high-level policy and program matters even if their day-to-day role was usually more 'on the ground': they recognised that they had valuable skills, knowledge and 'know-how' that complemented both that of other country team members who operated at higher policy levels in the system and the Prolead cohort as a whole. Fellows whose backgrounds were not primarily in health also said that they quickly appreciated they had a key role to play in health promotion on the basis of their skills and influence in their government hierarchy because they could facilitate policy change, institutional or legislative reform or resource mobilisation.

Most Prolead fellows said they developed a greater practical understanding of health promotion, their own role and that of their Ministry of Health or organization in promoting health and the challenges for health promotion that arise from today's complex environment. Some fellows stated they had developed more interest in changing public and health system policies as a result of Prolead. A key learning was the distinction between health education or 'IEC' (information, education, communication,) and the more complex notion of health promotion (as defined by the Ottawa Charter and concerned with advocacy, negotiation, mediating between many differing interests). This distinction was important because it related to *what* health promoters do and *how*.

Increased knowledge was gained by fellows in areas covered by coursework and encountered in team projects. Fellows highlighted total quality management, financing, advocacy, negotiation skills, designing and implementing projects.

Prolead fellows said they also gained many useful skills such as how to:

- do thorough assessments of problems and issues (eg the Ishikawa cause and effect diagrams (or 'fishbone'))

- approach problem-solving in different ways
- use tools to profile the health of a population and develop a strategic focus for investing in health development
- develop advocacy tools for use in recruiting stakeholder support
- access and use evidence in developing programs
- evaluate programs and produce evidence
- argue for health promotion
- write reports and prepare submissions
- use computers and different forms of software, and apply these skills for report writing, research, communication and networking
- present information to colleagues 'up the ladder' and 'down the ladder'.

The personal confidence of fellows who don't normally travel for work outside their countries was also bolstered by having to travel to Manila for the Prolead course and Bangkok for the 6th GCHP. This challenged them in a variety of ways, from organising the logistics of travel to interacting with people from many walks of life and a variety of countries, and led to a sense of personal achievement.

Awareness of the politics of health promotion (that is, to bring about change, the existing base of power and resources of an organization may be threatened, or perceived to be under threat) was enhanced through coursework and team projects in particular,

Among the fellows who took up the personal mentoring opportunity some said that it provided a sense of being important and cared for and deserving of interest by people in senior roles. Fellows explained that these perceptions had positive effects on their self-esteem and motivation, and made a difference to their approaches to decision-making.

Most fellows believed that their colleagues (peers and senior personnel) appreciated the value of Prolead and thought it has made a difference to their confidence and performance. In some cases, the ways that colleagues interacted with fellows changed for the better, including demonstrating more respect for their views, knowledge and judgements.

In general, the above changes were attributed to the combination of activities that comprised Prolead, rather than one specific element, and from exposure to various materials and products (such as Covey's books), which provided fellows with tools to increase their personal knowledge and effectiveness. Mentoring was seen by some fellows as useful and in some cases able to provide valued technical support as well as personal support.

Networks and Partners (N₁)

Fellows had the view that Prolead was regarded by their colleagues as having value, credibility and legitimacy (because of the WHO sponsorship) and would lead to better performance.

Numerous functional networks and partnerships were established by all teams in the process of advancing their team project objectives.

Fellows benefited in a range of ways from meeting each other and course faculty members from other countries, by listening to their stories of health promotion and capacity building and learning from their experiences. Benefits included increasing their knowledge of other countries in the region (their social and political contexts and health issues), expanding fellows' awareness of which problems are common across countries

(such as inadequate and insecure funding for health promotion), identifying new ways of approaching problems (such as mobilising community support to create political pressure of policy change) and detecting possibilities for international collaborations around specific themes (such as Healthy Islands).

For some countries, Prolead led to the formation of a nucleus of health promotion leaders (the fellows) that, while pursuing a team project, advanced action on securing infrastructure and financing for health promotion. In some cases, this work involved developing and using advocacy tools to scale up support among governments and public, making presentations and convening in-country meetings to gain stakeholder support and participation in developing a taxation base from tobacco/alcohol for health promotion. Along the way, skills learned during Prolead were applied in recruiting new networks and partners.

Opportunities to exchange information and ideas with each other and dozens of international colleagues occurred during the nine-month Prolead program, at the 6th GCHP, at the Regional meeting on the economic gains of promoting health and during field visits. These meetings allowed fellows to make important contacts and share learning experiences with people in their *own* countries – ministers, bureaucrats and key health promotion stakeholders. Mentioned by one set of stakeholders as valuable, this different form of contact with in-country colleagues helped some fellows to cement relationships with players who are instrumental to negotiating budgets and authority for health promotion infrastructure and programs.

Fellows whose projects related to setting up health promotion foundations said they benefited from the workshop at ThaiHealth prior to the 6th GCHP because it allowed them to consult staff from health promotion foundations and other experts about their team projects. It also allowed ministry officials from fellows' own countries to be exposed to foundations and develop their knowledge of health promotion and the strategic role of health promotion foundations.

Professional counterparts in other countries were identified through Prolead and valued by fellows as part of their expanding professional network. More knowledge of outside expertise, help and support including at an international level (WHO, AusAID) was gained through Prolead. For some fellows, individual mentors provided an introduction and entry point to new networks.

Public policy and health systems (P₁)

During coursework, Prolead country-based teams studied different models for health promotion foundations. This enabled some teams to produce a model tailored for their country situation and initiate action to secure a legislative base for a foundation.

A number of fellows stated that they developed a stronger appreciation of the significance for health promoters of health system reform and building healthy public policy during the course. Exposure during Prolead to concepts and practice of governance were considered useful to advancing these efforts.

6.2.2 Developmental changes from Prolead

Individuals (I₂)

Most fellows believed their leadership to be better and more certain as a result of Prolead, that they displayed increased confidence in applying their understanding of health promotion and in exercising their professional role in promoting health. Some fellows described how they had developed more courage to approach their superiors in

decision-making and had a stronger 'voice'. Fellows made an association between these behavioural changes and feeling more 'empowered'. In turn, fellows believed their colleagues had noticed some of these changes and had altered their responses accordingly. For instance some fellows felt that their views were being considered more seriously and they were being involved more systematically in discussions about broader policy matters. These changes were thought to have led to more effective teamwork; team discussions and work were informed by a diversity of views, ideas and experiences.

Some fellows commented that they felt more free and assured in talking about many issues within their ministry. This was because it had been shown during Prolead that health promotion was not just about the techniques of group and mass media communications ('health promotions') but that health promotion represents a multi-strategy approach to addressing many issues – from determinants of health (water, education, transport, housing etc) to communicable diseases (eg AIDS) to non-communicable diseases (eg diabetes). Health promotion was therefore the concern of ministries with responsibilities in agriculture, education and natural resources. Treasury was also a ministry with a pivotal role to play in ensuring the effectiveness of health promotion.

Some fellows commented that they had developed a stronger commitment to sharing information about and teaching health promotion theory and skills, methods and strategies and shifting staff members' perspectives from responding to problems to being proactive in developing health. Some fellows also indicated they increased their overall commitment to developing health promotion capacity within their own organization and sought opportunities to build capacity throughout their organization.

The team project helped most fellows improve their group work skills, which benefited the Prolead project and made a difference to their effectiveness at work.

Prolead helped some fellows to 'think internationally', which they regarded as useful because new, broader perspectives on enduring or difficult problems could be gained.

One set of stakeholders observed that Prolead made a difference to how fellows thought and acted to achieve certain goals – they pursued the right actions, which are under their control, but which were often neglected before. This was demonstrated in the advocacy to pass tobacco legislation in one country, for instance.

Networks and Partners (N₂)

New networks and partners were developed internally in some organizations as a result of the efforts of fellows. One fellow reported that networking to foster health promotion across vertical national programs (eg environment, physical activity, smoking) had been put in place since Prolead. Another said that they had insisted that health promotion staff operating at the MOH at all levels should have a mentor, as mentoring had benefited them during Prolead by providing them with individualised support and professional guidance and an extension of learnings.

Through Prolead, fellows also developed rapport and trust with each other, which has led to inter-country sharing of resources and know-how (eg setting up websites). This suggests that an alumnus might be a valuable initiative to sustain some of the beneficial outcomes of Prolead's emphasis on team-building.

Some fellows stated that Prolead, and twinning partners, had shown them how to establish the network of stakeholders needed for the advocacy involved in dedicating

taxation on tobacco to health promotion. These stakeholders ranged from MOH divisions to professional associations to health system leaders. Forming these networks was regarded as valuable for in-country capacity building. Some teams identified greater awareness of health promotion was achieved among governments (Cabinet, MOH) and the public.

An increase in the range of non-health sectors (eg retailers, schools) that were engaged with the health sector in health-related projects was regarded as a key outcome of Prolead. It related to the increased confidence of fellows to make meaningful contacts outside of the health sector and argue that health is 'everyone's business'.

Contacts with colleagues from health promotion foundations were useful on an ongoing basis because they enabled specific issues to be discussed with people who had direct experience of similar situations and insights into barriers and facilitators for system change.

Public policy and health systems (P₂)

The value of Prolead is ultimately reflected in how changes at the individual level among fellows and among country-based teams lead to a scaling up of the type of networks and partnerships needed to bring about changes in public policy and health systems that are conducive to optimising social determinants of health. These higher order changes take time to realise and hence were not as clearly evident as changes in individuals and networks and partnerships.

However, as progress towards policy and systems changes was already being made in a number of countries, teams were able to drive action more rapidly. For instance, some country teams were able to use knowledge and skills gained during Prolead to advocate more effectively for a tax on tobacco/alcohol that could be used for health promotion and disease prevention. In the case of Mongolia, legislation was passed to dedicate 2% of tobacco and alcohol tax for health promotion, while in the Philippines, legislation was passed to dedicate 5% of 'sin taxes' (tobacco and alcohol) for disease prevention. The issue of mechanisms or institutions for investing these new funds (eg a health promotion foundation) was under discussion in both countries.

Fellows identified examples of where they had been able to apply their learnings from Prolead to practical problems in their countries. In one country, Prolead fellows were able to drive more rapid action on a persistent problem of sanitation – by defining the nature and scale of problem more clearly through population health profiling and identifying its causes more comprehensively. Networks, including those introduced to them through Prolead, were then used to find a solution and raise funds. The difference Prolead made was in developing fellows' skills in how to do assessments that involve community groups, put the issue on the political agenda, mobilise action and resources and evaluate impact. Reflecting the emphasis of Prolead II, all country-based teams made progress in creating a political environment that will be conducive to shaping health-promoting forms of governance, infrastructure and financing in the future.

Some fellows observed that their MOH department of health promotion was tending to be viewed differently as a result of their participation in Prolead, because the department had demonstrably shifted to operating on the basis of the Ottawa Charter model of health promotion. While the production of information/ education/ communication materials still played a role in its work, it no longer constituted the main objective of their work. A consequence of this shift was that people working in vertical program areas (eg non-communicable disease) were sometimes approaching the

department of health promotion to become involved at the strategy planning stage of a program.

A higher level of activity in some MOH departments of health promotion had led to greater leverage to secure recurrent money for health promotion because their preventive focus, broader scope and more central role in achieving health system goals were recognised. A number of fellows reported that during Prolead, the responsiveness to health promotion policies and plans of key players in their countries was enhanced.

In some countries, university-based education about health promotion had benefited from Prolead. In one country for example, a health promotion syllabus was introduced to a teaching institution and was being taught by a fellow. These efforts were regarded by fellows as important exercises in building and sustaining national health promotion capacity. They represent bridge-building between academic sector and health promotion leaders.

Perspectives gained from stakeholders suggested that Prolead had introduced, at the regional level, a rich resource comprising training modules and materials, assessment instruments, and mentoring and twinning mechanisms. The Prolead I fellows, as a group, represent the building of capacity in countries and in the region by constituting a set of 'converts, advocates and catalysts' that can be called on to advance health promotion initiatives within their countries and in other countries.

6.3 Suggestions for program enhancement

While there was a high level of satisfaction with Prolead I and II, suggestions were made for program enhancement. These are recorded below.

6.3.1 Strategic intent and Focus

One set of stakeholders identified that as fellows acquire new thinking and approaches, health promotion is more likely to be effective. Furthermore, Prolead supports the rational use of limited resources for health promotion that can in turn moderate the heavy burden of diseases in countries and improve the overall health status of the population. The strategic intent of Prolead should remain the same.

6.3.2 Fellows

Fellows stated the view that Prolead participants should continue to include leaders from within departments of health, local health departments, finance departments and parliament but also include chief executives. Fellows thought that participation in Prolead would be useful for people who are instrumental to policy, planning and program and service delivery in government or for government at national, provincial or local levels: politicians, bureaucrats, national agencies for health promotion or community health, health policy experts. Their participation would mean that they The benefits identified included Leaders and administrators of agencies outside the health sector were also identified, along with administrators of non-government organizations and the private sector because their participation and resources for health promotion were regarded as important. International agencies with overlapping mandates and interests were identified as potential participants. One fellow suggested offering Prolead sessions to specific groups on a separate basis (eg policy makers, civil society/NGOs, businesses/industry), bringing the groups together to run joint workshops and hold cross-group debates. Better communication in the program could be achieved if fellows selected for Prolead speak good English.

6.3.3 Structure and Coursework

Fellows suggested the following:

Rotate venue of modules among participating and alumni countries to maximise exposure and make concrete the experiences being shared by participants.

Link the modules with international meetings such as occurred with the 6th GCHP.

Involve more people outside of health promotion.

Enable crediting for participation in Prolead in academic systems or consider Prolead components as actual degree units leading to, for example, a masters degree in health policy.

Provide more concrete examples of best practice and local case studies, particularly in relation to capacity building and nodal governance when these specific issues are being presented.

Use a more interactive approach.

Give more educational materials.

Add more content such as: conflict resolution, priority setting, evaluation, writing plans, effective networking, making intersectoral collaboration work effectively.

Facilitate participation from different sectors (media, agriculture, education).

Consider adding a fourth module.

6.3.4 Country-based team project and mentoring

Fellows suggested allowing more time, providing a larger budget and including additional activities, so that projects can realise their potential. The time commitment required to develop and implement team projects needed to be clarified at the start of the program to establish realistic expectations.

One set of stakeholders suggested that a series of national health promotion capacity mapping exercises occur at strategic times in relevant countries and areas, both for process and impact evaluation of Prolead. Data from this type of exercise could be presented to fellows in association with Module 1 to discuss and to aid their situation assessment.

With regard to mentoring, fellows suggested the following:

Retain mentoring but make sure the mentors for projects and individuals meet early in a face-to face situation. This will help to set agreements and expectations about aims, objectives and communication methods and patterns.

Offer individual mentoring as an optional component, one that fellows can choose to take up if they believe it will benefit their professional development.

Course organisers should provide more structure to mentoring eg the facilitation of teleconferences between mentors and fellows.

Through mentoring, more technical assistance should be offered.

6.3.5 Other activities

Fellows suggested the following:

Standardise and disseminate tools and introduce other tools.

Establish an alumnus to enable continued learning (reflecting the 'learning organization' approach) and the strengthening of a critical mass of health promotion leaders at country and regional levels.

Stage a global conference that looks at the impact of Prolead on countries and the benefits it has produced, as well as for Prolead alumni to share experiences since their participation in Prolead.

Link future Prolead workshops with other international events (as occurred with 6th GCHP in Bangkok) to enable broader, opportunistic exposure of Prolead.

Provide support to countries to develop curriculum and coursework so that local staff in countries can be trained.

Dissemination of Prolead I and II

Stakeholders proposed that dissemination of results occur through:

Social marketing on achievements to date.

Journal publications on experiences and impact.

Exposure through conferences and other forums.

6.4 Prolead: Moving to in-country version

While Prolead was designed and delivered as a regional program, the fellows were generally enthusiastic about in-country versions of Prolead and made the following suggestions:

- Tailor some of the content to focus on a key issue of relevance for the country eg if the goal is to pass legislation, the main coursework should be on legislative systems and the process of passing legislation.
- Challenge the idea that only people from health can understand problems about health. Involving people from a range of sectors would help to achieve this maturing of understanding.
- Link the delivery of Prolead with a university that can serve as degree granting so that the investment in time will somehow be translated into some other academic achievement.
- Include and perhaps emphasise the following content areas: governance methods; achieving participation; establishing and sustaining partnerships and projects; planning the activities of all related sectors around health promotion at all levels (national, regional, communities).
- State the educational (behavioural) objectives for each session.

Section 7. Looking forward to Prolead III and beyond

Evaluation processes of Prolead I and II have indicated the importance of matching Prolead’s structure with the learning requirements of fellows and matching its content and professional development approach with the changing environment in which health promoters have to operate.

7.1 The evolving agenda for leaders in health promotion: Governance

Arising from research and advocacy activities in the last decade in particular, and the importance of cities as an interface between local and global levels of action, a key challenge for health promoters is to form political and technical partnerships that can positively shape the social determinants of health. Increasing evidence underscores the value of intervening at these sources of influence on population health, particularly by effecting public policy changes through the combined efforts of government, civil society organisations, and business entities.

Prolead I and II attempted to address different, though related, leadership challenges: sustainable infrastructure and financing for health promotion, and governance for health.

Leadership Challenge I: Infrastructure for health promotion	Leadership Challenge II ²⁵: Governance (and health governance)
Policy and legislation Workforce, supported by professional development Organisational structures for program delivery Collaborative mechanisms across government Partnerships among government, NGOs and private sector Information base (including monitoring and evaluation research), and Health promotion financing	Governance - the management of the course of events in a system - ways in which institutions and decision-making processes are put in order to shape the functioning of social systems Health governance - the actions and means used by a society to organise itself in the promotion and protection of the health of its population - eg the policing of social relations and environmental conditions and the allocation of resources essential to well-being

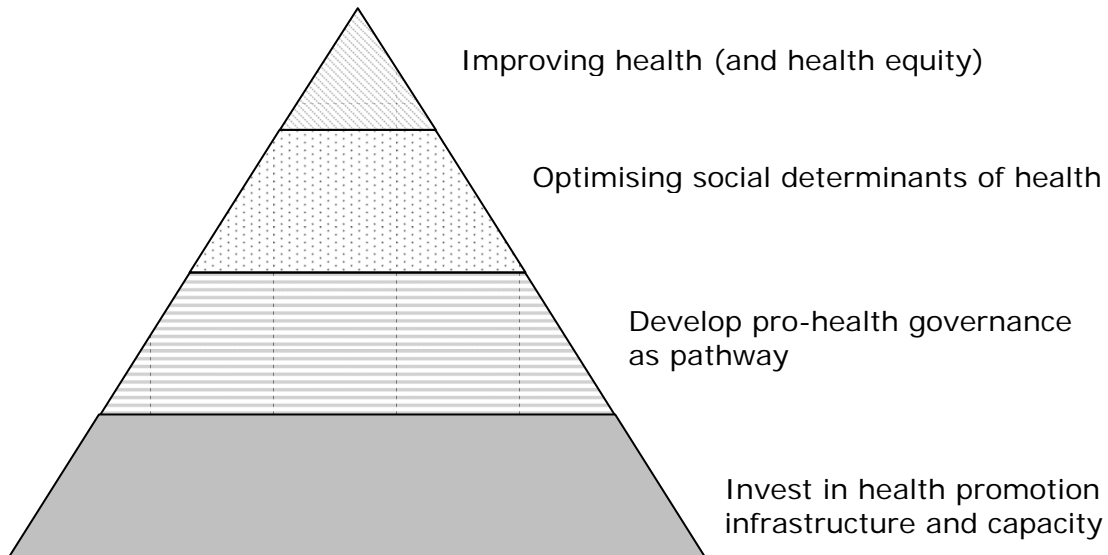
These two major leadership challenges remain important for Prolead III however a reshaping of emphasis is proposed that reflects the types of shifts required to underpin a sustainable foundation for health promotion.

While Prolead I recognised the importance of securing sufficient and appropriate inputs to health promotion; Prolead II placed more emphasis on allocative decision-making about health promotion resources and other public policy measures. In line with the evolving global context for health promotion, Prolead III should place more emphasis on how health promotion infrastructure and health governance mechanisms and processes can more explicitly address both the social determinants of health and health promotion capacity. Prolead III should incorporate consideration of distributional

²⁵ Burris S (2004). Governance, microgovernance and health. Temple Law Review. Vol 77: 335-361

outcomes, as measures are adopted to address risk and protective factors for health. This overall approach is represented in **Figure 3**.

Figure 3. Leadership challenge and program logic for Prolead III



Given the value of an international focus and the location of authority for health promotion at city and national (country) levels, Prolead III should consider two different versions: Prolead IIIc (city focus – now called Healthy Urbanisation Learning Circles), and Prolead IIIIn (national focus). By being incorporated into the WKC’s Core Project in at least five cities, Prolead IIIc/HULC would give emphasis to urban health governance as a pathway for optimising social determinants of health while Prolead IIIIn would retain a focus on national policy and investment for health promotion capacity development.

7.2 The Prolead Model

Health promotion leadership places emphasis on intra- and inter-personal skills to work within and across organisations and communities, in order to create the enabling conditions necessary for people to exercise greater control over their health. As such, Prolead is an illustration of the evolving paradigm of leadership development, in which there is a more explicit recognition of the need for leaders to be equipped to foster social capital rather than the more narrow (but not mutually exclusive) domain of human capital. (See **Table 7**)

Table 7: Human Capital versus Social Capital Approach to Leadership Development²⁶

Comparison dimension	Development target	
	Leader	Leadership
Focus for development	Human capital	Social capital
Leadership model	<u>Individual:</u> Personal power Knowledge Trustworthiness	<u>Relational:</u> Commitments Mutual respect Trust
Competence base	Intrapersonal	Interpersonal
Skills	<u>Self-awareness:</u> Emotional awareness Self-confidence Accurate self-image <u>Self-regulation:</u> Self control Trustworthiness Personal responsibility Adaptability <u>Self motivation:</u> Initiative Commitment Optimism	<u>Social awareness:</u> Empathy Service orientation Political awareness <u>Social skills:</u> Building bonds Team orientation Change catalyst Conflict management

Given the above considerations, Prolead IIIc/HULC should be concerned with optimising the social determinants of health. The social capital approach to leadership development should underpin its overall structure and approach. Prolead IIIc/HULC, by being linked in with the WKC and the WHO Commission on Social Determinants of Health's urbanisation and health agenda, will need to develop a larger critical mass of trained people at the city level that engages all relevant sectors, and involves civil society. In retaining a focus on partnerships at the national level, Prolead IIIIn will strengthen sustainable investments in health promotion infrastructure and capacity, which will in turn contribute to the development of healthy public policy and the reorientation of health services.

To pursue this leadership agenda, the basic principles of Prolead remain relevant, but some marginal modifications and adaptations can be made to other aspects of the program.

²⁶ Amended from Day (2001) from Hartley J & Hinksman B (2003). Leadership Development; A Systematic Review of the Literature. Coventry: The NHS Leadership Centre.

7.2.2 Principles

- Develop a critical mass of trained people within each country/city
- Prioritise the training of existing leaders
- Train ‘in place’
- Apply knowledge and skills in practice
- Focus learning around team projects
- Maintain relevance to local systems (with reference to national health promotion capacity mapping exercises) and issues
- Use regional networks and institutional links to support capacity-building.

An additional principle suggested for Prolead III: Utilise the experience of Prolead alumni members in training.

7.2.3 Program characteristics

Strategic intent and focus

The strategic intent for Prolead III should remain the same as for Prolead II: develop applied team leadership and management in countries globally.

To identify teams of leaders who promote health in countries;

To develop a critical mass of such leaders;

To create and sustain a learning and mentoring environment;

To support the "scaling up health promotion to levels where an impact on health can be expected".

The focus should be on pro-health governance (with Prolead IIIc/HULC focused on optimising social determinants of health and Prolead IIIIn focused on investment in health promotion infrastructure and capacity).

Fellows

Prolead IIIc/HULC fellows should be city-based, but include government (representatives from key sectors), civil society, and businesses, if not academics as well. Gender representation should be ensured. Prolead IIIIn fellows should include national health promotion manager and key partners (either within the health sector, in other government ministries, in the private sector, or in academic roles).

Structure and coursework

The three-module structure, over 9 months, should be continued with ongoing refinement of sequencing based on participant feedback. Given more time available for Prolead IIIc/HULC, the first module should be preceded by engaging fellows in the conduct of a rapid appraisal of local issues and an initial prioritisation of key local challenges. For Prolead IIIIn, consideration could be given to an 11-month period, in order to provide additional time for completion of projects and to receive fuller benefit from project mentoring.

A number of features of coursework that would foster Prolead III's leadership agenda were identified by fellows and include:

Approaches to teaching and learning, including the ways in which fellows gain knowledge and know-how, should foster characteristics associated with social capital;

There should be continued emphasis on the more dynamic process of strategic thinking (versus more traditional 'strategic planning') that enables leaders to innovate and apply simple management tools to navigate through complex organizational and environmental issues;

More content could be added to Modules II and III to enhance the opportunities for learning and reflect the areas of strength and weakness in countries that are indicated through national health promotion capacity mapping exercises;

Materials could be made available in advance of the modules to fast-track learning;

Emphasis should be continued on social technology, such as social mobilization, and advocacy;

Components and dimensions of health governance can be the criteria to which interventions may be measured for effectiveness;

Prolead alumni can complement core Prolead faculty in running workshops.

Country-based team projects and mentoring

Team projects should be continued. One key change would be for teams to, before Module 1 starts, undertake rapid assessment and prioritisation of local issues that will be addressed in projects. This will provide teams with more time to focus on designing and implementing projects. Mentoring organizations should continue to be recruited to support teams and the design and implementation phases of their projects.

Individual mentors should continue to be organised for fellows who wish to have one.

Mentors (individual and project) could be supported to make in-country visits in an early stage of Prolead to become familiar with fellows and the professional context in which they work, for fellows to become familiar with their background and what they can offer in the way of guidance and support and to establish reliable ways of communicating.

Other activities

A range of other activities should be offered to fellows to consolidate and extend their learning and networks.

While projects need to be given concentrated attention by country-based teams over the full nine months of Prolead, teams could also be supported to simultaneously build links beyond projects, especially with Prolead teams in other countries/cities. There may be opportunities for teams to assist with other policy developments, debates and capacity building needs in their countries and regions, for instance.

Field visits should continue to be organised based on course-related topics and the emerging needs and interests of fellows. Examples of practical action on the social determinants of health should be a focus for field visits. Field visits should be understood as providing further opportunities for fellows to expand their professional networks.

The Prolead alumni should be established and cultivated as a formal, active entity with contributions to make to international debates, research, workforce development and in-country and international professional education and training.

Section 8. Research agenda for Prolead III

The development and implementation of a research agenda for Prolead III has the potential to substantially add value to the program by extending learning opportunities and producing new insights among fellows, while contributing to the evaluation of Prolead. At the same time, research done in association with Prolead can contribute to common bodies of research on key leadership issues.

8.1 Scope of the research agenda

While Prolead III brings a focus to the training needs of health promotion leaders, it also points to a number of questions that might constitute a research agenda to support or accompany Prolead III and further develop Prolead. The implementation of Prolead offers a distinctive opportunity to examine questions related to two domains: 1) the health promotion leadership challenges (as described in **Section 7**) that are being addressed by the Prolead fellows, and 2) the leadership development approach itself.

The questions posed below take account of the nature of contexts for health promotion leadership (communities and societies are complex adaptive systems) and the nature of health promotion leadership itself (a political and also technical process that is concerned with social determinants of health).

8.1.1 Addressing dimensions of the leadership challenge:

Invest in health promotion infrastructure and capacity

What health system designs and incentives are most appropriate to improve population health, and in particular, enhance health equity?

How should health promotion be incorporated into health sector reform?

How should access, financing, and quality of formal and informal health services for marginalised populations be improved?

What are the basic types of health promotion infrastructure that will make a difference to population health? Can minimum standards be specified? If so, what are they?

How can health promotion infrastructure be assessed, mapped and monitored so as to provide data on factors influencing health promotion program performance?

What is involved in priority-setting to establish a viable health promotion infrastructure?

Develop pro-health governance as the pathway

What are the different elements of governance processes that are important to advance action on the social determinants of health?

What levers and incentives are there for health and other sectors to stay engaged in health promotion?

How can the interface between global, national, and local priorities and decision-making processes be managed to optimise the health of populations?

How can health considerations best be incorporated into urban planning processes?

Optimising social determinants of health in urban settings

- What makes a city or community work well and in favour of health?
- What is the contribution of governance to a place working well and in favour of health?
- How can global forces shaping social determinants of health be managed at the local level?
- Need for comparative studies, ideally through a 'cities and health observatory'.

8.1.2 Understanding leadership development:

Approaches to health promotion leadership development (within complex adaptive systems)

- What is the nature of health promotion leadership in complex systems?
- What skills, attributes and tools do health promotion leaders require to mobilise knowledge and capacity for health that are diffused through the contexts in which they work?
- What approaches to learning make it possible for leaders to become equipped to operate with influence in complex systems?

Evidence about transformative leadership

- What changes occur, and in what domains, as a result of Prolead? How can these changes be effectively tracked?
- What are the longer term transformative impacts of Prolead? How can these be evaluated?
- Where are Prolead fellows working now? What is their current role in health promotion? In what positions have Prolead fellows been employed since they finished their participation, and how has health promotion featured in these positions?
- How can Prolead generate and disseminate evidence concerning pro-health governance, including effective strategies for optimising social determinants of health?
- How can the process of research transfer/transformation become systematised so that health promotion policy-making and programs are evidence-based?

8.2 Implementing the research agenda

Undertaking research offers supplementary and complementary opportunities for fellows and country-based teams to develop perspectives and knowledge, gain skills, build new networks and partnerships and make an impact. An important outcome of developing the research aspect of Prolead is to engage fellows in considering the role and use of evidence in policy making and health system reform.

A potentially feasible tactic to implementing the research agenda is for Prolead teams to engage with relevant research organisations (eg national universities) and stakeholders (eg community organisations) to frame research questions in terms of city and national priorities. Action research²⁷ offers an approach that would be relevant for

²⁷ Action research is a form of collective self-reflective enquiry undertaken by participants in social situations in order to improve the rationality and justice of their own social or educational practices, as well as their understanding of those practices and the situations in which the practices are carried out... The approach is only action research

Prolead: it would bring together country-based teams with research partners in a critical enquiry about what they are doing and how. Its merit in this context is that action research: is 'problem-focused, context-specific and future-orientated', is based on a cycle in which research, action and evaluation are interlinked, seeks to 'improve and involve' and is based on a research relationship in which people taking part in research are also participating in the change process.²⁸ Importantly, it is educative throughout the action research cycle.

A number of issues associated with implementing a Prolead research agenda need to be further explored with a view to creating a realistic approach, a sufficient and reliable resource base and quality management. Issues that need to be examined include: access to research expertise, funding of research activities, ethics approval and monitoring of research plans, and documentation and dissemination of research results. Existing institutional partners for Prolead include universities, health promotion foundations and other public health institutes; each of these organizations have particular and relevant roles to play in framing and implementing a Prolead research agenda.

when it is collaborative, though it is important to realise that action research of the group is achieved through the critically examined action of individual group members. (Kemmis S and McTaggart R (1988) *The Action Research Planner*, Geelong, Victoria: Deakin University Press: 5-6)

²⁸ Hart E and Bond M. 1995 *Action-Research for Health and Social Care: A Guide to Practice*, Open University

Section 9. Conclusion

Leadership is a key element in strengthening health promotion effectiveness and capacity-building. Prolead, in developing applied team leadership and management in countries globally, addresses the need for such leadership to be deliberately cultivated. While Prolead has been implemented only twice to date, indications are that it offers a valuable strategy for developing leaders who are tuned into 21st health contexts and health issues and capable of working collaboratively and with diverse partners to improve health.

The key question this evaluation sought to address was: *Has Prolead helped?* Indications from this evaluation are that Prolead has, to date, made a real difference to how health promotion leadership is perceived and practiced and how it can be developed and sustained. It has:

- Trained 37 health promotion leaders across three regions
- Stimulated capacity-building for health promotion in countries
- Produced tangible benefits for fellows' countries such as setting national agendas for pro-health governance in order to tackle the social determinants of health through health promotion, and mobilising action to create new and autonomous structures and sustainable financing for health promotion
- Created bridges between international organisations (such as health promotion foundations, universities, SEAMEO-TROPMED Network) around the task of health promotion leadership development
- Established the basis for a Prolead alumni network that has an ongoing role to play in training leaders as well as engaging in international efforts associated with the Prolead agenda for change.

The Prolead experience to date suggests it can continue to support leadership development within and between countries, and contribute to building a critical mass of skilled and inspired health promotion leaders across regions. While the significance of their influence should not be underestimated, leadership is not sufficient in and of itself if cities and countries do not have appropriate mechanisms (governance) and infrastructure in place to take forward action on the social determinants of health agenda as it relates to their country. It is the combination of all these elements that allows progress to be made in improving and sustaining population health.

Over the last decade or so, it has become clear that health promotion programs will not be effective in achieving their goals unless certain elements are in place, particularly clear objectives, policy and planning that draws on suitable evidence, leadership, adequate resources, infrastructure, trained staff and community support and engagement. Similarly, for health promotion to be effective at city, national and international levels requires that these elements are in place and function as a purposeful, change-oriented system. Hence Prolead, with its focus on leadership development, must be accompanied by initiatives that, for example, expand and disseminate the emerging evidence base for health promotion action and strengthen the city and national workforces at all levels.

Appendix 1: Schedule of interview questions

1. Describe your overall experience of Prolead.
2. In retrospect, what were your most important learning experiences during Prolead
 - personally?
 - professionally?
3. How did you change personally as a result of your participation in Prolead?
4. How did you change professionally as a result of your participation in Prolead?

For example, did you develop any new skills, competencies, ways of thinking, problem-solving or behaving? Have you been able to work more effectively in your own organisation as a result of Prolead?

5. What contribution was made to your learning by the different components of Prolead?
 - coursework
 - team project
 - mentoring – individual and project
 - additional experiences.

For example:

- Did they help you to develop any specific skills or attributes?
- Did they help you develop useful networks and partners?
- Did they lead you to making any changes to public policy and health systems?

6. What changes would you make to Prolead? For example:
 - overall – in focus, objectives
 - curriculum and coursework
 - team project
 - mentoring – individual and project
 - additional experiences
7. If you were adapting Prolead to your country, what might you
 - emphasise?
 - de-emphasise?
 - add?
8. To whom would you recommend participation in Prolead? Why?

Appendix 2: Prolead fellows: 2004-2006

Prolead I Fellows (2004-2005)			
	Country	Name	Position/Organisation
Western Pacific Region	People's Republic of China	Dr Fu Hua	Deputy Dean and Professor, School of Public Health, Fudan University
		Dr Zhang Liqiang	Deputy Director WHO Collaborating Centre for Health Promotion and Education, Shanghai Health Education Institute
		Dr Hu Zhaoming	Deputy Director WHO Collaborating Centre for Health Promotion and Education, Shanghai Health Education Institute
	Fiji	Mrs Silveni Hazelman	Senior Health Sister Savusavu Health Centre, Ministry of Health
		Mr Manasa Rayasi	Acting Health Promotion Officer, Ministry of Health
	Malaysia	Mr Edmund Ewe	Director, Health Promotion Division, Ministry of Health
		Mr Azman Mohammed	Principal Assistant Director, Health Education Division, Public Health Department, Ministry of Health
	Mongolia	Mr Bekhbat Sodnom	Director, United Consulting LLC
		Dr Jargalsaikhan Dondog	Head of Health Promotion Department, National Centre for Health Development
		Dr Tsetsegdary Gombodorj *	Senior Officer in charge of NCD and MNH, Focal Point for TOH and MNH, Policy and Coordination Department, Ministry of Health * participated in meeting in Thailand, 2005 only
	Philippines	Mr Ramon J. Navarra Jr.	Supervising Legislative Staff Officer, Office of Senator Juan Flavies, Philippine Senate, Senate Committee on Health
		Ms Angelina Sebial	Director, National Center for Health Promotion, Department of Health
		Dr Alberto Herrera	City Health Officer, Marikina City Health Office
	Tonga	Dr Viliami Puloka	Senior Medical Officer, Public Health, Head of Health Promotion and Noncommunicable Diseases, Ministry of Health
		Mrs Kilisitina T. Tuamei'api	Principal Economist Economic/Budget Division, Ministry of Finance

Prolead II Fellows (2005-2006)			
	Country	Name	Position/Organisation
Eastern Mediterranean Region	Lebanon	Ms Mayada Kanj	Coordinator, Health Education Resource Unit, Faculty of Health Sciences, American University of Beirut
		Dr Nader Nassif	Lecturer, Department of Health Behaviour and Education, American University of Beirut
		Mrs Peggy Hanna	Director of Health Promotion and Public Relation Department, Ministry of Public Health
	Oman	Dr Jawad Ahmed Al-Lawati	Director, Department of Non-communicable Diseases Control, Ministry of Health
		Ms Sabah Al Bahlani	Director of Health Education and Information, Ministry of Health
		Mr Saleh Bin Said Al Haddabi	Director General of Health Services, Ministry of Health
South East Asian Region	India	Mr Papanna Rudramurthy Ramesh	Councillor Former Mayor of Bangalore, Bangalore Mahanagara Palike
		Dr Harikiran Arkalgud Govindaraju	Assistant Professor, R.V. Dental College and Hospital
		Dr Srinivasan Velu	Medical Officer, Karnataka State Road Transport Corporation
Western Pacific Region	Japan	Dr Takuro Hayashi	Chief Resident Emergency Department, Kobe City General Hospital
		Mr Kazuyuki Amano	Assistant Section Chief Public Health & Sanitation Division Public Health Bureau Health, Welfare & Environmental Services Department, Hyogo Prefectural Government
		Ms Fumiko Saikai	Officer General Affairs Department, Hyogo Emergency Medical Centre
	Republic of Korea	Dr Tong-Ryoung Jung	Team Leader, Health Promotion Support Team, Korean Health Promotion Fund Korea Institute for Health and Social Affairs
		Dr Hye-Kyung Park	Team Leader, Project Supporting team, Korea Institute for Health and Social Affairs
		Dr Sung-il Cho	Assistant Professor, Department of Epidemiology, School of Public Health, Seoul National University
	Viet Nam	Mr Tran Bui	Director, Hue City Centre for Health Care
		Dr Doan Thi Ngoc Van	Hue City Committee on Population, Family and Children Issues
		Dr Tran Man	Lecturer of Hue Medical College (Member of the Steering Committee of Healthy Cities Programmes in Hue City, Internal Medicine Division), Hue Medical College
SEAMEO-TROPMED	Indonesia	Ms Judhiastuty Februhartanty	Lecturer Regional Centre for Community Nutrition University of Indonesia, SEAMEO TROPMED Regional Centre for Community Nutrition

Prolead II Fellows (2005-2006) – con't			
	Country	Name	Position/Organisation
	Malaysia	Dr Lokman Hakim Sulaiman	Head, Environmental Health Research Centre (EHRC) Institute for Medical Research, SEAMEO TROPMED Regional Centre for Microbiology, Parasitology and Entomology
	Philippines	Prof Buenalyn Teresita Ramos	Chair and Associate Professor Department of Health Promotion and Education College of Public Health University of the Philippines, SEAMEO TROPMED Regional Centre for Public Health
	Thailand	Dr Wijitr Fungladda	Associate Professor Head, Department of Social and Environmental Medicine Faculty of Tropical Medicine Mahidol University , SEAMEO TROPMED Regional Centre for Tropical Medicine

Appendix 3: Mentoring

What is mentoring?

Mentoring is a process in which a person of greater experience provides guidance and support through a range of roles in order to facilitate the realization of a younger person's aspirations. They act as a role model/ exemplar, guide, tutor, coach, confidante, teacher, counselor and aid to developing knowledge and skills.

The mentor:

- supports and encourages
- informs, confirms, prescribes, questions, challenges
- counsels and helps problem solve
- gives informal and constructive feedback
- promotes development of contacts and networks
- advocates for the fellow
- is available, open, respectful, accepting, willing to share and learn.

The fellow is an active participant in the relationship. They:

- enter into a mentoring relationship with clear ideas of their desired objectives
- initiate contact and demonstrate commitment
- maintain regular contact with the mentor
- critically assess the progress of the mentoring process in conjunction with the mentor in an open way to make it as productive and relevant as possible.

A good mentoring relationship is one in which:

- there are shared interests and values
- there is a shared understanding of the mentoring relationship and what will be involved
- the mentor is interested in the progress of the fellow and maintains a developmental process with the fellow
- the fellow trusts the mentor and feels accepted and empowered
- the mentor provides for creative thinking and reflects the range of learning styles of the fellow
- a flexible process is developed that suits both parties and evolves over time.

What is the difference between supervision and mentoring?

Mentoring does not involve assessment, is independent of the workplace, and is self-paced.

In mentoring, there is equality in the relationship – that is, the mentor may be more experienced, but not necessarily at a higher academic level, in the same profession, or in a more senior part of the fellow's organization.

What are the benefits of mentoring?

For the mentor:

Mentoring is a way of making a contribution;

Mentors can gain new perspectives on issues;

Mentoring can enhance self-awareness, communication and leadership skills.

For the fellow:

Mentoring provides support for setting and achieving goals;

Fellows can enhance their personal development and self-confidence;

Fellows can extend their networks and support systems;

Mentoring can help fellows expand their vision.

Appendix 4: Country-based team projects 2004-2006

	Country/	Project title	Organisational Mentoring/ Project Twinning	Key Project Outcomes
Prolead I: Mentoring commenced in Module 2				
Western Pacific Region	China (Shanghai)	<i>Academics and implementers</i>	ThaiHealth	Paper drafted on feasibility of health promotion foundation
	Fiji	<i>National and local levels of governance</i>	VicHealth	Shifted community development work within the National Centre for Health Promotion to a facilitation approach, thus expanding proactive involvement of partners in healthy settings; Leveraged additional donor resources for health promotion
	Malaysia	<i>State and private sector partnership</i>	Australian Centre for Health Promotion	Expanded constituency for proposed health promotion foundation, especially from civil society organisations
	Mongolia	<i>Health educators and health policy advocates</i>	ThaiHealth	Established Mongolian Health Promotion Foundation
	Philippines	<i>Legislative and executive branches of government</i>	Swiss Health Promotion Foundation	Health promotion skills of National Centre for Health Promotion staff developed and legislation drafted to progress creation of Philippines Health Promotion Foundation
	Tonga	<i>Political leaders and career civil servants</i>	VicHealth	Expansion of health promotion team within MOH. Cabinet paper drafted on tobacco tax

	Country/	Project title	Organisational Mentoring/ Project Twinning	Key Project Outcomes
Prolead II: Mentoring commenced in Module 1				
Western Pacific Region	Japan	<i>Mental health promotion for emergency room staff in Kobe</i>	WHO Kobe Centre – Japan; visit to St Vincent's Hospital, Melbourne, Australia	Assessed mental health of staff in two institutions and achieved good participation Established partnerships and basis for: further analysis of data and design of effective system to reduce stress, advocacy and organisational change
		<i>Promoting food safety in disaster management plans in Hyogo Prefecture</i>		Technical materials and supporting communications strategy developed
	Vietnam	<i>Involving stakeholders in health promotion</i>	City of Kuching, Malaysia	Built stakeholder support for health promotion across wide array of agencies and organizations, through development of healthy city strategy and associated health promotion committee
	Republic of Korea	<i>Building consensus on the strategic vision for the health promotion fund</i>	Mr Joe Hafey and the Public Health Institute, California - USA	HP included in revision of Health Plan 2010. Amendment to Health Promotion Act proposed by national Assembly members. Financial and technical support for Healthy Cities Project. Full time faculty for new HP speciality in Seoul National University. Funding provided for key research and product development
Eastern Mediterranean Region	Lebanon	<i>Improving and coordinating media coverage of health issues in Lebanon</i>	Dr Bushra Jabre and the Johns Hopkins Centre for Communication Programs – USA	Secured funding for capacity building with media and project proposal drafted for communication strategy
	Oman	<i>Revitalising health promotion in Oman</i>	Dr Bertino Somaini and Swiss Health Promotion Foundation – Switzerland	Political and partner support recruited for HP. HP incorporated in MOH 5-year plan. Budget provided through WHO biennium budget for HP.
South East Asian Region	India (Bangalore)	<i>Advocacy and development of partnership for a health promotion foundation in Bangalore</i>	Initial advice from Ms Addy Carroll - Australia; visit to City of Kuching, Malaysia	Tri-sector partners brought together. Advocacy document prepared to drive development of strategic HP policy Two 'mega' projects launched
	SEAMEO-TROPMED Network: Indonesia Malaysia Philippines Thailand	<i>Enhancing human resource development in health promotion</i>	Support from La Trobe University, Deakin University, – Australia; University of Minnesota - USA	Political support gained from SEAMEO-TROPMED Governing Board, network and Centre Directors for curriculum reform of existing Centre programs and development of HP curriculum

Appendix 5: Direct Results from Prolead I

Direct results:	Individuals (I ₁)	Networks and Partners (N ₁)	Public policy and systems (P ₁)	
Western Pacific Region	<p>Fellows gained knowledge of key areas necessary for securing infrastructure and financing for HP including options for establishing independent financing mechanisms for HP and role of legislation. Fellows gained skills in using tools for analysis and prioritisation of issues; leadership, advocacy. Insights gained into HP as a political process and importance of strategic approach that uses intersectoral engagement to drive process</p>	China (Shanghai)	Partnerships established between key stakeholders for a HPF in Shanghai. School of Public Health, Fudan University that played a complementary, professional supportive role in developing the feasibility assessment for the HPF	Paper drafted on feasibility of Shanghai Health Promotion Foundation and included general principles, conditions of establishing the foundation, registration procedures, organization structure and operation of the foundation
		Fiji	Stronger partnerships and networks established for HP eg HP settings - education, labour-industrial relations, provincial development, tourism, churches. Common ground established between sectors through new community health profile	Shifted community development work within the National Centre for Health Promotion to a facilitation approach, thus expanding proactive involvement of partners in healthy settings; Leveraged additional donor resources for health promotion: \$US80,000 partnership grant obtained for 2005-2008 Policies for grants, training health profiles standardised
		Malaysia	Two seminars held to introduce HPF idea and obtain feedback and ideas for grants (1. 'Building partnerships for HP in Malaysia: 'Promoting health through sport and cultural activities'. Arts, sports, culture, govt health agencies represented. 2. 'Strengthening partnerships for HP'. Follow up to Seminar on capacity building in HP and attended by health NGOs Website created for Malaysian HPF initiative Health Promotion Awards and incentives scheme introduced	Groundwork strengthened for introduction of Malaysian HPF through alcohol and tobacco taxes: constituency expanded for proposed health promotion foundation, especially from civil society organisations. HPF grant schemes scoped
		Mongolia	Presentation made on Prolead to, and round table discussions about HP held for, key HP stakeholders in Mongolia 40 CDs on Prolead in Mongolia produced and distributed to stakeholders Presentation on Prolead to MOH, bureaucracy and media – broadcasted on TV, radio, other channels Presentation on WHO priority for HP to Mongolian Public Health Professional Association, primary and secondary level public health stakeholders Prolead presented to national committee for anti-alcohol and anti-tobacco	Needs assessment on advocacy for HP completed; advocacy tool completed and disseminated to stakeholders IEC strategy for healthy lifestyle developed \$US 60,000 allocated to HP for 2005

Direct results:	Individuals (I₁)	Networks and Partners (N₁)		Public policy and systems (P₁)
		Philippines	Creating partnerships within govt and between govt/NGOs/donors/others developed as the norm for HP work – eg with media, other sectors Trainin seminar conducted Staff attended Senate Hearings and sessions	Health promotion skills of National Centre for Health Promotion staff developed Allocation of ~ \$4.6 million for disease prevention from sin taxes Legislation drafted to advance creation of Philippines Health Promotion Foundation ‘Lobbying’ inserted into administrative order
		Tonga	Health promotion staff and sub-committee trained Relationships established with other HPFs, donor organizations, WHO with regard to HP	Health promotion team within National Centre for Disease Control in MOH expanded. Review of strategic plan for prevention and control of NCD completed; NCD replaced malaria as priority issue in MDG final report to UNDP Cabinet paper drafted on tobacco tax

Appendix 6: Direct results from Prolead II

Direct results:	Individuals (I ₁)	Networks and Partners (N ₁)	Public policy and systems (P ₁)	
Eastern Mediterranean Region	Lebanon	<p>Fellows' commitment strengthened for trying difficult things</p> <p>Insights gained: nature of political environment affecting HP; pros and cons of engaging partners; limiting effects of budget allocations and restrictions; necessity for dedicated staff because of project scope; complementarity of team members' skills</p>	<p>Needs assessment of media personnel</p> <p>Focus group and meeting with NGOs working with media</p> <p>Focus group and meeting with media</p> <p>Needs assessment of health professionals: MOH, WHO, World Bank, UNICEF involved</p> <p>Preliminary identification of focal point</p> <p>Compilation and production of materials/ tools for media</p> <p>Lobbying/advocacy at MOH</p> <p>Twinning with</p>	<p>Advocacy: Secured funding for capacity building with media; Draft project proposal produced for communication strategy</p>
	Oman	<p>Fellows gained appreciation of magnitude of task – to establish HP in Oman – and readiness of Oman for the challenge.</p> <p>Insights gained: need to continue advocacy and capacity building; intensity of collaboration required between other sectors and NGOs; importance of independent structure and financing of HP for sustainability</p>	<p>Shared appreciation of value of HP established among key national stakeholders</p> <p>Program managers participated in developing HP documents (advocacy focus)</p> <p>Members of Health Education Committee responsive to incorporate HP in organizations</p> <p>Twinning with/ mentoring by Swiss Health involved visits to Switzerland by Oman team and Oman by Swiss Health. These supported team process and advocacy activities with MOH and health bureaucracy</p>	<p>Policy: Planning undersecretary incorporated HP in MOH 5 year plan</p> <p>Financing: Political support for HP demonstrated by request from minister for proposal for HPF for cabinet; \$45K provided in WHO JPRM biennium for HP</p>
South East Asian Region	India (Bangalore Manahagara Palike – BMP)	<p>Fellows gained confidence, skills, appreciation of patience; learned about importance of nodal governance, interdependence of policy and grassroots implementation</p> <p>Fellows' vision, concept and approach towards health and governance changed</p> <p>Insights gained: difficulty of making progress in matters of HP governance when there is turnover in political leadership and project champions; competing priorities eg flooding, infrastructure limitations</p>	<p>Strategic directions paper produced with assistance of two technical advisors - advocating development of BMP HP policy. Discussion to review HP policy involved partners: NGOs, health institutions and public</p> <p>Policy translated into Kannada</p> <p>Twinning study tour to Kuching (Malaysia) to meet politicians and planners</p> <p>Exposed health administrative officials to HP and HP governance</p>	<p>Projects: 2 BMP Mega projects launched - supplementary nutrition for 3000 pregnant women; Preventive health care project for 20,000 BMP school children and families</p>

	Direct results:	Individuals (I₁)	Networks and Partners (N₁)	Public policy and systems (P₁)
Western Pacific Region	Japan (Kobe, Hyogo Prefecture)	Insights gained: importance of negotiation skills, win-win outcomes, systematic thinking; difficulty of integrating new information into practice, implementing new approaches in worksites, management of logistics when implementing projects, communication with Prolead colleagues Fellows learned new methods to improve health governance Fellows gained motivation for further activities	<i>Mental health: Emergency staff</i> Meeting organised that involved voluntary participation by experts and led to their support for the project Assessed mental health of staff in two institutions and achieved good participation Visited St Vincent's Hospital (Melbourne, Australia) – located good models and practices and established contacts <i>Food safety in disasters</i> Collaborations with food hygiene inspectors developed and plans for further collaborations through public health system planned	<i>Mental health: Emergency staff</i> Due to the focus of the project (organisational level), changes at this level were not expected. <i>Food safety in disasters</i> Technical materials and supporting communications strategy developed
	Republic of Korea	Insights gained: HP activities can be more powerful through many different kinds of community capacity building; importance of clarifying roles and accountabilities of each govt level in HP, combine top-down/bottom-up approaches	Network of stakeholders engaged to build consensus about HP strategic vision HP workers across technical areas brought together to develop HP strategic vision Cities (n=11) joined Alliance For Healthy Cities in WPR Provincial governments recognised for HP work Visited twinning organisation (Public Health Institute, California, USA) and DOH California, USA Partnerships established with US CDC in conducting conference on cardiovascular disease prevention	Policy: Revision of Health Plan 2010; Amendment to Health Promotion Act proposed by national Assembly members Financing: Financial and technical support for Healthy Cities Project Workforce: Full time faculty for new HP speciality in Seoul National University Research: Funding for research and product development: health determinants, tobacco control, concept and applications of health promotion
	Viet Nam	Fellows gained skills in using news tools for problem analysis and strategic work; Fellows gained insight into the political nature of HP and its role in responding to persistent public health problems Insights gained: into the significance and aspects of working collaboratively	Awareness of HP was increased across key stakeholders through training staff, advocacy and communication, seminar, meeting and discussion, mass media. Partnerships were formed: management board for projects, collaborators network	Changes in awareness among stakeholders regarding health promotion is likely to be associated with making a more favourable environment for public policy and health system changes

Direct results:	Individuals (I₁)	Networks and Partners (N₁)	Public policy and systems (P₁)	
SEAMEO-TROPED Network	Indonesia Malaysia Philippines Thailand	<p>Skills gained in moving ahead: use of existing expertise, communication, effective management of Network and Regional Offices</p> <p>Insights gained into challenges: overcoming different understandings of HP through educational activities, overcoming competition with other academic concerns through continuous education and communication, responding to time constraints by securing commitment and responsibilities of fellows, dealing with unexpected set backs through intense communication, support, looking forward and viewing crisis as opportunity</p>	<p>Partnerships strengthened: within SEAMEO-TROPED; between TROPED centres and national stakeholders eg govt</p> <p>New networks established with specific groups (US & Australian universities; University Network for HP)</p>	<p>Advocacy: Political support gained for curriculum reform of existing Centre programs and development of HP curriculum from SEAMEO-TROPED Governing Board, Network and Centre Directors</p>