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HEALTH FOR ALL
LEADERSHIP



HEALTH FOR ALL
LEADERSHIP INITIATIVE
OF THE
WORLD HEALTH
ORGANIZATION

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WORLD HEALTH ORGANIZATION

WORLD HEALTH ORGANIZATION'S
HEALTH FOR ALL LEADERSHIP INITIATIVE

HEALTH FOR ALL BY THE YEAR 2000 - A VISION OF THE FUTURE

The goal of Health for All by the Year 2000 is a vision founded on social equity; on the urgent need to reduce the gross inequality in the health status of people in the world, in developed and developing countries, and within countries. It is a vision based on the principle that health and development are closely interlinked. And, in fostering this principle, the World Health Organization has journeyed into realms that are far removed from the traditional spheres of providing medical care or organizing health services. It is a vision, therefore, whose range of view encompasses fundamental change - in the way health is perceived, promoted, protected, and delivered.

And these changes, many of which represent a fundamental shift in values, foresee adaptation to the evolving circumstances of the world's health. And they include:

- change in how people, individually, take greater responsibility for the protection and promotion of their health;
- change in the way people participate collectively in health, organizing themselves into action groups and enhancing self-reliance;
- change in the perception and value systems of the health providers - in which the health professionals have to be socially concerned, demystify health, involve people, empower them so that they may assume greater responsibility for their own health. They also have to broaden their understanding of health, no longer confined mainly to medical care or traditionally-defined preventive health care services.
- change in the organization and administration of the health system, going beyond the physical design involving redefinition of objectives of the principal institutions, reallocation of responsibilities and even of the power structure; getting health closer to the people by decentralizing and delegating authority, by revolutionizing the health care delivery system, emphasizing bottom-up planning and forging linkages, and by bringing other health-related sectors into closer alliance;
- finally, change in the attitudes and perception of policy makers in which health has to be seen and pursued as an integral part of development emphasizing a greater concern for social equity, bolstered by the courage to choose health care systems which are affordable, which give preferential attention to the underprivileged and vulnerable, and which provide rational means for deploying resources.

HEALTH FOR ALL - ISSUES AND CHALLENGES

These perceived changes are embodied in the Global Strategy to achieve Health for All by the Year 2000 through primary health care, which was unanimously adopted by the Member States of the World Health Organization in 1981.

The questions which have been most frequently raised in many circles are: Is the goal of Health for All by the Year 2000 achievable? Are countries making any progress? What are the difficulties faced by countries?

In May 1986, the World Health Assembly reviewed the results of the first evaluation of the HFA Strategy (which was undertaken by 146 Member States of WHO). This evaluation revealed that some progress has been made although it has not been sufficiently consistent or widespread. For example, a high level of political will was apparent, along with growing awareness at the national policy levels of the need for change in the health systems. In some countries, impressive efforts have been made to expand health services infrastructure. Some innovative approaches to reach the underserved population groups and to strengthen community-based health services are also noted. Overall, there has been some improvement in the world's health. Upward trends in life expectancy and downward trends in mortality, especially infant mortality are evident in many developing countries.

But, a number of factors have also restrained implementation of the national strategies. Political instability, natural disasters, armed conflicts and high population growth have prevailed in many developing countries. Recession economic climate has had serious repercussions on social progress, and, in many areas, has widened the gap between the rich and the poor. Managerial weakness in the health system persists. And insufficient commitment and support from professional health groups for primary health care and the values inherent in the HFA strategy still constitute a major obstacle to progress. In fact, it has often been said, that "our political leaders are convinced about the values of primary health care; our communities are motivated and are ready to be further involved, but our professional health groups and health administrators are not yet sufficiently convinced and committed. There appears to be an inertia in our health care system which needs to be overcome". And this is particularly felt by countries which have dedicated enormous efforts and resources in recent years to expand their health services infrastructure.

HEALTH FOR ALL LEADERSHIP INITIATIVE

Thus, it became evident that even though a positive start had been made by Member States in their quest for health for all, in spite of formidable economic and social conditions, the need to narrow the gap between policy and implementation persisted. A clear understanding of the critical issues affecting the implementation of the national strategies and courageous and imaginative initiatives to resolve these issues adequately by those in leadership positions in health and health-related fields were also considered imperative. Recognizing this need, the Director-General of WHO launched a new initiative in January, 1985, called "Health for All Leadership Development". The initiative is based on the premise that the implementation gap could be substantially narrowed if individuals in leadership positions understood more fully the process involved in developing and implementing the HFA strategy, pursued its values, and developed within themselves the appropriate qualities and abilities to lead the process.

The principal aim of the initiative is to create (or mobilize) a critical mass of people in each country who are in a position to motivate others and direct their national health development processes towards the goal of HFA. Strategically located throughout the entire spectrum of a national structure - including the health system, its related institutions, universities, research establishments, health professions, political organizations, non-governmental organizations, and the community - these people can mutually support each other in creating and pursuing conditions for change. An interdisciplinary global task force has been guiding the programme, permitting wide consultation and participation.

And what qualities of leadership are sought after? A concern for social justice; compassion for the under-privileged; dedication to the growth of self-reliance; commitment; ability to communicate; courage to take risks and make bold decisions; and faith in people's capabilities have emerged as the crucial leadership qualities for health for all in our experience.

And what are some of the assumptions about the "leadership tasks" related to HFA:

Leaders should be fully informed about Health for All, and the strategies for its achievement;

They should be able to identify central issues affecting implementation of their national strategies;

They should be able to specify their own personal role in resolving those issues which fall within the scope of their responsibilities;

They should be able to define strategic actions to resolve these issues;

They should be able to initiate the process of change required;

They should be able to involve and mobilize others, infusing a sense of purpose and a focus of action;

They should be able to support further leadership development.

Seen in this perspective, it is clear that leadership function does not devolve upon only those at the top level of an organization or a system. Leadership is required at every level, in every single unit that comprises the system. Our target groups, therefore, include policy/decision makers; senior managers from health and health-related sectors; educators; non-governmental organizations; parliamentarians; district-level administrators and political leaders; community leaders and WHO staff - especially those at country level. We are also seeking opportunities for identifying and developing leadership capabilities among young professionals.

Another fundamental question is "How can leadership development be initiated?". One approach is to stimulate awareness and interest in critical issues concerning HFA and increase commitment to pursue relevant actions through providing opportunities for interaction and exchange of experiences with individuals in leadership positions. Another approach is through "networking" which is a linkage of people and/or organizations which can support and strengthen its members; facilitate joint activities, and share knowledge and technical capabilities. There are other approaches and opportunities which need to be explored.

WHAT HAS BEEN DONE THUS FAR?

The global task force has been actively involved since early 1985 in guiding the initiative and monitoring progress. At the WHO regional level similar multidisciplinary task forces or action groups have been set up for implementation at country and regional levels.

Groups of leaders from the countries (including senior policy/decision makers, senior health administrators, community leaders, professionals from education and training institutions and nongovernmental organizations have been brought together in international and national colloquia and dialogues. These were combined, whenever possible, with exposure of the participants to successful leadership in action through field observation with the collaboration of host countries. Using innovative and stimulating approaches, these dialogues have been conducted in supportive, constructive and open environments, facilitating participants' full and active involvement. The participants themselves acted as resource persons for each other. To date over 200 leaders from over 40 countries of the world have participated in such dialogues.

To disseminate information about issues which are critical to HFA and to stimulate thinking and action, information packages have been developed. These have proven popular, one country for example has widely distributed these materials to parliamentarians and other senior government officials. Another has translated these into its national language for wider distribution to universities, health administrators and political leaders.

Many participants of these dialogues have, in turn, initiated leadership development activities in their own countries. These have been focussed at different levels of the health system.

A high priority is given to establishing a resource and support network for leadership development. Leaders from selected institutions and countries of Asia, the Western Pacific and the Eastern Mediterranean were brought together to explore HFA leadership development issues, strategies and examine possible mechanisms for resource networking. We are currently in the process of establishing collaborative relationships with selected networks and institutions to enlist their active involvement and support for this ambitious and challenging endeavour. We are also identifying potential institutions in Africa, the Americas and Europe for such networking.

In response to the interest evidenced in three WHO regions, we are currently exploring various opportunities and mechanisms for the development of leadership of young professionals. So far our main effort has been with the International Federation of Medical Students Association.

WHAT ARE THE LESSONS LEARNED

Because we are treading into a relatively new field, we are facing many probing questions, such as "What are the most effective ways of training leaders?", "What are the appropriate learning mechanisms?", "What is the right amount of trigger to stimulate change?".

We also have to deal with many recurrent myths about leadership (especially from the skeptics) such as, leadership is a rare skill; leaders are born, not made; leaders are always at the top; leaders control, manipulate, push.

The opportunity for "dialogue" with more than 200 "leaders" from diverse socio-cultural backgrounds has served to clarify a number of these commonly held myths about leadership. We learned that leadership opportunities are plentiful and within reach of people. And the major skills and capabilities of leadership can be learned and enhanced, perhaps not easily because there is no simple formula or model to follow, but certainly by trial and error. It is a deeply human process whose principal determinant is the experience and the learning environment itself. Yet, while the key principles of leadership can be elucidated, the process of internalizing them can be a long term challenge for individual leaders.

It has been said that leadership needs an organization, but not an institution, a structure but not a hierarchy. But, at many levels of the health system, the motivation, innovativeness, commitment and creativity of leaders must be sharpened so that leaders are willing to seek change.

The key issue is not "how to become a leader" but rather how to improve one's effectiveness at leadership - how to 'take charge' and create conditions for change and how to lead by pulling others - not pushing, by encouraging them to use their own initiative.

WHERE DO WE GO FROM HERE?

The task is ambitious and very challenging. Each small step that we take is important and is opening up new opportunities and vistas.

We will continue to organize, support and collaborate in such dialogues with leadership in different settings and levels both within countries and internationally. One of the objectives of this approach was to set in motion a chain reaction - or cascade effect - that is, one dialogue leading to others at different levels. This effect has been demonstrated (as is shown in the attached illustration).

We now need to focus on critical groups - who have the greatest capacity for initiating change, for example: political leaders, educators and community leaders. Parallely, we need to identify potential leaders for example within a district level team, and support them in developing conditions for change. Another immediate concern is to focus more sharply on developing the resource capability for leadership development within countries and WHO. Two approaches will be pursued for this. Inter-country courses for facilitators/resource persons for HFA leadership development will be organized in selected institutions. Collaborating relationships will be established with selected teaching institutions for the development of resource and learning materials and sharing technical expertise.

Information and education kits, as well as teaching-learning modules on HFA Leadership will continue to be prepared and provided for testing and further improvements.

We hope to establish a strong support and resource network globally to take up this challenge and further develop the relevant activities.

We will require the support and commitment of many leaders and leading groups in this endeavour. The role of educational institutions is particularly important, not just in elaborating or developing innovative approaches for strengthening leadership skills, but even more importantly, for generating a process of change which would have far reaching impact on the future generation of leaders. It is generally felt that leadership of the educational institutions (especially those preparing future health workers and leaders) have yet to make a firm commitment towards the goal of Health for All and take up the requisite challenge. Our public health teaching institutions throughout the world are in need of new agenda and new challenge. The challenge is there, it needs to be understood and taken up by the respective leadership.

Besides such technical resources, we would no doubt require financial resources to carry out these activities. In the current financial predicament that WHO is facing, the question of where the money is going to come from immediately comes to mind. This will, indeed, be the biggest challenge. We have to step up action to mobilize financial resources from other partners, especially bilateral agencies and foundations.

But we believe that if there is a genuine commitment, money can be found. We believe that the time is opportune to pursue this dimension of our work. We are in an era of rapid change. It is therefore even more necessary to have leadership which is prepared and concerned with the future and in selecting the proper "direction".

HFA LEADERSHIP DEVELOPMENT

