Round Table

Leadership in health

“Health for all” is a slogan easily accepted by everybody. Difficulties arise, however, during its implementation, since success requires fundamentally new attitudes to health. Change does not happen spontaneously but is brought about by leaders. As the health-for-all movement gains strength, leaders are emerging in this field. What are their characteristics? How do they tackle their problems? In order to throw some light on these and related questions, World Health Forum asked 11 such leaders to describe their experiences.

Phillip Bonnick interviewed by Eugene Vadies

—Rewards of tenacity

Between 1967 and 1977, representatives of eight adjoining communities in Kingston, Jamaica, made numerous unsuccessful efforts to obtain community-based health services for their population of nearly 100 000 people. In 1977 they formed the Duhaney Park Citizens’ Advisory Committee, whose main objective was the acquisition of funds for a community-based primary care facility. A major breakthrough came in 1978, when the United Nations Fund for Population Activities agreed to provide the necessary finance.

World Health Forum asked Eugene Vadies to interview the dynamic President of the Duhaney Park Community Council, Police Inspector Phillip Bonnick, on the development of the project.

Dr Vadies: How was it that the population of your eight communities had grown to over 100 000 by 1977 with no primary care facility and only one private doctor’s office?

Inspector Bonnick: During the 1970s Jamaica experienced a boom and many people migrated to the urban areas to take advantage of employment opportunities. We made numerous appeals to government and private donors for the provision of a community health facility but were always told that there was no money.

Dr Vadies: So where did people get their health services?

Inspector Bonnick: People with money could try to get appointments with the sole
doctor in the community. Otherwise, they had to travel to the hospitals in Kingston, some 10 miles away.

Don’t give up and don’t wait for public officials to tell you what to do. Be prepared to act yourself.

Dr Vadies: What problems concerned you most?

Inspector Bonnick: Our biggest worry was high unemployment, often in excess of 25% and mostly involving our youth. There were also high incidences of teenage pregnancy and sexually transmitted disease. The large numbers of unemployed young people served as a breeding ground for rival political gangs, which kept many residents in their homes, especially at night. It is very hard to achieve community participation when people will not come out of their homes.

Dr Vadies: Nevertheless, your citizens’ committee continued to meet. Did they decide specifically on solutions to these problems?

Inspector Bonnick: We identified various vital needs, such as child care and immunization services, more accessible care for the aged, family life education, and clinical services for young people.

Dr Vadies: When did you first sense that things might begin to change for the better?

Inspector Bonnick: A flicker of hope appeared early in 1978, when a local councillor informed our group that a health centre, staffed by a midwife and two community health aides and offering maternal and child health, family planning and nutrition services, was to be established in a two-bedroom house by July. Unfortunately, this did not happen and social unrest and violence became worse. Some people were moving out of our communities and others were moving out of the country!

Dr Vadies: Many community groups would probably have given up and disbanded after so much frustration. What made your group persist?

Inspector Bonnick: Attendance at our meetings dropped from an average of twelve community representatives to about four. I think we were so concerned, in fact angry, at the involvement of many of our young people in political gangs, that we decided to continue to meet in the hope of finding a solution.

Dr Vadies: Since your community group had no links with any government ministry or international organization, how did you get your foot in the door with the United Nations Fund for Population Activities?

Inspector Bonnick: At that time the agency had a dynamic representative named Dieter Ehrhard, who travelled a great deal and was often hard to reach. His driver, however, a friend of mine, was instrumental in getting me introduced to him.

Dr Vadies: Are you saying that Mr Ehrhard’s driver was the key to bringing about successful project activities to the tune of over US$ 1 million?
Inspector Bonnick: Absolutely! It took me three months to prepare a final document for submission to the United Nations Fund for Population Activities. When approval came we suddenly had over a million dollars to spend. We immediately went in search of a government ministry to carry out the project. Eventually, the Ministry of Youth agreed to take charge of it. It was decided that a new youth centre should be built in Duhaney Park for all our communities.

Dr Vadies: And after the funding for the youth centre, wasn't there more good news?

Inspector Bonnick: Yes. I wrote a letter to the Prime Minister, informing him of our need for a major health centre. Soon after this he visited Norway, and on his return informed us that he had asked that country’s Prime Minister for assistance. A little later we were told that funding had been approved by Norway, with the United Nations Fund for Population Activities as the funding agency and the Pan American Health Organization as the executing agency. A health centre with a multidisciplinary team was to be provided.

Dr Vadies: You said that your citizens’ committee had dwindled to only four people and that many local people remained very suspicious. What did you do about these problems?

Inspector Bonnick: Construction of the youth centre had still not begun because of continuing violence and mistrust in the communities. We realized that we would have to be very careful in announcing the newer and much larger health centre project. We called a meeting and invited all committee members and interested parties to attend. To our surprise, over 100 people did so.

I explained the history of our efforts and the funding for the youth centre and the new health centre. I also outlined the roles that would be played by the United Nations Fund for Population Activities, the Ministries of Health and Youth, and the Pan American Health Organization. At the end of my presentation the people gave the committee a standing ovation. Suddenly, all the stress and strain vanished. Seeing the response of those people made the efforts worthwhile.

Dr Vadies: But what about the wider community?

Inspector Bonnick: Without telephones or a community newspaper we had to rely on word of mouth and leaflets. During the meeting some people volunteered to print thousands of leaflets explaining the project and inviting participation and support. Others volunteered to distribute the leaflets. Quite soon the people on the streets, irrespective of their political affiliations, were talking enthusiastically about the project. Active membership of our citizens’ committee suddenly rose from four to more

Unemployed young people formed rival political gangs, which kept many residents in their homes. It is very hard to achieve community participation when people will not come out of their homes.

than twenty. Each of our eight communities was now represented. To cut a long story short, the new Duhaney Park Health Centre was officially opened in 1982 by the Norwegian Foreign Minister.
Dr Vadies: Looking back, what advice would you give to other community leaders confronted by problems similar to yours?

Inspector Bonnick: Don’t give up and don’t wait for public officials to appear and tell you what to do. Be prepared to act yourself.

Dr Vadies: What about motivation, getting people involved?

Inspector Bonnick: Different things motivate different communities. For us, it was watching our youth degenerate in an atmosphere of political rivalry, mistrust, and increasing violence.

Our situation is still far from perfect, but we have taken a big step. Ten years ago we had neither youth centre nor health centre. Today we have a youth centre that offers training in various skills, job placement services, and education. We also have a health centre that often serves more than 1000 patients a week, including many children.

Dr Vadies: So you now feel you can take a rest?

Inspector Bonnick: I don’t think that will be possible.

Dr Vadies: Why not?

Inspector Bonnick: We are now working on the generation of new funds for special projects. For example, with support from the Pan American Health Organization we have obtained small grants from the governments of Australia and the Netherlands for an emergency water tank at the health centre and for sewing machines and supplies for sewing classes at the youth centre...

Andrew K. Cole

—Diverse management skills on the road to health for all

I am County Health Officer for Lofa County in Liberia, and have worked in rural areas of the country for nine years. The county’s Kolahun District has a population of 72,000. The only physicians serving permanently here are my wife, who is an ophthalmologist, and myself. In addition to a hospital there are fourteen health posts and three health centres.

Credibility

Traditionally our people call healers zoes. A zoe has to have established credibility with the people. This can be done by curing someone or by correctly forecasting a natural disaster. Subsequently, the people will take all his advice on matters of health and well-being.

Western doctors and other health workers are faced with the same problem. In order to encourage the people to take their advice, they have to establish confidence in the health care delivery system by showing some dramatic ability to cure or prevent disease. Whereas it may take many years to demonstrate that immunization will wipe out measles, a health worker may only need to correctly diagnose and manage a child with febrile convulsions secondary to malaria in order to establish a good record of success in his health post and thus win acceptance. Once he is regarded as a good zoe, the people will listen to him and only then does he have the prospect of changing...

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people’s behaviour so as to improve their health.

**Community involvement**

The mistake is frequently made of assuming that we know all about the health problems of the people. Consequently, health programmes are often planned in distant offices and the people are only passive recipients. For programmes to be sustainable the community must feel involved from the start. Failure to sustain good health programmes destroys confidence in the system.

From the outset our leadership has been concerned to involve the community in every project. We have tried to bring in the community at all stages, from planning to implementation. We began in 1983 by doing a baseline survey to determine the people’s felt needs in relation to health. We then carried out an operations research project to determine how the community could most efficaciously pay for part or all of its primary health care. Initially, we introduced eight possible financing schemes to the people of five villages. After discussion of the advantages and disadvantages of each in community meetings, schemes involving various combinations of drug sales, community labour, production-based prepayment, and *ad hoc* assessment were chosen. So as to validate the schemes as solutions to the financing problem, it was necessary to make health care available to the people in the villages. Since there was a general lack of trained health personnel, a training programme for village health workers was instituted. In order to make drugs available, a district-wide revolving drug scheme was introduced with the help of seed money from the local farmers’ cooperative. At the time of writing this article, 31 villages have become involved.

**Hurdles**

The areas of greatest difficulty are:

— remuneration of village health workers;
— cost of supervision;
— training for key personnel.

Our communities agreed to remunerate the village health workers in kind by working in their fields. Unfortunately, many communities have not fully met this obligation, although the problem is slowly being resolved. We had assumed that, since the traditional healers were so well remunerated, the village health workers would also receive good treatment. In reality this did not happen. The village health workers evidently have to earn their place in society by gaining the confidence of the people. This takes time.

Recovering the cost of supervision is another difficulty we have had to face. Whereas the people will readily pay for drugs and are beginning to pay for the services of the village health workers, they are disinclined to cover the cost of supervision because its importance is not readily apparent to them. On an experimental basis, therefore, we are going

![For progress to be sustainable the community must feel involved from the start.](image)

to impose a 2% service charge on villagers who make purchases under the district’s revolving drug scheme.

The training of key personnel has presented difficulties. Supervisors and personnel for
the referral centres need training and retraining. Furthermore, there is a general shortage of all such personnel.

Traditional healers continue to be our greatest competitors. The people still go to them before seeking help from our health services. We try to work with them as colleagues and have permitted them to treat patients so wishing in our hospitals.

Shortcomings in communications and transport continue to hamper our efforts to expand the system.

Finally, some people entrusted with running the system use its meagre resources for personal gain. We think the best way to combat such dishonesty is to set a good example.

Mamdouh Gabr

—Building an oral rehydration programme

When I became Egypt’s Minister of Health in 1979 I realized that the introduction and widespread use of oral rehydration therapy could greatly reduce mortality from diarrhoeal diseases in young children. It was my responsibility to inform decision-makers about the magnitude of the problem and the socioeconomic benefits of oral rehydration therapy. When trying to win the support of influential people it was important to be open with them. Thus, for example, it would have been unwise to make unduly optimistic predictions, since these could eventually have had unfortunate consequences for other programmes. The cooperation of the Prime Minister, the Minister of Planning, and the Minister of Information was secured.

Resources

The best way of obtaining state resources is to drum up local ones and then ask the government to cover whatever needs remain. The motivation of a community to share in the costs of health services is best achieved through discussion with its leaders. Improving the allocation and cost-effectiveness of resources can also help in this connection. The obtainment of resources from international or bilateral organizations can strengthen government commitment.

The accumulation in health units of thousands of unused packets of oral rehydration salts, supplied gratis by the United Nations Children’s Fund (UNICEF), revealed a need to establish a coordinated project in order to motivate local health leaders, professionals and the public as well as to upgrade and expand our distribution facilities.

The World Health Organization offered technical assistance and supervision. Funds were needed for administration, training, storage, distribution, research, information campaigns, and the production or importation of oral rehydration salts.

Production by a local public drug company started in 1980. Millions of packets were sold to the public at a small profit through the private sector. UNICEF donated two packaging lines so that production could be increased. Negotiations with the United States Agency for International Development (USAID) were started with a view to establishing a national oral...
rehydration programme. The country’s extensive network of primary health care units was used to promote and distribute oral rehydration packets. Some information about the programme was disseminated via radio and television. Because social mobilization was so important, community and health leaders had to provide adequate education. The identification of leaders in communication within the mass media required good coordination between the Ministers of Health and Information, and between the directors of the media and the health authorities.

It was not difficult to convince USAID of the magnitude and cost-effectiveness of the project. It was my opinion that the Agency’s grant should go to the Ministry of Health, in the interest of coordinating all activities. An agreement was signed in 1982, ensuring sufficient United States and local resources for all purposes and optimal mobilization of Egyptian facilities.

Organization

Although oral rehydration services are within the ambit of primary health care, it was our opinion that, in order to get the project off to a good start, it should initially have a vertical autonomous organization in the Ministry of Health. Execution at local level, however, was a matter for the primary care system. The World Health Organization had certain reservations about this approach, fearing that it would have an adverse effect on primary care. In the end a single administrative body was set up for the project in the Ministry of Health. It was chaired by the Undersecretary of Health responsible for primary health care and involved all key persons in the primary care system and in associated institutions, including the universities, the Ministry of Information, the Ministry of Local Governorates, the World Health Organization, UNICEF and USAID. This ensured proper integration with other primary care services and allowed coordination with related activities that were essential to the project. The administrative body was authorized to distribute the available funds in accordance with certain guidelines. This gave the project complete autonomy and avoided unnecessary bureaucracy.

Due attention was given to proper planning and the motivation of personnel. Contingency plans were drawn up to overcome sudden constraints. Local circumstances were taken into consideration so that proper implementation would be achieved. It was decided to put the oral rehydration salts in 200-ml packages because these were more convenient for use in Egyptian households than were the original 1-litre packets. The difference in cost was minimal and UNICEF agreed to cover the cost of the new packaging machines.

The programme started with pilot projects and expanded gradually as supplies of oral rehydration salts were secured and personnel were trained. The local production of oral rehydration salts eventually met the demand. At present more than 20 million packets are produced annually.

The private sector was encouraged to participate in the project. Although Egypt has more than 3000 free primary health care units, over 60% of the population purchase
drugs from the private pharmacies. The oral rehydration salts were distributed gratis through the public sector and virtually at cost price through private pharmacies.

A major factor in the success of the project was the support won for it in the scientific community and among the public at large. We realized that the cooperation of health personnel, especially physicians, paediatricians and pharmacists, was crucial for the success of the project. They were involved from the beginning in all activities and were responsible for scientific studies. Seminars were organized in conjunction with scientific societies. Practical demonstration units showing the effectiveness of oral rehydration therapy were established in all major hospitals, whose staffs were in the practice of using intravenous rehydration.

Funds were allocated for public information through the mass media. The message was clear and appropriate to the local culture. This social marketing approach was very successful and created a public demand that served as a driving force and obliged the local authorities to solve financial and administrative difficulties.

Development in the Malaysian Ministry of Health has amply demonstrated. Of course, different health systems face different problems, and priorities vary. My main concern has been to achieve increased efficiency and effectiveness and to explore new possibilities in health care.

The desired direction of change may be clear but the crucial point is how to convert intention into effective action. In my case, the question was where to start and what methods to use in bringing about the desired changes. In determining which problem area should be given priority, the logical course is to collect data, analyse and interpret them, develop a vision or concept, and then act. In practice, however, many managers find this process too time-consuming. They are confronted with a multitude of problems and wish to go into action quickly. There is therefore a tendency to take short cuts. What is needed is a general direction for change with adjustments as one goes along. In most cases the problems stare one in the face and detailed studies are unnecessary. The credibility of a leader is enhanced if he or she is seen to be quick in both making decisions and acting on them.

Abdul Khalid bin Sahan

—Leadership for change

As a manager I have always considered myself to be a change agent. Clearly, improvement is impossible without change. We need to be development-orientated all the time, something my experience as Director of Training and Manpower and later as Director of Planning and

Key areas

It is not possible to deal with all problems simultaneously. What is usually done is to tackle a few key areas where the biggest pay-offs are expected, bearing in mind the capability and authority of the organization concerned. The self-confidence and credibility of management can be greatly reinforced if the first few steps are seen to be successful. Some managers waste energy by trying to do too many things at a time.

In Malaysia we decided to choose those areas of concern which were internal to the Ministry of Health and which, if acted on,
would not only bring about immediate substantial improvement but also catalyse further desired changes. Some of these areas are outlined below.

Cost containment

In line with government policy, we undertook a major exercise in cost containment. The intention was to avoid unnecessary spending and cost overruns and to minimize wastage, without sacrificing standards, essential programmes, or issues of social concern. The evaluation of requests for posts or equipment was made more stringent than it had been, all new programmes and technologies were costed in detail so that the long-term financial implications could be deduced, a standard drug list was introduced, and a conscious effort was made to increase productivity and efficiency. Staff commitment was important in this exercise. All medical personnel were involved but it was necessary to focus particularly on senior doctors, as they had a lot of influence in the system and all their decisions had financial implications. They were briefed on government intentions and became involved in the making of decisions, particularly those related to their work. Field visits were made by senior officials and reminders were repeatedly issued on the need to economize at every possible opportunity.

Personnel management

In addition to the redistribution of posts and staff, steps were taken to improve productivity and staff morale. A number of critical training programmes were revised so as to improve their relevance and effectiveness by emphasizing the required skills and attitudes. Senior doctors were brought into the planning, reorganizing and implementing of training programmes to an increased degree. Specialists were encouraged to try and interest young doctors in their disciplines and to identify suitable candidates for training. Considerable success has been achieved in this area.

The Ministry of Health strives for the expeditious solution of staff problems that may be raised by individuals or unions and associations. Encouragement is given to direct, open discussion of issues rather than to the writing of letters to the lay press. One can never be too personal or detailed in dealing with staff problems. I have received numerous letters from individual members of staff regarding their personal problems. All such letters were acknowledged and, if possible, dealt with promptly and personally. Similar treatment was given to complaints ventilated at meetings with field staff. In this way staff morale was improved and the credibility of and trust in the leadership were heightened. In personnel matters, nothing is too insignificant for even the top leadership to handle. Small gestures of personal involvement and interest are important in enhancing the credibility of leadership.

Technical training

A number of basic training programmes were reviewed in order to make them more effective. The acquisition of skills was emphasized through the adoption of
competence-based curricula. The Ministry of Health encouraged tutors to upgrade their educational skills by enabling them to attend courses or to hold their own seminars. Managers were encouraged to conduct

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continuing education for their staff. I have taken a direct personal interest in training, even to the extent of analysing examination results or reviewing past examination questions. One may argue that the Director-General should not involve himself in such matters, but I consider that nothing is too small for me if I am going to be an effective change agent, and that my interest in training has important symbolic connotations in the context of the desired change process.

Exerting influence

There is no single, universally applicable or acceptable way of influencing people. They can be persuaded to accept changes on the basis of certain information or premises. Many of my actions and decisions are based on logic, and in order to gain acceptance I make a point of explaining my actions and decisions. But even logical changes can be resisted by people with vested interests, or may be difficult to implement because of inflexible rules and procedures. This is where the ingenuity and credibility of the leader are tested to the full.

Many leaders advocate a common organizational vision. The Malaysian government’s new economic policy, involving the eradication of poverty and the restructuring of society, is one such vision. Hence the emphasis on programmes for disadvantaged areas and groups, which is expected to be reflected in all agency plans and activities.

In order to influence people through a common vision, this has to be clearly expounded and well publicized. Input is usually required from many parties and agencies. Actions and decisions should always be consistent with the vision, and leadership should set examples of consistency.

I use a participatory decision-making technique when looking at certain problem areas. This usually involves consultation and the holding of seminars and workshops. Participants are requested to come up with suggestions for solving problems that have been identified. I am usually invited to be present when consideration is being given to the final recommendations. The participants, of course, would like to see their recommendations accepted and implemented. Follow-up action should therefore begin as soon as possible so that enthusiasm is not dampened.

Pressure and incentives are also used to influence people. I use subtle pressure all the time. Threats of punishment are made only as a last resort. Pressure may be exerted by setting time limits for the completion of tasks, making unannounced visits, not accepting substandard work, and so on. My subordinates are also adept at using pressure, perhaps by name-dropping or sending copies of their letters to people they consider to have influence.

It is sometimes said that one should be liberal in giving praise or rewards, but I hold the view that, if given too freely, these
things lose their significance. However, I feel that recognition for good performance should be substantial and visible to all.

In the final analysis, the effectiveness of pressure and incentives depends a lot on the credibility of the person using them. If this person is known to have high expectations and a passion for excellence, and to have demonstrated high standards, the pressure and incentives applied will be that much more appreciated and valued.

Health-for-all leadership

As a strategy for achieving health for all, primary health care implies fundamental changes in the content of health programmes, the organization of health systems, the manner of resource allocation, and the perception and value systems of health care providers and the public. It necessitates a new working arrangement and a relationship that is more mutually reinforcing than that which existed previously.

The entry points for desired changes will be different in different situations. In all cases, however, those who intend to bring about change should be fully committed and have a passion for excellence and progress. Having set the vision or goal, one has to decide how to influence people so that it can be achieved. Some basic knowledge on how to bring about change is necessary. Unfortunately, many of us are forced to learn the hard way. There are, of course, numerous textbooks and case studies describing theories of change and techniques of influencing people.

I believe that an international initiative on leadership development can only be a sensitizing effort or a means of exchanging information and experience. Since leaders, the concept of leadership, and leadership styles are so context- and culture-bound, such an initiative should be reinforced by country-level action around a person or persons of proven ability to change events. The objective should be to equip people with the skill to influence others.

Laszlo Medve

—Reaching out to all who can help or be helped

Although the public health services in Hungary have developed immensely during the past 25 years, the health status of the adult population has declined. In attempting to reverse this trend, we in the health sector have established extensive relations with leaders of sectors who may be able to exert a positive influence in this area, and we have relied to a considerable degree on senior

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Reorientation involves, among other things, winning over the public through health promotion, which I pursue with the help of the mass media, personal contacts, round-table conferences, and so on. Another major task is to ensure that my colleagues understand and support my decisions and measures. In Hungary, classical clinical attitudes have prevailed and community prevention has been neglected for too long. Clearly, a changed outlook on health is overdue.

One of my chief concerns is to confront financial difficulties through the frequent modification of development programmes and the increasingly accurate setting of priorities. In this respect I rely on my colleagues in health economics to a considerable extent. We are currently elaborating a strategy to adjust the rising cost of the health care delivery system to economic reality, taking account of expenditure on the national programme of health promotion. Unfortunately, we have failed to set the price of health care delivery and therefore cannot utilize cost-effectiveness ratios in planning and evaluation. This is a major hindrance to rational budgeting.

I feel that, with regard to leadership tasks, one cannot treat systems and people separately. Neither causes difficulties; both are affected when problems have to be solved.

Leaders in the health care delivery system should be considered as distinct from those elsewhere; they have to possess both high-level professional knowledge and leadership skills. There is well-established postgraduate training for this group of leaders. I regard leaders who do not work in the health sector but whose activities influence the health status of the population as belonging to a separate category, whose members should be familiar with problems of the sector and with those areas of their work that affect the people’s health. Unfortunately, proper provision for the continuing education of these leaders has not yet been made.

Some time ago a Hungarian claimed to have invented an agent for the diagnosis and treatment of cancer. The news spread rapidly through the mass media and the public exerted great pressure on the authorities to make use of the agent. The scientific community was opposed to using it in the absence of clinical trials, and I, of course, held the same view. I made efforts to convince the public of the ineffectiveness of the agent through open debates in the mass media. Interestingly, these discussions provided us with a great deal of useful feedback on people’s health problems, and, I feel, enabled us to convey more to the population about the importance of the prevention and treatment of cancer than would have been the case had we simply issued a decree.

Amorn Nondasuta
interviewed by Roger Chical

—Actions louder than words

Dr Amorn Nondasuta was Director-General of Health in Thailand from 1980 to 1983, Permanent Secretary for Public Health from 1983 to 1986, and one of the chief architects of his country’s primary health care system. Dr Chical was the WHO Representative in Thailand from 1973 to 1977 and again from 1982 to 1985, and worked closely with Dr Amorn during both of those periods.

Dr Amorn Nondasuta and Dr Chical are with the Foundation for Quality of Life, Ministry of Public Health, Bld. 1/1, Devavesm Palace, Bangkok 10200, Thailand.
Dr Chical: Dr Amorn, between 1950 and 1967 you started community participation in health matters in northern Thailand, long before the term "primary health care" had come into prominence. Can you elaborate on this important initiative?

Dr Amorn: In the early days we found that there were always people who would come and help us in many ways. The idea then came to me that, if we could mobilize people a little more systematically, things might be better. So we assigned certain responsibilities to the people. I started to develop the concept of the village health communicator and, subsequently, adopted the idea of training villagers to perform curative care.

Dr Chical: So in fact you realized that the established health system was not satisfactory. How did you proceed with your innovations while classical plans and strategies still had very strong backing?

Dr Amorn: People already knew that the conventional strategies, like building hospitals and health centres, would not solve the problems. Meanwhile, the Department of Health set up several mobile clinics. I went with a mobile team into the villages and found that very few serious cases were seen. Most of the people we saw just wanted to get some medicine. I didn’t like the idea. So I thought about other possibilities, and developed the idea of getting the people to participate in immunization programmes. I also tried to promote the sale of latrines built by small shop-owners.

Dr Chical: In effect you identified a big challenge and adopted a bottom-up planning approach. Why did you select this approach in Thailand and how did you manage to carry it out successfully despite major difficulties and, sometimes, opposition?

Dr Amorn: As the Provincial Medical Officer in Chiangmai I found that we could break down strategies into activities, assign these to the different categories of people, and produce what is now known as a programme budget. Later, when the country health programme came, I attended the training course.

Dr Chical: In that programme you became the leader of a large team of people from various international organizations. The programme showed that the village volunteer and communicator scheme was the best strategy for primary health care in Thailand. Despite strong opposition from the medical establishment, the strategy was implemented nationwide. The health professions were also suspicious of the idea of "basic minimum needs". Could you comment on these matters?

Dr Amorn: I advocated the volunteer concept because I had experimented with it a long time previously. The academic people didn’t like it at all. Anyway, our ideas were liked by nonprofessionals, particularly in the villages. We started to gather people together who shared our views. The World

Leaders should be able to pass on their vision, thoughts and techniques in simple, digestible form to other people.

Health Organization came along with the proposal for the country health programme, so we introduced this idea into our national planning. The strategy was then introduced
You also became extensively involved in the management of the World Health Organization's programme in Thailand. Can you comment on this work?

Dr Amorn: Our results convinced us that our strategy was right. On this basis I was fully prepared to suggest changes in the utilization of the Organization’s regular budget. I also indicated that I did not like the way money was spent on sending people to take up fellowships and so forth. We spent US$ 14,000 per head to send people abroad and they came back and contributed nothing. There was clearly going to be no improvement if we went on like that. The people in the villages were the ones who mattered, and I was ready to take risks in order to help them.

I proposed that we should design a set of strategies to complement the established ones so as to reshape our health work in favour of community involvement, intersectoral cooperation, and so on. The Director-General of the World Health Organization agreed, so we began using its resources to support complementary strategies that we designed. These resources were necessary because it was difficult to convince the national Budget Bureau that such innovations were justifiable. You supported me and indeed developed some aspects of the concept. Of course, we had to fight quite a bit. When I was Deputy Permanent Secretary, some of my colleagues said I was a dreamer. I would say that I had practical dreams of the future, and that leaders should know where they are going.

Dr Chical: In fact you managed to involve leaders from the Ministries of the Interior, Education, Agriculture and Cooperatives, and Health. To obtain such a commitment you yourself needed a very deep understanding of the social, political, cultural, economic, administrative and organizational background.

Dr Chical: You helped to create leadership in the villages with a view to self-management of primary health care, which in fact became self-managed social and economic development. At the community level you identified leadership for technical cooperation among developing villages. Can you tell us about this?
Dr Amorn: It was going on spontaneously in the villages. It is normal for people to come together and exchange experiences. The regional Director of Sanitation in north-east Thailand proposed using village craftsmen, whom we had trained, to train people from other villages. We decided to start with sanitation work by arranging an exchange of experience and training between village craftsmen. You proposed that we should go into the villages and look at how the people worked and we then started to do something about village development funds. After we had gained some experience we were able to envisage a new programme at community level, involving the people in various ways. After consulting with villagers, I got the idea of setting aside some of the available money as a revolving fund for development. We obtained the cooperation of the Ministry of the Interior in campaigning for latrines, water jars, and family planning.

When one goes into the villages one sees a lot of possibilities and, indeed, one gets ideas from the people. As a leader one does not have to generate all the ideas oneself. I think an essential leadership quality is the possession of an analytical mind. Furthermore, if one cannot conceptualize one cannot get new ideas. If one copies strategies and activities from somewhere else, they could soon prove worthless in one’s own situation. Leaders should be able to pass on their vision, thoughts and techniques in simple, digestible form to other people.

Dr Chical: How do you move from national to international leadership?

Dr Amorn: In my work I have found people to be almost invariably simple, hospitable, and sincere, and I have tried to reciprocate. When I talk to the authorities in other countries I think I can communicate my emotion, my sincerity, to them. This, I believe, makes a lot of difference, because people feel that I really mean well for them. Of course, when people respond one must have good evidence of achievement to back one up. Otherwise, nobody will believe one later. Leadership cannot be built with empty talk.

Moshe Prywes

—Creed of a health leader

My medical career began in a detention camp, where I served as physician, surgeon, obstetrician, paediatrician, pharmacist, and director of a rudimentary hospital of 350 beds for my fellow-prisoners, and where I trained nurses and other paramedical personnel. We had only a handful of sets of simple instruments and few drugs. There were men and women of many origins in the camp, and I, as well as serving as healer, had to be teacher, priest and, sometimes, even judge to them.

Stark lessons

I discovered more about human nature than at any other time in my life. I witnessed dehumanization but also the sublime expression of dignity, brotherhood, mutual help, friendship and sacrifice. I learned that:

— what one is taught in medical school may have little relevance to the outside world;

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the most valuable quality that a physician can possess is the ability to provide care under any conditions;

by being straightforward and fair one wins people's confidence and can thus fulfil one's task with the greatest possible dignity and devotion.

After the Second World War I became Chief Medical Officer with the American Joint Distribution Committee in Paris, which had begun to organize medical services for the survivors of the holocaust in Europe. A new world of applied public health and physical and mental rehabilitation opened up before me. I realized that, in addition to curative, individual medicine, there existed another vast field in which physicians could serve: that of the care of populations. During this period I learned that, ultimately, public health for all may mean no less than good medicine for each; that the organization of medical care, the improvement of health delivery, the exercising of managerial skills, and the consideration of cost-effectiveness are integral parts of health leadership; that a good leader not only leads but also knows how to work in a team; and that an important responsibility of the health leader is to gain the involvement of local community leaders and activists in health promotion.

What one is taught in medical school may have little relevance to the outside world.

The academic world—and beyond

In 1951 I became Organizing Dean of Hadassah Medical School in the Hebrew University, Jerusalem. I was only 36 years old and had no experience in academic medicine or the organization of teaching and research. During my 22 years there I learned that academic medical centres have an important role in health leadership and that, from time to time, they should undergo a process of self-evaluation and accountability to the society in which they function. The responsibility for this rests with the leader, who should therefore initiate it without prompting.

In the late 1960s I recognized that Hadassah Medical School allowed me to fulfil only some of my medical aspirations. Academic medical centres promote science and produce highly specialized physicians but commonly neglect health for all. They often fail to open a window on the community, and have insufficient awareness of preventive medicine, primary care, and the impact of the prevailing system of health services.

In 1970, Kupat Holim, the largest medical organization in Israel, and the young University of the Negev in Beersheba, were striving to create a medical school that would produce practitioners other than highly skilled specialists. Both institutions asked me to prepare a draft programme for such a school. So I drew up a list of all the shortcomings of my own, highly scientifically oriented, medical school, then devised a plan for Beersheba from which they were excluded. The draft was submitted in 1972 to the National Council of Higher Education, on which the representatives of the universities opposed the project whereas the lay representatives supported it. Eventually the stalemate was broken by the chairman, who voted in support.

I was elected Founding Dean of the school, which, on my invitation, Senator Edward Kennedy of the USA opened in November
1974. This came about as follows. In September I was in New York and saw a television programme during which Senator Edward Kennedy, as Chairman of the Senate Health Committee, spoke about his national health insurance project. Among other things, he referred to the achievements of Israel in this field. This induced me to telephone him directly at the Senate. I introduced myself and said that, since he had mentioned my country in his speech, I would very much like him to visit Beersheba and open our new medical school. This he did, and subsequently became a very devoted friend of our University. The school adopted the slogan “Health for all” and had an initial intake of 30 students. During the subsequent years I had to keep the faculty alert to the concepts of the school and search for highly qualified staff. I also had to contend with the conflicting priorities of the university and the demands of the trade unions, which would not give up any of their prerogatives in order to foster our new approach. None of this was easy but the challenges were perpetual and responding to them was often enjoyable.

Samiti, Ajmer District, Rajasthan, since 1972. The Centre’s experience of community health work in rural areas has not simply amounted to putting a well-defined concept into practice. It can be seen as a struggle to create a meaningful concept of health intervention through active involvement with the poor. The specific features of the programme evolved as a result of debate. There were many shifts in perception among both the interveners and the rural community.

**Entry point**

The Centre saw the health programme as an entry point in respect of its larger concern for integrated rural development. In areas of chronic poverty and disease, health care was clearly a pressing requirement. Modern medical practices needed to be popularized and access to them assured, and this became an important objective of the agency. Intervention across cultural patterns and values was required, and the problem of communication arose. People asked why the agency was working where it was, what it wanted from the people, and so on. Questions were raised about the youth of the medical team and the presence of women in it, and it was suspected by some that the Centre wished to convert the people to Christianity. So the first step was to start a dialogue with influential members of the

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**Aruna Roy, S. Srinivasan, & Sharada Jain**

*Health in a broad canvas*

The Social Work and Research Centre at Tilonia in India is an integrated rural development agency that has been working with the rural poor in Silora Panchayat

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community, in order to increase their understanding and acceptance of the agency.

Eye camp

One of the first health initiatives consisted of organizing an eye camp. This was done largely because the people were already familiar with eye camps, which therefore raised relatively few questions in the community. In a society where purdah is common and women's diseases are a matter of staram or embarrassment, eye diseases are comparatively easy to deal with. Moreover, they are of concern to men and some women in their fifties or older, the people responsible for decision-making both in and out of the home.

Traditional health network and skills

At first the community network for health management was not readily understood or even perceived by the agency team. The traditional pattern of health management is not manifested in forms that are easily recognizable by outsiders. Almost all castes play distinct roles in health care. Some people set bones, some do physiotherapy; dais look after midwifery duties; nomadic groups treat poisonous bites; the bhopa or exorcist, although not very competent in dealing with physical diseases, is an accepted healer of hysteria and various tensions.

The medical team gradually appreciated that the dais, bone-setters, bhopas and others were important to the programme. Once the skills of these people were identified as resources, a dialogue was initiated. The people concerned were ready to cooperate with, support and supplement the Centre's health programme. The change in the attitude of the bhopas was particularly interesting. Whereas traditionally their role had been to drive away evil spirits that possessed patients, they now recommended visiting the Centre's dispensary instead of a temple. Meanwhile, the doctors in the team also began to think differently. For example, they recognized that the villagers had their own knowledge of disease and treatment, and that the foisting of alien methods of treatment on them was inadvisable if cheaper effective methods already existed.

With these shifts in attitudes a new phase of cooperation began. The aim was to give and take with understanding. A fresh confidence arose out of shared concern. The conflict between opposing systems slowly gave way to a common search for the causes of ill health. It became clear that greater success was achieved by building on existing skills than by imposing new ones.

Particularly rewarding were the interactions with the dais or village midwives. Through them a pre- and antenatal programme, and a family planning programme, made an unobtrusive but firm beginning. The delivery of children was made safer and it became possible to overcome villagers' fears of certain modern practices, e.g., the use of anti-tetanus injections.

Demystification

A difficult task was to initiate a process of demystification among the villagers—of both the modern system as projected by

A programme for health had to be seen as part of a much larger struggle for equality and participation.
doctors, nurses and others, and the traditional one. People regarded both the bhopa and the doctor as possessing superior knowledge. The “magic” of the bhopa was paralleled by the “magic” of drugs; both could be used for commercial ends at the expense of the patient. Reliable information clearly had to be disseminated in an idiom that could be absorbed. This was an immediate requirement in the health programme. It was met by a group consisting of both villagers and outsiders.

**Sociopolitical questions**

Health was but one of many areas that the agency wished to knit together. Issues related to agriculture, schooling, employment and technology choices were equally important. Working with these problems, one realized that the village community was not homogeneous. There were the rich and the poor, the landed and the landless. Our work therefore had political implications. The agency had to be concerned first and foremost with the poor. The health programme could not be neutral. It was apparent that village power structures had to be examined in order to avoid vesting medical authority in hands that might abuse it.

Villagers generally regarded curative medicine as more important than measures of prevention, which were said to be meaningful only when curative processes were readily accessible. This was because people wished to be cured of illness as fast as possible so that they could continue working for their living. The emergence of local leadership in favour of preventive medicine was clearly necessary.

Hunger and malnutrition, the biggest enemies of good health, are economic concerns. Access to any of the primary health needs—food, clean drinking-water, and so on—is related to the realities of money and power. The direct connection between poverty and disease was obvious in our work. More often than not, people cured of tuberculosis eventually came back with the same symptoms because chronic hunger and bad living conditions had precipitated a revival of the disease. It became clear that what was required to defeat tuberculosis was not just inoculation and medical care but also a more equitable distribution of wealth, land and food. A programme for health, therefore, had to be seen as part of a much larger struggle for equality and participation.

It is too much to hope that a voluntary agency will be able to provide adequate curative care over any significant area. Government is the only possible source of basic cover on the large scale. A voluntary agency such as ours can make a useful contribution in motivating, educating, mobilizing and facilitating. Lessons learnt from our Centre’s curative work are valuable for the government health programme. Voluntary agencies should remain centres of innovation and learning and play a more active role in making government networks more responsive and accountable to the people.

**Acknowledgements**

We wish to thank Dr Arti Sawhney and Manya Jayaram for background information on the health programme of the Social Work and Research Centre at Tilonia.
Guillermo Soberón

—Leaders must create conditions for change

Earthquakes shook Mexico City in September 1985, resulting in heavy losses of life and facilities. It was necessary to concentrate immediately on the care of the population, then to restore the health care system, and, while still engaged in the tasks of reconstruction, to resume work on programmes that had been initiated before the disaster.

Problems in reorienting the health system

These earthquakes coincided with a period of sharp reductions in public spending, which were preventing the implementation of established strategies and activities within a reasonable time. In addition, the Mexican Institute of Social Security had reservations about decentralization, essentially with

Health leadership requires the ability to take charge and create conditions for change, and to encourage others to use their own initiative.

respect to the extension of certain services to sectors of the population without social security entitlement, and about adopting agreed information and evaluation procedures.

In changing the organization and functions of the Ministry of Health and consolidating its position at the head of the sector, while transferring responsibility for the provision of health services for all sections of the population to State governments, we tried to keep in mind the rational and coherent organization of a health sector with uniform functional criteria. We have difficulty in finding managerial staff for the central offices and in the state health services. Inertia among managerial and operative staff is a major obstacle, as they resist the changes in duties necessitated by decentralization, and those in the type of health care needed to achieve a better balance of primary care.

Difficulties arise both with the system and with the people in it. At the system level, the difficulties in the Mexican Institute of Social Security go back several decades and would appear to stem from the vigorous personality of this institution and from incompatibilities in the basic principles on which its component bodies are founded. These problems have not been encountered with the other social security institutions.

The resistance on the part of managerial and operative personnel at the Ministry of Health has led to delays in the issuing of technical standards and regulations. Consequently, there has been a lack of clear directives at the operational levels, a refusal to accept more rational work schedules and other changes in the workplace, and a resistance to the provision of services at the primary level and in rural areas. Efforts to speed up changes in the attitudes of managerial staff have been made at annual meetings of all the central office staff. This has helped to develop a more integrated outlook among the Ministry’s various offices.

One of our greatest difficulties has been the limited amount of timely information
available on health problems and other factors affecting health; such information is needed to decide how activities should be carried out.

This, as well as a lack of drugs and curative medical supplies and an increase in their costs, presented the most critical problems we faced in trying to improve or partially reorient the health system in Mexico.

Help forthcoming

We are fortunate in that the President of the Republic has expressed himself to be firmly behind the health-for-all strategies. With the political will thus generated, a new legal framework of health has been developed and approved, comprising the General Law on Health, the National Health Programme and all its related regulations and agreements, and the right to the protection of health has been elevated to the level of a social guarantee under the Constitution.

In spite of the economic constraints affecting not only the health services but all other sectors as well, we have successfully promoted intersectoral action, which has enabled other ministries to participate effectively in programmes with a bearing on health, such as drug production, the addiction control programme, manpower training, etc. We have appealed to social and professional political organizations and to the general public to become involved in health programmes; their mobilization in strategies such as national immunization campaigns and family planning is encouraging.

Skills for leadership

With perseverance, a gradual approach, and determination, we are tackling our problems.

We are setting out to attain fundamental objectives; when a serious obstacle appears, it is necessary to fall back, negotiate, change strategies, wait patiently, and proceed subtly.

Common administrative strategies have been introduced for the forward programming of activities and anticipation of problems, the analysis of epidemiological, administrative, political and financial aspects of the situation to be tackled, and the training of personnel at all levels, with concentration on the development of administrative skills and the implementation of programmes.

My own view is that health leadership requires the ability to take charge and create conditions for change, and to encourage others to use their own initiative.

Kardinah Soepadjo Roestam

—Of the people, for the people

Pembinaan Kesejahteraan Keluarga, Indonesia’s Family Welfare Movement, is a grass-roots organization that aims to motivate women to achieve the best possible conditions of family life. In carrying out its work it has to take account of the hundreds of ethnic groups that exist in the country. Whatever innovations are introduced, the approach should be adjusted to the norms, values, needs, and culture of the people concerned. This means that the leaders, comprising motivating teams and cadres, should have an intimate knowledge of local conditions.

Mrs Soepadjo Roestam is Chief Executive Officer of the Indonesian Family Welfare Movement (PKK), Jalan Pahlawan No. 8, Kalibata Jakarta Selatan, Indonesia.
The Movement operates programmes relating to:

- the comprehension and practical application of the national ideology, *pancasila*;
- reciprocal cooperation or *gotong royong*;
- food;
- clothing;
- housing and home economics;
- education and craft skills;
- health;
- the development of cooperatives;
- conservation of the environment;
- appropriate domestic planning.

The Movement aims to reach family units even in remote areas. It operates throughout the country, covering 66,339 villages. The cadres commonly have to ride on horseback, walk long distances, or even make use of small boats, in order to visit outlying places. They take great pride in their role and develop a feeling of independence. In a remote village an illiterate woman may become the leader of the Movement’s activists and demonstrate an eagerness to work. This induces feelings of respect among the activists and encourages them to follow her example. Illiteracy does not prevent women from working hard on behalf of the society in which they live.

The basic programmes are planned, financed, carried out and evaluated by village motivating teams. This approach helps to achieve impetus in favour of family welfare and to create understanding and cooperation. Being a leader in the field of health tends to generate self-respect and self-confidence. The cadres gradually improve their knowledge, skills and attitudes.

**Integrated community health posts**

*A posyandu* is an integrated community health post covering family planning, maternal and child health care, immunization, nutrition activities, and the treatment of diarrhoea. The goals are to:

- decrease the infant mortality rate and the crude birth rate;
- encourage the creation of small, healthy and prosperous families;
- improve the ability of the community to develop health activities and supporting measures.

Each post opens once a month and usually serves 50–100 children under five years of age. Cadres, trained in the areas of health and family planning, perform the non-medical functions of the posts and assist in monitoring the participation of their members in programmes for such children and for eligible couples, pregnant mothers, lactating mothers, and families suffering from diarrhoeal disease. The cadres are able to contribute towards the improvement of participants in the Movement’s work. In some cases, women receive help from their husbands in weighing babies or preparing the sites of *posyandu* activities.

The Movement tries to reach all village families on a personal basis so that they will have the opportunity to develop
individually. It is considered important to persuade every participant that she has a vital role to play in the development of her village.

In the district of Lauwala there are still many illiterate mothers, and an attempt to convey messages about health and the Family Welfare Movement is being made by using music and songs. Public meetings conducted on this basis by literate cadres are also being used to encourage people to become literate and numerate.

Starting up

How can the Movement’s programmes be introduced into a village? One possibility is indicated by experience gained in the Kaliangkrik district, where the women used to carry water great distances. The Movement, with government and other help, constructed a simple piped-water system. This initiative provided the entry point needed by the Movement for the rest of its programmes.

Of course, the interventions vary with local conditions. In West Sumatra, where the women are diligent and skilful, the proper solution is to offer the opportunity of learning new skills. In North Sulawesi there is a village where beauty courses are used as the entry point. For Muslim villagers, good results can be obtained by providing encouragement to learn how to recite the Koran.

The best entry point may be difficult to find because social, cultural, psychological, economic and perhaps political factors may have to be considered. Sometimes village leaders have difficulty in this matter and the Movement’s motivating team at district or higher level then tries to help in the choice of suitable solutions.

Marie Joan Winch

-A new era for Aborigines

I work in the Perth Aboriginal Medical Service, which began functioning in 1973, since when many dedicated people have given their time and expertise to the cause of improving the health status of the indigenous people. The main aim of the Service is to introduce preventive programmes, a process not helped by the proliferation of medical jargon and the shortage of funds.

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Long struggle

As an Aboriginal child I experienced injustice and innuendo when our mother took us to hospital. The medical professionals would look knowingly at each other as if to say: “What do you expect? They’re only Aborigines”. When I wanted to study biology in high school I was swiftly guided into another area. When, in early adulthood, I endeavoured to train as a hospital nurse, white students were always given more responsibility than I was. If I dared to complain it was said in front of me that I did not want to work and was lazy. The result was that I dropped out of the system.
At the age of 38, when my daughter reached her sixteenth year, I decided to attend night school. A year later I matriculated and was accepted into the Western Australian Institute of Technology to study for a diploma in Applied Science in Nursing. I had a one-track mind to do all I could to improve Aboriginal health. During the vacations I worked as a driver for the Aboriginal Medical Service and I was eventually elected to its Council.

When I began working as a community nurse with the Aboriginal Medical Service in 1979 the problems were immense. Many Aborigines were living in camps on the fringes of Perth and some were existing under bridges and in old car bodies. The Aboriginal people were largely separated from the medical world by a vast chasm of white uniforms, sterile hospitals, medical jargon and cultural differences. I worked from dawn to dark and was sometimes called out at night and at weekends. Children were hospitalized for long periods and it was not uncommon for people to die in their makeshift camps, rejecting “white man’s medicine” to the last. I came to the conclusion that, if I continued with reactionary nursing, I would achieve nothing of lasting value.

I have always believed that people can be induced to rise to the expectations of their teachers and that the sky is the limit.

The right kind of education

Traditional health education given to a parent with a sick child is like water off a duck’s back. My burning thought was that effective health education was the key to improving Aboriginal health, so I put together an educational programme which, I considered, would be relevant and acceptable to our people. I took into account the main medical and social problems, the need to understand simple life-saving procedures such as giving dehydrated children extra fluids, and the need to desensitize both white professionals and Aborigines in a culturally acceptable service for health.

One of the major drawbacks that had kept Aborigines out of medical science was their inadequate basic education. We therefore decided that no formal education would be required for entry into our course, which was to be granted on the recommendation of the applicants’ own communities. We would have to be prepared to get our message across to people with little or no education. This aspiration was ridiculed by all the education experts who contemplated it. I, however, have always believed that people can be induced to rise to the expectations of their teachers and that the sky is the limit. A few white professionals agreed with me, and the doctor at the Aboriginal Medical Service, David Paul, was my greatest ally.

I wanted to convey to Aborigines that health care was their responsibility. The students had to learn how to debate Aboriginal health needs with white professionals. Because we had suffered 200 years of oppression our strongest unit had to be that of Aboriginal culture. We contacted Aborigines who had strong beliefs and asked them to contribute to our programme. Medical personnel who had worked with Aborigines were also asked to take part. This took a lot of time and effort—for many months I was involved in lobbying after work, as I was still engaged as a field nurse.
The next step was to obtain finance. The Department of Aboriginal Affairs agreed that the programme had merit but could provide no money for it. An approach was then made to the Federal Education Programme, which offered funding for students’ maintenance and equipment allowances. Our requirement for premises was met when the Lotteries Commission provided US$41 100 to enable us to put up partitions in a warehouse behind the offices of the Aboriginal Medical Service. Advertisements were placed in local papers and information was sent to as many communities as possible in both rural and urban areas. The programme was set out so that Aborigines could learn about all aspects of health and acquire skills, including literacy and numeracy, that would allow them to become key persons in preventive and curative health care in their own communities and to fulfil the role of teacher. Considerable attention was paid to the personal development of the participants, both as Aborigines and as members of Australian society.

Twenty-five students aged 18–51 years were selected from all over Western Australia. Their educational backgrounds were diverse, some of the students having studied fairly recently, others not having done so for over 30 years. The metamorphosis from quiet retiring people unable to communicate with each other to outgoing health workers who could conduct meetings and give lectures in the community was dramatic. For too long the Aborigines have been unduly self-effacing and negative. The time has come for them to assert—and help—themselves.

Ken Cox

Leadership for health for all

*World Health Forum* asked Professor Ken Cox to consider the experiences described above and to interpret them in terms of the nature and performance of leadership.

We respect leaders and we follow them. What are they doing to make this so? Can we extract some lessons from their strategy and their style? Can we emulate them? Can we use their experiences as guidelines for our own efforts towards health for all?

The above eleven stories vary in their focus, the size of the tasks and their audience. Nevertheless, some intriguing lessons emerge from the very different experiences they describe. Each leader had a vision, a direction, a goal that was articulated as a clear message. Each one brought together a group of like-minded people and worked with them to evolve their strategy and activities. The group’s capacity to manage new activities was built through mutual

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support. Much effort was needed to discuss, clarify, and demonstrate the ideas before they were accepted. Resources were won only after assiduous persuasion. The sequence was long drawn out, so commitment and stamina were essential.

What can we say about the leaders?

Does the key lie in individual personalities, or in what they did and how they did it? It is worth noting some of the personal characteristics that seem to be critical elements of success.

Their visions were “practical dreams” as Amorn Nondasuta put it, or rational determination as expressed by Moshe Prywes. While their heads were in the clouds their feet were firmly on the ground, but dreamers they were, for they were visualizing a very different state of affairs. Each was creating a new way of working together, a new capacity for a community to manage its own health care; each was changing the established pattern, showing people a new way of seeing their world and how it could work. Opportunities were being created to do things in a new way. Each dared to jump to a state he or she could imagine, but which did not exist.

Where do visions come from? The literature suggests they come from many different sources—from personal experiences of unhappy situations to be prevented in the future, from listening attentively to others and asking more and more questions, from ideas that arrive by happy coincidence when someone is ready for them, and from logical extension of the present. Some of those situations have been expressed in the above accounts.

Whatever the source of these visions, their direction has been to create something for others. Their grand designs were for social goals which all could share, never aiming to build an empire or an ego. For Phillip Bonnick, Kardinah Soepardjo Roestam, Amorn Nondasuta and Moshe Prywes, those goals were not limited to the health sector. All retained high political sensitivity and were in no way naïve.

To achieve their goals, all needed commitment, or what Marie Joan Winch called a “one-track mind”. Patience, persistence, perseverance and determination were identified by Guillermo Soberón, Bonnick and Abdul Khalid bin Sahan; Soepardjo Roestam saw the same qualities in the tenacity of her community working group. These leaders had long-term goals: their task was not based on a one-step success but on a sustained sequence with the goal always in mind.

What did they do?

What were their plans? How did they go about it? How did they do it?

While we can dissect a number of strategies, what comes through these accounts surprisingly strongly is a personal philosophy each demonstrates in building the capacities of others. They have made things happen through enabling others to act who could not have done so on their own. They were
not doing good to others, but creating a better world with others. Their approach has been towards a shared constructive humanity, doing the right thing together. That is, their skills have been in channelling the energy of others and in helping people believe in themselves and in their ability to bring about change. Most people, as Khalid bin Sahan noted, do not recognize or use the power they already have.

Helping people to gain pride in themselves and confidence in their abilities is not simple. For Andrew Cole, the key was a community-financed revolving drug scheme; for Mamdouh Gabr it meant engaging local leaders, professionals and the public in the oral rehydration programme; Laszlo Medve persuaded politicians and administrators to undertake health development; and Soepardjo Roestam pinpoints the growth of people’s self-respect through their valued social contribution. For Winch, generations of negative messages had to be reversed with the building of self-esteem. The symbolic importance of listening carefully to colleagues as individuals was emphasized by Khalid bin Sahan.

This ability to lead from behind, by helping others to become more capable, seems paradoxical if leadership is seen only in terms of power or strength. Leadership is often equated with making firm decisions swiftly, taking the problem by the scruff of the neck and organizing what everyone must do. Certainly these leaders were clearly in the forefront and responsible; but, in these examples in the health field, they all worked simultaneously with others at all levels rather than from the top down. This may seem a nice balancing act between authority and delegation. Their skill, however, seems to lie in motivating people. People follow leaders if they can gain pride from seeing the tasks as worthwhile and their contribution as important. Tasks can even be seen as fun when people are solving problems together and supporting one another in the process. Such a skill can be built only on a warm respect or love for one’s fellow human beings.

Credibility of both the leader and the message was necessary, and was best demonstrated through their usefulness. Roy’s community wanted curative care assured before any interest was taken in preventive care. Her team’s fitting with the existing health network, and building on local beliefs and skills, were essential first steps for acceptance before mutual seeking was possible. Khalid bin Sahan’s strategy of ensuring many small successes encouraged enthusiasm. The slogan “nothing succeeds like success” not only reflects raised morale but also provides a strategy that shows the vision in action.

The process had to start where the people were, not where the leaders would have liked them to be. Roy had to find an entry point to lower suspicion and gain trust, to begin with the health care of socially neutral areas, and to gain respect through providing some benefit from the care; Cole demonstrated ‘magic’ power as a first condition, but then involved the community in the village health worker scheme and even allowed traditional healers into the hospitals; Amorn Nondasuta capitalized on everyone’s penchant for conversation to create the village communicator scheme; Gabr used the pharmacies and the private sector for production and distribution of oral rehydration salts because that fitted local conditions best; and Soberón turned the disaster of earthquakes in Mexico into an opportunity to decentralize services, despite reductions in funding.

Such beginnings were not manipulations to gain access, but the start of helping the community to learn how to do things for
itself. Together, Bonnick’s people began to work for their health centre. Through their involvement these communities have begun to cease being passive recipients of programmes (which Cole saw would collapse when the external aid ceased); instead, they start to feel responsible for the changes, and can choose how and when to adapt solutions to their own conditions.

To be able to start the process, the leader needed to be in a strategic position, which legitimized using the opportunity to influence others and to begin implementation of changes. Influence was upwards to ensure political goodwill (and perhaps resources), sideways to draw in other sectors, and downwards to build a working team. Leadership was not for exercising the power of position, but for applying leverage in getting things going.

The strategies used were strongly directed to practical implementation. By converting intentions into acts the leaders gained a reputation for action, which in turn increased their effectiveness.

Implementation involves many people in many organizations, some of whom may see themselves adversely affected by any changes. Soberón was constrained by (legitimate) regulations from other sectors. The leader’s function was to Marshall everyone involved in the common task, which had to be clearly defined and accepted. Leaders had first to establish a common understanding and agreement; without their capacity to communicate their vision and a sense of direction others could willingly share, implementation would not have proceeded.

Let us not idealize the process of leadership, however. The task of spreading the message includes repeated discussion, clarification and consultation. Committees must meet very many times before they will make the commitment their name implies. The dissemination of new ideas entails prolonged groundwork in order to explain, listen to objections and uncertainty, and overcome resistance and inertia. Persuasion, publicity and lobbying comprise what Gabr called social marketing, while open debates were very helpful to Medve in feeding back people’s problems and priorities and ensuring more accurate targeting of programmes.

Working groups must be identified and mobilized and then fostered and organized (necessitating well-developed small group skills, as in Soepardjo Roestam’s approach). All the accounts reflect acceptance of a long-term commitment, and a persistence despite disappointments. “Don’t give up,” said Bonnick, “and don’t wait for public officials to appear and tell you what to do. Be prepared to act yourself”. These leaders epitomized the slogan “leadership begins with me”.

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These stories do not allow us to write a job description for leadership. No set recipe emerges, but rather a process with a number of essential elements. Each of these leaders had to make use of opportunities wherever they occurred, or even had to create opportunities if the situation was static. But, above all, they knew where they were going and they took people with them. They kept going, despite obstacles on the way. Many followers were encouraged (literally, they were ‘given heart’) to take the same path.

Together, things became possible which had daunted them as individuals. Together, they created something that had not existed before. When the leader’s task was over, they were able to keep going on their own.

The leader had ‘heart’, and also gave ‘heart’ to others.