LEADERSHIP IN PURSUIT OF HEALTH FOR ALL—OUTLOOK FOR THE NEXT MILLENIUM

Address by

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THE NETWORK OF COMMUNITY-ORIENTED EDUCATIONAL INSTITUTIONS FOR HEALTH SCIENCES WORKSHOP ON LEADERSHIP DEVELOPMENT OF COMMUNITY, HEALTH PROFESSIONALS AND EDUCATORS

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In 1977, the World Health Assembly in resolution WHA30.43 decided that the main social target of governments and WHO in the coming decades should be the attainment by all the citizens of the world by the year 2000 of a level of health that would permit them to lead a socially and economically productive life. This vision of Health For All was based on the principles of equity and social justice. It entailed a fundamental change in the way health was perceived and provided at that time under the traditional system. To initiate and foster this change, there was and still is a critical need to develop leaders who can develop a vision for the reform process, motivate others to pursue the objectives implied in the vision and direct national and international resources towards the common goal of health for all.

It is difficult to describe or define leadership. Different interpretations of leadership exist. Many studies have analysed the characteristics of leaders who have had a dramatic influence in changing the course of history—sometimes with charisma, sometimes with trauma. Effective management and material success are often linked to leadership qualities. It is often said that leaders are born, not made. However, I believe that leadership, to be effective, must be linked to the social changes it produces. These changes should be relevant to the needs, aspirations and values of the society. Good leadership reflects firm moral values, has integrity, and courage under trying circumstances. I believe that such “leaders” are not born that
way. They emerge to assume responsibility for redefining and reshaping the policies and programmes to respond to the needs and expectations of the civil society. Leadership of this kind is essential for achieving the noble goal of Health for All, a vision concerned strongly with social values and social change.

The vision of Health for All evolved through the collective decision of the world community. This decision was based on our common concern that the existing gross inequality in the health status of people between countries and within countries was politically, socially and economically unacceptable. The commitment evolved from our disenchantment with the existing patterns of health care delivery systems, which were neither relevant nor affordable. It reaffirmed that health is closely interlinked with the level of quality of life and is the prerequisite for all political, social and economic development. It also strengthened the conviction that health is not a matter for health professionals only, but that people have a right and duty to be responsible for health, for which they need to be empowered. The Health for All declaration was indeed the beginning of a new partnership between governments, civil society and international agencies, such as WHO. This partnership called for sharing of responsibilities to achieve the desired goal.

This brings us to the critical challenge that we face in pursuit of Health for All goals. The challenge is, “how can the health sector
provide the catalytic leadership in mobilizing a true partnership of all stakeholders including the community, to achieve an acceptable quality of life for the people?” Let us deliberate on the type of leadership that is really needed for this task.

There is a strong recognition that, unfortunately, health professionals have not yet come up to the expectations of society or demonstrated sound leadership for Health for All. Their concern for the disadvantaged and their ability to adjust their role from that of being providers of disease-oriented care to one that includes facilitating peoples’ own actions for health have not been reflected in their leadership roles. Similarly, it is clear that current education systems do not respond to the needs and challenges of Health for All. The situation is made worse by the insufficient resources available for health and social development, which have been reduced even in the recent past, especially in the developing countries, but also in the industrialized world. To overcome these constraints, the political, professional and private sector leadership needs to be provoked, urgently.

The existing situation is a clear leadership challenge but mankind has time and again risen to such challenges and crises. If we are committed to accelerating the pace of our march towards Health for All goals, the leadership for health has to be available. This commitment is required of political, professional, managerial and
community leadership. In the final analysis, it will not be simply finances and technology that will achieve Health for All but effective and dynamic leadership with the will to bring about the desired change.

The first task of this leadership should be to create awareness in society of its own needs and values, such as social justice and equity. Therefore, leadership for Health for All should aim at fully engaging each person involved in the process. It is also important to distinguish between leadership and management. Managers are people who “do things right” while leaders are people who “do the right things”. However, effective managers are often good leaders as leadership is an essential part of “good managing”. Similarly, occupying a leadership position in an organization does not automatically confer leadership qualities. This leadership in an organization is the result of the collective efforts of all individuals. In this context, everyone involved becomes a potential leader, irrespective of the position he or she occupies.

Perhaps the most important function of leadership is achieving change, especially for the collective purpose of society. Such leaders are agents of change and are moved by a vision. The vision of Health for All encompasses fundamental changes in the way health is promoted and protected. These changes are required at all levels of the health system, as well as related systems. Therefore, leadership for
health for all is needed for every single unit, at every level that comprises the health system, and throughout the spectrum of the national structure, i.e. in the community, among health professionals, in political organizations, health sector institutions, universities, nongovernmental organizations and the private sector.

At each level, different leadership functions evolve according to the responsibilities of the leadership position and the nature of the changes sought. At the central level, these functions include directing and guiding policies, evaluating and advocating for change, mobilizing and directing resources and motivating others. At the intermediate levels, leadership responsibilities include providing managerial direction for implementation, monitoring and evaluating, resolving issues and communicating with other stakeholders. At the community level, it essentially means coordinating community action for health, including resources, and influencing those at higher levels to support community health programmes.

Although the Health for All movement has been widely accepted worldwide, a substantial gap remains between what was agreed upon and what has been done. One major constraint is the lack of availability of sufficient numbers of leaders at the political, managerial, social and technical levels who can collectively pursue the process of change. It is essential to create a critical mass of people with the attributes necessary to motivate others and direct their
national health development processes. Strategically located throughout the entire spectrum of a national structure, these leaders can support each other in creating and pursuing conditions for change. The critical mass should consist of those who have a direct involvement in the health services system as well as those able to provide support in different capacities.

The process of achieving this critical mass of leaders in support of health should be continuous in nature; there is no simple formula or guideline. An appropriate and supportive learning environment is an essential prerequisite; the process of leadership development should be people-centered, aimed at identifying a human potential that will improve the situation, not only through “doing new things” but “doing things in new ways”. It should be concerned with developing group leadership rather than cultivating top level leaders.

The opportunities for undertaking leadership development are plentiful and there are many possible entry points for this process—in the workplace, in the community and in educational settings. Similarly, there are many individuals with the potential to become leaders and the willingness to work towards the social change required. However, care must be taken to avoid confusing leadership development with management training. Leadership development should focus on values and issues, which affect large groups, rather than on managerial tasks and problem-solving techniques. Leadership
cannot be taught through manuals or guidelines. It is an interactive process, a learning from experience, success and failure, and from others. The process must provide the skills to deal with a wide range of issues in a variety of settings and provide opportunities for enhancing skills and knowledge on a continuing basis. Trying to systematize the learning process risks removing it from the local specificity that is critical to understanding and developing leadership. Often, it is the leaders themselves who can provide the best insight into the Why, How and What of their leadership requirements.

The target groups for leadership development should cover all levels and segments of society. They may include top level policy and decision-makers, senior bureaucrats and technocrats, elected/appointed leaders at community level, nongovernmental organizations, informal workers, women and youth in educational settings. Seen from this perspective, it is clear that leadership development must permeate the total fabric of a nation so that the collective energy generated may become the “force” which should work towards human development of which health is an integral part. The process should equip people to become self-reliant, self-confident and self-supporting. It also means that this should be a self-sustained process wherein a new generation of leaders moves in as the older ones move out. Particular emphasis is needed on changing undergraduate medical and nursing training as well as postgraduate and in-service education to make these community-based and oriented
towards the health development of the population, rather than just the medical care of sick individuals.

In my opinion, leadership development should have a broader agenda than just improving technical competence. A dynamic leadership programme should have four interactive elements—ethical, political, social and technical. Leadership should be responsive to the demands of the community, while at the same time being directly accountable to the public at large for resource allocation and decisions. Therefore, the knowledge and skills which are required include the ability to analyse and interpret policy, develop future projections, set priorities, conceptualize the process of how these can be realized and evaluate one’s own and others activities. This should also involve more sophisticated skills in communication, negotiation, advocacy, conflict resolution, networking and team working to motivate and mobilize other members.

To meet the challenges of the new millennium and to address all the dimensions of the renewed strategy of Health for All, varied approaches for leadership development should be explored. These approaches should be suitably adapted to local situations, in accordance with the leadership functions and levels being addressed. These approaches should endeavour to improve the individual’s own abilities as a leader as well as provide broad-based advice on how to become a more effective manager by integrating leadership qualities.
Leadership training should be a priority in all national human resource development programmes. Courses should be arranged to meet the immediate needs for senior management as well as for those who will be acting as leaders in future. Developing leadership at the community level is a more intricate and dynamic process. Here, innovative non-traditional education approaches should be applied, utilizing adult-learning and culturally relevant methods. It is my firm belief that developing community leadership will be one of the most crucial challenges in the next millennium and one that will contribute most to accelerating progress towards Health for All.

Some supportive strategies which can assist our efforts in organizing leadership development include the following:

- Establishing and promoting a resource network, at national and international level, that links individuals and institutions that can initiate, stimulate and support leadership development.
- Identifying experiences of successful leadership in action at all levels and in different socioeconomic and cultural settings.
- Preparing relevant information and learning materials to clarify HFA principles and strategies. These materials should facilitate discussion only rather than act as guidelines for action.

For successful and sustainable leadership development, certain barriers must also be overcome. These include:
• lack of commitment to leadership development at many levels of the health system
• lack of career prospects and incentives
• failure to involve and motivate all segments of the health system, and supporting sectors and institutions
• inappropriate training or lack of opportunities for continuing education
• overcentralization with rigid and traditional bureaucratic structures, and
• poor communication and exchange of information.

Taking advantage of the opportunity provided here today, and in my capacity as WHO Regional Director for the Eastern Mediterranean, let me briefly describe the efforts being undertaken by the Organization in this field. One of WHO’s roles is to support countries in creating the necessary change that will provide the opportunities for the attainment by all peoples of the highest possible level of health. Very early on, WHO recognized the importance of committed and skilled leadership for making any substantial progress in this critical area. Accordingly, in 1985, WHO launched the global initiative of “Health for All Leadership Development”. The initiative was principally concerned with triggering and sustaining actions to enable the leadership, present and future, to achieve more rapid progress towards the goal of Health for All.
The initiative has since been vigorously pursued at all levels in WHO. Among the six regions of the WHO, the Eastern Mediterranean Region was particularly active and in the forefront of translating this initiative into concrete action. This was manifested in the resolution adopted by the Regional Committee in 1985 that stipulated that 10% of the country general fellowship allocation should be used within the framework of leadership development.

In follow-up to the recommendation of the Regional Committee, the Regional Office, in collaboration with the national authorities, has run a leadership development programme since the late 1980s. The major objective of the programme is to train and develop mid-career, potential leaders of the national health systems in order to accelerate national health development towards achieving Health for All. The participants of the programme are expected to gain knowledge and skills in four major areas that will enhance their competence and potential as leaders in their respective countries. These areas are leadership attributes; information collection and analysis; planning and management; and human resource development.

Up to 1998, five courses had been conducted successfully, benefiting a total of 64 participants from 15 countries of the Eastern Mediterranean Region and 2 countries (Mauritania and Algiers) from the African Region. The courses have been offered in Arabic, French
and English languages. The sixth course started in September 1998 in Alexandria, Egypt, with 16 participants from seven Member States.

During the Regional Committee meeting held in Beirut in October 1998, it was recommended that immediate steps should be undertaken to decentralize and institutionalize the programme at the national level. This, I believe is a step in the right direction and, to ensure the success of the process, we have decided to undertake a comprehensive evaluation of the courses organized so far. The evaluation will assist not only in analysing the impact of the programme based on the experience gained during the previous courses but will also identify alternate mechanisms of funding for organizing such courses at the country level.

Let me conclude by saying that leadership development for Health for All is a constantly evolving experience and challenge. At the same time, it offers an opportunity for civil society as a whole. It involves challenging the roots of our established traditional political, service and education systems. It is a challenge to the broader leadership issue in the society. It should be an integral part of every organization’s responsibilities, aimed at improving its current effectiveness and sustaining its future. To attain Health for All in the coming years of the next century, innovative strategies and mechanisms will be required for generating effective and collective leadership in society, working towards common goals and the needs
of the people. At no time in our journey towards Health for All since 1977 there has been a more pressing need to develop leadership at the national and international level for the benefit of humanity, a leadership that can bring out the best and most creative of civil society to attain a better quality of life in the 21st century.