

'Learning to Fly' in a world of information overload



Stella Parcell

Geoff Parcell

Geoff Parcell graduated in physics at the University of Sussex, United Kingdom in 1972, and has been a Master Practitioner of neuro-linguistic programming (NLP) for the last six years. He joined British Petroleum (BP) in 1974 as a geophysicist and explored for oil in many countries in Latin America, Asia and the Pacific. From 1990 to 1996 he was involved in managing change within BP by reducing IT spending and improving staff development and planning. In 1997 he joined BP's Knowledge Management team whose work involved encouraging the sharing of knowledge in the workplace and creating the right collaborative environment. In 2003, he was seconded to UNAIDS for 18 months. He left BP this year to become an independent consultant.

Why can't we use the knowledge we have more effectively? Why can't we always find the knowledge we need for our work? If only employers could tap into and use the expertise of their staff better. These challenges are key to Geoff Parcell's recent work with WHO as practitioner of knowledge management. Parcell, the co-author of a best-selling book on knowledge management called *Learning to Fly*, told the *Bulletin* that his work at WHO focuses on connecting people more than capturing knowledge. He believes that working in teams and creating new knowledge together can be a powerful way to work.

Q: What is knowledge management?

A: It's mainly common sense. Every time we send an email, talk to one another or pick up the phone we are sharing knowledge with one another. Paradoxically, you can't manage knowledge, but you can create an environment where knowledge flows easily. For me, it's less important to capture all the knowledge we have and it's more important to be connected to the people who have the knowledge. When I am planning a vacation, I can go to a travel agent and watch a TV programme. But if you talk to a person who has been there, you can ask them everything you need to know. That's when knowledge flows easily because you get the knowledge you want.

Q: Why do we need help to make knowledge flow more easily? Why do you think staff at WHO are not communicating properly with each other?

A: Imagine what we could achieve if all of us knew what each of us knows. But people are driven by their own focus and priorities. Where you have a common goal it's much easier to help one another get there. It's like sailing. If a crew of people sailing are all going in

different directions, they won't get anywhere. If you are very clear on which port you are trying to reach, even when you have done your task you are quite happy to help someone achieve theirs. At WHO, on occasions it seems that some people have lost sight of the fact they are trying to improve world health and reduce mortality, and their publication or report becomes an end in itself.

Q: How do you change this mentality?

A: When working on the response to AIDS [at UNAIDS] I found that if we started with the assumption that local communities have strengths, and that if you listen to them you learn something from them, then they feel good about what they are doing and do more of it and they are more willing to learn from you. Some agencies go in thinking advocacy is the only tool. The private sector has had to train its leaders to move from a role of being answer man to someone who leads and facilitates the conversation. That shift is happening at WHO, but not fast enough.

Q: How can that shift take place faster and what are you doing to encourage it at WHO?

A: First to acknowledge that the shift needs to happen, then take yourself out of the role of expert and put yourself in the role of connector. If we start with the assumption that someone has already done what I am about to do, let's talk and compare experiences, pool our ideas, learn from that and do something better than we have done before.

Q: At what level in the hierarchy should this process of change start?

A: At BP it started with country managers — a high level of acknowledgement that gave the signal to staff to spend time sharing knowledge. In BP business unit leaders were given 20% of their money for the overall results of the business not just to their business unit, so that drove them to spend up to 20% of their time helping other business units. Most people are rewarded by acknowledgement from their peers.

Q: How does this apply to WHO?

A: When we construct programmes at WHO, we can build on what has been done in the past: what are the lessons, what's worked, what hasn't worked and then move forward. There are lots of

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people in this organization who are keen to share and have something to share but feel their voice isn't being heard. If they start sharing that creates a new pressure. Before access to computers, middle managers were the aggregators of knowledge and provided a summary to the boss. Perhaps WHO needs to reconsider whether there has to be a middle manager. That means the top managers are listening directly to those who know. In BP's leadership philosophy, top managers give direction, set boundaries, provide space and offer support, but they don't tell you what to do.

Q: What are the limitations of applying your BP experience of knowledge management at UNAIDS or WHO?

A: I found that the NGOs were incredibly receptive to BP's approach, it gave them a framework and some of them were doing it anyway. It was much more difficult with UN agencies who feel they are the experts. There are technical and medical areas where you need expert advice. But WHO shouldn't see itself as the only organization that can offer advice because people in the field have a lot of experience too.

Q: People have vested interests in maintaining expert status and protecting this with jargon that others do not understand. You say we can counter this by appealing to a greater common good?

A: No, you don't have to be altruistic. A lot of egos get in the way undoubtedly, but you have to accept that people will have their own personal goals and aims. In a business world we try to align those personal goals and aims with business goals and aims. What you must have is a common vision. The '3 by 5' campaign is a good example. You can argue if that was the right goal, but people understood where they were heading by 2005. The problem is that most people haven't agreed on their destination and I don't see the mechanisms for defining that destination. Quite often it comes top-down, but a more powerful way is to sit down and agree on the best destination for AIDS. Why are WHO, UNFPA (United Nations Population Fund) and UNICEF (United Nations Children's Fund) doing things separately? They go into countries where

they seem to be competing with each other. If there is a common overarching target, a direction they were heading for that would still permit UNICEF to focus on children, UNFPA on women, and WHO on health care all still on the same track perhaps at different rates using different techniques, they will get to the same destination. Today I don't think we are aiming for the same place.

Q: What other knowledge management techniques can WHO use to work more efficiently?

A: I would start with self assessment. You give people a range of practices to consider, then they pick what they are really good at and what they need to improve. We already have a framework for HIV/AIDS, and if there were something like this for health, then countries could set their own priorities for the next twelve months as HIV/AIDS and malaria say, and then they would make progress. As it is we are trying to make progress on all fronts and succeeding in few. WHO and its partners are committed to access for health for

all as an overriding goal, but cannot always agree on how to make it happen. But if you agree we want fewer people dying and more people to be healthy, perhaps people working for those agencies can be more focused. If everyday, we ask ourselves 'Is what I am doing helping us get there?' we would be in better shape.

Q: What prevents people at WHO from feeling a common sense of purpose?

A: One factor is human resources policies. Morale is low, people say they are treated very badly, particularly if they are not permanent members of staff. You can understand in this environment why people are reluctant to share knowledge. One reform at BP was quite brutal at the time. Experts

who had been in the central office for 10 years with expertise that was a bit out of date were given two options: to leave and become external consultants or to go into an operational site and refresh their experience and expertise. By connecting with people who had relevant recent experiences, they could pool this. Rather than having one expert or 10 people with 10 experiences, they had 10 people who had shared their experiences and figured out the best way to go forward.

Q: How can stories and anecdotes play an important role for WHO which promotes health care that is based on reliable evidence?

A: I used to find anecdotes told during a meeting to be an incredible waste of time. But now I value them. Anecdotes based on real experiences give people the chance to hear a story they can identify with and extract meaning from for their own situation. Someone is not telling them what to do; they choose which elements of the story are relevant to their own situation, sometimes it will be literal, sometimes metaphorical. Stories give rise to possibilities, not raging certainty. Some of the problems we deal with cannot be solved by avoiding risk but by understanding and managing risk.

Q: Is the mark of a successful knowledge management initiative that it no longer needs to exist because everyone is doing it automatically?

A: BP closed down its core KM team after two years, they said 'it's embedded, it's there' but in fact that wasn't true. That's a good principle to aspire to: you are successful if you do yourself out of business. That that only works in a culture where you think you will have a job afterwards. My experience at BP was there does seem to be an ongoing role for someone maintaining the process, being the champion of knowledge management, reminding people who to connect with whom. ■

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UN Summit boosts health goals

The 60th anniversary UN World Summit gave a much-needed boost to efforts to improve health in developing countries, although there was little progress on proposals to increase development aid from rich to poor countries.

The reform document adopted by 151 heads of state and government gathered in New York from 14 to 16 September watered down UN Secretary General Kofi Annan's original proposals, but health experts said it was positive for the health-related Millennium Development Goals (MDGs).

"The summit laid down a marker to say 'we've got to take time to build health systems if we want to achieve the MDGs'. It put health systems in the middle of the action," said Dr Andrew Cassels, WHO Director of MDGs, Health and Development Policy.

Almost half of the final 35-page document concerned development

issues. Among other things, the section on health recognizes the importance of investing in adequately resourced and staffed health systems if countries are to achieve the health-related MDGs.

It recommitments governments to achieving universal access to reproductive health by 2015 — which is key for MDG 5 to improve maternal health and MDG 4 to improve child health — and encourages support of WHO's Global Outbreak Alert and Response Network. It also reconfirmed support for achieving MDG 6 on HIV/AIDS, malaria and other diseases, including tuberculosis.

World leaders also made a commitment to implement a package for HIV prevention, treatments and care to ensure universal access to treatment by 2010.

"In terms of HIV treatment, we are pleased that we have a timetable, even if countries aren't committed financially," said Max Lawson, policy advisor at Oxfam International.

"For our HIV campaign universal access is a victory."

Lawson said the document was weak in its reference to health-care workers and user fees for health services, which Oxfam believes should be phased out to help combat poverty.

Cassels said there was little progress on proposals to increase aid. The final document encouraged wealthy nations to set timetables for giving 0.7% of their gross national product (GNP) to development aid by 2015.

At the summit, US President George W. Bush announced a new International Partnership on Avian and Pandemic Influenza, in which WHO will play a central role.

"Overall the summit was positive for WHO," said Cassels. "It reflected some of our key messages for the MDGs, discussed means, and talk of the global flu pandemic was everywhere." ■

Juhie Bhatia, *New York*

Recent news from WHO

- WHO Director-General Lee Jong-wook called on UN Member States to build stronger health systems to achieve the **health-related Millennium Development Goals** at a roundtable at the 2005 World Summit in New York from 14 to 16 September.
- The **Global Polio Eradication Initiative**, of which WHO is a member, launched an emergency plan on 13 September to immunize 34 million children in the horn of Africa after a polio case was confirmed in Somalia, a country that has been polio-free since 2002.
- Three public health advocacy groups merged to create the **Partnership for Maternal, Newborn & Child Health** on 12 September. The new group, hosted by WHO, campaigns for better child and maternal health particularly in poor countries.
- A total of as many as 4000 people may eventually die as a result of **radiation exposure from the Chernobyl nuclear power plant accident** in 1986 in Ukraine, an international team of more than 100 scientists concluded. This and other findings were published on 5 September in a United Nations report entitled: Chernobyl's Legacy: Health, Environmental and Socio-Economic Impacts on Impacts. By mid-2005 fewer than 50 deaths had been directly attributed to radiation from the disaster.
- WHO called on countries to educate people who are taking **antimalarial drugs** about the importance of finishing their medication courses, as incomplete treatment can cause drug resistance. The call came after a WHO report published on 6 September called on countries to closely monitor the effectiveness of antimalarial drugs.
- In the wake of **Hurricane Katrina** which hit the US Gulf Coast in August, the Pan American Health Organization, the WHO regional office for the Americas, said on 1 September its experts were assisting the US Department of Health and Human Services at federal and state levels and the Centers for Disease Control (CDC) in a number of public health areas. On top of the devastation wrought by the unprecedented US natural disaster, there is growing concern about the health of thousands of survivors. To read more see: <http://www.paho.org/>
- WHO said in August that seven **antiretroviral (ARV) medicines** manufactured by Indian pharmaceuticals company Ranbaxy Laboratories Ltd which had previously been removed from the WHO list of prequalified medicines had been reinstated on that list.
- On 31 August, WHO's Regional Office for Africa called on African governments as well as civil society and nongovernmental organizations operating in the 46-country Region to involve **African traditional medicine** and its practitioners more in **HIV prevention**.
- WHO's Regional Office for Africa declared **tuberculosis an emergency in Africa** on 26 August at a Regional Committee meeting of African health ministers from the 46 Member States in Maputo, Mozambique. The move came in response to an epidemic that has more than quadrupled the annual number of new tuberculosis cases in most African countries since 1990.
- On 24 August, Swiss pharmaceuticals company Roche's donated three million treatments of antiviral drug Tamiflu (oseltamivir) to WHO's stockpile of antiviral drugs to help with an early response to a **future influenza pandemic**.

For more about these and other WHO news items please see: <http://www.who.int/mediacentre/events/2005/en/index.html>