STRATEGIC LEADERSHIP IN POPULATION AND REPRODUCTIVE HEALTH

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"Public health is the application of science in a value-rich environment"
Adetokunbo Lucas

INTRODUCTION - THE ROLE OF LEADERSHIP IN THE 21ST CENTURY

The 21st century will be the century of transformational change – dramatic change driven by major forces globally and locally - political, social, economic, technological and environmental.(Friedman, 2005) These will profoundly affect the capabilities of less developed countries to produce and maintain health and general well being. The challenge is to see these driving forces as an opportunity for positive change rather than a threat to the *status quo*.

To meet this challenge, we, as health professionals, first need to change ourselves – to change our own mental models – our fundamental understanding of how health is produced and how we can facilitate the production of health. We start with shifting the paradigm - from the traditional view that hospitals, health centers, health workers and other technical experts "produce" health – to a recognition that households, particularly mothers, are the primary *producers* of (reproductive) health. Second, we need to transform all of our institutions concerned with health development to take on the task of helping households and communities become more competent and resourceful in health production.

Leadership is critical for this transformational change - whether one is creating a new institution or changing an old one.(Kotter, 1996; Senge, 2006) And leaders are needed at every organizational level to nurture innovation and learning. Transformational leaders have three roles:

- **Catalytic** - Generating a shared vision of a health future people want to create;
- **Enabling** – creating a work environment characterized by teamwork, trust, open-mindedness, transparency and shared accountability for all outcomes;
- **Learning** – Encouraging the development of action-learning organizations with the flexibility to change that leverage the vast resources of ordinary people to more effectively and efficiently improve health.

BASIC PRINCIPLES

Leadership and management are two sides of the same coin; each is equally essential for any system to achieve its purpose.(Kotter, 1996) Good management guarantees operational stability by assuring that *things are done right* – effectively, efficiently and at the highest level of quality. Leadership is about change, making sure that the *right things are done* – by charting new paths where there are no maps and engaging others in a shared commitment to overcome the inevitable constraints to innovation and reach the goal of better health for all. (Goldratt, 2004; Taylor and Taylor, 2002)

THE TOP-DOWN OR "BLUEPRINT" APPROACH TO HEALTH INTERVENTIONS

While both leadership and management are needed to move any population-based health program forward, serious problems will arise when an intervention strategy requiring leadership and learning to produce fundamental institutional changes is reduced to a series of predefined management tasks that fail to consider the local context.[Rao and Walton, 2004] Let us begin by examining the traditional way of introducing health interventions in less developed countries that is most familiar to policy makers and program managers. This is the top-down or "blueprint" strategy as depicted in **Figure 1**. [Korten, 1980]

At the top are powerful interest groups (donors, foundations, NGOs, universities, etc.) usually operating in institutional "silos" that are focused on a single, or a limited number of diseases (e.g., HIV, malaria and TBC or maternal mortality) or package of interventions (vaccines, ORT, micronutrients, maternity care). These groups generate the funds and develop global/regional strategies to introduce their intervention, often based on "best practices" learned in some particular setting. These are presented to national policymakers and planners who develop the action plans ("blueprints") for national implementation. These plans are sent to the managers and providers in local level organizations for service delivery. Ultimately, it is the communities and households that accept (or reject) the interventions and produce (or fail to produce) the desired health outcomes. Management Information Systems (MIS) collect service statistics, and specialists collect research and evaluation data from time to time, all of which are sent back to higher levels for analyses and interpretation.

While the blueprint approach may work well for health interventions or logistic operations where individual voluntary choice is absent (e.g., smallpox eradication, food fortification, environmental sanitation, construction of facilities, procurement of commodities, etc.), it has major limitations when it comes to program strategies that require social, economic and cultural adaptations (e.g., family planning, immunizations, use of bed nets, maternity care, nutrition programs, etc.). Among the most serious limitations are:

- the assumption that the experiences of high level professionals (often in a single or limited number of scientific disciplines) armed with the data from "evidence-based research" have sufficient knowledge to prescribe intervention strategies that will be effective in any social context; [Chambers, 1997]

- the short-term time horizon and inflexible project design of most funding agencies, precluding the opportunity to learn from, and adapt to experiences in the field; [Rao and Walton, 2004]

- the assumption that the institutions, personnel and services in national Ministries of Health constitute the "health system" of a country, so that added investments in these facilities and operations will improve the nation's health; [WHO, 2002] and

- the disconnect between the *primary producers of health* in the households and communities (where the action is) from the *information* about what works or fails to work. Particularly, with outsiders gathering, analyzing and interpreting the data (infrequently, and remote from the action), there is usually no deep *understanding* of why the specific outcomes occurred. Thus, *little learning* is taking place, and without learning, there will be no fundamental changes in the health practices of these producers, and thus no "project sustainability".

What is the evidence that the top-down approach is flawed? One needs only to look at the great reproductive health disparities across developing countries and the many inequities within these countries after fifty years experience with this top-down strategy.[World Bank, 2004] Projects and programs depending on this approach can be expected to produce inequitable outcomes as well as fail to achieve sustainable health gains after the external inputs are removed.

A NEW PARADIGM FOR HEALTH SYSTEM TRANSFORMATION

A. The Household Production of Health Framework

To change the way we act, we must change the way we think. A first step is to change our "mental model" of the "health system" – from believing that Ministries of Health (with their doctors, nurses, hospitals, health centers, etc.) produce health to recognizing that households and communities are the primary producers of health. The key components of the Household Production of Health paradigm are depicted in the systems diagram in **Figure 2**. In this paradigm:

- **Households** *produce* health, especially women in the case of reproductive and child health. That is the reason that women's education and gender relations are such powerful determinants of reproductive and child health.

- Households live in the context of **communities** with their diversity of institutions and social relationships – ethnic and religious groups, shops and businesses, health practitioners, cooperatives, political parties, clubs, NGOs, schools, etc. (social capital).

- These are all under the jurisdiction of **government** with its multiplicity of agencies implementing (often divergent) policies by: controlling information; making and enforcing laws and regulations; collecting taxes or providing subsidies; investing in infrastructure and services; and, when there is insufficient information, supporting research.

- Finally, there are powerful **global driving forces** - political, economic, social, technological and environmental. Many actors are involved in this globalization process – national governments, international organizations, multinational corporations - that can impact profoundly on national development and ultimately household health production.

B. Institutional Capabilities for Production

The productivity of every institution in this framework – households, community organizations, government agencies and international groups - can be considered to be a function of three basic capabilities – ***resources, practices*** **and** ***values***. Focusing on reproductive health and the household, we can summarize these as follows:

- ***Resources*** in the household are of two types – material and non-material:

    - **Material** resources include those items commonly measured in *quantitative* surveys – income and wealth, housing, food, land, water sources, power supply, infrastructure, technologies, etc.

    - **Non-material** resources include time, beliefs/knowledge, skills, health, ethnicity, language(s), gender, reputation, status, social networks, etc. Quantitative surveys usually ignore most of these or only measure superficial indicators (e.g., knowledge of selected health interventions, ethnic group name, etc.).

- ***Practices*** encompass everything that household members do in the knowledge/belief that these enhance their health and welfare. These include marriage arrangements, sexual practices, pregnancy, birth and post-partum care, fertility control, preventive and curative practices, feeding practices, hygienic practices, etc. In fact, many well established practices (like female genital mutilation, early marriage, dietary preferences, unhygienic deliveries, etc.) can be harmful to health. Technical interventions are designed to make useful practices more effective, efficient and safe – e.g., ORT,

immunizations, contraception, etc. - while IEC and advocacy programs are designed to diminish harmful practices and promote new technologies and their attendant practices.

- ***Values*** provide the basis for deciding how households and communities are organized, what actions are "right or wrong" and what the criteria are for setting priorities. Typically, these can only be unearthed by deep engagement with the members of the societies of interest.(Chambers, 1997) In terms of social (health) and economic development, it is possible to broadly contrast values as "progress-resistant" versus "progress promoting". (Harrison and Huntington, 2000; Rao and Walton, 2004) Some of these contrasts are given below – with the caveats that these are somewhat arbitrary and that all societies and social institutions lie in a range between the extremes for any of these values:

    - Hierarchical/authoritrian vs. egalitarian/democratic
    - Status determined by birth (caste/gender) vs. achievement
    - Knowledge based on traditions vs. experimentation/learning
    - Honoring obligations/conformity vs. independence/creativity
    - Attributing destiny to fatalism/gods vs. self-reliance/entrepreneurship
    - Past/present oriented vs. future oriented
    - Advancement based on personal relationships vs. meritorious performance
    - Closed-mindedness/intolerance vs. open-mindedness/tolerance
    - Suspicion of "others" vs. trust/mutual respect

VALUES, CUTURE AND DEVELOPMENT

The interdependency and interactions of values, practices and resources can be considered as an institution's culture. Culture has been called the "DNA of societies" – it is the means by which a society replicates itself from generation to generation.(Gharajedaghi, 1999) The foundations of any culture are its values, and since values provide for institutional stability, they are hard to change. Consequently, international organizations and government agencies often ignore progress-resistant values when introducing health innovations. Unfortunately, neglecting the cultural context will only guarantee that the new interventions will meet with resistance in traditional cultures, and even those that seemingly succeed will usually not be sustainable when outside forces (e.g., funding, technical assistance, etc.) are removed. (Rao and Walton, 2004)

This point about the importance of"progress resistant" versus "progress promoting" institutional cultures should not be limited to a discussion of traditional communities in developing countries. All institutions including international organizations, government agencies and even academic centers have cultures that incorporate to various degrees cultural elements that are progress resistant as well as progress promoting. For example, many international organizations and government agencies have strong, controlling hierarchies that promote obedience and conformity. This leads to an institutional climate that discourages creativity and innovation. Highly trained professionals can be closed-minded about the value of other disciplines, much less the contributions that ordinary people can make toward solving problems in their own society.(Chambers, 1997) And the short time horizons, inflexibility, and external evaluations of many health projects generally preclude gaining any deep understanding of why things are as they are as a basis for generating fundamental and sustainable social changes. (Rao and Watson, 2004)

LEADERSHIP FOR HEALTH SYSTEM TRANSFORMATION

The household health production paradigm views the nation's health production system like its agricultural production system - where farming households are the primary producers, not the Ministry of Agriculture. Similarly, since the primary producers of health (mothers and other family members) do not work for the government, the health production system can be described as *multi-minded* and highly *decentralized* with a *self-sustaining culture* of production.(Gharajedaghi, 1999). Given this paradigm, national health systems do not suffer from a shortage of workers: rather they have millions, who are highly motivated, working 24 hours a day, 7 days a week to protect

their lives and the lives of their families! But what most of them lack, particularly the marginalized, are **non-material resources**, e.g.: basic knowledge about hygiene, sanitation, infection control, nutrition, immunization, contraception, the danger signs of pregnancy and childbirth, etc.; skills in recognizing and treating common diseases; and, the freedom to obtain necessary care because of prevailing cultural values and practices.

The challenge of leadership is to learn how to capture the hearts and minds of this vast, diverse workforce and work with them to make the fundamental changes in their values, practices and resource allocations that are essential to produce better health outcomes. At the same time, we need to change many of our own operating principles to assure that the households and communities have the knowledge, skills, technologies and services to more effectively and efficiently produce health. The goal is to increase the ***resourcefulness*** of households and communities, not just to add material resources.

We are talking about transforming all the institutions in the health production system, and this requires leadership that is visionary, enabling and oriented toward leaning. The leadership tasks are:

- First and foremost to bring together as many actors as possible from every level in the health system around a **shared vision** of a health future that they truly want to create – a vision that they are willing to "pay the price" for, even it means relinquishing cherished traditions and established power relationships. (Senge, 2006).

- Second, by giving a "voice" to those most in need, to **enable people to act** to solve their own problems. (Chambers, 1997; Rao and Walton, 2004). We need to bring down "research" and the attendant learning that it produces to the community and household level. (Taylor and Taylor, 2002) We may need to redefine "evidence" to include simple and practical metrics that communities themselves can collect, analyze, interpret and use to improve their health and well-being. (Chambers, 1997; Friedman, 2005)

- Third, to develop **action-learning** groups to promote a deep understanding among all parties about the values, practices and resources constraining health production and to design, implement and assess the strategies for change. .(Marquardt, 2004) In this context, a more powerful question than "What works?" is the question "What will it take to succeed?" (Friedman, 2005)

REACHING THE GOAL – OVERCOMING THE KEY CONSTRAINTS

To advance the population's health, we are talking about the need for a fundamental **redesign** of the health production system. This means changing institutional relationships of all of the key actors from the hierarchical process shown earlier in Figure 1 to a team learning process as illustrated in **Figure 3.**(**Korten, 1980; World** Bank, 2004) We have the same basic stakeholders - the households and communities, the technical experts involved in specific programs, and representatives of relevant government agencies.(Taylor and Taylor, 2002) The "interest groups" representing donors, NGOs or other outsiders no longer control the whole enterprise, but rather share knowledge and provide guidance as appropriate based on international experience.

Creating these new institutional relationships is essential in order to facilitate communication, broaden the base of authority and accountability, and link action to learning at every level.(World Bank, 2004) Leadership is critical here, because this system transformation requires a radical reorientation in the mindset of all stakeholders – from working in command-and-control hierarchies to working together as a team seeking to reach a common goal.

Example - Safe Motherhood

The "Safe Motherhood" initiative can be taken to illustrate the potential power of this action-learning approach. A useful analytical framework is the "three-delays" model that classifies the factors leading to high maternal mortality at three levels – the household, the community and the (government) maternity care system. If we consider this model as the "maternal health production system", we should appreciate that the **goal** of the system is to maximize the production of healthy, surviving mothers.(Goldratt, 2004) The task of an action-learning organization in any particular setting is to identify the what factors, at what level in the system, constitute the **key constraint**, blocking any improvement in maternal health outcomes. From a systems perspective, it is this key constraint that determines the performance (throughput) of *entire* system.(Goldratt, 2004)

In most settings with high maternal mortality, this constraint will be at the household and community level, due to lack of knowledge of all the elements of proper pregnancy and childbirth care or of the danger signs in pregnancy. Additionally, there may be cultural constraints to care seeking. If this is the case, **investing more (material) resources** in Basic or Comprehensive Obstetrical Care Centers (the third delay) will not improve the overall system performance (though it might save a few more lives among those mothers reaching the facilities). What is needed first and foremost is to **focus on the key constraint** at the household level, where the primary need is **non-material resources**. But, given the current power relationships as these relate to decision making in the health production system, serious attention has generally not been given addressing the needs of households and communities. So, what is required first is a change (**redesign**) in these relationships.

Figure 3 can be illustrative of a fundamental redesign of the maternal health production system. This transforms the system by changing the traditional hierarchical relationships to an action-learning team approach. In this redesigned system, there will be many areas where new kinds of data are needed to generate new understandings about the current realities in order to improve the system's performance. Three areas for action-learning are:

> **Needs – Outputs** With the active involvement of household and communities, every maternal death and morbidity can be identified and the true (cultural, social, economic) causes can be understood on a continuing basis. This provides the basis for learning deeply about the household and community *needs*, particularly relating to the non-material resources and the values constraining better outcomes. The program managers can concurrently learn how to work with communities in their specific cultural context to develop program *outputs* that will acceptably introduce new values, practices, knowledge and skills as well as technologies and services to improve their resourcefulness and in the production of health.
>
> **Tasks – Competencies** Program managers will need to learn how to do new *tasks* to design, implement and be accountable for programs that promote the household production of health. And this requires that policy-makers and planners learning how to change their own organizational culture by building trust and teamwork that will stimulate innovation and experimentation so that it can assist the managers and providers in gaining the *competencies* to solve old problems and create new solutions to emerging challenges.
>
> **Demands – Decisions** Policy-makers and planners need to learn how to engage all stakeholders, particularly the most disadvantaged, in a creative partnership that will enable them to effectively express their *demands* and have their voices heard in the halls of power, so that strategic *decisions* affecting health development are responsive to the voices of all sectors of society, not just the elites, technocrats or bureaucrats.

Action-learning is a continuing, iterative process with various groupings of stakeholders studying their situation, trying things out, assessing the results, and making changes based on the results then repeating the process.(Marquardt, 2004) A major finding of this process will be that there are substantial resources, material and non-material - including the vast numbers of highly motivated primary producers of health, and the creativity and ingenuity of all of the formal and informal health workers and other ordinary people in the system. **Redesigning** the system will permit these people to **reallocate** their own resources towards reaching the shared vision of better health outcomes for all mothers.

LEADER-MANAGERS

We need to nurture leader-managers who can:

1. **Serve as a *catalytic* force** in bringing together action-learning teams involving very diverse stakeholders. (Figueroa, 1999) Over time, as confidence grows, these teams will be characterized by:

    - a shared vision of a better health future;
    - a commitment to deeply examine the current reality;
    - an openness to new ideas;
    - a willingness to a challenge long standing assumptions
    - an encouragement of innovation and experimentation;
    - acceptance of mistakes as learning opportunities;
    - a shared responsibility for both the successes and failures; and
    - a readiness to change old ways as new evidence emerges;
    - transparency in reporting all actions and expenditures.

2. **Work at all levels** of the health production system, particularly at the front lines – the "street level" workers (Rao and Walton, 2004). A community midwife can vastly expand her reach and effectiveness by engaging mothers, fathers, traditional practitioners, religious leaders, small businesses and other community members in the vision that "no mother in our community will die of childbirth". Then she can seek their guidance as together they learn how to bring together her technical knowledge and skills and their resources (material and non-material) to most improve health production in their community.

3. **Create an "evidence-nurturing" environment** in addition to "evidence-based" thinking. Currently available research does not have all the answers. This is particularly true when it comes to introducing social interventions into complex multicultural societies. Often, the most creative ideas are in the frontiers of science where sharpening of questions is more important than finding answers. We should not be afraid to venture outside of the science of the day to create new knowledge. In the process, we may suffer from false starts and failed ideas but will gain enormously from lessons learned and dramatic new ways of looking at things. (Friedman, 2005)

CONCLUSION

We have introduced a new way of thinking about a country's "health system" that has relevance for leaders and managers concerned with improving the effectiveness and sustainability of health interventions. Basically, we propose that a nation's health production system should be looked on like its agricultural production system – just as farming households are the primary "producers" of crops, so all households are the primary producers of health. Correspondingly, just as the role of a Ministry of Agriculture is to help farmers be more productive in their own settings, so the role of a Ministry of Health should be to help households be more resourceful in producing health.

This new paradigm leads to fundamental redefinitions of the "health system" and health production metrics that provide the foundations for transformational change, specifically:

- a nation's health production system encompasses households, communities and all agencies of government, not just the Ministry of Health and its subsidiaries;

- the capabilities of the health production system are not limited to material goods and technologies but to non-material resources (e.g., time, beliefs/knowledge, social networks, etc.) and, more importantly, cultural values; and,

- the metrics of health system performance must expand from the "hard" measures of organizational inputs, processes, outputs and outcomes to the "soft" indicators of household and community resourcefulness in the production health.

Leadership and learning are the critical elements needed to respond to this new paradigm of the health production system. Leadership is needed at every level since an effective response requires fundamental transformations in the current operating principles (cultures) of the international donors, Ministries of Health and other government agencies as well as of communities and households. And learning at every level is essential to restructure the relationships among agencies and organizations and the people to be able to: understand deeply how health is produced at the household level; facilitate the changes needed to improve the performance of the health production system; measure and monitor household health productivity; and, flexibly respond to new knowledge being generated.

The challenge for the future is fundamental institutional transformation – not just in the ways of thinking and acting by households and communities - but also of governments and international organizations concerned with health development. To change others, we may have to change ourselves first.

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FIGURE 1

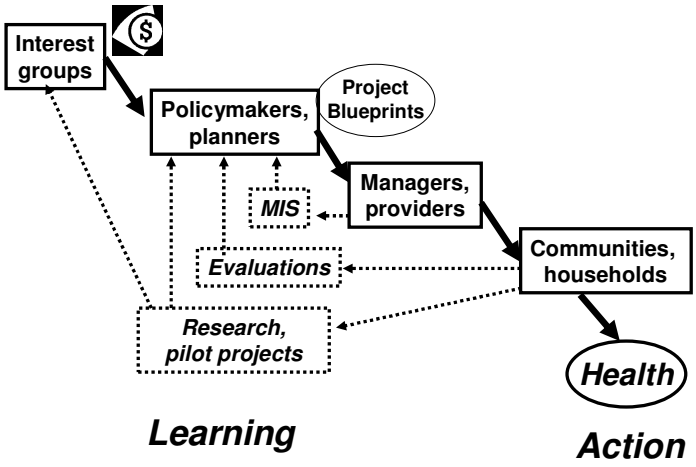

Figure 1. The top-down or "blueprint" approach to introducing health interventions. (Adapted from Korten, 1980)

FIGURE 2

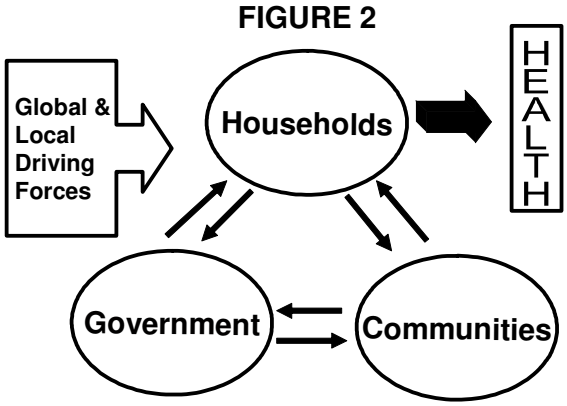

Figure 2. The household production of health framework.

FIGURE 3

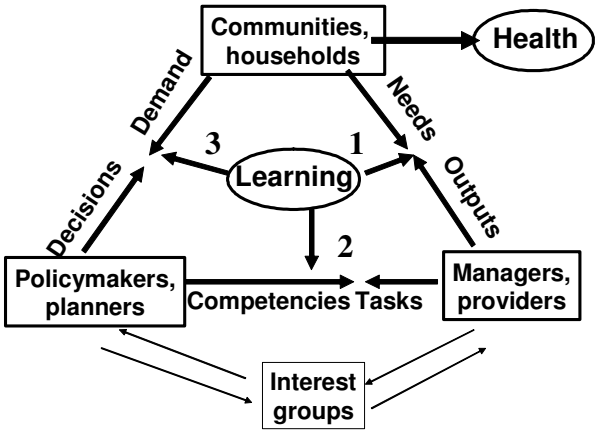

Figure 3. The action-learning process for introducing and institutionalizing health innovations. (Adapted from Korten, 1980)