OPEN MINDSETS

Participatory Leadership for Health

World Health
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Alliance for
Health Policy and
Systems Research

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CONTENTS

FOREWORD

In an increasingly globalized, connected and complex world, health systems are frequently challenged by crises of all kinds, from market meltdowns to deadly outbreaks and conflicts. The Ebola epidemic, for example, laid bare the devastating consequences of weak leadership across the sector and its impact on the entire health system. To be successful in this ever-shifting context, a new type of leadership is needed.

Definitions of leadership are numerous and extensively debated. Academia and business have multitudinous traditional conceptions of leadership which are focused on the individual, formal roles and functions of individuals or groups. Conversely, participatory leadership is shown when diverse groups are empowered and enabled to contribute freely to the effective functioning of a system, be it delivering health services, advocacy, legislation or research.

The flagship report *Open Mindsets: Participatory Leadership for Health* examines the different aspects of leadership. It draws on examples of participatory leadership from anti-tobacco lobbyists whose efforts saw the adoption of the Framework Convention on Tobacco Control (FCTC), to the establishment of the Global Fund for AIDS, Tuberculosis and Malaria. Similarly, the eradication of smallpox and the success in combating polio are examples of participatory leadership where many groups representing diverse interests and affiliations came together and brought about lasting change. In fact, it was this type of leadership that galvanized the nations of the world together to adopt the Millennium Development Goals in 2000. Leadership was exercised at multiple levels, spurring this global commitment, and the same work will be needed for the attainment of the Sustainable Development Goals (SDGs), where greater participation from diverse actors is crucial.

This report is intended to stimulate new thinking on leadership in health across the health system. It is the culmination of two years of research based on surveys from 65 countries, including interviews with prominent health leaders. It is not a comprehensive review or a guide on leadership in health, nor does it aim to replicate existing literature. Rather, it is a synthesis of existing literature to illustrate how a participative approach to leadership could offer a better strategy for improving health systems.

To effect system-wide changes, a participatory leadership approach is required, one that engages different stakeholders both within and outside the health system to find the answers that lead to change. We have already made progress in this respect but need to continue to work collectively and collaboratively to reach our goals. Demonstrating participatory leadership, the Alliance for Health Policy and Systems Research, together with its extensive network of partners, is working to generate the knowledge we need to build better health systems. We encourage policy-makers, researchers and programme implementers to join us in searching for new ways to strengthen health systems around the world. Using health systems and policy research offers us the opportunity to find lasting solutions to our most pressing health challenges today. Our future health depends on it.

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ACKNOWLEDGEMENTS

CHAPTER 1
KEY MESSAGES

- The importance of leadership in bringing about change to improve health and well-being is increasingly emphasized — especially with the shift to SDGs — and there is now a need and opportunity to act to strengthen leadership for health.

- In November 2014, at the Third Global Symposium on Health Systems Research, the Alliance set out to understand how leaders define and qualify leadership by asking a selected group of leaders in public health a single question: 'What are key attributes of leaders that create effective health systems?'

- In 2015, a survey was conducted across 65 countries and in-depth interviews were carried out with 22 prominent leaders, touching upon various components of leadership for health, ranging from the make-up of teams and organizational culture, to the use of evidence and the role of a guiding vision.

- While key individual traits are useful and even necessary in creating good leaders, they are not sufficient. The role of context, the reciprocal influence actors have upon one another's interests and priorities, and the enabling environments within the health eco-system are important considerations in understanding, supporting and creating leadership that addresses the needs of the population in future-thinking health systems.

- Strengthening leadership in health requires a focus on ensuring an eco-system that enables participation from diverse actors, nurtures debates and provides an opportunity for all actors to assert their leadership potential, as the need arises, to the benefit of improved health-system performance.

WHY LEADERSHIP, WHY NOW?

"If you want to go fast, go alone. If you want to go far, go with others."

AFRICAN PROVERB

What brought the nations of the world together to adopt the Millennium Development Goals (MDGs) in 2000? Leadership. What made several health systems of the world fall short of the 2015 targets set by the MDGs? Leadership[1]. In each case, the leadership was exercised at multiple levels, with different levels of success. As the world now sets out to achieve the new health targets set by the Sustainable Development Goals (SDGs), this report seeks to draw upon the lessons in global health in the four decades after Alma Ata, to review the evolving concepts of leadership in health systems and suggest ways in which a redesign can change thinking, action and outcomes.

Tasked with understanding good leadership for strengthening health systems in the context of the ever-changing, complex, interdependent health landscape, the Alliance for Health Policy and Systems Research set out first to understand how leaders define and qualify leadership. In September-October 2014, at the Third Global Symposium on Health Systems Research, a selected group of leaders in public health were approached and asked a single question: 'What are key attributes of leaders that create effective health systems?' These included leading researchers, heads of national health programmes, directors at multilateral organizations, ministry of health officials, and leaders at academic institutions. Many descriptive words and evocative phrases were shared, highlighting individual attributes of good leadership:

- Accepted
- **Adaptive**
- Analytical
- Charismatic
- Clear
- Commitment
- Competent
- Consistent
- Consultative
- Credible
- Creative
- Decisive
- Drive
- Engaging

- Enabling
- Evidence-based
- Focused
- Good coordination
- Good management
- Humble
- Inclusive
- Influential
- Informed
- Innovative
- Inspiring
- **Knowledgeable**
- Lead-by-example
- Listener

- Networker
- Persuasive
- Powerful
- Respectful
- Responsibility
- Results-oriented
- Strategic
- Strong
- **Team player**
- Transparency
- Trust
- Visionary
- Will power
- Wise

The three attributes most often listed were: team player, knowledgeable and adaptive. Though the respondents were identifying individual leadership attributes, the characteristics resonating most were those that brought about collective, shared, responsive and participatory leadership. In 2015, a survey was conducted across 65 countries, touching upon various components of leadership for health, ranging from the make-up of teams and organizational culture, to the use of evidence and the role of a guiding vision. Interviews with 22 prominent leaders in health were also conducted, gathering views on what creates effective leadership and what makes leadership in health different. Leaders were also asked to share their experiences on how change is brought about and managed, the role of context, and the norms, mechanisms and institutions that create enabling environments for effective leadership[2].

The views and stories shared by these leaders unveiled an important finding: while key individual traits are useful and even necessary in creating good leaders, they are not sufficient. The role of context, the reciprocal influence actors have upon one another's interests and priorities, and the enabling environments within the health ecosystem — all of these are important considerations in understanding, supporting and creating leadership that addresses the needs of the population in future-thinking health systems. This conceptualization of more participatory approaches to leadership fell in line with the global community's shift from vertical programmes supported through the MDGs towards an attempt to capture the holistic nature of wellbeing through the horizontal approach of the SDGs[3].

In writing this flagship report, we therefore highlight the pertinence of leadership in health seizing the social, political and scientific opportunities and space created by renewed interest in cross-sectoral, multidisciplinary sustainable development agendas. In particular, we reflect on the value of participatory leadership — which draws its strength from the engagement of multiple actors in a dynamic tension resulting from differences — and explore ways in which it has contributed to ensuring the prominence of health and wellbeing in this new global environment. The report builds on and extends previously published work on health systems which examined the role of leadership, such as *Changing Mindsets, Systems Thinking for Health Systems Strengthening* and *Health Professional Education for the 21st Century*[4]. It is by no means a comprehensive review of, or a proffered guide to, leadership in health. It is intended to highlight the need for viewing leadership in health through the composite lens of the health system, especially in the changing context of global health as identified by the SDGs. This should stimulate more multidisciplinary research on the nature, quality and contributions of leadership in health systems, especially in low- and middle-income countries (LMICs). That will help to strengthen existing leadership as well as create pathways for future leadership.

CHAPTER 2
KEY MESSAGES

- The health sector is different from others in that it is concerned with both outcomes (improved health) and values (equity in health outcomes, appropriateness of services/care).

- Whereas health was once the sole domain of clinical providers, it has evolved to integrate with the wider domain of public health and, as a result of the concern for both outcomes and values, a wide range of actors are involved in and contribute to policy change in health in different ways.

- Current discussions of leadership often emphasize the role of a single leader or a single group of leaders working together, whereas many positive changes in health have come about as a result of collective leadership by multiple actors who challenge and support one another.

- In light of the ambition of the SDGs, greater participation from a range of actors as leaders will be required.

THE CASE FOR PARTICIPATORY LEADERSHIP IN HEALTH

"A leader is best when people barely know he exists, when his work is done, his aim fulfilled, they will say: we did it ourselves."

LAO TZU, CHINESE PHILOSOPHER

Prior to the emergence of the organized health system, public health related functions were viewed as important to societal health, even if scientific knowledge on effective actions was limited. The use of quarantine as a means of preventing the spread of the Black Death dates to the 14th century[5]. However, for much of the 20th century, the biomedical paradigm has defined the role of the organized health system[6]. Traditionally, leadership in many health systems (policy-makers as well as health professionals) have viewed the predominant function of the health system as clinical service provision for illness care[7]. Even as preventive services were added, they too mostly represented an extension of the biomedical paradigm and the social determinants of health were largely ignored[8]. In the 21st century, leadership of health systems has to adopt and project a more enlightened vision, encompassing a broad array of public health and clinical functions to be delivered by the health system and affirmative action on the social determinants of health through enabling actions elicited from other sectors[9]. Leadership of health systems now needs to rescue itself from the involuted and shrunken role it assigned to itself in the last century and evolve into a broader role that befits the mandate conferred by the SDGs.

Much has changed in the global health discourse since Alma Ata and, even more recently, during the transition from MDGs to SDGs. The concept of comprehensive primary care that was espoused by the Alma Ata declaration was subsumed by the prescription of selective primary care in the decades of economic liberalization that followed[10]. The unrelenting focus on vertical health programmes that started then carried over into this century, through the MDGs. However, the attempts to force fit well-intended vertical programmes into weak health systems yielded sub-optimal results[11]. There is now a greater recognition and respect for health systems as an integrated platform on which all health programmes have to enact their operations in concert. The world was also recently reminded by the Ebola epidemic that health systems can only be neglected at our peril. While the epidemic sorely tested the leadership of health systems in the affected countries, the need to invest in health systems as a whole became clear even to those who had been sceptical about the imperative of building an integrated health system.

Equity has also rightfully gained greater prominence in directing policy and evaluating outcomes in health. The movement for universal health coverage (UHC) gained momentum, with the health SDG listing it as a major global target[12]. A larger vision of health emerged from the Ottawa charter but the dominant biomedical paradigm stalled the advance of health promotion[13]. However, the previously muted recognition that social determinants of health need to be vigorously addressed in order to promote population health and reduce glaring health inequalities within and across countries, was amplified by a WHO Commission[14]. The SDGs reflect this understanding, with clear linkages between the health goal and all other development goals. Health systems now also need to engage explicitly and energetically with partners in other sectors to align their policies and programmes to the health goal. In addressing the SDG agenda in a period of rapid demographic, epidemiological and health transitions, health systems are frequently challenged by global economic crises or unstable political and social situations that range from conflict to mass migration[15]. This changed context calls for a re-examination of leadership in health systems.

The past two decades have also seen a strong surge in civil society activism and citizen participation in shaping the national and global health discourse, from policy debates and rights-based demand for services to community monitoring. Greater accountability is now demanded of both the public and private sectors. Academia is also beginning to assert its role as a catalyst for needed social change in addition to being a producer of knowledge. Such wide-ranging participation of multiple stakeholder groups, often through a rapid response to proposed or failed policy, represents a process of advancing democratization. It also provides checks and balances which do not allow unitary leadership to exercise power in an arbitrary manner.

Since social determinants have a major impact on health, the health system must advocate and act to promote equity in other domains too — be it in poverty reduction, access to education, assurance of nutritious food or promotion of gender equity[16]. This commitment must become the hallmark of health-system leadership, in a world where growing inequalities pose a serious threat to human health and wellbeing. Sensitivity to the needs of vulnerable groups is essential, lest mechanistic rules of decision-making based only on cost- effectiveness or the dynamics of elite capture marginalize the voiceless. Gender equity too becomes a high priority, not only in terms of service provision but also for unimpeded leadership development and a greater role in decision-making.

Hitherto, discussions of leadership in health systems have been focused mostly on experiences in high-income countries[17]. Literature from LMICs has been sparse. The literature has mostly been inward looking, examining the managerial competence of the health-system leadership in the design and delivery of health programmes by public health services[18]. The role of a large number of actors in the national health system (academic and research institutions, civil society organizations, private sector, patient groups, citizen representatives) and that of international actors (transnational industry, donors, development partners, philanthropic foundations) has not been studied in the context of how leadership in each of these groups complements or conflicts with others, to impact on the overall leadership of the health system[2]. Further, the leadership of health systems, in securing with non-health sectors and coordinating concerted action on convergent goals, has not been well studied — especially within the LMICs[19].

Much of the available literature, whether specifically on health-system leadership or extrapolated from business or political leadership, has focused on attributes of individual leadership as determinants of success, failure or plodding progress[20]. This is explained by the traditional focus on individual leaders as transformational agents changing the course of history, even though the complex interplay of social forces and system components contribute immensely to change in most domains of human enterprise. Indeed, it is this complexity which deters an in-depth examination of leadership and permits the easier option of ascribing identifiable leadership to individuals who are visible at the helm rather than to the systems of which they are the most prominent part[21]. The media too play a role in elevating individuals as leaders to whom credit or discredit is attached, while systemic strengths and infirmities are seldom discussed[22]. Yet, it is the sturdiness of the system as a whole, with leadership exercised effectively at multiple levels, which will stand the test of a serious challenge. In health, this calls for a harmonious confluence of leadership across a wide array of actors, to collectively create a strong leadership for the health system.

A clear message that resonates across different surveys of public-health leadership is that health systems must avoid models of leadership that are dependent on domineering individuals[2]. Even the image of an accomplished leader, who combines laudable values and commendable expertise but functions as a solo decision-maker, is viewed as an outmoded elitist construct[22]. Terms used for the preferred model of leadership include: 'interactive', 'collective', 'consultative', 'distributed' and 'horizontal'[23]. Apart from invoking the democratic spirit of collective decision-making, these terms also recognize that a complex system cannot be efficiently driven by linear, hierarchical decision-making and must draw upon conjoined perspectives and diverse strengths across the system for non-linear but well-coordinated functioning. 'Distributed but not disconnected' describes the model of such participatory leadership[24,25].

All of these transitions call for a model of leadership which engages and enables multiple actors involved in or with the health system. Even as health system strengthening was championed, the construct of 'transformational' leadership was held up as the preferred model of leadership, in contrast to a 'transactional' model. This model too focused on the quality of individual leadership and on the routine management of operations rather than leading organizations and systems to change. There is now a need to develop a composite construct of leadership in health systems which is not limited to individual leadership, one that solicits, facilitates and enables greater participation in leadership.

CHAPTER 3
KEY MESSAGES

- The role of different actors extends variably across the ecosystem of health, extending from agenda-setting and policy development to policy implementation and ensuring sustainability.

- Within each of these groups of actors, individual leadership does matter and can be of high value in fostering an open, consultative process of democratic decision-making to bring out the collective strength of participatory leadership.

- Different actors play different roles in knowledge generation, decision-making, advocacy, implementation and monitoring. Leadership in each of these areas contributes to the ultimate success of public health policies and initiatives.

- Dynamic tensions among actors can be creative, if there is a dialectical process that guides the debate to clarity of ideas and consensus on actions.

- Participatory leadership should also provide mechanisms for mounting disruptive challenges to the status quo as well as system stabilizers which enable the health system to withstand internal or external turbulence.

THE DYNAMICS OF PARTICIPATORY LEADERSHIP

"It is amazing what you can accomplish when you do not care who gets credit."

HARRY TRUMAN
33ʳᵈ PRESIDENT OF THE UNITED STATES OF AMERICA

It is widely acknowledged that the health system is a complex system[26]. This is not only because of different components (described as building blocks in the classical WHO model) and diverse functions (addressing the varied health needs of populations and individuals), but also because of the multitude of actors who are engaged within it. These include governments, academia, civil society, the private sector, voluntary groups (including faith-based organizations and patient groups) and media, apart from communities themselves[27.] The role of different actors extends variably across the ecosystem of health, extending from agenda-setting and policy development to policy implementation and ensuring sustainability[15]. The goals of the health system cannot be achieved without all of these groups contributing through a participatory leadership.

Participatory leadership is exemplified when diverse actor groups are empowered and enabled to contribute freely in different ways to the effective functioning of a system — be it advocacy, legislation, innovation in implementation or research to measure impact — all actions collectively contributing to positive change[28]. Under this paradigm, leadership is not defined in terms of formal roles and functions of individuals or groups of actors, but rather by the opportunities available for each group to contribute and to share responsibility for actions across the pathway of change, from decision to implementation. Within each of these groups of actors, individual leadership does matter and can be of high value. Even within a group, such leadership has to foster an open, consultative process of decision-making to bring out the collective strength of participatory leadership. The dynamics of decision-making will vary across groups, differing between a government, an academic institution, a civil-society organization or a health-care delivery unit. However, in each of these a process which facilitates participatory leadership will facilitate a clear collective vision and common goal-oriented action. Equally important, the leaders of various groups need to consult and collaborate among themselves, to act in concert for collectively advancing the agenda of the health system.

As highlighted in chapter 2, the goals of the health system are shaped by two different, though usually complementary, priorities. These are health outcomes and values. Some sections of the health system focus much more on health outcomes, with measurable indicators of improvement in specific population health indicators or on metrics related to any of the building blocks, such as health financing[29]. Others are more concerned about values such as equity, social justice, gender equality, non- discrimination and human rights. Ideally, actions undertaken by the health system have to ensure that both these priorities are addressed in a complementary, even synergistic, manner. When a dynamic tension arises between the two, participatory leadership, within and across different groups of actors, would help to resolve conflict and generate consensus by balancing the priorities. Such a dynamic tension can be creative, if there is a dialectical process that guides the debate to clarity of ideas and consensus on actions.

For example, balancing the demands of different disease burdens and cost-effectiveness of available interventions with equity, which calls for preference to vulnerable groups, can make for a difficult priority-setting process in health planning, but participatory leadership can result in the development and adoption of an agreed framework that blends — or, at the very least, considers — all of these. Similarly, when a biomedical paradigm of health appears to conflict with a social epidemiology paradigm, participatory leadership can enable both knowledge streams and perspectives to be integrated to act on all the determinants of health. However, differences in values and competing interests may pose a greater problem. For example, the private sector's view of health care as an industry may collide with the wider societal view of health as a public good and health care as a universally accessible right. Even in such cases, participatory leadership by different stakeholders across society will help governments to define a constructive framework for health-service delivery in which citizens' interests are protected and health-care providers are suitably incentivized.

Given the diversity of actors and their perspectives, the health system will see different actors playing different roles in knowledge generation, decision-making, advocacy, implementation and monitoring. Leadership in each of these areas contributes to the ultimate success of a public-health initiative. The leadership across these groups is not disconnected or sequential. Advocacy, based on knowledge, influences both decision-making and implementation. In turn, implementation and monitoring may set the agenda for new knowledge creation, to find innovative solutions to overcome identified barriers that are limiting outreach and effectiveness or fall short on equity. Thus the groups exercise a reciprocal influence that enhances their collective ability to deliver their agreed agenda.

This does not mean that leadership throughout the health system is expected to be of similar nature or always in agreement. Roles and responsibilities, as well as the nature of accountability, vary across different segments and at different levels. Differences of viewpoint may arise between individuals or

system components, reflecting an assertion of leadership by each of them. Though it may not always be possible, the outcome of debates within a participatory-leadership model is more often reasoned consensus than imposition through power play. The different types of leadership, at different levels, should be complementary and mutually reinforcing. At any stage of a health initiative, one group may play the role of prime mover in exercising leadership with other groups actively supporting, dissenting or observing with interest. The role of the prime mover may shift to another group of actors at a different stage. Nevertheless, the whole enterprise of transformational health action calls for participatory leadership across the band of actors. Over time, it is the collective strength of the leadership drawn from all actors that will spell success in any endeavour.

Even within a participatory model, the nature of leadership will vary with the type of actors and their role in the health system[30]. At a senior level, the leaders will need to be global in their approach, while those with more circumscribed responsibilities will have focused leadership tasks. However, open systems of guidance and feedback across all levels will create the environment for participatory leadership[31]. This will help those in senior policy-making leadership positions to get ground-level reality checks and those at the operational level of leadership to understand the larger context in which they are positioning their work.

Participatory leadership also provides mechanisms for mounting disruptive challenges to the status quo as well as system stabilizers which enable the health system to withstand internal or external turbulence[32]. When there is an opportunity for democratic debate and free exchange of ideas, prevailing concepts and established modes of working are open to bona fide questioning by anyone in the system. Rigidly hierarchical systems and authoritarian leaders would view this as insubordination or deviant behaviour. Systems where participatory leadership becomes the norm would, however, see this as a stimulus for new thinking. That system would also ensure that the collective decisions which emerge from the debate would become the new norm and would be implemented by all in a disciplined manner.

Since health has many determinants that lie outside the conventional domain of the health sector, the health system also needs to engage actively with other relevant sectors to sensitize them to public-health concerns and align their actions to public-health goals[32]. This calls for participatory leadership within the health system itself, to mobilize effective engagement with actors in other sectors. For example, when the health ministry engages with other ministries for increasing tobacco taxes or mandating pictorial health warnings on tobacco product packs, civil-society organizations ramp up their advocacy so that the non-health ministries are also influenced by public opinion. Similarly, when automobile emission standards are discussed, health and environmental activists

join hands with researchers to propose evidence-based action to reduce air pollution. Multisectoral action also calls for participatory leadership across sectors, whether in ensuring road safety or production and processing of food products that meet nutrition goals. The health sector will be the prime mover in some cases and the catalyst or co-implementer in others. Participatory leadership is needed therefore both for energizing the health system to purposefully engage with other sectors and for such engagement to result in impactful action that will improve health[33]. The SDGs provide the framework for such integrated leadership, with co- benefits spreading across different domains of development clearly identified for several actions mainly initiated or implemented by any one sector.

While developing processes that enable participatory leadership, all actors who are engaged in that endeavour must not only promote democratic participation of all stakeholders but must also ensure that hitherto marginalized groups and vulnerable sections find voice and visibility on that platform. This is especially true of gender equity, so that more women leaders can emerge, unimpeded by patriarchal systems, and play a strong role in setting policy priorities as well as leading implementation[34]. Similarly, the interests of ethnic, religious or linguistic minorities must be projected and protected adequately in the space provided by participatory leadership. Women's health, for example, represents a confluence of both priorities: health outcomes (on a variety of health indicators) as well as an important value (gender sensitivity of the health system). This is further enabled by participatory leadership of women and minorities as researchers, policy-makers, implementers, community leaders and health activists.

Health policy and systems researchers are important contributors to the conglomerate of participatory leadership. From informing, influencing, analysing and critiquing health policies to applying implementation science to study the process, outcomes and impact of health interventions, researchers help to advance action across the health system[35]. They connect with and catalyse other actors, ranging from policy-makers and health-system managers to health professionals and civil-society groups. They thus support the practice of participatory leadership by engaging several actors. Understanding the extent, dynamics, outcomes, impact, enablers and barriers of participatory leadership, at different stages of a health initiative, should also become a priority for researchers engaged with the study of health policy and systems.

Finally, health systems are often threatened by instability in leadership, due to frequent changes involving the political leadership, civil servants in health ministries, techno-bureaucracy, health-system managers or even key persons involved in implementation. While such transfers should be minimized as much as possible, to provide stable tenures which are long enough to build commitment and demonstrate impact, the system can insure itself against instability through participatory leadership. When all or many in the health system are actively participating in a collective-leadership model, at different levels of decision-making and implementation, the departure of one or two individuals at any time should not unsettle the system. There will also be greater resilience to emergencies created by pandemic threats, conflict, natural disasters or economic crises, if the system has built-in adaptability through readily available and dependable leadership at multiple levels.

CHAPTER 4
KEY MESSAGES

- The leadership of a collective is seldom referred to, even though the eradication of smallpox and the success in combatting polio are obvious examples of concerted action across the globe, demonstrating the participatory leadership of many groups representing diverse interests and affiliations.

- While the initial stimulus for public-health action may come from any one of a diverse set of actors, the momentum for successful, scalable and sustainable public-health interventions can only be created by participatory leadership that brings and binds together many different groups who provide complementary strengths.

- Multisectoral coalitions are also now advancing action for eliminating all forms of malnutrition, control of noncommunicable diseases, protection of mental health and reducing air pollution. All of these partnerships will require consultative and participatory collective leadership to achieve success.

- There is a need to create more platforms where all the diverse sets of actors regularly engage in a mutually respectful discussion of global health challenges and plan for concerted action to address them.

PARTICIPATORY LEADERSHIP IN ACTION

"The size of your dreams must always exceed your current capacity to achieve them. If your dreams do not scare you, they are not big enough."

ELLEN JOHNSON SIRLEAF
PRESIDENT OF LIBERIA

The history of public health and medicine does not lack examples of outstanding individual leaders who transformed thinking through radical new ideas, contributed path-breaking new knowledge or introduced game-changing innovations. From John Snow, Rudolph Virchow and Louis Pasteur, to Jenner, Sabin and Salk, such figures are venerated in the annals of health sciences. However, leadership of a collective is seldom referred to, even though the eradication of smallpox and the success in combatting polio are obvious examples of concerted action across the globe, demonstrating the participatory leadership of many groups representing diverse interests and affiliations. The following global examples show the importance of engaging multiple actors who, in some instances, directly challenge one another. They all highlight, however, the impact of participatory leadership in bringing about change.

CATALYSING ACTION FOR TOBACCO CONTROL

Tobacco control illustrates the value of participatory leadership and the ways in which actors leveraged and built upon one another's successes. The original catalyst was the robust scientific demonstration of the connection between smoking and lung cancer, by the British Doctors' study[36]. The gathering evidence was then compiled into a powerful policy-relevant document, the US Surgeon General's report, which opened the doors to political action for tobacco control[37]. Civil-society action called for strong regulatory measures and advocacy was amplified when new scientific knowledge on other disease associations accumulated[38]. The tipping point came with the revelation that second-hand smoke did great harm to non-smokers, including children, causing public outrage [39-41]. Further evidence on the economic, social and environmental consequences of tobacco as well as revelations about the wilful suppression of evidence of harm, by the tobacco industry, added to the global resolve to control tobacco consumption in all forms[42]. Leadership by the World Health Organization led to the world's first public-health treaty being adopted under the auspices of a United Nations organization [43].

The Framework Convention on Tobacco Control (FCTC) was adopted in 2003 and now has 180 countries as Parties to the convention[44]. Behind each of the governments who signed were strong national coalitions of researchers, public-health practitioners, civil-society activists and lawyers. The media too played a major role in highlighting the ill effects of tobacco, creating a public mood in favour of strong measures to curb the tobacco menace. All of these added to worldwide action to implement a set of evidence-based measures to control tobacco (MPOWER)[45]. The Conference of Parties (COP) is a platform where all countries who have signed up to the FCTC periodically meet to decide collectively on processes and progress related to treaty implementation. An international protocol on the control of illicit trade in tobacco products was negotiated and adopted as part of such follow-up processes.

Many countries, including for instance Australia, Turkey and Uruguay, have demonstrated the political will to implement energetically tobacco-control policies, despite fierce opposition from the tobacco industry. Australia's success in the legal battle on plain packaging of tobacco products and Uruguay's victory in the international trade arbitration on large pictorial health warnings have come as a boost to the global tobacco-control movement, while Turkey's success in reducing tobacco consumption showed that political commitment coupled with effective implementation can change cultural norms around smoking[46-48]. Even as researchers gather new evidence on tobacco-related harm and effective interventions for control, and as regulators clamp down on tobacco marketing and resolutely face up to the tobacco industry, a worldwide alliance of civil-society advocates lends the strength of their collective voice to their efforts. The Framework Convention Alliance (FCA) is an outstanding example of participatory leadership, both in its internal governance and its external partnerships.

THE POWER OF THE PEOPLE

While patients affected by tobacco-related diseases contributed to tobacco control through personal advocacy as well as litigation against the tobacco industry, the power of leadership exercised by patient groups came to the forefront in the global movement against HIV/AIDS. From drawing public and policy-maker attention to this global scourge, to successful campaigns for access to antiretroviral drugs, HIV-affected persons have played a very prominent role in creating a global coalition against AIDS. Their leadership has been evident from the point of organizing themselves into effective advocacy groups and winning allies in civil society and media, to influencing policy-makers to commit financial resources and compelling the pharmaceutical industry to lower drug prices[49]. The establishment of the Global Fund for AIDS, Tuberculosis and Malaria and of the United States President's Emergency Plan for AIDS Relief (PEPFAR) are testimony to the impact of the participatory leadership exhibited by the global movement for control of HIV/AIDS[50,51]. The United Nations (UN) paved the way by convening the first ever High-Level Meeting on a health issue, focusing on a robust global response to the HIV pandemic[52]. Several UN agencies, like WHO and UNAIDS, helped to create such a response.

Health systems too have responded to the HIV/AIDS challenge with new models of health care, with task-shifting and task-sharing among health-care providers. Non-physician health-care providers became prominent in countries with shortages of doctors and self-care too improved health outcomes[53-55]. Success in containing the HIV/AIDS epidemic is a result of multiple stakeholders contributing their leadership in different domains, but providing a concerted response.

ACHIEVING UNIVERSAL HEALTH COVERAGE

The movement for universal health coverage (UHC) provides an evolutionary profile of participatory leadership bringing together diverse forces in society to find a common cause. The initial steps were taken in Bismarckian Germany, as a response to labour movements[56]. The Beveridge Report opened the road to the introduction of National Health Service through Aneurin Bevan's initiative in the United Kingdom[56,57]. Later UHC has been adopted as a public-policy goal and advanced as a health-system feature in many countries across the world. The World Health Assembly resolution of 2005 brought forth collective commitment of countries to endorse UHC[58]. The inclusion of UHC as a target (3.8) in the SDGs now is an attempt to put all countries on the path to action for achieving that target[59]. The political will for inclusion of this target in the SDGs could not have been generated but for the collective advocacy of multiple groups, ranging from health professionals to economists and from patient groups to policy-makers.

The design and implementation of UHC will need participatory leadership of diverse groups in different country settings. Different sources of health financing will need to be combined, different purchasing mechanisms will have to converge and different types of health-care providers will have to be co-opted to deliver appropriate care to all in an easily accessible and affordable manner. At any level of resources there would be a dynamic tension in finding the balance between the levels of population coverage, service coverage and cost coverage. This would call for enlightened collective decision-making, through participatory leadership of multiple stakeholders. Even as UHC is envisaged to be the unifying platform for all health services, the task of reconciling the competing demands of different sections of people, providers and programme managers would not be easy without participatory leadership that brings them all together.

BATTLING ANTIMICROBIAL RESISTANCE

Antimicrobial resistance is now estimated to be responsible for over 700,000 deaths worldwide, including 214,000 deaths due to neonatal sepsis[60,61]. Call for a response to this came early in this century from a federal inter-agency task force and professional scientific societies in USA[62,63]. As concerns grew, concerted international response began to take shape. In 2012–13, several landmark reports were

published by the US Centers for Disease Control, the Chief Medical Officer of the United Kingdom (UK) and the World Economic Forum[62,64]. In 2014, the World Health Assembly adopted a resolution moved by Sweden and the UK, which paved the way for a WHO Global Action Plan[65]. This plan was adopted by the World Health Assembly in 2015 and has been endorsed by the Food and Agriculture Organization (FAO) of the United Nations and the World Organisation for Animal Health (OIE).

The momentum created by these initiatives led to a UN High-Level Meeting, involving Heads of Government, at the UN General Assembly in September 2016[66]. Global action that follows will have to engage multiple agencies and extend across the domains of human, animal and environmental health. The emergence of zoonotic diseases similarly calls for close cooperation across these domains. One Health, a programme of integrated eco-surveillance of zoonotic pathogens across wild life, veterinary populations and human communities, is another example of cross-sectoral collaboration where participatory leadership of many actors is needed to protect human health against dangerous infections[67].

COLLABORATION TO PREVENT ROAD-TRAFFIC INJURIES

Injuries, including those resulting from gun violence and road-traffic crashes represent areas where the response lies mostly in other sectors but needs to be catalysed and monitored by the health system. For a long time, health systems have coped with the rising disease burdens from these avoidable causes of death and disability, without eliciting a multisectoral preventive response from policy-makers. In the last few decades, however, this has started to change. The field of road traffic injury (RTI) prevention is now being steadily built because of the participatory leadership of different actors.

US researcher William Haddon initially contributed to the recognition of RTI as a preventable public-health problem by developing the Haddon Matrix which framed injuries in epidemiological terms[68]. Action on mandatory seat belts in automobiles and curbs on drunk driving followed. When the first Global Burden of Disease study highlighted the large burden of injuries, WHO began working with a range of partners to create a platform for raising awareness and support for road safety[69]. Investments in research started to increase and the Road Traffic Injuries Research Network was established[70]. Civil-society organizations, such as the Association for Safe International Road Travel, also emerged and non-health actors, such as the Global Road Safety Partnership, engaged with the cause[71,72]. The World Health Report of 2004, which focused on RTI, provided great impetus for collaborative action and stimulated donor funding[73]. RS-10, an initiative funded by Bloomberg Philanthropies, has encouraged complementarity of inputs by different actors including researchers, civil society, transport, law enforcement and urban planning[74]. This culminated in the 2010 UN Resolution and the declaration of the Decade of Action for Road Safety which has helped to catalyse and generate support for national actions for prevention of RTI[75].

LESSONS LEARNED

These examples of participatory leadership indicate that, while the initial stimulus for public-health action may come from any one of a diverse set of actors, the momentum for successful, scalable and sustainable public-health interventions can only be created by participatory leadership that brings and binds together many different groups who provide complementary strengths. This has indeed been true of most major public-health successes, whether in global programmes to protect maternal and child health, curb the promotion of breast-milk substitutes, eradicate smallpox, combat polio, or in the prevention of blindness, blood safety, sanitation and public-health responses to humanitarian crises. Multisectoral coalitions are also now advancing action for eliminating all forms of malnutrition, control of noncommunicable diseases, protection of mental health and reducing air pollution. All of these partnerships will require consultative and participatory leadership to achieve success.

Learning from such experiences suggests the need for creating platforms that enable participatory leadership to emerge from the engagement of diverse groups of actors in a consultative process. All relevant stakeholders need to be brought together for advancing the agenda of health and sustainable development, within the national context. At the global level, separate platforms exist for intergovernmental consultations, civil-society debates, academic conferences and private-sector conclaves. However, very few platforms exist where all the diverse sets of actors regularly engage in a mutually respectful discussion of global health challenges and plan for concerted action to address them. There is a need to create more such platforms.

As the SDG mandate gets implemented, there will be more learning on the value of participatory leadership. Much of the new learning has to come from low- and middle-income countries which are experiencing major health transitions and have several health-system challenges to cope with. Even as a new model of leadership is advocated and adopted in these settings, capacity for research also needs to be enhanced to study its dynamics and impact.

CHAPTER 5
KEY MESSAGES

- Leadership of health systems must be imbued with vision and values that reflect commitment to societal good and equity.

- In decision-making, health-system leadership should be guided by knowledge from different sources which is combined to create actionable evidence. Leadership also has to be capable of operating in conditions of uncertainty and inconclusive evidence.

- The ability to absorb, appraise and apply the knowledge generated by such research will provide course corrections as needed, in addition to identifying more effective and equitable delivery pathways.

- The institutionalization of participatory leadership will make the system far less vulnerable to change of individual leaders at any level.

HEALTH LEADERSHIP IN THE 21ST CENTURY

"Diversity, complexity, creativity and adaptability will be the greatest at the local level with an appropriate minimum of regulation to enable the individuals to know what the rules are and what is happening, so that they can collaborate creatively."

ROBERT CHAMBERS
PROFESSOR AND DEVELOPMENT SCHOLAR

Now that we have seen how participatory leadership can bring about positive change in health, the question remains as to how we must provide impetus to the process of stimulating and supporting such leadership in the health systems which have to play a major role in advancing the goals of sustainable development. The principles underlying participatory leadership have hitherto been inconsistently and sporadically applied. The agenda of sustainable development requires that participatory leadership become an article of faith for health systems and be developed by clear intent. That will enable these systems to become fit for purpose in effectively and equitably delivering health in a rapidly changing world. The vision and value of participatory leadership, profiled in the previous chapters, now need to be advanced into the global agenda of health-system strengthening.

In the 21st century, leadership of health systems should be able to bridge the domains of science, finance, public policy, ethics, management and implementation and diplomacy. In a fast-changing context, it needs to be alert, agile, adaptive, action oriented and accountable. Leadership of health systems must be imbued with vision and values that reflect commitment to societal good and equity. These are not sui generis: they must be generated through broad-ranging consultations that engage diverse stakeholders, from health-care providers to patients and researchers to advocates. Priorities, in policy and programmes, must be set on the course coordinates provided by the consensus that crystallizes common will for common good.

In decision-making, health-system leadership should be guided by knowledge from different sources that are combined to create actionable evidence. Leadership also has to be capable of operating in conditions of uncertainty and inconclusive evidence. Transdisciplinary learning and real-world awareness, gleaned through a combination of quantitative and qualitative research along with diverse approaches to decision analysis, will be needed in such situations. Leadership in health systems should be capable of making the best use of its internal resources and external partnerships, to translate the most relevant and readily applicable knowledge into the most productive action pathways that can provide the maximum benefit for population health with the greatest impact on health equity. Clearly, such omniscient leadership is not vested in one individual or a single institution. It is the collective strength of the health system that must generate the quality and consistency of leadership required to raise the performance of the health system high above the welter of complexity.

As noted in chapter 1, the three attributes which were accorded the highest priority by the respondents in 2014 were: team player, knowledgeable and adaptive[2]. The first emphasizes the need for an inclusive, consultative and enabling leadership that builds, nurtures, values and draws upon the strength of all members of a team. This reinforces the need for participatory leadership. The second calls for expertise which combines the knowledge and skills that can successfully and speedily advance the mission of the health system. However, no single individual can be the repository of all necessary knowledge and skills in an area as complex as health. Hence the need to acquire, enhance and utilize the knowledge and skills that exist across the system. This too is a benefit of participatory leadership. Being adaptive is an essential quality which enables the health system to seize new opportunities (such as technology) or survive unanticipated challenges (such as a pandemic). However, such adaptability must extend across the system; for a rigid system will resist change and fail, even if a high-level decision-maker has an adaptive mindset. Thus, all the essential qualities of leadership must extend across the system to realize the strength of participatory leadership that springs from a 'distributed but not disconnected' model. The role of individual leaders is to ensure that this happens.

Apart from knowledge and skills, values are vital to leadership of health systems. Their defining mission is to promote health and wellbeing for all persons at all ages, as mandated by SDG 3[59]. Universality of health benefits also means unwavering commitment to health equity. Enthusiasm for innovation, coupled with a firm belief in rigorous evaluation, is another attribute that leadership of health systems must foster in all of its constituents. Innovations to solve problems, break barriers, enhance effectiveness or promote equity can spring from anywhere in the health system or may be adopted or adapted from other sectors. The surge in technological innovations, from point-of-care diagnostics to new therapeutic modalities, will also call for judicious application based on considerations of cost-effectiveness, affordability, health-system readiness, sustainability, scalability and equity. Leaders will have to understand the politics and economics of technology diffusion and make choices guided by rational health-system priorities. Since technology is often seductive in appeal and hyped up in advocacy, leadership in health systems must be judicious in the choice of appropriate and affordable technologies and the extent of their deployment.

Even when technologies are effective, leadership must ensure equitable access to their benefits. Innovations in health-service delivery also extend beyond technologies. Leadership of health systems must be ready to embrace potentially useful and implementable innovations only after critical assessment of their match with prioritized health-system needs and resource implications. Investment in implementation science and evaluation through mixed methods research is especially important. The ability to absorb, appraise and apply the knowledge generated by such research will provide course corrections as needed, in addition to identifying more effective and equitable delivery pathways.

The institutionalization of participatory leadership will make the system far less vulnerable to change of individual leaders at any level. The active engagement of many stakeholders, such as civil society and academia, in the decision-making and monitoring processes of the health system will also act to check harmful deviance from mission and values and to check aberrant behaviour by any individual leader. Being able to self-correct and to learn from failures is a desirable feature of leadership at every level. While integrity is an expected feature of good leadership, challenges posed by corruption or poor governance are also best overcome if the participatory process asserts itself and the distributed leadership demands cleansing.

Leadership also demands political astuteness in managing complexity as well as in positioning health prominently in the political and electoral agendas. The ability to navigate through multistakeholder consultations, the skill to engineer intersectoral partnerships and felicity in engaging the media to become an ally — these qualities will mark out an effective leader. While these are often individual attributes to begin with, they can be developed across the system through mentorship and guidance.

Although we have not specifically addressed it in this report, as it is a topic that merits substantial discussion on its own, the governance of health systems is an area where leadership must become familiar with the political realities of policy-making and execution. Differences in relations between political decision-makers and senior civil servants, or between health-system managers and health professionals providing services, are frequently observed problems that undermine the efficiency of health systems. Fault lines can emerge across the health systems, due to differences in perceived priorities, knowledge, skills, attitudes or values. These differences may be of a higher magnitude when the health system has to deal with other sectors. It is, therefore, necessary to understand how the dynamics of participatory leadership can pre-empt or overcome such problems.

In the future, health systems will increasingly have to function through partnerships built within the health system and with others who operate outside its conventional boundaries but have considerable impact on health. Such partnerships will involve multiple stakeholders and will operate at global, local and national levels. There is reciprocity of influence between the components of this complex system. This calls for leadership — at multiple locales and levels — which is inclusive, collaborative, open minded, adaptive, persuasive and receptive. It also calls for **open mindsets** that reflect the value of transdisciplinary knowledge generation for multisectoral application, and an entrepreneurial ability that can create productive partnerships and direct them towards prioritized goals of the health system. This is the essence of **participatory leadership**.

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The Alliance works to:

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2. **Support institutional capacity** for the conduct and uptake of health policy and systems research
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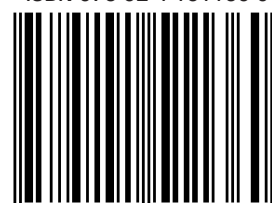4. **Increase the demand for and use of knowledge** for strengthening health systems.

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