Four

Analyzing Vision–Reality Gap

Without imagination we would never venture outside the box. Our reality would only exist within the confines of the status quo.... For your dreams to become your reality, you need only bridge the gap ...
—Jonathan Wells[1]

Introduction: What Is Vision–Reality Gap?

A visionary leader would have developed a compelling shared vision and generated the necessary drive and energy to translate that vision into reality. However, with time, there are chances that the current reality may differ from the existing vision. Therefore, to direct the drive and energy, the leader needs to analyze the vision–reality gap. A visionary leader assesses the gap between the vision and reality, and then identifies the root causes that need to be addressed for devising a path.

A vision is a picture of the desired future. Therefore, the first step in analyzing vision–reality gap would be to understand the picture of current reality and identify the essential respects in which these two pictures differ. However, to be able to analyze these differences and assess their magnitude, it is necessary to identify the indicators that can be used to assess the gap between vision and current reality. For instance, MMR is one of the associated indicators for the vision of "healthy mothers." One could

[1] Wells, J. *Advanced life skills*. Self published. Retrieved from www.advancedlifeskills.com.

compare the current MMR with the one that prevails in, say, developed countries to assess vision–reality gap.

In the following section of this chapter, we present some possible visions and the associated indicators. However, it is not enough to assess the current situation. Things are never what they seem or appear on the surface. As the only constant in life is change, a leader must constantly see and think beyond the obvious. An important item in the basket of skills necessary to be a visionary leader is the ability to "envision" the future, to see beyond the obvious, to analyze events or activities beyond the superficial level. Therefore, the leader would need to understand temporal and spatial trends to assess how the situation is most likely to change in the future without any action. We call this "seeing the big picture."

It is not enough to identify gaps but to also understand these gaps from a leadership perspective and analyze them using systems thinking. By thinking of system as a whole, a visionary leader starts seeing things differently when he/she starts thinking of them differently. Systems thinking would lead to understanding cause-effect relationship. This is discussed in the third section (Systems Thinking).

There is a need to identify root causes for vision–reality gap. Only then a path can be devised to bridge the gap between vision and the reality. The fourth section (How to Think in an Organized Way in a Complex Situation?) presents two ways to identify root causes: why-why tree and root cause analysis tree. The path chosen would need to address root causes so that the gap between vision and reality can be narrowed. Finding a path is the subject matter of next chapter.

Analyzing Vision–Reality Gap

As mentioned earlier, we need to identify indicators to describe the vision in quantitative terms so that the magnitude of gap between vision and reality can be assessed. In Table 4.1, we show some illustrative indicators used in defining a few societal visions.

Table 4.1: *Illustrative Indicators for Assessing Vision–Reality Gap*

Vision	*Illustrative Indicator*
Make poverty history	Proportion of people whose income is less than $1 a day
No hunger	Proportion of people who are undernourished
Healthy children	Under-five mortality
Healthy mothers	MMR

Source: Authors.

These indicators may not capture the vision in its all ramifications. For instance, the indicator for "healthy child" vision is under-five mortality rate. However, the vision also means not merely absence of morbidities (mortality is an extreme form of morbidity) but also physical, mental, and social well-being, and other indicators need to be devised to fully assess vision–reality gap.

It is not enough to assess current vision–reality gap by using appropriate indicators. One also needs to ascertain what the gap is likely to be in future, if the current trends continue, and where the gap is likely to be more.

Therefore, leaders see the "big picture" when they assess the vision–reality gap.

- Trends over time and projections
- Trends over geographic space and differential in gap
- Results from different levels of administration and how they would be perceived
- From different level of objectives

In the following paragraphs, we discuss ways to analyze vision–reality gap using MMR as an indicator.

See the Big Picture: Trends over Time

Trends over time are an important indication of both reality on the ground and effectiveness of program interventions for maternal health. For instance, Tamil Nadu state in India, an improved

reporting system could explain the big increase in maternal deaths between 1994 (640) and 2001 (1,636).[2] Then, in three years, maternal deaths decreased to 1,219 (2004) perhaps indicating that the high figure that emerged from better reporting in 2001 prompted quick effective actions by the authorities to improve maternal health. One would now need to ascertain whether such decline would continue with current program interventions or new actions would be needed.

See the Big Picture: Trends over Geographic Areas

The National Maternal Mortality Survey in 1992–1993 revealed that the metropolitan areas and Upper Egypt had a higher MMR than Lower Egypt (see Table 4.2). In response to these results, the Egyptian Ministry of Health and Population intensified the efforts of Safe Motherhood Programs in Upper Egypt. The result is that the regional situation had reversed in 2000. Clearly the gains in reducing MMR have been limited in the Lower Egypt region and efforts may also have to be directed there for further success.

Table 4.2: *MMR Comparisons between Geographic Areas in Egypt*

Regions	*MMR 1992*	*MMR 2000*
Metropolitan	233	48
Lower Egypt	132	93
Upper Egypt	217	89
Frontier	*	120
National	174	82

Source: Campbell et al. (2005).[3]
Note: * Not included in project.

[2] Dasgupta, J. (ed.) (2009). Maternal death and disability in India: welcome kit for parliamentarians. SAHAYOG. Available at http://www.clraindia.org/include/Final.pdf%20maternal.pdf (accessed on March 13, 2014).

[3] Campbell, O., Gipson, R., Issa, A. H., Matta, N., El Deeb, B., El Mohandes, A., Manosur, E. (2005). National maternal mortality ratio in

See the Big Picture: Results from Different Levels of Administration

The overall situation of maternal deaths should be seen from different levels. Maternal deaths could be a rare event (may be once in two years) in a village, say, with a population of 5,000, a 25 per thousand birth rate, and MMR of 40 per 100,000 live births. Therefore, residents of this village may not perceive maternal mortality as a serious issue. However, an international comparison at the state or national level may show that there is considerable avoidable maternal mortality. Also for some other village, it could be a different picture. So, to better understand the issue, we need to look from different levels, from village to district to state to region, and so on.

See the Big Picture: From Different Level of Objectives

A high MMR not only symbolizes an individual death or a calamity for the surviving child and family but is also an indicator of gender values in the society where women's health may be undervalued. Therefore, a vision of gender equality could use MMR as an indicator of progress in reducing the gap between this vision and reality.

Systems Thinking

It has often been said that when you start thinking differently, you see things differently, and then your actions start to change. For a visionary leader to effectively deal with changes and challenges, he/she must constantly think and see things beyond what is obvious and within their sphere of influence or control.

Egypt halved between 1992–1993 and 2002. Bulletin of the World Health Organization, *83*(6), 462–472.

Visionary leaders need to promote systems thinking because this will foster greater appreciation and understanding of shared vision, better coordination, and teamwork. This is a vital leadership trait for greater personal and organizational effectiveness.

Everything around us exists in a world of its own, that is, everything has its own "system." In this regard, because it is necessary to deal with systems—what to "think" of them or how to analyze them and hence what action to take—it is imperative that leaders understand systems thinking.

What Is Systems Thinking?

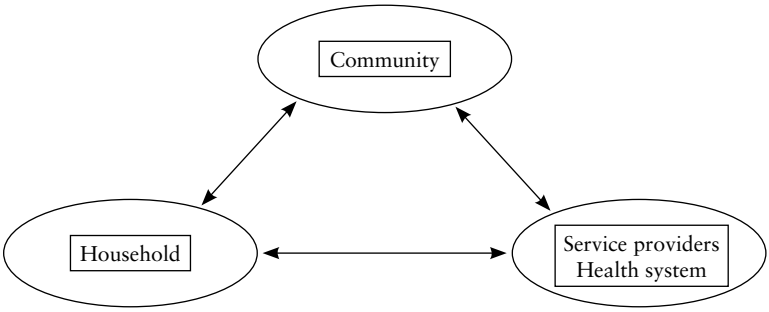
A system is a group of interacting, interrelated, or independent elements forming a complex whole.[4] A system is something that maintains its existence and functions as a whole through the interactions of its parts. It has properties above and beyond the properties of the parts that comprise it. These interactions and changes in behavior of one may influence the other parts of the system. Change in one part of the system causes change in other parts of the system and vice versa. The component parts are all cause-and-effect linked. Some of these may be unintended. So, if a leader wishes to take action to bridge the gap between vision and reality, there is a need to think of the underlying system which is creating the gap.

Our modern life both dictates and reinforces our dependency on systems, on assemblages of people or technology or both; however, among our greatest difficulties is making "systems" work where and when we want them to. Gawande says that we are obsessed in medicine with having great components—the best drugs, the best devices, the best specialists—but pay little attention on how to make them fit well together. He quotes Berwick, President of the Institute for Health Care Improvement in Boston as noting how wrong-headed this approach is: "Anyone who

[4] Answers.com.

understands systems will know immediately that optimizing parts is not a good route to system excellence."[5]

Figure 4.1: *A Country's Health System*



Source: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs. www.benandhenryleadership.blogspot.com (accessed on March 18, 2014).

The health system comprises individuals/households, communities, and government/private service providers (see Figure 4.1). To understand a country's health system, we need to ask: who are the primary producers of health and how do they interact? The primary producers of health are households or families including the individuals, community groups, and health service delivery systems including government and private sector. Their interaction produces health. However, the households may be the producers of health as their decisions have the most impact.

According to Senge (1990), systems thinking can be regarded as a discipline on how to look at things as a whole and finding appropriate solutions. It thus provides a framework from which interrelationships can be examined for patterns of change, and not as static snapshots. Put simply, in systems thinking, every picture tells a story.[6] Because systems have links and connections, and because nothing exists in isolation within an organization,

[5] Gawande, A. (2009). *The checklist manifesto: How to get things right*. Metropolitan Books, New York: USA.

[6] Goodman, M., Kemeny, J., & Roberts, C. (1994). The language of systems thinking: Links and loops, in P. Senge (ed.), *The fifth discipline fieldbook: Strategies and tools for building a learning organization*, p. 113. New York: Doubleday/ Currency.

there is always a cause and an effect. The key elements in systems thinking are interdependent, and linkages can be weak or strong, and thus they determine the capacity and resilience of your "systems."

Systems thinking can be manifested in four main ways:

1. *Spatial perspective*: To see components or parts in terms of a whole package
2. *Temporal perspective*: To see the present in terms of the past and future
3. *Relational perspective*: To see how events and variables are related
4. *Process perspective*: To see how processes or patterns unfold and how they affect the whole

Systems are *dynamic and organic* mechanisms, often demonstrating complex and unpredictable behavior. Smooth functioning of systems depends on a lack of friction or constraints between and among these mechanisms. Peter Senge's Laws of the Fifth Discipline[7] identify the usual failures in the absence of system thinking as:

- Today's problems come from yesterday's solution
- The harder you push, the harder the system pushes you back
- Behavior grows better before it gets worse
- The easy way out usually leads back in
- The cure can be worse than the disease (shifting the burden)
- Faster is slower
- Cause and effect are not closely related in time and space
- Small changes can produce big results but areas of highest leverage are often the least obvious
- You can have your cake and eat it too, but not at once
- Dividing an elephant in half does not produce two small elephants

[7] Senge, P. (1990). *The fifth discipline: The art and practice of the learning organization*. New York: Doubleday/Currency.

Why Think of a System When Analyzing Vision–Reality Gap?

Visionary leaders could more effectively develop and achieve results if they can use the system to their advantage. Greater appreciation and understanding of a shared vision can be fostered and better coordination and teamwork can be achieved through promoting systems thinking within an organization.

Improving a part may not improve the system as a whole. As a system is made up of component parts, the behavior and actions of each part have an impact on the performance of the others. Therefore, one needs to find what is constraining the performance of the system. In other words, a constraint is something that limits or restricts a system's performance.

A straightforward and simple way to see the effect of this is the Boy Scout troop illustration. A Boy Scout troop takes a hike up to a mountain. The distance is 10 km, and they estimate that by walking at 2 km per hour, they can reach the top in five hours. But as different troop members walk at different pace, the time to reach the top is determined by the slowest person. Suppose the slowest person walks at 1 km per hour, it may take 10 hours for the whole troop to reach the mountain. Thus, we need to address a key constraint affecting the performance of the system, in this case the slowest person. The key constraints would change as the speed of the slowest person is increased; some other person may become the slowest.

EXAMPLE: Reducing Unmet Need for Contraception
The unmet need for contraception arises when women who do not want a child or do not want one for two years or more do not practice contraception. It depends upon

- Access to information on contraception
- Access to family planning services
- Quality of family planning services
- Sociocultural influences that mediate between the individual and health service delivery system

For instance, out of women in the group with need for contraception either for limiting or spacing birth, only 90 percent have the information, of whom only 85 percent have access to services. Of these women, only 80 percent feel that the quality is adequate and 85 percent of them are able to utilize the services because of the socioeconomic constraints. Therefore, the need for contraception that will be met is calculated at only 52 percent (= 0.90 × 0.85 × 0.80 × 0.85) women will be met. Increasing knowledge to 95 percent will increase the met need to only 55 percent.

EXAMPLE: Better Resource Allocation in Reducing Maternal Mortality

The following factors determine the possibility of death when there is a complication in delivery (see Figure 4.2):

- Delay in decision to seek medical attention (lack of knowledge of danger signs, complicated decision-making, etc.)
- Delay in transport of patients (availability of transport, distance, etc.)
- Delay in delivery of needed emergency care (needed staff, supplies, medicines, blood, equipments, etc., not available)

Figure 4.2: *Components of the Three Delays*

Source: www.maternityworldwide.org (accessed on March 18, 2014).

Reduction in any one of these delays will reduce overall delays. However, the death may still not be averted if there is considerable delay in providing needed emergency care. Avoiding maternal deaths is possible, but programs must be designed using the right kind of information.

The MMR in Tami Nadu in India reduced from 380 in 1993 to 90 in 2007 maternal deaths per 100,000 births, thus nearly

achieving MDG 4.[8] A variety of innovations in maternal health service delivery coupled with improvements in socioeconomic conditions led to this accomplishment. However, the state wishes to reduce MMR further and, therefore, it looks for causes of vision–reality gap. The investigation of causes of maternal deaths through maternal death audit was launched as a concurrent activity of identification and reporting process and intensified over a period of time. The following methods for investigation are often used to find answers on what should be done to reduce MMR:[9]

- *Community-Based Maternal Death Reviews (Verbal Autopsy)*: This investigation has helped in finding out the medical and non-medical causes of death and ascertaining the personal, family, or community factors that may have contributed to the deaths of pregnant women which occurred outside of a health facility.
- *Facility-Based Maternal Death Reviews*: A qualitative in-depth investigation of the causes and circumstances surrounding maternal deaths occurring at health facilities.
- *Surveys of Severe Morbidity* (Near Miss Cases Audit): The review of cases of severe morbidity identifies "Near Miss Case" as "any pregnant or recently delivered woman (within six weeks after termination of pregnancy or delivery), in whom immediate survival is threatened and who survives by chance or because of the hospital care she receives."
- *Clinical Audit*: Clinical audit is a "quality improvement process" that seeks to improve patient care and outcomes by the systemic review of care against explicit criteria and implementation of change.

[8] Padmanaban, P., & Desikachari, B. R. (2005). Averting maternal deaths and disabilities: Rights-based approach towards reduction of maternal mortality ratio in Tamil Nadu. Retrieved from www.searo.who.int/Regional Health Forum_Volume 9_No_1_Reviewing Maternal Deaths.pdf.

[9] WHO. Reviewing maternal deaths and complications. Retrieved from www.who.int/reproductive-health.

In Tamil Nadu, key findings from Investigation of Maternal Deaths (Verbal Autopsy) in a year were found to be as follows:[10]

- Misdistribution of First Referral Units (FRUs) and shortage of specialists
- Substandard care in the existing institutions
- Unnecessary referrals
- Majority of the patients visited more than two institutions before death
- Delay in accessing emergency transport
- Underutilization of PHCs resulted in the overcrowding of FRUs for normal deliveries
- Unmet need for abortion or tubectomy services
- Obstetric first aid not provided before referral
- No birth preparedness

Several solutions were then implemented including the following:

- Comprehensive emergency obstetric care centers with contractual appointments of staff
- Emergency transportation
- Blood storage facilities in 385 PHCs
- Capacity building of staff nurses and village health nurses
- Emergency obstetric management protocols in place
- Strengthening of FRUs
- Marketing of PHCs as places for delivery

In summary, we need to think of the system as a whole because:

- Improving a part may not improve the system performance as a whole
- Obvious solution could be wrong
- Leaders need to know what needs to be corrected and how much attention and resources are needed to do it.

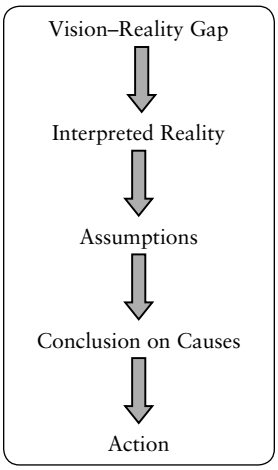
[10] Retrieved from www.similima.com 20.

One could change the system functioning, get better performance by reallocating resources and/or utilizing new resources well.

Assumption: Inference Ladder

One of the reasons for misdiagnosing causes of vision–reality gap is the role assumptions play in interpreting reality.[11] The argument runs as follows (see Figure 4.3). We observe the reality based on observable facts. What we observe, however, may be biased by our beliefs and experiences. As it is said, we often see what we want to see. We interpret this reality and analyze it based upon our assumptions, sometimes without making them explicit. Conclusions are then drawn on the causes based on some beliefs, and actions are taken to address only these causes.

Figure 4.3: *Assumption–Inference Ladder*



Source: Senge, 1994.[12]

By consciously using the ladder of inference, the leader can learn to get back to the facts and use beliefs and experiences to remove biases leading to selectivity. By explicitly examining assumptions, the step-by-step analysis can lead to better results avoiding unnecessary mistakes. It is often said that conflicting conclusions arise because of different assumptions underlying them. In summary, the following are needed:

- Becoming more aware of your own thinking and reasoning (reflection).

[11] Senge, P. M., Kleiner, A., Roberts, C., Ross, R. B., & Smith, B. J. (1994). *The fifth discipline handbook*. New York, USA: Crown Publishing Group.

[12] Ibid.

- Making your thinking and reasoning more visible to others (advocacy).
- Inquiry into others' thinking and reasoning (inquiry).

Let us apply this reasoning to a group participating in leadership development program. The group was reviewing the contraceptive prevalence rate in a region and observed that the rate was low because of the large population of Muslims in the region, as many of them see the use of contraception against their religious beliefs. So, the action identified was to request local religious leader to issue a fatwa. However, survey and focus group discussions revealed that the non-users of contraception were concerned about side effects of contraception and poor quality of care. Therefore, the action needed was to improve the quality of care of RH services including family planning.

How to Analyze Systems?

A system could be analyzed in terms of its functioning and cost. There are many ways to analyze functioning of a health system. One can use performance metric to see if the system is functioning at a desired level of performance or not. For instance, one way is to use equity metric and analyze how well the health system provides services to the poor. A variety of tools, such as cost-benefit analysis and cost-effectiveness, are used for analyzing the cost of the system. One can also analyze the impact of potential interventions to identify the most cost-effective intervention.

How to Think in an Organized Way in a Complex Situation?

Clearly when we think of the systems, we need to think of the links and linkages among them. This often leads to complexity and dynamic behavior. An important feature of complex systems

is that they are very often stable and resistant to change. Often dynamic behavior of systems is determined by feedback linkages. Some feedback linkages are reinforcing and in that, good things become better (virtuous cycle) or bad things become worse (vicious cycle). A mix of reinforcing feedback linkages often keeps the system in a stable state. When changes do occur, however, these can be very sudden and dramatic. Changes may be easy if a leader knows where to intervene or apply leverage.

Often, in human organizations, the best leverage points are how people think or the mental models supporting the system. For instance, the progress in improving adolescent RH may be constrained because community may believe that providing information about sexuality and contraception will make adolescents more promiscuous.

Usually the gap leader will see only the surface of an iceberg with the real system structure and causes submerged. The big picture comprising seeing trends and patterns provides a deeper level of understanding and leads to looking at underlying causes in other parts of the system. For instance, among the multiple causes of why women may deliver at home, one could be the rude behavior of health service providers at the institution (see Box 4.1).

Box 4.1: *Know Your Vision–Reality Gap*

Leadership Checklist

Do you have the big picture of vision–reality gap?
Do you know the causes of vision–reality gap in systems?

Source: Authors.

Identifying Key Constraint

One of the key tools we have to gain understanding of the cause-effect and to identify the key constraint is to ask the "why" questions. The technique basically requires asking "why" and repeating it at each level. Some people say that at least five levels

may need to be analyzed to find the root cause of the vision–reality gap.

EXAMPLE: The Why Tree: Analyzing Low Coverage of Postinor in Mongolia

In the following paragraphs, we discuss the use of "Why Tree" as a tool to analyze why there was low coverage of Postinor, an emergency contraceptive pill, in spite of it being available. The question raised was: "Why is the rate of abortion so high for young people in Mongolia, particularly those of university-going age? Why is Postinor not used more widely?"

To understand the key constraint, one sought answers to the series of "why" questions.

Why do young persons in Mongolia not use Postinor?

It is because they cannot get access to it; they may not know about it. Even if they know, they may not be able to access it. In Mongolia, Postinor is supplied by doctors who have to serve a large geographical area. They go from village to village, carrying a very limited (and maybe old) supply of Postinor. These doctors are not likely to be available when young people need this emergency contraceptive pill.

Why is Postinor only available from doctors?

Postinor supplies are sent by a foreign donor to the Mongolia Ministry of Health at the central level. The supplies are divided up into various districts and then a small quantity is further allocated to individual doctors. These doctors are, in fact, "traveling" doctors as they have to go from settlement to settlement in the rural areas of Mongolia to provide health services.

Why are doctors not being reached by young people?

Government doctors' geographical coverage is wide, they are never in one place for long or they will appear at a particular area after a long time. Thus most likely, they are never there when needed.

Why is Postinor not made available to pharmacists?

Pharmacies only exist in urban areas in Mongolia. Even, if Postinor is made available through pharmacies, it would be sold,

rather than given free of charge. Only young people living in urban areas with some money would get access to it, which due to widespread poverty is not a likely situation.

Why do many young people not know about Postinor?

Because it is not a contraceptive method that is promoted among young people.

Why are young persons in colleges and universities not reached?

It is because the current government program practice is to teach what amounts to "sex education" only in secondary schools. Mostly this falls on the biology teachers who don't generally feel comfortable teaching it, so they teach "life skills" instead. So, the quality of information on RH is low to nil. After secondary school, there are basically no programs on RH for young people, when they actually need them.

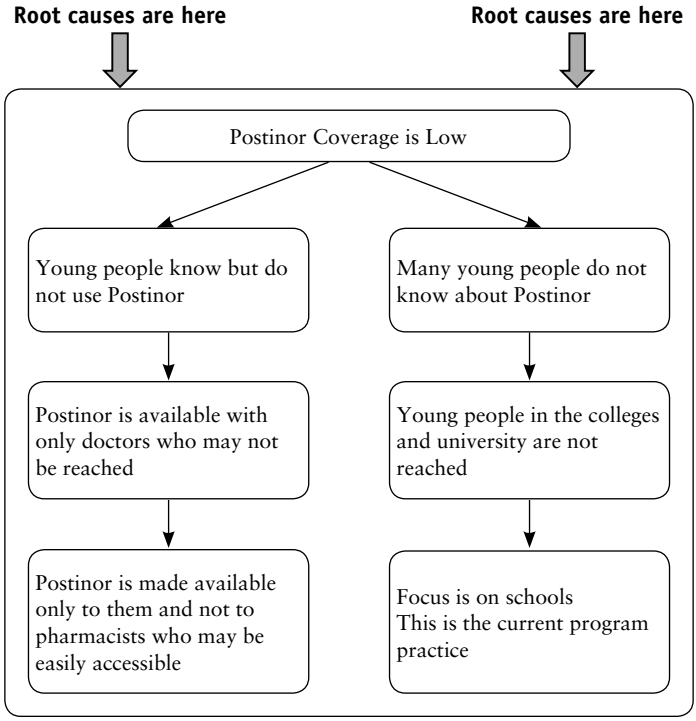
Two chains of causes as seen in the diagram help to explain why the performance of Postinor fell short of expectations where young people were concerned (see Figure 4.4).

The rate of abortion is high for university-age young people because they have no easy access to family planning methods and information. It is found that, at their age, they are mostly experimenting with casual sex and not in any stable long-term relationship to warrant regular or consistent usage of contraceptives. Postinor would be an ideal emergency measure, but unfortunately, the Why-Tree analysis shows that this is not the situation. Abortion then becomes the easiest solution to unwanted pregnancies (see Figure 4.5).

Finding the new path involves identifying and addressing root causes of vision–reality gap and core cause, if it accounts for several root causes. Goldratt,[13] in his theory of constraint management, provides a methodology to identify root causes that constrain the achievement of vision. A constraint at a point in time in the system is the one that limits performance of the current path in the system. It is the weakest link between input and outcome.

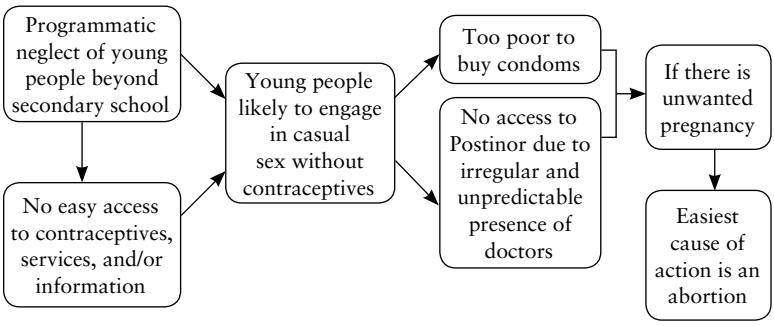
[13] Goldratt, E. Y. M. (1999). *Theory of constraints*. Great Barrington, Massachusetts: North River Press.

Figure 4.4: *The Why Tree*



Source: Authors.

Figure 4.5: *Reality-Tree Analysis: Why Abortion Rate Is High among Young People in Mongolia*



Source : Authors.

An in-depth analysis is needed to find out the core or root causes. Goldratt has developed a tool called "current tree analysis" to highlight the constraint in the existing reality that constrains reaching the vision and to identify the root causes of these constraints and not just the symptoms of vision–reality gap.

The team developing the current reality tree should (i) have an intimate and intuitive knowledge of the system based upon experience and data; (ii) be able to recognize and understand the pattern and connections between different parts of the system, and (iii) be ready for an in-depth discussion about the causes.

Constructing the current reality tree

The team starts by listing all the "undesirable effects" (UDEs) in the current situation pertaining to the vision. The UDEs are the undesirable realities such as women not accessing skilled birth attendant for improved maternal health, unsafe sex when considering reduction in HIV, patients not completing the treatment when addressing tuberculosis, etc. To keep this exercise manageable, it is recommended that this listing may be limited to about 10. Sometimes, tendency is to list the UDEs as "people are poor" or "education levels are low." While these may be true, it does not help identify the system constraints. It may be that the poor do not access services because they cannot afford them and improving affordability could be a way to address this constraint. It is to be noted that UDEs are effects caused by something else. One needs to ensure that UDEs are clearly and completely defined. Index cards or post-it-notes may be used to move UDEs around or add new UDEs.

The team then proceeds to examine causalities by asking whether one UDE is the cause of another UDE either directly or through some missing connections or intermediate steps. Current reality tree is organized by placing the cause underneath the effect and connecting them. This process needs to be repeated until all such connections have been made. In this process, it may be needed to clarify assumptions, beliefs, policies, and practices. For instance, illiterate often do not access services because the information and communication efforts are not appropriate for them.

The team now needs to review to ensure that all the UDEs and their connections have been identified. The connected UDEs can then be clustered and UDEs which are not the result of any other UDE are the root causes. If any one of them accounts for more than 70 percent of all the UDEs then it could be considered a core cause.

For changes in path to address core or root causes, one needs to ask what needs to be changed, to what and how. One should first investigate whether activities can be effectively reorganized to address the root cause. For instance, service providers may be rewarded on the number of malaria cases they have treated rather than reducing new cases of malaria. One should then consider redesigning the system. For instance, health promotion resources may be reallocated between media and interpersonal activities. Only if these two measures—reorganizing or redesigning—do not suffice, possibilities for further investments should be considered.

CASE STUDY 1. **Inspiring and Empowering Communities on HIV/AIDS: Seeing the Big Picture through Mobilizing for Active Participation (MAP) in Tanzania**[14]

Tanzania is not only one of the poorest countries in the world, but also among the countries with the highest HIV/AIDS prevalence in the world and the rate of infection is rising rapidly. It is one of the countries experiencing a reversal in human development due to the HIV/AIDS pandemic, and the cost of care for a person living with HIV/AIDS (PLWHA) is about twice the Tanzanian GDP per capita. There are glimmers of hope however: (1) Tanzania has begun very meaningful work in mobilizing a community-level response to the epidemic and (2) prevalence rates of HIV infection have been declining consistently for three years in two regions, where prevention and care interventions have been implemented in a comprehensive package.

[14] Swai, Ronald. 2003. Country presentation on *Inspiring and Empowering Communities on HIV/AIDS*. At the ICOMP International Seminar on strategic leadership of HIV/AIDS programs, May 5–8, 2003, Uganda. Adapted for this publication.

National responses cannot attain much success in scope, continuity and quality by acting alone without the support of communities.
(Dr Ronald O Swai, Head, National AIDS Control Program, Tanzania)

There is no doubt that communities are the source of all successful health programs, they are the direct link between those needing services and service providers. Communities' natural coping structures and mechanisms must be used as the starting point for coordination and strengthening of community initiatives. Too often many communities are relegated to being beneficiaries rather than producers, and their voices are left unheeded. The exclusion of communities will lead to weak responses to HIV/AIDS. Experience has shown however, that in combating HIV/AIDS, local communities can be empowered to implement their own programs. The essential ingredient is giving communities the needed "push"—the opportunity for input and then ongoing support to move forward—in short, inspiring, and empowering communities, see Box 4.2.

Box 4.2: *Three Phases of National Response*

1983–1990: Medical response (first National Task Force in 1985)

1990–1995: Public health response

1995 to present: Multi-sectoral response (an official multi-sectoral strategy prepared only in 2002)

Source: Authors.

Shifting the National Response toward Communities

Community mobilization and empowerment, and creation of a supportive social and cultural environment have now become cardinal elements of Tanzania's response to HIV/AIDS.

After nearly 20 years of providing information and a wide range of biomedical services, Tanzania's focus has shifted

from "top-down" to "people strategies," where partnerships are formed and ownership of problems and their solutions lies with the stakeholders. This approach is expressed in the National Multi-Sectoral Strategy Framework for HIV/AIDS, with a vision of a Tanzania free from the threat of HIV/AIDS and which cares for and supports all those who are infected and affected by HIV/AIDS.

Mapping: A Tool for Community Mobilization

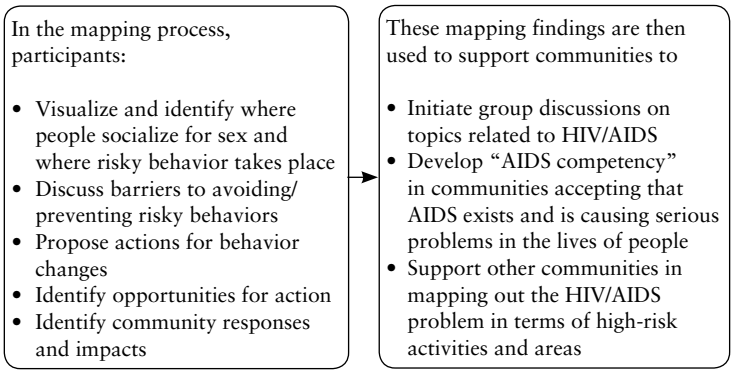
A community in Tanzania has implemented a donor-funded pilot program on community mobilization called "Mapping" which has been used with great success. The word MAP means "Mobilizing for Active Participation," and it involves drawing a map of "risky areas," where risky behavior takes place in a community. The goal is to create a participatory process of community empowerment; the program is planned so as to avoid top-down approaches and instead build partnership through decentralized actions with clear roles for all.

In Tanzania, the concept of mapping has been used as an entry point to community participation in problem identification, planning, and implementation of HIV/AIDS prevention and control activities. Through mapping, the community members come up with their own position on what must be done to solve the problem of HIV/AIDS at their community level. In fact, participants are separated by gender and subgroup (that is, PLWHAs, youth, etc.) to better understand the different problems that each group faces (see Figure 4.6).

As a result, communities have proposed several initiatives:

- Restricting youth from drinking establishments
- Increasing condom accessibility
- Presenting the mapping findings at community meetings to stimulate discussion about HIV/AIDS between men and women and among youth

Figure 4.6: *From Mapping to Action*



Source: Author.

Efforts such as these will be supported by the newly created District HIV/AIDS Committees, which are beginning to assume a leadership role in coordinating the multi-sectoral health-based HIV/AIDS interventions at the district, ward, and community levels, see Box 4.3.

Box 4.3: *Visionary Leadership Challenges in Inspiring and Empowering Communities*

Communities are the direct link between those needing services and the service providers, and therefore, it is essential that they should be given authority and be empowered. The visionary leadership challenges are

- How to create mechanisms for community institutions to participate in HIV/AIDS programs?
- What are the effective ways to strengthen and sustain community leadership for HIV/AIDS?
- How to involve religious leadership at the community level?
- How to enhance community leadership capabilities to address HIV/AIDS issues?

Source: Authors.

In community mapping sessions, communities have found a way to generate solutions to their own problems. Elements

of successful community empowerment include ownership and inclusiveness.

The overall challenge for the Tanzanian government then is to mobilize resources and design mechanisms to scale up successful interventions and make them accessible to all populations at risk. This calls for a strong partnership between the government and communities, and it is mandatory to create a synergy of efforts and increase coverage. Neither can do it alone.

A starting point for strengthening the coordination of community initiatives is taking a thorough inventory of all actors involved in HIV/AIDS prevention, care, and support, including the health sector, NGOs, government at all levels, and community groups. The goal is for these various sectors to become both advocates and leaders, and use the Community AIDS Action Committee as a facilitator in creating a successful, multi-sectoral response with community empowerment as its base.

Discussion of the Case

A visionary leader would be able to see that:

At the first and immediate level, HIV/AIDS affects the individual and the family and loved ones. Not much action can be effected as the concern here is mainly with the personal experience of the infected person—with getting treatment, living positively, and modifying behavior.

At the second level, HIV/AIDS goes on to affect the community impacting on the resources of its health system and socioeconomic conditions such as stigma suffered by PLWHAs and their families or availability of personnel for work. The community can take action such as the MAP approach in Tanzania. Here a lot can be done by the communities taking ownership of such initiatives as MAP and action through specific activities such as increasing condom access, encouraging more open discussions on HIV/AIDS, etc.

At the third level, policymakers at the national level can see the clear benefits of giving ownership of HIV/AIDS prevention and care to the communities (such as the MAP approach in Tanzania). They can capitalize on the efficacy of this model by duplicating it throughout the country. The challenges would be on how to energize the communities and how to mobilize resources for this to be achieved.

In other words, one needs to step back and see whether the benefits and actions are doing well, and think how then to implement more (see Box 4.4).

Box 4.4: *Conclusion*

Through the mapping process, several lessons have been learned.

- A response that excludes communities will not work
- Communities need to develop the capacity to analyze the causes of vulnerability to HIV infection and to propose their own actions
- Successful community empowerment requires leadership and political commitment
- Ownership by the community is key in creating a supportive environment for behavior-change interventions
- Alliances create a synergistic effect of efforts
- Community empowerment activities need to be integrated into other ongoing community services
- Involvement of PLWHAs strengthens the responses to HIV/AIDS
- Community support is effective when it is provided at several levels

Source: Adapted by authors.

CASE STUDY 2: Eradicating Female Genital Mutilation (FGM) in Upper Appia[15]

One-third (33 percent) of the women population in Upper Appia has undergone female genital mutilation (FGM). This is

[15] The health of a nation: A case study for strategic thinking, planning and action. Prepared for the Africa Regional Workshop on the WHO Strategic Approach to Improving the Quality of Reproductive Health Care Services held in Nyeri, Kenya, November 5–8, 2002.

primarily in the eastern provinces of the country. While almost three-fourth (74 percent) of the women population in the East is circumcised, only 10 percent in the West undergo this practice. The immediate and long-term negative health consequences of FGM have been well documented in Upper Appia and there have been increasing efforts to address this issue.

In order to bring together some of the small-scale efforts undertaken to address FGM, a local women's NGO called Women's Rights and Protection (WRAP) organized a meeting called "No More Cutting!" The purpose was to develop coordinated activities to more effectively meet their goal of addressing FGM. They brought together all the key players involved in FGM work in Upper Appia, including women's groups, health representatives, and Muslim leaders and groups. The meeting opened with a passionate speech by the executive director of WRAP arguing for the elimination of violence against women, of which FGM was one example. She concluded by stating the goal of the meeting: to end FGM now and completely in Upper Appia. This goal statement brought immediate reactions from the audience. Some representatives from the health field said that the goal should be to reduce the negative health consequences of the practice by making sure it was done under safe conditions. A representative of one of the Muslim groups argued that FGM was an important rite of passage, and that instead of trying to get rid of it completely, they should work to create alternate rites with fewer health risks. The leader of another women's group disagreed strongly, saying that these approaches just legitimized the practice and treated the symptoms without getting at the real cause of the problem. The meeting ran over time as this debate raged on for much of the morning, forcing the presenters to significantly cut short their talks, leaving no time to develop a group plan of action. The organizers of the meeting met afterwards, feeling quite discouraged about the outcome and complaining about the fact that the participants did not agree with their goal. Some wanted to just give up on the coordination idea, but one member suggested that they should bring in an experienced facilitator to try and bring the different groups together.

A few months later, after emotions had cooled down, another meeting was held. The facilitator began by asking participants to talk about the issues that they focused on in their work. She made a list of these issues and the group worked together to cluster the different issues in categories. In spite of the differences among the groups, they all saw the many common areas of interest. The facilitator then had participants describe the activities they undertook to address some of these issues. As the group worked together during the day, they saw the strong potential for collaboration in many areas. They concluded the day with a new goal statement: to improve women's status in Upper Appia through education and empowerment activities. The activities included addressing FGM as well as many other issues affecting women's lives. The WRAP organizers were pleased to see the participants continue to talk amongst themselves after the meeting ended, exchanging business cards, and making plans to meet again.

Case discussion

The meeting was called by WRAP to address the problem of FGM. It invited all the key players—women's groups, health representatives, and Muslim leaders and groups—to address the problem of FGM as violence against women. The goal of the meeting was clear—to end FGM once and for all now. However, instead of getting a consensus, the meeting aroused heated reactions and arguments from the various groups present. Why?

WRAP's intentions and arguments were good. It even had a catchy slogan for the meeting: "No More Cutting!" But in addressing a well-entrenched traditional practice, WRAP cannot expect to get agreement at one go or at the first try. Furthermore, it did not see the "big picture" at the first meeting. Heifetz and Linsky,[16] in their book *Leadership on the*

[16] Heifetz, R. A., & Linsky, M. (2002). *Leadership on the line: Staying alive through the dangers of leading*. Boston: Harvard Business School Press.

Line, suggested that leaders should occasionally go out to the balcony and take a look at the room from there. From this vantage point, they believed leaders would see the behavior and actions of people inside in a different light. After getting a refreshing and new perspective, they could go back into the room and resume whatever they were doing.

WRAP took a break—and possibly got this balcony perspective—and organized a second meeting a few months later because FGM was too important an issue to give up on at one try.

There were a couple of new actions taken at the second meeting:

1. *Addressing FGM as both a health risk and a way to improve women's status*: Tempers are generally more subdued when it comes to more practical concerns such as women's health and status. Everyone wants to be a part of this. The way the earlier meeting addressed FGM, it was an assault on religion and ancient practices.
2. *The use of a facilitator*: A facilitator acted as a neutral third party and, therefore, it was easier to solicit more open responses calmly.

The outcome was that positive dialogue and networking were initiated. Everyone agreed to "talk" and that could be the start of effective collaborations and actions.

Seeing the "big picture" occurred when WRAP was able to see FGM in the wide context of Upper Appia society and saw the need to change its strategy. While WRAP's vision was "Beyond Imagination," calling for an ancient traditional practice to be stopped immediately was something "Not Easy to Do." It achieved something positive ("Looks Difficult") at its second meeting and will surely go on to "Not Possible."