Eight

Delivering Superior Results: Applying the Visionary Leadership Framework

If your actions inspire others to dream more, learn more, do more and become more, you are a leader.
—John Quincy Adams

Introduction

There is a massive amount of literature on ways leaders can deliver superior results. For instance, Malcolm Gladwell discusses personal excellence as "outliers" in his book[1] *Outlier: The Story of Success*. "Outliers" is a scientific term used to describe things or phenomena that lie outside normal experience. People who are outliers, for one reason or another, are so accomplished and so extraordinary and so outside of the ordinary experience, that we think they are "outliers." He attributes such excellence to hard work and opportunities presented by external circumstances. He postulates the 10,000-hour rule—that practice of 10,000 hours is needed to build an expertise in any field. In addition, the fact is that some people also get an extraordinary set of opportunities so that they become outliers. The latter is considered "luck."

Does one have to be lucky to deliver superior results? Jim Collins in his book[2] *Great by Choice* argues that almost all

[1] Gladwell, M. (2008). *Outliers: The story of success*. New York, USA: Little, Brown and Company.

[2] Collins, J., & Hansen, M. T. (2011). *Great by choice: Uncertainty, chaos and luck—Why some thrive despite them all*. New York, USA: Harper Collins.

organizations get favorable external opportunities but what they do with it that determines how great they become. He discusses two teams of adventurers who wanted to reach the South Pole:

> In October 1911, two teams of adventurers made their final preparations in their quest to be the first people in modern history to reach the South Pole. For one team, it would be a race to victory and a safe return home. For the second team, it would be a devastating defeat, reaching the Pole only to find the wind-whipped flags of their rivals planted 34 days earlier, followed by a race for their lives—a race that they lost in the end, as the advancing winter swallowed them up. All five members of the second Pole team perished, staggering from exhaustion, suffering the dead-black pain of frostbite, and then freezing to death as some wrote in their final journal entries and notes to loved ones back home.
>
> Here we have two expedition leaders—Ronald Amundsen, the winner, and Robert Falcon Scott, the loser—of similar ages (39 and 43) and with comparable experience. Amundsen and Scott started their respective journeys for the Pole within days of each other. One leader led his team to victory and safety. The other led his team to defeat and death. What separated these two men? Amundsen and Scott achieved dramatically different outcomes not because they faced dramatically different circumstances. In the first 34 days of their respective expeditions, Amundsen and Scott had exactly the same ratio, 56 percent, of good days to bad days of weather. If they faced the same environment in the same year with the same goal, the cause of their respective success and failure simply cannot be the environment. They had divergent outcomes principally because they displayed very different behaviors.

We believe that leaders intuitively apply the visionary leadership framework. However, a systematic application of the framework will improve your odds of delivering superior results. In Chapters Three through Seven, we have discussed specific components of the framework. We now discuss specific issues that may arise when the framework is systematically applied in a situation in the second section (Applying the Framework). We then conclude the discussion in the third section. It is followed by two examples—gender violence against women and youth's access to reproductive health care.

Applying the Framework

In applying the visionary leadership framework, a leader needs to decide from where he should begin the process. The first question is—is there a shared vision for the issue at hand? Often leaders realize that the first step they should take is to create a shared vision. For instance, a team from a district in Gujarat, India, which had gone through a leadership development program, wanted to reduce maternal mortality in their district and found that there was no shared vision on maternal mortality among the staff. Upon discussion, it was realized that maternal health was almost always last in the agenda for quarterly review meetings and, consequently, the discussion was often shortened for want of time, creating an impression that maternal health was not as important as other areas such as family planning or malaria. So this review process was changed and the sequence of topics for quarterly review was altered to begin the discussion with a different program each quarter. Thus, at least in one quarter maternal health was reviewed first and this provided a communication opportunity for creating a shared vision for maternal health.

If there is a shared vision, the leader needs to assess—why there is a gap between vision and reality? What are the key constraints or root causes holding up progress? This would require a thorough understanding of the situation. Often, the leaders in this situation consult a wide range of stakeholders and hold dialogue with them. It would also involve reviewing of all the documents. Sometimes, it may happen that adequate information is not available and some operations research may need to be commissioned. Several agencies have also developed methodologies for situation analysis to assist in this process.

The above analysis will also identify whether the path currently followed is appropriate. If not, the challenge is to review/change path and/or strategies, and inspire/empower the relevant stakeholders as well as strengthen RBM. Often, however, it may be that there are no actions being taken to address the issue. Therefore, a new path is needed. This is a much bigger challenge

as the quantum of change involved is large. On the other hand, there may be no vested interest opposing the new path.

Having identified a path, there would be a need to orchestrate its implementation. Often a constraint exists because the incentives for implementers either do not reward for or there is a disincentive for addressing that constraint. Therefore, there will be a need to look at both overt and covert incentives/disincentives for implementers and to adapt them for progress toward the desired path.

If a careful process of creating a shared vision has been followed then many implementers may already be inspired. However, this may have to be supplemented by a communication strategy. The leader would also need to see what will be needed to empower the providers or individuals/households/communities. Often these include necessary facilities, supplies, equipment, information, or competencies. Key disempowering factors would also need to be addressed.

Finally, RBM priorities would be needed. Often the attention is directed toward this issue because shortfalls in "doing things right" are obvious. However, it is important that attention be directed toward "doing the right things." Therefore, it would be useful to ensure the above steps of assessing vision–reality gaps as well as finding the right path and formulating strategies. One can then pay attention to implementation. This is not to say that implementation is less important. Many well-designed paths and crafted strategies have delivered poor results or even failed because of flaws in their execution.

In summary, a leader needs to carefully diagnose where the problems lie and then seek to correct them. Often a commonly perceived problem may not actually be a problem. For instance, a team of government officials in a predominantly Muslim area in the Philippines felt that family planning performance was poor and had wished to popularize a fatwa in favor of family planning which had already been issued. However, systematic application of visionary leadership framework revealed that while religious concerns were important, even more important were the clients' concerns with the quality of care and addressing side effects of

contraceptive use. Thus, actions are needed to improve the quality of care.

Sometimes, for a variety of reasons, it may not be possible to work with the most critical element in the leadership framework. Therefore, a leader can begin wherever it is feasible in the circle—creating a shared vision, assessing vision–reality gap, finding a path, and inspiring/empowering stakeholders to follow the chosen path. However, as we will see in the following paragraphs, to realize the vision of Universal Health Coverage (UHC) in India, it is necessary to carry out all these iteratively.

Applying Visionary Leadership Framework for Universal Health Coverage in India

United Nations Task Force, on the Post-2015 U.N. Development Agenda,[3] says that ensuring people's rights, health, and education is vital for inclusive social development; one of the four core dimensions along with environment sustainability, inclusive economic development, and peace and security.

In India, the Planning Commission of India constituted the High Level Expert Group (HLEG) in 2010 on UHC. Several of its recommendations are a part of the 12th Five-Year Plan (2012–2017). During the last decade, the Government of India has also taken many steps to universalize elementary education. Therefore, we will present the HLEG recommendations in the visionary leadership framework, review government steps to universalize elementary education, and discuss leadership challenges through comparison of these experiences in promoting UHC. We believe that these learnings and challenges will help in getting insights to ensure UHC. We also believe that application of visionary leadership framework discussed in this book will help

[3] UN Systems Task Team on the Post-2015 UN Development Agenda. (2012). Realizing the future we want for all: Report to the secretary general. New York.

in many core competencies and skills required for leadership to translate the vision of UHC into reality.

Universal Health Coverage

The HLEG[4] defined UHC as

> Ensuring equitable access for all Indian citizens resident in any part of the country, regardless of income level, social status, gender, caste or religion to affordable, accountable, appropriate health services of assured quality (promotive, preventive, curative, rehabilitative) as well as public health services addressing the wider determinants of health delivered to individuals and populations, with the government being the guarantor and enable, although not necessarily the only provider, of health and related services.

The given definition incorporates three dimensions of universal health assurance: health care, health coverage, and health protection. The Foundation for UHC is a universal entitlement to comprehensive health security and intrinsic to the notion of universality which is a fundamental commitment to health as a human right.

Vision

The vision of UHC by 2022 comprised the following:

- Entitlement: Universal health entitlement to every citizen
- National health package: Guaranteed access to an essential health package (including cashless inpatient and outpatient care provided free of cost) at primary, secondary, and tertiary care by the central government

[4] High Level Expert Group. (2011). Report on universal health coverage of India. Instituted by the Planning Commission of India. October 2011. Retrieved from www.planningcommission.nic.in/reports/genrep/rep_uhc2111.pdf/.

- Choice of facilities: Public sector facilities and contracted-in private providers

Vision–reality gap

There is a large gap between the above vision and reality.[5] Despite significant economic growth, health outcomes have not correspondingly improved. Total health-care expenditure is variously estimated to be between 4.8 and 6 percent, and around 70 percent of this expenditure is out-of-pocket, much of it is on outpatient consultation and medicines. It is estimated that 3.4 million households fall below the poverty line every year due to catastrophic health expenditures. The government only spends about 1.2 percent of gross domestic product (GDP), one of the lowest in the world, and this is expected to increase to 1.5 percent by the end of the 12th Plan. The HLEG has estimated that 3 percent of GDP would be required for UHC.

Path for UHC

The HLEG review of global experience with UHC concluded that there does not appear to be a single universal method of financing UHC and that HLEG-proposed approach of UHC is unique, building upon lessons learned in India.

Paths toward UHC used by countries can be broadly differentiated by financing mechanisms and service delivery organization. Sri Lanka realized universal coverage by largely relying on public health facilities. Thailand's Universal Coverage Scheme is financed through government taxes and pays largely public providers on capitation basis. Canada has a publicly financed and privately run health-care system that provides free universal coverage to all its citizens. Sweden has a universal delivery system with decentralized decision-making and implementation with minimal use fees. Since its launch in 1948, the National Health Service in the UK has grown to become the world's largest

[5] Planning Commission of India. (2012). Health Chapter 12th Plan. New Delhi.

publicly funded health service. On the other hand, Japan relies on insurance mechanisms which are well-regulated.

The proposed architecture of UHC by HLEG has specific recommendations in six critical areas:

1. Health financing and health protection
2. Health service norms
3. Human resources for health
4. Community participation and citizen engagement
5. Access to medicines, vaccines, and technology
6. Management and institutional reforms

Inspire and empower stakeholders

Although management and institutional reforms have been recommended by HLEG, most of the reliance is on incentive structures through introducing competition or capitation type payments to and empower service providers and community. HLEG comments, "It is crucial for any UHC scheme to incorporate economic incentives and provider payment mechanisms that encourage principles of quality, efficiency, cost-effectiveness and safety." Unfortunately, there is not much discussion in the HLEG report on ways to create a shared vision among providers and community to inspire them and reinforce underpinning values of UHC that will empower them.

Results-based management

UHC outcomes are expected to have (1) achieved greater health equity, (2) improved health outcomes with gradual but significant reduction in disease burden, (3) improved health promotion, and (4) improved health surveillance.

HLEG recommends developing a national health information technology network and the need to ensure accountability to patients and communities as well as several regulatory, development, and education authorities. However, most of the focus seems to be on outputs and inputs and less on outcomes such

as improvement in health status, reduction in out-of-pocket expenses, or increased efficiency of health care.

HLEG document recommendations are appreciable and it is envisaged that it will help charter a path toward providing UHC. The HLEG document further emphasizes the learning from Indian experiences in making UHC a reality. In this context, a similar program on universalization of elementary education (*Sarva Shiksha Abhiyan*) by Government of India may help in learning the lessons and understanding the challenges in providing UHC.

Universalization of Elementary Education

The constitutional, legal, and national policies and statements have upheld the cause of universal elementary education (UEE).[6] The Constitution in 1950 mandated,

> The State shall endeavour to provide, within a period of ten years from the commencement of this Constitution for free and compulsory education to all children until they complete the age of 14 years. Although progress was made over six decades towards this goal, The Free and Compulsory Education for Children Bill (RTE) was introduced and passed by parliament in 2008, and became effective in April 2010.

Vision

The Right to Education (RTE) Act symbolizes the vision of UEE. It defines various aspects of the rights and entitlements of children and obligations of governments with respect to quality of education.[7] It mandates that no child shall be prevented from pursuing and completing elementary education for lack of money for fees or charges. The appropriate government and local authorities should provide and ensure compulsory admission, attendance,

[6] The World Bank Group. (2012). India economic update. Economic policy and poverty team, South Asia region.

[7] *The Gazette of India*. (2009). The Right of Children to Free and Compulsory Education Act, 2009. Ministry of Law and Justice, New Delhi, Government of India.

and completion of elementary education by all children in the 6 to 14 age group. The Act specifies standards for schools, prescribes norms for teachers, and deals with curriculum and evaluations.

Vision–reality gap

By the year 2000, out of the 200 million children in the age group of 6 to 14 years, 59 million children were not attending school.[8] There were problems related to dropout rate, low levels of learning achievement, and low participation of girls, and tribal and disadvantaged groups. That year the government launched the *Sarva Shiksha Abhiyan* (SSA, Movement of education for all), which is discussed in the following paragraphs.

By 2009, the number of out-of-school children in the age group of 6 to 14 years reduced to 8 million and enrolments climbed from around 160 million in 2002 to 193 million in 2011.[9] The average annual dropout rate fell to 6.8 percent in 2010–2011. Around 150,000 new primary schools and 93,000 upper primary schools were opened. However, this success in improving access was not supported by retention, satisfactory curricular interventions, and classroom practices.

Path

The main path for UEE is SSA, launched in 2001.[10] SSA was conceived as a centrally sponsored scheme to improve the educational status in the country through interventions designed to improve accessibility, reduce gender and social gaps, and improve the quality of learning. It is being implemented in partnership with state governments to cover the entire country and address the needs of 192 million children in 1.1 million habitations. The SSA seeks to open new schools in those habitations which do not have

[8] Ministry of Human Resource Development (MHRD). (2000). *Sarva Shiksha Abhiyan*: Programme for universal elementary education in india. Retrieved from www.educationforallinindia.com/.

[9] The World Bank (2012); Ibid.

[10] Planning Commission, Government of India. (2007). *Eleventh Five Year Plan (2007–2012)*. Oxford University Press.

schooling facilities and strengthen existing school infrastructure through provision of additional classrooms, toilets, drinking water, maintenance grant, and school improvement grants. Existing schools with inadequate teacher strength are provided with additional teachers, while the capacity of existing teachers is being strengthened by extensive training, grants for developing teaching-learning materials, and strengthening of the academic support structure at the cluster, block, and district level. SSA seeks to provide quality elementary education including life skills.

The objectives of SSA are

- All children in school, Education Guarantee Centre, Alternate School, "Back-to-School" camp by 2003; extended to 2005
- Bridge all gender and social category gaps at primary stage by 2007 and at elementary education level by 2010
- Universal retention by 2010
- Focus on elementary education of satisfactory quality with emphasis on education for life

The RTE Act further provided boost to operations of SSA.

Inspiring and empowering stakeholders

Despite significant achievements, its efforts to inspire and empower stakeholders were inadequate. Banerjee et al. argue that public participation in improving education is negligible.[11] Participation of community is believed to provide "voice" to the people and also facilitate "demand-driven" initiatives that make a difference. In SSA, local action is an essential element in the process of ensuring UEE. Primary vehicles for participation are Village Education Committees (VECs). An evaluation by Planning

[11] Banerjee, A., Banerji, R., Duflo, E., Glennerster, R., Kenniston, D., Khemani, S., & Shotland, M. (2007). Can information campaigns raise awareness and local participation in primary education? *Economic and Political Weekly*, 42(15), 1365–1372.

Commission[12] had this to say, "Community ownership of schools which was to be the backbone for the successful implementation of the program at the grassroots level has met with partial success as most VECs took a ringside view of school activities." This evaluation also found that motivation levels of teachers were low and the quality of learning varied considerably among the states. Ministry of Human Resources Development (MHRD) in its report of second year of RTE implementation mentions,[13] "Community involvement would be key to improving attendance and therefore deserves to become significant part of the agenda in the year to come."

Results management

The reporting system of SSA includes data on enrolment, retention, completion, and school facilities. The outcomes in terms of learning are measured through student's learning assessment and state-level achievement surveys.

However, the Annual Status of Education Report (ASER, 2011) by Pratham, a leading NGO, found that not only are India's learning levels poor on an international scale, but also the levels in government schools in the North have generally declined.[14] Despite RTE, enrolment in private schools is increasing. It argues that the learning level of a child in government school results from many factors where school is an important but only one of the factors. Nevertheless, an energized school system for learning focus can enhance learning effectiveness. Therefore, ASER makes a case that there is perhaps a need to rethink from a "right to school" to "right to learning." It recommends that there is, therefore, a need to rethink educational finance.

[12] Programme Evaluation Organization, Planning Commission, Government of India (2010). *Evaluation Report on Sarva Shiksha Abhiyan*. PEO Report No. 203.

[13] Department of School Education and Literacy, MHRD, Government of India. (2012). *The Right of Children to Free and Compulsory Education Act, 2009: The 2nd year*.

[14] Pratham Organization. (2012). *Annual Status of Education Report (Rural) 2011*.

Implications from UEE experience to UHC

As can be seen from the above description, there is considerable similarity in the vision for UEE and UHC. Both visualize universal access. However, the vision of UEE is enshrined in a legal act with rights framework. This is not yet so for right to health.

Also, the situation with regard to vision–reality gap is similar except for the time difference. There was considerable gap in access and enrolment in primary education in the year 2000. This gap has been largely bridged by SSA. The National Rural Health Mission (NRHM) launched in 2005, like SSA, sought to strengthen infrastructure including facilities and human resources, enhance community participation, and improve management. By 2011, access had been improved, although much remained to be done. The 12th Plan seeks to continue such investments both in rural and urban areas. Thus, the paths chosen for UEE and UHC are also comparable. They both focus on access and emphasize inputs and activities. Although emphasis on quality is sought, to date SSA has experienced difficulty in achieving it and this has implications for UHC.

Therefore, several issues that have arisen in the quest for UEE are also likely to arise in the progress for UHC. These include resource requirements, the role of private sector, inspiring and empowering stakeholders (Chapter Six), and RBM (Chapter Seven).

RTE Act includes a provision that private unaided schools must assure that 25 percent of the first-year students are children from economically weaker sections of the society. It is a measure to push universal enrolment, enhance education quality, and promote social integration. This provision was, however, challenged in the courts and it gained particular prominence in the media.

Jain and Dholakia[15] estimate that resource requirements for UEE, that completely rely on government schools, would be much higher even if 6 percent of GDP is allocated for the education sector. This is so because average salaries of teachers in government

[15] Jain, P. S., & Dholakia, R. H. (2009). Feasibility of Implementation of Right to Education Act, *Economic and Political Weekly*, *44*.

schools are much higher than for private schools without a demonstrated difference in quality of education. They argue for a mix of private and public schools or, as an extreme measure, reliance on voucher system. Most of the state governments have shunned the recruitment of full-time qualified and trained teachers, and appointed para, contractual, and part-time teachers.[16] Some have opposed this on the ground that one cannot rely on private sector to ensure UEE and government needs to provide the necessary resources for UEE. Venu Narayan[17] says that it is difficult to generalize in terms of quality of education delivered at public and private schools. He argues that the case for public provision and control of education (and its close cousin, health care) is well known because of its large external social effects. However, he prefers facilitative regulation of private schools and quality-driven reforms in public schools which is a better alternative to public–private partnership. Thus, there is a whole range of options: from fully public to a substantial public with private sector responsibilities to a separate but well-regulated private and public sector.

Similar situation is likely to arise for UHC also. Currently, nearly two-thirds of health-care expenditure is private out-of-pocket. UHC envisages reversal of this situation and anticipates that the out-of-pocket expenditure will reduce to about one-third of the total with growth in public expenditure. Almost all the countries are struggling with cost escalation in health sector. Therefore, it is not clear what the total expenditure in the health sector would be and, of that, what proportion of expenditure will be in private sector. The HLEG also recommends contracting-in of private sector to utilize its available capacity. It is not clear how well that would work out. In addition, there is ideological opposition by some to the role of private sector, which they see as exploitative.

[16] Rustagi, P. (2009). *Concerns, conflicts, and cohesions: Universalization of elementary education in India*. New Delhi: Oxford University Press.

[17] Narayan, V. (2010). The private and the public school education. *Economic and Political Weekly*, *45(6)*, *23–26*.

SSA faced implementation challenges in inspiring and empowering stakeholders.[18] There were challenges on both the number and quality of teachers. Of the roughly 1.2 million candidates taking the tests for primary or upper primary grades, less than 10 percent passed. Universal enrolment by no means ensures universal attendance and completion. On an average, only two-thirds of the students enrolled in primary classes are present in government schools. Financial constraint was one of the reasons. Poor households did not give adequate emphasis on attendance and completion as they often did not see the value of education and perceived its quality to be low.

It is not easy to inspire parents and communities. Banerjee et al. tested three interventions:[19] (1) information campaign in the village, (2) direct experience of parents and community members in terms of children's learning ability, and (3) in addition, training a group of volunteers to conduct an educational camp. The results showed that none of the interventions increased community participation in a significant way in education except that children's learning was better for those who attended the education camp in the third intervention. Very little difference was made in the functioning of VECs.

RBM is another challenge. As mentioned earlier, one of the criticisms against RTE has been that it focuses too much on the (physical) input side and does not pay adequate attention to quality issues despite plentiful evidence that the overall level of student learning outcomes is very low. The RTE Act offers a holistic vision of quality, but does not set benchmarks and indicators to turn the vision into reality. It is difficult to measure outcomes. Therefore, attention shifts to measuring inputs and activities. Mechanisms need to be found to ensure that the focus shifts to measuring and rewarding providers and communities for outputs and outcomes, particularly in terms of quality.

[18] World Bank (2012); Narayan, V. (2010). The private and the public school education.

[19] Banerjee, A., et al. (2008). *Pitfalls of participatory programs: Evidence from a randomized evaluation of education in India*. Working paper 14311. Retrieved from www.uber.org/papers/w14311/.

The World Bank[20] review of UEE concludes that what is important now is to build consensus among all stakeholders—governments, teachers, communities, parents, as well as the private providers—and ensure better implementation with a focus on quality improvements, the benefits of which need to be distributed in an equitable manner. These indeed would also be the challenges for UHC and the leaders of both UEE and UHC should be prepared to meet them if the goals are to be realized.

Constraints in Applying Visionary Leadership Framework

There are several patterns of working which may inhibit application of visionary leadership framework.

1. *Tendency to do things the same way*: Many leaders fall into a habit of doing things the same way even after the context or needs have changed. While at one time this pattern of working may have yielded results, there is no assurance that this will be the case in the future. So, a visionary leader should periodically review and apply the framework for the issue at hand. Often the signal to rethink comes after the performance has deteriorated substantially. This reactive response results in considerable delay to reverse the performance trend and precious time is lost in the process.
2. *Tendency to jump to the solution*: Often leaders have the tendency to jump to a quick answer as they may feel that their past success and current position warrants this. Unfortunately, this may result in incorrect diagnosis and possibly a prognosis which may be suboptimal. It is better to apply the framework even though a similar situation may have arisen earlier or elsewhere. Of course, it should not come as a surprise if a similar plan of action results.

[20] The World Bank (2012); Ibid.

3. *Limiting participation to follower group*: Often a leader begins to lose touch with wider constituency or people who think differently. He/she needs to be on guard against like-minded thinking and seek diverse perspectives, particularly from the individuals/households and communities. Sometimes leaders create an informal group which can provide such feedback directly or as a distillate.
4. *Looking only at zone of control*: A leader's role is to influence others, particularly those not in his/her direct control. However, many leaders are reluctant to influence other sectors, perhaps concerned that those influenced may also wish to influence them. However, many problems can only be effectively addressed when several agencies work in partnership to address them, building on their distinctive competencies.

Conclusion

There are a large number of leadership theories, as we have seen. Nevertheless, the field remains open and many vexatious questions remain. Before concluding, we discuss some of these questions here.

What is the primary significance of leadership? Attempts to link leadership to organizational performance in corporate sector have varying findings.[21] Some say that it is not significant compared to external forces such as industry structure and company history. Others argue that even after taking these factors into account, the influence of leadership on absolute performance is substantial. Another school of researchers put more importance on leaders' ability to influence purpose of and meaning into lives of people over their impact on economic performance. Perhaps leaders have indirect influence on performance through influenc-

[21] Noharia, N., & Khurana, R. (2010). Advancing leadership theory and practice. In N. Noharia, & R. Khurana (eds), *Handbook of leadership theory and practice*. Boston, New York: Harvard Business Press.

ing social nature and structure of organizations such as goals, incentives, culture, member composition, etc.

Leadership development has to also address two issues: (1) Can leadership be developed? If the leader is seen as a special person with unique personality and character traits, then short-term leadership development programs may have a limited role. On the other hand, some things could be done to develop competencies for leadership as a social role where it is seen as an influence relationship with the followers. (2) Should the leadership development emphasize leader's capacity for "thinking and doing" (emphasizing on various competencies) compared to "becoming and being" which puts an emphasis on evolving identity? The latter argues that what makes someone a leader is not because they have special attributes such as charisma but that they are able to fulfill vital functions that meet their followers' needs for meaning, social order, group identity, and goal accomplishment. Generally scholars agree that leadership development should do both.

Most models of leadership posit that universal attributes, functions, or relationships are core to any leadership. However, many equally realize that there is no best way to lead and an effective approach is contingent upon the situation and the characteristics of a leader. However, the variations in situations and characteristics may be so large that it is not possible to prescribe actions for all such combinations. It is hard to imagine that leadership does not have core set of leadership functions. On the other hand, leaders need to tailor their actions to situations and their own personality.

The answer to the above dualities does not seem to lie in "either–or" but rather "and."

However, as we have presented in the preceding chapters, there is much agreement on what leaders need to do—create a shared vision, assess vision–reality gap, develop paths to bridge this gap, and inspire and empower stakeholders to traverse that path. They also need to create strategies, structures, and systems for achieving the desired results. This is the leadership journey that this book seeks to spark and assist prospective and current leaders of public health.

Examples of Applying the Framework

In the following, we discuss two examples of ways of applying the visionary leadership framework. These include:

- Enhancing gender equity: Addressing violence against women
- Improving adolescent health

Visionary Leadership for Enhancing Gender Equity: Addressing Violence against Women

There is a strong link among gender equality and equity, domestic violence (DV) and women's health. The International Conference on Population and Development (ICPD), 1994, laid out the following Principle 4: Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women.

Violence against Women (VAW), also referred to as gender-based violence (GBV), arises from unequal power relationships between men and women. It has received increasing attention as a human rights issue since the late 1980s, and the international community has now made great strides in setting standards and elaborating a legal framework through the enactment of various treaties and covenants.

The Declaration on the Elimination of Violence against Women[22] adopted by the United Nations General Assembly in 1993 defines GBV and VAW as:

> Physical, sexual and psychological violence occurring in the family and in the general community, including battering, sexual abuse of children, dowry-related violence, rape, FGM, non-spousal violence,

[22] United Nations. (1993). Declaration on the elimination of violence against women. Retrieved from www.un.org/documents/ga/res/48/a48r104.htm/.

> sexual harassment, trafficking in women, forced prostitution, and violence perpetrated or condoned by the state. (Article 2)

Despite such efforts, women continue to be subjected to various forms of violence throughout their life cycle (see Box 8.1). Most of this is DV perpetrated by an intimate partner and includes by definition "violence that occurs within the private sphere, generally between individuals who are related through intimacy, blood, or law." DV remains a widespread phenomenon in many countries. A review of studies from 35 countries[23] indicated that:

- Ten to 52 percent of women and girls reported physical abuse
- Up to 30 percent experienced sexual violence by an intimate partner

Box 8.1: *VAW Globally*

One out of three women in the world has been beaten, coerced into sex or abused in some other way, and most often by a man she knows, including her husband or other male relatives. Worldwide violence against women and girls causes more deaths and disability for women and girls between 15 and 44 years than cancer, malaria, traffic accidents, and war.

Source: UNFPA, 2005, *State of World Population Report*.

The health implications of DV are equally alarming and range from fatal to non-fatal outcomes affecting a woman's physical, mental, and RH. Studies suggest that DV is a frequent cause of suicides among women, and women who are beaten by their husbands or boyfriends are 48 percent more likely to become infected by HIV.[24]

[23] WHO. (2005). *WHO multi-country study on women's health and domestic violence: Summary report of initial results on prevalence, health outcomes and women's responses*. Geneva: WHO.

[24] UNFPA. (2005). *Beijing at ten: UNFPA's commitment to the platform for action*. New York: UNFPA.

The causes of violence are extremely complex and has its roots in the interaction of many factors—biological, social, cultural, economic, and political.[25] These include harmful traditional or religious practices, unequal access to resources, education, and employment opportunities which perpetuate women's subordinated status in society and VAW.

The focus in this case example is on DV as it is the most predominant form of VAW in the region. To effectively tackle DV, country leaders must now move beyond legislation on VAW to coordinated action on multiple levels and in multiple sectors. This vision must then be translated into action plans backed by enforced laws that protect women's and their sexual and reproductive health (SRH) rights. Sufficient resource allocation for a coordinating body is necessary for implementing DV policies across different sectors and stakeholders.

Creating a shared vision for addressing domestic violence

The magnitude of domestic/intimate partner violence is strongly tied to the cultural context and existing gender biases. There needs to be strong political commitment to address these multifaceted issues including a shared vision by a wide range of actors—from local health authorities and community leaders to NGOs and national governments.

Where awareness on VAW is low or political commitment is weak, it may be necessary to first carry out IEC and advocacy at different levels. For example:

- The annual worldwide campaign on the "16 Days of Activism against Gender Violence" brings together a diverse range of organizations and actors including survivors of violence to educate the public, press for changes in the law, and development of national plans of action.
- At the regional level, the Mekong Sub-Regional Network (Cambodia, Lao PDR, Myanmar, Thailand, Vietnam)

[25] WHO. (2002). *World report on violence and health*. Geneva: WHO.

jointly advocates for changes in policies, laws, and attitudes on sexual harassment, DV, and rape.
- After much lobbying and advocacy on marital rape by women's groups in Malaysia, a Domestic Violence Act was passed in 1994 and One Stop Crisis Centers (OSCCs) were established in hospitals to manage rape cases.

Campaigns to end violence require long-term efforts and funding. Besides advocacy, a shared vision can also be created through consultation and by engaging stakeholders in policy dialogues for improved DV legislation, programs, and financial/human resources (see Box 8.2).

Box 8.2: *Leadership to Address Domestic Violence*

Leadership Checklist

1. Does a policy framework to address DV exist in the country?
2. Is necessary legislation on DV in place?
3. Have IEC advocacy campaigns on VAW been carried out?
4. Is information on the magnitude of DV in the country available and widely shared?
5. Are there consultative processes to address DV involving all stakeholders?
6. Do you and your colleagues have a personal vision on eliminating DV? Can you jointly create a shared vision?

Source: Authors.

Experience of the Philippines: The President issued a Call to Action against DV in July 1997 and convened government officials for consultation on implementation strategies. Through this collective process, a multi-sectoral Plan of Action was adopted for the (1) formation of an interagency task force on generating statistics, (2) adoption of a fast-lane and one-interview system of investigation, (3) center and hospital-based assistance to victims, and (4) counseling services for both victims and offenders.[26]

[26] Special rapporteur on VAW. (1999). *Violence against women in the family*. Commission on Human Rights 55th Session.

Experience of Thailand: A Task Force of Women was formed under the 1997 Constitution to address DV and sexual harassment in the workplace, bringing together key players from NGOs, professionals, and universities. A Policy and Action Plan to end VAW and children was approved by the Thai Cabinet in 2000. The national plan integrated components in different areas—prevention, legal reform, protection and welfare, education and research, cooperation mechanisms, monitoring and evaluation systems, and the need for national budget allocations for implementation by government agencies and NGOs.[27]

Although these countries experience illustrate consultative processes for developing action plans, they tend to be top down and lack active participation of all stakeholders, particularly communities. There exists a leadership opportunity here to motivate and mobilize stakeholders, including building their capacity, for cocreating a shared vision beyond advocacy efforts.

Assess vision–reality gap of DV prevalence

In addition to understanding the root causes of DV, the challenge for leaders is to generate evidence to ensure that policies are informed by accurate data on the incidence and severity of violence. Unfortunately, this is seriously lacking in many countries due to the culture of silence surrounding GBV and no specific statistics is available since DV is often categorized as general assault.

National data collection needs to be strengthened for continually monitoring the prevalence of DV and existing "vision–reality" gaps (see Box 8.3). Research and evaluation studies should be further supported for evidence-based advocacy and identifying successful interventions to scale up.

[27] Jacobs, G. (ed.). (2003). Not a minute more: Ending violence against women. New York: UNIFEM.

Box 8.3: *Recommendations from UN Agencies*

WHO (2005)

- Data collection systems to monitor VAW under the responsibility of an institution, agency, or government unit.
- Support research and collaboration for a stronger basis for advocacy and scaling up.

UNFPA (2004)

- Accurate, timely, and cross-country comparable data to provide benchmarks and monitor ICPD implementation.

United Nations Development Fund for Women (UNIFEM) (2003)

- Strengthen national and international capacities to provide evidence to inform public policies.
- Research initiatives on the causes, consequences, costs, and remedies of VAW; evaluate effectiveness of programs.

Special Rapporteur on VAW (2003, 1999)

- Compliance to international standards by focusing on a set of indicators and gender-disaggregated data on VAW.
- Up-to-date statistical data collected and recorded in a public forum to evaluate the impact of law and policies.

Source: UNFPA. 2004. *Investing in People: National Progress in Implementing ICPD Programme of Action 1994–2004*. New York: UNFPA; Special Rapporteur on VAW. 2003. *International, Regional and National Development in the Area of VAW 1994–2003*. Commission on Human Rights 59th Session.

Seeing the Big Picture

Before the next step of designing appropriate interventions (i.e., finding a path), visionary leaders must "see the big picture." It is crucial that programs are based on the right kind of information on the magnitude, causes, and impacts of DV (see Box 8.4).

Box 8.4: *Assessing Vision–Reality Gap on Domestic Violence*

Leadership Checklist

1. Can you generate evidence on vision–reality gap on DV?
2. Are there country research and evaluation studies on DV?
3. Do you know who the key stakeholders for addressing DV are?
4. Are there benchmarks and indicators to monitor DV?

Source: Authors.

Trends over time. Changes in the incidence of DV against women and the related reasons need to be identified. These serve as important indicators of the current situation, emerging trends, and the effectiveness of VAW program interventions.

Increasing incidence of violence, Bangladesh. Data collected between 1996 and 2002 by the Ministry of Women and Children's Affairs shows an alarming rise in the number of reported cases of VAW. Beatings and murders of women within households have been linked to the escalation of dowry demands and more general harassment. Despite a number of existing laws to protect the rights of women, such an increase points to urgent action required in adequately enforcing laws and addressing the root causes.

Geographical variations. DV also varies over space especially in regions or areas where traditional sociocultural values and practices reinforce the lower status of women. Prioritizing efforts and resources for the communities most in need will create the highest impact and ensure cost-effectiveness.

Different levels of administration. In involving a range of stakeholders, the reality must be understood at all levels—village, town, district, province, and state. This will enable different perspectives to be incorporated in planning and strategies.

Multiple objectives. Reducing DV/VAW not only promotes women's rights and health but meets wider objectives such as gender equality, improved family relationships, and women's empowerment.

Finding a Path: Learning from Best Practices in VAW

Once the vision and shared values are established, the next step for leaders is finding the path to address DV. They should develop strategies to strengthen institutional capacity development and coordination across sectors.

Lessons can be learned from best practices that have enabled operational systems and built organizational capacity. Successful interventions may be identified from VAW programs, contact with and reports by international/national NGOs and peers, and the relevant websites.

Leaders must first know of best or promising practices, then they should be able to adapt such experiences to the local context, particularly sociocultural norms, and learn from any failures. Where best practices are limited, operations research helps in testing improvements and innovative activities in the community.

Implementing policies: Effective DV interventions

Several case studies from Asia and East Africa demonstrate what cross-sectoral interventions have worked in one or more of the following areas:

- Gender-sensitive and DV protocols in RH services and hospitals
- Gender sensitization and training for service providers and related sectors (e.g., criminal justice system)
- IEC and advocacy on gender equality and VAW
- Community awareness and mobilization

CASE STUDY* 1: *Integrated Model for RH and DV

Thousands of Tanzanian women are living in abusive relationships and women in the Mwanza region are among the most affected by violence. They are denied a voice by the traditional

community practices that place them at a lower social status than men and restrict them from leaving their homes and receiving health care from male providers.

The Jijenge Project in Mwanza, Tanzania,[28] aims to improve the reproductive and health rights of women. The project has been implemented by the African Medical and Research Foundation (AMREF) and consists of several components.

- Clinical component in district health facilities to improve knowledge and skills among health workers in the provision of women-friendly services. This includes training on gender-sensitive services, capacity building for management teams on gender-sensitive council health plans and budgets, and encouraging men's participation in services.
- Community component in wards to raise awareness on women's SRH rights and strengthen community structures. Activities included training community resource persons, building capacity of Ward Development Committees on gender-sensitive planning and budgets, and sensitizing and mobilizing communities (training community leaders on VAW, DV watch group, and community-based counselors trained in GBV).
- Combined community mobilization and clinical interventions.
- Advocacy at the community and district levels for policies supportive of women's RH rights (e.g., community by-laws against GBV, resource allocation for RH). Multi-sectoral partnerships, networking, and coalition building to promote health and rights of women.

[28] Matasha, E., Swalehe, Z., Kamanya, V., Mohammed F., Gavyole A., & Waibale P. (2002). *Gender focus in primary health care: A case study of improving women's sexual & reproductive health & rights in the context of gender relations, the Jijenge Experience*. Retrieved from www.aeci.es/vita/docs/ftp/ponencia-edna-matasha.pdf/.

CASE STUDY* 2: Working *with the Criminal Justice System

In the South-Asian context, VAW is a serious problem with high incidence of domestic abuse, dowry-related violence, and honor killings. Gender-sensitizing and training law enforcers (judges and police) have been critical, particularly in upholding VAW legislation. Collaboration with NGOs has proven to bring about change in the gender biases of the judiciary and practices discriminatory to women.

Bangladesh: The Centre for Women and Children's Studies (CWCS) brought together police officers and NGOs to design a training manual for law-enforcement personnel on GBV. More than 400 officers were trained in 12 regions.

India: A women's NGO, Sakshi, trained judges on women's rights in the judicial system. Activities included visits to women's shelters and meetings with NGOs to better understand women's needs. Some of the trained judges later became peer-educators and training has expanded to Bangladesh, Nepal, Pakistan, and Sri Lanka.

Pakistan: Local NGO Rozan conducted 21 behavioral change workshops for the police force (mostly policemen) on several issues—self-growth, gender and the implications of stereotyping men and women, and sensitization to VAW/children and the role of the police. Rozan also advocated for capacity building in the police system and institutionalization of community–police collaboration.

CASE STUDY* 3: *One Stop Crisis Center (OSCC)

A range of services need to be improved, integrated, and scaled up for both DV prevention and rehabilitative care for victims. At tertiary levels of care, health ministries and hospitals should develop standard protocols for documenting reports of partner violence, rape, and sexual abuse.[29]

[29] Watts, C., & Mayhew, S. (2004). Reproductive health services and intimate partner violence: Shaping a pragmatic response in sub-Saharan Africa. *International Family Planning Perspectives*, *30*(4), 207–213.

Linkages and joint efforts with NGOs are essential for offering support services such as counseling, shelter homes, and legal aid centers. The role of RH providers is also being increasingly recognized in helping to identify, support, and refer victims of partner violence.

Bangladesh: A few police headquarters have special cells for women and all divisional headquarters have an OSCC.

Malaysia: The Ministry of Health (MOH) established OSCCs in hospitals since 1986 based on the concept of "Integrated and Coordinated Teamwork of Multi-sectoral and Inter-agency Network for the Management of Survivors of VAW and Children."[30] By 1997, 90 percent of the hospitals had OSCCs providing a number of VAW services (medical attention and referral, counseling from NGOs, legal aid, special police desks, and provision of shelter). A standard operating procedure known as "Crisis Intervention Levels" or "Critical Pathways" was drawn up as a guide on the roles and responsibilities of the various agencies and departments involved. The NGOs working with the OSCCs are mostly women's organizations and federal departments which include health, police, social welfare, legal aid bureau, religious department, universities, judiciary, and law.

Inspiring and empowering stakeholder

Leaders must pay attention to inspiring and empowering key stakeholders involved in implementing policies. Gaining their support and increasing their capacities is instrumental in the fight against DV.

Stakeholders include public and private service providers, the criminal justice system, and communities (community and religious leaders, men and women, adolescents). Possible strategies and actions to inspire/empower them are to

[30] Satia, J., & Hii, M. (2001). *Innovative approaches to population programme management: VAW (Vol. 9)*. Kuala Lumpur: ICOMP.

1. Involve them in the whole process from vision sharing to management
2. Advocate and influence them at an emotional level taking into consideration political and sociocultural factors
3. Provide support for them to effectively perform their roles such as through resource mobilization, budgets, sensitization and training for VAW

Health-care practitioners, law enforcers, and social workers are at the forefront in dealing with abused women. Therefore, they must be sensitized and equipped with the skills to provide gender-sensitive and quality services for the care of victims as well as prevent DV. Training for these stakeholders to effectively address DV includes:

1. Gender awareness and analysis
2. Crisis management strategies: Identify symptoms of violence, document injuries, provide individual and family counseling, make referrals, and take legal actions

Empowering Communities

Mobilizing local communities to change gender-biased attitudes/practices and empowering them is key to reducing DV through

1. Awareness-raising campaigns including media coverage
2. IEC materials on available help (e.g., legal aid, shelter home, crisis centers)
3. Community watch groups, support networks, peer groups
4. Training community leaders and organizations, women, and men
5. Outreach activities: Counseling, hotline, and education activities
6. Encouraging men's and boy's involvement as partners

Planned Parenthood Association of Thailand (PPAT): Men's perceived superiority in Thai society results in DV as a common practice. PPAT (an NGO) created a support network at the grassroots level by forming a VAW Watch Group and setting up

Box 8.5: *Applying Visionary Leadership Framework to Address Domestic Violence*

Leadership Checklist

1. As a visionary leader of health, what should you do to address DV using the visionary leadership framework?
2. Have key stakeholders received the necessary support and training to implement policies?
3. How have communities been mobilized?

Source: Authors.

referral systems. It raised awareness and collaborated with the mass media, health professionals, police force, community leaders, government, and NGOs (see Box 8.5).

> *I have never thought of the importance of DV but with an incident of a husband killing his wife due to jealousy in the community, I became more aware of the impact of DV and have since taken action.* (A VAW Watch Group Leader)

Management lessons for DV programs

With committed leaders and appropriate strategies, eliminating DV can be an achievable goal. Sound program management is needed in planning and design, implementation, and monitoring and evaluation.

In tackling a multidimensional issue such as DV, strengthening cross-sectoral partnerships and their roles is essential. Joint forces among the civil society, private sector, and government agencies enable each to play effectively individual roles in undertaking preventive, treatment, or rehabilitative measures to counter the pandemic. Collaboration amongst stakeholders is also important for pooling the existing resources.

Research findings show that when assessing the vision–reality gap and diagnosis of the root causes, DV needs to be integrated into planning. This will help in highlighting the seriousness of the problem and in identifying effective program strategies.

A management strategy and coordination mechanism is then needed to organize and streamline the roles of different partners.

This would draw on each partner agency's strengths and avoid unnecessary duplication or confusion of roles. Monitoring mechanisms, such as regular meetings for a working committee represented by all sectors, help ensure exchange of information and experiences to improve DV programs.

Visionary Leadership for Youth Reproductive Health Programs that Empower Young People

The world's population of young people in the age group of 15 to 24 years stands at 1.16 billion. The threat of HIV infection has brought the issue of youth RH into focus. Worldwide, half of new HIV infections are among youth, and the majority of those infected are female. Rising HIV/AIDS rates and young people's special vulnerability due to migration, unemployment, and rising age of marriage signaled the need for accelerated action.

> *Investing in adolescents' health and rights will yield large benefits for generations to come.*
> (UNFPA State of World Population Report 2003)

The issue of SRH is culturally sensitive in many countries and there is no consensus on how best to address this. For instance, some have favored advocating "abstinence only" programs whereas others favor a broader approach of "abstinence, be faithful, or use condoms" or popularly known as "ABC" approach.

Youth's access to RH care

The data on access to RH by young people using three indicators for universal RH care access,[31] agreed by UNFPA/WHO,

[31] Ashford, L., Clifton, D., & Kaneda, T. (2006). World's youth data sheet 2006. Washington, D.C.: Population Reference Bureau; Demographic and Health Surveys (DHS 2003); Ross, J., Stover, J., & Adelaja, D. (2005). *Profiles for family planning and reproductive health programs, 116 countries* (2nd edition). Glastonbury: The Futures Group International.

reveals large differentials in deliveries assisted by skilled birth attendants for young women. Low rates of deliveries attended by skilled birth attendants and lack of emergency obstetric care make maternal mortality and morbidity a significant risk for young women. Pregnancy is the leading cause of death worldwide for young women aged 15–19.[32] Married adolescent girls aged 15–19 are less likely to use modern contraceptives than married young women aged 20–24 in Asia. Young women's unmet need exceeds that of women of all ages considerably—23 percent versus 16 percent. Only a small percentage of youth have comprehensive knowledge of HIV/AIDS prevention.[33] Data indicates that among women in the age group of 15–24 years, only 1 percent in Indonesia, 3 percent in the Philippines, 25 percent in Vietnam, and 37 percent in Cambodia have comprehensive knowledge. Although they are more vulnerable, young women in general have lesser knowledge than young men.

Neglecting the SRH of young people can lead to high social and economic costs, both immediate and in the years ahead. For example, it has been estimated that Thailand lost an estimated 400,000 lives and over one million person-years from the labor force due to premature deaths from HIV/AIDS alone.

The benefits of SRH interventions, on the other hand, are far reaching.[34] For instance, improving SRH of young people reduces the likelihood of teenage pregnancy and its associated social and economic costs. It also encourages couples and individuals to decide freely and responsibly the number, spacing and timing of their children, which enables higher household savings and investment, and facilitates higher productivity. Delayed marriage and well-timed parenthood allow for greater educational achievements and thus greater career and employment opportunities.

[32] International Center for Research on Women (ICRW). (2006). *Child marriage and education*. Washington, D.C.: ICRW.

[33] Comprehensive knowledge of HIV/AIDS prevention is defined as "correctly identify[ing] at least two ways of preventing the sexual transmission of HIV, who reject the two most common local misconceptions about HIV transmission, and who know that a healthy-looking person can have HIV."

[34] UNFPA. (2003). *State of world population report*.

The prevention and treatment of STIs including HIV/AIDS also reduces stigma and help young people to stay healthy. Healthy families can earn more and save more, spurning economic growth.

Visionary leadership challenge

However, improving the SRH of youth is a complex, multifaceted task. This poses many leadership challenges including:

Making a Difference: Kirby et al.[35] reviewed 83 studies that documented impact of sex and HIV education programs on sexual behaviors of young people in developed and developing countries. Half of these studies focused only on preventing HIV or STIs; and about one-third covered STIs, HIV, and pregnancy. The review showed that 40 to 60 percent of the studies reported impact on one or more of the following aspects of sexual behavior: initiation of sex, frequency of sex, number of sexual partners, condom use, contraceptive use in general, and composite measure of sexual risk-taking.

Involving Multiple Sectors of Government: Most youth RH programs are implemented by NGOs. Many governments have shied away because of the sensitive nature of programs as many politicians even view them as impinging on cultural and religious sensibilities. There is also a need for different sectors to get involved—education, health, social welfare, sports, and others. The World Bank (2006)[36] estimated that although 82 percent of all countries have national youth policies, 70 percent of them are focused on narrow youth issues, with few links to other sectors. Where multi-sectoral youth policies exist, they fail to establish clear lines of accountability among the different sectors.

[35] Kirby, D., Laris, B. A., & Rolleri, L. (2005). *Impact on sex and HIV education programs on sexual behaviours of youth in developing and developed countries*. Youth Research Working Paper No. 2. California: Family Health International.

[36] World Bank. (2006). *World development report 2007: Development and the next generation*. Washington, D.C.: The World Bank.

Addressing Gender Issues: Throughout much of the world, families and societies treat girls and boys unequally with girls facing deprivation, lack of opportunity, and lower levels of investment in their health, nutrition, and education. Societal gender norms confront girls with special challenges including restrictions on their independence and mobility, inequality in educational and employment opportunities, pressure to marry and start bearing children at an early age, and unequal power relations that limit their control over their sexual and reproductive lives. Therefore, youth programs need to make special efforts for girls.

Youth Participation: For successful youth programs, young people themselves need to be involved in all phases of the program—advocacy, planning, implementation, monitoring and evaluation. Therefore, capacity of adults and youth needs to be strengthened for meaningful adult–youth partnership.

These and other challenges need to be addressed by applying visionary leadership competencies, as we will discuss now (see Box 8.6).

Box 8.6: *Creating Shared Vision on ASRH*

Leadership Checklist

1. Is there evidence of current reality on youth/ASRH?
2. Who are the key stakeholders for youth RH?
2. Can the evidence be used to create a shared vision among the stakeholders?
4. Can stakeholders with diverse perspectives have youth empowerment as the shared vision?

Source: Authors.

Creating a shared vision

Generally, most youth/adolescent RH programs address HIV/AIDS and, therefore, their vision is avoidance of risky behavior. This vision is widely accepted. However, it raises sensitive issues related to sexuality of youth. Some have argued for a broader

vision: improving SRH as teenage pregnancy is also an issue in many countries.

Adolescent health had not received much attention in the past as adolescence was usually considered a healthy period of life. However, as substance abuse, road accidents, and other problems among the youth have increased, there is an argument that one should center the vision on adolescent health including SRH.

However, the health-related vision has difficulties. One, programs that include activities on less controversial youth issues such as livelihood or literacy skills are more likely to be accepted. Two, different stakeholders (youth, parents, teachers, health workers, community leaders) have different priorities. A more holistic vision of overall youth development, although more attractive to many, is too complex for mobilizing support for programs.

Growing experience with SRH programs shows that youth programs that empower young people can make a difference. It means that youth are assisted to develop competencies (attitude, knowledge, skills, practice, and behavior) that lead to their empowerment, which they can utilize for their self-development as well as to influence family and community (see Figure 8.1). Thus, to empower youth is to give them power to successfully approach and face challenges that relate to their everyday life, specifically to their SRH and rights.

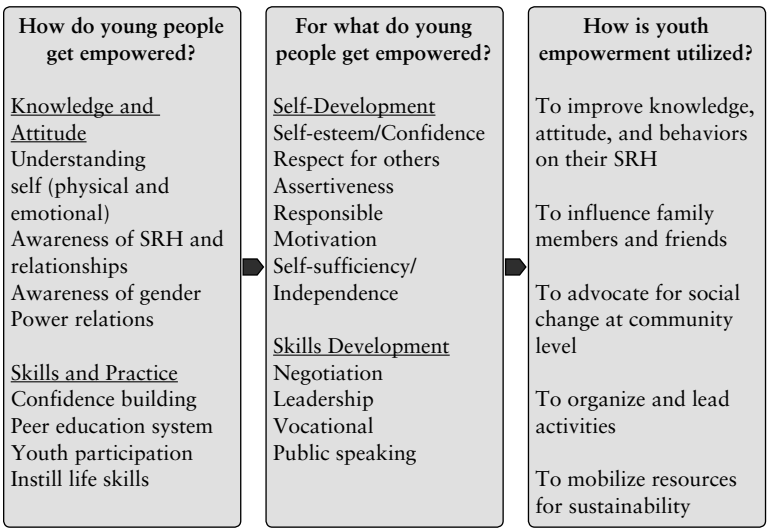
Evidence-based advocacy is needed to influence legislation, policies, programs, and strategies to promote health and development of young people. Thus, analysis of vision–reality gap can be used to create a shared vision among key stakeholders.

Vision–reality gap

It is difficult to assess and analyze the vision–reality gap because data is often lacking and fragmented. For instance:

- Demographic and Health Survey (DHS) provides information on teenage pregnancies, contraceptive use, and on knowledge of HIV.

Figure 8.1: *Empowerment of Young People*



Source: Authors.

- HIV/AIDS surveillance provides information on risky behaviors as well as estimates of HIV prevalence.
- Hospital statistics provide an indication of admissions due to abortion complications among youth.
- Drug control department would estimate prevalence of substance abuse.
- Transport department would have statistics of road accidents involving young drivers.

The vision–reality gap also differs among different youth segments and special surveys may be needed. For instance, Young Adults Fertility Survey (YAFS) in the Philippines provides valuable information on vision–reality gap (see Box 8.7).

Analyzing vision–reality gap requires changes in mental models and systems thinking. *One*, visionary leaders need to see the *big picture* including a range of issues affecting youth: education, employment, income generation, migration, SRH as well as needs of vulnerable groups like orphans and street children. *Two*, they need to analyze changes in these variables over time and over

Box 8.7: *Vision–Reality Gap for Youth RH*

Leadership Checklist

1. How is the reality of youth RH changing overtime?
2. How does the reality of youth RH differ among different segments of youth by age, residence, education, sexual behavior, and so on?

Source: Authors.

different geographic areas. *Three*, they need to understand a variety of influences on youth: self-experiences, peer influence, family, teachers, communities, media, relevant laws and policies, and broader socioeconomic environment. *Four*, they need to develop capacity for working partnership with youth. This is a challenge for most program managers as they may believe that their greater experience makes them more suited to make decisions affecting young people. Youth partnership is a key to progress in improving youth SRH (see Box 8.8).

Box 8.8: *Youth Involvement in Improving SRH*

Leadership Checklist

1. Is there a clear national framework for youth RH? If not, can one be created?
2. Is there a supportive environment for youth empowerment?
3. What mix of interventions—behavior change, youth-friendly services, and youth leadership development—can be a path to bridge vision–reality gap on youth RH?

Source: Authors.

Finding path/strategy

Clear National Framework

The World Bank recommends a clear national youth framework to set priorities and guide coordination. The framework should be developed and backed by youth-related ministries and the finance ministry, and it should establish a plan of action specifying sector responsibilities for various youth goals. Sector ministries are

best placed to implement youth policies within their own sectors and to complement, or at least not hinder, other sector efforts. The youth ministry or focal body can guide or coordinate and follow up on policy implementation by, for example, convening youth constituents to obtain their feedback on program quality.[37] Integrating youth policy in overall national development planning is one way to help ensure budget allocation for youth policy implementation. An example is that of Thailand's youth policy which coincides with that of the national development plan.[38]

Creating an Enabling Environment: Working with Gatekeepers

Many factors that impact adversely upon the SRH of young people stem from their immediate social environment, including poverty and unemployment; restrictive social and gender norms, especially those that reduce equitable access to information and services; and the impact of social and economic changes. While programs to improve the SRH of young people cannot focus directly on inequities and injustices in society, they must create an immediate social environment that fosters personal development and open communication to encourage young people to adopt healthy types of behavior. (See Box 8.9 for an example of getting approval from gatekeepers.)

Families, communities, media, and others can communicate positive norms and actions to promote healthy behavior among young people and adults alike. It must be remembered that program efforts need to take into account the fact that young people are not all alike, and that interventions and the ways in which they are delivered will vary according to the differing needs and circumstances surrounding young people's lives. For this reason, it is imperative that young people themselves should also play an active role in improving their immediate environment and the conditions that affect their SRH. For gatekeepers and other stakeholders, capacity-building for gatekeepers and other stakeholders to become supportive of young people's programs could include

[37] World Bank. 2006. *World development report 2007: development and the next generation*. Washington, D.C.: The World Bank.

[38] Retrieved from http://www.unescap.org/esid/hds/Youth/ypol.asp/.

Box 8.9: *Integrating Non-RH Interventions to Win Gatekeepers Over*

The Adolescent Girls' Literacy Initiative for RH in Nepal reaches rural and poor girls through literacy classes. Where the status of girls was particularly low, a "parent-friendly" strategy was employed because it would not have been possible to reach these girls and others with limited mobility due to social or financial constraints. To reach this marginalized group, the project presented the gatekeepers (in this case, parents) with an obvious, non-controversial benefit for their daughters—literacy skills. RH was integrated with literacy classes—literacy being important to promoting RH care access as well—and the girls benefited from both.

Source: Adhikari, Ramesh, Nepal, Binod, & Tamang, Anand. Undated. *Adolescent Girls Literacy Initiative for Reproductive Health (A GIFT for RH)*. Nepal: CEDPA (Center for Development and Population Activities), AMK (Aaama Milan Kendra), and CREHPA (Center for Research on Environment Health and Population Activities).

opportunities for them to learn and understand as well as inject their own inputs into the project (see Box 8.10).

Box 8.10: *Developing Path to Address Youth RH*

1. Has a participative process been followed in developing path?
2. Are there coalitions of NGOs that advocate for youth RH?
3. Do youth fully participate in youth RH programs?

Source: Authors.

Programs to empower youth through youth-friendly and youth-empowering services. The Government of Thailand has established youth-friendly "corners" to provide primary prevention, link health, and social networks. Gender needs special attention as young girls suffer more. Globally, of the HIV-positive youth, about two-thirds are girls.

Behavioral change. Changing the risky behavior of young people is a key challenge for youth SRH programs. The behavioral change communication would provide an opportunity for youth to get insight into their personal situation. It will instill the motivation and skills needed to adopt and maintain a changed behavior. The change would be to improve the condition of one's own life and the society.

Youth leadership development. Youth leadership development programs would enable community young leaders to

- Expand their vision and technical knowledge to strengthen their leadership skills
- Create innovative solutions to SRH challenges faced by youth
- Take an active role in their communities for the development of youth RH programs
- Participate and contribute to program development, implementation, monitoring and evaluation
- Dialogue with authorities at higher levels for youth to have an effective voice in policy decisions related to youth SRH and be able to mobilize resources

Inspiring/empowering stakeholders

A broad range of stakeholders are involved in youth SRH: young people, parents, teachers, spiritual leaders, employers, various government ministries, NGOs, and communities. Many of them would need to be inspired/empowered for implementation of the path chosen.

Political commitment is a key to implementing any path for improving youth SRH. For instance, countries most successful in addressing HIV/AIDS are those where top political leaders took the epidemic seriously and expressed their commitment publicly.

The process of developing a path/strategy is crucial for inspiring/empowering stakeholders. The anticipatory learning and action approach has been used in many countries to design programs, which has mobilized various stakeholders including communities to examine their own situation including concerns, values, and priorities and devise their own solutions to the challenges they face.

Coalitions need to be created for advocating legal reforms, enforcement measures, and legislative reviews to safeguard adolescents' rights, especially in critical areas such as violence, marriage, education, and RH.

Youth–adult partnership is influenced by the adult's attitude toward youth. Young people can be perceived as objects, as recipients, or as partners. Both parties would need to develop capacity for partnership.

Implementing Youth Programs that Empower Young People

Research has shown that a number of key elements determine the level of youth SRH program successes, which include:

1. Youth participation at all levels of the program
2. Program components that address common roots and determinants of youth attitudinal and behavioral problems
3. Interventions that incorporate youth-friendly collaborative models for comprehensiveness (health, education, life skills, etc.)
4. An enabling environment for youth empowerment

UNFPA recommends the following building blocks for programs for adolescent girls programs:[39]

1. Creating an environment conducive to keeping girls in school through the secondary level, or at least ensure that they are literate.
2. Ensuring that the particular RH needs of adolescents are addressed and youth-friendly services provided.
3. Working with communities, including local political and religious leaders, to increase public awareness on SRH issues affecting adolescents.
4. Providing life skills and counseling so that adolescent girls are aware of their rights and know about the available services.

[39] UNFPA (2003). State of World Population 2003. p.45.

5. Developing vocational training and income-generating programs for adolescent girls to increase their status, independence, and opportunities.
6. Mobilizing support of decision-makers at all levels to support programs aimed at improving adolescent SRH
7. Contributing to equitable and sustainable development by reinforcing the capacity of national governments to engage girls in the social, economic and political life of the country.

Thus, planning and implementation of youth SRH programs should ensure that they are youth-focused, youth-empowering, gender-sensitive, and participative. They should be tailored to fit diversity of youth concerns, behaviors, and needs. Monitoring and evaluation should be an integral part of the program from the start. Resource mobilization is a key challenge for youth programs as many ministries and agencies are involved. Ideally, these should be mainstreamed in the relevant programs of the ministries and agencies concerned. Once again, following a participative process in all the phases of program development would help in mobilizing necessary resources (see Box 8.11).

Box 8.11: *Multi-sector Response to Youth RH*

Leadership Checklist

1. Can you advocate for holistic youth RH policies?
2. Can you catalyze multi-sector action?
3. Can you ensure full participation of youth in youth RH programs?

Source: Authors.