One

Strengthened Leadership and Political Will for Better Health

The main reason leaders are needed is to move the organization forward, to make progress. Leadership is where tomorrow begins.
—Kouzes and Posner

Introduction

In much of the developing world, there is a wide gap between what has been achieved and what is desired in health. Technologies are available to address the various health concerns which may help in achieving the many health-related goals. However, this has not yet happened. The World Health Organization's (WHO) Framework for Action[1] underscores the importance of strengthening health systems to improve health outcomes. There is a need to emphasize the role of institution building in health systems so that access and quality of available health services can be improved.[2] However, a missing piece of this triangulation of critical factors for closing the gap and achieving desired health outcomes may as well be found in visionary leadership.

[1] WHO (2007). *Everybody's business. Strengthening health systems to improve health outcomes. WHO's framework for action*. Geneva: WHO.

[2] Satia, J. K., & Chowdhury, Tawfiq-e-Elahi (2005). *Achieving the MDGs in Asia. Policies and strategies for institutional development in population and reproductive health*. Technical Background Paper written for the Second Regional MDG Report. Bangkok and Kathmandu: UNFPA Country Technical Services Teams.

In the following section of this chapter, a case is made for strengthening leadership in health as the success in improving health has been inadequate. Progress has been slow in achieving several health-related Millennium Development Goals (MDGs) as well as in addressing communicable or noncommunicable diseases or health-sector reforms. Most reviews of progress have shown a lack of leadership and political will, and have argued for greater leadership that could lead to enhanced policy attention and resources which would result in targeted effective programs for achieving global standards such as the MDGs. The need for strengthening leadership is not new or limited to the developing countries alone. In 1994, the Milbank Memorial Fund organized a meeting on "leadership in public health."[3] In the introduction of the report, Daniel M. Fox and William L. Roper summarized the views of participants and authors as follows:

> The authors of these papers agree that problems of leadership contribute to the difficulty of making and implementing policy to improve the health of the American public. By leadership they mean the capacity of professionals to work effectively during long careers in a variety of organizations that command resources and favorable attention from elected officials and the general public. The authors, along with many of their colleagues among senior public health professionals, believe that more effective leadership would improve the translation of existing knowledge about the prevention and control of disease into policies that lead to longer and healthier lives.

Leaders can make a difference, as discussed in the third section (Leaders Can Make a Difference) of this chapter, where a case of a leader making a difference in the functioning of health center in a state in India is presented. Many such examples abound in the literature.[4] A recent example of leadership's role in Senegal's decision to offer free health care is discussed.

[3] Coye, M. J., Foege, W. H., & Roper, W. G. (1994). Leadership in public health. New York, USA: Milbank Memorial Fund. Available at www.milbank.org/uploads/documents/mrlead.html (accessed on January 17, 2012).

[4] For instance, International Council on Management of Population Programmes (ICOMP). (2006). Making a difference for population and

What do leaders need to do? While a lack of adequate resources is often mentioned as a key barrier to achieving better results, the examples presented in the coming section, Leaders Can Make a Difference, contradict this. We first discuss an example where a woman's life was saved despite pregnancy complications. The experience of Sri Lanka with reducing maternal mortality shows what can be achieved in resource-constrained settings. Similarly, several countries have achieved remarkable success in reversing or preventing the spread of Human Immunodeficiency Virus (HIV), including Thailand, Uganda, and Senegal. Practices which led to their success have been analyzed by Joint United Nations Programme on HIV/AIDS (UNAIDS). We map these practices through a leadership perspective leading to outcomes of shared vision, aligned values, coordinated practices/behaviors, and leveraged resources of the health system. This is the outcome leaders need to achieve.

Inadequate Progress in Improving Health: Case for Strengthened Leadership

The Millennium Development Goals

In 2000, the 189 U.N. member states met at the Millennium Summit and adopted eight goals and 18 targets to combat poverty, hunger, disease, discrimination against women, degradation of land, and illiteracy. The world development community is challenged to achieve MDGs by 2015.

The Millennium Declaration (paragraphs 11 and 12) states:[5]

> We will spare no effort to free our fellow men, women and children from the abject and dehumanising conditions of extreme poverty, to

development: Leaders in action. Volume 1: Profiles of emerging leaders. Volume 2: Profiles of selected visionary leaders in Asia and Africa.

[5] U.N. (2000). *Millennium Declaration*. Retrieved from www.un.org/millennium declaration/ares552e.htm.

which more than a billion of them are currently subjected. We are committed to making the right to development a reality for everyone and to freeing the entire human race from want.

We resolve therefore to create an environment—at the national and global levels—which is conducive to development and to the elimination of poverty.

Table 1.1: *The Millennium Development Goals*

No.	*Goals*
1	Eradicate extreme poverty and hunger
2	Achieve universal primary education
3	Promote gender equality and empower women
4	Reduce child mortality
5	Improve maternal health
6	Combat HIV/AIDS, malaria, and other diseases
7	Ensure environmental sustainability
8	Develop a global partnership for development

Source: United Nations, the Millennium Development Goals Report, 2011.

Three of the eight MDGs are health-related goals (see Table 1.1): child mortality (MDG 4), maternal health (MDG 5), and HIV/AIDS (MDG 6). In addition, gender (MDG 3) is a crosscutting issue that impacts many health issues including the three mentioned. Other MDGs such as poverty and education have a strong correlated relationship with the social determinants of health.

Inadequate Progress toward Health Millennium Development Goals

A quick review in 2004 reveals that most countries were not on track to reach health-related MDGs. According to the World Bank,[6] South Asia was off track on six goals: gender equality,

[6] World Bank. (2004b). *Global Monitoring Report: Policies and Actions for Achieving the Millennium Development Goals and Related Outcomes*. Washington, D.C.: World Bank.

universal primary school completion, child mortality, maternal mortality, communicable diseases, and sanitation. East Asia and the Pacific region as a whole were off track on child mortality, maternal mortality, and communicable diseases. Only about 25 percent of countries in South Asia, East Asia and the Pacific were on track to achieve under-five mortality rate. This situation is even worse for maternal mortality, where less than 15 percent of the countries were on track to reach this goal.

Although recent estimates for child mortality vary, assessments have highlighted that several countries are off track to achieve the MDG 4 which calls for a two-thirds reduction in mortality in children younger than five years between 1990 and 2015. It is estimated that worldwide mortality in children younger than five years has dropped from 11.9 million deaths in 1990 to 7.7 million deaths in 2010, a per year decline of about 2.1 percent compared to 4.4 percent per year needed to achieve MDG 4.[7] Examination of distribution of yearly rates of change in under-five mortality shows that the MDG 4 target of reduction rate of 4.4 percent per year corresponds to the performance of countries at the 67 percentile level; clearly a stretch target. This distribution of progress for child mortality also highlights that bursts of rapid decline are possible. The study by Rajratnam et al. (2010) suggests that, "For example, 66 countries have decreased child mortality by more than 30% in just 5 years during the period of this study." Such a remarkable decline provides hope that accelerated progress is possible. These robust estimates of mortality in children younger than five years show that several low-income countries have been able to achieve accelerated declines. These positive developments suggest that the progress can be accelerated in poor countries, but they may need to address leadership challenges that could lead to enhanced policy attention and resources for targeted programmes with increased effectiveness.

The MDG 5 aims to improve maternal health with a goal of reducing maternal mortality ratio (MMR), number of maternal

[7] Rajratnam, J. K. et al. (2010). Neonatal, post neonatal, childhood, and under-5 mortality for 187 countries, 1970–2010: A systematic analysis of progress towards Millennium Development Goal 4. *The Lancet, 375*(9730), 1988–2008, June 2010.

deaths per 100,000 live births, by 75 percent between 1990 and 2015. It thus seeks to achieve a 5.5 percent annual decline in MMR from 1990. The recent U.N. report[8] estimated that globally the annual percentage decline in MMR between 1990 and 2008 was only 2.3 percent, less than half of what is needed to achieve the MDG 5. An estimated 358,000 maternal deaths occurred worldwide in 2008, a 34 percent decline from the level of 1990. The U.N. report goes on to say

> The modest and encouraging progress in reducing maternal mortality is likely due to increased attention to developing and implementing policies and strategies targeting increased access to effective interventions. Such efforts need to be expanded and intensified to accelerate progress towards reducing the still very wide disparities between developing and developed countries.

We will later on discuss how Sri Lanka was able to halve their MMR in about 7 to 10 years and relate it to addressing leadership challenges. Progress at this pace in reducing MMR would have been adequate to achieve the MDG 5. This clearly shows that much needed leadership was not forthcoming.

Nowhere is the influence of leadership more visible than for HIV/AIDS programs, particularly by people living with HIV (PLHIV). The results are visible in progress toward a target of MDG 6 which aims to "combat HIV/AIDS, malaria, and other diseases." The U.N. report[9] on progress toward MDG 6 suggests that against the target—to halve infections by 2015 and begin to reverse the spread of HIV/AIDS—the spread of HIV appears to have stabilized in most regions, and more people on antiretroviral treatment (ART) have a longer survival rate. The report says, "The latest epidemiological data indicates that, globally, the spread of HIV appears to have peaked in 1996, when 3.5 million people were newly infected. By 2008, that number had dropped

[8] WHO, UNICEF, UNFPA, and the World Bank. (2011). *Trends in maternal mortality: 1990 to 2008*. Retrieved from www.who.int/pmnch, accessed in March 2014.

[9] U.N. (2010). *The millennium development goals report, United Nations*. Retrieved from www.un.org/millenniumgoals/, accessed in March 2014.

to an estimated 2.7 million." However, much more is required for rapidly reducing the new infections.

Progress is also visible towards the MDG No. 6 (a) and (c) targets—to have halted by 2015 and begun to reverse the spread of HIV/AIDS, and incidence of malaria and other major diseases—which has been largely driven by external attention and resources as evinced by the formation of the Global Fund to Fight AIDS, Tuberculosis and Malaria in 2002. The U.N. report says, "Sustained malaria control is central to achieving many of the MDGs, and available data show significant progress in scaling up prevention and treatment efforts." The report concludes, "[M]ore attention needs to be given to ensuring success in large countries that account for most malaria cases and deaths if the MDG target is to be reached." The external influence on large countries is likely to be restrained and more vigorous in-country leadership is needed to address disease burden due to malaria.

The progress on tuberculosis is inching forward as incidence rate per capita continues to decline slowly. The U.N. report concludes, "If current trends are sustained, the world as a whole will have already achieved the MDG target of halting and reversing the incidence of tuberculosis in 2004." However, because of lack of access to high-quality care, tuberculosis remains the second important cause for the number of people it kills. In 2008, 1.8 million people died from this disease.

The MDGs passed the 12-year mark in 2012 and there are three more years to go before the target year 2015. There has been progress but it has been uneven and patchy. For instance, where there have been movements toward achievements of MDG targets, there was evidence that leadership was vigorous and contributed toward the actions for desired health outcomes. So, this is the opportunity and leadership challenge for achieving MDGs by 2015.

Noncommunicable Diseases

Although no specific MDGs were set for noncommunicable diseases (NCDs), they are the cause of a majority of deaths, and the global disease burden of NCDs is increasing.

The Lancet NCD Action Group and the NCD Alliance say[10] that there is a need to create a sustained global involvement against premature deaths and preventable morbidity and disability from NCDs, mainly heart disease, stroke, cancer, diabetes, and chronic respiratory diseases. As a response, it proposes five key priority actions—leadership, prevention, treatment, international cooperation, and monitoring and accountability—in concert with five priority intervention areas. These areas are (1) tobacco control, (2) salt reduction, (3) improved diets and physical activity, (4) reduction in hazardous alcohol intake, and (5) essential drugs and technologies.

The report goes on to say,

> The first key action for success is strong and sustained political leadership at the higher national and international levels.... Individual champions and politicians will also need to take a leadership role. The health sector has a leading role in responding to NCDs but many other government sectors including finance, agriculture, foreign affairs and trade, justice, education, urban design and transport, have to be part of the whole-of-government response, along with civil society and private sector.

Clearly, the health program leadership of NCDs would have to go beyond their zone of control to influence these other sectors.

Health Sector

Health sector is facing many challenges due to medical advances as well as rapid epidemiological and economic transitions, although their nature and intensity vary from country to country. All health systems are struggling to contain costs while improving health equity.

Such a situation, in turn, poses many challenges for leaders of health sector. An independent Commission on the Education of Health Professionals for the 21st century called for a third

[10] Beaglehole, R. et al. (2011). Priority actions for the non-communicable disease crisis. *377*. Retrieved from www.thelancet.com.

generation of health professionals that should be system-based to improve the performance of health systems.[11]

The "education" of health professionals needs to move progressively, beginning with informative to formative and then to transformative. At the first level, informative learning involves acquiring the necessary knowledge and skills. Then, a formative learning process would socialize health professionals around a certain value system that helps define them as professionals. Finally, transformative learning involves the development of leadership attributes which is aimed at producing enlightened agents of change.

The ultimate purpose is to assure universal coverage of the high quality comprehensive services that are essential to advance opportunity for health equity within and between countries.

Health-sector reforms require not only top-level political leadership but also leadership in the health sector at various levels. This calls for leadership to make a difference in health and, thereby, accelerate progress in achieving MDGs.

Leaders Can Make a Difference

Leaders Can Do It

***CASE STUDY 1*: Chainpur Primary Health Center, Jharkhand, India**

The Chainpur Primary Health Center (PHC) is located about 3 km from the district hospital in Palamu District of Jharkhand state in India.[12] In 2006, the PHC was in a bad shape. Grass

[11] Frank, J. et al. (2011). Health professionals for a new century: Transforming education to strengthen health systems in an interdependent world. *The Lancet*, *376*(9756), 1923–1958.

[12] Kumar, A., & Satia, J. (2010). Rural health innovation through leadership development and organisational effectiveness. *Jharkhand Journal of Social Development*, *3*(2), 1–7.

had grown in the PHC compound and the hand pump had rusted from non-use. Very few people used the PHC services. Dr A, medical officer in-charge (MOIC), and his colleague Dr G felt that not much could be done. "Who will come to Chainpur when you can go to district hospital in 20 minutes?" they said to a visiting team from an academic institute to discuss the participation of Dr A in a leadership development and organization effectiveness (LDOE) program being launched with support from a donor. Despite his reservations, Dr A agreed to participate.

Through two round tables of training and during follow-ups by LDOE team, several ideas for improvement were discussed and routinely rejected as it was felt that "not much could be done." However, Dr A and G began to feel that something should be done.

As a part of the training, Dr A participated in advanced leadership training in Malaysia and was inspired by the functioning of the Malaysian health system during a field visit. Dr A motivated his colleague Dr G that they should try to improve the PHC. As funds were available from the National Rural Health Mission (NRHM), their first attempt was to improve the then moribund delivery room.

Feedback from women was used to improve the quality of facilities and make the services user-friendly. For instance, payment of incentives for institutional delivery under a national scheme was given before the women left for homes after delivery. As district hospital was close-by, women with complications in pregnancy could be easily referred there. Consequently, the number of deliveries increased significantly.

The layout of outpatient waiting room was improved. Benches were provided and a small television and purified water dispenser were installed with community contribution. These and other measures, despite being modest in nature, led the district health officer to praise Chainpur PHC and recommend other medical officers to visit it and observe its functioning. A journalist visited Chainpur PHC and wrote about

it in a newspaper. This became a model known as "Chainpur Model" in Palamu district (see Box 1.1).

Box 1.1: *Chainpur PHC*

Take Home Messages on Leadership: Chainpur PHC	
What did it take to initiate a change?	
What did it take to make a change?	
What were the costs and benefits?	

Source: Authors.

Leaders Can Get It Done

CASE STUDY 2: How Did Sierra Leone Provide Free Health Care?

On April 27, 2010, Sierra Leone started free health care for pregnant women, new mothers, and young children. John Donnelly took an in-depth look at how the war-torn nation managed it.[13]

In November 2009, Koroma, the president of Sierra Leone, announced at a donors' conference in London that he is initiating a free health-care plan on April 27, 2010, just five months away, which coincided with the 49th anniversary of the country's independence from Great Britain. Now, one year later, the results are in: the free health care plan has substantially increased services for mothers and particularly for children. The number of children treated for malaria, for instance, has roughly tripled from the previous year, a striking example of how the lack of money proved to be a barrier to care.

[13] Special Report (2011). How did Sierra Leone provide free health care? *The Lancet* 377(9775), 1393–1396. Retrieved from www.thelancet.com.

"What happened in Sierra Leone was breathtaking," said Rob Yates, a senior health economist at the UK's Department for International Development (DFID) a month after the launch. Yates has advised several governments in Africa on launching free health-care initiatives. "In five months, they were able to do a systematic reform in the Sierra Leone health system," he said. "They had leadership that galvanized the whole system. We haven't realized the full importance of what they have done. The planning was more thorough than any I have seen. Other governments can learn from Sierra Leone." In Sierra Leone, the key factor, according to those interviewed, was the president: he put the health care directive at the top of his priority list. Political will drove the process.

Although donor community was initially reluctant, they were willing to follow. There were other crucial factors. The Ministry of Health and Sanitation, which was responsible for implementation of the initiative, was fortunate to have key leaders in technical positions, such as the chief medical officer, the director of reproductive health services, and the head of human resources. They took on additional responsibilities at a time when the ministry was without a minister. This was critical to the success of the free health-care plan.

They motivated people and played the role of health diplomat. One of them, although knowing what had to be done, did not adopt a direct nature of leading. It was conciliatory, warm, and friendly. It was, "Do you think we could do this?" instead of "Why the hell has this not happened?" Another took on the role of ministry spokesperson for free health care. Just before the launch of free health care, he went on radio shows and held press conferences. Key leaders in the ministry were assigned districts and each traveled to the areas a couple of days before the launch.

The effort to bring free health care to Sierra Leone was not easy or simple, and the ministry officials readily admitted to making wrong decisions at various points. But to make the initiative a success, scores of people worked long hours for months toward a single goal that they believed in (see Box 1.2).

Box 1.2: *Sierra Leone's Free Health-Care Plan*

Take Home Messages on Leadership: Sierra Leone's Free Health-Care Plan	
What and who made the difference?	
What resources were most crucial?	
What were the costs and benefits?	

Source: Authors.

Leaders Know What Needs to Be Done

***CASE STUDY 3*: Woman Whose Life Was Saved: Overcoming Adversity at Maternal and Prenatal Clinic, Tarapoto Regional Health Center, San Martin**[14]

Rosa Diaz Barboza is a resident of the Tabalosos District in San Martin. At 18 years of age, Rosa was a happily married woman settling down in life with her husband, life on the farm, and expecting her first child. Her remote home is located three hours from the closest health post, which is only accessible by foot and even then, when it rains, the road is sometimes completely blocked and no one is able to get in or out. However, despite all these geographical difficulties, during the first trimester of Rosa's pregnancy, outreach efforts by the regional health center were able to get to Rosa and she received prenatal education and care.

[14] Prepared by Dr Raul Estuardo Arroyo Tirado, Jr., Cahuide #143, Tarapoto, Peru. Retrieved from rarroyo@terra.com.pe. Translated by Besen Obenson, May 2002. Project funded by Pathfinders International. Case study contributed by Partners in Population and Development. With author's permission.

During a routine prenatal visit, it was discovered that Rosa's pregnancy could be a high risk one due to several factors, including anemia. Taking into consideration the potential geographical difficulties, lack of equipment, and qualified staff, Rosa was referred to the health center in San Juan de Talliquihui where she could be attended to by not only a nurse but also a qualified clinical midwife.

At the eighth month of her pregnancy, Rosa and her husband began the long journey to San Juan which involved a three-hour trek uphill to reach the closest road. In San Juan, they stayed with relatives and Rosa's husband picked up odd jobs to start saving money for the baby. At the health clinic, Rosa was examined every week and everything seemed to be progressing normally. Nevertheless, clinic staff continuously praised Rosa and her husband for planning ahead.

In the early hours of June 25, Rosa began having labor pain and the midwife was called immediately who confirmed that she was indeed in active labor. At 8:30 am, Rosa was transported to the health center where they were met by the obstetrics/gynecology nurse. By 9:30 am, Rosa was ready to give birth but unfortunately, the only comfortable bed in the center was occupied, so she was forced to give birth on a hard plank which made the labor process even more painful.

At 10:09 am, Luzmirella was born—she took her first breath and let out a loud yell. She appeared healthy and normal and Rosa seemed to be handling the situation well. Everyone was relieved and Rosa's husband quickly ran home for a pillow and blanket for his wife. Forty minutes later, the nurse observed that Rosa's placenta had still not been expelled and she was bleeding slightly. Concerned by her prior anemia diagnosis and to be on the safer side, she decided to begin the protocol to prevent shock (low-risk level) (RED ALERT—a very successful series of first aid protocols for the prevention of shock developed by the regional health center) and tried to extract the placenta manually, but she was unsuccessful.

At that point, she gathered the family members and suggested that they take Rosa to the hospital in Cuñumbuque.

This hospital, located an hour and a half away by car, has a doctor on call 24 hours a day. Initially, Rosa refused to go saying she would rather die than be moved in her current condition. After requesting privacy with his wife, Rosa's husband pleaded to her saying if not for him, she had to do it for their child. At this point, Rosa agreed to the transfer.

San Juan is a rural, remote town and, as such, community leaders have developed contingency plans for emergencies. For this situation, they decided to do two things:

1. Communicate via citizens band (CB) radios with people living along the highway to inform them about the emergency and to request a vehicle which can take a while
2. Send someone to the hospital to return with the hospital's ambulance

Due to the communities' valiant efforts, by 12:30 pm, Rosa was on her way to the hospital. At this point, she was hemorrhaging heavily and all the nurse could do was continue with the protocol, administer injections of saline solution, and massage Rosa's abdomen. Rosa was feverish and not responsive, and she slipped in and out of consciousness.

At 1:30 pm, over 3.5 hours after giving birth, they got Rosa to the hospital in Cuñumbuque. By this time, she was completely non-responsive and had lost all sensory feelings. Doctors there immediately transferred her to the operating room where they tried a manual extraction of the placenta, which at this point was halfway out. After 30 minutes, the doctor decided that Rosa needed specialized attention by a qualified surgeon with the necessary equipment.

With IVs in both arms to prevent extreme shock due the profuse blood loss, Rosa was transferred again to the Maternity and Prenatal Clinic and, it was there that at 4:00 pm, the placenta was finally extracted and Rosa was given over 4 liters of blood.

The doctor who eventually removed the placenta said that it was due to *all* the actions taken by all the parties involved that

saved Rosa's life: from the health promoter who encouraged Rosa to go to the health post, to the man who practically ran all the way to the hospital to get the ambulance, and the nurse who massaged Rosa's belly for two hours. The small room where Rosa was immediately moved to was a somber gathering till she opened her eyes and asked for her baby.

Currently, Rosa and her husband are planning Luzmirella's first birthday party in June. They plan on inviting all the hospital staff who helped ensure that Luzmirella, a healthy, rambunctious 11-month old, can actually celebrate her first and hopefully many more birthdays.

Table 1.2 examines the factors related to the recovery of Rosa. Family/household, community, and government health systems not only coordinated their responses but also leveraged resources available to them. These, in turn, were guided by shared vision about life being precious and valued maternal health.

Table 1.2: *Success Factors Related to the Recovery of Rosa*

	Individual/ Household	*Community*	*Government Health System*
Vision →	Woman's life is precious	Save life when there are pregnancy complications	Save life
Values →	Proper health care can save life during pregnancy complications	Pregnancy complications need to be addressed	Continuum of care
Practices →	Stay near the health facility when pregnancy is due	Implement a contingency plan	Health providers, nurse, doctors all do that is needed
Resources →	Family contributes its resources	Community members contribute their labor	Health system uses all available resources

Source: Authors.

The above example shows that *shared vision, aligned values, coordinated practices, and leveraging resources among*

individuals/households, communities, and health system can reduce maternal deaths. Achieving this is the function of leadership as discussed in the following paragraphs.

***CASE STUDY 4*: Reducing Maternal Mortality in Sri Lanka**[15]

We know that technologies to achieve health-related goals are available, but inadequate or lack of resources is often regarded as the key barrier to better results. A World Bank study on Sri Lanka's success in reducing maternal mortality [16](Pathmanathan, et al., 2003) shows that resource constraints may not be a barrier. The Sri Lanka experience points to both the health system's development and the role of institutional development in strengthening access to and quality of available maternal health services as critical to lowering maternal mortality.

Taking the experiences of Sri Lanka and Malaysia over five decades, the World Bank study says that MDG 5 (reducing maternal mortality ratio by three-quarters between 1990 and 2015) is achievable in developing countries. However, since the 1990s, the overall progress in reducing maternal mortality globally falls short of the goal. See the second section (Inadequate Progress in Improving Health: Case for Strengthened Leadership).

What will it take to achieve MDG 5? Sri Lanka shows that reducing maternal mortality was affordable despite the country's income level and growth rate. The path it took involves these basic interventions:

1. Skilled birth attendants during childbirth

[15] ICOMP. (2005). *Discussion note prepared for the regional seminar on Strategic Leadership of Reproductive Health Programmes* organized by ICOMP, Kuala Lumpur, November 28–December 1, 2005.

[16] Indra, Pathmanathan et al. (2003). Investing in maternal health: learning from Malaysia and Sri Lanka. *Health, population and nutrition series*,Washington, D.C., USA: The World Bank.

2. Management of emergencies and complications from pregnancy to childbirth
3. Monitoring maternal deaths

These interventions have to be anchored by two critical developments: (1) the health system and (2) institutional changes.

1. Health system: To reduce maternal mortality, Sri Lanka adopted the following strategies for health system development:

    - Building a foundation for effective maternity care
    - Removing barriers to access
    - Improving utilization of available facilities

2. Institutional changes: To support an effective health system development, changes in certain core and complementary institutions were necessary such as:

    - Human resource development and management
    - Reaching out to the poor
    - Building a functional referral system
    - Removing barriers to access
    - Facilitating community mobilization
    - Strengthening accountability
    - Stronger organizational management including implementation of increasingly sophisticated monitoring system

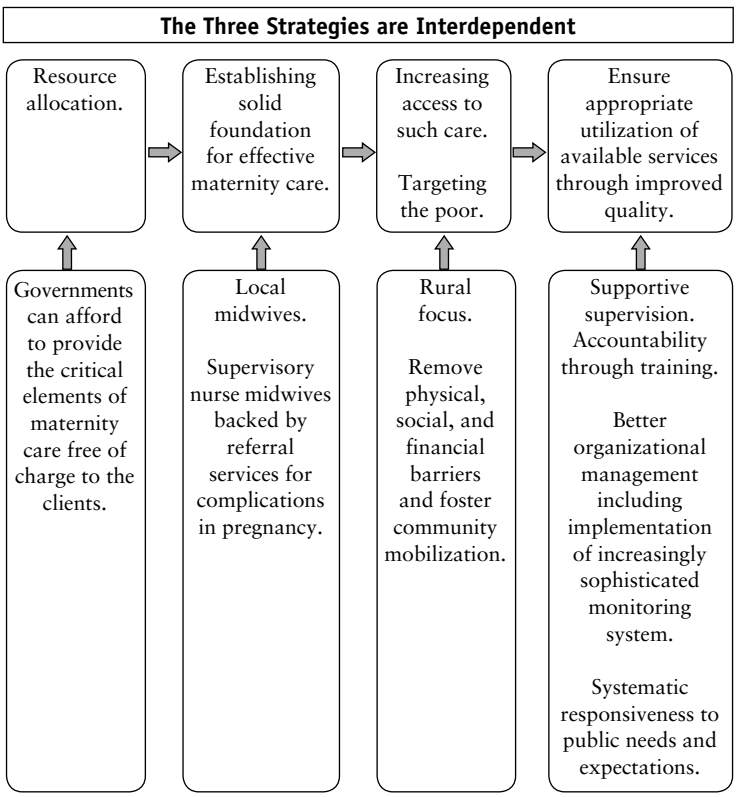
Other forces were also at work. An enabling environment as a result of early gains in female education and the empowerment of women through the electoral process ensured sustained national, political, and managerial commitment to maternal health. Improvements in national transportation system also contributed to better and quicker access to health services as well as improved health-seeking behavior. Financial

barriers to maternity care were removed by the government's political commitment and society's expectations of health and education services to be provided free of charge.

Oversight institutions are also known to have complemented these efforts synergistically. Civil registration of births and deaths was governed by legislation, and maternal deaths were viewed with sufficient concern to warrant special reporting by the Registrar General.

Figure 1.1 shows the conventional perspective of health system development for reducing maternal mortality. However,

Figure 1.1: *Conventional Perspective: Health System Development for Reducing Maternal Mortality*



Source: Authors.

as shown in Table 1.3, these can also be seen from a leadership perspective of creating shared vision, aligning values, coordinating practices, and leveraging resources among individuals/households and communities.

Table 1.3: *It Can Be Done: Leadership Perspective*

Tasks	*Household/ Family*	*Community*	*Health System*
Create shared vision	Female education		Sophisticated monitoring system and special reporting
Align values	Empower women	Political and managerial commitment	Systematic responsiveness to public needs and expectations
Coordinate practices	Remove physical, social, and financial barriers	Mobilize community	Supervisory nurse midwives backed by a referral system for complications in pregnancy
Leverage resources		Improve transport	Free of charge services

Source: Authors.

Leaders Know it Can Be Done—Leaders' Perspectives to Address HIV/AIDS

In the following paragraphs we discuss three countries[17] which had achieved notable success in combating HIV/AIDS in early stages of AIDS epidemic—Uganda, Senegal, and Thailand—which have been documented by UNAIDS as best practice case studies.

[17] ICOMP. (2005). *Discussion note prepared for the regional seminar on Strategic Leadership of Reproductive Health Programmes* organised by ICOMP, Kuala Lumpur, November 28–December 1, 2005.

Uganda

Uganda is one of the world's poorer countries and one of the most severely affected by the HIV/AIDS epidemic. In 1998, it had 21 million people, with less than 14 percent living in cities. The gross national product per capita was equivalent to about US$240. Total HIV prevalence among adults was over 8 percent.

Fortunately, Uganda is also one of the African countries where the HIV epidemic was recognized relatively early and so prevention efforts were started on a national level.[18]

- In 1986, the president publicly acknowledged the country's HIV/AIDS problem and made a commitment to mobilizing efforts against it. A national budget for the AIDS program was established early during the epidemic.
- The country adopted a multi-sectoral approach. The Uganda AIDS Commission was set up in the Office of the President and HIV/AIDS control program was established in several government ministries, including the Ministry of Health.
- Different levels of the society were involved such as political, community, and religious leaders. The Islamic Medical Association of Uganda supported community education on HIV/AIDS throughout the country, including the distribution of condoms.[19] Radio messages on HIV/AIDS were broadcast widely.
- Condom social marketing services, backed by USAID, were implemented countrywide.
- HIV voluntary counseling and testing were made available extensively and outside the formal health-care service.

[18] For more detailed information, see "A measure of success in Uganda: The value of monitoring both HIV prevalence and sexual behavior," Case Study UNAIDS/98.8, Geneva, May 1988.

[19] For further information, see "AIDS education through Imams: A spiritually motivated community effort in Uganda," Case Study UNAIDS/98.33, Geneva, October 1988.

Uganda's success in HIV prevention can be seen from the following:

- Percentage of adults infected declined from a peak of about 14 percent to about 6 percent in 2003.
- Steep increase in condom use: The proportion of men who said that they had ever used a condom rose from 15 percent to 55 percent. Among women, the total rose from 6 percent to 39 percent.
- Behavior change: Percentage of sexually experienced men at age 18 fell from nearly 90 percent in 1989 to 50 percent in 1995.

Senegal

Much has been written about the need to intervene early to stop the spread of HIV before it spreads to the general population. Senegal's HIV prevention program has been extensive and contains the elements of an effective program. There is good evidence that Senegal has maintained one of the lowest rates of infection in sub-Saharan Africa by changing the behavior of many of its citizens.[20]

Like Uganda, Senegal is not a rich country. In 1998, it had 9 million people, with 44 percent living in towns. Per capita income was below US$600 a year. Total HIV prevalence among adults was estimated at about 1.8 percent.

Senegal has for long emphasized prevention and primary health care. Reproductive health (RH) and child health are well-established priorities. In addition, registered sex workers are required to have regular health checkups and are treated for any curable sexually transmitted infections (STIs) that are found.

What was the response in Senegal?

- As in Uganda, politicians in Senegal were quick to move against the epidemic once the first cases appeared in the second half of the 1980s.

[20] For more detailed information, see "Acting early to prevent AIDS: The case of Senegal." UNAIDS Key Material, June 1999.

- Since 93 percent of Senegalese are Muslims, the government made efforts to involve religious leaders. HIV/AIDS became a regular topic in Friday sermons in mosques and senior religious figures talked about it on television and radio.
- Many other levels of Senegalese society joined in. By 1995, 200 nongovernmental organizations (NGOs) were active in the response, as were women's groups with about half a million members.
- HIV prevention was included, while sex education was introduced in schools. Parallel efforts reached out to young people who are not in school.
- HIV voluntary and confidential counseling and testing were made available.
- Programs were immediately put in place to support sex workers to persuade their clients to use condoms.
- STIs moved up on the list of health priorities. Senegal was one of the first countries in Africa to establish a national STI control program that integrated STI care into regular primary health services.

Senegal's success in HIV prevention can be seen from the following:

- HIV prevalence among pregnant women was just over 1.4 percent at the end of 1996, with no significant trend over time.
- Condom distribution rose from 500,000 pieces in 1988 to 7 million pieces in 1997.
- Median age at first sex for women in 1997 for 25–29 years age group was 17.7 years but increased to 18.7 years for 20–24 years age group.

Clearly, earlier improvements in the social structure and health services put Senegal in a good position to respond more effectively to HIV and AIDS. In addition, strong political commitment and the implementation of effective prevention activities helped keep Senegal's rates of HIV infection among the lowest in sub-Saharan Africa.

Thailand

Few countries show the link between behavior and HIV infection as clearly as Thailand.[21] Overall, behavioral changes have reduced the number of new HIV infections each year from almost 143,000 in 1991 to 29,000 in 2000.

Thailand has a little over 60 million people, about 20 percent of whom live in cities. The gross national product per capita was equivalent to about US$2,700 in 1998. HIV prevalence among adults was estimated at about 1.9 percent, with higher prevalence in certain geographical areas and among certain groups. Thailand's HIV prevalence might be lower than that of Uganda's but it had a similar number of people living with HIV/AIDS.

The effective nationwide prevention program, which began in 1991, included several elements:

- The prime minister chaired the National AIDS Program.
- The Office of the Prime Minister took an active role in policy discussion, led the national public education effort using government-run mass media (that is, public, not private), and took part in monitoring.
- The Parliament established a subcommittee on AIDS.
- The National Economic and Social Development Board worked closely with the Ministry of Public Health to integrate the National AIDS Plan into the five-year National Development Plan.
- The government AIDS budget increased drastically during the following years.

[21] For more information, see "Relationships of HIV and STD declines in Thailand to behavioral change: A synthesis of existing studies," Key Material, UNAIDS/98.2, 1998. See also, "Collecting lower HIV infection rates with changes in sexual behavior in Thailand: Data collection and comparison," Case Study, UNAIDS/98. June 1998; "The success of the 100 percent Condom Promotion Programme in Thailand: Evaluation of the 100 percent Condom Promotion Programme and the validation of the decline in trends for selected STDs," Institute for Population and Social Research, Mahidol University, Thailand (funded by the Thai Ministry of Public Health and UNAIDS, February 2000).

- Each key ministry had its own AIDS plan and budget as well as a person as the AIDS focal point.
- All provincial governors led the AIDS program in their respective provinces through the provincial development planning system.
- The business community, people living with HIV/AIDS, religious leaders, and other community leaders became very involved in contributing to policy dialogue, resource mobilization, and the local implementation of activities.
- In Thailand, 1991 was the turning point for human rights protection for PLHIV. HIV was removed from the list of diseases that required notification to the health authority. The ban on entry to Thailand of people with HIV/AIDS was lifted. A set of national policy guidelines to protect the rights of PLHIV was issued.[22]

The most striking effect of the national program, famously known as 100 percent condom program, can be seen from the following:

- Total number of people living with HIV/AIDS decreased from nearly 750,000 in 1995 to 650,000 in 2000.
- Men (aged 15–49) visiting sex workers dropped from 19 percent in 1990 to 9 percent in 1993.
- Reported number of STIs in male fell from about 200,000 in 1989 to less than 20,000 in 1994.
- Consistent condom use among sex workers increased from over 50 percent in 1990 to almost 90 percent in 1996.

IT can be done: Conventional view

To demonstrate that success can be achieved even in resource-poor settings, the experiences of these three countries with differing cultures and different levels of the epidemic are discussed here. Uganda was hard hit throughout the 1980s and has had almost two million cumulative AIDS-related deaths since then.

[22] Ungphakorn, J., & Sittitrai, W. (1994). The Thai response to the HIV/AIDS epidemic. UNAIDS, *8* (Suppl.), S155–S163.

Senegal, on the other hand, had not been seriously affected by the epidemic. In Thailand, the epidemic became prominent only by the end of the 1980s, but spread rapidly once it took hold. These are three different situations, but behavioral change and some containment of the epidemic were achieved in these three developing countries even with resource constraints.

What are some essential features of effective programs which are shared by the three countries? In each one, national AIDS programs share a package of common features that UNAIDS regards as "best practice," namely:

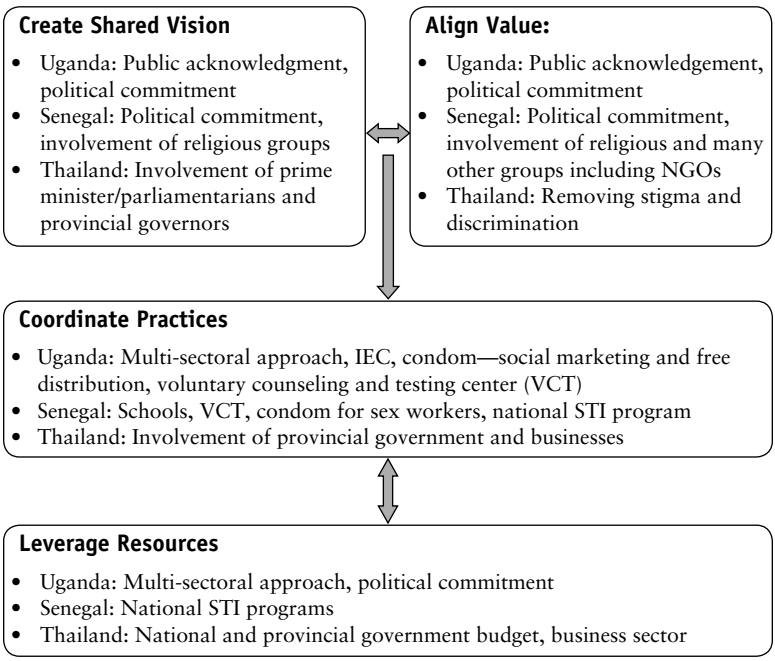
- Strong political commitment at the highest level to deal with the epidemic (this ensures policies and funding to address the epidemic)
- Multi-sectoral approaches to prevention and care and, at the government level, involvement of multiple ministries
- Multilevel responses (at national, provincial, district, and community levels)
- Effective monitoring of the epidemic and risk behaviors, and dissemination of the findings both to improve policies and programs and to sustain awareness
- A combination of efforts aimed at the general population and focused on groups at high risk, at the same time
- Implementation on a large scale
- Integrated prevention and care

These actions proved to be effective because leadership was involved. The influence of leaders at different levels of society in each country—the president/prime minister, the ministry officials, religious and community leaders, and so on—was seen in the delivery of policy directions and program interventions according to the desired or articulated goals and objectives.

The above actions can be interpreted from the leadership perspective as shown in Figure 1.2.

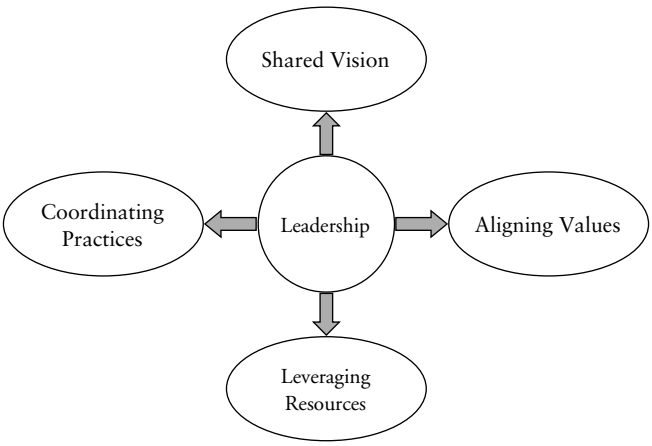
Thus, the success of policies and programs is reflected through leadership actions of creating a shared vision, aligning values, coordinating practices, and leveraging resources among the individuals/households, communities, and health system, as shown in Figure 1.3.

Figure 1.2: *It Can Be Done: Leadership Perspective*



Source: Authors.

Figure 1.3: *The Leadership Perspective for Superior Results*



Source: Authors.

As the context changes, the leaders need to continually work on these actions to ensure sustained progress. The above mentioned early successes in HIV programs were not necessarily sustained in continuing reduction in adult prevalence of HIV infections. The HIV prevalence in Uganda has stabilized between 6.5 percent and 7 percent since 2001. The adult HIV prevalence remained low in Senegal at 2 percent or under. On the other hand in Thailand, the rate of new HIV infections decreased by more than 25 percent between 2001 and 2009. Current adult HIV prevalence is estimated to be close to 1 percent, a significant decline from a peak rate of about 2 percent in 1995.