LEADERSHIP FOR HEALTH DEVELOPMENT IN EAST AFRICA: A FRESH APPROACH

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Introduction

Of all the world’s regions, sub-Saharan Africa, including East Africa, is least likely to achieve the Millennium Development Goals as set by the United Nations at the Millennium Summit in 2000 (1, 2). This is because there are many challenges to reaching these goals that include the low levels of Official Development Assistance, inadequate private investments and insignificant financial contributions flowing into the region. However, this situation has recently changed with a massive infusion of resources to address poverty and disease control from both private and public international programs such as among others, the Global Fund, Gates Foundation, G-8 Africa Aid Package, Debt forgiveness, the United States Presidential Initiatives and the World Bank. Amidst this positive change, limited human resources, rather than funding constraint is now becoming the major obstacle to health development. The principal obstacle to all spheres of health development is therefore limited human capacity. The dynamics driving many of the continent’s problems are sub-regional in nature, yet donor efforts are targeted at the country level. This situation renders country-level efforts in harnessing the resources to address subregional problems largely ineffective. Africa therefore needs strong regional coalitions to promote health initiatives, which span national borders. Building human capacity across borders should be part of such a strategic and coordinated regional strategy.

The health human resource crisis

At the heart of the problem is the limited supply of health workers. By almost any health indicator chosen, low numbers of health workers, combined with urban-rural disparities in distribution, are associated with poor health status of the population. In the 1980s the doctor:population ratio in Sub-Saharan Africa was 1 to 10,800 people compared to 1:1,400 in all developing countries put together and an average of 1:300 in developed countries. The situation did not change in 1990 where in some countries there was one doctor for over 30,000 people while WHO recommends one doctor for every 5000 people. The human resource crisis has been worsened by increased morbidity and mortality due to preventable diseases. Although malaria control activities have been in place for over 50 years, the disease continues to be the most common cause of morbidity and mortality and it is the single biggest killer of pregnant women and children under the age of five years.

The continent also has the highest rates of HIV infection in the world. Each day 6000 people die from AIDS related conditions and an additional 11000 are infected. While Europe has 18.9 health workers per 1000 population, and the Americas have 24.8, Africa has only 2.3. (see figure 1). Furthermore, in Africa, with perhaps the greatest need for an increase in public health specialists, the numbers and the training capacity is particularly weak. Many who fill public health positions have not had access to the training that would help effectively implement the sweeping health systems changes required. Higher education initiatives, such as those, which would increase the public health workforce, are typically not a priority for donors.

Need for strong leadership in public health

To fully utilize the opportunities provided by increased financial resources, a business-as-usual approach in managing health sector development in the region won’t work. The new financing health initiatives require strong leadership with foresight. To convert financial resources into health benefits, public health leaders are needed who can strategically manage financial and human resources, collaborate across sectors, help create a vision for new ways of working, and effectively set priorities and allocate resources. Traditional public health, medical, nursing and allied health training has not frequently prioritized these competencies.

Leadership implies the ability to create, to influence, to inspire and to guide. More specifically, being a public health leader means an enhanced ability to think strategically, to communicate effectively, to make decisions using population-based data, and to manage conflicts. Above all the expectation of a leader is one who will bring about change—and in this African context—this must be dramatic change. In order to sustain resource flows, substantial and evident changes in health status of the population must occur quickly.

A fresh approach

In 2005, USAID committed resources towards the development of an East African Public Health Leadership Initiative. The Muhimbili University College of Health Sciences and the Makerere University recently received a grant to develop a regional program that has as its goal to strengthen leadership capacity in the East African region. Working together with Johns Hopkins, Tulane, and George Washington Universities, the new initiative is aimed at introducing training, capacity development tools and inter-country exchanges that will greatly increase the quality and depth of public health leadership in the East African region.
This initiative is in its planning stages. Part of its mandate is to engage public health schools and graduate training programs throughout the sub-region as key stakeholders in building leadership capacity. The program has several basic components. The first is to strengthen the leadership components of in-service and pre-service training within the public health, medical and nursing sectors. An initial assessment of existing curriculum and programs and health sector management needs is being conducted to identify needs for leadership content, courses and graduate degree programmes. The two schools will initially undertake a review within their countries, which they will share to the wider East African public health community in late 2006. Subsequently, leadership curriculum materials will be made available to other public health schools in the region for their adaptation and use.

A second component of the leadership initiative is to develop a network among public health schools and graduate training programs in the region. The network’s purpose is two-fold. First, the network will create a forum for discussion and engagement on public health issues requiring regional approaches. A second purpose is creation of a mechanism for sharing knowledge, training materials, and electronic resources to enhance leadership capacity in the sub-region. An Internet-based public health resource center, including distance-education courses that would be publicly available is planned as a support to this network. Certificate programs, e-learning and new creative approaches to creating surge in public health capacity will be required to produce the human resources needed in the region to move health indicators out of their current stagnation to more dynamic and better levels.

A key quality of leadership is relevance. To be relevant, public health schools must both practice and teach effective communication and initiate effective cross-sectoral engagement. Public health schools must both engage effectively with the public health practice sector and they must also work across divisions with other disciplines and sectors. They also must be able to transmit these competencies through their educational programs. In this, the two universities will receive assistance from the World Bank Institute, the educational arm of the World Bank. Another key group in developing good public health practices for the population are the media. Programs to help journalists understand what health messages to communicate and what questions to ask health leadership will be developed or expanded.

If public health schools are to successfully promote this new vision for leadership, faculty development will be required. First, the strengthening of faculty skills in leadership principles will be addressed. This will enable the integration of the leadership competencies of strategic planning, resource mobilization, conflict resolution, and resource management across the field of public health. Faculty networking across the region will build a forum for exchanging and internalizing leadership best practices.

In the end, the intent of this program is to develop a regional resource for public health leadership that will transform public health development in East Africa. An initial regional strategy meeting will be held in 2006, where Deans and Directors of Schools and Departments of Public Health will engage with senior sector managers and relevant international program executives to review progress to date and to identify strategies to galvanize a regional network.

Leadership is action not position. The primary responsibility of a leader is to create a state of mind among health workers in which the improved health status of the population is the one goal that transcends all other health systems goals. It is the hope of all the partners in this new undertaking that this enterprise will help create such a vision for public leadership in all sectors of development.