Editorial

Health leadership in sub-Saharan Africa

Introduction

It is clear that with the current rate of progress sub-Saharan Africa will not achieve any of the health Millennium Development Goals by 2015. All key health indicators are at worse levels than in any other developing region. The problem is undoubtedly multi-factorial, with many solutions tabled, including the need for strong and effective leadership. Here, we present our opinion about the current state of health leadership in Africa and how it could be improved. We look at the defining qualities of some historic and contemporary leaders and discuss how these could be adapted to lead Africa out of its current health problems.

Leadership and its characteristics

People such as Alexander the Great, Abraham Lincoln, Mahatma Ghandi, Nelson Mandela, Kofi Annan and Wangari Maathai are generally regarded as great political or military leaders within their historical context. They are famed not for their words, plans or schemes, but for their lifetime achievements and the impact of these deeds beyond their lifetimes. There are also numerous examples of successful business leadership. Similarly, we believe that health leadership in sub-Saharan Africa should be judged in terms of achievements rather than plans and processes, underpinned by the same principles that determine successful military, political or business leadership.

What are the defining characteristics of strong, effective leadership? These can be summed up briefly as vision, innovation, risk taking, integrity, the ability to listen and learn, decisiveness, an in depth understanding of the business at hand, empathy, consistency and personal responsibility. Many of the great leaders mentioned above in military matters, politics and industry have shown these characteristics.[1–10] We believe that our health leaders need to learn from such examples.

Current status of health leadership and delivery in Africa

Leaders within ministries of health and non-governmental organizations are charged with the responsibility of delivering health care to their population. Today, with health sector reform and sector-wide approaches to health[11] dominating the ideology of health care delivery in many African countries, health leadership and delivery in these countries is characterized by bureaucratic consensus, plans, processes and meetings to develop systems and structures to enable processes such as recruitment, training, procurement and monitoring to take place. Not enough emphasis is placed on assessing the impact of all this activity on deliverables for the people in need. All too often the vital data to support whether objectives have been met and outcomes achieved are absent or only partially available, and leaders are not held accountable for this lack of tangible outcomes.

An example of good health leadership in sub-Saharan Africa

Achievements in health delivery outcomes and wider impact outcomes are not always easy to measure, but that should not prevent us from trying. Despite being devastated by the HIV/AIDS epidemic, it was inconceivable 10 years ago that a resource-poor country such as Malawi could ever deliver antiretroviral therapy (ART) on a national scale to meet the country's needs. However, through the committed leadership of the Ministry of Health and its partners, as of September 2008, over 135,000 patients remained alive and on ART at clinics throughout the country,[12] and there is early evidence of population-level impact of the programme through a reduction of adult mortality.[13] Some of the leadership characteristics that were important in ensuring rapid, large scaling up of ART are shown in Box 1.[14–17]

A new paradigm of leadership in Africa

Good health leadership has to start with strong and stable governance, where the top leadership is aware that health is a priority and is committed to tackling health issues. Leaders within the Ministry of Health need to be selected on the basis of qualifications, experience and merit, rather than for political reasons or for their connections. A philosophy of good leadership can be nurtured through health manpower development programmes, formal leadership training courses and the use of retired and experienced staff as advisors and mentors. Once the senior leadership has been appointed, and provided performance is satisfactory, frequent changes must be avoided in order to maintain an institutional memory and confidence with partners and other stakeholders. These leaders then need to set the strategic vision and mobilize efforts towards its realization and ensure the effective organization and utilization of human and other resources to achieve results and meet the aims.

Good leaders must understand the technical aspects of their respective departments. They need to consult widely and wisely, to abide by well-tried policies that have been endorsed at international and regional level, and then make timely and firm decisions. They need to engage in the implementation and delivery of services and empower competent managers to help them. They, and their managers, should travel regularly to the field to support, supervise, praise or admonish front-line health workers who work in remote settings: this is what gives leaders credibility and health programmes a face. Good leaders must ensure that data on outcomes are available in a timely fashion and that such data are as accurate and reliable as possible. Finally, good leaders must take responsibility for their sphere of work and be held accountable by their peers, their

Box 1 Leadership qualities that lead to the development and implementation of the national plan to scale up antiretroviral therapy (ART) in Malawi

Characteristic	*Details*
Innovation	Scale-up based on simplification of the ART delivery system by using one generic fixed-dose combination therapy with stavudine-lamivudine-nevirapine[14]
Risk taking	Rapid scale-up to all districts in the country in the first year of the national plan had risks centred around drug security and theft from health facilities and poor patient adherence with the subsequent development of drug resistance. These risks were mitigated by ensuring that pharmacies were secure, checking drug consumption against drug usage and focusing on group and individual counselling before start of ART[14]
Vision	Rapid scale-up of ART was driven by the 'moral imperative' that it was unacceptable to move slowly and cautiously in the face of 85,000 AIDS-related deaths in Malawi each year[14]
Decisiveness	A national scale-up plan was put together in six weeks and, after consultation with stakeholders and international donors (some of whom disagreed with the approach), a decision was taken by Ministry of Health to approve the plan and start implementation immediately
In depth understanding of the business	The national ART scale-up plan was based on the DOTS paradigm,[15] and national ART guidelines again based on the DOTS paradigm.[16] There was a clear understanding at all levels about what had to be done
Consistency	Despite criticisms of the public health approach to ART scale-up, the principles and practice were continued unchanged during the first years of implementation[17]
Personal responsibility	All leading players in the Ministry of Health took personal responsibility for the ART scale-up plan. As one national spokesman put it 'Either we will all get medals, or we will lose our jobs'

DOTS, directly observed therapy

subordinates and the general public for the success or failure of deliverable outcomes.

Failing health leadership is not uncommon and systems have to be put in place at all levels to identify the problems and deal with them quickly and effectively. Failing leadership at district and facility level can usually be rectified within the hierarchical structures of ministries of health, provided there is the will to do so. However, failing leadership at a high level is difficult and politically sensitive to deal with, but can be rectified by strong collective action from the civil society, the national press, parliament and the executive, donors and international technical agencies. For donors involved in sector wide approaches to health, there should be independent review processes that enable partners to raise concerns if it is evident that lack of leadership or bad leadership is undermining health outcomes, without dictating to government how things should change.

Conclusion

We believe that strong, pragmatic health leadership in sub-Saharan Africa is one of the keys to improving health outcomes on this continent. Other equally essential keys include a strong political will right from the top of government, a fiscally-sound ministry of finance and a strong civil society. Leaders who are serious about improving health, and who are held accountable for success or failure, will strive to ensure that services function, that health products are always available and that health-care workers are motivated. This provides the best chance to improve progress towards national and global health goals.

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