

Developing a replicable model for building the human capacity of public health systems in Africa

The African Public Health Leadership and
Systems Innovation Initiative

Concept Paper

May 2007

The *African Public Health Leadership and Systems Innovation Initiative* will develop a replicable model for improving public health leadership and system performance.

The *Initiative* will apply a high-performance, business-consulting approach called the Innovation Lab. The Innovation Lab increases health leader effectiveness by cultivating managerial and administrative skills *and* by addressing the attitudes, values, and relationships that drive behavior. It stimulates system change by enabling cross-sectoral health leadership teams to develop and launch innovation projects that address pivotal health system opportunities or bottlenecks. Through the Innovation Lab, we convene health leadership teams from government, business, and civil society. Teams are guided through an intensive leadership development and project-based learning experience unfolding over two years.

Our vision is to replicate this approach across Africa. As a first step, we propose a demonstration project in Namibia to develop the model and make curricula and other intellectual property available for subsequent replications.

The African Public Health Leadership and Systems Innovation Initiative Concept Paper

In a speech to the World Health Assembly in 2005, Bill Gates asked the assembled leaders to imagine a world rejoicing over the discovery of an effective AIDS vaccine – and also to picture the accompanying horror that millions of people would continue to die because the vaccine was not widely distributed.¹ Gates called for public health technology that is deliverable, usable, and accessible particularly in the developing world. Melinda Gates echoed this at the 2006 Global AIDS Conference, commenting that “no discovery can save lives unless we distribute it to everyone who needs it, and the record so far suggests we’ve got a lot of work ahead of us.”²

Delivering public health services requires functional and effective country-level health systems: capable health leaders, qualified healthcare providers, effective human resource systems, reliable data, adequate physical infrastructure, and many other critical inputs. Bringing health initiatives to scale often requires massive collaboration within government as well as coordinated effort among government, international agencies, business, civil society, and citizens. Across most of the developing world, and especially in sub-Saharan Africa, such systems are exceedingly fragile. Likewise, the infrastructure for collaboration and coordination is often weak or non-existent.

A considerable body of research pinpoints weak health systems as a critical impediment to improved health across Africa.³ Although the international donor community has invested heavily in African public health initiatives, resources have largely been directed towards developing “upstream” health technology (vaccines, medicines, etc.) that address specific disease conditions.⁴ Such investments are undeniably essential. Nevertheless, we believe they will be insufficient if not coupled with support to strengthen the “downstream” human resources, institutional capabilities, and systems needed to deliver health technology and services to end users.

The *African Public Health Leadership and Systems Innovation Initiative* is designed to create and test within Africa a replicable model for improving health system performance. The approach will complement the investments being made in public health *science and technology* by applying a robust body of *social technologies* to enhance the enabling environments that influence the quality of health service delivery. The *Initiative* will address the following problem statement and hypothesis:

Problem Statement: Effective public health interventions are not achieving scale in most African countries because the health systems required to deliver them are ineffective or inefficient. This is caused by a set of interdependent factors including human capacity constraints, resource limitations, gaps between policies and implementation, systemic blockages to evidence-based decision-making, etc. The leadership capacity required to overcome such obstacles is underdeveloped, both in terms of technical, managerial, and administrative skill as well as other dimensions of leadership such as the ability to articulate a clear vision, catalyze change, motivate others, and collaborate across boundaries.

Hypothesis: The ability of health systems to increase productivity and bring effective health interventions to scale can be catalyzed by enhancing the quality and performance of health leaders, by aligning the vision, values, and commitments of senior health leadership teams, and by capacitating health leaders to themselves design *and test new approaches to scaling and problem solving from within the system itself*.

A *Consortium* of partners, including international development experts (Synergos Institute), management consultants (Generon Consulting and McKinsey & Company), and academic action researchers (Society

for Organizational Learning (SoL) / Presencing Institute) has come together to test the hypothesis. The partnership exemplifies a new approach to global problem solving by breaking down traditional boundaries between business, civil society, and academia to create hybrid solutions that draw on the best each domain has to offer. Synergos, a non-profit organization based in New York with a regional office in South Africa, will serve as managing partner.

Our long-term vision is to rollout health leadership and systems innovation initiatives in countries across Africa. The initiatives will target people who are underserved by current health systems, particularly those living at less than \$2/day. As the first step towards this larger vision, the *Consortium* proposes a 30-month demonstration project that will evidence the efficacy of this approach in one national context, Namibia.

Goals, Objectives & Deliverables

The *Initiative* integrates two **goals**, to be achieved over two and a half years.

1. To create a replicable model for developing African health leaders, catalyzing health systems innovation, and improving the performance of healthcare delivery systems in Africa.
2. To improve performance of the Namibian healthcare system and to accelerate the scaling of health initiatives that address Millennium Development Goals (MDG) in Namibia by strengthening the effectiveness of public health leaders through cross-sectoral problem solving, improvements in health leader decision-making, and the shifting of critical aspects of the system in which those leaders operate.

The *Initiative* seeks to achieve four **objectives**:

1. **Leadership:** Develop the leadership capacity, managerial skills and decision-making abilities of 40-45 current and emerging leaders from the Namibian public health system, with participation from government, business, civil society, and communities.
2. **Health System Innovations:** Support Namibian health leaders to design and pilot 2-3 major health system Innovation Projects that indicate progress towards meeting one or more of the country's stated health-related MDGs (possible focus areas include maternal & child health, water & sanitation, or nutrition).
3. **Dissemination:** Document and make widely accessible in Africa and globally the tools, curricula, and intellectual property developed in the Namibia project.
4. **Sustainability & Replication:** Create conditions to sustain health leadership development and systems change activities in Namibia and develop strategy to replicate the approach in other African countries.

The main **deliverables** resulting from the *Initiative* are:

- A **replicable and open-source health leadership development and systems change model**, tailored to the African public health context, which integrates intellectual property from leading management consulting, academic, and non-profit development organizations.
- A cadre of **40-45 Namibian current and emerging health leaders with improved management abilities, advanced leadership skills, better decision-making abilities, and increased motivation and commitment**. As a result of the *Initiative*, these leaders will demonstrate enhanced collective alignment and an improved ability to manage change processes that increase the productivity and effectiveness of the Namibian health system. They will emerge with a clearer perception of the blockages to effective decision-making within the health system and an understanding of how such blockages can be overcome.

- A suite of **2-3 major health innovation projects demonstrating early stage progress towards addressing stated Namibian health goals** which can be scaled and mainstreamed. The projects will illustrate the capacity of the Namibian health system leaders to devise and implement creative ways of improving health system performance themselves.
- The creation of a **Namibian Health Systems Innovation Network** which embeds within Namibia a perpetual capacity to create and diffuse health knowledge and to stimulate future innovations within the Namibian health system. The Network is to be an inter-generational, self-organizing group of 50-100 health leaders and activists comprised of Namibian government, business, and civil society representatives.
- A **high-capacity Namibian/African team of managers, trainers, and facilitators** capable of sustaining project activities in Namibia and supporting next-country replication.
- An **institutional base from which to sustain health leadership development and systems change activities** in Namibia and a strategy for replicating the *Initiative* in Namibia and other African countries.
- A set of **accessible materials which share curriculum, toolboxes, learning histories**, and other intellectual property created through the *Initiative*.

***Building the Human Capacities of Systems:
The Importance of Leadership***

To the casual observer, the nature of leadership and the quality of leaders may seem a soft, intangible dimension of the overall performance of human organizations, including health delivery systems. Yet, as Jim Collins argues in his groundbreaking works Built to Last and Good to Great, it is the quality of leaders and leadership that ultimately drives success or failure in virtually all organizations and complex human systems. Other authors including Peger Senge (MIT), Warren Bennis (University of Southern California), John Gardner (Stanford), Peter Drucker (Claremont University), and Rosabeth Moss Kanter (Harvard) argue that leaders exert a disproportionate influence in organizational and systemic outcomes, over and above other factors such as financial resources, physical infrastructure, or technology.

In essence, leadership exerts itself in two critical ways. First, leaders are responsible for articulating a compelling vision of the future, devising strategies for achieving that vision, and aligning and motivating the people required to achieve the vision. Second, leaders ensure that actions are taken in order to realize the vision by creating appropriate plans, procedures and programs for execution; ensuring performance; and monitoring and evaluating results. If the capacity of leadership is underdeveloped in either of these two dimensions, organizational or systemic performance will suffer.

An extensive and growing body of literature furthermore suggests that leaders have access to two critical leverage points to shape behavior and improve the performance of organizations or complex systems. One is addressing the interior condition of leaders and key influencers within a system—their underlying beliefs, mindsets, and attitudes. The other is to shift the systemic operating environment—rewards, rules, paradigms, enablers, values, and culture.

(See Michael Rennie, Joseph Jaworski, Robert Quinn, Donella Meadows, Robert Greenleaf, Stephen Covey).

Why Namibia?

Namibia offers numerous advantages as the first national context in which to demonstrate the efficacy of this approach. The strong invitation we have secured from senior Namibian government officials, including both the President and Prime Minister, suggest that the project will benefit from high-level political support and national-level visibility. Leaders of the Namibian business community, academia,

and civil society have also expressed support for the *Initiative*. Namibia's manageable scale and stability suggest that our team can move faster, touch a larger portion of the healthcare system, and demonstrate results sooner than if we had chosen an alternative location. The proposed *Initiative* is also highly congruent with Namibia's long-range planning framework, *Vision 2030*, which emphasizes public health advancement, public-private partnerships, and human and institutional capacity development.

Lessons learned in Namibia can be readily applied elsewhere in Africa. Although Namibia presents some distinguishing characteristics (sparsely populated, relatively affluent, comparatively functional, etc.), the country's development and health challenges show a close likeness to other African countries. Despite Namibia's relatively high per capita income, it ranks only 125 out of 177 countries on the Human Development Index.⁵ Inequality is pervasive: Namibia consistently ranks as one of the most unequal countries globally in terms of income distribution.⁶ Over half of all Namibians live on under \$2 per day⁷.

In health terms, Namibians suffer from a range of diseases and conditions common in Africa. Namibia's overall HIV prevalence is 21.3%. HIV prevalence among pregnant women has risen from 4% to 22% between 1992 and 2002.⁸ Maternal mortality has increased markedly over the same time period.⁹ As in other African countries, diarrhea, malaria, and malnutrition are leading causes of death in children under five.¹⁰ The country has also shown slow progress towards increasing rural household access to clean water, and some 79% of all rural Namibians do not have access to proper sanitation facilities.¹¹

Project Design

Our approach to leadership development and systems change brings together 80 years combined experience across four institutions working in international development, health systems, business, community, and academia. The project design is based on *Consortium* member field experience in a broad range of settings and is grounded in two important insights: shifting the performance of any system requires directly addressing the mindsets, behaviors, and skills of the leaders within that system *and* sustaining any change among leaders in a system requires addressing the mechanisms in the system that shape leaders' behavior. From these two basic observations, we have developed our approach based on the following design principles:

1. **Engage leaders who represent a strategic sub-set of the system:** Understand the whole system and its potential change levers by working with key influencers and frontline practitioners from government, business, media, education, faith communities, traditional leadership, donor agencies, etc.; engage and learn from patients, beneficiaries, community groups, and others who are often voiceless in determining system outcomes.
2. **Engage the system from within:** Offer catalytic support to leaders in their effort to lead and own a change process rather than imposing solutions from the outside. Provide technical, financial, and other support as needed to increase the likelihood that change processes led from within the system will succeed. Cultivate political support to enable change.
3. **Develop the leader as a whole person and embed new capacities:** Develop inspiring leaders with the values, commitment, and courage to lead fundamental change in the system, and equip them with technical skills required to implement change. Coach leaders over extended periods to embed new capacities and continue mentoring leaders as they apply new capacities in action.
4. **Build and reinforce skills through experience:** Enable leaders to acquire new technical and management capabilities through direct experience and project-based learning; socialize and support ongoing skill building through peer-to-peer learning.
5. **Develop an inter-generational leadership team of the emerging, improved system:** Identify those who can serve as the emerging leader team of a future health system. Build the team's collective

ability to align around a common vision and to act together. Sustain the leadership team's ability to perpetually generate and diffuse knowledge through formalized, trust-based relationship networks.

6. **Catalyze action among the leaders to remove bottlenecks and shift the system:** Identify pattern-shifting interventions that alter systemic arrangements; seek sustainable solutions that combine government, business, and civil society talent and resources.
7. **Support and bring to scale what is already working:** Identify, enhance, and extend existing pockets of excellence in a system. Address system inefficiencies by building on core system strengths, and norming existing high-performance behaviour models.
8. **Ensure change efforts are sustainable and replicable:** Build local ownership from the beginning; nurture the leadership and capacity required to sustain and replicate results long after outsiders exit.

The U-Process Innovation Lab¹² model will serve as the underlying methodological framework the *Consortium* will use to operationalize these principles. Distinguishing this model is an approach focusing on “whole persons” and “whole systems.” We make health leaders more effective by cultivating managerial, technical, and problem-solving skills *and also* by addressing the mindsets, attitudes, relationships, and core values that shape commitments, drive behaviour, and inspire others. We bring about system change by identifying points of leverage within a health system, and then supporting leadership teams to design and pilot change initiatives that address pivotal opportunities and bottlenecks.

Through the Innovation Lab, we convene teams of 40-45 current and emerging leaders working across a health system—with participation from government, business, civil society, and communities. Teams are tasked with identifying and testing solutions to address a specific health challenge. The team participates in a three-part sequence of workshops and field activities, including:

1. *Sensing:* Immersive learning to deepen awareness of constraints and opportunities in a health system. Learning may involve journeys to affected communities, local health clinics, national health planning offices, or even visits to health systems of other countries. Learning activities are integrated with training and coaching to build managerial capacity and shift mindsets and attitudes;
2. *Reflecting:* Opportunities for the team to reflect upon and integrate all they have learned, to gain perspective, to surface new possibilities, and to commit to new actions individually and collectively; and
3. *Prototyping & Piloting:* Iteratively designing and rapidly testing innovation concepts. Promising concepts are developed as prototypes and are subsequently tested at scale as field pilot projects, which participants themselves implement. Pilots are rigorously evaluated and those proven effective are adapted for mainstream institutionalization.

Innovation Labs are integrated into the surrounding social and political context, with national decision makers and influencers brought in early as project champions. (See Appendices 1 and 2 for Model Graphic & Participant Experience.)

Project Activities

The project is to be divided into five main activities:

1. **Assess Health System and Engage Namibian Leaders & Partners:** Assess performance of the health system, identify barriers and enablers to effective decision-making and performance, establish baselines, line up agreements with local partners and government agencies, identify health content frame (i.e. maternal/child health, nutrition, sanitation).

2. **Develop Curriculum & Recruit Faculty:** Use system assessment to build tailored curriculum, create curriculum delivery model, hire African staff and faculty, recruit Innovation Lab participants and champions.
3. **Conduct Innovation Lab:** Deliver 9-month Innovation Lab, involving a total of 40-45 participants, advisors and champions; build leadership skill through Innovation Labs and yield 2-3 Innovation Projects for piloting.
4. **Pilot Innovation Projects:** Identify target populations and baselines, secure government and other support, launch 2-3 Innovation Projects; evaluate impact and develop strategies and work plans to mainstream successful pilots.
5. **Replication and Sustainability:** Secure institutional housing for Namibia project, formalize Namibian Health Innovation Network, document and communicate learning, develop strategy to sustain and replicate the *Initiative* in Namibia and elsewhere in Africa.

Activities will be sequenced as follows:

Activity	Year 1				Year 2				Year 3	
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
1. Systems Assessment										
2. Curriculum Design										
3. Innovation Lab										
4. Pilot Innovation Projects										
5. Replication & Sustainability										

About the Consortium

Over the past twenty years, *Consortium* members have pioneered the development of a variety of complementary best practice and promising practice approaches to the challenges of multi-stakeholder partnerships, leadership development, high-performance teams, organizational learning and transformation as well as public problem solving and civic scenario planning. Consortium members possess extensive experience working in Africa. Each *Consortium* member, described below, is committed to placing their human capacity, intellectual resources, and accumulated knowledge at the disposal of the *Initiative*.

- **The Synergos Institute** develops effective, sustainable, and locally rooted solutions to poverty. Synergos – which means working together – engages partners to mobilize resources and bridge social and economic divides to reduce poverty and increase equity around the world. An independent, nonprofit organization founded in 1987, Synergos facilitates effective cooperation between communities, civil society organizations, government, and corporations to enable stakeholders to realize their social and economic development goals. Synergos’ programs catalyze partnerships that address complex development challenges, strengthen the organizational capacity of community development foundations, and convene the world’s leading philanthropists to deepen the impact of their social investments.

Synergos has a staff of 40 and a headquarters in New York City. The Institute has worked in some 20 countries across Asia, Africa, and Latin America. In Africa, Synergos maintains a three-person Cape Town field office and an extensive network of relationships across the continent, particularly in South Africa, Namibia, Zimbabwe, Kenya, and Mozambique.

- **Generon Consulting** represents a new breed of international consulting firm – one that is motivated by a desire to create a more equitable, peaceful, and sustainable world. Generon addresses the most vital challenges facing organizations and societies by creating breakthrough, system shifting innovations through the transformation of individual and collective patterns of seeing, thinking, and acting. Generon helps leaders of companies, governments, and civil society organizations create better futures. Generon is the creator of the Change Laboratory, which is based on the U-Process.

Generon's core competency is in applying the U-Process to "stuck" problems within and across organizations. Generon also has a strong presence in Southern Africa, including a senior associate based in Johannesburg. The firms' co-founder is a naturalized South African, based part-time in Cape Town.

- **McKinsey & Company** is a management consulting firm that helps leading organizations improve their performance. McKinsey works with private companies and public-sector bodies in the areas of strategy, operations, organization, and technology. McKinsey possesses decades of experience with large-scale transformation in the private and public sectors. Its mindsets and capabilities approach to leadership development is setting a new standard for performance enhancement among top corporate and public leaders. McKinsey has deep expertise in the area of global public health and has led numerous public health initiatives across Africa, particularly in the area of HIV. McKinsey's Africa operations are based in Johannesburg.
- **Society for Organizational Learning (SoL)/Presencing Institute** is an intentional learning community composed of organizations, individuals, and local SoL communities around the world. SoL/Presencing Institute is devoted to the interdependent development of people and their institutions in service of inspired performance and meaningful results. SoL/Presencing Institute serves as a space in which individuals and institutions can create together that which they cannot create alone. SoL/Presencing Institute was created to connect corporations and organizations, researchers and consultants to generate knowledge about and capacity for fundamental innovation and change by engaging in collaborative action inquiry projects. The SoL / Presencing Institute is an action research community that uses and advances the U-Process methodology to lead systemic innovation and change, and to generate business results, new intellectual capital as well as on-going personal and professional networks.

At the cornerstone of the *Consortium* is a preexisting strategic alliance between Synergos and Generon Consulting, formed in 2004, to apply the U-Process Innovation Lab methodology to global, regional, and national multistakeholder public problem-solving initiatives. The *African Public Health Leadership and Systems Innovation Initiative* is the fourth such project to be developed under the auspices of this collaboration. Among these joint activities is *Bhavishya*: Partnership for Child Nutrition, a historic public-private partnership to reduce child malnutrition in India. Bhavishya is now test piloting major *Innovation projects* developed through the Innovation Lab process.

Innovation Lab Experience: Partnership for Child Nutrition – India

Synergos & Generon have formed a global alliance with Unilever and UNICEF to create the Partnership for Child Nutrition. The global partnership's first activities are based in India, where the initiative has attracted a broad network of supporters and champions, including Tata Industries, ICICI Bank, the Self-Employed Womens Association, and the Maharashtra State Mission for Child Welfare. Together, the Indian and international partners seek to reduce the rate of child malnutrition in India by half by 2015.

The project has applied the U-Process Innovation Lab approach. On April 10, 2006 an Innovation Lab Team comprised of government, business, and civil society leaders convened for the first time. The project has succeeded in creating India's first ever tri-sectoral alliance for child nutrition. The team participated in a sequence of sensing, reflecting, and action-planning activities over several months. As intended, the process also yielded a number of on-the-ground innovation projects now being tested. Field tests are being conducted in urban and rural areas of Maharashtra State, covering a population of 2 million. UNICEF-India, the State Government of Maharashtra, Indian corporations, and non-profits are jointly implementing the pilots. Innovation projects focus on:

- Improving the effectiveness of Government feeding programs through inter-agency collaboration and community oversight
- Greater public education on nutrition and child health
- Improving nutrition information management and dissemination

Pilots will last approximately 12 months, after which successful initiatives will be adapted for mainstream institutionalization.

Citations

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- ¹¹ Government of the Republic of Namibia, Office of the President. “Namibia 2004: Millennium Development Goals,” published by The National Planning Commission, Government Office Park, Private Bag 13356: Windhoek Namibia, August 2004.
- ¹² The U-Process / Innovation Lab model was developed by Otto Scharmer, Joseph Jaworski, Adam Kahane, Betty Sue Flowers, and Peter Senge