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A Leadership Development Plan Of Health Professions Education Institution To Address Health Inequities In Myanmar

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Abstract

Myanmar is a rural and ethnically diverse country of extreme poverty, with one of the most poorly funded state health-care systems in the world. The 2020 census confirmed a population of 54.4 million people, and a maternal mortality ratio of 250 per 100,000 livebirths in 2017 (Bank 2020). The gap in life expectancy starkly illustrates this, with a range of 11 years between the highest and lowest values across Myanmar. Myanmar is prone to natural disasters, has a longstanding civil war during which human rights abuse and violence were and are commonplace, and the education system has an unstable infrastructure. (Lancet 2015). Myanmar is undergoing a complex political and economic transformation, from a long civil war and military regime to a peace process and democratisation. Since 2011, the Myanmar Ministry of Health has started to rehabilitate the fragile health system, setting the goal of achieving universal health coverage by 2030. To achieve this target, Myanmar will have to face substantial challenges; arguably one of the most important difficulties is how to allocate limited health-care resources equitably and effectively. Attention to the most vulnerable people would substantially improve national health outcomes. Myanmar is a country in which people's access to health services is determined more by where they live than their need for care, a situation that is fundamentally inequitable. The challenge is to reduce levels of inequity between different groups in the population and different geographical areas including minorities and those living in conflict-affected areas. Reducing health inequity should be declared a national health priority. This will require that both officials and the public become aware of what needs to be done to close the equity gap (Sein, Myint, and Cassels 2015). Crafting policies to mitigate rather than exacerbate health disparities needs professional and innovative leadership (Zaw et al. 2015). Producing and utilization of qualified professionals for health services, accredited transformed curriculum and quality health professionals can strengthen the health system (Reeve et al. 2017). The traditional "ivory tower" model of medical education is failing to meet the health and social needs of the underserved (Neusy and Palsdottir 2011). Communities can be mobilized and supported to take responsibility for their own health and promote health-seeking behaviour, becoming partners in developing solutions to their health challenges (Neusy and Palsdottir 2011). Transformational leadership change and developing new health professions education institution with appropriate transforming curriculum in global trend is crucial to solve the health inequity in Myanmar.

Introduction

This paper is to develop a new health professions education institution with appropriate transforming curriculum in line with global trend and local situation together with applying

appropriate leadership theories and models to fill the gap of health inequity. Among many leadership theories and model, the transformational leadership model will be used. In transformation leadership building, it is necessary to looks beyond the traditional curriculum and seeks the involvement of communities and other stakeholders which helps define the knowledge, skills, and attitudes around which new curriculum is built, and helps guide the selection of educational methodologies, taking into account context and resource constraints (Neusy and Palsdottir 2011). Transformational leadership is for all levels of the organization: teams, departments, divisions, and organization as a whole. Leaders are visionary, inspiring, daring, risk-takers, and thoughtful thinkers. Health professional educational leadership involves processes on the levels of students, teachers as community and at the organizational level (Laksov 2017). Students of socially accountable schools were more likely to stay in rural areas and serve disadvantaged to meet the needs of underserved communities (Reeve et al. 2017). Transformation of medical education and medical practice into more socially accountable endeavours that improve health system equity and performance (Neusy and Palsdottir 2011). A framework of leadership competencies for health professional education can be drawn from global knowledge and experiences but must be relevant to local context. Competencies such as self-awareness, self-regulation, commitment, motivation, enthusiasm, empathy, social skills, decisiveness, courage, and integrity emerge as universal set of requirements, which can be learned and developed. Since these competencies are contextualized for interdisciplinary work, further research is desirable to assess sustainable individual and organizational gains in case of changes in the team composition within the healthcare settings (Negandhi et al. 2015). To instil the culture of rapport, inspiration, or empathy to engage followers with courage, confidence, and the willingness to make sacrifices for the greater good in any context by valuing people, listening their needs and problems, showing care, trust and humble is ideal. As a leader in health professional, one must be visionary, passionate, creative, flexible, inspiring, innovative, courageous, imaginative, experimental and initiates change. A leader must be having a solid familiarity with the tasks of different levels; developing a sense of responsibility of staff: helping to develop good character that will help the team, carrying out staff professional responsibilities; ensure that tasks are understood, supervised, and accomplished. A leader must also be able to communicate effectively. Good communication skills enable, foster, and create the understanding and trust necessary to encourage others to follow a leader. Without effective communication, a leader accomplishes little (Barrett 2006).

The four ‘I’’s of transformational leadership have to be adopted:
(1) Idealised influence
(2)Inspirational Motivation
(3) Individualised consideration
(4) Intellectual stimulation (van Diggele et al. 2020).

To be an effective leader, good time management, organisational skills, the ability to network professionally, strong communication skills are most important factors. Readiness for acceptance of feedback and self-awareness are also important in development of leadership skills. The leader facilitates the expression of leadership, when and how to stand back, support and enable others to lead, managing personal and professional practice. Emotional intelligence such as self-awareness, self-regulation, motivation, empathy, and social skill are essential. It is also need to realise that titles are not always linked to leadership roles. The role of today’s leader requires stepping forward, collaborating, and contributing. A good leader is

a good team player who values and seeks the opinions of others. Leadership requires clear, respectful communication that acknowledges the input and achievements of others (van Diggele et al., 2020). To improve the people, building organizational trust, gaining trust and instilling collaborative culture in organisation together with information sharing and problem solving are accountable. Firstly we need to understand the trust which is defined as "the willingness of a party to be vulnerable to the actions of another party based on the expectation that the other will perform a particular action important to the trustor, irrespective of the ability to monitor or control that other party" (The, Review, and Jul 1995). Then follow by building trust in collaboration of stakeholders and instillation culture of collaboration, Changing mindsets and embedding new mindset of people in organization (Casey Jr. 2019). We also can apply with VUCA (Volatility, Uncertainty, Complexity, and Ambiguity skills). The level of skill represented in these descriptions would be adequate in an environment in which most decision-making situations involved individuals or small groups and clear rules or guidelines could be applied. VUCA make decisions, plan forward, manage risks, foster change and solve problems (Binar 2019).

Sampling Method – Universal sampling for academicians and students in faculty and purposive sampling for collaborators and stakeholders to be included in the programme.

Impact Measurement

Stakeholder Mapping and Analysis will be done to monitor transformational leadership process and implementation while improving curriculum review meetings and workshops with faculty members. Scoreboard keeping, lead measures, lag measures monitoring will be done weekly, monthly, and annually. Monthly curriculum review meetings with collaborators, health service providers, academicians, and student representatives will be regularly done for monitoring and development. Baseline indicators of health care will be collected and recorded to compare after new curriculum is developed to assess the effectiveness of transformational leadership and new curriculum with efficient manpower and collaborators with pre and post intervention method. Improvement of faculty members, student outcome, healt care providers of newly produced graduates, and health inequity improvement can be assessed by using the 4 D's of Execution for transforming leadership:

- **Discipline 1 – Careful focus on a clear lag measure**: Conventional Medical Curriculum and delivery are inappropriate with community need.
- **Discipline 2 – Acting on the high-leverage lead measures**: Producing and utilization of qualified and ethical professional human resources for health services, accreditation of newly transformed medical curriculum for health professions education institution. Tracers study of new graduates will be done to track the health services they provide for quality and outcome.
- **Discipline 3 – Regular scorekeeping and monitoring of the lead measures and the lag measure:** A compelling scoreboard engages people and keeps them on track toward the goal.
- **Discipline 4 – The cadence of accountability**: the weekly, monthly, and annual meetings with members who have the same goal, intersectoral collaborators, health service providers, academicians etc. Check the scoreboard, celebrate successes, and to improve if there are limitations (Covey 2015).

Feasibility

Curriculum review process and conducting workshops in two academic years to produce new curriculum and manpower capacity building workshop monthly. Professional content experts will be invited for workshops and finding reference institution accreditation process should be planned. Financial support and budget allocation for curriculum review process should be planned. Sufficient budget for implementation and impact evaluation of curriculum review and transformational leadership of Health Professional Education Institution should be allocated. Perspective coordination, contextual thinking, decision-making process and collaborative capacity will be applied throughout the programme.

Conclusion

Transformational leadership change and developing health professions education institution programmes with appropriate transforming curriculum is a form of social innovation in health care and also a basic need for strengthening health system and one of the solutions of health inequity in Myanmar.

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