Guest editorial

Exploring types of leadership in the delivery of global health services

Last year is etched in our minds as one where the world came to a standstill. The coronavirus, initially contained in certain parts of East Asia, rapidly spread across the globe. Even when the World Health Organization announced that COVID-19 had attained the status of a pandemic, few countries gave it the attention it warranted. As a result, what started as mild skepticism turned to panic and fear as COVID-19 brought countries to their break points. At the time, the prevailing wisdom was that having faced Ebola, SARs and other communicable diseases in the past, the world was already adequately equipped to tackle this pandemic. Yet, as the weeks passed with more and more massive death tolls, it became increasingly clear that the world is not ready and prepared to deal with this pandemic.

In 2017-2018, I directed the Ohio Wesleyan University Sagan National Colloquium on Global Health Challenges for the 21st century. The Colloquium was devoted to an investigation of global health challenges in both the developed and developing world by addressing new and emerging infectious diseases. It explored specific roles played by governments and nongovernmental organizations in promoting health and also explored health-care strategies used in different world communities to overcome disparities in health-care access. Faced with the present crisis, and in an attempt to better understand COVID-19 and its impact on different populations, I considered the following questions:

Q1. How has COVID-19 been examined through the lens of multiple perspectives?

Q2. What are the social determinants of health? What part does it play in our understanding of the disease?

Q3. What specific approaches are appropriate for a general discussion of this pandemic? Does the biological and or medical model yield the most useful information for understanding the epidemiology of this pandemic? Or should another be considered?

Q4. What might using the "social constructionist" approach teach us about the way COVID-19 is experienced in different communities globally?

Q5. How have other countries approached and addressed this pandemic? What best practices are there for other countries to employ?

Q6. Finally, is COVID-19 a *new* pandemic? In other words, are the ways we historically responded to pandemics such as SARS, HINI, Ebola and HIV/AIDS a sufficient response?

II. The Role of Scientific Research in Responding to COVID-19

Globally, until recently, countries headed by women (Germany, Denmark, Norway and New Zealand) have done better in flattening the curve than countries led by men. Although different countries have used different techniques in dealing with COVID-19, it has been made abundantly clear that scientific research yields better approaches to dealing with the pandemic than other unscientific and untested and non-verified approach to the pandemic. This is because scientific inquiries can potentially identify risk factors and particularly vulnerable groups. For example, in the USA, Werner *et al.* (2020) surveyed 2,558 people and concluded that 75% of cases were among individuals aged 35 and older.

Leadership in Health Services
Vol. 34 No. 3, 2021
pp. 217-219

1751-1879
DOI 10.1108/LHS-07-2021-099

Research found that individuals with underlying medical conditions – such as those with history of asthma, cardiac diseases and obesity – were also more severely impacted by the disease. Among ethnic minority groups, the data suggests that minority groups had infection rates three times the rate of the majority. Rather than blaming the victim, we need to explore the social determinants of such trends. For example, minority groups may be more likely to be "essential workers," have less flexibility to work remotely or have less choice is using public transit. The logical approach is to seek information from multiple sources and authors to be informed about trends and to be able to be proactive in developing the necessary tools to allow us to manage the pandemic.

Our approach should not ignore legacies of discrimination because of unequal distribution of resources or prior acts of systematic exclusion and isolation. Although the use of socioeconomic status might be useful in explaining the disparate impact of COVID-19 on other populations, it is likely an incomplete explanation. One must also consider how health-care structures – namely, its financing and accessibility – might impact those with limited means and those who lack significant political power in negotiating access to healthcare and ultimately access to the COVID vaccine. It is notable that countries that have well-developed safety nets were successful in cushioning the negative effect of the pandemic on the economic circumstances of families. Similarly, countries guaranteeing universal healthcare also appear to have done well in mitigating the health effects on families. This data provides insight into how (and why) social determinants and health-care access can play a role in the disease's effect on certain populations.

Global attention has focused on how developed countries have been able to flatten the curve – yet very little is discussed about the success of *developing countries* in minimizing the spread of the virus. The data on developing countries presents a clear lesson: even though they are hampered by poor and inadequate intensive care beds and limited access to ventilators, the evidence suggests that proactive measures taken by governments through vigorous public health campaigns, easy access to testing and effective policing of quarantining has worked to stem the tide. It has also been suggested that leadership has played a big role in this effort. Thus, as discussed by Waffa Sadr and Jessica Justman (2020:e11), "confronting epidemics is not new to Africans and their experience may prove to be an advantage." They argue for a global push through coordinated efforts by the international community to use effective techniques through vaccine distribution to help developing countries stem the tide of the COVID-19. They also caution us not to drop the ball in investing in existing health challenges facing the continent.

A final word

Underlying this special edition is the recognition that different contexts and cultures will require different types of leadership. With that as the organizing principle, we recognize the complexity of global issues related to both public and medical health and the myriads of possible strategies for dealing with them. At the same time, there is a strong sense that no single style of leadership has an edge in the search for effective solutions to health service delivery issues around the world. Cultural issues and differences will provide many different leadership strategies as reflected in the papers included in this issue. As presented in this special edition, cultural issues and differences in approaches to healthcare and different leadership strategies shape our understanding of health-care systems function against the constraints of limited financial resources. The journal attempts in this special issue to document real-life research projects, case studies and descriptions of some of the leadership

initiatives underway, recognizing that in sharing this knowledge, the issue may provide insights into best practices and improved health services delivery for both marginalized groups in countries with less than developed health service provision and indeed the entire global health community.

We thank the authors for their contributions, and we believe their works have enriched the diversity, depth and breadth of what we strive to achieve with this special issue. It is indeed an honor to have had the opportunity to work with you to bring your works to fruition. Your works have enhanced and contributed to the existing body of knowledge and research worthy of this edition.

Randolph Quaye
World Studies Department, Ohio Wesleyan University, Delaware, Ohio, USA