Learning to lead
by Sumedha Khanna

Four hundred years ago, stone sculptors in the village of Tinjan, in the Istrian district of what is now Yugoslavia, hewed a granite table several metres in diameter, its surface carefully carved with floral designs. The round table was placed in a churchyard which had been formed by building a lofty stone retaining wall to wrest space in the mountainous terrain. Throughout the centuries squat segments of a cylindrical column served as stools for the village leaders who gathered at the round table, taking counsel on the village problems and agreeing on solutions. The villagers sat about or stood and listened to the deliberations of the leaders, whose vision grew as they looked across the valley to the mountains rimming the horizon.

Four hundred years later, a group of health leaders positioned themselves around this table, shaded by huge trees much younger than the table, to share their personal experiences and exchange thoughts on initiating and sustaining leadership development. They came from Australia, Cameroon, India, Kuwait, Mozambique, Pakistan, Somalia, Tanzania, Thailand and Yugoslavia, representing many and varied cultural backgrounds, each reflecting unique experiences, each drawing upon energy generating from personal driving forces. They had evolved as leaders through developing their own lifetime values and relied on these to guide them through the challenges they faced—challenges which evoked changes within themselves as they tried to help others too to become leaders.

The roads in Don Yai village in the Khong District of northern Thailand are not paved, but are cut from the same soil that the villagers till. Alongside one such road, adjoining a cluster of ten households and nestling under the cool shade of palm trees, is a small circular building. A used tyre fastened to a post is painted with Thai letters which identify the hut as the cluster meeting place. The thatched roof encircles a tree which serves as the main support and shelters the handmade wooden benches. A blackboard is fastened to the supporting tree.

Thai writing on the blackboard defines indicators for measuring the quality of life for the families comprising the cluster. The village leader has participated with the villagers in defining these indicators, discussing with the heads of households the status of progress towards their goals and determining what needs to be done by the cluster, individually and collectively, to generate further progress.

Recently a group of health leaders from Bangladesh, India, Indonesia, Malaysia, Sri Lanka and Thailand sat on the benches under this thatched roof. Some remembered their own roots which had grown in villages such as this, reflecting on the long, yet gratifying, road leading to their own achievement of leadership. Through an interpreter, the village leader explained how the basic minimum needs of the villagers, including health, were assessed so that the village could achieve an acceptable quality of life for its people.

The masonry arches of the community centre in the village of Tilonia, in the Ajmer District of the state of Rajasthan, are hint at former Mogul influence. But the village lacks such pretension. Its location on a sun-baked plain allows few trees to afford shelter from the ubiquitous glare of sunshine. Goats close-crop that pasture which has not been mowed for cattle. To foreigners the environment may seem somewhat forbidding, but to the families of Tilonia this is home.

Seated on a mat on the floor of the centre, flanked by six other women, shawl-draped leaders from the Tilonia area, a social development worker explains how these women became leaders in a culture not readily conducive to such a happening. She relates how these women-leaders had the determination to learn to read before they could specify what activities would become the major focus of their work. She describes how, with her own urban middle-class background, she had to change, to acquire new values, in order to gain the respect and confidence of the village people. For only in this way could she enable others to take charge and become leaders in determining their own well-being and quality of life.

Seated on mats in the same room, a group of leaders of health-related and academic institutions from Australia, China, Indonesia, Japan, Kuwait, Pakistan, Saudi Arabia, Sri Lanka, Thailand and Yugoslavia listened to the experiences in leadership development of these women at the village level. The group learned that, even among illiterate and seemingly backward communities, there was potential for leadership. They appreciated that, in developing leadership, many intrinsic changes must be undergone in order to tune in to the local environment and to gain credibility among the local people.

These and many other similar scenes have become the milestones...
of the health leadership development initiative launched by the Director-General of WHO in 1986 to support Member States in their commitment to move from policy to action in pursuit of the goal of Health for all. The principal aim of this initiative is to create a critical mass of people capable of providing leadership within the Health for all movement for all movement in each country.

It is not easy to learn to be a leader. There is no simple formula, no vigorous classroom exercise, no cookbook approach that leads to successful acquisition and development of leadership qualities. It is essentially a deeply human process, relying upon personal potential, resourcefulness, intuition and insight. It is both inward-looking and forward-looking.

It is not easy to train others for leadership roles. There is much experience worldwide in the training of managers and senior executives, but there is little for leaders, especially leaders in the social development fields. Leaders engaged in the human aspects of the development process derive their principal energy from the innate values which they acquire and hone during their lifetimes. They are also perpetual learners. Learning is the essential fuel for leaders because they learn from past experience and from response to the future. They know that the process involves "unlearning" as well, the necessary discarding of irrelevant and orthodox knowledge.

These leaders are not "born." They are present in every setting, at every level. Once identified, they must not only be given suitable opportunities, but their leadership capabilities, which are value- or mission-oriented and based on personal, real-life experiences, must be enhanced as well.

What are these "qualities of leadership" which are understood to be crucial to the mission of Health for all? They are: concern for social justice; compassion for the under-privileged; dedication to the growth of self-reliance; strong commitment; ability to communicate; courage to take risks and make bold decisions, and faith in people's potential.

What are the specific "leadership tasks" related to the Health for all movement? They can be summarized as follows: to be fully knowledgeable about Health for all and the strategies for its achievement; to be able to identify central issues affecting the carrying out of national strategies; to realise and specify one's own personal role in resolving those issues which fall within the scope of one's responsibilities; to define strategic actions needed to resolve these issues, to involve and mobilise others by infusing a sense of purpose and a focus of action; and to enable others to take charge and to lead.

It is readily apparent, then, that the dialogue approach is both logical for and relevant to leadership development. Designed to achieve maximum participation, the approach has proved successful in stimulating the shift from intellectual to emotional commitment and the will to translate this commitment into action. Further, the philosophy of the dialogue allows the participant sufficient time, opportunity and support for reflection in a relatively unstructured setting, within which each person can feel freed, opened and "unfrozen."

Dialogue discussion is conducted in a comparatively informal, non-directive manner in which members of the group "set the course." The function of the discussion is to examine one's own ideas, feelings, attitudes and opinions with a view toward modifying them and incorporating insight as well as another's experience and ideas. Thus, the participants feel that they are involved in creating something from within themselves and for themselves, and begin to see things in a new light.

Exposure to real-life experiences of other leaders is an integral part of the dialogue process. Sharing experiences on how issues have been tackled, and how the difficulties and obstacles have been resolved generates consensus building. In a spirit of open cooperation, participants reinforce each other's ideas and gain confidence and support.

The dialogue also serves as a trigger for generating personal commitment to the leadership role. It sharpens the ability to identify required changes and provides the vision of how these changes can be effectively brought about. Because knowledge alone is not the principal basis for development, leaders need "emotional energy" and an openness to self-appraisal to permit forward movement. Participants also realise that differences in opinions and experiences are opportunities for expanding one's own viewpoints and learning, that each is a reservoir of knowledge, skills and experience waiting to be drawn upon and shared. Participants in one such dialogue concluded: "They had so much to say, so much to share, so much to give, that the solutions were right there."

These dialogues require very sensitive, perceptive "facilitators" who fully understand their role. Rather than trying to control the group's energy, they allow the group action to emerge naturally and learn to trust what is happening. Such facilitating also requires the kind of leadership which does not impose a personal agenda or value system, which is open to whatever emerges, which judges no one; in other words, leadership which enables others to lead.