Lessons in Leadership

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Lessons in las respuestas son excedentemente más
complejas y requieren un cambio comple-
Leadership to de pensamiento, orientación y compor-
tamiento que nos incluyen. Este ensayo
es sobre un viaje personal de aprendizaje
MAY KHADEM acerca del liderazgo el cual revela suposi-
ciones falsas ampliamente compartidas
Abstract que han llevado a muchos fuera de rumbo
As individual health professionals and al atender los desafíos en la lucha contra
institutions struggle to address health la ceguera.
disparities worldwide, it becomes in-
creasingly apparent that the answers are Despite the trillions of dollars spent
exceedingly complex and require a com- on addressing health challenges in the
plete change in thinking, orientation, and world over the past several decades,
behavior that includes ourselves. This pa- the problems of extreme poverty,
per is about a personal journey of learn- hunger, disease, and social injustice
ing about leadership that reveals widely remain dire. The world has failed to
shared false assumptions that have led address the well-recognized major
many off course in addressing the chal-
global issues of our time—climate
lenges in the fight against blindness as
change, pollution, economic failure,
well as other public health concerns.
extreme inequality, homelessness, and

Résumé

Au fur et à mesure que les professionnels de la santé et les institutions s'efforcent de remédier aux inégalités en matière de santé dans le monde, il devient de plus en plus clair que les réponses sont extrêmement complexes et exigent un changement radical de nos façons de penser, de nos orientations et de nos comportements. Le présent document décrit un cheminement personnel d'apprentissage du leadership qui dévoile de fausses hypothèses largement répandues qui ont mené bien des gens à faire fausse route en tentant de relever les défis qui se posent dans la lutte contre la cécité.

Resumen

A medida que individuos profesionales de la salud e instituciones luchan por atender disparidades de salud alrededor del mundo, se vuelve cada vez más aparente que

violence, among many others.

According to the World Economic Forum's 2015 "Survey on the Global Agenda," a surprising eighty-six percent of respondents perceived a global crisis in leadership. The most distrusted were religious leaders, followed by leaders in government, business, and non-governmental agencies (14–16).

Even heads of charitable organizations were suspect, with only half of the respondents showing confidence in them. Among the key ingredients identified for successful leadership were morality, prioritization of social justice, empathy, collaboration, courage, a global perspective, long-term planning, and good communication skills (14–16). Ironically, when the World Health Organization (WHO) evaluated its initiative "Health for All by the Year 2000,"1 a global plan to provide primary healthcare to all the world's citizens, the initiative itself

solution seemed very simple to me—go to these countries, find the blind people, and cure them!

was deemed a failure—not because of lack of resources or know-how, but for lack of "moral leadership" (WHO, "Report" 7).

When I started my career as a young ophthalmologist, I was very idealistic. I knew there was a lot of unnecessary blindness in the world, and I wanted to be part of the solution. At the time—in the early 1990s—it was estimated that there were 45 million blind people and another 200 million with low vision (WHO, "Vision 2020" 3). These numbers have not changed significantly over the past few decades (WHO, "Blindness: Vision 2020"). Most visual impairment—almost eighty percent—is avoidable; that is, it is either curable or preventable (WHO, "Blindness and Vision Impairment"). "What an opportunity," I thought. I presumed that surely those dedicated to the fight against blindness should be able to address its leading causes worldwide. Since half of blindness was due to cataracts and a simple operation could restore sight, at least this

Well, I have since learned that all is not so simple. In fact, responding to such a problem is exceedingly complicated. As it turns out, it is not sufficient that individuals be treated; rather, whole systems must simultaneously be transformed. And to treat problems at a systemic level, one needs unity of vision and purpose. In short, the key to bringing about a solution is leadership. To support this argument, I would like to share my journey of learning about leadership over more than thirty years of work, spanning thirteen projects in ten different countries.

EMBARKING ON A JOURNEY

I started my career working for the International Eye Foundation in a project funded by USAID2 in the Caribbean island nation of Grenada, a tiny country less than ten by twenty miles with a population of 100,000. After the United States invaded the country in the mid-1980s, the lo-

particular cause could be easily treated. The global blindness prevention community had knowledge and skills, and all that was needed was to mobilize these resources. Since most of the people blinded by cataracts lived in poor and middle-income countries, the

1 For more details, please see the World Health Organization's "Declaration of Alma-Ata." International Conference on Primary Health Care, 1978.

blindness and visual impairment in the world occurs in low and middle-income countries where fewer resources are available, and Grenada was such a country (WHO, "Vision 2020" 3). There, I learned that it is possible to transform an entire healthcare system and make it sustainable. Grenada went from being a country with no modern eye care to one in which comprehensive eye services became available—and are still functioning to this day.

At the time, I wasn't really sure what the essential prerequisites for success

cal infrastructure had to be rebuilt.

The project in which I was involved sought to create and make sustainable a national eye care system from the ground up. Almost ninety percent of people blinded by cataracts lived in

2 United States Agency for International Development, an independent agency of the US federal government that is primarily responsible for administering civilian foreign aid and development assistance.

While the inhabitants accepted it, they understandably resented it. We had never before witnessed such distrust of foreigners, sometimes even manifested as open hostility. It surprised us, but it also forced us to re-examine our assumptions. We learned our first important lesson there.

Lesson 1: Charity is not a long-term solution. It has a role in times of crisis and for disaster relief, but to use it long-term is harmful. It disempowers local resources, creates dependency,

were, but the experience changed the course of my life.

When I returned to the United States almost three years later, I joined an ophthalmology practice in Chicago, but my heart was still taken with health development in areas of need.

And so, for the next two years, together with some colleagues, I made short visits to the Turks and Caicos Islands and to Guyana to offer services where resources were lacking. Turks and Caicos was particularly underserved: eye care, and eye surgery in particular, were only available intermittently through the International Eye Foundation (the sponsor of my work in Grenada),[3] which would recruit ophthalmologists to travel there for surgery every six months or so. This method of ministering to eye care in Turks and Caicos had been going on for years; the country was totally dependent on foreign charity.

3 Details regarding the work of this foundation can be found on its website: www.iefusa.org.

and strips people of their dignity.

I have come to believe that in many cases, sustained charity is like giving sugar to a diabetic who is having a hypoglycemic episode. It may be life-saving in the short term, but it exacerbates the illness if continued long-term. When we reflected on our learning with other like-minded colleagues, we realized that we shared many experiences. We tried to imagine what a Bahá'í-inspired effort might look like. How would the approach to health development be different if it were informed by the vision of the oneness of humanity and the imperative of social justice? In 1991, we had the opportunity to make a trip to Albania just after the government had transitioned from a dictatorship that had kept it isolated from the rest of the world for over fifty years. We assembled a group of three physicians in different specialties (a pediatrician, a dermatologist, and an ophthalmologist), together with a teacher, a nutritionist, and a businessman, and in this space did: a combination

of
went on a fact-finding mission to Al- charity and technical assistance.
At
bania, hoping to find opportunities for the time, “capacity-building”
was the
service where we might experiment new buzzword among organizations
with a different model. Meanwhile, working in development. It sounded
one of the colleagues we were con- great, but in reality, it was
reduced to
sulting with had been a volunteer in “technical transfer of
knowledge,”—
Honduras at Hospital Bayan, also a still an improvement over the
tradi-
Bahá’í-inspired initiative, and encour- tional model, whereby visiting
experts
aged us to collaborate more closely would provide all the care.
with that institution. We had also been One of Health for Humanity’s
ini-
encouraged by then-member of the tiatives had developed into a
ten-year
Universal House of Justice Dr. David project5 to help develop eye
services
Ruhe to collaborate with the Bahá’í in Albania, which, due to its
fifty-year
community in Guyana in their efforts isolation, still had services and
in-
to provide health services for the Am- stitutions pre-dating World War
II.
erindian population in the Rupununi Through this project, we got busy
region of Guyana. As these oppor- providing training by sending
volun-
tunities developed into projects, the teers to Albania to offer it
locally and
need to formalize our efforts resulted by sending the local
ophthalmologists
in the founding in 1992 of Health for abroad for more specialized
versions.
Humanity, a Bahá’í-inspired health de- We equipped six eye centers
(Tirana,
velopment organization. Vlorë, Peshkopi, Shkodër,
Korçë, and
We began by applying for grants Elbasan) so that the entire country
and undertook efforts to address a would have access to eye care
services.
variety of health concerns, including We also helped to develop a
resident
the leading causes of blindness. Based training program at the University

on our past experiences and through study of others' learnings,4 we appreciated the fact that we had to focus on building local capacity rather than creating dependency on charity. The problem was that we really did not know how to go about doing this. We did what most organizations working

4 In particular, we read messages on social and economic development written by the Universal House of Justice in 1983 and 1993, as well as guidance from the Office of Social and Economic Development at the Bahá'í World Centre.

these problems, but at the time, we did not know how to achieve this. This is when we learned our next important lesson.

Lesson 2: "Capacity-building" is not just technical transfer of knowledge.

Halfway through the project, we came across the work of Dr. Eloy Anello and the training in "moral leadership" he developed at Nur University, which he had founded in rural Bolivia.6 The

Eye Hospital in Tirana.

Throughout the project, we noticed problems: some equipment ended up in places we did not intend, some went missing, and local decision-making favored nepotism and short-term agendas. If we were to bring about meaningful transformation, something was missing. It seemed to us an ethical framework that all could agree to might protect the project from

5 Funded mostly by the Open Society Institute (www.opensocietyfoundations.org), as well as a number of smaller donors.

our program. Although several projects received this training, we had to face the fact that we did not have an effective way to measure its impact or a means whereby we could incorporate it in a systematic way. Our work in this arena was thus a bit haphazard. We really did not have a deep insight into its transformative power until ten years later, when we did an evaluation of the Albania Eye Project at its termination, reviewing the work at the six eye centers and interviewing doctors,

nurses,
training he had instigated was struc- residents, and patients to
tured to help participants explore understand
their assumptions about leadership, the changes that had occurred.
human nature, and dysfunctional ways The first thing we noticed
of thinking that interfere with mean- was that
ingful progress. Once participants de- the doctors we had trained had
velop these insights, they are assisted become
in embracing those particular ethical quite prosperous, with beautiful
principles that will become a founda- homes
tion for their work. We all felt this and luxurious lifestyles. Eye
conceptual framework might help us. services
Consequently, with the help of Dr. were available throughout the
Anello (and of his colleagues),7 we coun-
began to introduce this training into try, and the ophthalmologists
the Albania Eye Project and into a were
new project we had just undertaken to well-trained. Albanians could
combat river blindness in Cameroon. receive
The participants' response to this quality eye care at centers
training was very enthusiastic, even accessible
quite moving. As a result, we became to them, and the cataract surgery
convinced that this framework for rate
training would be a helpful addition to had increased more than
6 For details, please visit www.nur.edu. twentyfold.
7 We are greatly indebted to Charles Some patients were even coming
Howard and John Kepner for their dedi- from
cated assistance with this training for the nearby Kosovo and Macedonia for
treatment. Naturally, we deemed
all
this to be a propitious result.
But we also learned about
anoth-
er outcome that was, instead, very
disturbing. Those receiving this
care
were the same people who used to
get
it in nearby countries, such as
Greece
or Italy. In other words, those
who
could afford the services were the
ones
who had access. However, the people
who could not afford to pay—the
very
populace we were most concerned

staff in Chicago and for projects in Albania, Cameroon, Mongolia, and Argentina.

The problem of avoidable blindness, while perhaps somewhat less urgent, was still very much a problem!

Then, in the course of interviewing the staff we had worked with, we had a breakthrough. At the end of every interview, we would ask if they wished to share anything we had not specifically asked about. The head nurse told us:

> The leadership training changed my life; it was the best part of the project . . . You gave the nurses value. It helped us to appreciate ourselves . . . After that, I changed my style of communication with those under me. They saw a difference in me and they liked it. It changed them too. They work differently now. Since I changed my behavior with my subordinates, they changed their behavior with each other and with the patients. It was a new experience . . . . The way we organize our work changed completely . . . . We never used to prepare the patients for surgery. We never said anything to them. We talk to patients now. We explain everything and answer their questions. We have a new relationship with each other and with the patients. Even the doctors are happier. We have a new vision now . . . and it

its incorporation into the nursing school curriculum.

We were so excited to learn about the training's impact that we re-interviewed the attending doctors and residents. One former resident told us:

> The training completely changed the way we worked. Before, we didn't even know each other's names and everyone was competitive and private with information. After, we saw that it is better for us to help each other and to share information. We were much happier after and learned more. (Health for Humanity)

However, a senior doctor summed up the sentiments of his colleagues by saying, "It was like a good movie. It was great at the time, but when it was over, it was over" (Health for Humanity). Since the nurses, the ones with the least agency in the healthcare hierarchy, were most impacted by the training, and the senior doctors the least, we concluded that the impact was inversely proportional to the degree of agency people had. The residents felt the impact, though to a lesser degree than the nurses. The senior doctors only recalled a pleasant memory, but it did not change their behavior. What we had witnessed seemed

is growing as we learn more . . . to be a powerful way to mobilize the (Health for Humanity) talents of the entire workforce. We came to believe that if this kind of

He told us he had provided the moral leadership training for his staff and he even took the initiative of arranging

training were intimately woven into all aspects of medical and surgical training, it could help create a shared

ethical/moral framework that all would be more likely to honor. Clearly, without such a framework to guide decision-making, healthcare workers' technical skills and knowledge would not necessarily benefit their community. In some instances, they might even cause harm if used for personal gain at the expense of patients' welfare.

And so it was that we encountered the next lesson in this organic process of learning about building capacity.

Lesson 3: True capacity-building has an indispensable spiritual dimension.

Throughout this period, Health for Humanity was collaborating with WHO and with the International Agency for the Prevention of Blindness (IAPB)8 and sharing learning with other non-governmental organizations working in this area. We

Health for Humanity. The survey was sent out to 147 individuals. Of these, sixty-one responded, a 41% return. The survey results showed that of the total respondents, 93% felt that moral values were essential to their success; 83% said effective leadership is a significant challenge for them; 66% stated that technical training failed to deliver the desired results; 54% were having significant problems with honesty and trustworthiness; and 32% said their projects were struggling or not effective at all. Almost all stated that some equipment or funds were diverted to unintended uses in their projects.

When asked to rate the ingredients for success, 74% rated moral values and ethical behavior as the most important and surgical skill and academic knowledge as the least important! When asked to prioritize ingredients for success, the top three were strong core values,

ser-
met annually and reviewed progress toward the goal of an initiative called "Vision 2020: The Right to Sight," a global plan for the elimination of avoidable blindness by the year 2020.[9] We were curious about the experience of other organizations, so we sent out a survey to the institutional members of IAPB. At the time, IAPB had ninety-four institutional members, eighty of which were non-governmental organizations, including our own

8 A multilateral organization that collaborates with WHO to oversee and coordinate efforts to eliminate avoidable blindness.

9 https://www.who.int/blindness/partnerships/vision2020/en/.

vice orientation, and honesty. These respondents were the global leaders in their field and, to our amazement, they were forthrightly acknowledging that moral values are indispensable to success in addressing public health challenges! Clearly, what we were experiencing was shared among other organizations working in health development, and very likely was common in international development in general. When we shared the survey results with the IAPB member institutions, we were invited to offer the leadership training to these organizations at the agency's next quadrennial General Assembly, in Argentina in 2008. The anecdotal stories we heard, together with the survey results and the unexpected interest from member organizations and from multilateral agencies, convinced us that there is a great need for this kind of training. We now had the objective evidence.

resistance we felt made us question whether change, let alone transformation, was even possible. However, we reminded ourselves that it was a process, perhaps slow in the beginning, but gradually transformative as people found their voice and began to claim their agency.

Lesson 4: There is growing consensus among leaders in health development that without the moral/ethical dimension, [illegible] We saw evidence of this change two years later when one of the doc-

mension, development efforts will not succeed.

Meanwhile, just as the Albania project ended, Health for Humanity received funding to carry out a more modest project to train cataract surgeons in Ulaanbaatar, Mongolia. We were increasingly convinced that values-based training had to be intimately integrated into the project so we tried to weave it into all activities. We used the materials developed by Dr. Anello and translated the manual into Mongolian.

At the time, Mongolia's healthcare system had a deeply entrenched authoritarian style of leadership. One person made all the decisions, and everyone else deferred. Nevertheless, we were able to convince the director of the eye department that the training would be helpful to everyone, including her. She gave her blessing and even participated, but it was not easy for her.

After decades—maybe even centuries—of passivity when it came to expressing individual opinions or problem-solving, it was very hard to engage the doctors, and very hard for the boss to share authority. The . . . After the second training, ten

tors from Mongolia shared the following comments in her presentation at the 2008 IAPB General Assembly:

> This training was totally different from others, as we had had only technical assistance from different NGOs. We always talked about academic knowledge [and] clinical and surgical training, but the importance of changing attitudes and behaviors in order to achieve something had not been considered. So, the training made many people think about who we are, what we are doing, and where we want to be . . . I think the most important impact of the training was that people started to express their views. Before, it was rare to hear anyone share what they truly felt in the larger group. There was a fear to talk about the real situation. But after the training, we felt like we got new eyes to see things around us. Now at the different meetings, those who participated in the trainings are not afraid to express how they really feel . . . Now, we make decisions through consultation within the group

and try to include all the doctors training in our development efforts. However, we were still experiment-

ophthalmologists from different hospitals in Ulaanbaatar decided to meet regularly to solve problems and make decisions . . . .

We were thrilled. They had learned about consultation! This one capacity was by far the most vital tool for learning and problem-solving. Now they were unstoppable, and we had learned another lesson regarding the training program.

Lesson 5: Consultation is the most powerful means for continuous learning and improvement.

Our greatest confirmation about the power of consultation in this organic process came from Mongolia's State Secretary for Health, Byambaagiin Batsereedene. "I remember how bad the conditions used to be, and now the eye department is a modern department with high quality services," she said. "However, it is not just the technical improvement that is noticeable," she continued. "There is something else I have not seen before. The doctors treat the patients differently . . . . The ophthalmologists . . .changed . . . . They have a very good relationship with the ing. We had not yet standardized the training. But we had learned that a spiritual framework, when combined with the capacity for consultation, becomes a powerful force for change and transformation.

Lesson 6: The outcome of a spiritual framework applied through consultation is measurable systemic transformation.

When work is informed by spiritual principles and learning is applied through consultation, the resulting change is apparent in both quantifiable material outcomes and in qualitative transformation of relationships.

The resulting ripple effects can be far-reaching.

As the Mongolia project was winding down, we were recruited to assist with leadership training for WHO's Good Governance for Medicines Programme, an initiative to fight corruption in the pharmaceutical sector.10 Dr. Anello was already involved in this project, and the invitation gave me the opportunity to work more closely with him over the next year and a half. We collaborated on rewriting and expanding the training manual he had

devel-
patients and with each other and have oped. We worked together to develop
now become a model department, not training materials first for represen-
only for the hospital, but for all of tatives of Ministries of Health from
Mongolia. I want to see this spread." 10 An interesting overview of this
There was no longer any doubt. If program can be found at www.who.int/
we wanted to have a lasting impact, healthsystems/topics/financing/heal-
we had to incorporate this kind of threport/25GGM.pdf.

the Eastern Mediterranean region that has set the global standard for
convening in Jordan, and later for rep- high-quality affordable eye care, Ara-
resentatives from all over the world vind Eye Hospital in India.12
convening in Geneva. Aravind sees more patients, does
During this period, Dr. Anello ex- more surgery, and trains more oph-
pressed the desire to expand on the thalmologists than any other hospital
work we had been doing and to collab- in the world. All patients receive state-
orate with me and with author Juanita of-the-art eye care, regardless of their
(Joan) Hernandez on publishing his ability to pay. Most of the care is ei-
book in English. Unfortunately, his ther entirely free or subsidized. Even
health did not permit it at the time, so, the hospital has a very solid prof-
but Transformative Leadership: Devel- it margin. Harvard Business School
oping the Hidden Dimension was pub- spread the hospital's fame through a
lished some five years later, in 2014. A case study it published in 1993 (Ran-
companion workbook Transformative gan). Since then, numerous articles
Leadership: Mastering the Hidden Di- have been written about the miracle
mension, was published in 2017. The of Aravind—a hospital that has been
book has also been translated into and instrumental in dramatically reducing
published in Chinese. the prevalence of blindness in India.

In 2010, my family had the privilege of moving to China—a country with the greatest burden of blindness in the world. While modern eye care is available in the big cities, it is almost nonexistent in the rural areas. We formed another NGO in China called "Vision in Practice" (or "Aikai" in Chinese).11 Under the auspices of this organization, we were fortunate to obtain the assistance of a hospital

I had the privilege of spending a month there in order to learn how the hospital achieves these amazing outcomes, and I was pleased to see that the magic is not just the efficiency and standardization that so many focus on in their reports about the institution. There is something else crucial going on. When a patient enters the hospital, regardless of who that patient is or how the patient is dressed, he or she is greeted with a deferential bow and accompanied to receive care. On every floor of the hospital there are signs with quotations from the founder, Dr. Venkataswamy, about service: "Work is worship"; "I pray to be a better instrument, a receptacle for the divine force"; "When we take care of our patients,

11 Vision in Practice was founded in 2011 in partnership with Jeff Parker, an American journalist who co-founded a journal for ophthalmologists in China called Ophthalmology World Report. Through his work, he had become familiar with the Aravind model and had already started to help Chinese ophthalmologists obtain surgical training there. Together, we were able to expand these training opportunities.

12 For details, please visit www.aravind.org/.

it is ourselves we are helping. It is ourselves we are healing"; "If work is approached from a spiritual perspec-

first, but when everyone else was compromising and putting pressure on me, it was stressful. But I remembered

our
tive, then it becomes divine work"; and many similar axioms. On every floor there is a prayer room, and arching over the door are symbols of all the world religions. In other words, the hospital has managed to institutionalize a spiritual framework, and, what is more important, they have provided ample evidence that it works.

Partnering with this amazing institution was a great opportunity. With Aravind's help, we were able to send some eighty Chinese ophthalmologists for surgical training in India. We helped six hospitals to be mentored by Aravind, and we worked intensively with two of them to transform their services.

A good example of our efforts' impact on an individual level was demonstrated by one of our associates who worked closely with us on the eye projects in China. After our work together ended, she started working for a financial institution. She told us that her job was very stressful and pressured her to compromise her principles. When she refused to do this, she

training and the importance of values.
I knew what I had to do."

An example of the effect of utilizing the tool of consultation in conjunction with the virtue of humility and cooperation at the institutional level can be found in one of the rural hospitals we worked with to raise the standard of eye care which required a painful process of putting the patient's needs first by re-examining assumptions about the doctor-patient relationship. Raising the capacity of all the staff members meant that a spirit of collaboration and mutual aid had to replace the competitive environment. These were difficult changes. However, within two years, a surgical training center was established, all patients began receiving comprehensive eye services—including surgery if needed—regardless of their ability to pay, and the surgical volume more than doubled. The staff told us that they now have guidelines to help them with difficult decisions. They have changed many of their policies that were oppressive or self-serving,

such
was isolated and even mocked. Those around her were enjoying all kinds of "perks" while she stayed on the sidelines, just carrying out her responsibilities. However, within a year, her entire team was fired and the department restructured because of its questionable practices. She was one of only two people who survived the upheaval. She told us, "Being honest was easy at first. Even when it's difficult, we can make wiser choices than before. (Personal Correspondence)

Lesson 7: True leadership is servitude.

So far, we have talked about lessons learned about leadership, but not much about the substance of the training. The training we employ is inspired by the Bahá'í teachings. The term "leadership" is probably not the best description. Searching the Bahá'í

as arbitrary rules unrelated to patient care, accepting gifts for favors, prioritizing wealthy patients, and the like.

The chief surgeon told us:

We see things so differently now. When we live by the moral values, we feel more confident. As a result of the training, we feel the strength to overcome any kind of problem. We learned how to work as real doctors, how to

create a team that is service-aimed, how to encourage each other to keep learning and believe in ourselves. When we improve, it makes us happy. Even when it's difficult, we can make everyone is, at wiser choices than before. (Personal Correspondence)

necessity for humankind at every level to exhibit and maintain virtuous leadership and guidance. For while service to humankind is the hallmark of the Bahá'í teachings, some level, both a servant and a leader, a student and a teacher. Nowhere is this dual function more evident than in the guidance of the current Five Year plans of the Universal House of Justice in which a culture of learning is characterized by a process where everyone is striving to understand the nature of true servitude, while simultaneously accompanying and tutoring others: "The first quality for leadership, both among individuals

Writings to gain a deeper understanding of what leadership means in a spiritual context, one will find countless allusions to two somewhat antithetical discourses. On the one hand, there are plentiful passages referring to the desire for leadership as a characteristic of those who are attracted to the desire for power. For example, Bahá'u'lláh notes how religious leaders of the past have misled their followers by the desire to retain their positions: "Leaders of religion, in every age, have hindered their people from attaining the shores of eternal salvation, inasmuch as they held the reins of authority in their mighty grasp. Some for the lust of leadership, others through want of knowledge and understanding, have been the cause of the deprivation of the people" (Kitáb-i-Íqán 15).

On the other hand, there are quite as many passages discussing the use and Assemblies, is the capacity to use the energy and competence that exists in the rank and file of its followers" (Shoghi Effendi, quoted in Building Momentum 16).

Of course, 'Abdu'l-Bahá, whose very title, meaning "Servant of Bahá" (Bahá'u'lláh), embodies service, exemplifies perfectly the synthesis of leadership and servitude. On the one hand He forthrightly asserts His station as Center of the Covenant and head of the Bahá'í Faith. And yet He describes this leadership position in terms of a servitude to Bahá'u'lláh:

> My name is 'Abdu'l-Bahá, my identity is 'Abdu'l-Bahá, my qualification is 'Abdu'l-Bahá, my reality is 'Abdu'l-Bahá, my praise is 'Abdu'l-Bahá. Thraldom to the Blessed Perfection is my glorious and refulgent diadem; and servitude to all the human race is my

> perpetual religion . . . No name, no title, no mention, no commendation hath he nor will ever have except 'Abdu'l-Bahá. This is they found within their own spiritual heritage, they can recognize the flaws in their thinking. They come to realize that the greatest challenge

my longing. This is my supreme apex. This is my greatest yearning. This is my eternal life. This is my everlasting glory! (Tablets 429)

In fact, ‘Abdu’l-Bahá equates servitude with leadership:

> This is not servitude but sovereignty, and this is not service but chieftainship and greatness! This is the garment of everlasting glory with which thou hast clothed thyself, and this is the rose of eternal exaltation with which thou hast adorned thy head. It is said in the New Testament: “Whosoever will be chief among you, let him be your servant.” (Tablets 510)

What we are talking about, then, is transformative servitude—a process of personal transformation and service to the community. Therefore, in the training, we help participants identify the challenges with which they are struggling. They then examine the assumptions underlying those challenges. These often have to do with preconceptions of human nature, self-serving habits of thinking, expectations about leadership, and definitions of success. Once they have examined these assumptions based on scientific evidence and universal moral values face is their own personal journey of transformation. They come to realize how indispensable service is in that journey. They are then ready to embrace spiritually informed guidelines with which to construct a conceptual framework for their work. Then, when making difficult decisions or in times of crisis, that principle-based framework can guide them to make the right choices, instead of resorting to previous self-serving habits of thinking.

My own most important learning from this entire journey is that at the heart of servitude is a spiritual journey of personal and collective transformation, for it is only through service that we can transform ourselves, our communities, and ultimately our world.

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