

Résumé violence, among many others.

Au fur et à mesure que les professionnels According to the World Economic de la santé et les institutions s'efforcent Forum's 2015 "Survey on the Global de remédier aux inégalités en matière de Agenda," a surprising eighty-six per- cent of respondents perceived santé dans le monde, il devient de plus en cent of respondents perceived a global crisis in leadership. The plus clair que les réponses sont extrême- most distrust- ed were religious leaders, ment complexes et exigent un change- followed by ed were religious leaders, ment radical de nos façons de penser, de leaders in government, business, and non-governmental agencies nos orientations et de nos comportements. (14–16).

Le présent document décrit un chemine- Even heads of charitable organiza- ment personnel d'apprentissage du lead- tions were suspect, with only half of ership qui dévoile de fausses hypothèses the respondents showing confidence largement répandues qui ont mené bien in them. Among the key ingredients des gens à faire fausse route en tentant de relever les défis qui se posent dans la lutte leadership identified for successful contre la cécité. were morality, prioritization of social justice, empathy, collaboration, cour- age, a global perspective, Resumen long-term planning, and good A medida que individuos profesionales de communication skills (14–16). Ironically, la salud e instituciones luchan por atender when the World Health Organization (WHO) disparidades de salud alrededor del mun- do, se vuelve cada vez más aparente que evaluated its initiative "Health for All

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by the Year 2000,"¹ a global plan to solution seemed very simple to me— go to these countries, find the blind world's citizens, the initiative itself people, and cure them!

was deemed a failure—not because of that all lack of resources or know-how, but responding for lack of “moral leadership” (WHO, “Report” 7). it is not 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 short, 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 is not so simple. In fact, responding to such a problem is complicated. As it turns out, sufficient that individuals be treated; rather, whole systems must be transformed. And to solve problems at a systemic level, one needs unity of vision and purpose. In fact, the key to bringing about a solution is leadership. To support this I would like to share my journey of learning about leadership over more than thirty years of work, thirteen projects in ten different countries.

EMBARKING ON A JOURNEY

I started my career working at the International Eye Foundation in a project funded by USAID2 in the Caribbean island nation of Grenada, a tiny country less than ten by 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 involved community had knowledge and skills, sustainable 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 independent

1 For more details, please see the World Health Organization’s “Declaration of Alma-Ata.” International Conference on Primary Health Care, 1978. Lessons in Leadership

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 re-examine 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—times of crisis and are still functioning to this day. At the time, I wasn’t really sure what disempowers the essential prerequisites for success dependency,

cal infrastructure had to be

The project in which I was sought to create and make a national eye care system from ground up. Almost ninety percent

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

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

Lesson 1: Charity is not a solution. It has a role in sis and for disaster relief, but long-term is harmful. It local resources, creates

were, but the experience changed the dignity. course of my life. and strips people of their

When I returned to the United States almost three years later, I joined I have come to believe that in many cases, sustained charity is like giv-

an ophthalmology practice in Chica- ing sugar to a diabetic who is having

go, but my heart was still taken with a hypoglycemic episode. It may be health development in areas of need. life-saving in the short term, but it

And so, for the next two years, togeth- exacerbates the illness if continued

er with some colleagues, I made short long-term. When we reflected on our visits to the Turks and Caicos Islands learning with other like-minded col-

and to Guyana to offer services where leagues, we realized that we shared resources were lacking. many experiences. We tried to imag-

Turks and Caicos was particularly ine what a Bahá'í-inspired effort might

underserved: eye care, and eye sur- look like. How would the approach gery in particular, were only available to health development be different if

intermittently through the Interna- it were informed by the vision of the

tional Eye Foundation (the sponsor of oneness of humanity and the imper- my work in Grenada),³ which would ative of social justice? In 1991, we

recruit ophthalmologists to travel had the opportunity to make a trip there for surgery every six months to Albania just after the government

or so. This method of ministering to had transitioned from a dictatorship

eye care in Turks and Caicos had been that had kept it isolated from the rest

going on for years; the country was of the world for over fifty years. We

totally dependent on foreign charity. assembled a group of three physicians

³ Details regarding the work of this in different specialties (a pediatrician,

foundation can be found on its website: a dermatologist, and an ophthal- www.iefusa.org. mologist), together with a teacher, a

nutritionist, and a businessman, and in this space did: a combination

of went on a fact-finding mission to Albania, hoping to find opportunities for service where we might experiment with a different model. Meanwhile, one of the colleagues we were consulting with had been a volunteer in Honduras at Hospital Bayan, also a Bahá'í-inspired initiative, and encouraged us to collaborate more closely with that institution. We had also been encouraged by then-member of the Universal House of Justice Dr. David Ruhe to collaborate with the Bahá'í community in Guyana in their efforts to provide health services for the Amerindian population in the Rupununi region of Guyana. As these opportunities developed into projects, the need to formalize our efforts resulted in the founding in 1992 of Health for Humanity, a Bahá'í-inspired health development organization. We began by applying for grants and undertook efforts to address a variety of health concerns, including the leading causes of blindness. Based

charity and technical assistance. the time, “capacity-building” new buzzword among organizations working in development. It sounded great, but in reality, it was “technical transfer of still an improvement over the tional model, whereby visiting would provide all the care. One of Health for Humanity’s tiatives had developed into a project5 to help develop eye in Albania, which, due to its isolation, still had services and stitutions pre-dating World War II. Through this project, we got busy providing training by sending teers to Albania to offer it by sending the local abroad for more specialized We equipped six eye centers Vlorë, Peshkopi, Shkodër, Elbasan) so that the entire country would have access to eye care We also helped to develop a 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 some

creating dependency on charity. The decision-making 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 (www.opensocietyfoundations.org), as well as a number of smaller donors.

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at the Bahá'í World Centre. Lessons in Leadership

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these problems, but at the time, we did not know how to achieve this. This is

had to when we learned our next important lesson.

lesson. impact or

lesson.

impact or

a means whereby we could incorporate

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

re-ally did not have a deep insight into its

Halfway through the project, we came across the work of Dr. Eloy Anello and the training in "moral leadership" termination,

he developed at Nur University, which he had founded in rural Bolivia.⁶ The

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Eye Hospital in Tirana.

Throughout the project, we

problems: some equipment ended up in places we did not intend,

went missing, and local

ing favored nepotism and

agendas. If we were to bring about meaningful transformation, some-

thing was missing. It seemed to us an ethical framework that all could

to might protect the project from

5 Funded mostly by the Open

Institute

org), as well as a number of

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our program. Although several

ects received this training, we

face the fact that we did not

effective way to measure its

it in a systematic way. Our

arena was thus a bit haphazard. We

transformative power until ten

later, when we did an evaluation

Albania Eye Project at its

reviewing the work at the six eye

ters and interviewing doctors,

nurses, training he had instigated was structured to help participants explore their assumptions about leadership, was that human nature, and dysfunctional ways of thinking that interfere with meaningful progress. Once participants develop these insights, they are assisted in embracing those particular ethical principles that will become a foundation for their work. We all felt this conceptual framework might help us. Consequently, with the help of Dr. Anello (and of his colleagues),⁷ we began to introduce this training into the Albania Eye Project and into a new project we had just undertaken to combat river blindness in Cameroon. The participants' response to this training was very enthusiastic, even quite moving. As a result, we became convinced that this framework for training would be a helpful addition to who

6 For details, please visit www.nur.edu.
7 We are greatly indebted to Charles Howard and John Kepner for their dedicated assistance with this training for the

residents, and patients to the changes that had occurred. The first thing we noticed the doctors we had trained had quite prosperous, with beautiful and luxurious lifestyles. Eye services were available throughout the country, and the ophthalmologists well-trained. Albanians could quality eye care at centers to them, and the cataract surgery had increased more than Some patients were even coming nearby Kosovo and Macedonia for treatment. Naturally, we deemed this to be a propitious result. But we also learned about another outcome that was, instead, very disturbing. Those receiving this care were the same people who used to it in nearby countries, such as Greece or Italy. In other words, those who had access. However, the people who could not afford to pay—the populace we were most concerned

staff in Chicago and for projects in Albania, Cameroon, Mongolia, and Argentina. about—were still not receiving care.

The problem of avoidable blindness,

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while perhaps somewhat less urgent, its incorporation into the nursing school curriculum. was still very much a problem! We were so excited to learn about the training's impact that we Then, in the course of interviewing the staff we had worked with, re-in- interviewed the attending doctors and residents. One former resident told us: 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 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. Even the doctors are happier. We have a new vision now . . . and it 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 training were intimately woven into
 leadership training for his staff and he all aspects of medical and surgical
 even took the initiative of arranging training, it could help create a
 shared
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ethical/moral framework that all Health for Humanity. The survey was
 would be more likely to honor. Clear- sent out to 147 individuals. Of
 these, sixty-one responded, a 41% return.
 ly, without such a framework to guide The survey results showed that of
 decision-making, healthcare workers' total respondents, 93% felt that
 the values were essential to their
 technical skills and knowledge would 83% said effective leadership is a
 moral significant challenge for them; 66%
 not necessarily benefit their communi- ty. In some instances, they might even
 success; cause harm if used for personal gain
 ty. In some instances, they might even stated
 cause harm if used for personal gain
 stated
 at the expense of patients' welfare. that technical training failed to
 deliver the desired results; 54% were
 And so it was that we encountered the significant problems with honesty
 having and trustworthiness; and 32% said
 next lesson in this organic process of effective at all. Almost all stated
 learning about building capacity. some equipment or funds were divert-
 their projects were struggling or not ed to unintended uses in their projects.
 Lesson 3: True capacity-building has When asked to rate the ingredients
 that success, 74% rated moral values and
 an indispensable spiritual dimension. ical behavior as the most important
 ed to unintended uses in their projects. surgical skill and academic
 Throughout this period, Health for as the least important! When asked
 for prioritize ingredients for success,
 Humanity was collaborating with top three were strong core values,
 eth- WHO and with the International
 and Agency for the Prevention of Blind-
 knowledge
 ness (IAPB)⁸ and sharing learning
 to
 with other non-governmental orga-
 the
 nizations working in this area. We

ser-
met annually and reviewed progress vice orientation, and honesty.
These
toward the goal of an initiative called respondents were the global leaders
in
“Vision 2020: The Right to Sight,” their field and, to our
amazement, they
a global plan for the elimination of were forthrightly acknowledging
that
avoidable blindness by the year 2020.⁹ moral values are indispensable to
success
We were curious about the expe- in addressing public health
challenges!
rience of other organizations, so we Clearly, what we were
experiencing
sent out a survey to the institutional was shared among other
organizations
members of IAPB. At the time, IAPB working in health development, and
had ninety-four institutional members, very likely was common in interna-
eighty of which were non-governmen- tional development in general. When
tal organizations, including our own we shared the survey results with
the
8 A multilateral organization that IAPB member institutions, we were
collaborates with WHO to oversee and invited to offer the leadership
training
coordinate efforts to eliminate avoidable to these organizations at the
agency’s
blindness. next quadrennial General Assembly,
9 [https://www.who.int/blindness/](https://www.who.int/blindness/partnerships/vision2020/en/) in Argentina in 2008. The anecdotal
[partnerships/vision2020/en/](https://www.who.int/blindness/partnerships/vision2020/en/). stories we heard, together with the
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survey results and the unexpected in- resistance we felt made us question
terest from member organizations and whether change, let alone
transforma-
from multilateral agencies, convinced tion, was even possible. However,
we
us that there is a great need for this reminded ourselves that it was a
pro-
kind of training. We now had the ob- cess, perhaps slow in the
beginning,
jective evidence. but gradually transformative as
people
found their voice and began to claim
Lesson 4: There is growing consensus their agency.
among leaders in health development We saw evidence of this change
that without the moral/ethical di- two years later when one of the doc-

mension, development efforts will not succeed.

the 2008 IAPB General Assembly:

Meanwhile, just as the Albania project ended, Health for Humanity received different

funding to carry out a more modest project to train cataract surgeons in different

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 express

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

situation. She gave her blessing and

even participated, but it was not easy

felt

for her. like we got new eyes to see things

After decades—maybe even centuries—of passivity when it came participated

to expressing individual opinions or to

problem-solving, it was very hard to

engage the doctors, and very hard for the boss to share authority. The Lessons in Leadership

and try to include all the doctors . . . 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

NGOs. We always talked about academic knowledge [and] clinical and surgical training, but

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

63 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

comes a powerful force for change and 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 systemic learned another lesson regarding the training program.

When work is informed by spirituality

Lesson 5: Consultation is the most applied powerful means for continuous learning and improvement. Our greatest confirmation about the relationships. Our greatest confirmation about the power of consultation in this organic process came from Mongolia's State Secretary for Health, Byambaagiin Batsreedene. "I remember how bad assist the conditions used to be, and now the WHO's eye department is a modern department with high quality services," she corrup-said. "However, it is not just the technical improvement that is noticeable," this she continued. "There is something me the else I have not seen before. The doctors with treat the patients differently The We ophthalmologists . . . changed They expand-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,

transformation.

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

transformation.

al principles and learning is

through consultation, the resulting change is apparent in both quantifi-

tive transformation of

The resulting ripple effects can

far-reaching.

As the Mongolia project was

ing down, we were recruited to

with leadership training for

Good Governance for Medicines Programme, an initiative to fight

tion in the pharmaceutical

Anello was already involved in

project, and the invitation gave

opportunity to work more closely

him over the next year and a half.

collaborated on rewriting and

ing the training manual he had

devel-
 patients and with each other and have
 develop
 now become a model department, not
 represen-
 only for the hospital, but for all of
 from
 Mongolia. I want to see this spread.”
 this
 There was no longer any doubt. If
 we wanted to have a lasting impact,
 healthsystems/topics/financing/heal-
 we had to incorporate this kind of
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 the Eastern Mediterranean region
 for
 convening in Jordan, and later for rep-
 Ara-
 representatives from all over the world
 convening in Geneva.
 During this period, Dr. Anello ex-
 pressed the desire to expand on the
 hospital
 work we had been doing and to collab-
 state-
 orate with me and with author Juanita
 their
 (Joan) Hernandez on publishing his
 ei-
 book in English. Unfortunately, his
 Even
 health did not permit it at the time,
 prof-
 but Transformative Leadership: Devel-
 oping the Hidden Dimension was pub-
 through a
 lished some five years later, in 2014. A
 (Ran-
 companion workbook Transformative
 Leadership: Mastering the Hidden Di-
 mension, was published in 2017. The
 been
 book has also been translated into and
 reducing
 published in Chinese.
 India.

oped. We worked together to
 training materials first for
 tatives of Ministries of Health
 10 An interesting overview of
 program can be found at www.who.int/threport/25GGM.pdf.
 that has set the global standard
 high-quality affordable eye care,
 vind Eye Hospital in India.¹²
 Aravind sees more patients, does
 more surgery, and trains more oph-
 thalmologists than any other
 in the world. All patients receive
 of-the-art eye care, regardless of
 ability to pay. Most of the care is
 ther entirely free or subsidized.
 so, the hospital has a very solid
 it margin. Harvard Business School
 spread the hospital's fame
 case study it published in 1993
 gan). Since then, numerous articles
 have been written about the miracle
 of Aravind—a hospital that has
 instrumental in dramatically
 the prevalence of blindness in

In 2010, my family had the privilege of moving to China—a country with the greatest burden of blindness out-in the world. While modern eye care that 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 or 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. Dr. 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. www.aravind.org/

I had the privilege of spending a month there in order to learn how hospital achieves these amazing comes, and I was pleased to see the magic is not just the standardization that so many focus in their reports about the There is something else on. When a patient enters the regardless of who that patient is how the patient is dressed, he or she is greeted with a deferential bow accompanied to receive care. On floor of the hospital there are with quotations from the founder, Venkataswamy, about service: “Work is worship”; “I pray to be a ment, a receptacle for the divine “When we take care of our patients, 12 For details, please visit www.aravind.org/

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it is ourselves we are helping. It is ourselves we are healing”; “If work is on me, approached from a spiritual perspective first, but when everyone else was promising and putting pressure it was stressful. But I remembered

our
tive, then it becomes divine work”; and training and the importance of
values.
many similar axioms. On every floor I knew what I had to do.”
there is a prayer room, and arching An example of the effect of
utiliz-
over the door are symbols of all the ing the tool of consultation in
con-
world religions. In other words, the junction with the virtue of
humility
hospital has managed to institution- and cooperation at the
institutional
alize a spiritual framework, and, what level can be found in one of the
rural
is more important, they have provided hospitals we worked with to raise
the
ample evidence that it works. standard of eye care which required
Partnering with this amazing insti- a painful process of putting the pa-
tution was a great opportunity. With tient’s needs first by
re-examining as-
Aravind’s help, we were able to send sumptions about the
doctor-patient re-
some eighty Chinese ophthalmolo- lationship. Raising the capacity of
all
gists for surgical training in India. We the staff members meant that a
spirit
helped six hospitals to be mentored by of collaboration and mutual aid had
Aravind, and we worked intensively to replace the competitive environ-
with two of them to transform their ment. These were difficult changes.
services. However, within two years, a
surgical
A good example of our efforts’ im- training center was established, all
pa-
tients began receiving
comprehensive
strated by one of our associates who eye services—including surgery if
worked closely with us on the eye needed—regardless of their
ability
to pay, and the surgical volume
projects in China. After our work to-
more
than doubled. The staff told us
gether ended, she started working for
that
they now have guidelines to help
a financial institution. She told us that
them
her job was very stressful and pres-
sured her to compromise her princi-
ples. When she refused to do this, she
with difficult decisions. They have
changed many of their policies that
were oppressive or self-serving,

such
 was isolated and even mocked. Those
 patient
 around her were enjoying all kinds of
 prior-
 “perks” while she stayed on the side-
 the like.
 lines, just carrying out her responsi-
 bilities. However, within a year, her
 now.
 entire team was fired and the depart-
 we
 ment restructured because of its ques-
 the
 tionable practices. She was one of only
 over-
 two people who survived the upheaval.
 learned
 She told us, “Being honest was easy at
 to

as arbitrary rules unrelated to
 care, accepting gifts for favors,
 itizing wealthy patients, and
 The chief surgeon told us:
 We see things so differently
 When we live by the moral values,
 feel more confident. As a result of
 training, we feel the strength to
 come any kind of problem. We
 how to work as real doctors, how

create a team that is service-aimed,
 lev-
 how to encourage each other to keep
 learning and believe in ourselves.
 When we improve, it makes us happy.
 hallmark
 Even when it's difficult, we can make
 everyone is, at
 wiser choices than before. (Personal
 lead-
 Correspondence)
 Nowhere
 is this dual function more evident than
 Lesson 7: True leadership is servitude.
 Year plans of the Universal House of
 So far, we have talked about lessons
 learning
 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
 quality for
 best description. Searching the Bahá'í
 individuals

necessity for humankind at every
 el to exhibit and maintain virtuous
 leadership and guidance. For while
 service to humankind is the
 of the Bahá'í teachings,
 some level, both a servant and a
 er, a student and a teacher.
 in the guidance of the current Five
 Justice in which a culture of
 is characterized by a process where
 everyone is striving to understand
 the nature of true servitude, while
 simultaneously accompanying and
 tutoring others: “The first
 leadership, both among

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 perpetual religion . . . No name, no title, no mention, no commendation hath he nor will ever have except 'Abdu'l-Bahá. This is they

and Assemblies, is the capacity to the energy and competence that in the rank and file of its (Shoghi Effendi, quoted in Building Momentum 16).

Of course, 'Abdu'l-Bahá, very title, meaning "Servant of (Bahá'u'lláh), embodies plifies perfectly the synthesis of ership and servitude. On the He forthrightly asserts His station Center of the Covenant and head of the Bahá'í Faith. And yet He this leadership position in terms servitude to Bahá'u'lláh: My name is 'Abdu'l-Bahá, my identity is 'Abdu'l-Bahá, my ification is 'Abdu'l-Bahá, ality is 'Abdu'l-Bahá, my is 'Abdu'l-Bahá. Thraldom

Blessed Perfection is my

and refulgent diadem; and servitude to all the human race is my

67

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)

with which to construct a conceptual

In fact, ‘Abdu’l-Bahá equates servitude when

with leadership: times

of crisis, that principle-based frame-

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)

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

framework for their work. Then,

making difficult decisions or in

work 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.

What we are talking about, then, is transformative servitude—a process of personal transformation and service to the community. Therefore, in the ‘Abdu’l-Bahá.

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 precon-

ceptions 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

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