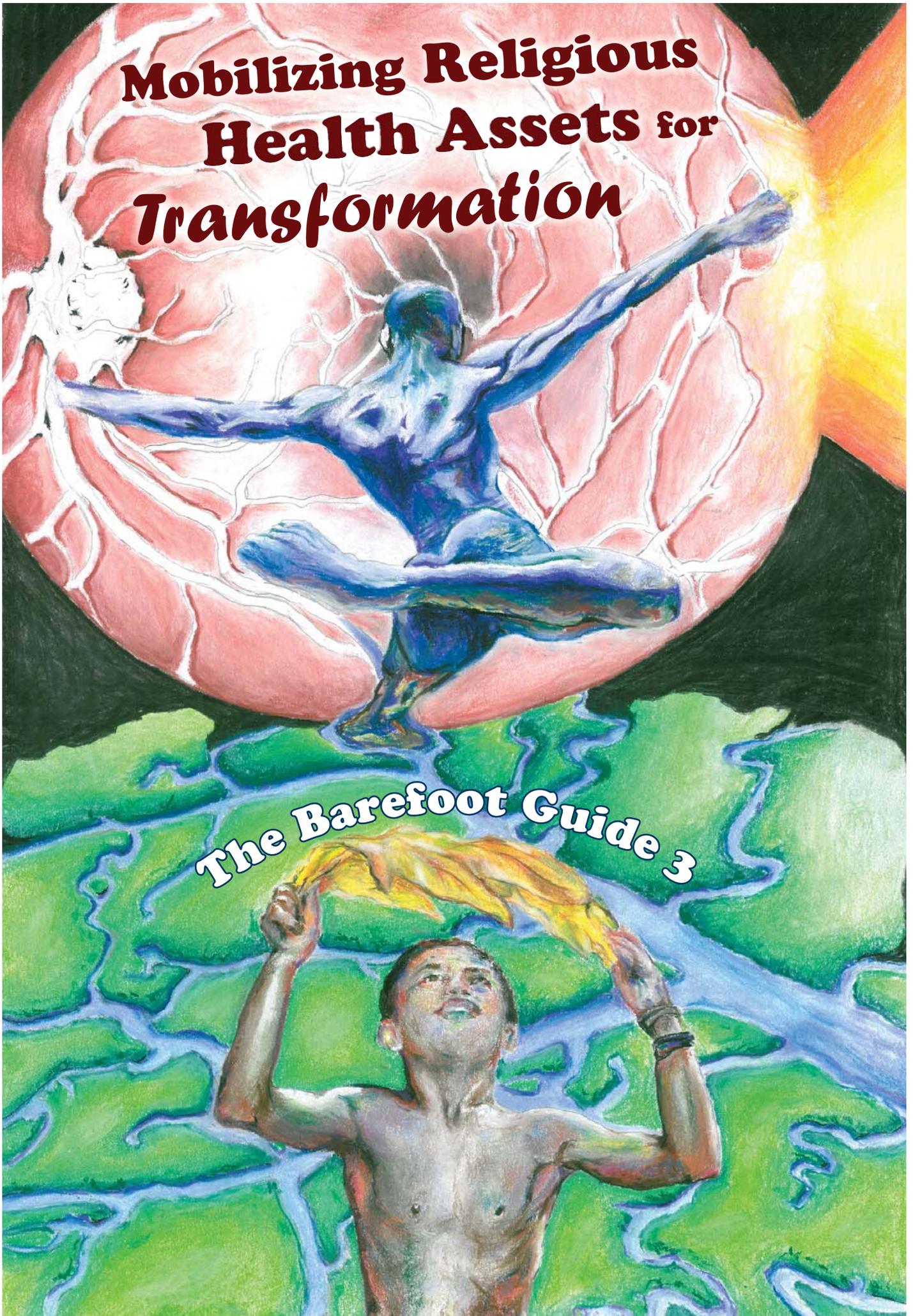


Mobilizing Religious Health Assets for Transformation

The Barefoot Guide 3



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International Religious Health Assets Programme

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The
Barefoot
Guide

to mobilizing
religious
health
assets
for
transformation



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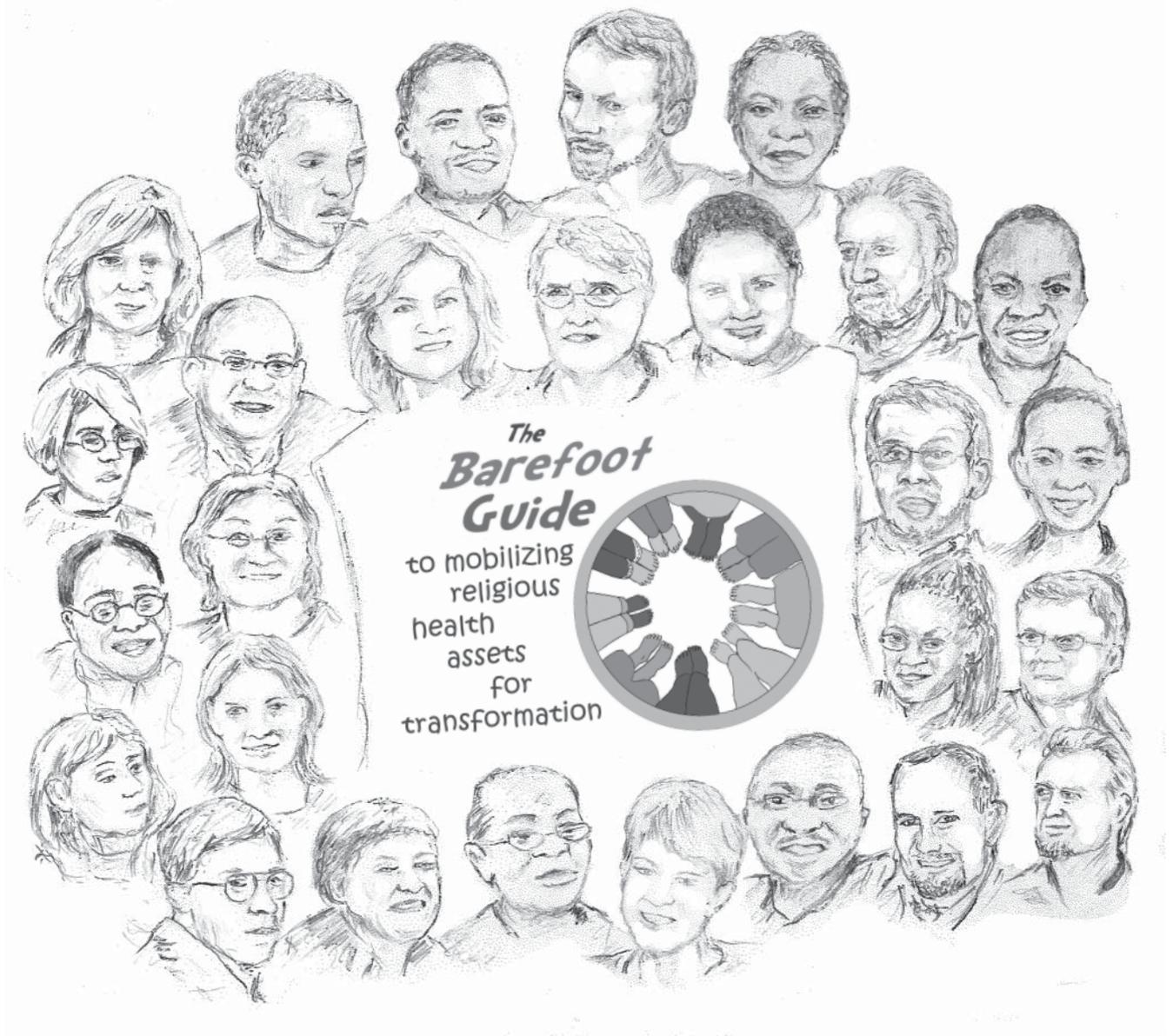
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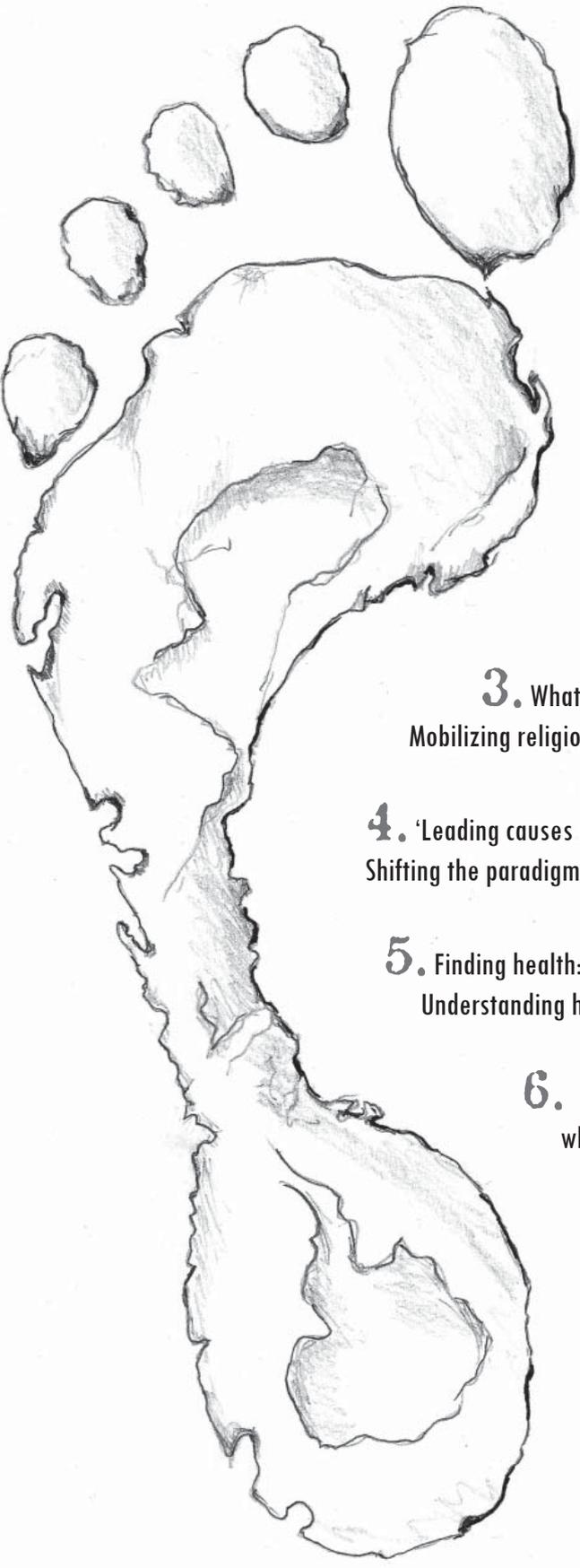
You can find a growing collection of exercises, readings, handouts and case studies that accompany the *Barefoot Guide* at www.barefootguide.org.



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Welcome to

The Barefoot Guide to Mobilizing Religious Health Assets for Transformation

What do Hippocrates, Dr. Martin Luther King, Bill Gates and the Dalai Lama all agree on? That health, freedom and social justice cannot be separated. Anyone who loves a neighborhood, a nation or a small planet enough to work for its future, inevitably measures success by its health and well-being. How long do the neighbors live, and with what degree of freedom from the burden of illness? Do they have water, food, shelter and access to medical services?

Dr. King, who fought and died for political rights, could still say that *“of all the forms of inequality, injustice in healthcare is the most shocking and inhumane.”* That is because it is most fundamental. Health is one way to describe our capacity to be alive and to play our role as members of families and neighborhoods, indeed as citizens.

Jimmy Carter, who with Bill Foege (you will hear about *him* in the second chapter!) instituted the Interfaith Health Program at his presidential Carter Center in Atlanta, once said, “we must make the choices that lead to life.”

But how does one choose life for the community? How do we as leaders make sure that our lives are about life and health? What could be more important to know than that?

The journey this Barefoot Guide will take you on is a response to those questions!

Of all the forms of inequality, injustice in health care is the most shocking and inhumane.

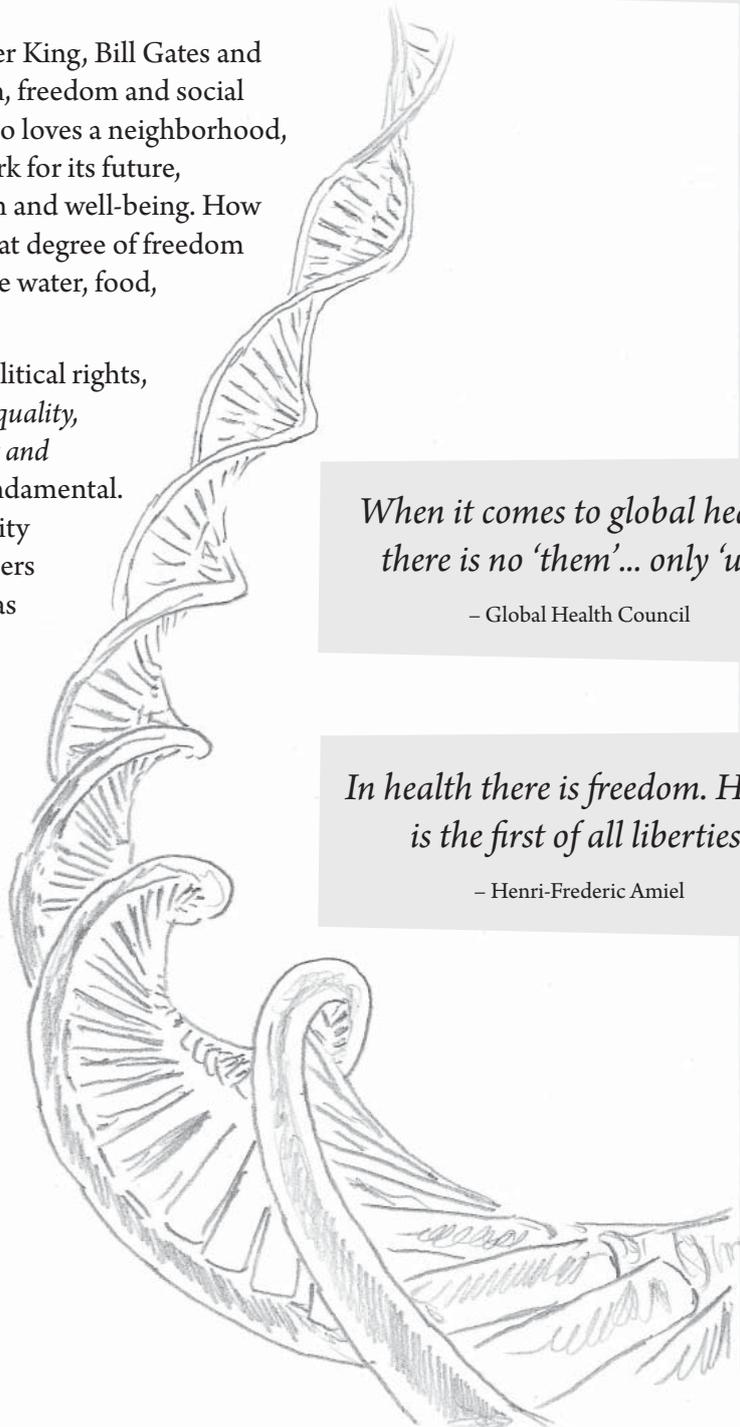
– Martin Luther King, Jr

When it comes to global health, there is no ‘them’... only ‘us.’

– Global Health Council

In health there is freedom. Health is the first of all liberties.

– Henri-Frederic Amiel



4 things you should know about this Guide

1

The connection between religion and public health is important. This is not just an opinion but a fact. For example in Africa, depending on the country, anything between 20-70% of public healthcare is delivered through religious institutions or groups. This BFG focuses on understanding and working with that reality. However, many of the things we say about 'religion' are not necessarily unique to religious people, groups, organisations or traditions. Our focus on 'religion' and its manifestations is not because of their uniqueness, but because so much that matters to many people, communities and societies can be understood as an expression of some kind of religious commitment and engagement. And so many initiatives, actions, practices and organisations that have some religious character are involved in health while, at the same time, too little attention has been paid to them. The time is ripe to pay them serious attention. That's our rationale.

2

We also need to be clear that we often use examples from particular religious traditions with which we are most familiar. At the same time, we are in *no way* suggesting that any particular religious tradition can be privileged in this respect. Virtually everything we talk about is not specific to any one religion, nor does it seek to promote one or create a new one. Because we have worked with and discussed these concepts with people from various different religious traditions, we feel confident that they resonate in different degrees with every formal tradition, with traditions that are not formally named as a 'religion,' and with much informal practice that has a religious or spiritual dimension to it.

3

The *Barefoot Guide to Mobilizing Religious Health Assets* has a special character that we should highlight: it introduces and uses language in new ways. So instead of apologizing for including ideas and words that are likely to seem strange at first, it is actually our intention to push you to think differently by doing so. We have been working with these ideas and words at all levels for some years now, including many local communities in different countries, so we are confident that it is worth taking this approach.

4

This *Barefoot Guide to Mobilizing Religious Health Assets* is the third in the series. It is meant to accompany the first two Guides, which are about *Working with Organisations and Social Change* (no. 1) and *Learning Practices in Organisations and Social Change* (no. 2). Occasionally we make reference to these volumes, but we also encourage you to use them together in your own ways, wherever it makes sense to you.

Thinking differently about the health of the public

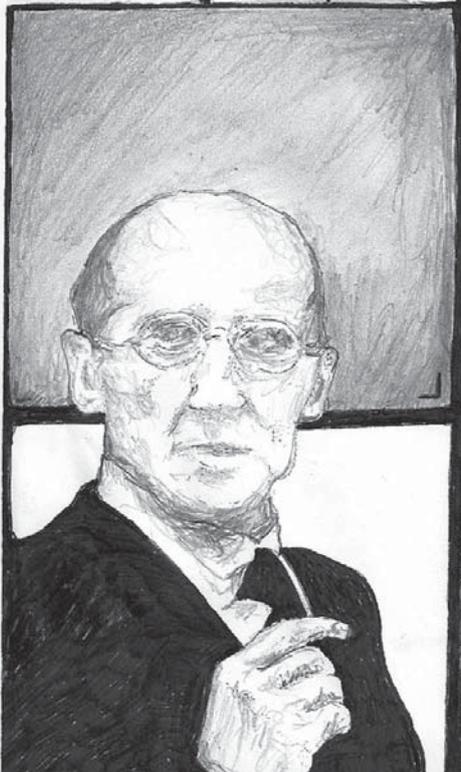
Mobilizing religious health assets for transformation

Like Roots

*Our hands imbibe like roots, so I place
them on what is beautiful in this world.*

*And I fold them in prayer, and they
draw from the heavens light.*

St Francis of Assisi



***Religious assets for health are everywhere,
they matter to a lot of people, and they can
be mobilized for the health of all.***

That's our claim. What you are getting in this Barefoot Guide is a way of understanding why we say that, and how you can use these ideas to take up the challenge of health in your own communities, whether you consider yourself especially religious or not. It is an invitation to join us on a journey, one whose goal is a better life for all.



Most journeys begin with a story and so does this one. It's about a city and a public health epidemic, serious enough to kill or frighten away most of its population. The city is Memphis, Tennessee. Near today's I55 Interstate highway, which runs busily through the city, is Elmwood Cemetery. In 1878, one and a half thousand people were buried in this graveyard, in haste and fear, so quickly that they remain unnamed. Thousands more were buried where they fell.

Nobody understood it at the time, but it was an outbreak of yellow fever carried by mosquitoes. The disease was known enough to fear it, but fear without understanding just causes panic, then and now. In Memphis, surrounded by lowland swamps, when the 'American Plague' broke out almost anyone who could flee did. But something else happened too. A bit like what physicists call 'a strange attractor,' some people *came* to Memphis to help, *because* of the threat. Astonishing martyrs, they were moved by their faith; they came and stayed, to care for the sick and dying. From around the nation they gave themselves on streets of sorrow – priests working alongside prostitutes and former slaves. Though many died within days of their arrival, still they came.



We are also hearing here a story about what the World Health Organization calls 'the social determinants of health'!

Health has never been just about medicine. Of course, medical knowledge is important, partly because it helps us to look for ways of preventing other plagues. Still, what was most important in Memphis were not strictly medical: to remove the trash, cover up the sewage, drain the swamps, and drill deeply for clean water. Even building sidewalks, or doing food inspection helped! These public actions give the health of the public a chance then – and now.

Science, engineering, or public health is still only half the story, though! Just as important – maybe more – is how people acted towards each other. *With* each other. Offering all kinds of care and support. Not only as individuals, but for the sake of all who lived in the city. For the sake of the *public*, we can say. For many people, this comes from their spirit, their faith, their deepest identity So, our question in this Guide is this: What would a similar movement of people mean to our time, facing our plagues?



In a nutshell, that is what this Barefoot Guide is all about. To get where we are going, let's first think more about why public health matters. And about why religion matters.

WHY DOES 'PUBLIC HEALTH' MATTER?

What we mean by 'the public' is you, us, the people, all the people in fact – *our life together*. So public health is not just about the health of individual people. It's about the health of communities, of whole societies.

This raises some big questions: Do poor people have the same access to health as rich? Or women and children as men? Or Black people as whites? And so on. When we look at it this way, we can't avoid economic, gender, racial and similar issues.

Ask yourself this, for example: who decides what kind of health we need? Do poor people (or women, children, anyone discriminated against for some unjustifiable reason or another) have a say in where health is provided, how it is provided, or even *if* it is provided? Should it be left only to 'experts' who know a lot about their subject, but maybe not about the people? Or to politicians? Bureaucrats? To the markets and the profit motive? What if a society, not just its people, is 'sick' in some way that affects our health?

Questions like these don't have easy answers. They depend, in part, on how much say ordinary people have in what happens to them and how.

So to talk about 'public health', is also to think of '*the health of the public*'.



Public health at its root – like religion in its deepest foundations – is not just a set of specialized ideas and practices, but a way of seeing and working on the health of the whole people, the public.

WHY DOES 'RELIGION' MATTER?



Raul

Raul: So, I see how health is an important to the community, but why bring religion into it? It causes so many problems. It's also often against science, for reasons that seem a bit silly, if you ask me!

Zindzi: Oh, religion bothers you? Others too, I guess. But maybe I should ask you: what do you really mean by 'religion'?

Raul: Hmmp, that's obvious, isn't it? Churches, mosques, temples. All sorts of conflicting beliefs about 'God,' or something sacred. Why should one belief be right and another not? It's not science, anyway.

Zindzi: Well, maybe it's not as obvious as you think! Scholars of religion debate this question, and they have many differing views! But let's not get into their fights. To help us along, we can choose a definition of 'religion' that works for most people, most times. That will be enough.

Raul: OK, so what definition is that? I'm curious.

Zindzi: Well, let's simply accept an ordinary understanding – someone who says 'this is my faith or religion, it matters to me, and I live by it.' So it works for them. We can call this is a *pragmatic* idea of religion, a practical, realistic approach.

Raul: What's so realistic about that? Isn't it just their opinion? Maybe it's ignorance even! What if what they call their religion or faith simply covers up what they don't understand? Or, worse, merely expresses their prejudices!

Zindzi: Sure, we can't rule that out. Actually, quite a few people think religion is useless, or not relevant to them. But what about the incredibly large number of people who *do* find it relevant to their lives? Why do you want to ignore them? Whatever their reasons, it affects what they do and how they do it. Including their health!

Raul: OK, so let's say I don't ignore them. Let's say I accept that religion means a lot to most people. Still, it's not clear to me what religion has to do with health.

Zindzi: Well, if we understand health quite broadly—as about full human (and natural) well-being – then health is actually right at the heart of deep religious ideas in many traditions! It's about a whole, healed world, where unnecessary suffering and pain is done away with, where people live in peace with each other, and with the earth and its creatures. Actually, that's also what the World Health Organization calls health! It's not just the absence of disease, the WHO says. It's the presence of a full and healthy life for all!



Zindzi

Raul: Hmm. Fair enough. Still pretty general, though. I'm still not sure exactly about the connection to religion.

Zindzi: OK, let's think about an example from my part of the world, where the Basotho people live. They don't have two words in their language for religion and health, only one! In Sesotho, that's *bophelo*. It actually means that *my* health is tied to *your* health, to *my family's* health, to the health of *my community and society*, my ancestors, and *the earth* as well. If one part is unhealthy, the other parts are affected. You can't separate health and a religious way of thinking for them. Both are about a whole and full life!

Raul: OK, so health is something big, it affects everything. But you seem to be thinking about more than language. What's the big deal?

Zindzi: Well, lots of people, in many, many places, think like the Basotho about religion and health, as something holistic. But it's not just about words. Many religious practices have something to do with clean living, safe food, and so on. And I see many religious people who are motivated to do something about health, not just their health, but everybody's.

Raul: Hmm, you're going to have to keep going. What's your point, really?

Zindzi: Yeah, well, I think it's worth paying attention to all the things religious people have done because of their concern for health, not just for their own people, but anyone. They do something about it! They start initiatives, movements, programmes, organizations, even hospitals, and things like that. They have a passion about it, at least, many do. And it's people from many faiths, over a long time, all over the world. Well, if it's that widespread and common, don't you think it would be a little dumb, just silly, not to take that into account? It's not very scientific not to, actually!

Raul: Alright, let me buy that for now. Is that what you mean by 'religious health assets'? Or what?

Zindzi: Yeah, sort of, as long as you remember it's not just things you can see and touch. But we can talk more about that later. Right now, I'm trying to stress the connection between religion, health and well-being. It's so deep, it covers so much. Actually, I have a special term for that: I call it '*comprehensive well-being*.' That's really what *bophelo* is all about.



Health is about the whole of life, and it includes our relationship to others, to the environment, to everything. That's where it overlaps with religion. And that's why many religious people get involved in the health of the people. They do all sorts of things, some you can see or touch, like starting a hospital, a clinic or a project, some you can't, like give care, compassion or emotional support. In that way, *religion works as an asset*.

Jonas Salk, a brilliant doctor, is world famous for inventing the polio vaccine. But still, he thought that we do not pay enough attention to what causes health or gives life. This interests us too. If disease and death can spread, why not health, why not vitality? We spend a lot of time,

It is possible to create an epidemic of health!



and huge amounts of energy, money and other resources, on fighting death. How about using as much time and energy, Salk asked, to focus on what gives us life? Why don't we figure out, with the same scientific intelligence we use to understand 'death', what gives us energy, vitality, resilience and well-being? Can we create an *epidemic of health*, even where people are battling death in some form or another? Salk thought so, and he believed we would be wise if we did. So, he asked, 'Are we being good ancestors? Survival of the wisest depends upon whether we use our tools as good ancestors of the future.' That's our hope too.

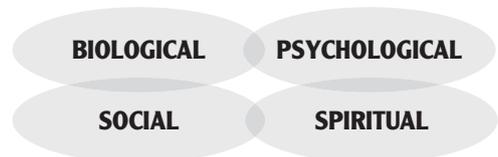
(Quotes from <http://www.epidemicofhealth.org>)

Hmm, OK, but this Guide deals with ideas. So what do ideas have to do with an epidemic?



Well, we are advocating a different way of seeing religion and public health, one we believe means a different way of acting, one that is more hopeful than what we currently experience. Using lots of concrete examples, we want to persuade you too. Why? We think you will find it matches the best of what you already know.

Here's one way of picturing how much what Salk calls an epidemic of health can draw on. Every one of the *four-fold dimensions of health* supports the others. So they can be 'treated' as a whole. It works!



Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.



The World Health Organization has a definition of health that's pretty close. They left out 'spiritual', but people from Africa have convinced them since then that it should not be left out.

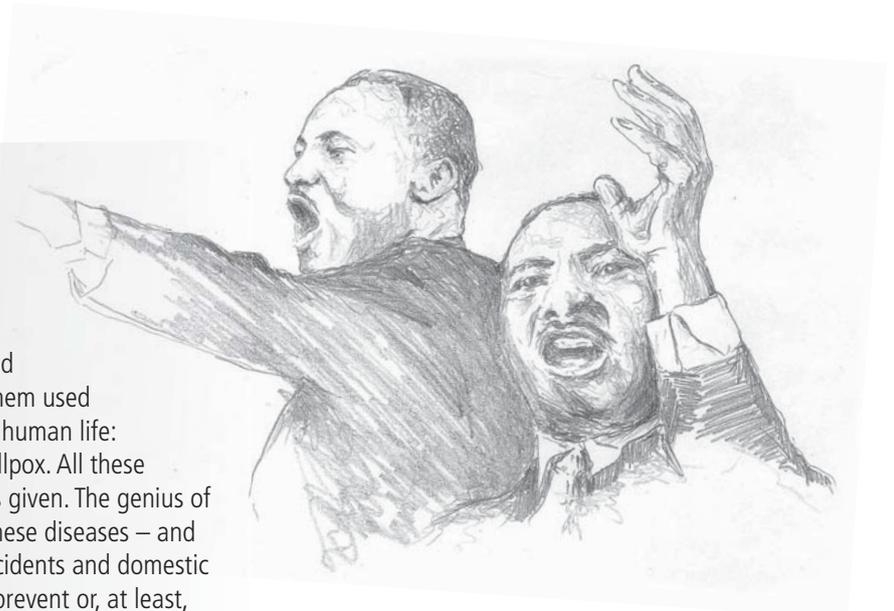


In April, 1968, Dr. Martin Luther King, Jr. was shot in Memphis. He was there to support sanitary workers who had been striking and marching against bad health conditions, a result of bad working conditions, social inequality, and political exclusion. King observed that only 'maladjusted' people changed anything. He meant people who won't simply accept things as they are. People who have a critical urge to move from the inaction that weakens people to the life-giving creative actions that show how things might be. King was a pastor and activist, but he was a thinker, a scholar too – with a special vision of what that means.

Scholarship should serve not only the pleasures of wonder and curiosity, but also the arts of change. It's about committed engagement, transformative practice and passionate thinking.

COMMITTED ENGAGEMENT

It's a great moral scandal of our times – how much suffering can be not only relieved but prevented! We know enough about patterns of disease to develop all sorts of inventions and techniques to stop or control them. Many of them used to be thought of as normal and hazardous for human life: tuberculosis, cancer, cholera, yellow fever, smallpox. All these deadly companions used to be taken simply as given. The genius of public health science has helped us see that these diseases – and many other socially determined ills, like car accidents and domestic violence – can actively be tackled, enough to prevent or, at least, seriously reduce their destructive effects. But the scandal is how little of we can prevent *is in fact* prevented! Too often, we still imitate those early days in Memphis (remember our story?), when there was no proper drainage, clean water and sanitation. So much *can* be done with the right will, with committed engagement.



TRANSFORMATIVE PRACTICE



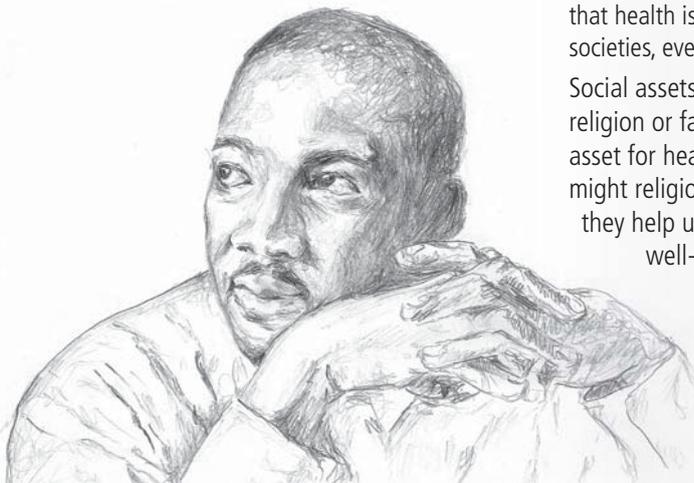
We know enough about what to do that is *not* being done to advance the health of the public to make us humble. Actually, we ought to be embarrassed. We *should* be able purposely to bend the path of our communities' life journeys toward better health and well-being. Of course, we can!

What helps us move toward that action? Part of the answer is a thoughtful grasp of the link between faith and health – two sides of life that, too often, are seen as distant from each other when they are really one. If this sounds like more ideas, not enough action, ideas do matter for right action.

Bad ones *do* result in bad structures, they *do* produce bad plans, and they *do* result in bad outcomes – even from otherwise intelligent people. Think of the trillions of dollars lost in our time because of obviously bad economic ideas! These are ideas that religious leaders, philosophers, even economists, had warned about. They included a policy of deregulation that was like an agreement to let the greedy regulate themselves. Something similar applies to health, where people have been reduced to being individual 'consumers' or 'clients' served by a small cadre of well-paid professionals.

In the chapters to come we will be telling stories and sharing ideas that show a different way.

PASSIONATE THINKING



What is the thinking around which we should organize? One part is that health is social. It has to do with everyone, communities, whole societies, even the earth we depend upon.

Social assets include – usually have, in every culture – some kind of religion or faith. Of course, not everything in a religion or faith is an asset for health. But much is. And that's the question: what is? How might religious assets help overcome barriers to health? How might they help us wisely harness new health technologies in service of well-being?

To answer such key questions we need better ideas than those that mostly rule the minds of leaders of public, private and religious bodies. More than that, we need *better-connected ideas* – a coherent paradigm that frames, holds together, and makes actionable, a comprehensive way of seeing the parts as a whole.

Is this something that only people who have degrees or work in universities can do? Do we have to depend upon 'experts'?



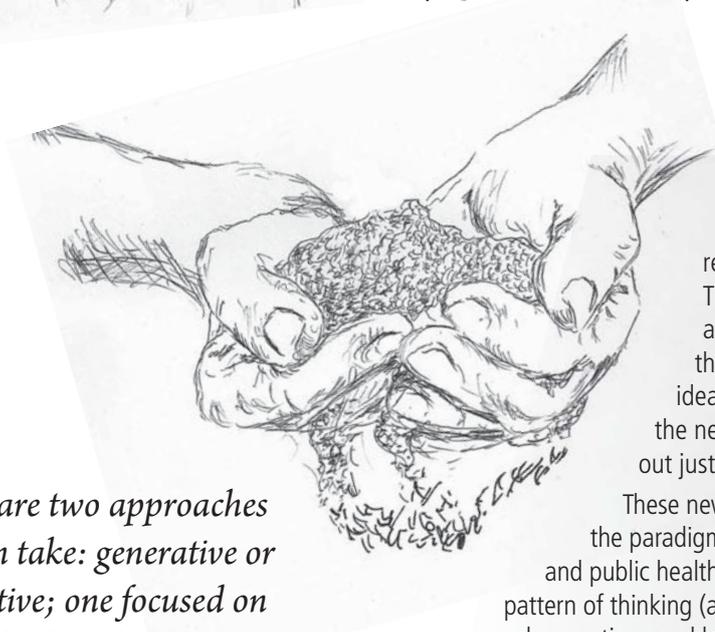
Oh, no, not at all! Maybe you've heard of Robben Island? That's a picture of it down below. That's where Nelson Mandela and many other political prisoners were held for a long, long time. You can guess — no-one was going to give them education or training! But they taught each other about all sorts of things, not just political either! That's why people often call Robben Island 'the peoples' university.' We can teach each other!



SEEDS AND WEEDS



Let me tell you a little parable. I'm Gary, so we'll call it a story about 'Gary's Rule.' I was trying to make my wife happy by doing some gardening, which I learned is not possible if you don't know anything. And the most dangerous thing to not know is the difference between a weed and a seed. "You've taken out the flower seeds!" Uh-oh. Gary's Rule? If you want your thinking to bear fruit, be careful to remove the weeds from your thinking, not the seeds. And when in doubt ask someone to help you tell them apart.



“There are two approaches one can take: generative or restrictive; one focused on growth, the other keeping things the way they were”

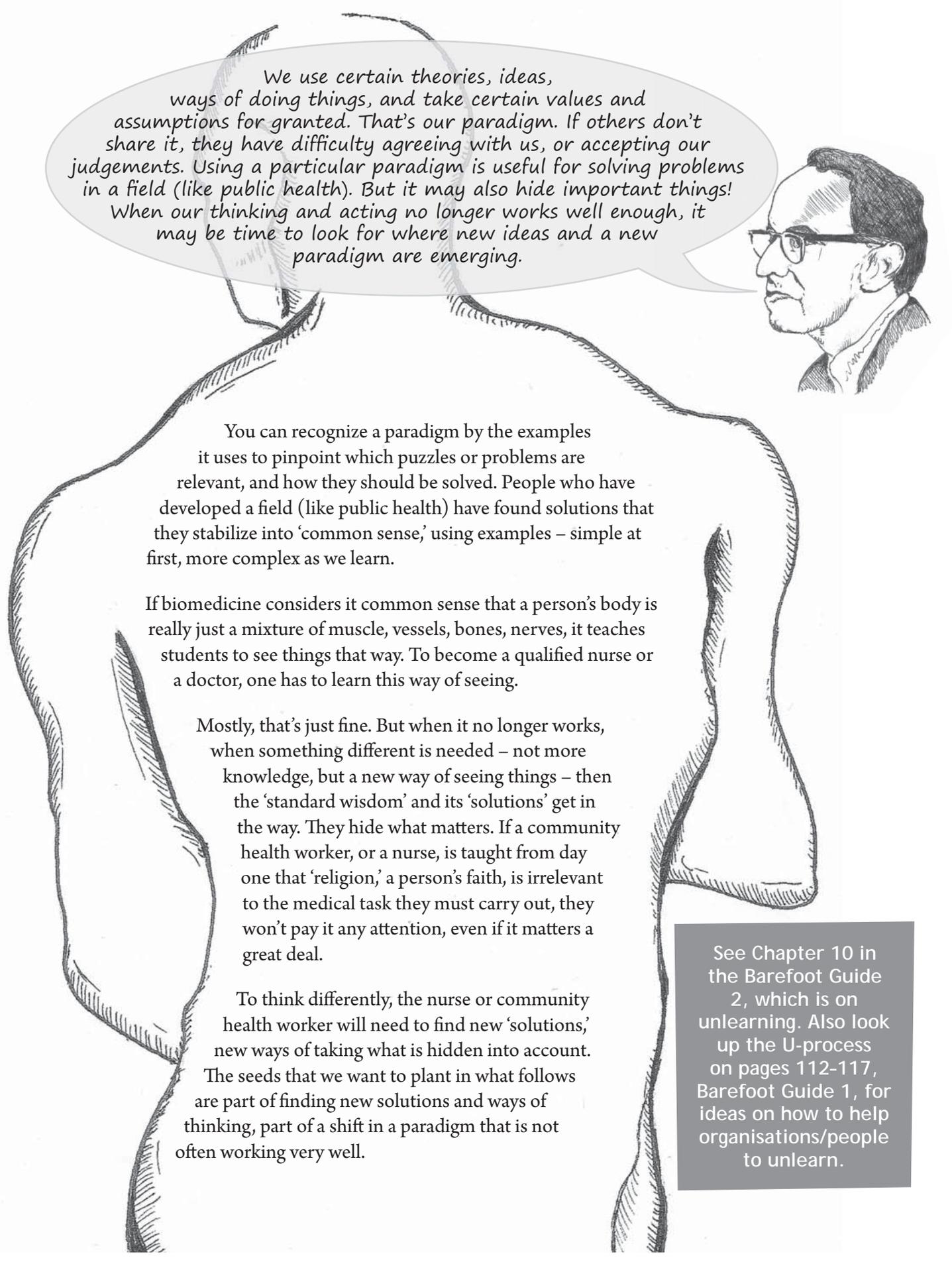
Many weeds, or unhelpful ideas, get in the way of our thinking about religion and the health of the public. They choke out the time and space, new and important ideas need to grow. In this Guide, we are planting many new idea seeds that we think are generative of the new growth we need. Don't weed them out just because you don't recognize them, yet.

These new, generative ideas are meant to 'shift the paradigm' we use for thinking about religion and public health. A paradigm, Thomas Kuhn says, is pattern of thinking (and acting) that shapes the way one asks questions and looks for answers. To shift a paradigm, when what you have now is not working, means to change your thinking, to examine the mental models you are using, and to find the appropriate new ones.



Thomas Kuhn

Thomas Kuhn is famous for his book on what he called *The Structure of Scientific Revolutions*. He is the one who wrote about what he called a 'paradigm shift.' This is a move from one view of 'standard wisdom' which doesn't work so well anymore, to another that works better – like the shift from Newton's science to Einstein's. One cannot solve existing problems any more using old ideas. Inventing the right new ideas is a big part of better thought and better action.



We use certain theories, ideas, ways of doing things, and take certain values and assumptions for granted. That's our paradigm. If others don't share it, they have difficulty agreeing with us, or accepting our judgements. Using a particular paradigm is useful for solving problems in a field (like public health). But it may also hide important things! When our thinking and acting no longer works well enough, it may be time to look for where new ideas and a new paradigm are emerging.

You can recognize a paradigm by the examples it uses to pinpoint which puzzles or problems are relevant, and how they should be solved. People who have developed a field (like public health) have found solutions that they stabilize into 'common sense,' using examples – simple at first, more complex as we learn.

If biomedicine considers it common sense that a person's body is really just a mixture of muscle, vessels, bones, nerves, it teaches students to see things that way. To become a qualified nurse or a doctor, one has to learn this way of seeing.

Mostly, that's just fine. But when it no longer works, when something different is needed – not more knowledge, but a new way of seeing things – then the 'standard wisdom' and its 'solutions' get in the way. They hide what matters. If a community health worker, or a nurse, is taught from day one that 'religion,' a person's faith, is irrelevant to the medical task they must carry out, they won't pay it any attention, even if it matters a great deal.

To think differently, the nurse or community health worker will need to find new 'solutions,' new ways of taking what is hidden into account. The seeds that we want to plant in what follows are part of finding new solutions and ways of thinking, part of a shift in a paradigm that is not often working very well.

See Chapter 10 in the Barefoot Guide 2, which is on unlearning. Also look up the U-process on pages 112-117, Barefoot Guide 1, for ideas on how to help organisations/people to unlearn.

WHICH ARE THE WEEDS?

We weeds, unlike stones, are alive. We keep growing, and it's hard to get rid of us. But if we get in the way of the plants that must grow, we may need some clearing. Bad ideas can be like weeds. Here are some, still in many people's brains, that probably need clearing.



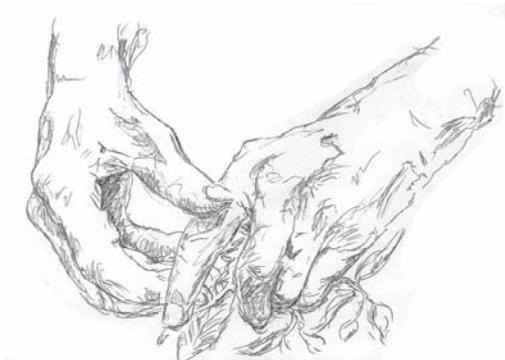
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BAD IDEA #1: "Religion will disappear as reason grows."



Many social scientists used to think that religion would fade away – or should even be done away with – as society 'advanced.' The thought people would see that their beliefs were ignorant and not rational, an illusion, unreal, merely an ideology. A truly modern society and enlightened person would not need religion. Some of those same social scientists now realize they were wrong. Even if they personally aren't religious, they see that religion remains important to many people and societies. It must be taken seriously, and given proper attention.

BAD IDEA #2: "Religion will be merely a private affair."



Some of those social scientists also argued that in a modern plural society, where people hold many different beliefs, religion would create conflict in public life. So people should keep their faith to themselves and those who agree with them. It is their private affair. Also, no one religion should be privileged by the state. Because the state is meant to serve everyone whatever their belief, it actually makes sense to separate the state from any particular religion in a plural society. Still, this does not mean that people should not draw on their religious convictions in debating the norms and values that shape life together. That's what it means to be a citizen. Then religion does have a public place.

BAD IDEA #3: “Religion is not political.”

Others say religion must have nothing to do with politics. Really? That means it should have nothing to say about public life. ‘Politics’ is from the Greek word polis, and it refers to the whole body of citizens who make decisions about their life together. To have nothing to do with ‘politics’ means not to care about our life together. Some religious people do think that what matters is ‘heaven’ or ‘souls’, not our life together or the world we live in. Talking about religion and public health then makes no sense, of course. But this is a pretty bad idea, and most religions through most of time would not find it very convincing. We don’t either.



BAD IDEA #4: “Health is about individuals.”

If some people think religion or faith is an individual’s business only, many people who work in health think really only about individual health too. Actually, many religious leaders are not much better – they also can’t see how health is really a public issue. So we find lots written about a person’s spirituality or religiousness and their health, how prayer, for example, helps people recover from serious illness or operations. But this does not help us think properly about the health of the public. We need something more.



BAD IDEA #5: “Body and spirit are separate.”

Scientific and religious thinking often get this wrong. Science, because it focuses on the material world, and its methods work best there, tends to ignore spirit. Take biomedicine; it’s heavily invested in understanding the body as a ‘thing,’ separate from spirit. Some religious ideas go the other way. They see ‘spirit’ (‘soul’?) as what’s real; the body is less important, or even regarded as inferior, a trap from which spirit must free itself. But persons-are-bodies-are-minds-are-spirit! The whole person is important to health. Both science and religion need to pay attention to the whole.



BAD IDEA #6: “Religious authority is always right.”

Religion can be dangerous to health too! Creating stigma around HIV is a well-known example. Usually the problem is not religion itself, but authorities who insist that they, and only they, hold the truth. They resist other ideas, don’t question their own thinking – a bad fit with the open questioning of science. But the best religious thinkers do ask open questions! They are able to transcend the limits of their own time and place. They introduce innovations into their communities. That is what we must work with.



SEVEN INTERCONNECTED SEEDS

Ways of Seeing Religion and Health

The rest of the Guide gives you much more insight and information into seven 'seeds' we want to plant for you. But here's the whole packet quickly!

**Embodied
Religious Mind
(Some history)**

Number 1

This is about getting some history back. Public health has a much closer relationship to 'religion' than many people realize, partly because the link has been lost. We tell three famous stories that show just how close the link can be. Perhaps you can also ask yourself: *what stories you can tell*, in your own context, that show the close relationship between the two?

**Religious Health
Assets**

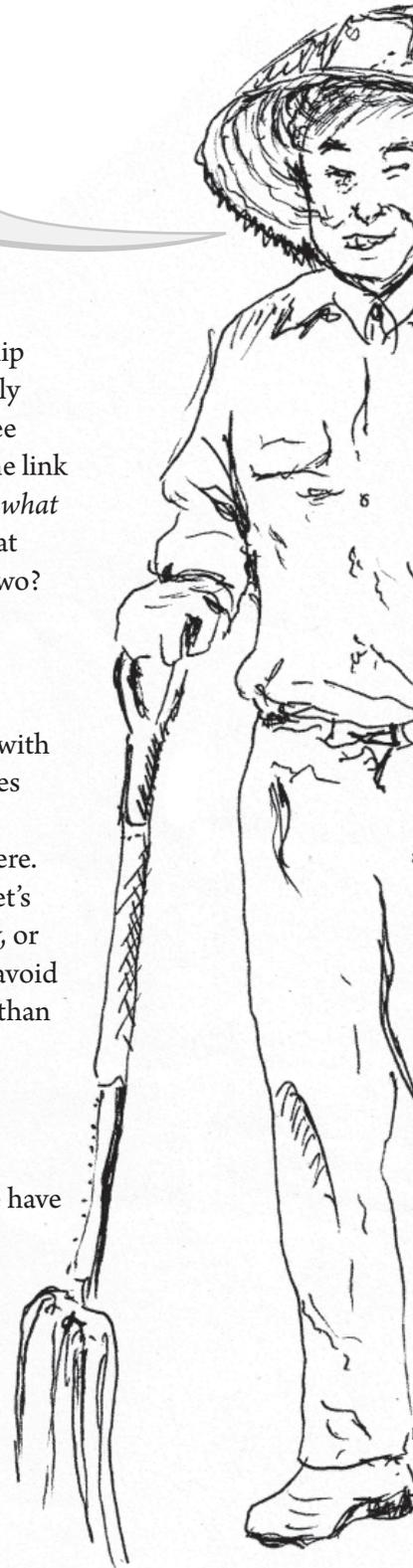
Number 2

Let's think differently! Many people start with what 'needs' a community has. That focuses on what is *not* there – for a person, family, community or society – that should be there. We use an asset based approach instead: let's ask what *is* there that people already know, or use, or rely on for their health. This helps avoid dependency. It builds on strengths rather than weaknesses.

**Leading Causes
of Life**

Number 3

We all know we die at some point. But we have lots of experts who tell us what is killing us and why, about 'the leading causes of death,' for example. Like starting with assets, what if we were to ask, and better to understand, *what causes life?* What gives us health and why? Remarkably, even in terrible circumstances, people show resilience, a 'lust for life.' Building on that can shift many things.



Number 4

Health providers are trained to do things in particular ways. *The person who seeks health* may do things differently for their health, maybe even ignore or resist what the health provider wants. We tend to have our own ideas about health and about whom we trust, often shaped by cultural or religious values and norms that matter to us. This impacts on healthcare.

It affects how health is delivered and whether it is accepted and acted on. That's what a healthworld is about.

Healthworlds

Number 5

People congregate together, because human beings are '*wired*' for *connection*, for relationships, community. In being with others, as in many faith groups, people often gain energy, inspiration, and hope. They are able to imagine creative new things that might be possible, and find ways to build positive futures together. People who gather together have strengths, and we can name them, and work with them.

Congregate Strengths

Number 6

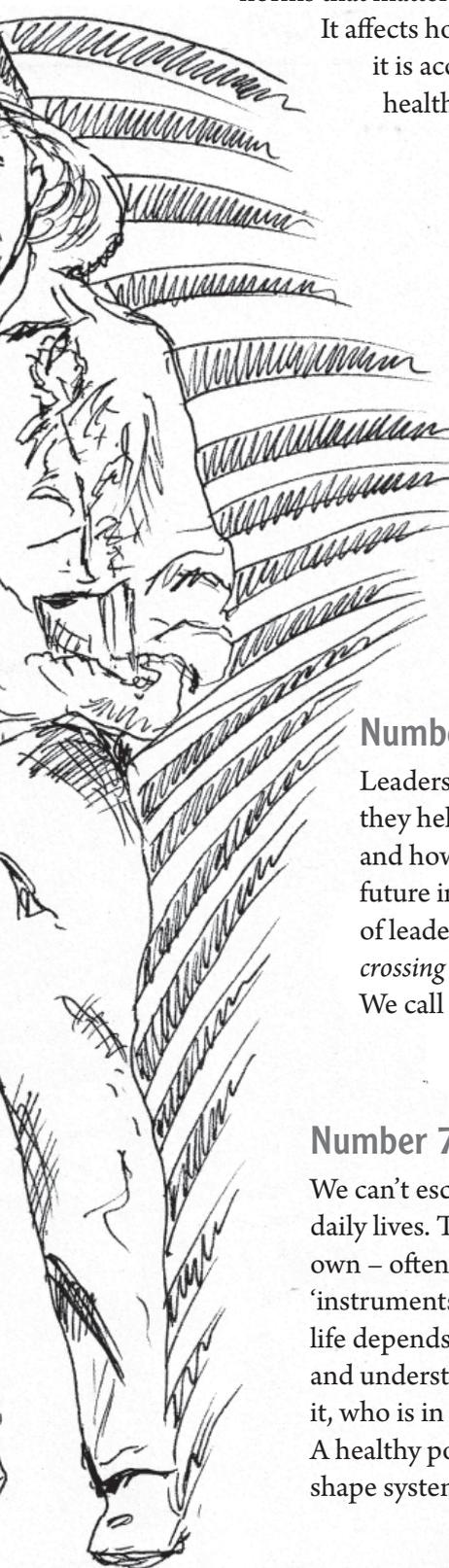
Leaders matter. Especially in how they live their lives, how they help others develop their own emergent possibilities, and how they help everyone form a new and more healthy future in a complex, often challenging world. This kind of leader is not 'above' others, but part of their journey, *crossing boundaries* that restrict us, opening up new wholes. We call this 'boundary leadership.'

Boundary Leadership

Number 7

We can't escape political and economic systems that shape our daily lives. They are a challenge. And they have a logic of their own – often an '*instrumental*' done! But we are not simply '*instruments*' to be used for someone else's purposes. Human life depends deeply on communication, on being understood and understanding. Knowledge also matters: who produces it, who is in control of it, what decisions are made using it. A healthy political economy needs everyone's capabilities to shape systems for the health of all.

Healthy Political Economy



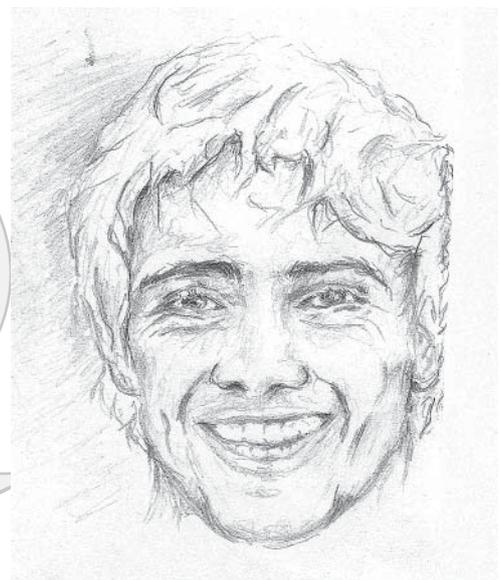
HERE'S ANOTHER WAY OF LOOKING AT THE SEVEN SEEDS



This diagram connects all the 'seeds' or ideas we have mentioned that we see as necessary for the kind of 'garden' we want when we think of 'the health of the public and the health of all.' It is important to remember that they belong together. They are connected in practice, in how things actually work, we have found in many different contexts and places. Our thinking is better when it includes the whole.

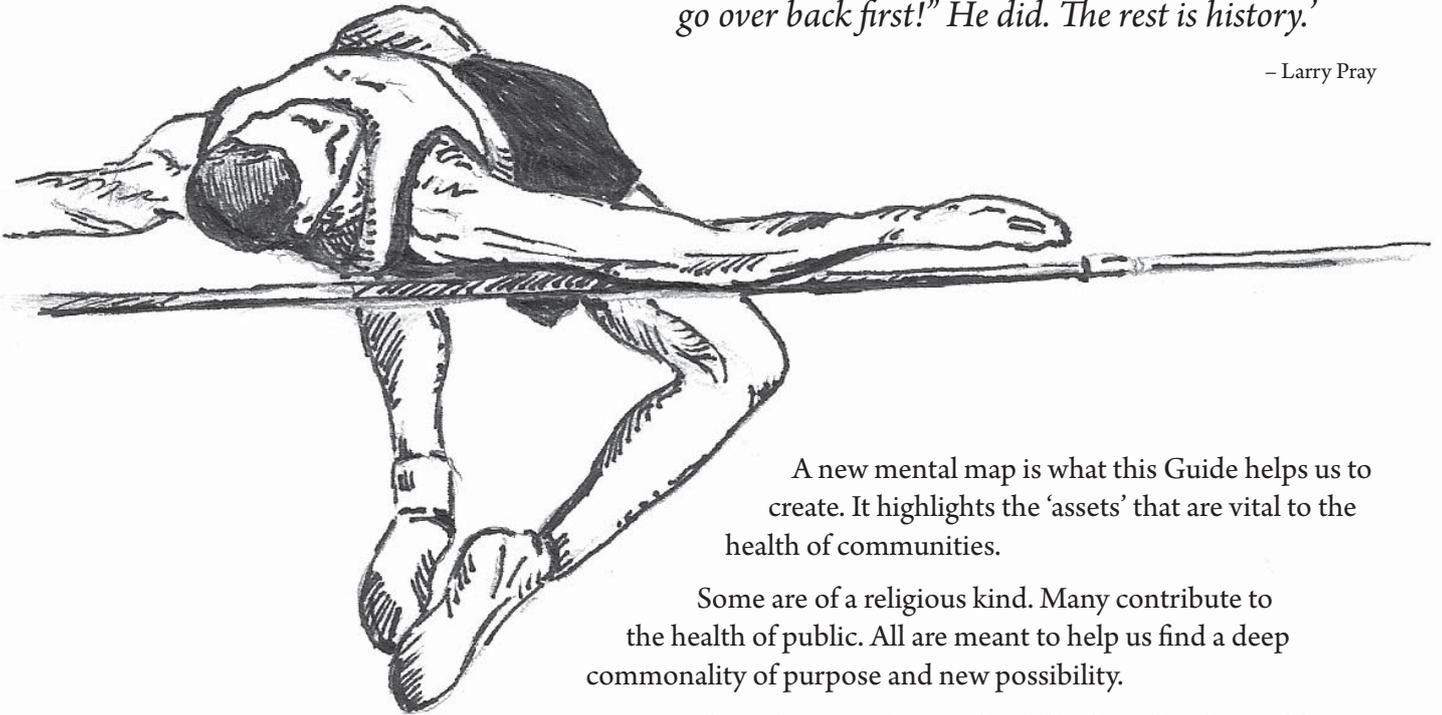
... and 'Deep Accountability'?

All these ideas mean little if we don't have a practical commitment to the intentions lying behind them – to transform the conditions in which people live, so that they really do have better health, not just individuals, but also communities and societies. 'Deep accountability' means being responsible for that vision. It sits at the centre of all these ideas, and it has to if they are to make any difference in reality.



'The scissors kick was a wonderful way to do the high jump. Until a guy said, "What the heck, I think I will go over back first!" He did. The rest is history.'

– Larry Pray



A new mental map is what this Guide helps us to create. It highlights the 'assets' that are vital to the health of communities.

Some are of a religious kind. Many contribute to the health of public. All are meant to help us find a deep commonality of purpose and new possibility.

We are not the only ones who see the difficulties that face public health at present. Or who are interested in what is emerging that embodies the shape of the future. The situation in public health is critical, and the potential role of religion in the health of the public is not well grasped either by health workers or religious leaders.

That's what makes the question of shifting the paradigm of religion and health worth asking.

Benedictine Blessing

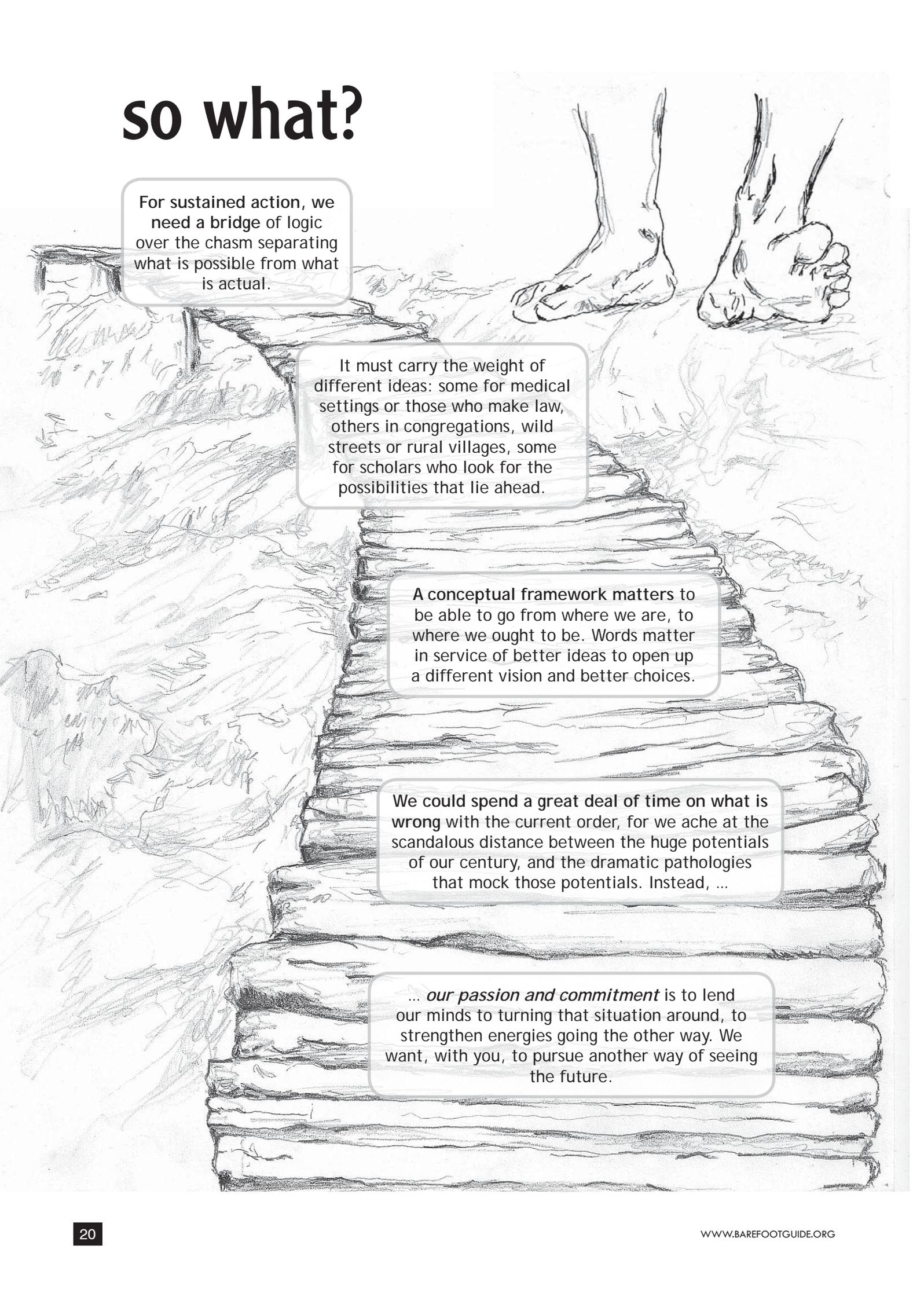
May God bless you with anger at injustice, oppression, and exploitation of people, so that you may work for justice, freedom and peace.

May God bless you with tears to shed for those who suffer from pain, rejection, starvation, and war, so that you may reach out your hand to comfort them and to turn their pain into joy.

And may God bless you with enough foolishness to believe that you can make a difference in this world, so that you can do what others claim cannot be done.

–by Sr. Ruth Fox, OSB (1985)

so what?



For sustained action, we need a bridge of logic over the chasm separating what is possible from what is actual.

It must carry the weight of different ideas: some for medical settings or those who make law, others in congregations, wild streets or rural villages, some for scholars who look for the possibilities that lie ahead.

A conceptual framework matters to be able to go from where we are, to where we ought to be. Words matter in service of better ideas to open up a different vision and better choices.

We could spend a great deal of time on what is wrong with the current order, for we ache at the scandalous distance between the huge potentials of our century, and the dramatic pathologies that mock those potentials. Instead, ...

... *our passion and commitment* is to lend our minds to turning that situation around, to strengthen energies going the other way. We want, with you, to pursue another way of seeing the future.

We want our history back!

Linking religion and public health

If you go to see a doctor, the first thing they do is to 'take your history.' No machine can do that; they have to talk to you, ask questions so they can develop some ideas about what has led to a particular health situation. We will now do something similar—'take a history' of the link between religion and public health. It is a very long story, much of which—like a slow-growing medical condition—needs thoughtful questions to uncover it all. It matters because history is not really about the past; it gives us clarity about what might come next! Taking a history gives leaders a chance to shape the future.

BEFORE YOU READ FURTHER, LET'S THINK ABOUT WHAT YOU KNOW!

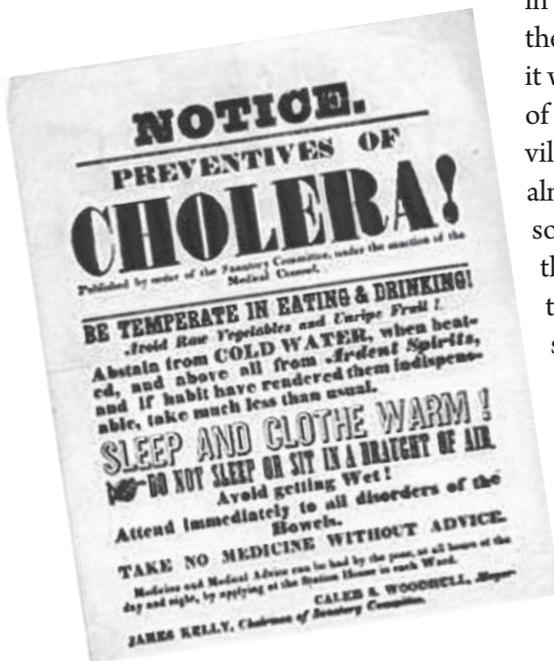
There are certainly people or organizations, in the communities or society where you live and work, that have been important to the health of the public. Think beyond the obvious people with official jobs called "public health." Who else has contributed? How long have they been there? Why did they begin? What was their original vision? Do they still match that vision? Have the communities or society within which they are situated become healthier because of their presence and work? If we think of health as a right for all, as a sign of how much justice and equity there is in your communities and society, have the people and organizations committed to health help produce that?



To help you think about the link between religion and public health, we share three stories. Why these three? Because they are *the* three iconic stories of public health in the last 150 years – about the foundations of modern epidemiology (cholera story), the rise of primary health care (the key mandate linked to the who), and the eradication of smallpox (still the standard case for all inoculation and disease control measures). It happens that they are all connected to some Christian persons or institutions, but that's a coincidence. You may know of similar happenings in your context and tradition, too.

‘MAPPING THE BODY’... Chronicles of Cholera

Almost everyone who studies public health hears about *one story* in their first year of studies. That epic tale begins in London in the 1850's, a hard time for a city that is *very* different now than it was then. The Industrial Revolution was in full swing; tens of thousands of people who once worked the land or served in villages now came to London to find work. Familiar today, it was almost unprecedented then. London was so very crowded that sometimes five, six, even ten people shared one room in a house, the poorer ones in the upper part, and the slightly less poor in the lower. Significantly, they fetched their water from pumps scattered across the different streets.

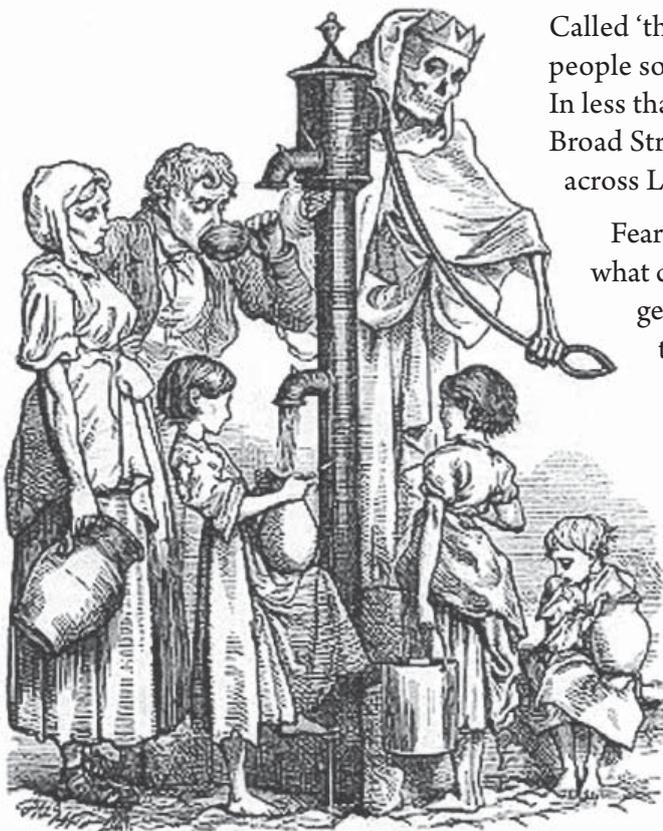


London *stank*. Sewerage was thrown into yards or basement cisterns, or ran along streets. Dirt was everywhere. A Punch magazine cartoon of the time shows garbage piled high in the middle of a street – perhaps Broad Street in Soho (close to where Karl Marx lived with his family). ‘A Court for King Cholera!’ the cartoon said. This deadly, frightening disease thrived in these conditions.

Not long after the cartoon, in 1854 cholera *did* break out, in Broad Street! Still a relatively unknown disease in England, it came with colonial ships from the Ganges River in India. Called ‘the blue death,’ cholera acted quickly, dehydrating people so rapidly that some died in hours, especially children. In less than a week several hundred had died in and around Broad Street. Those who could fled in panic, and fear crackled across London.

Fear thrives in ignorance, and nobody really understood what caused cholera. Not much was known then about germs, like bacteria or viruses. Everyone believed that the wretched, stinking air carried disease, the ‘miasma theory,’ from the Greek word for air. The stench made it seem obvious: cholera must move by air, and it was hard to think of any reason to question this.

A wakeful leader knows, however, that when fixed assumptions aren't working, it's exactly the right time to ask questions! John Snow was a doctor who lived near Broad Street, and he loved to ask questions. Already well-known as an inventor of modern anesthesia and physician to Queen Victoria, he suspected that cholera came from water, not air. This made his medical colleagues think him not only wrong about cholera, but a crank, and the editor one of the famous medical journal, *The Lancet*, publicly mocked him for his views – couldn't he smell?



Yet Snow became part of the history of modern public health, despite those who mocked him. Spending the first two days around Broad Street, he counted the deaths in each household, marked them on an area map, and looked for a logic. Seeing with new eyes, he saw a pattern of deaths. At its centre was a pump supplying water to people in the area – the one in Broad Street.

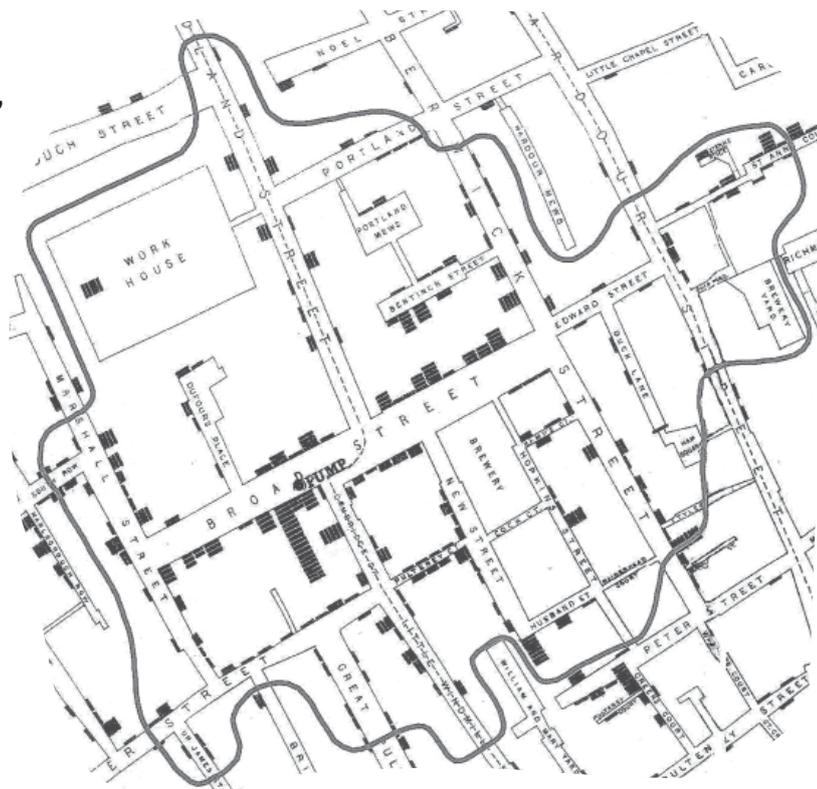
“Take off the handle!” he pleaded with local authorities. They were reluctant, but desperate, so they did. Within a couple of days, the number of sick people and deaths went down dramatically. Still no-one was convinced Snow was right. The Broad Street pump was known to have the best water in Soho. Why should *it* be the source of cholera?

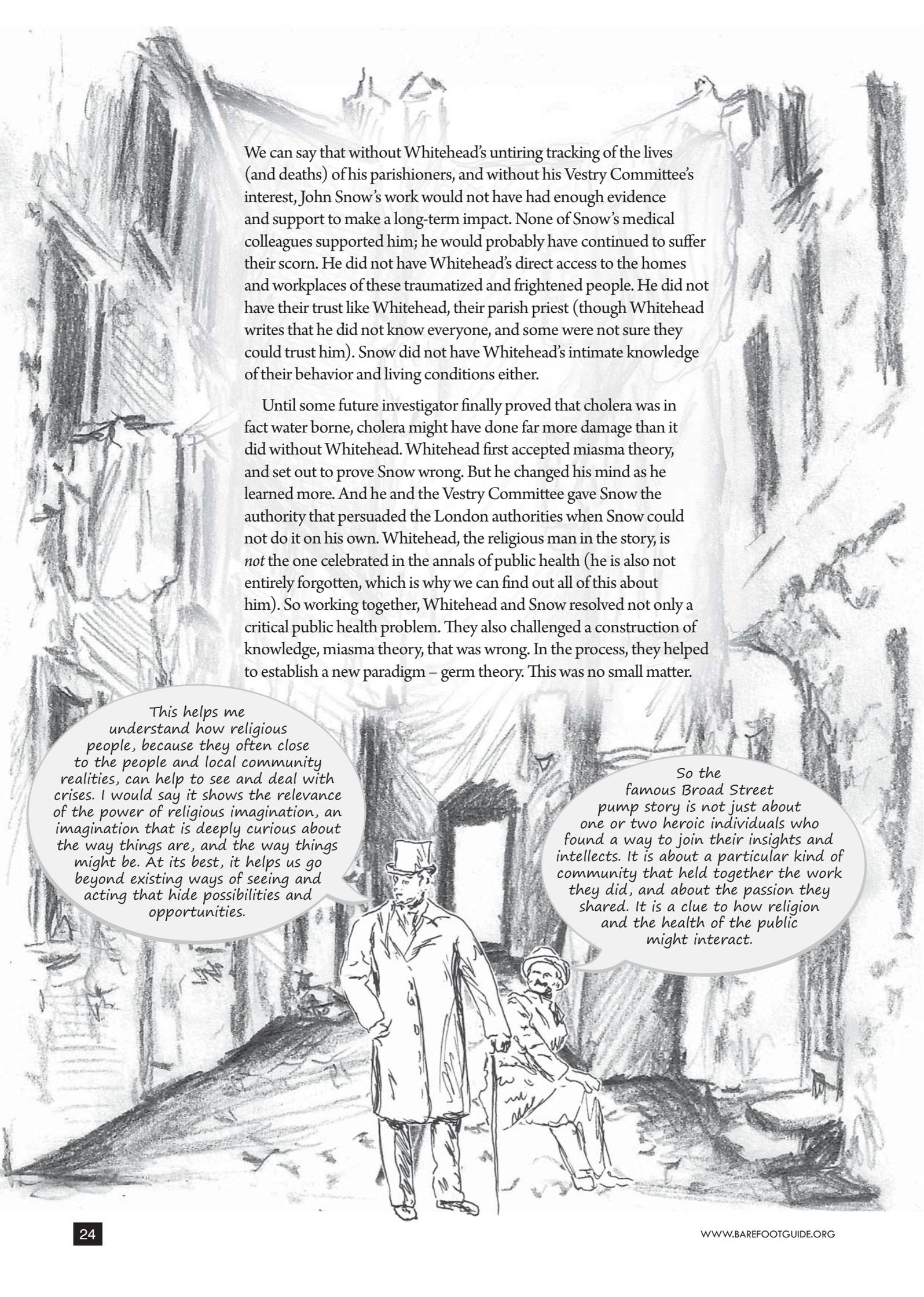
Here’s part of the story that gets particularly interesting for us, and it is not so well known. Actually, public health students hardly ever hear it. They are taught Snow’s way of mapping disease, a key method of the science of public health, epidemiology – the study of epidemics. They don’t hear about crucial evidence that eventually led people to accept Snow’s theory that cholera is a water-borne disease, evidence that came not from Snow, but from another man – the Reverend Henry Whitehead.

Yes, a Reverend. But an unusual pastor, in that his faith encouraged him to ask questions, really basic ones. The curate of the Anglican church in the Broad Street area, his church Vestry Committee asked him to test Snow’s theory, which Whitehead expected to prove wrong. So he started visiting all the people he could find: those sick and dying, those who had lost someone to cholera, those in the area who did not become ill. He took detailed notes, for months, even tracking down people who, having moved away in fear, had not come back to Soho.

This was no intellectual game for him; his parishioners were dying. He knew them from funerals, weddings, births and celebrations. He knew where they walked, what conditions they lived in, how they coped. And, most of them trusted him. He could spend time in their homes, coming back over and over again to ask more questions as John Snow had no way of doing. So he learned information Snow needed. Why did people die who lived near another pump, or had left the area, if the Broad Street pump was to blame? Why did some who lived near the Broad Street pump not get sick or die? What caused the initial outbreak?

He was able to answer *all* of these questions, and later, after Snow had died (fairly young), Whitehead became an advisor to the City of London about how to stop cholera. Whitehead embodied religious passion and *compassion*, the trust his pastoring of people earned him, his close connection to them and their lives, his willingness to go way beyond duty, and the support he got from his Vestry Committee (who had asked him and Snow to work together, which they did). We obviously need curious, courageous physicians like John Snow in every community. But we need to remember how much we also need curious and compassionate spiritual leaders. When those two kinds of passion converge, there is no telling what is possible.





We can say that without Whitehead's untiring tracking of the lives (and deaths) of his parishioners, and without his Vestry Committee's interest, John Snow's work would not have had enough evidence and support to make a long-term impact. None of Snow's medical colleagues supported him; he would probably have continued to suffer their scorn. He did not have Whitehead's direct access to the homes and workplaces of these traumatized and frightened people. He did not have their trust like Whitehead, their parish priest (though Whitehead writes that he did not know everyone, and some were not sure they could trust him). Snow did not have Whitehead's intimate knowledge of their behavior and living conditions either.

Until some future investigator finally proved that cholera was in fact water borne, cholera might have done far more damage than it did without Whitehead. Whitehead first accepted miasma theory, and set out to prove Snow wrong. But he changed his mind as he learned more. And he and the Vestry Committee gave Snow the authority that persuaded the London authorities when Snow could not do it on his own. Whitehead, the religious man in the story, is *not* the one celebrated in the annals of public health (he is also not entirely forgotten, which is why we can find out all of this about him). So working together, Whitehead and Snow resolved not only a critical public health problem. They also challenged a construction of knowledge, miasma theory, that was wrong. In the process, they helped to establish a new paradigm – germ theory. This was no small matter.

This helps me understand how religious people, because they often close to the people and local community realities, can help to see and deal with crises. I would say it shows the relevance of the power of religious imagination, an imagination that is deeply curious about the way things are, and the way things might be. At its best, it helps us go beyond existing ways of seeing and acting that hide possibilities and opportunities.

So the famous Broad Street pump story is not just about one or two heroic individuals who found a way to join their insights and intellects. It is about a particular kind of community that held together the work they did, and about the passion they shared. It is a clue to how religion and the health of the public might interact.

No-one Heals Alone!

After the Second World War, new countries were emerging and the United Nations was created. One of the big new global ideas was the first world-wide public health agency, the World Health Organization (WHO). Like everyone else in a changed world, the WHO had to work out its main focus, its 'mandate,' as many people call it. The next few stories, about the role of some religious leaders, are an important part of how that mandate came into being.

Story 1: Playing in your own backyard

In the 1960's, as Africa began to shake off the shackles of colonization, medical missionaries and churches were among those looking to fit in with the newly independent states. Malawi's a good example. Protestants and Catholics provided almost half of the formal health care. But twenty-six different church bodies controlled it! And, they neither worked with each other much, nor with the state health system. As the President of Malawi said, they were all 'playing in their own backyards and they never look over the wall.' This made it impossible to work with them. So leaders of the churches came together to figure out what they should do. They had a survey of their physical health assets done. The very first recommendation of the report from that survey made the most critical point. It noted that different churches and denominations put a lot of stress on naming and protecting their identities, in which they had a lot at stake. But, the report said, it was time for the churches to 'disregard the labels on their doors, which never cured anybody!' And so was born the Christian Health Association of Malawi. Because its members also had close links to local people through their congregations, they also began to pay attention not just to the health of individuals, but to community health.

‘ ... Labels never cured anybody ... ’

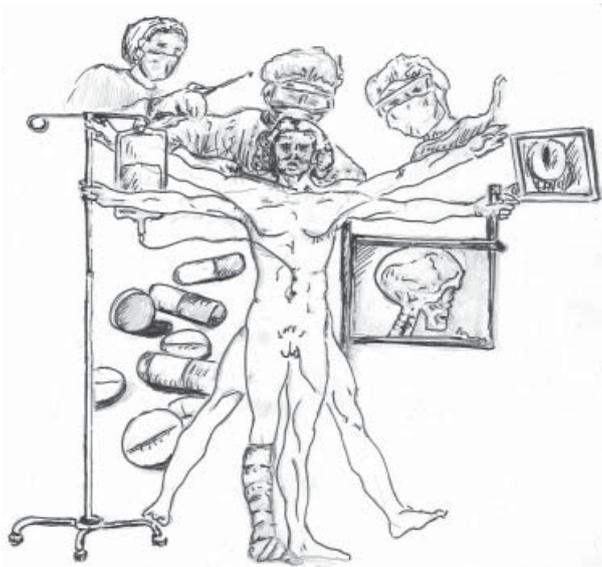


One thing that becomes clear in this story: organizations really do matter - not their existence as such, but *how* they work and *why*. Some kinds of organizations are not able to go beyond the boundaries that define them, when they really need to. This is especially important if one wants to change situations that need to be changed. For more on how to understand and build organizations that are good at this.

See The First Barefoot Guide To Working with Organizations and Social Change



Story 2: A factory for repairing things



Our first story hinted at why people needed to come together to make a difference beyond their own backyards. But medical missionaries were asking even deeper questions. Many of their hospitals and clinics were world-class. But what the doctors and nurses became increasingly uneasy about was how limited this reach was. They served only those who came to them, not the many thousands more they should be able to reach in communities all around them. They mainly fixed what was already broken, doing little to prevent people becoming broken. Hospitals and clinical care also cost a lot, and many illnesses did not need high costs to prevent them. So the World Council of Churches and others called a meeting in Tübingen in Germany. 'Is there any better way to advance health?' they asked. The answer?: "no-one heals alone!" Health and healing must incorporate the whole community, not just those who had access or could afford it. At a second meeting in Tübingen in 1967, Dr Robert Lambourne was even blunter: medicine has been caught up in specializations, technologies and measurements. No longer really a place for the care of persons, it has lost its humanizing vision to become a 'factory for repairing things.' It had become too focused on defeating death, rather than strengthening life. A much deeper, richer vision of health was necessary.

Story 3: They who are not



In 1966, to take up the issues identified at the Tübingen meetings, the World Council of Churches founded the Christian Medical Commission (CMC), a group of 25 influential leaders, eighteen of them health professionals. Its goal was to enable people all over the world, Christian or not, to think about the deep challenges to the health of the public. Again Dr Robert Lambourne expressed its concern. He called the global failure to deliver health to *all* the people who needed it 'the final injustice, the ultimate injustice.' Dr John Bryant, Chair of the CMC and an internationally known health scientist, pointed out that despite massive efforts and money, 'vast numbers of people do not benefit from modern knowledge and technology in relation to health.' The poorest, he said, are too often excluded at every level, 'lost from sight; difficult to find.' They are, to most health providers, '*they who are not.*' With this kind of thinking, and with a clear recognition of how power, politics, markets and science tend to work, the CMC called for a new vision of health care. This had to recognize the total needs of human beings in community. It had to treat not just individuals but 'the community as patient.' So the CMC began to look for ways to make this real.

Story 4: The birth of Primary Health Care

Two of the people appointed to the Christian Medical Commission were senior staff of the WHO, which was very interested in the ideas emerging from the CMC. They regularly reported back on these ideas: that health care should be just and equitable, available to all, especially the poorest and those who could not reach any hospital or clinic; that it should be rooted in communities or villages to help achieve this; that it should be understood as something more than just 'the absence of disease.' From the CMC's search for alternative models, the WHO also learned of people around the world who were breaking open the old models and building the new ones that were needed. Eventually, in 1974, Halfdan Mahler, the General Secretary of the WHO, called a full consultation with the CMC to help plan a new future for health through a joint working committee. Then, using a great deal of what had been learned from the CMC, in 1975 the WHO published its ground-breaking book on *Health by the People*. What had been the concern of Christian Medical Missionaries (and some others) went global. The new vision was called 'primary health care,' and it is captured in the famous 1978 Alma Ata Declaration of the WHO. Now, almost 50 years later, we are coming back to this vision. It still needs to be fulfilled.

“No-one heals alone!”



'This is from the first four paragraphs of the WHO's Alma Ata Declaration.'

Declaration:

I

... health [which is] a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right ... the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

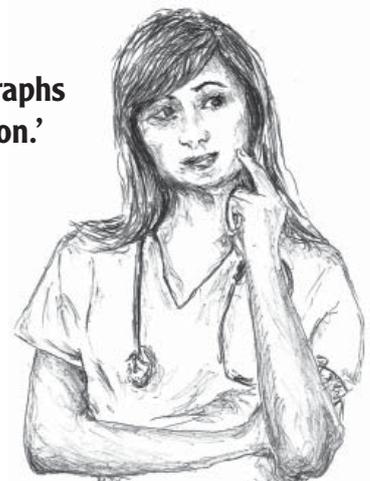
The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development ... is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development ...

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.





'Who matters in creating health? How are we ever going to have 'health for all'? Is it up to governments? Why should we believe they can do it, when they are often too weak to do it, or too busy focused on other things, or have too many corrupted or uninterested people in them?'

'Yeah, OK, I understand your worries or suspicion. The dream of Alma Ata and universal 'health for all' has not worked out that way – they hoped to get there by the year 2000! But there's nothing wrong with the dream! Actually, despite the past, people everywhere now are saying that we have to reawaken this dream. Everywhere. Backed by everyone. Especially those who want change!'

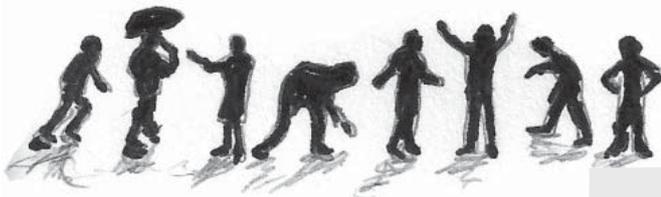


'And what about medicalization? It's a weed! I don't mean medical science, which we need. I mean turning everything about health into drug treatment or a special technique using fancy and expensive equipment that most people will never see!'

'That's a big issue. Technologies, pharmaceuticals, instruments, things, are so much at the centre nowadays. What we really want is the humanization of medicine!'



'It means we have to deal not just with individuals and their health, with my body or yours. We have to deal with the social body, the things that make lots of us sick or unwell. Or stop us getting well or having proper health.'



Story 5: A graven image of excellence...

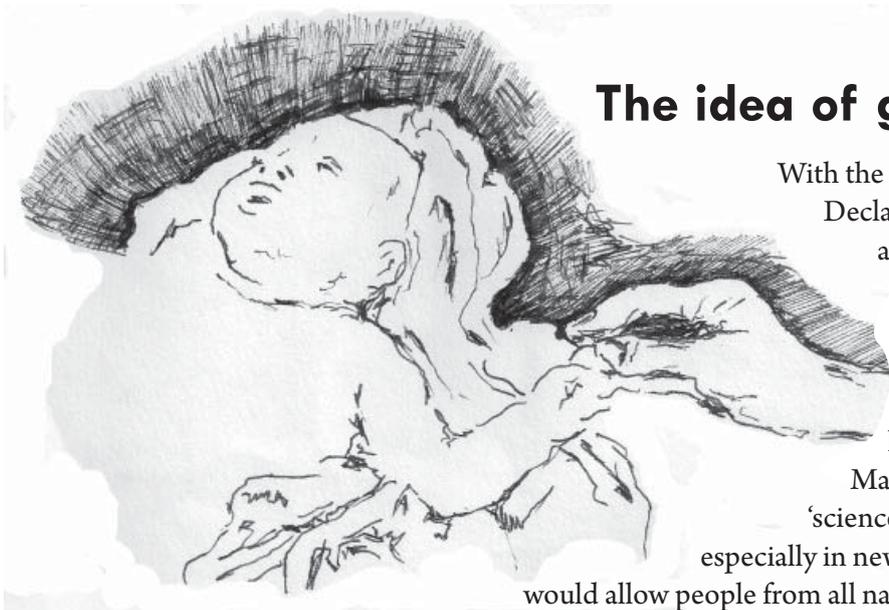
The ideas behind the thinking of the CMC and the WHO on primary health care are not about doing away with the sciences of medicine or hospitals and the like. Excellent health care of that kind is important, but not enough. Dr Lambourne again helps us see this. In a true story, he told the CMC of a famous hospital for children in Africa. It offered the best available medicine and care. And still, year after year, the rate at which children in its district died remained awfully high. Then an observant new head of paediatric (child) care arrived. He noticed that most of what was needed could and should be done by village health workers. So he trained them. Remarkably, in five years the infant mortality rate dropped by almost two-thirds. 'What was killing all those children before?', asked Lambourne. 'A sacred, stereotyped view of excellence!', he said, 'a graven image of excellence, tempting us to idolatry.' Excellence as a scientific or medical ideal is a long way from enough to achieve the revolution of 'health for all.' What really matters is *how resources are used* – money, people, buildings, organizations, state bureaucracies, research, health assets.



THE SURPRISING HISTORY OF SMALLPOX AND THE RELIGIOUS MIND

Outbreak in Biafra

In 1966 a deadly smallpox epidemic began in the Nigerian province of Ogoja. The WHO and others thought they could control smallpox if they could immunize at least 80% of the population. They called it 'herd immunization' (a strange phrase, we admit). But this method is almost impossible in many places. Health leaders had the technologies to do it (see the box below on "The Idea of Global Health"), but that's not the only think that counts - at all! Let's see what else did count in the end to get rid of smallpox completely.



The idea of global health

With the Alma Ata Declaration, the WHO adopted a grand vision for public health. Two 'world wars,' the holocaust, and the atomic bomb, had made many people realize that something had to be done to change the world. Many people thought that 'reason' and 'science' would bring the progress needed, especially in new international organizations that would allow people from all nations to work together. Many new

nations were emerging too, especially with decolonization. Through the United Nations global action in education, scientific knowledge, children rights, labour, development and health became possible.

Through the WHO, the idea of "global health" was born, to bring together ideas, institutions and technologies across the world. Primary health care makes it more radical, because it promotes the participation of people in local communities in building a new era of health. Other

huge inventions in health science include the jet vaccination gun (it is easy to use and effective), the bifurcated needle (it always gives the right dosage of vaccine),

and freeze-dried vaccine (it means people living even where there is no electricity can be immunized on a big scale). Global

health is about the health of all.



“Think like a virus!”

A window of possibility existed for stopping smallpox, *if* one could gain sufficient intelligence about the human networks through which it travelled.

The vital key to this window, however, lay in understanding the human context in which the virus traveled. It required, in effect, drawing a map of the contagion that, much like Snow’s cholera map, was informed by knowledge of the way people actually lived and moved on the map. This is why Foege turned immediately to other missionaries.

He knew fourteen of them in the region, and arranged to meet them every evening on the radio, comparing information about other sightings of smallpox. Each, in turn, used their extended networks of friends and members to go into every village and marketplace looking for signs of the disease. When an infected person was found, a map of their likely social pathways was drawn, and everyone on it immunized. However laborious, it was far more tightly targeted, efficient and faster, than trying to immunize the entire population, especially one at war.

From the initial six cases, four more were found in the first week. In the second week the radio network discussed twelve more, and then another nine in the third week. By the fourth week there was silence on new cases; the disease had lost its foothold and had, indeed, been defeated. This became the fundamental logic on which the global strategy to eliminate smallpox rested. Applied subsequently in India, which presented an entirely different order of complexities, the last case was reported only nine years after Foege made that first radio contact with his fellow medical missionaries.

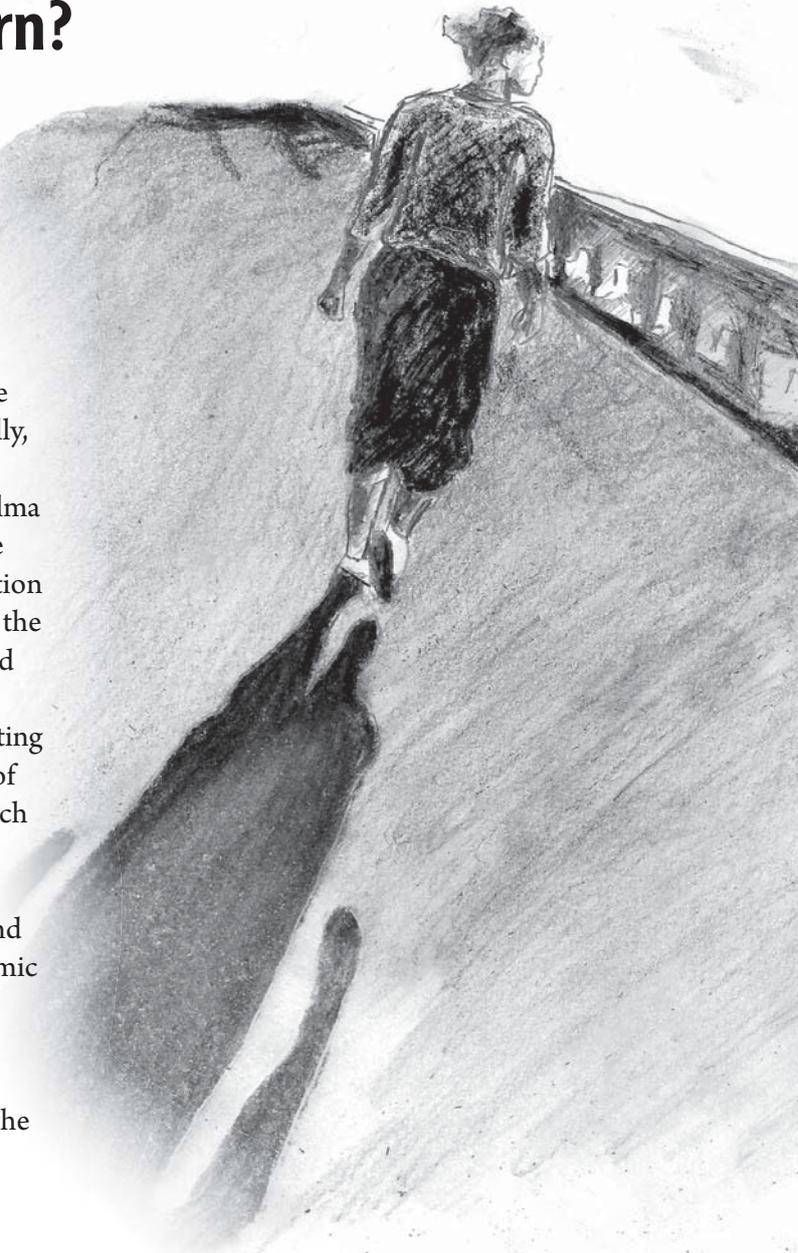


Religion can also be unhelpful. In Benin, the power of deities was identified with the disease itself, which supported a self-defeating myth about its inevitability and invincibility, and gave authority to local healers who hid the disease, often out of economic self-interest, or undertook practices that unwittingly spread it. This does not mean indigenous religions are the problem. It does mean that religion, any religion, can blind us to something crucial.

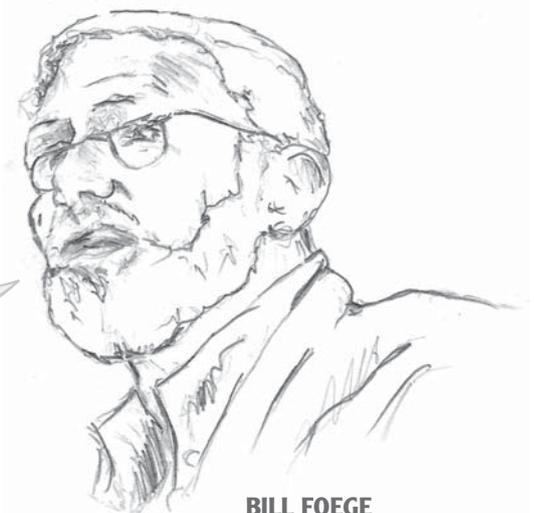
What lessons do we learn?

I want my history back!

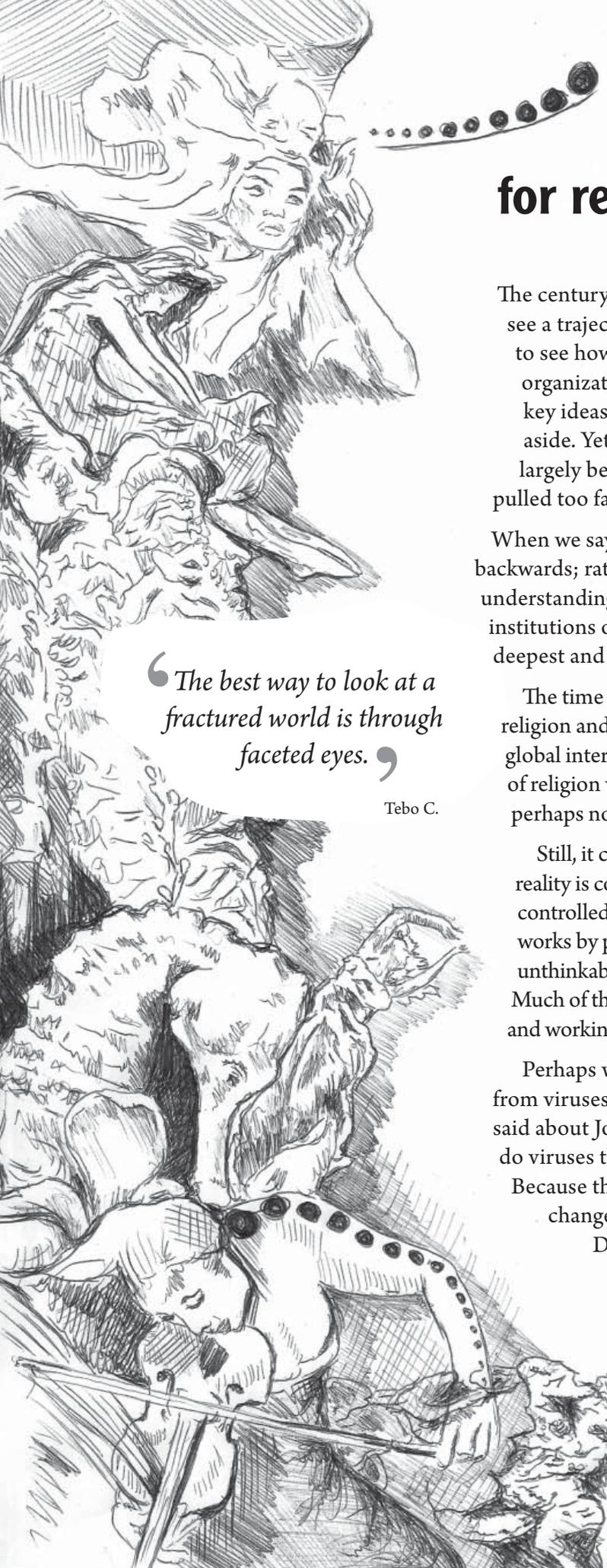
That a deadly and horribly disfiguring disease could permanently be removed from human experience by systematic action was an unthinkable thought until it happened. What else, previously unthinkable, might be possible? The elimination of polio, measles, or more obscure blights such as guinea worm? Or, most basically, health for all? That last question, the most radical, demands an expansive imagination. The histories of Alma Ata and smallpox eradication show that it included the religious imagination, which had shifted the prioritization of centralized clinical medicine offered by hospitals to the kind of life-changing health science possible “at the end of the road,” upstream, extended into the reality of the tiniest village. If smallpox inspired thoughts of eradicating other diseases, primary health care inspired thoughts of extending to all the most basic promises of science. Each offered hope at different ends of the same tunnel: the great majority of diseases are transmitted in ways that are not as easy to interrupt and contain as smallpox, and most of them thrive in a complex stew of social economic and political reality that favors some people and not others. The idea of health for all is thus a grand vision situated within the hope of altering social conditions towards greater justice *and* mercy. It needs to recover the important connections between religion and health.



Where others look for early signs of pathology and the underlying pathogen, we look for effective community building and the underlying dynamic. Where most look for interventions that can stop the spread of disease, we are committed to interventions leading to an epidemic of good health.



BILL FOEGE



A new springtime for religion and public health

The century or more our three stories cover is long enough to see a trajectory. It's also short enough, contemporary enough, to see how integrated the threads of individual histories and organizations can be in the search for 'health for all.' All the key ideas that emerged then still matter, none can be left aside. Yet the link between religion and public health has largely been lost in the last decades, the integrated threads pulled too far apart.

When we say 'we want our history back,' we don't mean going backwards; rather, we mean going forwards, with a deeper understanding of what is possible when religious people and institutions of faith are fully aligned with each other and with the deepest and most important goals of public health.

“The best way to look at a fractured world is through faceted eyes.”

Tebo C.

The time for simplistically ignoring, separating out or attacking religion and its traditions is over. With many new insights and global interest, there is good reason to think that a reconnection of religion with the health of the public is in a new spring – and perhaps not just globally, but also in *your* community.

Still, it can't be 'more of the same.' We will need to accept that reality is complex and unpredictable, that it cannot be simply controlled or bullied. This requires an *adaptive* logic, one that works by putting together things that seem unlikely, even unthinkable within an established and secured existing logic. Much of this Guide is about a new adaptive logic, about imagining and working with another way.

Perhaps we need to 'think like a virus,' as Foege put it, to learn from viruses. That's exactly what Dr Nathan Wolfe, a virologist, said about Jonas Salk's idea of 'an epidemic of health.' Why do viruses thrive in the face of constant challenges, he asked?

Because they are capable of 'adaptive novelty' – they can change. And they do so by sharing their essence – their DNA – with each other, in the process creating a new form of life. It's what we see around the

world in thousands of communities. Maybe it is happening or can happen in your community too. One way to read our three stories, then, is to see them as models for the kind of combined imagination, hope, experience and intelligence that is needed to meet the challenges of our time.

What we have to work with: Mobilizing religious health assets

This chapter is about an important idea – ‘religious health assets.’ A simple, but powerful, idea that raises many issues that are not so simple. Let us begin with a story.

ASSET ... *What one has that is valuable or useful*

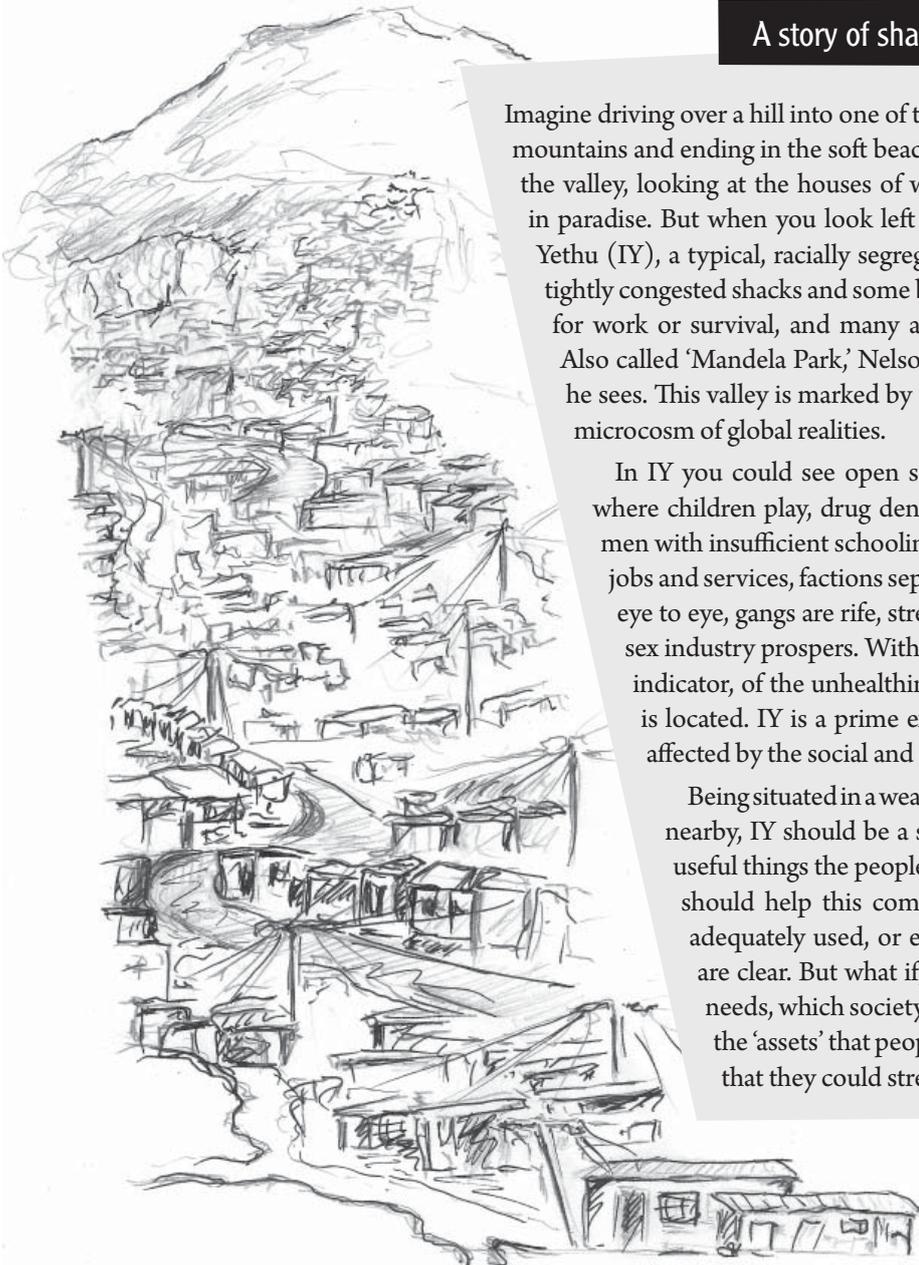
A story of shacks and shackles

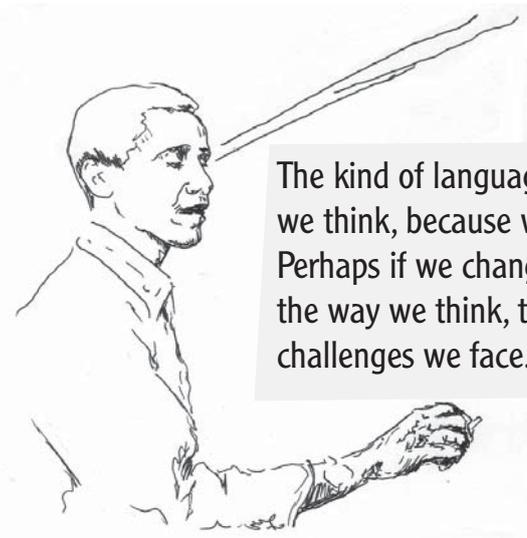
Imagine driving over a hill into one of the most beautiful valleys, enclosed by high mountains and ending in the soft beach sand of a stunning bay. As you drive into the valley, looking at the houses of well-off residents, you might think you are in paradise. But when you look left at the opposite hillside, you see Imizamo Yethu (IY), a typical, racially segregated South African settlement, filled with tightly congested shacks and some brick houses. Most people in IY are looking for work or survival, and many are refugees from other African countries. Also called ‘Mandela Park,’ Nelson Mandela would not be happy with what he sees. This valley is marked by deep inequality, a kind of social poison – a microcosm of global realities.

In IY you could see open sewerage, animal faeces, trash filled gullies where children play, drug dens and drinking places, unemployed young men with insufficient schooling stilling their despair. People compete for jobs and services, factions separate them, landlords and tenants don’t see eye to eye, gangs are rife, street children scavenge, and an often abusive sex industry prospers. With major health hazards, IY is a symptom, an indicator, of the unhealthiness of the broader society within which it is located. IY is a prime example of how individual health is deeply affected by the social and environmental determinants of health.

Being situated in a wealthy area, with government health resources nearby, IY should be a success story, but it isn’t. The valuable and useful things the people have or have access to – their assets – that should help this community to thrive are not harmonious, or adequately used, or even considered as assets. The needs of IY are clear. But what if, instead of focusing *only* on problems and needs, which society tends to do, more emphasis was placed on the ‘assets’ that people in the community already have access to that they could strengthen and work with?

“Would that help? And what would that mean? Let’s see.”





The kind of language we use influences the way we think, because we think in words, in concepts. Perhaps if we change our language, we can change the way we think, the way we understand the challenges we face. Try these concepts ...



DIALOGICAL ACTION

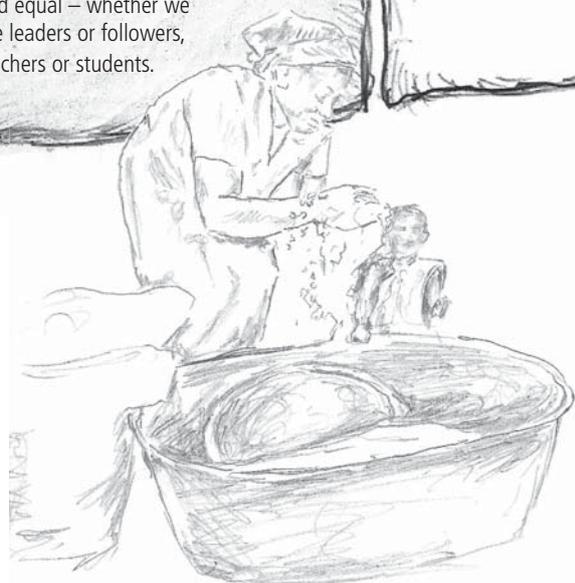
This is about creating ourselves in dialogue with others, as human beings. It comes from the Brazilian Paulo Freire's ideas about education that is liberating. He believed that human beings cannot and should not be treated as 'things.' To treat people as fully human means to give them freedom to speak their own 'word,' seeing communication as dialogue, and making the struggle for humanization a struggle for dialogue free of domination, conquest, manipulation and oppression, of whatever kind. The struggle itself, to be true, must also be humanizing. Simply put, conversations we have with each other help create who we are and how we relate to each other. If we want to become free and equal as human beings in our relationships and collective actions, then the way we speak to each other must also be free and equal – whether we are leaders or followers, teachers or students.

APPRECIATIVE INQUIRY

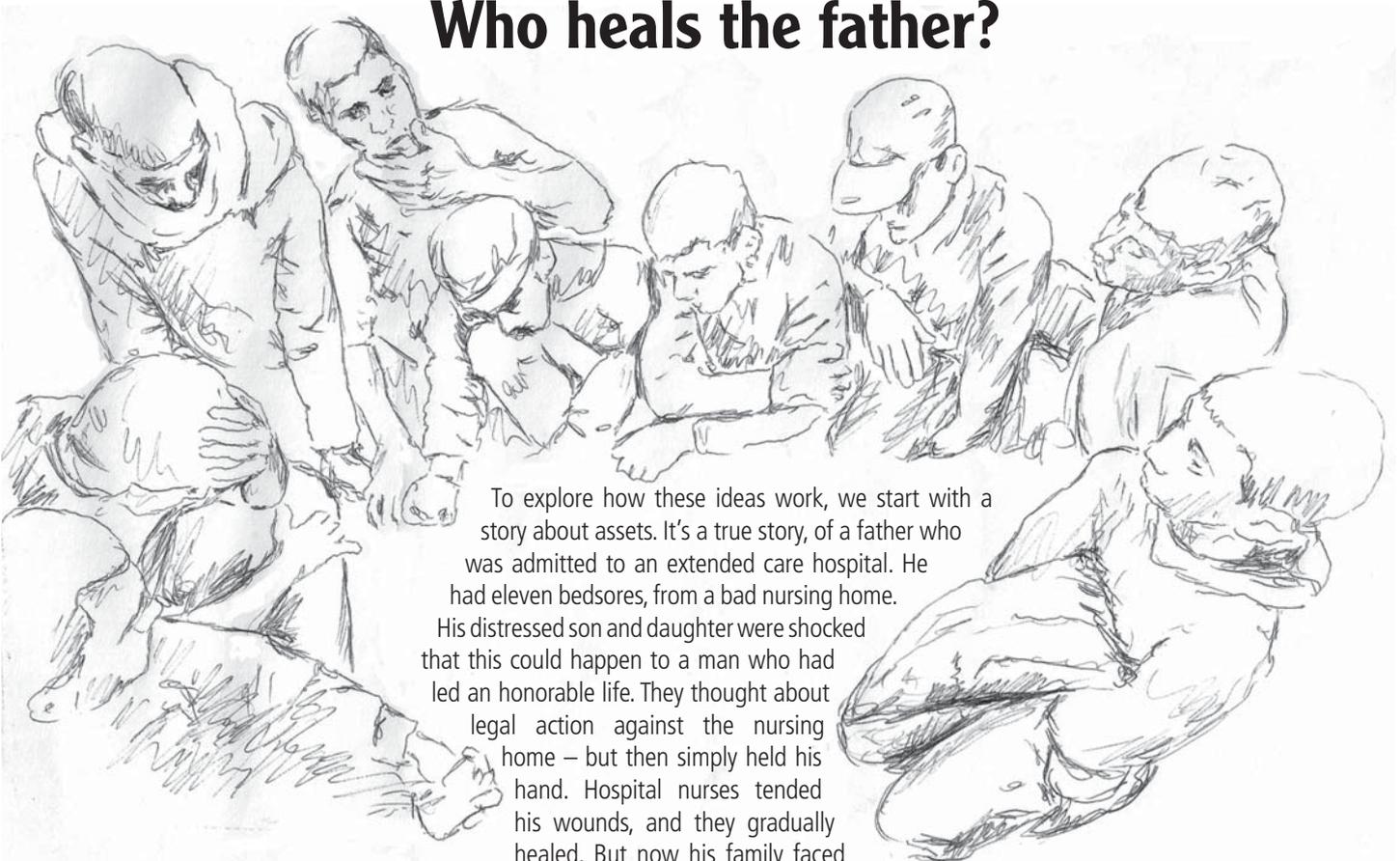
Appreciative inquiry takes seriously – and properly respects! – people's own experience, wisdom and knowledge of their context. It doesn't pretend that there are no problems; it knows that many things threaten one's well-being. That includes situations that are filled with crisis, trauma or mistrust, when something more than appreciation is needed, maybe naming those problems first before one can move on (see the U-process in BFG1, chapter 5). Still, it focuses in principle on what gives life and energy to organizations. And on helping people identify their achievements, look for their strengths, and discover how resilient, adaptive and innovative they actually are. This means we treat their fundamental human dignity like 'walking on holy ground.' – it cannot be trampled upon.

ASSET-BASED COMMUNITY DEVELOPMENT (ABCD)

What if instead of beginning with needs, problems and deficits – the negative aspects of life – we start with strengths and assets? What if we focus more on strengthening what is working, or could work, rather than emphasising difficulties, as many approaches to community development tend to do? Even theories stressing participation often focus on needs and deficits above all. An Asset-based approach believes that people respond best, and are less dependent on others, if they begin with what they have, what they can do for themselves and learn from each other, rather than what they don't have or can't do. And it is important to know that assets are not just things you can see or touch, but also things like trust, good neighbourliness, hope and compassion. Everyone in every community has some hidden inner resourcefulness that, if surfaced and strengthened, can become the foundation on which to build change.



Who heals the father?



To explore how these ideas work, we start with a story about assets. It's a true story, of a father who was admitted to an extended care hospital. He had eleven bedsores, from a bad nursing home. His distressed son and daughter were shocked that this could happen to a man who had led an honorable life. They thought about legal action against the nursing home – but then simply held his hand. Hospital nurses tended his wounds, and they gradually healed. But now his family faced

the hard work of the next stage in his journey. He had little medical insurance. On what, upon whom, could he depend for help once outside the hospital walls? Who would sustain his healing? His widely spread family may visit, talk, pray and read to him – all crucial healing experiences – but who would help his family help him find his strength and capacity to be an agent in his own life?

The hard issues involve things that cannot simply be bought, only nurtured. Health is a journey, not a list of medical events. The hospital is, and can only be, one part of it, especially for chronic illnesses, more. Our real work is about walking a longer journey of health. What other assets do we have to work with in any person's journey?

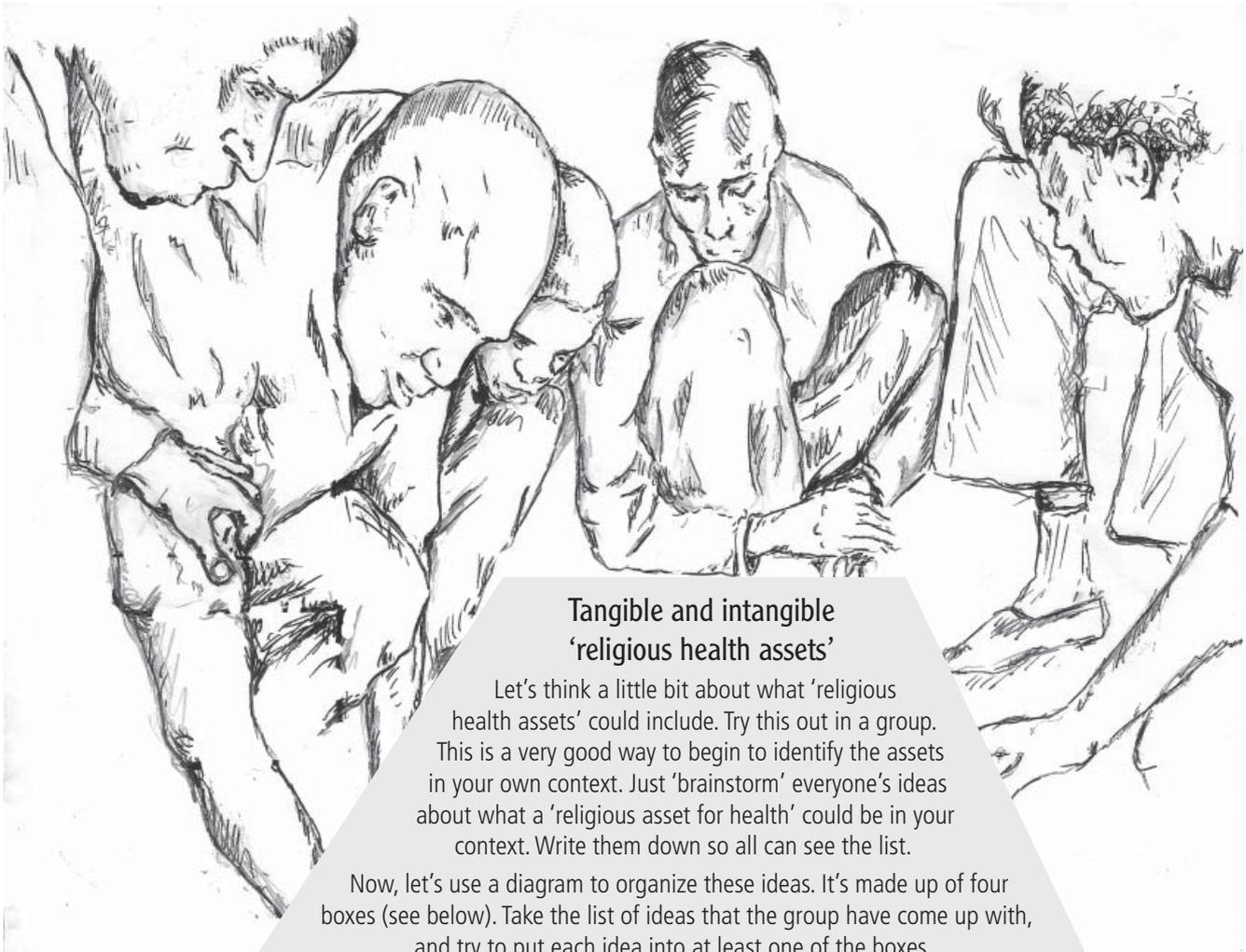
This father's family discovered a wealth of religious assets around them, mostly intangible but all real. Some support came from being members of the Congregational Health Network (CHN), an innovative extension of care now part of the Methodist Healthcare system in their city, Memphis. Their pastor cared; so did trained volunteer members of his congregation. The administrator of the hospital attends a related church, through which she was able to offer additional support. Prayer and care went together, naturally. These were no less important than the medical treatment he received at hospital.

Some of these assets are paid for, others are not. Some, one can touch and see, others not. Some are material, some are spiritual. And in fact, maybe the most important asset of all is intangible – trust! We can actually describe this father's hope for a better journey through life, even with a chronic condition, as depending upon human webs of trust and caring, without which all those other assets remain disconnected and ineffective.

Religious assets for health are not everywhere, but some faith is common wherever human communities grow. If faith can be toxic, it can also be generative. That's the critical point. Religion can, often does, contribute to a comprehensive, sustainable strategy for advancing health. To mobilize its assets requires an understanding of the interwoven logic of faith and health. And a new set of leadership capacities to make it work.

Here we have a story that focuses on 'religious health assets,' but we have yet to explain exactly what this strange phrase means. So let's delve deeper into that now.





Tangible and intangible 'religious health assets'

Let's think a little bit about what 'religious health assets' could include. Try this out in a group. This is a very good way to begin to identify the assets in your own context. Just 'brainstorm' everyone's ideas about what a 'religious asset for health' could be in your context. Write them down so all can see the list.

Now, let's use a diagram to organize these ideas. It's made up of four boxes (see below). Take the list of ideas that the group have come up with, and try to put each idea into at least one of the boxes.

This creates what we call a 'religious health assets matrix.'

How do you decide into which box an idea goes? Well, on the left side of the matrix we call 'assets' either 'tangible'—you can touch or see them—or 'intangible'—you can't touch or see them.

Decide which it is. Then, look at the labels at the bottom of the matrix.

These are public health words. An 'asset' can have either a 'proximate' (close and direct) or a 'distal' (distant and indirect) impact on health. The impact is proximate if it is direct, immediate or obvious (like a religious cleanliness practice or a religious clinic), and distal if it is indirect or not so obvious (like compassion, or a funeral rite).

Try this out first. Once you've experimented a bit, we'll probe these ideas some more.

A RELIGIOUS HEALTH ASSETS MATRIX

KIND OF RELIGIOUS HEALTH ASSET	Intangible	e.g. prayer resilience advocacy	e.g. trust belonging hope
	Tangible	e.g. clinics healers care groups	e.g. choir education rituals
		Proximate	Distal
		HEALTH IMPACT	

The difference between tangible and intangible assets is so important, that we should probe it a bit more. Most people think first about tangible assets, things one can see and touch, as if they are more 'real.' But intangible assets are just as real, and often they are the most important.

TANGIBLE

... Something you can touch or see, like a clinic, a healer, a care group, a ritual, etc.



Go back to the matrix your group has created. What have you listed as 'tangible' assets (they can have either proximate or distal impact on health)? Some tangible 'religious health assets' (RHAs) we have thought of you may have too. They will be different in every context. But here are some of the ideas we had for tangible RHAs: hospitals, clinics and dispensaries; religious doctors and health workers; faith healers; care groups. These are all 'proximate' – you can see how they directly impact on health care. Some 'distal' tangible RHAs might include: a choir (singing together seems to help many people!); religious rituals, including funerals (they are important for mental health, for example); networks or helpful connections to others; and so on. By now the idea should be clearer.



INTANGIBLE

... Something you can't touch or see, like a prayer, motivation, resilience, and so on.

OK, let's look at your matrix again, this time seeing what you have listed as 'intangible' assets (either proximate or distal). We think these include some of the most interesting and important 'religious health assets.' Some we have thought of in our contexts include: trust; resilience; care-giving; meditation or prayer; compassion; and so on. Odd as it may seem, these can all be seen as 'proximate,' impacting directly on health, and many scientific studies even try to show this. Some 'distal' intangible RHAs might include: meaning; belonging; spiritual energy; hope; a sacred space; and so on.



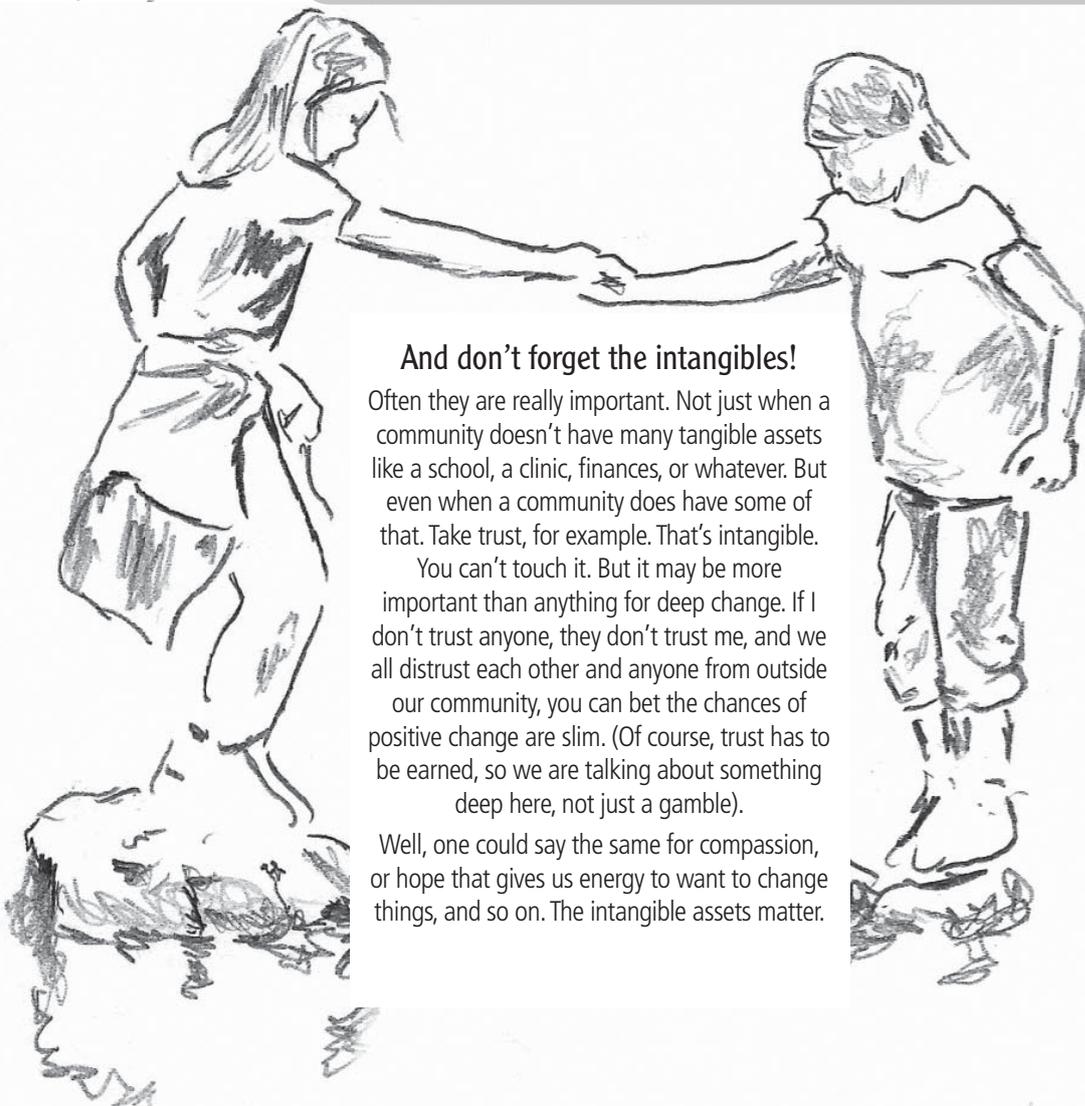


We need to be careful about this matrix. It's **not** a kind of scientific tool. It's more like a guide to **thinking about** religious health assets. It helps us see just how many things – experiences, relationships, and so on – that are part of people's faith or religion, can actually be an asset for health. It's also very useful as a prompt to our conversations and dialogical action, helping make things more visible so that we can all more fully, freely, equally and humanly engage in the issues.

Normally we don't look at reality that way. We tend to see what's wrong, what's missing, what's needed. That's important, sure, but if we start there, we start with what's negative. An asset-based approach says, 'Hey, let's see what **WE HAVE** to work with! Let's look at our resources and resourcefulness! Let's use that, let's build on it! Let's start with our strengths, what we already know is worth something to us! Let's make sure other people know that too, especially those who say they want to help!'

The RHA Matrix helps others see the many things, processes or energies there are that we can work with. That's important because most people—especially those responsible for public health—usually **don't** see these assets at all. They are invisible. Making them take notice may help them do something different with their resources and policies, of more use to us.

But it also helps us, because we are often not clear about our own assets. Starting with what we don't have may even be depressing, especially if our history is that we don't get much from anyone else! The RHA Matrix is a first step in recognizing our assets so we can work with them.



And don't forget the intangibles!

Often they are really important. Not just when a community doesn't have many tangible assets like a school, a clinic, finances, or whatever. But even when a community does have some of that. Take trust, for example. That's intangible.

You can't touch it. But it may be more important than anything for deep change. If I don't trust anyone, they don't trust me, and we all distrust each other and anyone from outside our community, you can bet the chances of positive change are slim. (Of course, trust has to be earned, so we are talking about something deep here, not just a gamble).

Well, one could say the same for compassion, or hope that gives us energy to want to change things, and so on. The intangible assets matter.

Maybe by now it's clear to you anyway, but let me just emphasize this: when we speak of assets, whether they are tangible or intangible, proximate or distal, **THEY ARE A COMPLETE WHOLE.** They need to be seen as a whole, interacting and supporting each other. All the parts may be important, not just this one or that one. Some more than others, maybe, but the whole is our focus.



OK, here's the next important point. Whatever assets you have, they aren't worth much unless you use them. **Unless you do something with them!**



AGENCY

Yup, that's what we are talking about. So what do we mean by 'agency'?

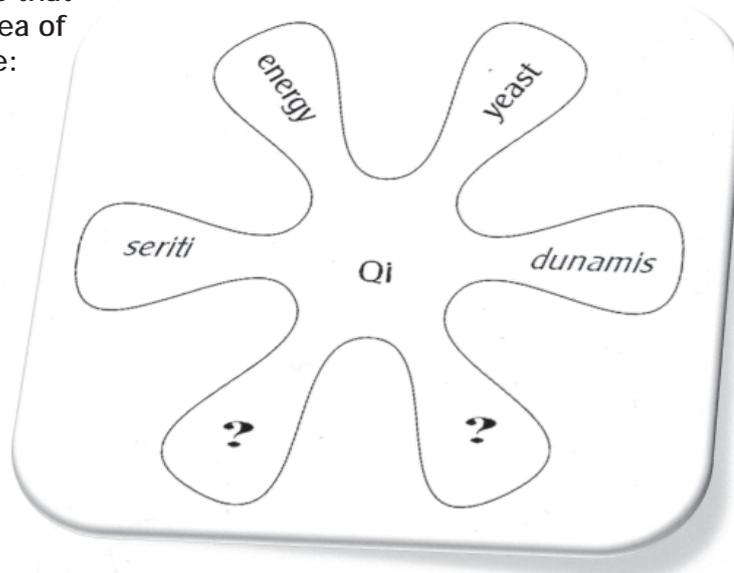
‘Agency is *‘the power to do’*’

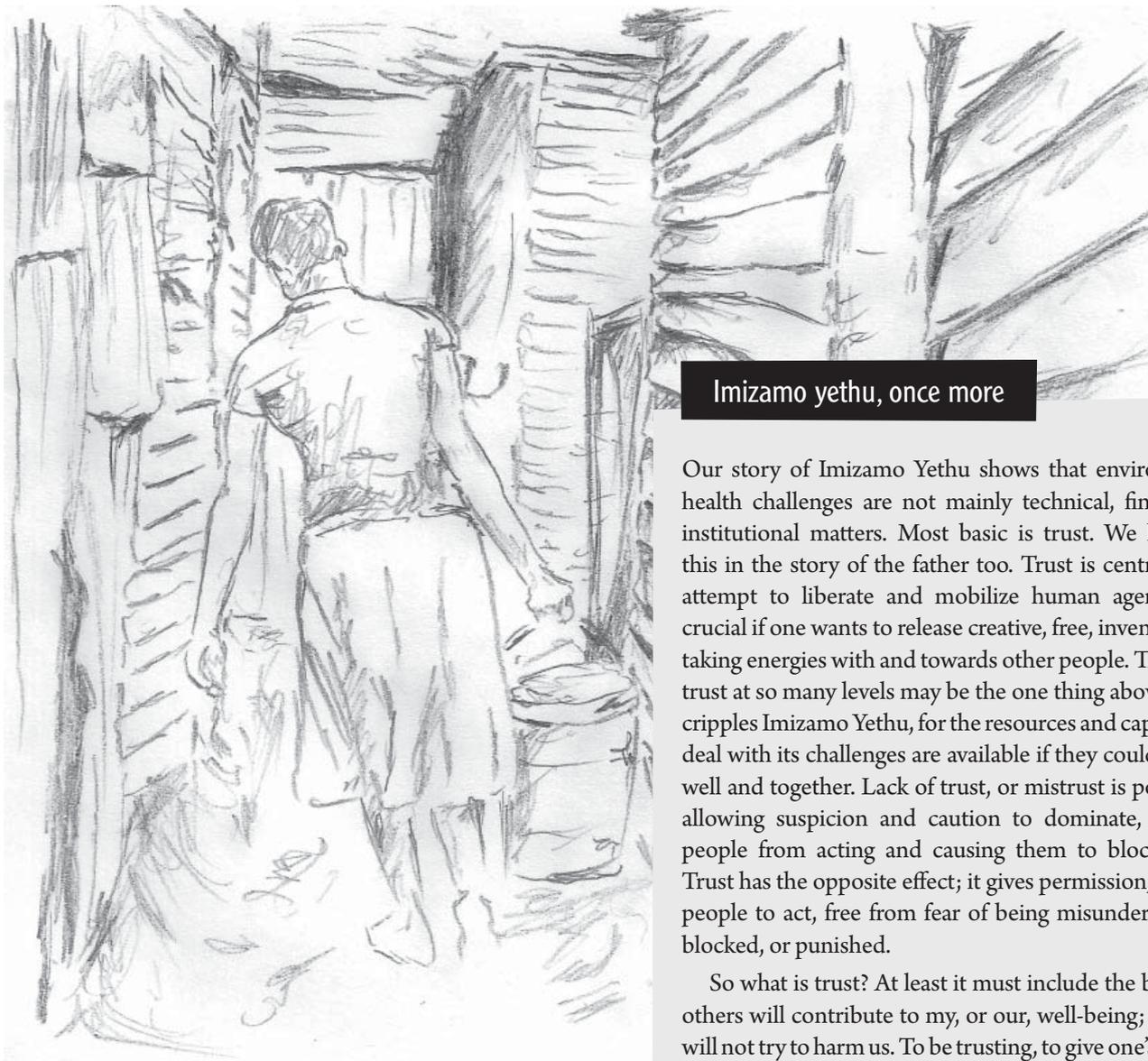
Here's a clue: this is one of the series of **The Barefoot Guide**. Feet are made for walking. Just as feet that do not walk are pretty useless, so assets that are not used don't mean much. We say they are 'at rest.' To become valuable, you need to do something with them. That requires you to use your agency, your 'power to do.'



There are lots of words that can be linked to the idea of agency - here are some:

What other words can you think of?





Imizamo yethu, once more

Our story of Imizamo Yethu shows that environmental health challenges are not mainly technical, financial or institutional matters. Most basic is trust. We hinted at this in the story of the father too. Trust is central to any attempt to liberate and mobilize human agency. It is crucial if one wants to release creative, free, inventive, risk-taking energies with and towards other people. The lack of trust at so many levels may be the one thing above all that cripples Imizamo Yethu, for the resources and capacities to deal with its challenges are available if they could be used well and together. Lack of trust, or mistrust is poisonous, allowing suspicion and caution to dominate, stopping people from acting and causing them to block others. Trust has the opposite effect; it gives permission, liberates people to act, free from fear of being misunderstood, or blocked, or punished.

So what is trust? At least it must include the belief that others will contribute to my, or our, well-being; that they will not try to harm us. To be trusting, to give one's trust is a risk. And it has to be earned, not once but again and again. It has to be confirmed by an experience of trustworthiness. If that is true, then the intangible asset we call trust is not just about individuals, but about communities, about society as a whole. That's what makes it relevant to the health of all. And it is relevant to healthcare in general, simply because health systems are fundamentally relational, and because so many of the most critical challenges for health systems are relationship problems.

But trust, as we have said, is not something you can touch or see, or something you can sell or buy in the market. It only comes through relationship with others, through ways of being that can be trusted. It is more about human will, human intention, and our role as citizens of the world, than about the economy or the state. To win someone's trust means to take them seriously, to respect their dignity and freedom, to understand why and how they think. And the same for them. It is, and can only be, mutual. That's what makes it so difficult – and so valuable an asset.

“Look for the assets, especially the ‘intangible’ ones most people don’t notice. Seeing the assets is good, aligning them is better, but sustaining a web of trust to hold and enhance them is the best.”

Finding ‘religious health assets’

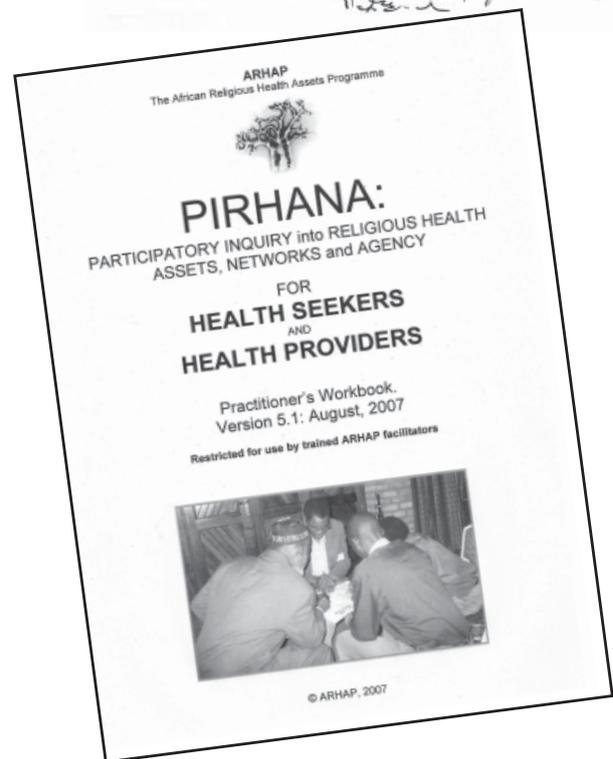
We’ve said that you can’t build a community on what it doesn’t have, but how does a community find out more about what it does have? Here’s one method we have used to get at that.



“This toolset aims at understanding three things at the same time: networks, assets and agency.

That’s because, as we noted, assets are ‘at rest’ and not of much use until someone ‘does something’ (agency) with them.

But also because we know that ‘agency’ really only becomes powerful when people work together and are connected to other people who can help—which is why the toolset also asks about ‘networks.’”



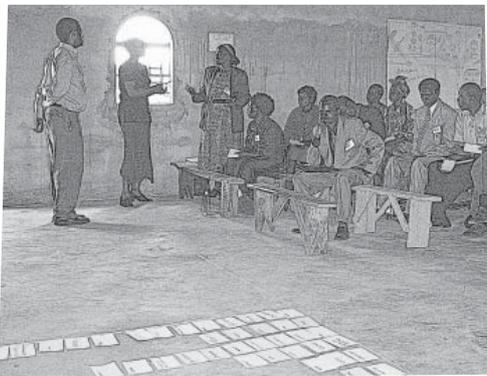
The PIRHANA toolset is a series of exercises carefully designed to build upon each other so that one exercise leads to deeper insight in the next. The exercises come from many other ideas, like Participatory Rural Appraisal and Participatory Learning and Action. The toolset is not magic; it has to be used with proper care to be valuable! You can find the whole manual on the BFG website and at www.irhap.uct.ac.za.



Let's give you a feel for how the exercises go. Here are three that will help you see how people begin to identify the assets they share and can work with.



This is always our 1st exercise. We call it '**community mapping**.' In groups (like one of women, one of men, one mixed, one maybe of youth), participants draw their *own* maps of their community or area. They agree on what really matters to them, and they mark where they think there are assets for their community, and where there are difficulties. These are mainly 'tangible' assets one can see, as you would expect. When all groups are done, the maps are put up and everyone talks about them together.



The 2nd exercise asks participants to create a '**health and sickness index**.' Everyone thinks of two key factors that *help their well-being* in their community, and writes them down on two cards. All cards are laid on the floor. Looking at what everyone has written, the exercise is done again, now choosing from everyone's words the two one thinks are most important. The new cards are collected, and similar ones put together. In this way a 'bar graph' is made (see picture). The same thing is done again for two factors that *work against well-being*. The other side of the bar graph is now created.



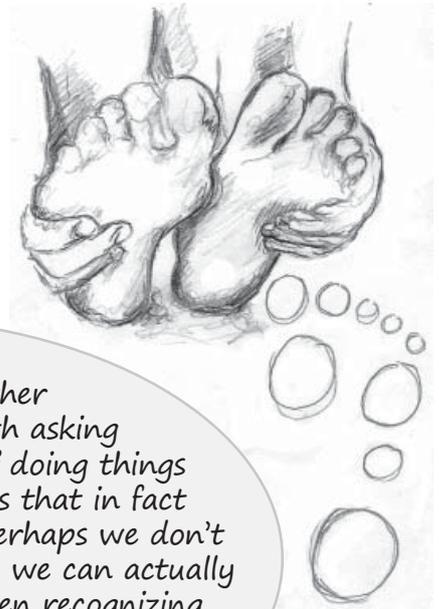
In the 3rd exercise, the most important tangible assets ('facilities') that people agreed on in the community mapping exercise are listed along the top of a set of square blocks (see picture). Down the left side are listed terms that summarize the most important factors that help, or work against, well-being in the community. The same groups as in exercise 1 now decide on which facilities are good at a factor by placing beans in the right block: 5 beans is 'very good,' no beans means 'nothing.' In this way a '**ranking of facilities and well-being**' is created.

The exercises go on from there, and eventually the participants end up thinking together about which assets they might use more effectively for their community, and what for, a form of dialogical action. Another version of the model we call CHAMP ('Community Health Assets Mapping for Partnership'). It goes one step further. It adds exercises that help to create new partnerships with others. This takes assets, agency and networks to the point where one can begin, together, to take the kind of action one wants!



WARNING!

PIRHANA/CHAMP tools are easily misused. It's a big challenge to stick to its key principles, to be completely disciplined about them. Above all, facilitators have to work against *their own tendency to want to control things and decide things*. No matter how controversial or disagreeable a participants point of view might be, it *has* to be sought, and it has to be listened to; it's part of the reality one wants to understand. Without that, the value of the toolset is questionable!



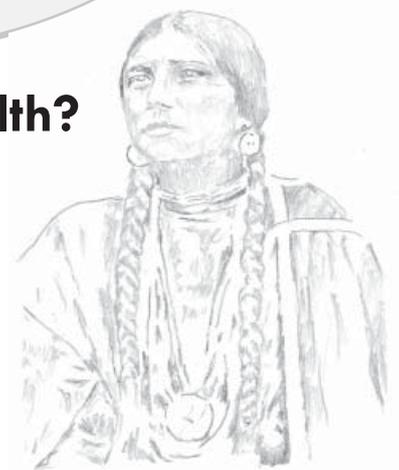
Existing 'religious health assets'

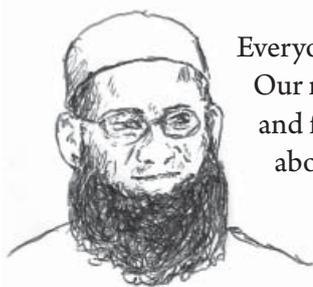


Before we move on to some further important ideas, it is worth asking ourselves about existing ways of doing things in religious or faith communities that in fact do contribute to health. Though perhaps we don't always think of them as something we can actually work with, maybe we should. Even recognizing these kinds of assets already a positive step in thinking about how to link religion to the goal of the health of all. For example ...

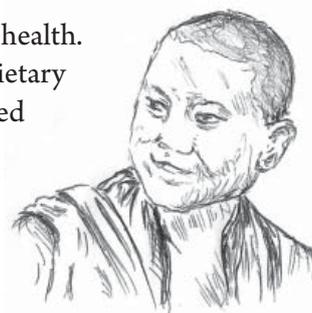
What kinds of practices contribute to health?

Well, in our Native American tradition health is very strongly linked to balance in all aspects of life (physical, mental, emotional, spiritual) based on the teachings of the Medicine Wheel, or what we prefer to call the 'sacred hoop.' This is a universal symbol of healing, of how everything is interconnected, including our relationship to other creatures, the earth, spirit. So we also respect those who show us the way, Elders who are recognized, respected and active in our common healing journey. It's a holistic foundation of peaceful interaction and personal growth, a guide for how to live a healed and healing life.





Everyone knows that what we eat and drink has a lot to do with our health. Our religious traditions have lots of long and rich wisdom about dietary and food health, and about fasting as a way of helping be disciplined about it.



It's not just about protecting believers from things that could harm them. It's much more about the quality of life, the kind of life we are meant to live, well, fulfilled, healthy, honouring our bodies as we honour the deepest source of life. That's why we can even call it sacred.

'In Islam, for example, eating *Halaal* foods is a matter of faith, foods that are clean, properly prepared, not likely to contain dangerous germs (like pork can). This is because we believe that our bodies are given by God or Allah to us in trust. So we are against taking substances that are harmful for the body too, like alcohol or recreational drugs. And we believe in washing our hands, arms, face and feet before prayer. For us, leading a healthy life is a religious obligation!'

'It's not so different for Jews. In a way, for us action is more important than belief. You don't just say the right things, you do them! Food and drink must also be clean and blessed, which we call *kosher*, meaning 'fitting' or 'proper.' This is based on our covenant with G-d, which we learn about from our holy books of law, the *Torah*. This is also to help us learn to exercise discipline and self-control.'



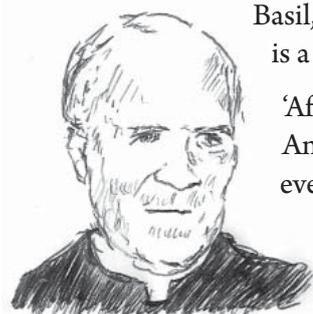
'Well, in Buddhism many of us are vegetarians, though fish is fine too. Basically, we believe in striving for a balanced life. For us a diseased life is not a good life, and our rituals and practices are all designed to overcome disease – of any kind, including spiritual and mental. Even suffering and illness for us is a chance to find a way to bring about the most good if we can work with it to reduce its harm and help us grow spiritually.'



'In Hindu traditions, the law of *karma* is very important for health. It means that one reaps what one sows. As one lives, so shall one's life be. If we mistreat ourselves, our bodies, or other people and creatures, then we will suffer, and the more we do so, the more we burden ourselves with suffering. In some ways, then, our health is dependent on our thoughts, our words and our actions, which can hurt or cause illness in many ways. So we also believe in clean living, in healthy eating and drinking, in respect for life, and many of us are also vegetarians.'

'Most kinds of Christians don't follow food laws and such like. But the body is understood as the temple of God. It should not be abused, neither one's own body nor anybody else's. And health is at the centre of what we mean by salvation too – a word that comes from the Greek *salus* – which means 'holistic health,' mind, body and soul. Long ago St.

Basil, an Orthodox Christian from the Middle East, said that medicine is a model for the cure of the soul!'



'African traditional religions are a little like of those of Native American and other indigenous peoples. Spirit, body and earth, even our ancestors, are part of one reality, and health has to do with all of these aspects. So we are used to having healers as part of our communities. Some of them are very wise about how to use plants and other medicines. Some of them know a lot about a person's mind and soul.'



Some related ideas

‘PIRHANA/CHAMP weaves together several important ideas besides an **asset-based approach, appreciative inquiry and dialogical action.** But some other ideas also lie behind it, including these ...’

On all that one is (Human Capabilities)

Working with religious (or community) health assets can help one to function better. But that’s not enough if, for example, one wants fairness and justice! Amartya Sen and Martha Nussbaum speak about ‘human capabilities’ which are about *being able to exercise our full range of capabilities* central to full human being. These include life(!), bodily health and integrity, developing one’s senses, imagination and thought, emotional development, some control over one’s own life and environment, being able to live with and for others with dignity, care of other creatures and the earth, play, having some rights to one’s material goods. The capabilities approach is about living for ‘what ought to be,’ the *Good* – mine, yours and everyone else’s.



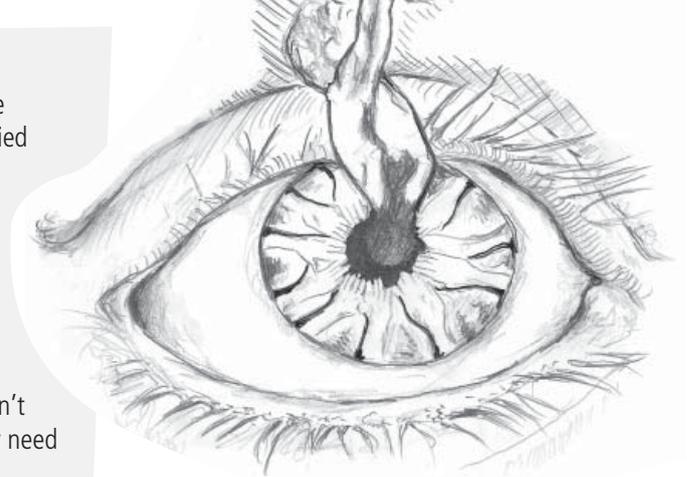
On creative freedom (Spiritual Capacity)

We, as human beings, have an astonishing capacity to imagination possibilities that do not exist and to make them real. We do this with nature: think of the huge machines that fly in the air, a liver transplant, or even a simple hoe. We also do it with culture and society: think of art forms that see things differently, or ways of organizing ourselves and our communities. It is the creative power of what we can call the human spirit. But this power also gives us the capacity to destroy things! So we have a profound responsibility for how we use it. Our many different spiritualities show that we are deeply aware of this gift, of how to honour it as something that belongs to us all and binds us all.



On being seen (Legibility)

People in public health say, ‘if you are not on the map, you are invisible, not seen.’ If one is not counted, measured, or identified by people who make policy and allocate resources (e.g. the state’s health ministry), then for them one literally ‘doesn’t count.’ James Scott calls this being ‘legible.’ But ‘being legible’ raises challenging questions. If people do not trust their political authorities, they may not *want* to be legible! Also, life is messy, unpredictable, and reality is complex, so putting all the emphasis on what is ‘legible’ may lead to bad decisions and actions. And many things that matter greatly can’t be ‘measured’ – like some intangible assets, for example; they need to be nurtured, not ‘counted.’



This chapter is about ‘What we have to work with.’ But what kind of ‘work’ is this? Much more than a formal or informal job, and beyond mere daily activity, it’s a life work—the work of one’s life. It’s what is called forth by the demand for justice and the ‘health for all,’ for the fullness of human well-being in a whole world. We call it ‘poiesis’ work!



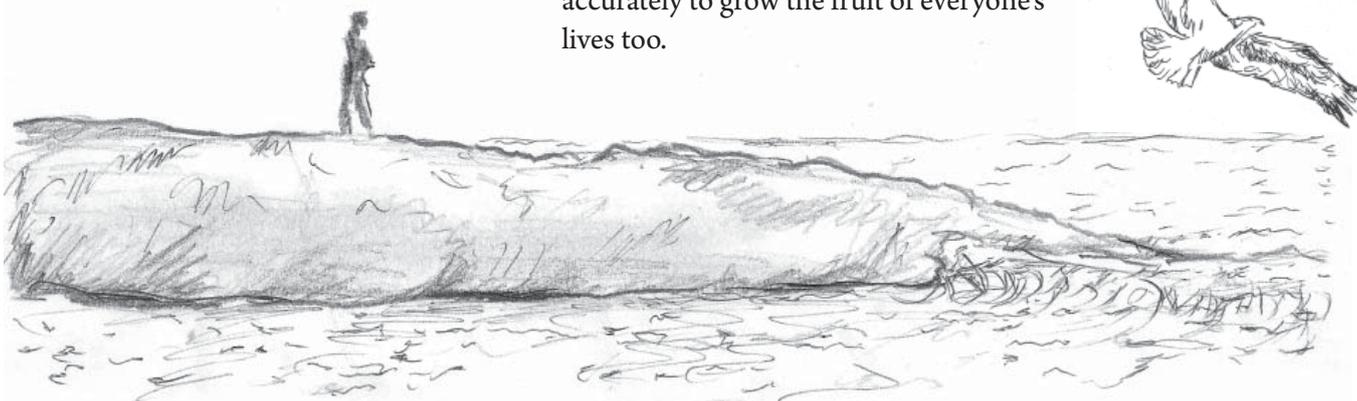
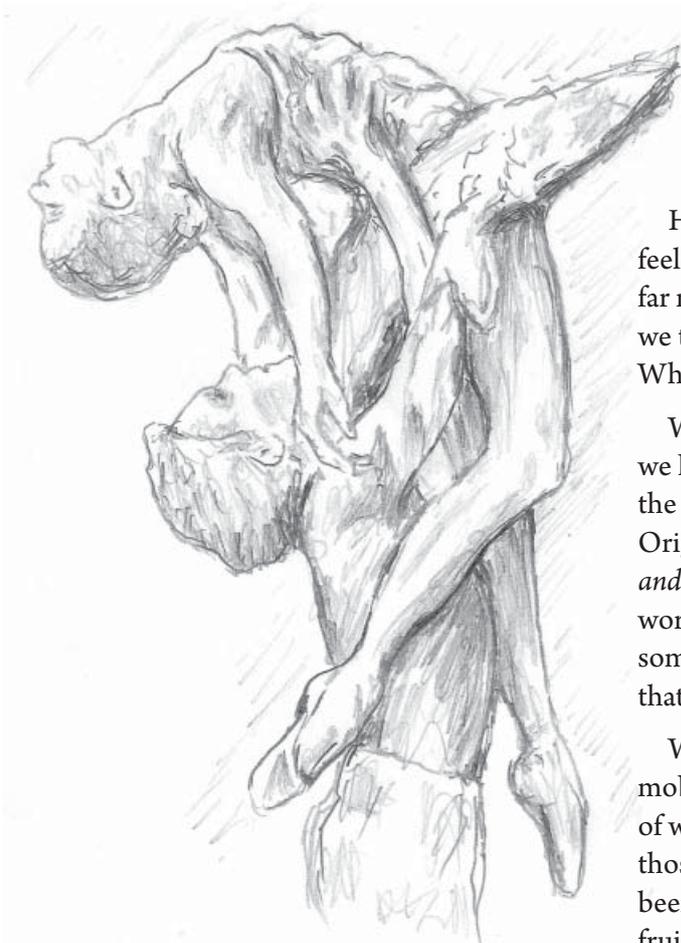
Poiesis work

When you care for a community you ache for its unnecessary suffering. This chapter aims at opening our minds and hearts to how much we have to work with in responding to the ache of urgency and new possibility. Maybe the world is not made for pain. Maybe religion is not just relevant at the end of life or when injustice must be endured. This chapter also points to what happens inside a leader when they begin to feel themselves – ourselves – captured by a possible vision worth risking for, worth *working* for.

Here language lets us down. The power and delight of feelings one’s life being called into being, and found useful, is far more than what the word “work” usually means. How do we talk about the life of working with vision, assets and hope? What word captures its radically hopeful and realistic nature?

We can find no English word for this kind of real work. So we have turned to an ancient Greek term, ‘poiesis.’ It’s from the root of ‘to make,’ the same root from which we get ‘poetry.’ Originally it was a verb. It referred to *the action that transforms and continues the world.* That’s the deep meaning of poiesis work. It’s not just about technical production, or simply making something. It’s work that merges thought with matter and time, that links person with the world, that ‘calls forth a new world.’

When we think then of what we have to work with in mobilizing religious assets for health, we mean a *poiesis* kind of work. It’s the kind of work a true leader does together with those he or she cares about. If you think of others who have been that kind of leader, you should be able to see how the fruit of their lives is far more than an assembly of technical constructions. And how you, and we, can hope more accurately to grow the fruit of everyone’s lives too.



‘Leading causes of life’: Shifting the paradigm

*Life is what it is about, I want
no truck with death.*



Pablo Neruda

*I have set before you life and death, blessings and cursings; therefore,
choose life, that both you and your descendants may live.*

– Deuteronomy 30:19

***We have already introduced you to a new
‘language’ in other chapters (like ‘religious health
assets’). In this chapter we offer you more. New
language helps us to think, act and lead in new ways.***

Public health science and practice tends to talk as if illness or, worse, death, is the main thing going on in human life – ‘mortality,’ ‘morbidity,’ ‘burden of disease,’ or ‘the leading causes of death.’ In reality, life is what is going on in life! How, and why, is what this chapter is about.



The language of life is the language of health. The idea of ‘leading causes of life’ helps turn on the lights about life’s basic structure, about what keeps us alive. This is not happy talk that ignores

the many threats to life we must face. Rather, it pays balancing attention toward human health and how it spreads. Compare people to viruses: Viruses are opportunistic, unpredictable, persistent, and sometimes deadly to their human hosts – they seem to have all the high cards. Yet actually, a good part of our lives uses a natural set of life strategies for seeking health and wholeness. Can we think about life with the same precision and rigour we use to analyse, beat back or postpone death? Yes. And we should. Death – what breaks us – is simple compared to life. While that which ‘generates’ life is highly complex, its many facets exist in exquisitely rich relationship with each other – and life is what is already working! Let’s think about why that is so.

*In looking for the
‘causes of life,’ you won’t feel
naïve or delusional. You’ll more
likely feel you have noticed something
vital, compelling, powerful, and begin to
sense the stirring of choices that matter.
You’ll feel hope. That will inform how
and why to risk so your
community can live.*



Can we think about what gives or *generates* life with the same precision and rigour that we use to analyze and beat back or postpone death!



Hmmm, OK. I get the basic thrust, but I don't quite see what you mean by '*causes*' of life?

Well, we already know how to look for causes of death. We just need to see *what else* is going on in the world of patients, families, communities and societies. You have to know to look.

Look how? Look at what?

When we looked at what gives, or '*generates*,' life we discovered that there are five basic causes.

So what *are* these five basic '*causes*'?

We find life through *connections* that count. We thrive in webs of meaning that make reality *coherent*. We flourish in *working together* on things that matter, using our creative abilities or agency. We bloom when we experience giving and receiving some kind of *blessing* across generations. And we grow as *hope* draws us forward. We'll talk more about these later.

Sounds inspiring, but isn't it all rather idealistic? Aren't you just picking things out of the air that are really hard to see in practice?

Not at all! These '*causes*' are a very practical guide to working with life. They work best when you face really complex or large challenges. They also help when dealing with what some have called the '*wicked problems*' that seem to defy any solution. You can see the causes best in the way people are able to face lives of great hardship.

Wow, that's very abstract! You're going to have to be a little more specific than that, for me to understand what seems like an interesting framework!

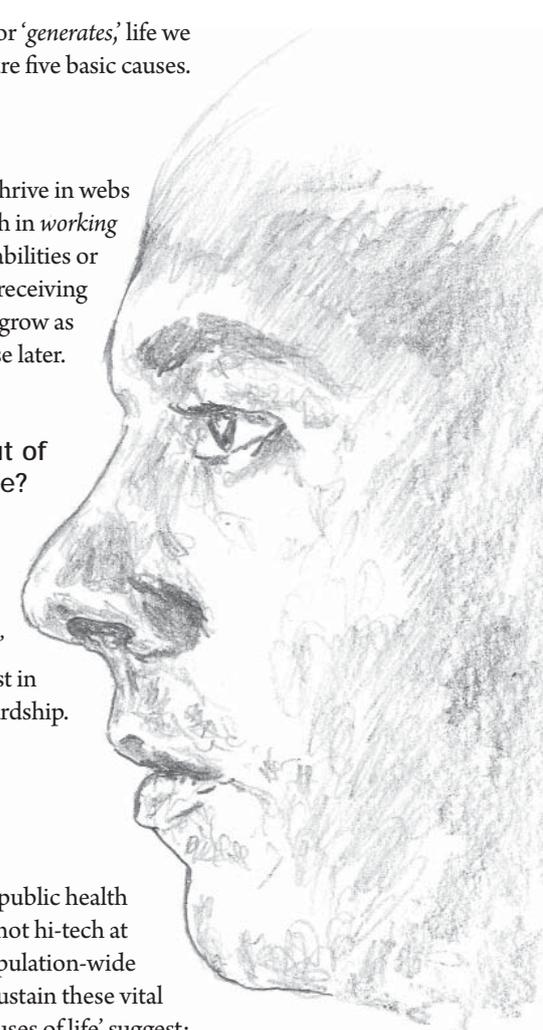
OK, here's an example. We have learnt from experience that *the* public health interventions that save the most lives and help people live longer are not hi-tech at all. The biggest impact on average lifespan comes from fairly simple, population-wide actions – clean water, sanitation, good food, shelter – but to create and sustain these vital things requires a community to find its life in exactly the ways the five '*causes of life*' suggest: when we are well connected, understand our lives and each other, act together, live in hope, and nurture and encourage each other from generation to generation.

Ah, now you're making concrete sense. But aren't people aware of this already?

Sure. The point is that these high impact interventions are *not about death or what we can generally call 'pathology.'* If you want more of life to happen it helps to see *life processes*, not just anti-death processes. Life processes reflect things that contribute to the life of the whole community.

Now you've got me thinking. It would be good to explore this some more.

That's what we'll do.



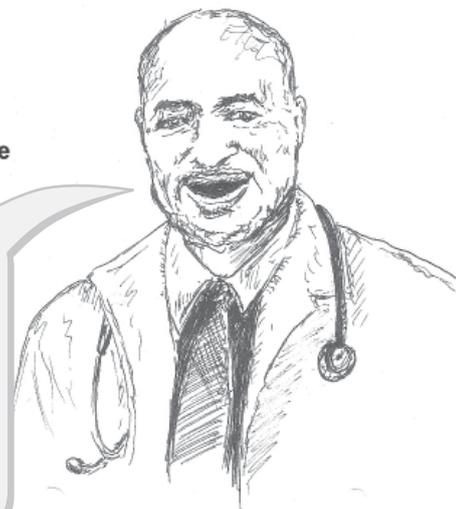
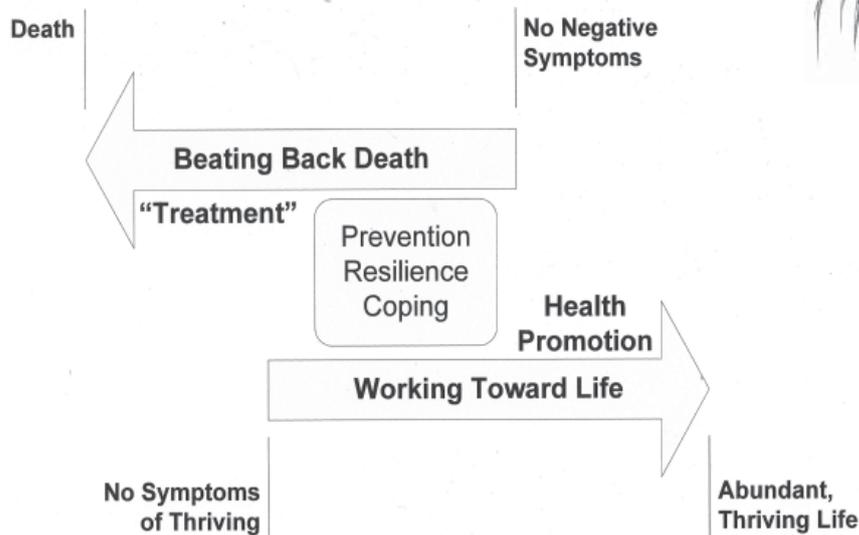
Choosing life is not as clear as fighting death, in the same way that trying to wage peace is not as straightforward as trying to stop a war. A stopped war is not the same as peace.

Life is different and much more than non-death.

Charles Darwin, famous for his scientific theory of evolution, was actually curious about how life can be so vital, so abundant, so dynamic, so capable of thriving in the most complex and amazing ways. What unifying logic accounts for that in the face of all that threatens life? What allows life to emerge and adapt constantly? So we ask the same type of question: what is generative of health, of comprehensive well-being?



Sociologist Cory Keyes has given us one model, which we adapt here. It looks like this:



What we health professionals and researchers spend most of our time doing is in the top half of this diagram. We invest huge amounts of energy and money in beating back death, in pathologies, to be technical! Yet, there is growing interest in and science about understanding what it means to work towards life. So Keyes, in his diagram, is interested in the 'science of thriving.' What is it that enables people—and communities!—to live more fully? What are the 'symptoms' of thriving? One is resilience. Another is our ability to cope with threats to our life, as individuals and as communities.



Here's where the Leading Causes of Life (LCL) model comes in. It asks, where does resilience, for example, come from? What increases resilience? **Which generative life processes are at work here?** What helps people choose life in the face of what threatens it, whether a disease of the body or a sickness of society?

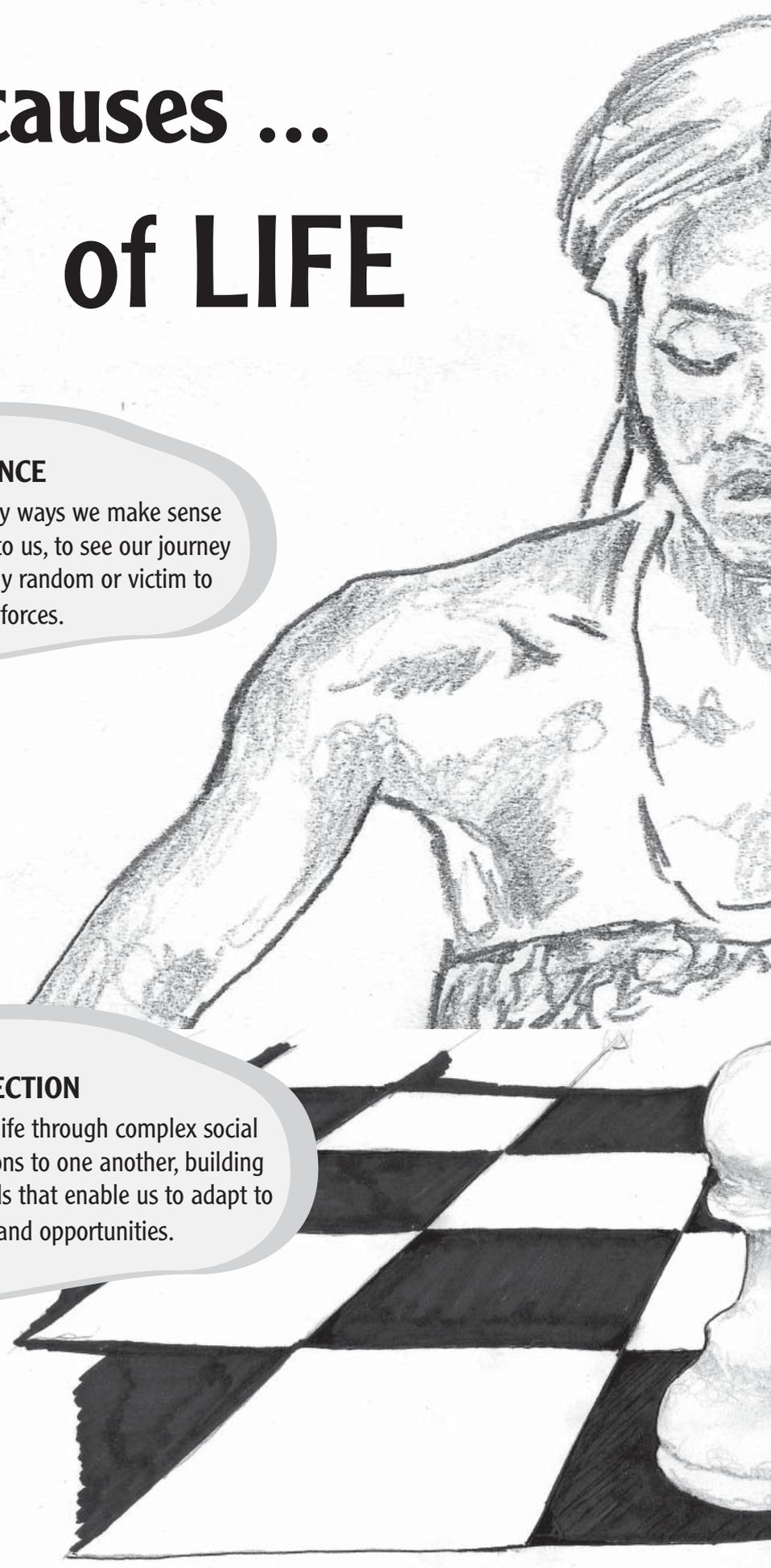
Leading causes ... of LIFE

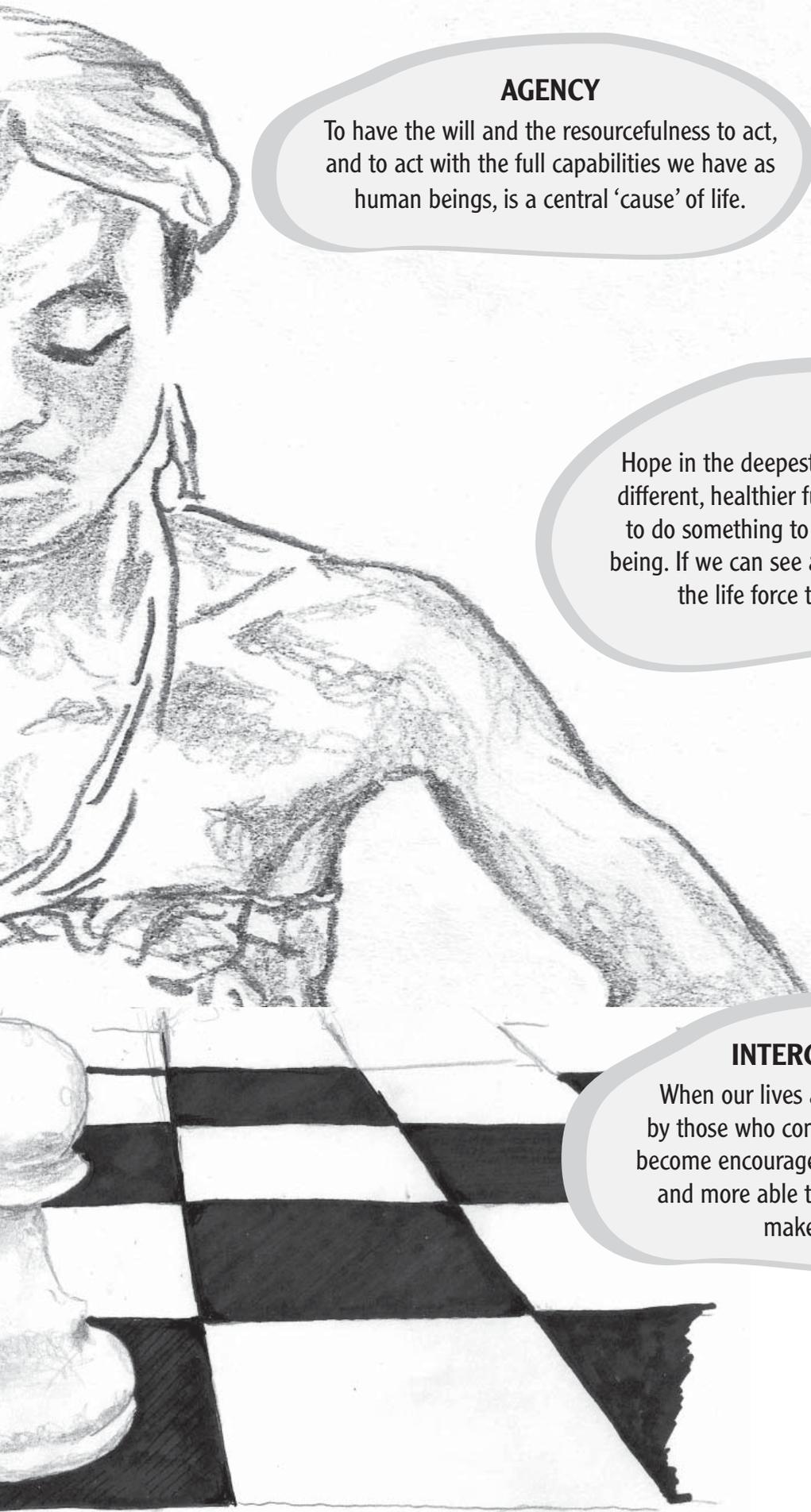
COHERENCE

Coherence refers to the many ways we make sense of life, how life makes sense to us, to see our journey as intelligible and not wholly random or victim to inexplicable forces.

CONNECTION

As human beings we find life through complex social relationships and connections to one another, building communities of various kinds that enable us to adapt to changing threats and opportunities.





AGENCY

To have the will and the resourcefulness to act, and to act with the full capabilities we have as human beings, is a central 'cause' of life.

HOPE

Hope in the deepest sense is about imagining a different, healthier future and finding the energy to do something to try to bring that future into being. If we can see a positive future this nurtures the life force to enable it to happen.

INTERGENERATIVITY

When our lives are blessed and nurtured by those who come before and after us, we become encouraged, strengthened, enlivened and more able to shape our own lives, to make vital choices.



SICKLE-CELL ANAEMIA: LIFE-LOGIC AT WORK

Sickle cell anemia is transmitted only by genes one has inherited. It originates in Africa, and is limited to people of African descent. Someone who has it experiences unpredictable 'crises' of wrenching pain that run throughout the body. There is no prevention or cure; and if you have the gene, you carry the disease. But there is a radical difference in the life of a person living with the disease if they get competent care when a crisis happens. A curious and oddly brutal disease, we can ask if the Leading Causes of Life (LCL) theory would help in how to care for someone experiencing a sickle cell crisis. It means seeing the encounter between a patient and a medical delivery system as part of a life process, *not* just a treatment event.

Timely pain management is crucial. It requires very strong medications; and sickle cell patients usually know which ones. But if one comes to an emergency room complaining of severe pain, wanting a drug, without any broken bones or obvious medical condition, how do medical staff know if you are just a drug-seeker, or what? So a patient is likely to experience humiliation on top of their pain. Even more, many sickle cell patients are unable to hold down a good job and have no medical insurance. Since every crisis is unpredictable, sickle cell patients often wait too long before seeking help. The human suffering and financial expense is compounded by delay. If treated within two hours, the crisis can be controlled and reduced to a one day stay in the hospital. If not treated quickly enough, then it often means three to five days in hospital.

The LCL theory tells us that more than medicine determines how one gets that two hour window right. The key decisions are not just those made by an overworked emergency room clinician, but by others helping to make critical life decisions. So what affects the decision to come to the emergency room quickly, not slowly? First, *connection*. People living with sickle cell have many vital connections, besides family, beyond the emergency room – for example, members of a social association, or perhaps a religious community. If the hospital can build a trusted connection to these people, then the entry to care for a patient is much less fearful. Trusted connection can turn an unknown person who may look like a drug seeker into a human being who has an existing relationship with the hospital. This is not wishful thinking. It is underway in the Methodist Healthcare system in Memphis through its Congregational Health Network. People are trained to nurture these connections, both within the hospital and the communities the hospital serves. The trained individuals are informed about the patients suffering with sickle cell and know to bring the patients to the hospital quickly or receive them appropriately.

An experience normally full of fear and embarrassment (besides pain) now has a better chance at being handled with respect, understanding, and community. The pain will not be less, but the decision to come quickly is much easier, the diagnosis not delayed by suspicion of the patient's motive. It is much more likely that the two hour window will be met and that the person will return home later in the day. Money is saved, but also, everyone ends up with more life.

In the process the whole team – the whole system – learns. The community is more alive because it is more coherent about what is going on – the congregation, ER staff, hospital administration, spiritual care staff, friends, and family. All parties experience themselves as participants in the event. They can share in the successful passage through a crisis of one they care about in a way that reinforces everyone's sense of coherence, connection, and agency. Rather than diminishing the life force, this painful passage has the potential to build the hope of a person in themselves, in their extended social networks, and in the resources necessary to cope with, even overcome, a life circumstance which cannot be predicted or avoided.

All five 'leading causes of life' are here in this story. Now is a good time to say a little more about each of them.



COHERENCE

When a people find a deep, true story, coherence channels a powerful identity to shape the future.

Coherence is a story of our life that we can believe in, that holds things together for us, and makes sense of them. Coherence enables us to see life as intelligible and not filled merely with wholly random events and inexplicable forces. Viktor Frankl, a Jewish psychiatrist who survived the Auschwitz concentration camp, tells us something of what this means. In the concentration, he noticed camp three basic reaction patterns to incarceration: first shock, followed by apathy; then depersonalization, moral deformity, bitterness; and finally – *if one survived!* – disillusionment. Yet some less hardy prisoners seemed to survive camp life better than did those who appeared tougher. Having a sense of meaning was the only way Frankl could explain this observation. He used the words of Nietzsche to make the point: ‘He who has a why to live can bear with almost any *how*.’

Coherence is so vital to human beings that they instinctively fear incoherence. It’s a fundamental threat to be faced with a loss of meaning. Religious ways of seeing often provide that meaning. It should come as no surprise, then, that attacking someone’s system of meaning (their religion, for example) can lead them to respond defensively, even with violence if they are sufficiently threatened. When the fundamental story that holds a person’s life together frays at the edges and starts to unravel, incoherence gains strength, and the threat to life is quickly felt.

We could even think of a hospital in this way, often a place that feels utterly incoherent to those who enter it. When in pain or frightened, it’s common to feel a disorienting condition of fear and vulnerability in a hospital. On the other hand, there is evidence that a sense of coherence gives people and those around them the capacity to be agents in their own healing. Coherence may not be enough, but it frequently tilts the balance. Besides anything else, coherence provides a way of seeing and trusting the connections across which life might flow via those who hold one up until one is healed. And even when our individual story comes to a close, the coherence of the ending gives life and power to those who remain.

Coherence enables us to adapt to challenges and to change, to manage complex relationships and the complexity of life itself. Of course, some stories of our life are better than others – a story that makes sense of hurting, oppressing or dehumanizing people may be coherent, but it will not be healthy. So even if coherence on its own is not enough, it is still a leading cause of life.



CONNECTION

Walking through any local African community market with its dozens of tiny stalls, hairdressing shops and places to drink, one also often sees dirt, flies, dangerous bits of garbage and other 'risk vectors' of disease or injury. But the market is actually a life vector, a connecting point for many kinds of relationships across which sizzle vital goods like food, hope, and intelligence. The market is a multi-relevant place of connection, just the kind that humans prefer and on which they flourish. Such connections, which also exist in community centers or congregations and a host of other places, are often generative of life.

Humans are social creatures. We thrive on our complex social connections to each other.

Healthy, thriving human communities are connected in ways that enable them to adapt to changing threats and opportunities as a whole. Connection also helps protect and strengthen people who face a disease or illness through social structures that support them, family ties, and respect for elders. When those things start weakening or collapsing, an unhealthy human community is the likely result, one that is incapable of adapting to changing reality. It loses its connections and their generative power.

In Sesotho, the language of the Basotho people, there is a concept that speaks to this: *bophelo*. It makes clear just how deep and extensive connection is in support of life as a whole. It refers to the full interconnectedness of everything: a person, their family, community, nation, the land and other creatures, and even those who have gone before, the ancestors whose heritage one lives out of. They are like the facets of a diamond, not just parts of a machine. Disconnect any one of them at any point, and one affects the whole. Damage any one of these facets, and the others will feel some consequences.

The health of each facet impacts of the health of all.

Neuroscience has also come to recognize how important connection is. Our brain is designed to recognize, initiate, manage, and respond to highly complex social relationships that define our life. The brain can recognize the face of one person among thousands in less than a quarter of a second.

Connection is more than a nice thought. Seeing the world as a weave of thick or thin, strong or weak relationships has implications for understanding the health of the public. Developing greater intelligence on how these relationships work is critical to understanding how people and communities seek their own health and life.



AGENCY

We human beings go here or there, now or later, fast or slow; we lift, reach, touch, hold, dig, study, watch, fight, love, seek, build, invent, and make things. In other words, we *do* things, we *act* in the world. To be able to act, and to act with the full capabilities we have, is a central 'cause' of life. It brings us alive. This is what we mean by our agency. Agency is the power to do or to act. It defines the quality of our lives. When we are prevented from exercising our *agency* creatively, we suffer.

The wise nurse on a cancer ward nurtures the agency of the patients, finding ways for them to express choice, even if only between cereal and oatmeal for breakfast. The physical therapist pulls the patients onto their feet after a shockingly brief period of passive rest, because the human body is designed to grow on its own capacity to do, or it starts dying. If this is true for muscles and bone, how much more for the spirit, the mind, for individuals, for communities, and for life in general?

To undermine human agency diminishes life. In *The Careless Society*, John McKnight, a creator of the asset based community development approach, documents how professional helpers can undermine the agency of communities by creating relations of dependency. This then gives the helper greater agency than the helped. The best organisations work hard to avoid making this deadly mistake, and so do the best of religious and other leaders, or the most successful of physicians and community organizers.

One can clearly see agency where the largest organisations don't expect it – in the midst of the over-whelming swell of AIDS orphans in Africa. The obvious answer to this challenge – to rapidly establish orphanages – seems unlikely in already broken African economies. But a study by UNICEF and others learned that small groups of village women had already acted quietly, on a large scale, to deal with the challenge. On average, in thousands of villages, each group of women (usually members of a small church) takes care of about a hundred children without any encouragement, training, or funding from donors or health agencies. The carers might not be able to explain where the HIV virus comes from or how it spreads (though they know more and more, and knowledge is also part of agency). But the women feed, shelter, and find ways to clothe and protect the kids. They give them a chance at life.

Such individual and community agency creates the possibility of more agency. It opens up space for the other causes of life too. Still, it takes both courage and art to foster the agency of those who are expected to be grateful for what is being done for them. One might even say that agency is a sacred and generative well of life to be nurtured with the deepest respect.



INTERGENERATIVITY (‘Blessing’)

Every significant moment of our lives is part of a journey. One of the great passages of life, of course, is our dying. We can call it life at the end of life. What gives us life then? If the end of your life has not come unexpectedly and suddenly, then that is often when one can see a life whole – or, at least, how *one* life, yours or mine, is part of a larger whole.

Here’s where the concept of *intergenerativity* comes into play. It refers to how one’s own life is blessed or honoured by others who thereby encourage, strengthen, enliven and help shape one’s own life. Maybe a personal story will help make this clear.

As Gary’s aging mother approached her death, he remembers that though her body was breaking down, she was still able to exercise a high level of mental and spiritual acuity. He could talk directly to her about her funeral for which he would be primarily responsible.

She decided how she wanted it to be, and they wept together as they planned it all. When the day came, he spoke to all present about her and her life, about how it shaped him and his life. Finally he broke down, joining his brothers, sister, wife and daughters as a family that would live on. His younger daughter, only seven, put her hand on his knee and whispered, – Daddy, you’ve been a good son today. He was in right relationship – a generative relationship – to his mother, to all she carried of her family with her, to those around him, and to those that will live beyond him. Three generations were gathered, and in honouring each other, they were blessed, strengthened, enlivened, and encouraged to live more fully. That’s the key to intergenerativity.

Intergenerativity not only happens between individuals or in families, but in communities, in movements, in whole societies, if they take care to respect it. That’s why people like Martin Luther King Jr., Nelson Mandela, Mahatma Gandhi and many others, in every society, are often so important, long after they are dead. Life is fundamentally intergenerational, not just from the old to the young, but the other way, too; not just between generations that can see and touch each other, but across the span of those whose lives influence each other over time and space. When intergenerativity is not respected, when it is damaged or perhaps destroyed by others, one discovers how unhealthy it can be without it. Community psychologists call this historical trauma. It’s something that Native Americans, the KhoiSan in southern Africa, the war generations of Germany, Rwanda or Cambodia know all about.

To pay attention to intergenerativity as a cause of life is to draw the community to its own life by systematically bringing into view its unconnected connections across generations, its opportunities for a broader expression of agency inspired by both the living and the dead, its active engagement in supporting and blessing crucial life passages, and its capacities for exercising decency even in the face of overwhelming need.



HOPE

Hope is grounded in life itself! Philosopher Gabriel Marcel was even able to call children ‘the biological basis of hope.’ But it is easy to confuse hope with wishful thinking or mere optimism. That’s not hope!

Hope in the deepest sense is about imagining a different, healthier future and finding the energy to bring that future into being. It’s not naïve about how hard that can be. Ernst Bloch, who studied hope in human beings, called it ‘anticipatory consciousness’ – a consciousness that is not satisfied with the way things are, but thinks about the way things should be. It’s transformative.

Of course, we need both past and future to live in the present, but the point is that humans live out of their expectations, and not just their histories. We anticipate, expect, weigh the likelihood, and then act as if that is what is unfolding. To the extent that our action is informed or reflective, rather than just instinctive, reactive, or impulsive, human hope is about a ‘risk-able’ expectation. We can even call it a ‘memory of the future.’ Obviously, we can hope for things that are destructive, and because we have the capacity, we can act towards that end. But then we are dealing with pathologies rather than causes of life. These are two sides of the same coin. The side that works for life is our focus.

So too, the best of religious traditions – many kinds of religious traditions – is about hope, about a transformed life and world. Our friend Ted Karpf, who has worked in public health in many parts of the world, puts it well: ‘The best of religion tells you stories of past that inform the present and inspire for the future. That is the social function of religion. It speaks deeply, to the bones across time. It inspires curiosity, inspiration, and responsibility.’ That’s what we are looking for.

Hope is linked to agency. It’s about acting with a just and whole vision of the world, even when we think people are pushing us over a cliff into some abyss or that we are about to run into a brick wall in trying to build this hoped for future. In the biggest sense, hope helps us sense something that is real – that we are part of the living processes that make up the whole web of life. We would call it a web of transformation that is animated by hope.

Hope is linked to agency in another way too. As we have already noted, we human beings have this immensely powerful capacity to imagine something new and to think of ways to bring it into being, which is more than merely biological. We add something to what we experience that was not there before. We invent, we make, we create what did not exist. We are able to transcend what is given to us, and this is a capacity we already begin to learn as children, when we call it ‘play.’ So hope is embedded in our imagination as a cause of life, and it flows through every other cause.



The story of Masangane:

This is the remarkable story of an adventure in community engagement in the face of one of the most difficult challenges of our time: how to confront, and deal with, the human immuno-deficiency virus (HIV) and its terrible effects.

Masangane is a comprehensive, integrated faith-inspired organization confronting HIV and AIDS in a mountainous rural area in the eastern Cape of South Africa. There are many such groups in Africa, but *Masangane* has some strengths really worth noticing. For example, stigma is a big problem with HIV and AIDS, and fighting people's fear and shame of it is not easy. *Masangane* did two things that help. First, without shame, almost with pride, it openly embraced people infected or affected by the illness. And that's exactly why it has the name *masangane*, which in Xhosa means, 'let us embrace'! Doing this also gives people new power to act – agency! – especially those who are HIV positive. Second, *Masangane* decided early on that its workers, whose job was to help others, would themselves be people who are openly HIV positive, willing to take a stand and ready to express their own agency. That makes a huge difference, and it is remarkably life-giving for all.

For most of its ten years of life so far, *Masangane* has been run by local people who are themselves infected or affected by HIV and AIDS. They are experts in the life of their own communities even if seldom formally trained. But still, they needed a nurse who knew what to do and who could train them too. They needed other support as well: moral, medical, financial, administrative and more – something the Moravian Church pastor who began *Masangane*, the Reverend MCGoyi, saw clearly. He drew on his church connections – to raise funds from international religious groups and others; to find an openly HIV positive nurse through *Medicin Sans Frontiers* ('Doctors Without Borders'); to get training from the Treatment Action Campaign; to source affordable medicines; to win support from local doctors; and, to build relationships to the local state hospital and public health system. The breadth and strength of these crucial connections is what sustains *Masangane's* existence, and gives it its capacity to give life to others.

How the causes of life go to work

One could tell the story in many different ways; here we connect it to the 'causes of life' and how they work. Masangane, begun by people with imagination and passion, brings these 'causes' alive, making a difference where it matters.



The internal life of *Masangane* is also very important for its workers. Daily they face illness and ongoing stigma, even in their own home or among friends. Many fear never having intimate relationships again or being able to conceive children. It's easy to lose confidence in oneself, to wonder what one's life could possibly mean or why it's worth living. So *Masangane* takes care to mentor and monitor people on ARV treatment, to help them form support groups, to find positive ways of reinterpreting their cultural or faith values, to counsel them, to find a new beauty in their increased health once the treatment begins to work. In all these ways, they find and give to others a new coherence in life, without which they might easily give up and lapse into depression and apathy.

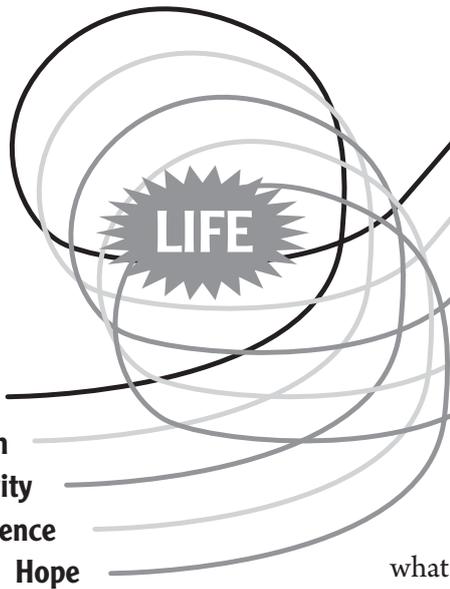
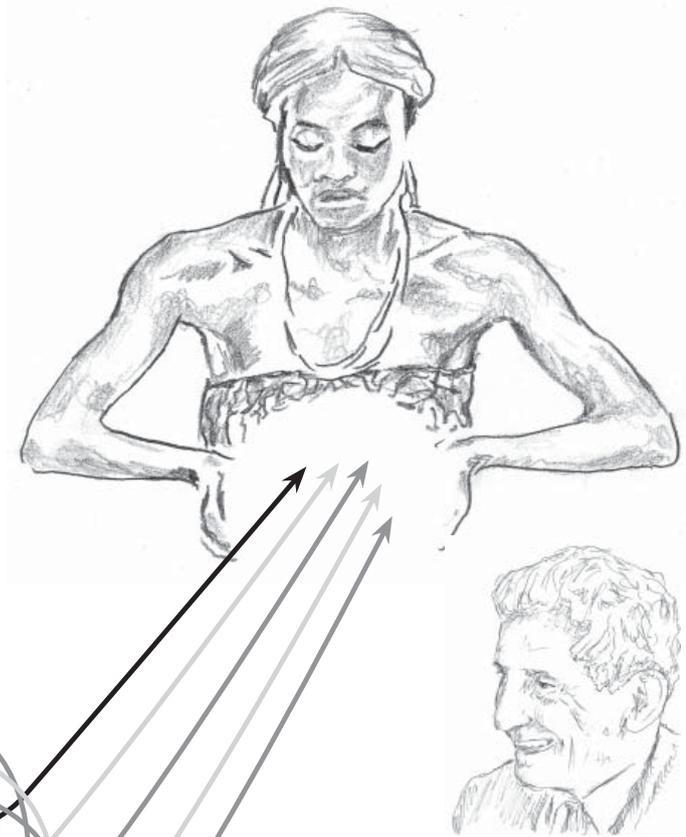
Mosiru, a young man *Masangane* helps, writes that his father had to go to work on the mines, but wished every day to be with his children. It was never meant to be; he died when they were very young. This also meant no money for the family. This is the story of so many children, thousands and thousands of orphans who need, and want, to know and remember their parents. So *Masangane* began to work with orphan care projects in its area. Its workers learned from another organization how to make 'Memory Boxes' – collecting anything they could that would help a child find a bond to their missing parents. This is intergenerativity at work, and building this store of memories is only one part of it. *Masangane* staff later also learned how to lead children on camps where they could share their experiences, help each other talk about their parents, and think about what kind of parents they wanted to be. Here one can see life flows into and out of these encounters, helping bind the past, the present and the future with new hope.



When Rev. Mgcoyi began *Masangane*, he instilled one value above all: become known in the community as 'people we can trust.' HIV, then, seemed so hopeless. Like a death sentence, there was no cure, only an expectation of increasing sickness as AIDS symptoms grew worse. Why would anyone trust those who said that things could be different? *Masangane*, remember, is made up mainly of people who themselves are HIV positive, who had the courage to face it, who accepted ARV treatment, and who had not only become completely healthy but – in contrast to someone suffering from late stage AIDS – now 'looked beautiful' again! Also, *Masangane* offered connection to others, some coherence in facing the illness, and a sense of agency that one thought was lost. All of this generates enormous hope – not wishful thinking but, like a golden thread running through all who have been touched by *Masangane*, a conviction that one can and will live a full and generous life again.

How life works – ‘Emergent Order’

The Leading Causes of Life enhance each other as they swirl in a living ensemble among and between persons and social bodies.



- Agency
- Connection
- Intergenerativity
- Coherence
- Hope

David Bohm, a famous quantum physicist influenced by close colleague Albert Einstein and Krishnamurti, thinks reality is only properly understood in terms of its total connectedness. And reality is more like a song than a construction project.

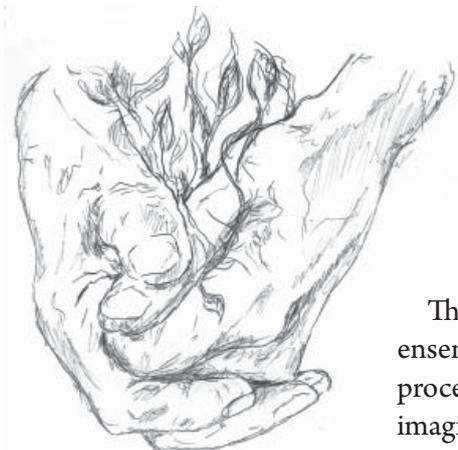
For Bohm, ‘life is enfolded in the totality.’ Life is what allows order to emerge, even where we think there is only disorder (or ‘death,’ we could say). Change comes from the movement of life, which can only properly be understood when we see life as a series of intermingled elements. These elements are all present together, folded into each other and into the whole.

In the same way, the ‘leading causes of life’ model sees the wholeness of human communities through generations, through life passages and the whole journey.

Keeping and holding the ‘causes’ together, understanding and working with people in this way, keeps us focused on what counts for health, and helps us enhance what gives life.

We can call it a **transformational ensemble**, a group of ideas and practices that move us towards deep and durable change.

The ‘leading cause of life’ enhance each other as they swirl in a living ensemble among and between persons and social bodies. Making the life process visible feeds another powerful component, the human and social imagination that sees beyond what is to what might be.



Here we introduce a deep point, maybe best approached by asking the question: what makes us human, meaning different from other animals or creatures (as far as we know anyway)? It's our *imagination*! That doesn't mean other creatures may not have some form of imagination – a pride of lions, for example, knows how to hunt, and it knows how to do so in unpredictable and changing circumstances. So what is it about our imagination that is different?

To grasp the extraordinary capacity of human imagination is actually not that difficult, yet still profound. To begin to explain why, we start with a small but powerful story. The following is a true story, about a young man – let's call him Roger – who lived in a country where justice and freedom was not meant for all.

A profound story of 'Creative Freedom'

The country is South Africa under Apartheid. Roger was white and the State, controlled by whites, was in a quasi-war against its own black citizens, as well as against neighbouring states who supported the anti-Apartheid liberation struggle. Roger was 'called up' to do military service. But he had become convinced that this was an unjust thing to do, and so he became a conscientious objector to serving in the army. He was arrested and put into detention barracks. For some months he was in solitary confinement in a small cell, with only a Bible to read (allowed because the state called itself 'Christian'), and no-one but the warder to talk to from time to time.

Now you would think that this kind of severe loss of freedom and isolation would crush a person. Well, it has crushed some individuals, but not Roger. He used his *imagination*.

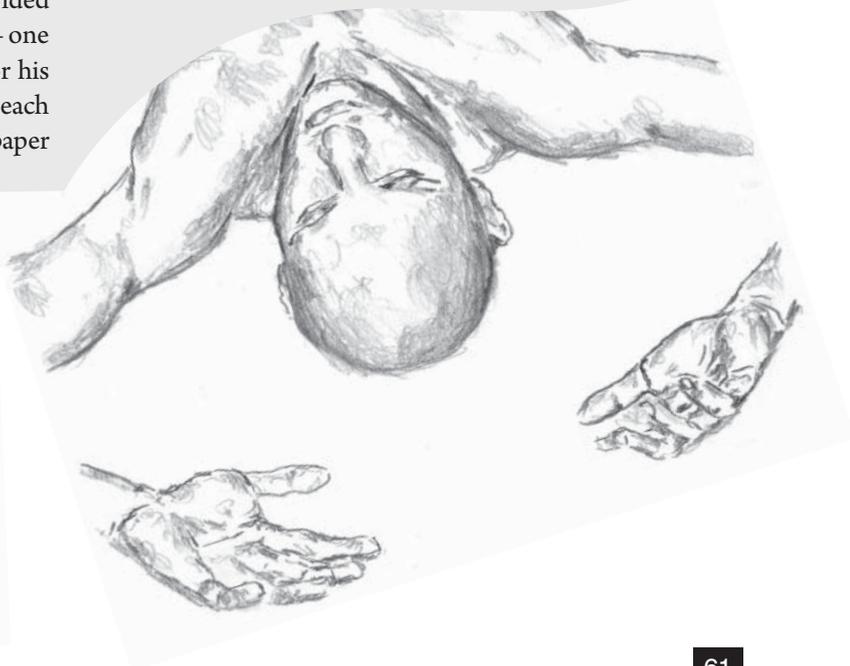
First, he deliberately imagined every day that his family and comrades were trying to reach him, to communicate with him, to connect – even though he was not allowed to hear from them. He had faith and hope that they were trying, and this gave him strength, for he did not feel alone. Second, he asked for a Bible that had both the English and the Greek text in it, and began to use it to teach himself Greek to give some coherence to his tedious days. Now he needed to express some agency, so he did two things. Mentally he divided his small cell into three parts using imaginary lines – one part for his 'bedroom,' one for his 'lounge,' one for his 'bathroom' (the cell had a toilet). He spent a part of each day in a different 'room.' Then he took some toilet paper

and made tiny little chess pieces, small enough to hide easily (his room was regularly searched for things he was 'not supposed to have'), practicing chess strategies whenever he could. Finally, he sang songs and hymns he knew, thinking about their rhythms and arrangements, and experimenting with them.

Connection, transgenerative memories, coherence, agency, hope: all played a part in his ability to survive this kind of experience, and to survive well. But behind them all was the power of his imagination.

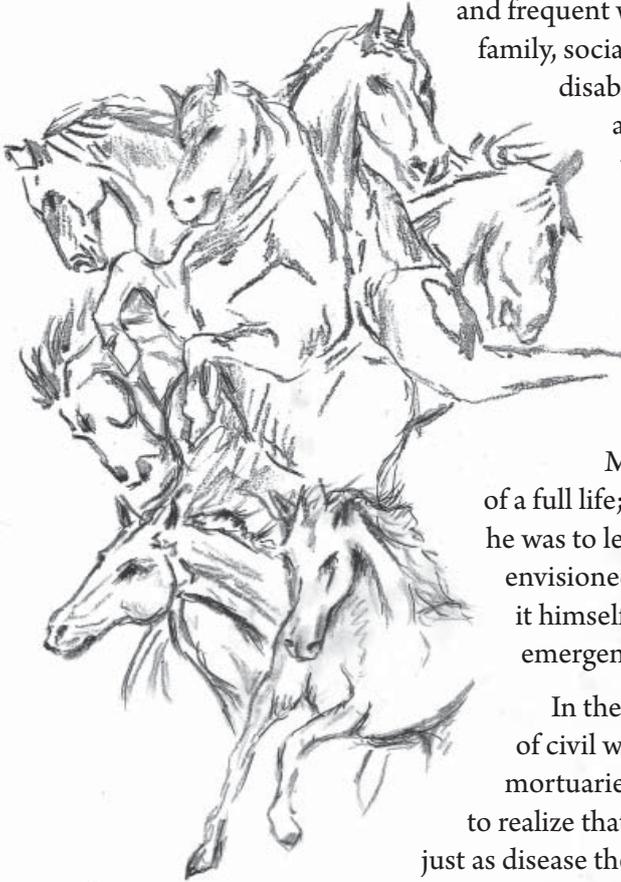
The special character of this kind of imagination was its *creative freedom*. It is an ability to imagine what nature cannot produce on its own, to add something that did not exist before, and to bring it into being. You cannot imagine a lion in a cage being able to imitate what Roger was capable of. This is an incredibly powerful freedom. We are capable of using this power of imagination in some of the most constrained experiences we can envision (at least if one not been tortured or hurt to the point where one can no longer function at all).

This is why the 'leading causes of life' really make sense, for they ask us to turn our capacity for creative freedom towards the generative causes that give us life. And this has the potential for profound transformation of ourselves, our communities and our world.



Though chaos fights back ...

The Leading Causes of Life paradigm does not directly deal with the many and frequent ways life fails to order human experience at the personal, family, social and even political scale. Disorder – disease, injury, disability, destruction – is not just a lack of health. Unpredictable and turbulent, disorder appears to fight back against the underlying order of life. Life does not always win.



Nearly all religions have some way of naming the disorder that fights back – as chaos, displeased ancestors, fallen angels, dangerous spirits, demons, Satan, or malevolent forces. We don't have to accept any particular religious way of naming disorder, but we would be unrealistic not to recognize how much it is part of human experience.

Martin Luther King Jr., for example, did not simply fall short of a full life; he was shot down on his way to dinner with friends before he was to lead another march for freedom. He expected the new order he envisioned as possible, yet he sensed that he would never experience it himself. Like him, we have to deal with the interplay between emergent new order and the reality of disorder.

In the same way, one does not have to be present on the battlefields of civil wars, in the killing fields of tyrannical states, or in the mortuaries of those who have died from accidents or violence, in order to realize that the logic of life is not all that describes human experience – just as disease theory or explanations of how we die is not the whole story.

It is not enough simply to hold the two stories in tension – *one* of healing and life, of generative imagination or emergent order, and the *other* of disease and death, formless void or active disorder. They are entangled with each other, and we are wise not to pretend anything else.

... life thrives nevertheless!

'At the same time, if we only repeat a litany of despair, no matter how accurate it may be, we will never heal the injustices that beset us or the illnesses that afflict us.'



[Learned from my teacher Ross Snyder]

'This is the story of our life, of our parents' life, and of our children's children ... that the world sets our feet on a rocky road, and the rough places are not made plain nor the crooked made straight. If we sense the sound of marching, of ancient energies about to break forth, of strength to stand up to adversity, of voices speaking up for justice, of people bearing the neighbours' burden and calling us to invest our life in the truth that sets us free, then we live in the 'nevertheless.' However feeble our efforts in defiance of difficulties, living courageously and giving justice we are caught up in a greater good beyond the horizon. Thus we hold the world together, nevertheless ...'



Finding health: Understanding healthworlds

'... the invisible message of the interaction between professional and client is, "You will be better because I know better." Through the propagation of belief in authoritative expertise, professionals cut through the fabric of community and sow clienthood where citizenship once grew.'

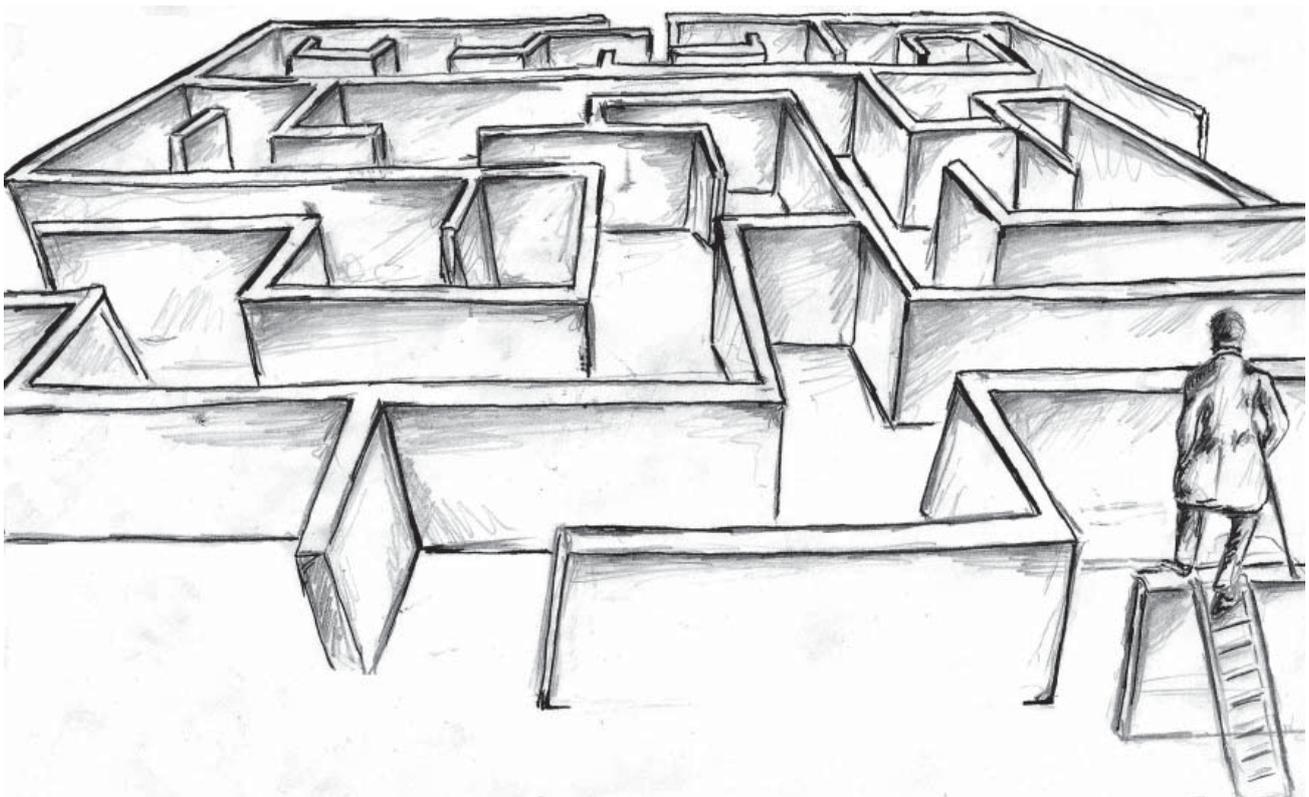
– John McKnight, *The Careless Society*

Finding health and well-being - for a community or a person - is not as simple as it may seem. Most often a complex reality is involved. If we don't take this reality seriously enough, anything we do could simply fail. In this chapter, we ask: How do people understand their health? What do they do to protect or improve it?

QUESTION TO THINK ABOUT

- In your context, when you are feeling ill and need help to whom do you go, whom do you trust?

(You will find some helpful ways of thinking about your context in Chapter 11 of *The Barefoot Guide to Learning in Organisations*, 'In the Sea of Change: Understanding your context.')



Clashing worldviews: Leonard's story

For years, Leonard worked one day a week maintaining the garden of two professionals. A young Xhosa man seeking work in the city, he lived in a shack with his brother. Despite being honorable, trustworthy, diligent and pleasant, he could find no full-time employment – a painful reality.

One day Leonard came in agony, eyes swollen and infected. His employers took him to their private doctor who prescribed antibiotic ointment, painkillers and rest. The infection went, but then reappeared later. No longer confident in doctors, Leonard sought other treatment from a *sangoma*, a traditional, holistic healer – a kind of psychologist, family therapist, community counselor, behavioral expert and nutritionist all in one.

But Leonard's health worsened and other, more worrying symptoms began to appear. And he began to arrive for work at odd, unexpected hours, increasingly confused even about which day it was. He grew scared of people, fearful even of returning home in case others saw him. His one employer, experienced in HIV and AIDS work, knew the symptoms. She pleaded with him to go with her to test for HIV. He wanted no one local to know he had the virus; the stigma and shame was too strong. So she took him to an NGO in another part of the city where Leonard was counseled, tested – and diagnosed positive.

The obvious next step was to measure Leonard's CD4 cell count to see if he could start treatment. This was too much for him. He refused all pleas, asking instead for

money to return to his home village in the distant rural area. His employers thought he was going home to die.

Weeks later he suddenly reappeared! Not returning home at all, he had gone to a nearby township to be treated by a second *sangoma*, also an herbalist. He did look better, felt healthier. But the HIV virus, hiding deep, was almost certainly still there. So again his employer recommended a CD4 count. 'No!' he said, 'I am well. *Your* doctors are wrong – I don't and never did have HIV!' The *sangoma* had told him he *was* now well, so what else could he think but that the entire health system on which his employers relied was suspect, if not wholly untrustworthy? He had shifted his mental frame of reference for thinking about his health and well-being.

This changed frame of reference didn't appear from nowhere. Another way of thinking about health besides biomedicine or 'Western' science was always present in Leonard. Suppressed in public, it was alive in private. This created a sheath between different ways of understanding health and healing. First Leonard was willing to mix the two ways of thinking, but now he had built a wall between them.

This kind of conflict between different ways of seeing health is not peculiar to Africa or to HIV. It happens everywhere, and needs to be taken into account. It shows how important it is to understand people's worldviews, often religious. And that not doing so can lead to failure in delivering health where it is needed.



The story of Leonard raises vital questions about the relationship of health seekers to health providers. Providers, whether 'Western,' 'indigenous,' or otherwise, commonly assume that they know best. But health seekers have their own views too, acting in ways they regard as reasonable and appropriate to their circumstances.

Recognizing the agency of the health-seeker

Many, many people and institutions provide health in most societies. Providers, hospitals and clinics especially, often control resources, and have a long-established, respected role, with influential structures and associations behind them. They can powerfully determine what should be done, for whom, by whom, when and where.

But neither power nor knowledge, resources nor means, are spread evenly. Global health statistics even show that a big chunk of health provision goes to those who are well-off and powerful, reminding one sadly of that old saying, 'Unto those who have, more shall be given.'

Health providers are also the 'experts,' taking for granted that they know what others don't. And they *do* possess an often overwhelming and incomprehensible body of knowledge, which they can wield in ways that leave the health seeker pretty disempowered. Health seekers are usually expected simply to trust whatever is placed before them, whether one thinks of clinical, biomedical, complementary, alternative or indigenous providers. Trusting another person or institution with one's health is no small matter, and trust of providers doesn't come easily.

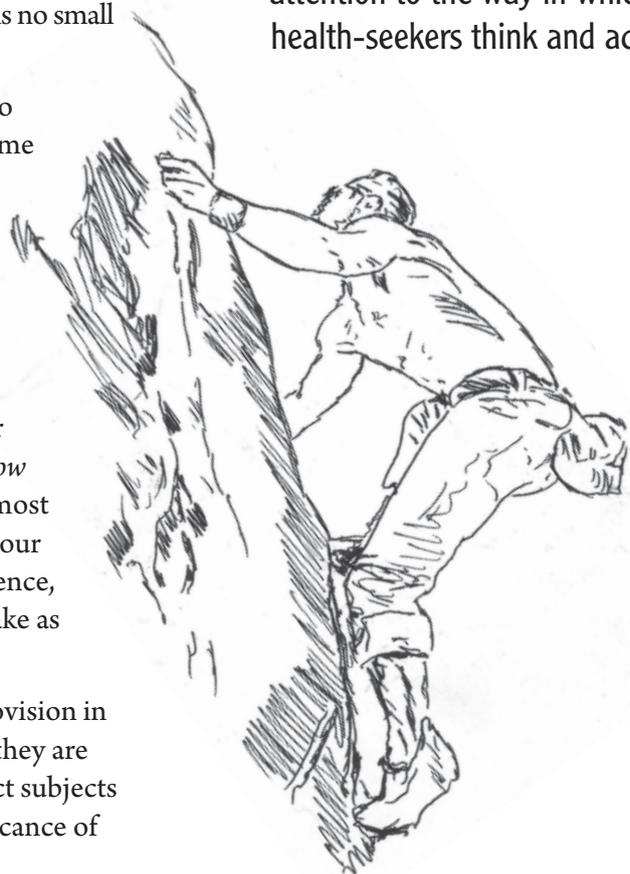
And actually, 'ordinary' people or communities who are seeking health often know more than experts assume – maybe not about the science, but about themselves and their circumstances. They inherit wisdom from their parents or elders, from precious folk traditions, or from plain experience, insight and understanding of their own situation and context – about which the provider often knows little.

Health seekers, then, are *not* without power of their own. *Think about how you deal with your own health, how you make choices and decide what to do or not do.* Like most health seekers, you probably weigh the odds, survey your options, consider your risks, shift your points of reference, assess and reassess who and what you will trust and take as authoritative. And you make choices accordingly.

So health seekers negotiate the terrain of health provision in complex, sometimes contradictory ways. Even when they are confused, frightened, and in great need, they are in fact subjects who exercise their agency as best they can. The significance of that reality is what we want to explore further.

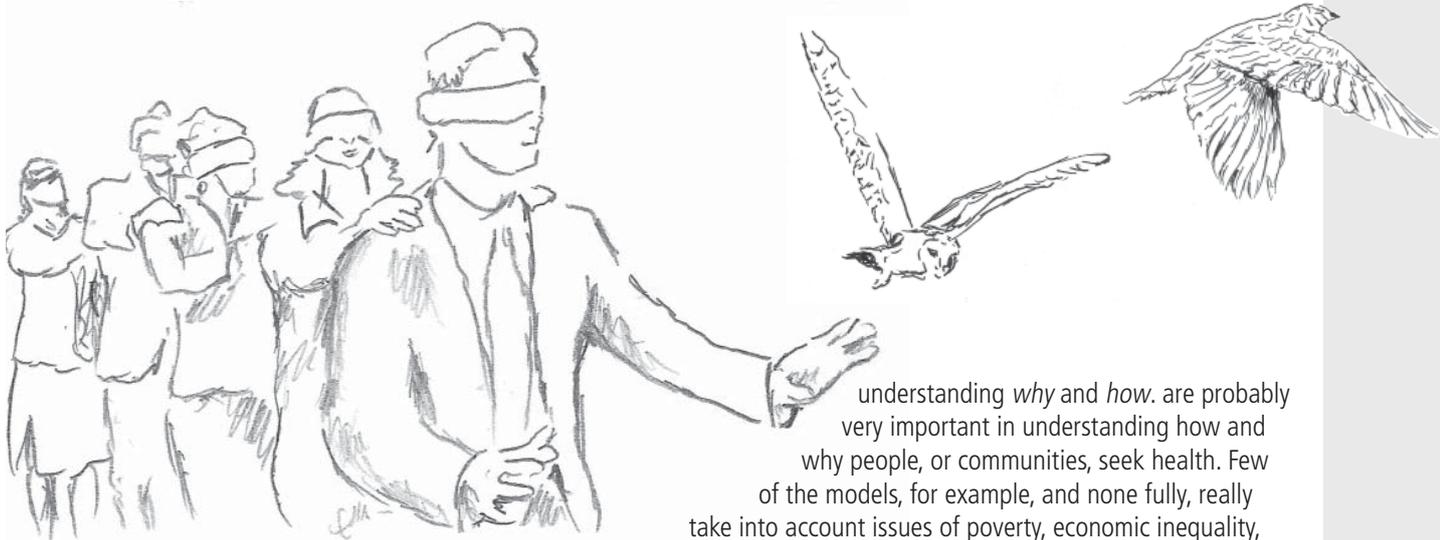


Leonard's story shows that what one trusts and believes has a significant impact on one's health behaviour. So if we want to deal better with contested and conflicting approaches to health, one vital aspect is to begin to pay attention to the way in which health-seekers think and act.



What do we know about health-seeking behaviour?

To pay attention to health seekers is not new in the history of health sciences, but to do so well is a big task.



understanding *why* and *how*, are probably very important in understanding how and why people, or communities, seek health. Few of the models, for example, and none fully, really take into account issues of poverty, economic inequality, gender disparity, how vulnerable people are in their context, or what their full cultural and religious influences are.

‘Physician, know thyself!’

This ancient saying suggests that a truly good doctor is one who has self-understanding. But we can turn this statement around to say, ‘*Physician, know the one who seeks your help!*’ Figuring out the complex behavior of people seeking health is no simple task, though! People seem to follow their own rules and logic, and they keep changing!

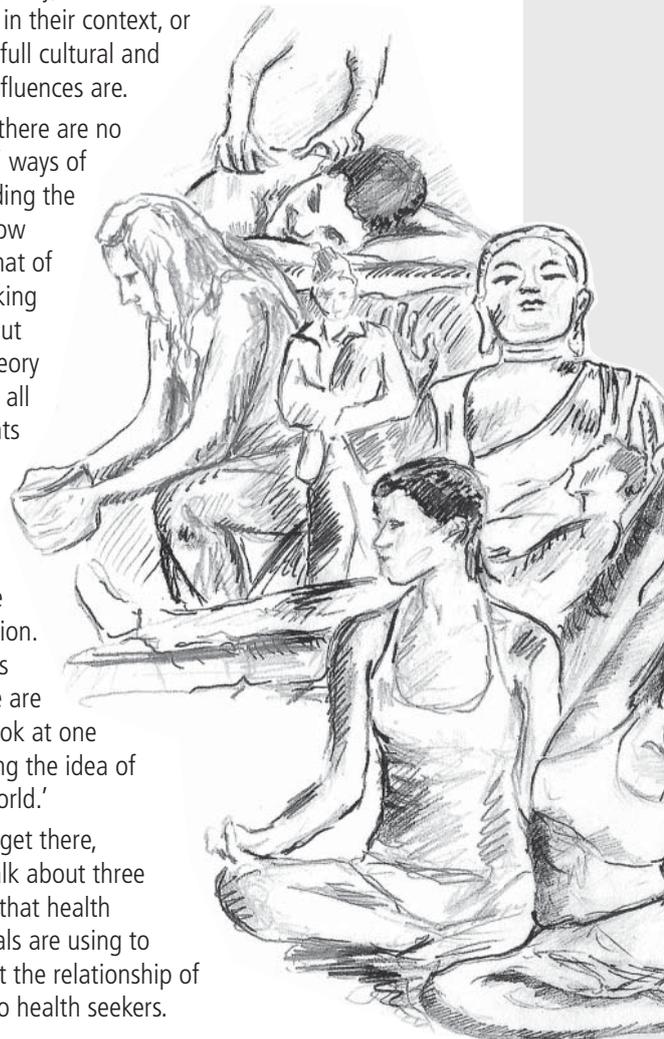
Health providers tend to prefer a simple view of health seeking behavior that they can use to plan what they will provide and how. Still, it is becoming clearer that a lot goes wrong because human beings are seen and related to in ways that are too simple. And some things have been learned.

For example, some researchers have tried to find more adequate ways of linking medical concepts and community wisdom or knowledge through what are called ‘KAP surveys’ – exploring ‘Knowledge,’ ‘Attitudes,’ and ‘Practices’ of a community. This helps to describe *what* a community actually thinks, but it doesn’t really say much about *why*. So other researchers have tried to go further using a model called ‘FES’ (don’t we love our acronyms!) – ‘Focused Ethnographic Studies’ – to identify the concepts and categories local people use to understand their health and well-being.

We could go on, but it’s not really necessary. The point is that asking *what* people think and do is only part of what we need to know; it’s too limited. Equally important is

Of course, there are no ‘cookbook’ ways of understanding the *why*, the *how* and the *what* of health seeking behavior. But a better theory that brings all the elements together maybe would give us a push in the right direction. Later in this chapter we are going to look at one theory, using the idea of a ‘healthworld.’

To help us get there, let’s first talk about three new ideas that health professionals are using to think about the relationship of providers to health seekers.



Some new shifts in perspective

To pay attention to health seekers is not new in the history of health sciences, but to do so well is a big task.

‘Quality of Care’

The influential Institute of Medicine (IOM) says that a big challenge in health care comes from the ‘quality chasm.’ They mean a lack of safe, effective, timely, efficient and fair health care, even where there are lots of facilities, medical staff, medicines and technologies. Imagine how big the problem is where there’s a serious lack of resources! ‘The current care systems,’ said the IOM, ‘cannot do the job. Trying harder will not work. Changing systems of care will.’

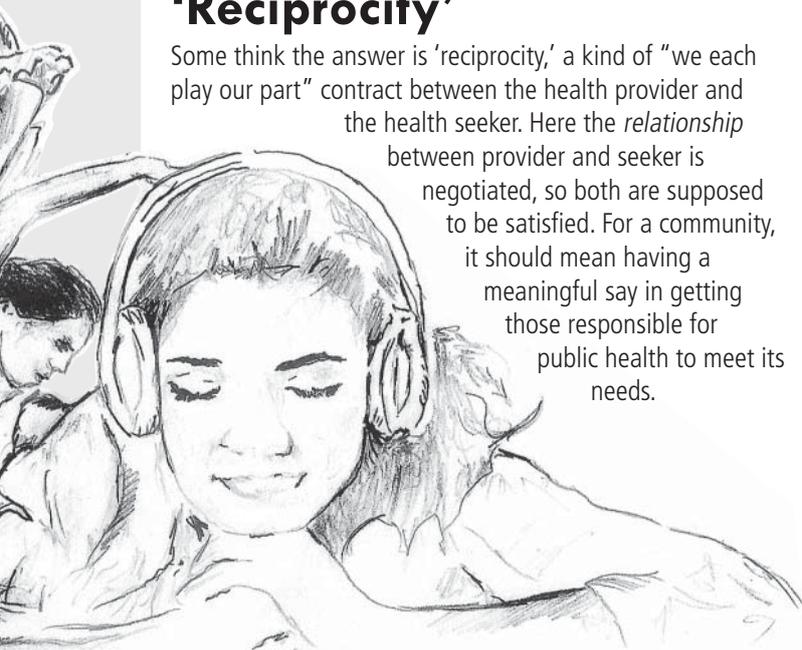


One key goal to achieve ‘quality care’ is for it to become ‘patient-centred’: providing care ‘that is respectful of and responsive to individual patient preferences, needs, and values and *ensuring that patient values guide all clinical decisions.*’ That last bit is pretty radical! Maybe, then, even talking about a ‘patient’ is a problem.

A ‘patient’ is someone in care, in the provider’s space, a ‘case,’ someone with ‘a problem to be solved.’ (perhaps someone who needs to be patient while the doctor finds a cure!) This is a ‘thin’ description of a real person, and very individualistic. Yet health seekers are not simply patients. They are also agents of their own health, on their own journeys of health, within their own cultural space, in many relationships with friends, family and co-workers, dependent on a complex network of supports. That’s the deeper picture we want to see, a ‘thick’ description of persons-in-community.

‘Reciprocity’

Some think the answer is ‘reciprocity,’ a kind of “we each play our part” contract between the health provider and the health seeker. Here the *relationship* between provider and seeker is negotiated, so both are supposed to be satisfied. For a community, it should mean having a meaningful say in getting those responsible for public health to meet its needs.



Is this enough? A contract between health provider and health seeker is like the an exchange in a market economy – ‘I give you this for that.’ And for the exchange to be just, it assumes everyone has roughly equal choices, opportunities, and means. But what happens where there is no such equality, as is often true for those who need health care most? As Paul Ricoeur says, there is no real reciprocity where justice is not present.

A contract offers only a limited kind of justice.

A covenant, however, is very different: it depends on a moral understanding – on truth-speaking, on a mutuality that binds people even when there is a dispute, on trustworthiness (‘my word is good’). A covenant is about establishing, ensuring and building just relationships.



‘Decent Care’

This new idea is inspired partly by the International Labor Organization’s concept of ‘decent work.’ A bit like the IOM’s ‘patient-centered care,’ it goes much further. It forces us to ask what we mean by decency! Those who introduced the idea are clear. It rests, first, on respect for everyone’s dignity and self-worth – anything less is indecent! Respecting one’s *dignity* means defending the freedom that enables one to exercise one’s full human being – which fits with a holistic view of health. Respecting someone’s *self-worth* means taking seriously one’s own way of seeing and acting. For the relationship between a health provider and seeker, that means *making decisions together* about what is to be done and how. This applies both to individuals, and to a community.

For communities ‘decent care’ means enrolling the community in problem-solving and support for care. It aims at dignity and agency, it recognizes that we are all interdependent and that solidarity is important, it deals with things at the appropriate level, and it aims to be sustainable over time.

We (seekers and providers) are still discovering how to make this new idea of decent care work fully. But it points to a fresh and potentially much healthier direction for the health of all.

Generational trauma: Ruby's story



Ruby was born in 1925 in the Mississippi Delta, daughter of an African American sharecropping family. Eldest of twelve children, several dying young, she was smart, her mother's hope for a better life. But she had little schooling. Her beloved grandmother, Ms Addie, promised to find some way to send her up river to her Great Aunt in Chicago, to a real school, so she could be 'somebody' and help her family.



Before school Ruby had to plant, hoe, and pick cotton during season. Sharecropper life: hard, thick with racism, exploitative, and marked by fatalism, seemingly stuck in heart-breaking work and abject poverty. But the landowner's wife was fond of Ruby and taught her to read. She read everything, even newspapers used for toilet paper.



Her father, wasting money, drank too much, but Ruby only minded when he beat her mother. Then she covered her ears and tried to imagine life in Chicago. Meanwhile, Ms Addie's health got worse. Her weight dropped, shoes on swollen feet caused blisters, her feet stung and tingled, and walking got harder.



The old female root doctor who lived nearby gave her herb poultices for her feet, and when she could afford it, she soaked them in Epsom salts. Animals had better quality care on the farm! Physicians also charged exorbitant prices, so people seldom sought them. Then Ms Addie *had* to call a doctor, her toes turning red, then black. Shaking his head, he said the toe must go. She had 'high sugar,' diabetes. Ruby

watched in horror as Ms Addie slowly lost her toes, feet, and limbs. Ms Addie was happy to die, telling Ruby, 'Baby, cry when you are born and laugh when you die, because you are going Home to God and out of the misery of this awful life.'

Ruby pined, lost interest in learning, and looked for ways to escape the poverty and bleakness. Weary of everything, she met Anthony. Fine-looking, a few years older, and earning some money at a local cotton gin, he owned a store-bought shirt, pair of pants, and shoes that were not hand-me-downs. A smooth talker, he soon impregnated Ruby. But she could not tell her barely functioning mother and tried to hide the reality, tight-wrapping her belly before going to pick cotton. One day she collapsed in the fields. Her mother just sighed, 'Girl, you were our only hope. You ain't gonna have no better life now.'

Anthony married Ruby, but her belly wrapping meant their first-born child was 'mildly retarded.' Two more children came, and Anthony started drinking, like Ruby's father. After a few beatings, Ruby had had enough, moving in with her cousin in Memphis who found her a house-cleaning job.

Now, in her sixties, like her grandmother, she also entered the journey of diabetes. Her weight dropped, her feet began to sting, and bathroom trips became frequent. A kind nurse told her the 'sugar' could be 'managed' if Ruby controlled her diet and checked her sugar level regularly. But Ruby sank into depression. Images of her beloved grandmother losing her legs paralyzed her with fear. Worst was giving up her coconut pie, fried chicken and corn bread, her only real treats. Ruby told no-one of her diabetes, and did not change her behavior, deciding it was better to 'go on Home to God early.'

Health-seeking behavior is not just about personal choices. Ruby's story makes clear that any one person's journey of illness is rooted in a wider, deeper context. Diabetes is partly a lifestyle matter. But lifestyles are deeply shaped by social conditions, historical traumas too. Poverty, exploitation, the systematic hurting of people – like sharecroppers who came from a history of slavery – are group experiences that work like bad feedback loops from which it is hard to escape. To grasp how people understand their health, and why they behave in certain ways, one has to understand their history too.

Eventually Ruby buckled at work, her situation dire. Her daughter pleaded with her to survive for her grandchildren's college graduation and for her disabled son. This helped. Ruby began to check her sugar levels. Encouraged by her pastor, she joined diabetes classes. Her peers encouraged her to follow her first love, reading. She read everything she could about her 'sugar.' She began to feel hope, even attending aerobic classes. In her mid-seventies, Ruby felt better than she had in years, and when a faith-based Community Health Center opened in her neighborhood, it was a dream come true. Here medical support came with spiritual support. All these relationships and the web of support helped Ruby overcome her fatalism, and now she lives as well as anyone could at her age, managing what physicians call her chronic illness – but what she calls her life. And what we might call her *bophelo*!

Good science and proper knowledge is important. But – as Ruby’s story shows – alone it’s not enough. In many crucial circumstances seeking health is not just about having the right information or treatment available. A person’s choices are affected by many things, like historical and social conditions, or what is experienced by other people who are important to one. That’s not straightforward; we could say it’s full of human ‘messiness,’ or complexity. To understand why and how demands no less intelligence than any exploration of anatomy, biochemistry, or neurology. If the immense possibilities of gene combination are a challenge of the highest order to researchers, then so too is understanding how health seekers perceive and act in the world. In both cases, we need to find basic patterns and processes that can bring some order to the complexity.



So let’s talk about *bophelo*

... a special way of seeing the dance of life

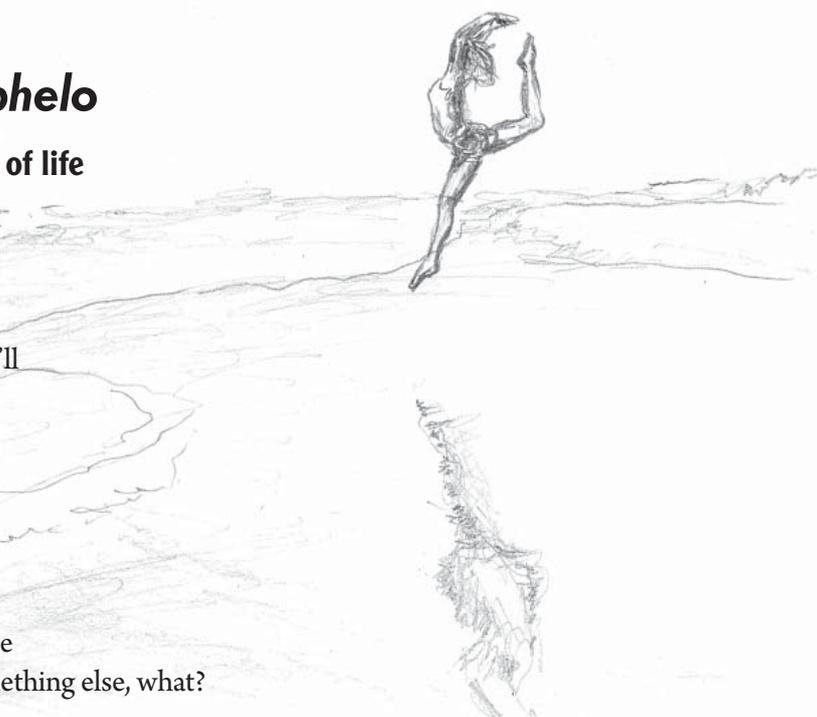
This term comes from the highest country in the world, Lesotho. If one asks people there ‘What is the right word in Sesotho for health?’, the answer one gets is, ‘*bophelo*.’ We’ll explain its full meaning in a moment.

But first, it’s worth asking the same question of you in your context. What is the deepest word for ‘health’ in *your* language? What does it cover? Is it personal or individual health, or more than that? If more, what more? Is it just about the body and the mind or the spirit too? If something else, what?

It’s also worth noting that *bophelo*, in the fullest understanding of the Basotho people, is also the word that would mean ‘religion’! That’s worth thinking. Health and religion are one, and as concepts they can’t be separated in a Sotho person’s worldview. Whichever way you look at it, both are about the fullness of life, about one reality.

(Actually, while we are about it, let’s note that the link of health and religion is also present in other worldviews. Just as one example: Christians talk a lot about ‘salvation,’ and many Christians think this is a purely religious word. In fact, it’s from the Graeco-Roman root word ‘salus’ – which means health!)

So, now we’ll have a closer look at the deep meaning of *bophelo* – and, while we do that, keep in mind the equivalent or closest word in your own language.



‘Health is the whole and the whole is health’

Many people have concepts similar in meaning to the Sotho *bophelo*-like the Xhosa/Zulu, the Bemba in Zambia, the Karanga in Zimbabwe, the Navajo in North America, Urdu speaking people in India, and others in China.

“From a *bophelo* point of view, then, health cannot be reduced to an individual person, let alone to a biological condition. It includes a rich, and decisive, web of extended relationships – to others (including those who gone before), and to the earth that sustains one.”

At the heart of the idea of *bophelo* lies a social ecology, a deep connection between several levels of human life, all of which belong together. The diagram below illustrates this. We begin with the person, *motho*.

Each person (*motho*) has *bophelo* in two ways: *biological*, being a living organism and social, being formed by others. Nelson Mandela, Archbishop Tutu and others express this truth through the African term *ubuntu*: ‘a person is a person only through other people.’ A person (*motho*) cannot exist in isolation, only in relation to others.

Yet a person is not born in a vacuum, but into an existing set of relations. The first level is *lelapa*, the family and its homestead. If a part of the family or the homestead is unwell in some way, then the interconnectedness of *bophelo* means that every person linked to that family or home is also affected. The health of each person is dependent on the health of the whole, and vice-versa.

At the same time, people and their families are always rooted in a wider social and geographical space: a community, a village, a nation. That wider space also enhances and sustains one’s *bophelo*.

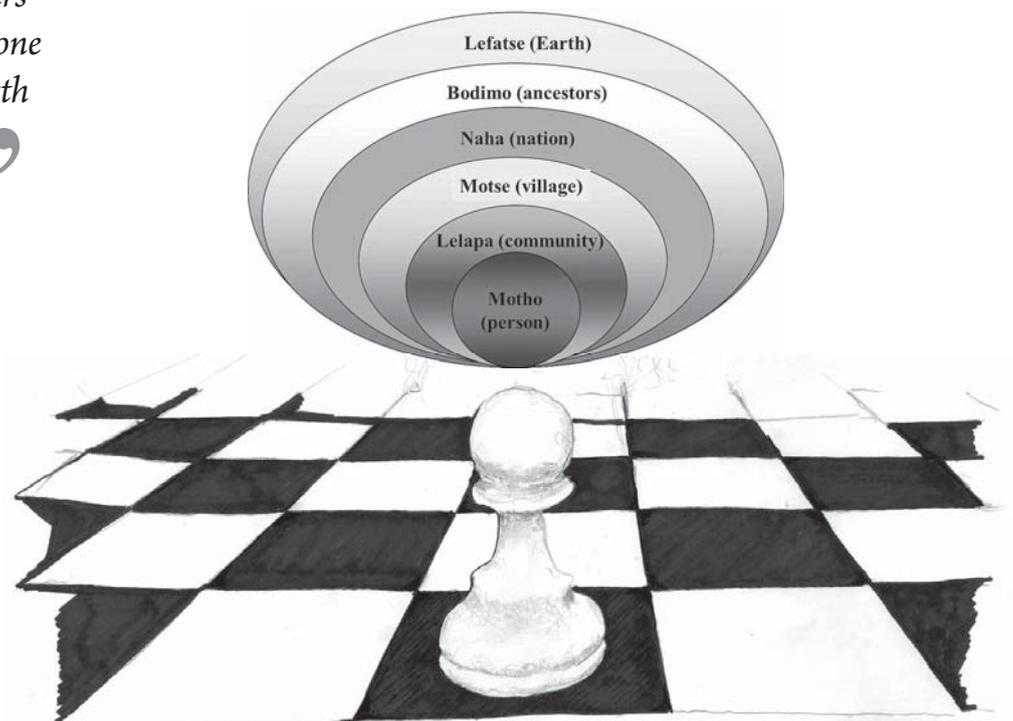
For example, people in villages in Lesotho, a country very dependent on migrant labour to South Africa, say that a village with a post office has ‘more *bophelo*’ than ones without. Why? Because the post office is where the money that migrants (men mainly) earn in South Africa can be sent, where it can be saved, and where letters are sent and received to keep families in communication. That means greater well-being and increased health!

Another relational spheres of *bophelo* concerns those who have died, the ancestors, whose contribution to the family, the community, the village, the nation is honoured and remembered *as part of the life of those now alive*. To honour them means to pass down through the generations the values, memories and heritage of the people.

The last sphere is the earth itself, the land, whose ‘health’ or ‘illness’ is just as critical to everyone as anything else. Our *bophelo* is affected by drought, floods, storms and other natural events, and also – maybe more so nowadays – by human use or misuse of the land and the earth as whole.

So *bophelo* is really about comprehensive well-being in a fully healthy society. If *any one* of sphere lacks in *bophelo*, it compromises the whole. It’s actually not far from the WHO’s definition of health!

Socio-spacial configuration of *Bophelo* in the Sesotho healthworld



Ways of seeing health and well-being

Think back to the stories of Leonard and Ruby. They live in *at least* two ‘worlds of perception and practice’ at the same time. One world is shaped by biomedical understandings and systems. The other is ruled by traditional family and folk practices that have not disappeared, often so important to people that if one tries to erase them, people will resist, openly or in secret. That’s why people *don’t* simply ‘do what they are told’! They are careful about what, and whom, they trust. And usually quite shrewd about how they make their choices and act around their own health and the health of those for whom they care.

In Ruby’s and Leonard’s cases, each of the different worlds of perception and practice they live out of has its own logic, emotional content, and material foundations. These ‘worlds’ also intermingle, and how they interact changes all the time, depending on the situation.

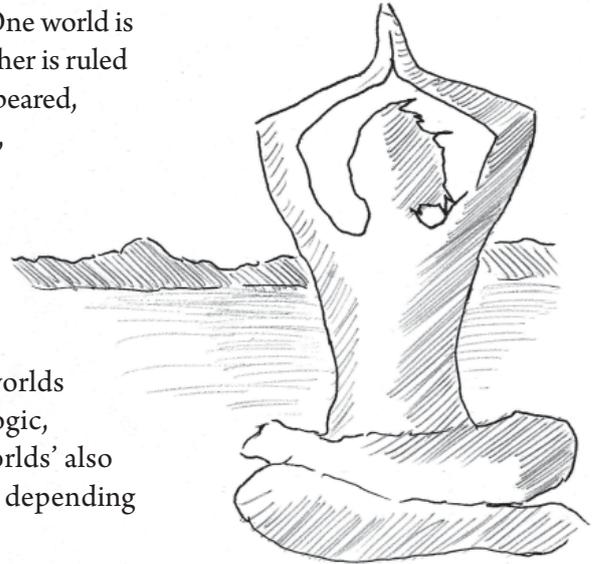
If Leonard or Ruby make their own judgments about what best meets their search for health, what affects their judgements? Clearly, they learn from their own experiences and of others around them, their upbringing, their deepest cultural values, the real possibilities open to them for seeking health, the social conditions that shape their history, their material and financial security, and so on. *Only one part of their thinking would be shaped by biomedical science!*

Here’s a thought experiment: ask yourself, ‘how would or do I deal with a serious challenge to my health (a life-threatening condition, perhaps interpersonal violence, and so on)? To whom or what would I turn for help, relief or healing?’

Chances are you act out of different ‘worlds of perception and practice’ too. We all mix and match! And we do so according to what makes most sense to us in any one circumstance, no matter what some authority like a doctor thinks we should be doing or not doing! We harmonise any contradictions in our own way, and live with what can’t be harmonized if we have to. It’s our health, after all (or the health of someone, or a community, we care about).

We think there is a way to conceptualise this reality so that we can understand it better, and why it’s important to take it seriously. It’s the idea of the *healthworld*. Actually, it’s inspired by concepts like *bophelo*! Through it, one can also grasp why religion – a framing set of ideas and practices that orient one towards reality and shape one’s actions – is often so deeply rooted in health perceptions and behaviors. More, if we think of Ruby’s story, it is also helps recognize that deprivation, depression, and despair are signals of a *damaged and broken* healthworld – diabetes, for example, is closely correlated with poverty and deprivation, social determinants that powerfully impact on health seeking behavior.

So let’s unpack this idea a bit.



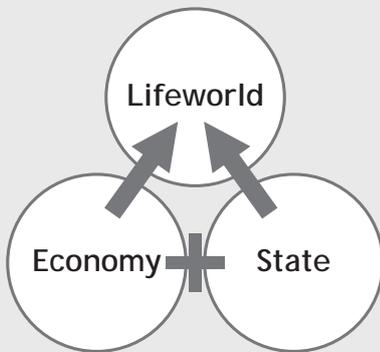
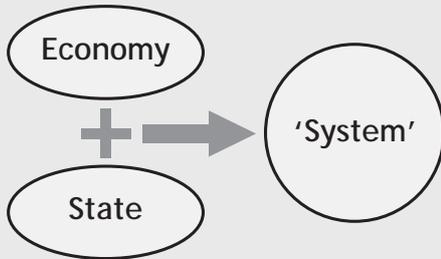
‘Studies on health seeking behavior show that ‘mixing’ different health systems is normal. In reality, we all live in a ‘mangle of practice’ that needs to be understood.’





UNDERSTANDING

Paul Germond, a researcher in the African Religious Health Assets Programme, was thinking about how to talk of bophelo more generally; he suggested the idea of the ‘healthworld,’ which he and Jim Cochrane then developed together.



Lifeworld

Many sociologists think of big, complex modern societies – even ‘global society’ – as an interplay between three major spheres of human life. One sphere is shaped by *power* (how it is shared or not shared), the realm of politics or the state. Another, to do with what we produce, distribute and consume (the economy), is shaped by ‘*money*,’ or business and markets. These two spheres make up the social *systems* that govern our lives.

Now *both* of these spheres are ruled by a certain kind of thinking and acting we can call ‘instrumental.’ It’s basically a logic of non-human ‘things’ or ‘*instruments*’ – which drives politics and economics. If we think of this in relation to human life, we could say it’s really about ‘*using*’ someone to achieve some purpose, just like Ruby and her sharecropper family were used to achieve profits. From an economic point of view it seems rational, from a human point of view it seems cruel. This has nothing to do with whether a country is capitalist, socialist or whatever – all modern societies work with system logic, even if in different ways. Systems are important in organizing large scale societies with modern technologies (of course, *how* they do this can be good or bad!). *But it is not all of what it means to be a human being!*

So, really important is the third sphere of human existence, our ‘lifeworld.’ Leaving aside the theory, it’s enough to say that we are not robots – which are perfect expressions of system logic! We live rich, diverse and complex emotional, relational, historical and cultural lives. We express this in countless ways, through symbolic and ritual practices, associations of one kind or another, products of the imagination, play and recreation, our language, values and beliefs, our faiths or religion, our learning and knowledge, our enjoyment of sport, music, art, theatre. And all of this shapes our healthworld.

Here a *different kind of logic* really matters, which we can call ‘communicative.’ It’s all about how we interact with each other to live a life that really matters to us. It’s about our ability to communicate what matters to us and our community. It’s what kept Ruby going when her daughter faced her, and it’s what Leonard depended upon in turning to his own cultural roots. But social, material and environmental conditions within which we live can limit our ability to communicate, just as they did Ruby’s and Leonard’s. That’s one reason why education, or language and the skills to use it well, are important, or why, in Chapter Three, we emphasise ‘dialogical action.’

Healthworld and lifeworld

A person’s or community’s healthworld represents a deep human desire – to live a life that is full, whole – a life filled with well-being. No one, no religion, is without that aim in some form. We resist those who prevent us from living a fulfilled life. We find ways of coping when our ability for full well-being is disabled in some way, just as communities try to find creative ways to overcome the restrictions placed upon them by poverty, oppression or exploitation. We use words like liberation, redemption, salvation, *moksha*, *nirvana*, to express this yearning. It is fundamental to our lifeworld.



‘HEALTHWORLDS’

But we are not alone. From birth we become conscious of existing only through our relationship with someone else – usually our mother, then with more people as we grow older. Each contributes something to our identity. *We are only a ‘self’ in relation to others!* So, the search for a rich and full life is *never merely individual*.

We are bound up with one another, in family, community, and wider society. So we are called to recognize and treat the other just as we want others to recognize or treat us. The most appropriate word for this is *justice*. That, too, is fundamental to our lifeworld.

Well-being also means being able to develop our capabilities to the full. Deep down in us is a capacity to imagine some new possibility, to invent ways of making it happen. We can and do change the world. We get excited when we find it is possible for us. And we get depressed when we fail. Either way, we seek the *creative freedom* that comes with the full development of our capabilities, and that is the third fundamental region of the lifeworld.

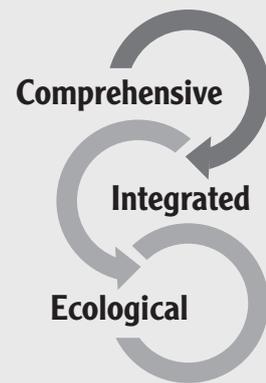
Healthworld, justice and freedom. They belong together.

Healthworld damaged

But they can be torn apart! Injustice may occur with enough frequency and impact to deeply damage or disable the healthworld. Think of Ruby’s story! Her fatalism came from frustration in the face of what looked like a life she would never be able to change. Her freedom to learn was seriously restricted. Her choices as a woman were limited by how men defined her. And this was an experience down the generations that must seemed almost inevitable. No wonder her health was so bad. Only a different kind of experience might really alter her situation, and produce a different health outcome. If this is true for Ruby, it is just as true for communities.

Healthworld embodied

Our healthworld – the perspectives, norms, values, beliefs, and experiences that affect how we act in seeking full well-being – is not just in the mind, in cultural or religious symbols, and the like. We know it in our body too. It is felt in the flesh and written on the body, as the stories of Leonard and Ruby show so powerfully. ‘You look stressed, exhausted, crushed,’ we say to someone, and we mean that their body tells us something about their condition as a whole – mind, body, soul, spirit. And it includes the body of the community, the social body too, and the earth within which we live as embodied beings (remember *bophelo*). To work for health means to work for the whole.



QUESTION TO ASK

- What ‘mix’ of ideas and practices do you (a person or a community) tend to draw upon when you face a challenge to your health? In other words, what are the elements of *your* healthworld?

SO WHAT?



So what has this chapter tried to show?

It's about understanding how we – me, you, probably everyone – act around our health, or the health of our family or community. We choose what seems to work for us from different health systems. We also choose our ideas about our health according to what the challenge is, and who and what we trust. Our health behavior, either as individuals, or around the challenges to the health of the whole community, even our society, is complex. And we think it is important to grasp better how this complexity works in practice.

Why does this matter? What difference would it make?

We could decide, because people and their health are so complex, that it's better to simplify things as much as we can, to make it easier to take action. Quite often that's not a bad thing – if we need a broken leg fixed, a migraine controlled, or a heart repaired, then we don't want any 'messy' complexity. We want someone who knows exactly what to do. But just as often the simple things are not enough, or only temporary – especially if we think about health as a life-long journey, with realities such as poverty and inequality having such an impact on health. Or if a migraine is only one symptom of all kinds of stress and damage that has to be understood holistically. That's what the stories of Leonard and Ruby show so clearly. Then understanding that complexity becomes really important!

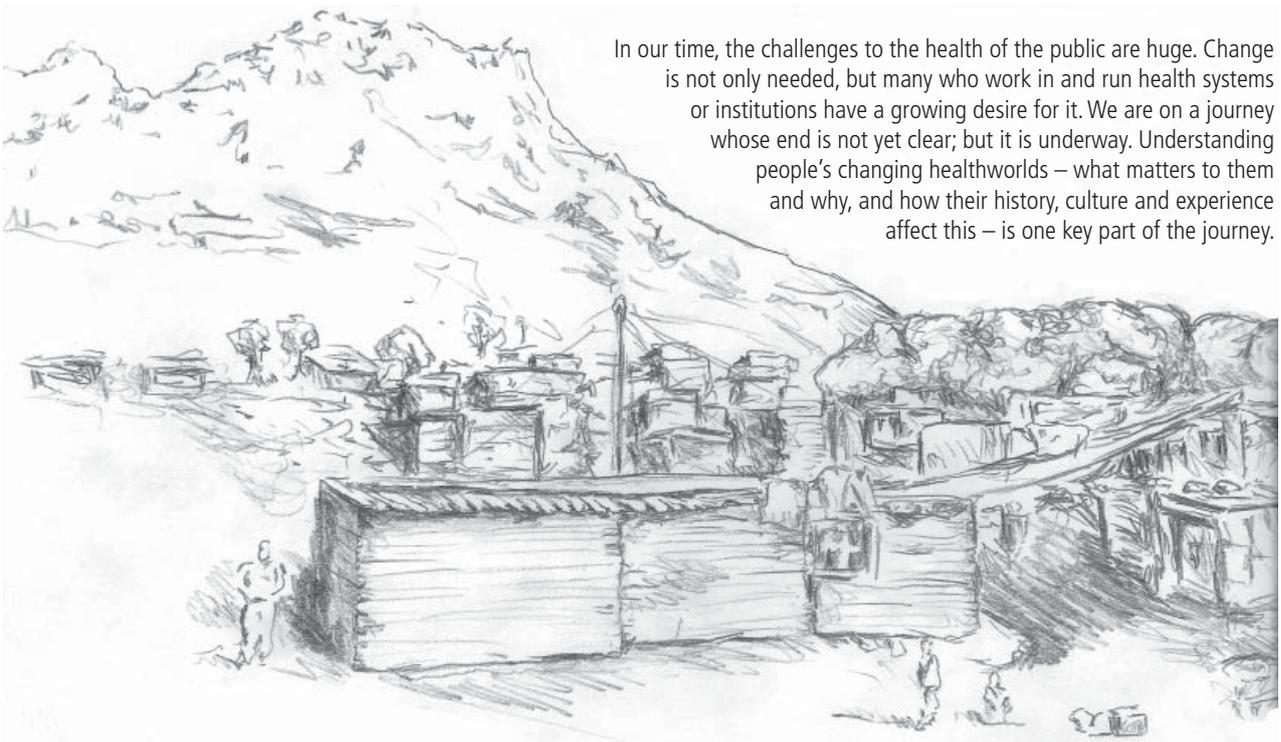


Why introduce the idea of the 'healthworld'?

We talked about the Sesotho word *bophelo*, and how it points to health as *comprehensive* – as based on the connections between individual persons, their family, community, and so on. We saw that if one part of that whole 'ecology' of health is hurt, then all parts suffer in some way. But we need a more general concept that expresses this truth. So we invented the idea of the healthworld. Actually, it's not a total invention. As we tried to show, it is *that* part of our lifeworld that shapes our desire for *full well-being* which, at root, is linked to freedom and justice at the same time. Health, freedom and justice belong together. That's a powerful idea.



In our time, the challenges to the health of the public are huge. Change is not only needed, but many who work in and run health systems or institutions have a growing desire for it. We are on a journey whose end is not yet clear; but it is underway. Understanding people's changing healthworlds – what matters to them and why, and how their history, culture and experience affect this – is one key part of the journey.



Strengths of people who come together

*Zebras look very much like horses – except for those stripes, of course! Roughly the same size, with similar if better eyes and ears, they run about the same speed. But unlike horses – which have been used by cowboys, thieves, Olympians, farmers and warriors – zebras, despite millennia of attempts, have never been tamed. Why not? Well, it helps if you **don't expect them to be a horse!** Then you'd wonder about the strengths of zebras, and how they play their role in the natural ecology.*



In this chapter, we look at the particular strengths of people who come together in ways that we associate with religion or faith. These kinds of gatherings may appear, just as zebras look like horses, to be like other social or community organizations; but in *important ways they are not.*

Every kind of religion, faith, spiritual tradition or community of belief is marked by the way it gathers; how it comes together formally, informally, regularly or around the landmarks in the lives of people, families and communities. Every year more than a million believers come together at Mecca, every week millions gather in churches, every day a billion Hindus pause at a temple. From Himalyan ridgeline monasteries where young Buddhists mediate in rows, to Confucian study groups – people come together. For a few pages forget what you know about other kinds of organizations and ask with a fresh mind, what are the strengths of *these* kinds of gatherings? What role to *they* play in the social ecology?

QUESTIONS TO THINK ABOUT

- In your experience of your own faith community – or of others you know around you – what do *you* see as the *strengths* that people or communities gain from such organisations or groups?
- Why do you think these *are* strengths?
- How would you think these strengths can be best used, and for what?

Deeply woven roots: The power to act together

Driving down this unimportant street to the parking lot of The Healing Place church in Memphis, you would have seen police cars, crime tape and shocked faces. Yellow crime tape ran from a telephone pole to a dirty, green car. A security camera video caught it all: a man nobody knew pulled his Oldsmobile up to a pole to which he tied a rope, before getting back into the car. Presently he slid the rope around his neck, paused and drove from this world into another. Pastor William Young, watching with his Deacons, thought of many other deaths, from his time in Vietnam or on the bitter streets of Memphis--and an Easter morning seven years earlier when, under the cross in front of the church, a woman had shot herself.

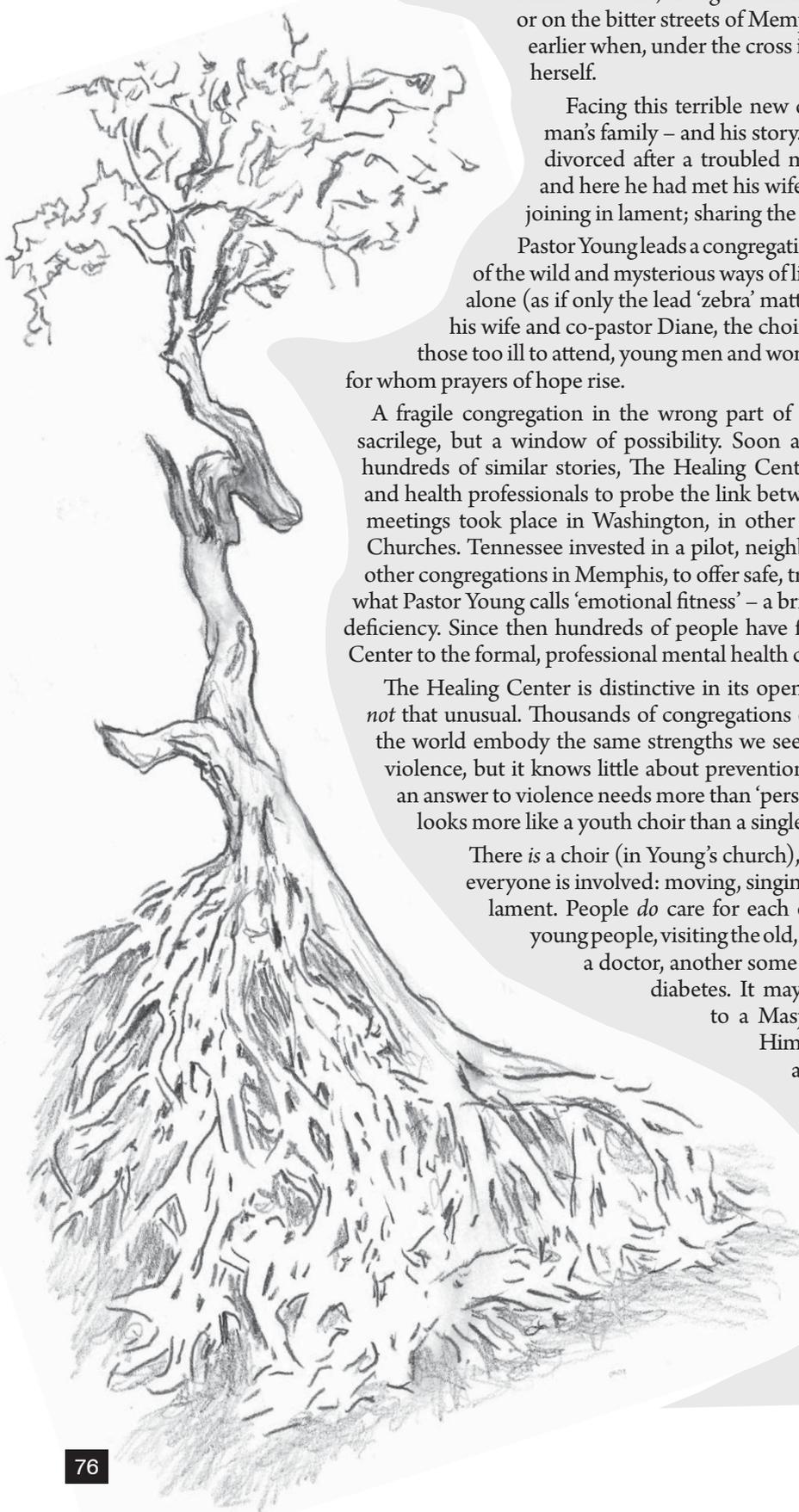
Facing this terrible new death, the congregation found the dead man's family – and his story. This spot was no coincidence. Recently divorced after a troubled marriage, he had played here as a child, and here he had met his wife. Church members attended his funeral, joining in lament; sharing the bonds of humanity, spirit and sorrow.

Pastor Young leads a congregation, an entity that 'forms faith' in the midst of the wild and mysterious ways of life and death. This story is not about him alone (as if only the lead 'zebra' matters). It's about the *whole* congregation – his wife and co-pastor Diane, the choir, secretary, youth workers, worshippers, those too ill to attend, young men and women growing in spirit and muscle, infants for whom prayers of hope rise.

A fragile congregation in the wrong part of Memphis found in those deaths not a sacrilege, but a window of possibility. Soon after that first woman's death, aware of hundreds of similar stories, The Healing Center called a national gathering of clergy and health professionals to probe the link between the black church and suicide. More meetings took place in Washington, in other states, and with the World Council of Churches. Tennessee invested in a pilot, neighborhood level collaboration with twelve other congregations in Memphis, to offer safe, trusted, peer counseling and screening for what Pastor Young calls 'emotional fitness' – a brilliant refocusing on strength rather than deficiency. Since then hundreds of people have found a safe pathway from The Healing Center to the formal, professional mental health care system.

The Healing Center is distinctive in its open embrace of the tragedy of suicide, but *not* that unusual. Thousands of congregations or 'faith-forming entities' (FFE) across the world embody the same strengths we see there. A hospital can treat survivors of violence, but it knows little about prevention. 'Congregational intelligence' sees that an answer to violence needs more than 'personal, individualized' therapy: the answer looks more like a youth choir than a single professional therapist.

There is a choir (in Young's church), and highly participatory worship where everyone is involved: moving, singing, praying, raising up voices of hope and lament. People *do* care for each other: talking, sharing food, overseeing young people, visiting the old, finding this person a place to live, that one a doctor, another some meaning in life or help with debilitating diabetes. It may look different in the American South to a Masjid in Southern Senegal or a shrine in Himalaya. Yet all 'faith-forming entities' share a similar pattern of strengths blending spirit, compassion and very practical help. These are the strengths to accompany, convene, pray, story, endure, connect and bless. This *is* different from an anti-suicide project or mental health agency. The members of the congregation are not merely clients, consumers, providers or professionals. They embody a vital power at work in the life of the community.



Working from Strengths



Are religious gatherings really that different from other kinds of gathering? Religious groups *are* organized! Many have bylaws, budgets, buildings, phones, staff, regular meetings and the whole organizational apparatus! They look like horses actually, not zebras, so in what ways do you think they may be different?

What we call ‘things that congregate’ are in some ways no different than horses, or organizations; they do all sorts of things other kinds of organizations do. But their DNA, is different. That’s the important point. It might help to distinguish between *faith-based-organizations* (FBO), which are designed for some project, task or function, and faith-forming entities (FFE), designed primarily to form and express faith. If you appreciate their different strengths, you’ll be able to appreciate their roles in real communities, as part of the family of groups or gatherings you find in communities. You might even saddle up a zebra and go somewhere you never imagined!



Won’t you say a bit more about Faith Forming Entities? Do I have to be a member of one of them? There must be a zillion types, and what am I supposed to do if I don’t share the beliefs of any of them?

They do all have one thing in common: they gather somehow. They get together. And the *kind* of gatherings they have *create patterns of social strengths* that you can appreciate even if they are different from your own. Just now we will look at a pattern of eight strengths that gives you a better idea of what they really are. Maybe it will actually give you a new appreciation for your own tradition, allow you to enjoy your own stripes in a new way!



Are you telling me that I’ve got to keep track of *eight* categories in order to work with the different religious groups in my community?



Well, if you were trying to create an encyclopaedic list, you’d quickly find its *more* complicated than that. The eight strengths are more like a painter thinks of the three primary colors they have to work with. Enjoy the complexity of shades, blends and textures the pallet makes possible. But don’t worry too much, it’s mostly common sense!



Well, OK, we’ll see. One more thing: some churches, temples and masjid are really big, but so many are *tiny*! Do these kinds of gatherings have to be a certain size before they show these eight strengths?



Probably not. Even the tiniest, most informal faith-forming thing seems to have some of these strengths. Think back to Chapter Three, and the idea that religious health assets have both tangible and intangible qualities. Smaller FFE’s may have few

tangible assets but lots of intangible ones. It’s like that with the eight strengths of people who congregate too – many are not easily visible, but they are very much there. Look closely, and you’ll see strengths where others only see what is missing.



OK. Stop with the theory now. Let’s get to the strengths. What are they?



Faith Forming Entities enable people to do things with and for each other that they cannot do alone.

8 strengths of people ...

1. ACCOMPANYING

People in *Faith-Forming Entities* create patterns of presence. They encourage people to be there for each other, playing roles beyond lines of blood or money. Like groups of women who care for the children of others, suffering from a stigmatized disease such as HIV/AIDS. Or who look after isolated elders who have outlived their own family.

2. CONVENING

FFEs come together for worship, but also to advocate, learn, teach, train, explore what is possible in the life of hopeful and troubled people, and to build ongoing organizations. A health professional or a lay person with faith – not just official religious leaders – may be able to convene a moral opportunity, too.

3. CONNECTING

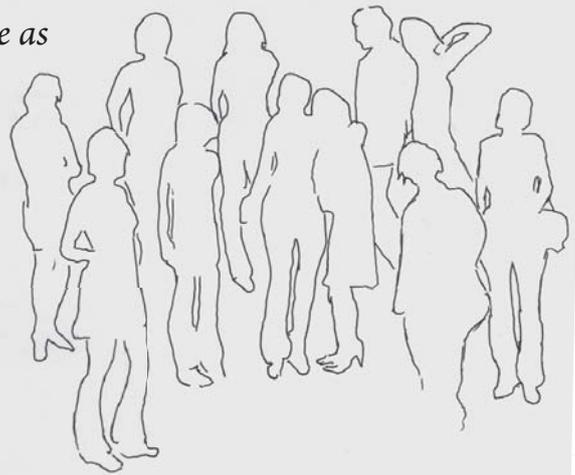
Congregations are able to help tangible and intangible things flow to those in need, when they need it. Sometimes this is planned and organized by a committee; but often it is organic, humanly spontaneous, emerging around a cup of tea or coffee.

4. STORYING

Each of us has a life story with a past, a present and a future. People often come to a faith or religious group when they are confused about that story or have lost their place in it, when it no longer feels like theirs. *Faith-Forming Entities* are able to draw from rich traditions and deep roots in the daily reality of members' lives to reconnect to their story or even to help find a new and truer story – not only for a person, but a family, a neighborhood or even a nation.

This helps to unleash the many strengths that we have as human beings. Here are eight of the key strengths.

...who come together



5. GIVING SANCTUARY

Some faiths have *places* as sanctuaries – safe spaces – for protection. But their strength is also to create a safe space for hard questions, for negotiation amid conflict, for caring for those excluded elsewhere. Every true religion honours the basic duty of welcoming the stranger and offering them practical hospitality.

6. BLESSING

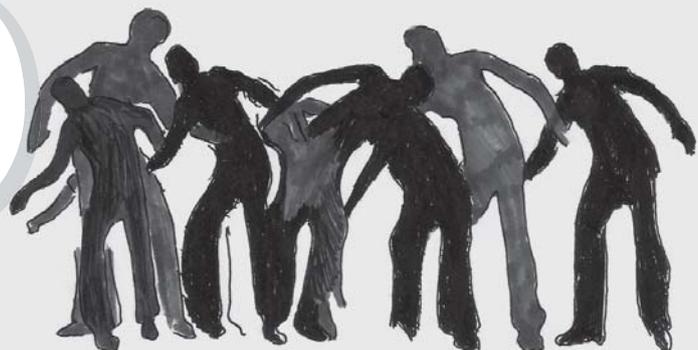
The world is not short on judgment and moral instruction (not least from public health)! But most serious life changes happen when someone forgives – blesses and encourages. Every faith has *rituals* for beginnings, but also for cleansing and starting over for individuals and communities, sometimes even for nations. We often need people to tell us that despite everything it's OK and to encourage us to take our next step.

7. PRAYING

Now and then we are faced with the bigger questions of life, with contemplating turning points that challenge our faith in ourselves, in each other and even in God or the sacred. Prayer, in community, offers support and courage for standing on these edges, for staying with these questions and their consequences, and for risking new, hopeful action.

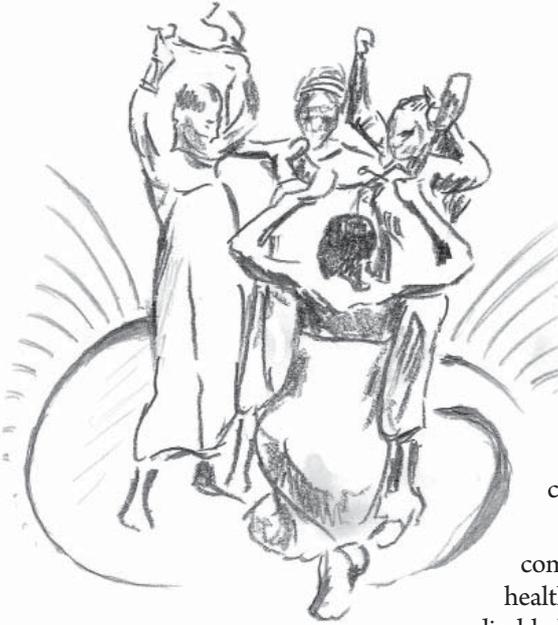
8. ENDURING

Faith-Forming Entities live longer than people. Their memory goes back before any current leaders, their hope extends beyond the lives of their youngest children. They see the long cycles, so they are usually not so anxious or urgent about schedules. Thus they form *character and resilience for things that take time* – like building real communities.



Circles of dignity

AMAWOTI, DURBAN



After devastating floods had torn through Amawoti, a poor informal settlement outside Durban of about a 100 000 people, local community members, with the help of a faith community, started the Ilimo Community Project to begin with housing relief and to distribute supplies to people in need. Soon, though, Ilimo began to address the wider health needs of the community too, much of it the result of poverty and oppression at a time when Apartheid in South Africa was coming to its end. For Ilimo health wasn't just about medical care, but also about power structures that affected access to care.

Soon Ilimo, a group of about a dozen people working with other community leaders in Amawoti, found itself engaged in environmental health (housing and sanitation), personal health (including rehabilitation of disabled people) cooperative economic activities (gardening, sewing, making building blocks), and training and education of leaders (by inviting skilled people they trusted would help the community).

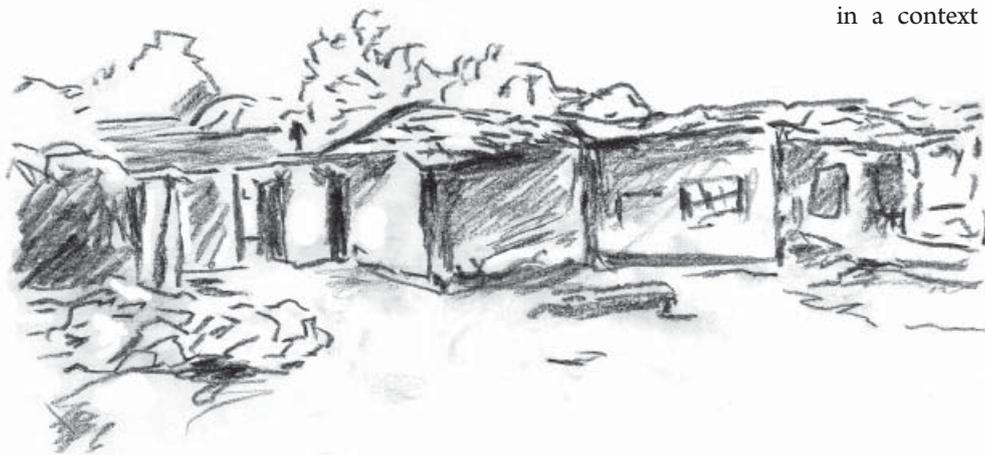
Sounds like a good, standard, non-governmental organization (NGO) project. It was. But it was also something else, too. Ilimo consisted of people who thought their religious faith should make a difference. 'Doing the right thing' came naturally to them, in a way. But how did faith help? That's what they wanted to understand better as well. So the members of Ilimo also began to study their Bible. Every week they meet on a Friday for a couple of hours or more, choosing a text that seemed to speak to whatever challenges they were facing at the time. No preaching, no teaching by some expert, no dogmatic reading that everyone had to accept. Instead, they worked with questions.



How do we deal with gangsters and thieves in our community? (Expose them; but more importantly, recognize that 'daily bread' is everyone's right, and that there are alternatives ways to get that right met). What do we do about the police who act on behalf of the Apartheid state against our people? (An Easter march to the local police station, the only significant infrastructure provided by the state, was one thing they initiated). What about faction fights and the local warlords who are exploiting us, the violence against the community? (Speak out, intervene where possible, forgive and heal when it becomes necessary, mobilise mothers and others who are sick of it, call meetings with those responsible to hear each other and find other solutions).

All of this and more made up the discussions in the Bible studies every week, and it went on for almost four years, and much was achieved. Ilimo utilized all the 'strengths of people who congregate' as it went about its work. It was the work,

in a context where this incorporates every dimension of life, of establishing circles of dignity, and of creating a new story, founded on a self-reflective use of the deep and long-standing symbols of their faith, of what this community could be.



Streams of resistance

NIKOLAIKIRCHE, LEIPZIG

What could more dramatically illustrate the strengths of people who congregate than the story of the Nikolaikirche (Church of St Nicholas) in Leipzig, Germany!? It was late 1989, and Germany was still separated into East and West. The East German state was in trouble. Its main support from a rapidly changing Soviet Union began to disappear, and internal dissent was growing against rigid, authoritarian rule and the infiltration into every aspect of life of the state secret police (the 'Stasi').

Since the mid-1980s Pastor Christian Führer and his colleagues, late on Monday afternoons, regularly held 'prayers for peace' in the Nikolaikirche. It was part of their work with local community groups who were challenging the state. Others calling for freedom and the human rights in East Germany found courage from this, and joined the prayers. That was in September.

Soon Monday prayer meeting became open demonstrations against the government. It was not without risk. The security forces quickly resorted to some limited force, and detained many people too who gathered in the square in front of the Nikolaikirche, too. But the attention of the rest of the world was gained. Action against the demonstrations became more problematical for the state, because of the church's involvement, as the spotlight on the state itself.

In other cities a stream of protest began to emerge too, and tensions escalated. Back in Leipzig the Monday prayer meeting had grown into a mass demonstration, with posters proclaiming, 'We are the people!', 'Onto the streets!', and 'No violence!' Throughout, the leadership of the Nikolaikirche and other linked civic and political organisations met with leaders of the government and the ruling Communist Party, always trying to move towards a 'peaceful revolution' and a just solution to the situation.

The 8th October was the anniversary of the founding of the East German state after World War II. On the 9th October, influenced by the leadership of the Nikolaikirche (which put the slogan 'Open to all' in front of its doors) to remain peaceful, the demonstrators marched through the city of Leipzig, past the Stasi building, carrying lighted candles – 70 000 people in all took part!

It's not clear why the security forces, who were armed and everywhere, including snipers in building and of roofs, did not respond with violence. But that they were confused about what to do in the face of such a large gathering seems clear; and soon it was too late. The next week there were 120 000 people, and the following week an astonishing 320 000 people on the march from the Nikolaikirche. Two weeks later the Berlin Wall came down and a new era began.



What if everything is changing?

“if congregations didn’t exist, public health people would have to invent them in order to have groups so integral to the neighborhoods capable of carrying health science right to the places it matters most.”

– Dr. Paul Weisner,
University of Washington

In every society, alongside many other social forms, you will find an elaborate assortment of faith-forming entities. People continue to congregate – to come together – for reasons of faith and spirituality. And congregations remain relevant to the health of vast numbers of individuals, families, neighborhoods, and their societies.

And now they move and change even more than in the past, because everything is so much faster and more connected than we could have imagined even a short hundred years ago. The sociologist Zygmunt Baumann calls this ‘*liquid modernity*,’ which describes a world filled with the rapidly changing and fast moving forms of association, technologies and modes of communication. Even relatively unskilled work-seekers now travel vast distances in large numbers, often taking huge risks, to places their ancestors might only have heard about. Even the smallest, most distant communities feel the impact.

In the midst of this sea of movement and change, the strengths of congregations are still recognizable. In fact, these strengths often help people cope or find their way without losing their sense of self and identity.

The idea that *faith-forming things* have strengths suggests how an alignment between religion and public health might be approached, especially in times of rapid change. These strengths give us insight about what *not* to do. They help us see why organizational practices imported from secular programs may *not* work, why they may even *hurt* the vitality and strengths of the faith-forming entity and thus undermine the community services and programmes that rely upon it. To draw on *faith-forming things* for getting things done means understanding the way that they live and have their effect, especially where everything is changing.

Why bother with congregational strengths?

A congregation is a kind of voluntary organization, but its special strengths live from certain deep, durable ways of being – a long history of faith and experience, strong communal or family solidarity, rituals and values that embrace all aspects of life, an expectation (hope) able to withstand deep tests. Congregations can get ‘stuck’ in their ways, obstinately resisting progressive developments through inflexibility or narrowness, but much that they do out of their life together – their strengths – can be worked with and built upon. The model of strengths here arose from the *Interfaith Health Program* (IHP) in its work in the 1990’s with public health professionals, and it’s worth understanding why. Health folks were keen to use congregations for their many good health projects, but they did not see how important it is to understand the nature of ‘groups that worshipped.’ IHP leaders had to say: ‘Whoa! Slow down! These are *different* kinds of groups, with *peculiar* strengths. Let’s really

understand them if you really want them to be useful.’ From this came the model of strengths. It wasn’t just useful to health folks, however. When the IHP tested it with faith leaders, they were just as surprised to learn about *their own* strengths! With new eyes they saw what their committees and programs, their rules and buildings, could be for, and what they might be able to do. Actually, the basic strengths were always there if one knew where to look. Find those congregations that do a lot of ‘heaving lifting’ – that care for, and do something about, hard kinds of problems, decade after decade – and analyse what gives them that strength. Even if only 10% of the faith groups in any community in the world are like that, they are natural partners for almost anything that will give life to the community. What’s more, 10% is actually enough, if it is aligned by smart leaders. Even better, once one recognizes the strengths, it becomes possible to help other congregations begin to do the same thing.

Strengths for the journey

Stages of the journey

To say that life is a journey is not a metaphor. It's a far more accurate description of what happens along the way from birth to death, a better way of grasping the social circumstances of both birth and death. Faith and health languages *both* fail when they describe events, interventions, health strategies, services, or 'outcomes' as a disconnected clutter of separate actions. They are best understood as parts of a sequence, a narrative, a stream of causation and influence – stages of a journey.

Accompanying the people

That journey is seldom taken alone. Faith-forming entities are actually organized around the life stages of journeys that people take – preschool, adolescence, young couples, older women, and so on – or offer help for the journey in disruptive life passages like divorce, retirement, living with cancer, or substance dependence. The best known rituals, like weddings and funerals, draw people into a relationship with others who are willing to accompany them through life. These are landmarks on a journey of meaning.

Lifespan attention

Whatever the social and political context, health is lifespan phenomenon. Access to specific medical services form a small fraction of what determines the quality of health and life along the way. A doctor taking a traditional medical 'history' of a person in need focuses on diseases and their immediate causes. Hospitals are so confused that they mistakenly refer to people as 'inpatients' when, in fact, just as a fish is not normally 'in' the boat, they are *out* of their normal way of life. So paying attention to a longer, lifespan history of health is vital, and it includes a lifetime imbedded in issues of social location, identity, security, love, intimacy, confidence, and optimism.

The tangle of relationships

Trying to pull any one living thread from the tangled journey of health and life, and still make sense of it, only shows how interwoven they are in reality. So we must look at the whole system, not just its parts, even to properly understand those parts. It is much easier to live in this weave than to map or name all the threads. The tangle of relationships that make up the weave call for our attention, requiring us sensitively to adjust what we do and how we do it all the time.

Seeing the assets

The basic strengths of a faith-forming entity or congregation are clear in patterns that cross lines of theology, class, and culture. They are visible in villages, town and cities everywhere. They are evident in every religious or faith tradition. One of the most important implications of the eight-fold model of strengths is that it helps those standing in one stream of faith to see another stream as an asset for health without stripping it down to instrumental manipulation. Because it forces us to focus on how people actually live their lives, it helps us move beyond simplistic functionalism toward vitality.

The strengths of people who congregate are relevant beyond single events—they impact on life's journey.



It is not impossible to dream of thousands of congregations working alongside public health, sharing an understanding that health is a seamless whole—physical, mental, social, spiritual—that poverty and illiteracy and addiction and prejudice and pollution and violence and hopelessness and fatalism are forms of brokenness, diseases that require the deployment of both their assets in building whole, healthy communities.

– Dr Bill Foegen



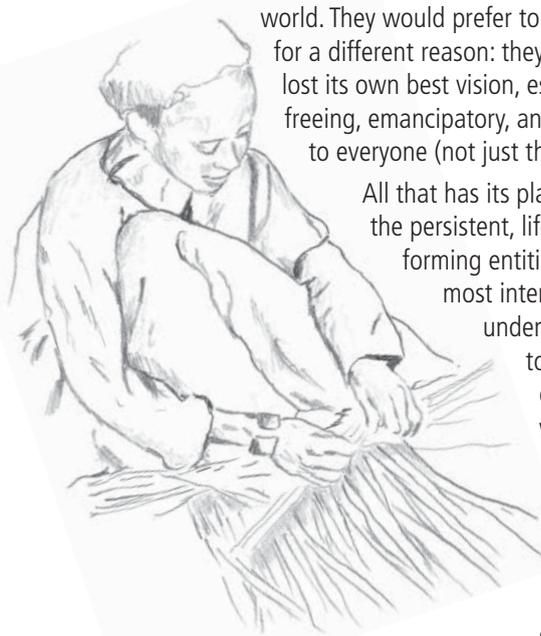
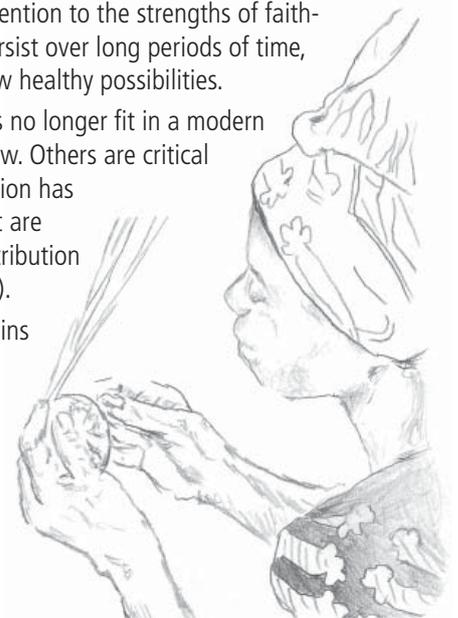
Weaving the strengths

You don't have to be a skeptic about religion to see the obvious and chronic weaknesses of congregations – of 'people who come together' – in the name of their faith. Faith-forming entities may have narrow vision, or poor leadership, training, and management. And we all know religious people can be feeble, self-interested, and capable of stupidity and meanness. Even the scriptures of many religious faiths are pretty clear on that!

Still, to admit the weakness or failures of faith-forming entities is one thing. Simply to ignore their strengths or accomplishments or even their potential is another thing entirely. That's why this chapter has introduced a perspective or framework that helps us pay closer attention to the strengths of faith-forming entities. These strengths often persist over long periods of time, helping faith-forming entities generate new healthy possibilities.

Many social scientists think religion and its faith-forming entities no longer fit in a modern world. They would prefer to get rid of religion or 'fix' it somehow. Others are critical for a different reason: they feel that a particular faith or tradition has lost its own best vision, especially those dimensions of it that are freeing, emancipatory, and liberatory or make a positive contribution to everyone (not just those who follow that particular one).

All that has its place. But none of it adequately explains the persistent, life-enhancing contribution of faith-forming entities. It is *this* capacity which is the most interesting and most useful thing to understand – especially if one wants to align the assets of 'people who come together' in congregations with other community assets, for the sake of the health of the whole community.



This chapter argues that faith-forming entities are best understood and engaged in terms of their strengths. Why? Because they enable and express social life in flexible webs of trust. Because they often function as religious health assets for the wider community in which they exist. Because they accompany people in their journeys of life. Because they nurture people, and often raise up boundary leaders. Because they often do something about the interface between faith and the health of the people. And because they do so in ways that are replicated and adapted over generations.

The strengths of congregations are holistic and work at many levels. They might be expressed through individuals, but they are not contained in one person, not even the religious leader. It's the social entity that counts. Just as personal health is in many ways deeply social, so too with the strengths of the congregation. When we think of a competent, compassionate and brilliant leader like Pastor William Young of our first story (on page 80), we best understand what's going on there if we think of him not like an architect, a director or a boss, but more like a gardener who pays attention to everything in the garden, and draws everyone around him into caring for it.

Boundary leadership

In this chapter, we talk about the kind of leadership that nurtures innovation and transformation. We call them ‘boundary leaders.’ If you are reading the Barefoot Guide, you might recognize one (in the mirror)! Let’s look at how a boundary leader thinks and acts in reality.

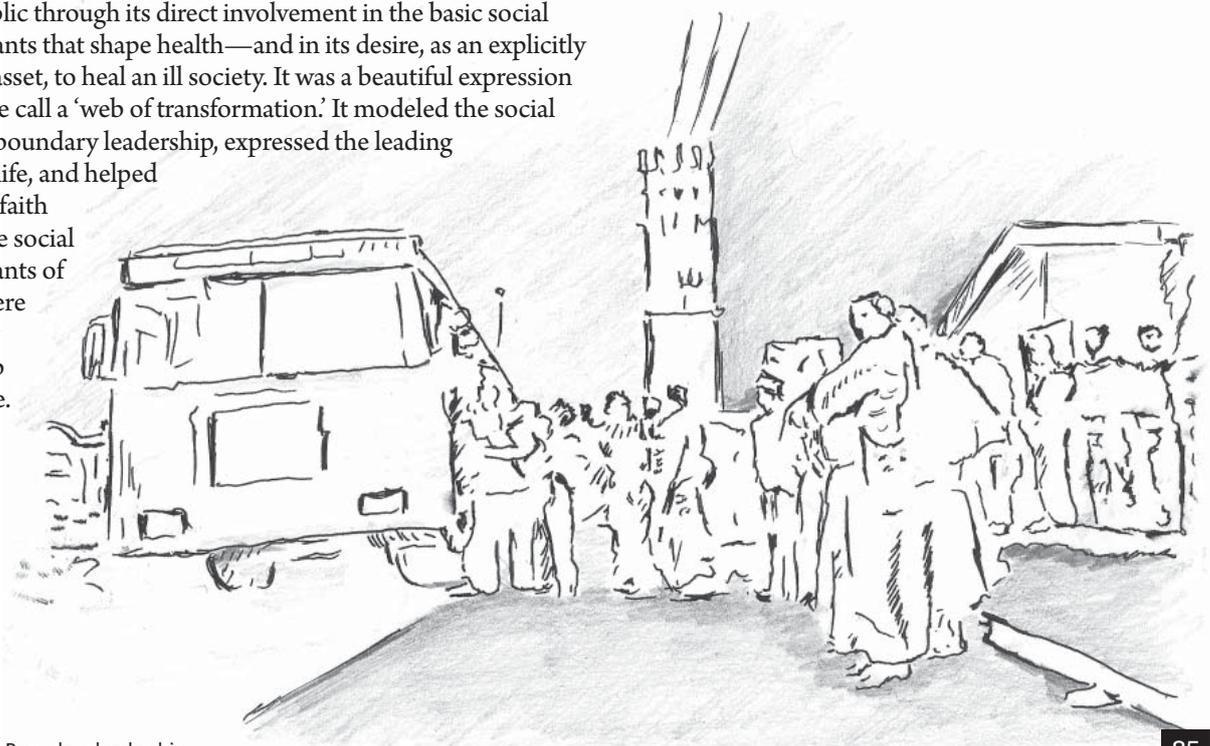
Mowbray is a suburb of Cape Town—a transport hub, a place of transition. Here all sorts of workers are on their way into or out of the city, getting on and off trains and buses. Stalls line the sidewalk, crowds push this way and that, commerce and conflict spilling out from the noise, smells and energy of a thriving society.

In Apartheid times, black workers poured through these terminals to work in white businesses and homes. Here a Methodist pastor, Reverend Theo Kotze, opened the regional office of the Christian Institute (CI), an organization established to challenge the racist state of South Africa (and the churches complicit in its injustice!). Kotze saw Mowbray as the centre of a new way of life that could emerge in the zone between a deathly old order and a much needed new order. The rich zone of living connections could defy the forced separation that marked Apartheid.

The CI was founded to nurture the power of faith against the force of Apartheid, people coming together to use humble tools of resistance and emergence: bible study, lunch served to all of whatever ‘color’ or faith, truth-telling meetings, highly practical work to help those displaced from their homes or needing medical care. It connected people across many barriers when few such places existed. It was where things could break open and out; through the cracks you could see a whole new world.

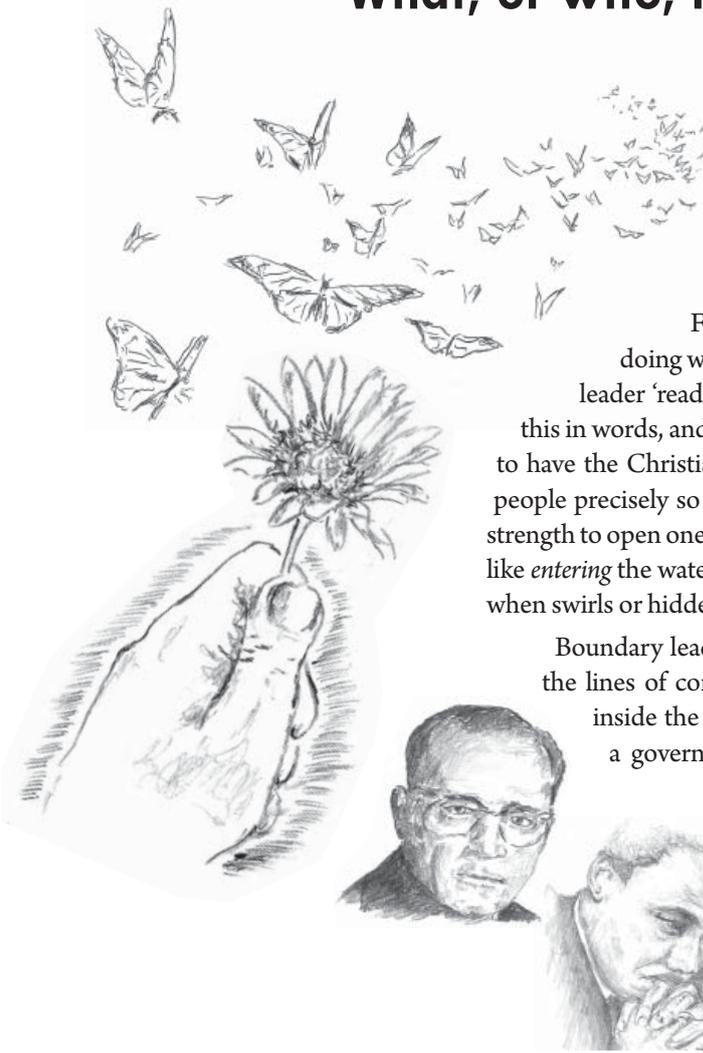
Those getting off the buses in Mowbray moved across real boundaries—cultural, economic, racial, and political. The realities that shaped their health could be described in the language of status (low), determinants (pathological), and patterns (grossly unequal). The story of the CI links to the health of the public through its direct involvement in the basic social determinants that shape health—and in its desire, as an explicitly religious asset, to heal an ill society. It was a beautiful expression of what we call a ‘web of transformation.’ It modeled the social reality of boundary leadership, expressed the leading causes of life, and helped

people of faith engage the social determinants of health. Here boundary leadership came alive.



In service of the whole:

What, or who, is a boundary leader?



Boundary leaders may look like traditional leaders, but they can also be people who seem, on the surface, to be 'like everyone else.' So what makes on a boundary leader? Most obviously, they see beyond and work across the boundaries of life that most of us are too afraid to cross. Certain characteristics, which can be identified, mark them as boundary leaders.

First, a boundary leader *leads by learning to participate*, with others, in doing work that matters for the well-being of all. This helps a good boundary leader 'read' their community, see deeply into its conditions and its hopes, put this in words, and continually test whether or not they have got it right. Kotze wanted to have the Christian Institute office where he and his staff could easily connect with people precisely so he could properly 'read' their reality. It takes patience. And it takes strength to open oneself up over and over again to the views and experiences of others. It's like *entering* the water – not just reading *about* water – yet still keeping one's footing even when swirls or hidden rocks make that difficult.

Boundary leaders are not confined by grids on a map, easy words, or the official the lines of control, ownership, naming and accountability. They don't always fit inside the spaces or borders made by others. They see things differently from a government or other organizations that 'think like a state' (or maybe a religious institution). They are not intent on defining and policing boundaries. When think concretely, they do so in ways that reflect the fullness of what they have learned by participating in the reality of community. They can't deny or forget what they know, because it is in that living reality that they find their own lives. This accounts for what often looks like courage in iconic boundary leaders such as Kotze or Martin Luther King, but is actually more like a habit.



Era Chandrasekar, is a great example. Once an insurance salesman in India, he noticed many men on the streets around him whose lives are marked by mental illness, with no real care. He went to talk to them, and set loose an unusual and hopeful project, Udhavum Ullangal (Tamil for 'Helping Hearts'). Helping Hearts offers skilled intervention for these men but – and this is crucial – it does so *on the streets*, not inside a hospital or clinic.

Helping Hearts does provide medical care. But it goes much further than that limited boundary to create a wholly new social ecology. Volunteers are trained to administer appropriate psychiatric pharmaceuticals correctly, and to monitor and record each man's response so that the physician who visits each month can optimally adjust the medication. Efforts are made to reach out to the families of the men – from whom they are frequently cut off because of their unpredictable behavior and the terrible stigma attached to untreated mental illness. Very practically, the men also work to beautify the community by planting trees on the city streets. This is also therapy for the men, who have a chance to do something visibly constructive for others, and it's therapy for the community, which gets a chance to appreciate and thank them.

The ill men, volunteers, and medical professionals (who work outside their 'normal' place of formal service) *participate* in a life that welcomes all of them into a new way of being in the world. They create a 'new normal'! The 'old normal' was filled with fear, stigma, exclusion, and disgrace. The new normal sees these men participating in the health and well-being of the whole community. The first step toward that new normal is the vision of *the possibility of something new* that can emerge in the boundary zones that otherwise block imagination, and separate people.

More on ‘boundary leadership’

People are not born into boundary leadership, even if some tend towards it more than others. It is a skill to be learned. Much more, it is an approach to life. It comes from being willing to work across and in between the boundaries put in place by others – like racial, gendered, economic, disciplinary, or institutional boundaries – to see if something better can emerge by doing so.

Boundary leadership shows itself in a willingness to move into the spaces between boundaries, the ‘boundary zones.’ Here ‘official’ lines of authority may not be working or are hurting people; here boxed in definitions of how and why to live restrict wholeness and well-being.

In the boundary zones relationships tend to be fluid, dynamic, and in motion. So to work as a boundary leader is often uncomfortable, sometimes lonely. It’s also risky: boundary leadership may attract a negative reaction from others – like those that police a boundary, or are threatened by too much flexibility or change. Even then, boundary leaders manage to deal with those who oppose them transformative ways. Kotze of the Christian Institute, for example, did not just confront security police (who were often around!); he tried to talk to them as human beings who might have a faith of their own. Boundary leaders don’t stand apart from transformation, but within it. And they experience that transformation themselves, too.

Let’s not think, though, that boundary leaders are just exceptional people in amazing institutions! Boundary leadership can be found, and encouraged, in every and any community or group. What matters is the pattern of how boundary leaders emerge from within a weave of social life, how they find ways to thrive even in the midst of constraints and the pathologies of a particular situation. The heart of boundary leadership lies in a way of recognising the boundaries *where things come together* for ill or good, of seeing where what appears to be disconnected can be connected to generate new and hopeful action. The lives of boundary leaders go back and forth across the social wounds of their situation or community, like sutures that bind together a knife cut on one’s body.

To recognize a boundary leader, just look for where the social body – the life of the community or society – is drawn together in ways that are hopeful, even inspiring, where healing of the broken social body becomes visible. For boundary leaders, the world is not only broken, but breaking open new in ways that allow for wholeness to emerge – even in places as hurtful as the overcrowded shack settlements of Cape Town or the gritty and sometimes violent streets of downtown Memphis. Boundary leadership takes that on, and finds ways of breaking through it towards new, more promising futures.



As they expand their understanding of their community as a whole, boundary leaders help a healthier society emerge. They create social power relevant to their own movements. But they also tend to make power widely available to others. They have an empowering influence. They see the whole and ‘lend their lives’ to all to the life of all.



Living in, understanding ...

LEGIBILITY and ILLEGIBILITY

If boundary leadership crosses or goes beyond formal lines of authority and power, then today it is the modern nation state that most creates (and protects!) those formal lines. It's the job of states to assemble huge amounts of knowledge and skills to manage large-scale societies. Why then do they so often fail to improve the human condition despite their power and resources?

Besides uncaring or hostile governments, says anthropologist **James Scott**, there is a deeper issue. Large-scale systems have important limits. Because they must record, filter, classify and control millions of details, they must simplify this information to manage it. But simplification means they fail to 'read' the complex, often contradictory and shifting reality of real human beings in their daily lives. Even well-intentioned states only 'see' what states *can* see, and so they miss many other things, often vital ones!

Scott gives the example of a forest. When the German state first created official forestry (a long time ago), it radically changed people's ways of living with a forest. The new state wanted a national focus on the production of wood. To plant and grow the most profitable trees, it needed to manage the forest. That meant making the forest 'legible' – counting and recording the trees it was interested in, and growing more of them, and less of everything else. This meant simplifying the forest, taking out what was not seen as valuable, and reducing its ecology.

That is *not* how a natural forest works. It needs *all* of its species to be ecologically healthy and sustainable. Worse, that's not how German people at that time *lived* with the forest! State forest management meant that their way of life – using logs for houses, wood for fires, bark and roots as medicines, moss and leaves as bedding, small animals or birds for food – was destroyed, even outlawed.

Making things 'legible' describes how the state 'sees' things. In the process, other things become 'illegible,' like the natural complexity of the forest, which is no longer 'seen' properly. The mechanisms that the state (or business) uses to *make some things visible* through counting, documenting, organizing and controlling reality, also *hide the rest* of its real complexity. What makes this problematic is that a large part of that complexity has to do with how real human beings live their lives. Just because a state cannot see something does not mean it is not there or inconsequential.

That's where boundary leaders come in. They *call us back to the full complexity*, and they find ways to cross the boundaries (often barriers) that are put up between what how systems work, and how people actually live their lives. A boundary leader would have seen beyond the limited and simplistic vision of a forest as a tree farm and appreciated the whole ecology – the complex, developing, interweaving relationships – and thus the whole of its living reality. The essential role of the boundary leader is to refuse to dumb down that reality, and instead to 'see' and participate in the complex whole.



... this 'messy' world

LITERAL or PARTICIPATORY KNOWLEDGE



Wendell Berry, a farmer and social commentator, does not 'see' or think like a modern state. He emphasizes an opposite way of seeing. He calls it '*the empathetic mind*' – the ability to understand and share the feelings of others. That's another way of describing a boundary leader. An empathetic mind fears any oversimplification that strips away vital knowledge, especially the kind that comes from deep relationships (to the earth and others) and profound experience.

Berry would not apply this only to states or businesses. He thinks that formal religious traditions and their orthodoxies are also much richer, more complex, more 'real' than people realize. Even those who lead religious institutions or movements regularly lose their capacity to 'read' the complex characteristics of human social ecologies (especially when they rigidly defend what they think are fixed ideas in their own traditions). Academics, too, can be dangerous when their mental tools remove them from participating in lived reality.

The empathetic mind likes 'messy,' living complexity more than elegant abstraction or clever concepts. It stands against simplicity (naiveté, innocence, lack of penetration), though not against simplicity (intelligibility, clarification). It likes the boundary zones. People with an empathetic mind thrive in leading and living in and across those boundaries.



Another way of thinking about Scott's 'legibility' and Berry's 'empathetic mind' is what physicist **David Bohm** calls two ways of knowing: 'literal,' and 'participatory.' 'Literal knowledge' is useful for technical challenges, like states managing forests. This is knowledge as a kind of instrument or tool to help us get something done efficiently and effectively. Participatory knowledge is different: it comes from *participating in* something with others. So it expects human reality to be complex and messy, and respects that humans cannot merely be used, controlled or manipulated. Participatory knowing is not afraid of the vital complexity of community or social life, or of what it does not understand. This non-anxious humility – another aspect of boundary leadership – frees one to move toward actions that see what might otherwise not be seen, and to hope for things that might otherwise not be hoped. This can be truly useful to the whole community.

Boundary Leadership



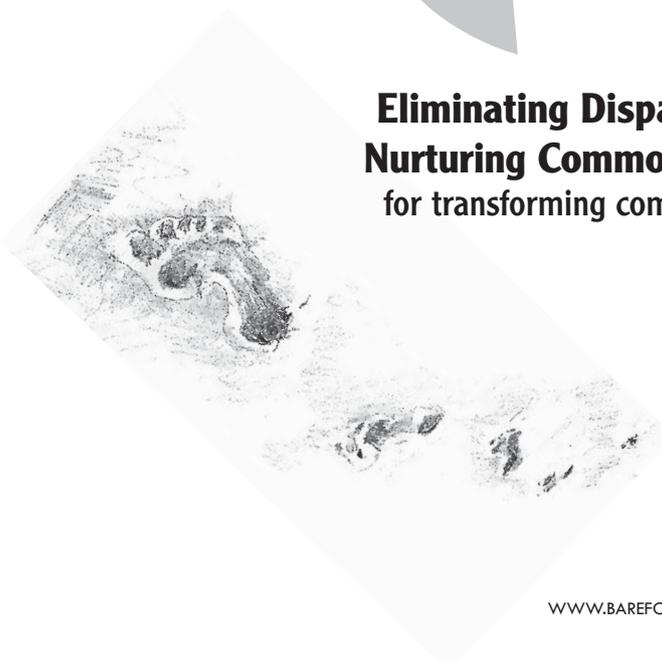
Boundary Leadership

Here we see a diagram that shows one way of understanding how boundary leadership is linked in an ongoing cycle (not a straight line!) to webs of relationships with other – that are able to work for transformation, develop a common vision, align a wide range of assets, rebuild community in the face of disparities, conflicts and inequalities, and help create further boundary leadership. The diagram comes from meetings between religious leaders and public health leaders, people known for their work and leadership in helping transform communities for greater well-being. They found they had a very similar journey. They had not simply been trained, hired, and promoted, while accumulating experience and more skills, finally finding themselves in a position of influence and control. The ‘career ladder’ idea didn’t fit their lives. Instead, they realized, their real leadership was a continual cycle, like this diagram.

Calling and Accountability
for cultivating boundary leadership

Transforming Community
for a deeper call and
new accountability

**Eliminating Disparities,
Nurturing Common Hope**
for transforming community



Cycle



for cultivating web of
transformative leadership



Transforming Relationships
for the emergence of a new vision



Visioning
healthier communities through
faith and health alignment



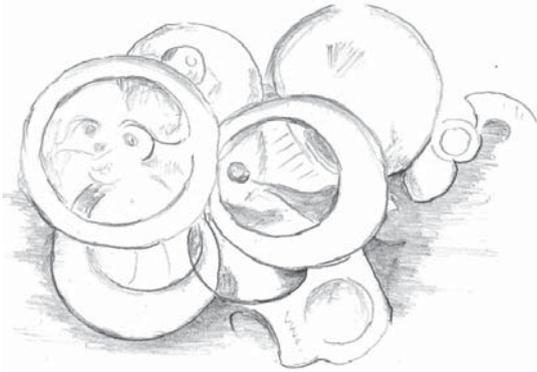
Aligning Faith & Health
for the elimination of disparities
and the nurturing of common hope



The boundary leadership cycle diagram helps to see how boundary leadership moves into various phases or kinds of activity. But it's just a diagram. In anyone's real life, things are actually more interesting than that. We should see it not as a fixed circle, but as a flow that shifts and changes all the time.

Often a new cycle of boundary leadership begins because of some transformational connection or relationship that one did not seek or expect, a surprising encounter or event that sparks a new insight, or opens a door to new visions. Or one finds oneself deeply immersed in a struggle to solve a problem, and there one comes across others with whom one can march forward – a community of transformation, like the one that made Martin Luther King what he was. Wherever one starts in the cycle, one is likely to move around and across it many times, over a long life of working in the boundary zones.

Boundary leaders are not ‘loners’!



‘Marginality brings certain gifts: greater self-knowledge, greater awareness of others, and a kind of risky comfort with life on the edge.’

Leading ‘across’ or ‘in between’ boundaries – usually set up to protect or define something – means one is often on the margins of things. That carries a price: boundary leaders often don’t feel fully appreciated by the institutions for which they work, and they often feel somewhat alone.

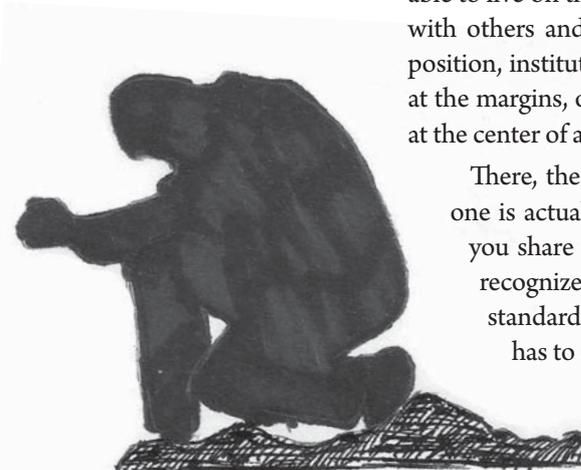
We tend to tell our life story through the families, communities, organisations or institutions of which we are part. They all have familiar boundaries, providing strong identities. What if you were to tell your story differently – through the groups on whose edges you are, where the boundaries are not so clear?

If you are a boundary leader, it’s common to find your ‘normal’ bonds and identities being challenged by being on the edges. You might feel estranged from, or in awkward relationship to those bonds or identities, and others, who are part of those bonds and identities, might feel that you have somehow disappointed or even betrayed them – especially if they can’t understand why you are moving in a different, newer path. That can contribute to feeling alone on the margins.

At the same time, boundary leaders find themselves able to hold these tensions creatively together, not letting go of any side. They stand in between, not just apart from those identities and bonds. Marginality brings certain gifts: greater self-knowledge, greater awareness of others, and a kind of risky comfort with life on the edge. The central gifts of being able to live on the margins, however, are its power to promote empathy with others and, because of that, a critical perspective on one’s own position, institution, community, society or religion. When one stands at the margins, one’s feet stand astride the boundaries between people, at the center of a larger and more adequate whole.

There, the empathetic mind of the boundary leader is at work – one is actually not a ‘loner’ at all. Other boundary leaders around you share your journey, too, if you can see them. You might not recognize them at first, because she or he seems to be in some standard role or function as part of their work or action. So one has to see differently from a state. One has to learn (maybe re-learn) how to read each other’s complex lives. That often helps a boundary leader find friendship, collegiality and guidance into the boundary zones just when it is needed most.

You may be a boundary leader, but you are not a loner. So ask yourself: Who lives on your boundaries? Who seems to be growing your way? How could you help each other read your community more fully?

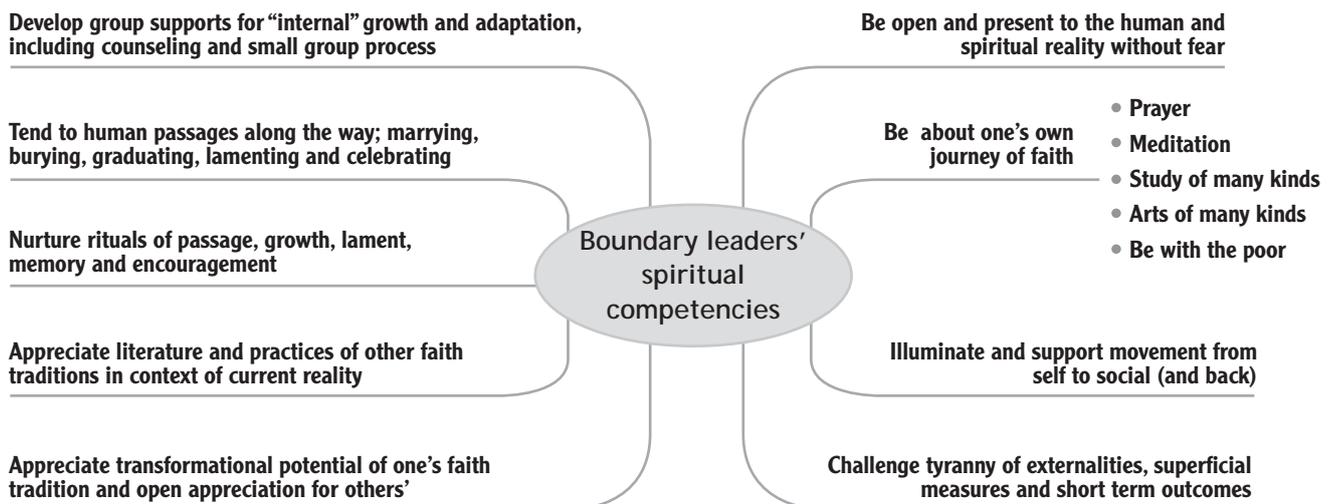


Boundary leaders are ‘spiritual’

Boundary leaders live in fluid webs of relationship that invite them beyond the circles of their original faith, traditional values or familiar worldviews. Inevitably, the complexity of their lives and relationships creates unpredictable and challenging patterns of learning. This often feels unsettling and disorienting – not just regarding human relationships, but also one’s relationship with ‘the ultimate,’ the ‘holy one’ or to the ‘ground of being.’ Whether or not one is religious, there is a spiritual challenge, and not just an organisational one, for which boundary leaders frequently feel they need spiritual competencies.



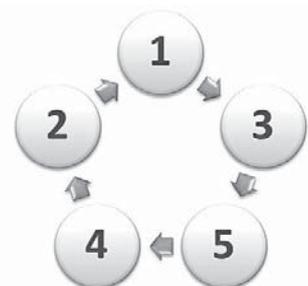
This map below comes from a deep dialogue between public health leaders and community-based workers, reflecting on the question: ‘If health of our community depends on transformation, what are the competencies that we as leaders need to nurture to be agents of transformation?’ These are what they saw as the spiritual competencies we need. One does not get them in a workshop – only through a lifetime of spiritual development.

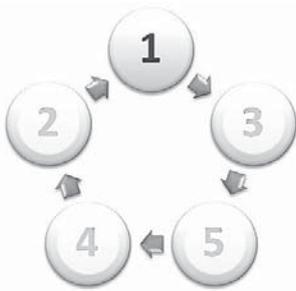


The five marks of boundary leadership

We have talked about various ways in which one can recognize a boundary leader (such as yourself!). We have now also spoken of the spiritual competencies that boundary leaders commonly find they need to develop. Now it’s time to talk of the *five main marks* that are characteristic of the full range of boundary leadership practice and experience.

The journey of any particular boundary leader (yourself?) may seem utterly unique and surprising. When one feels misunderstood or marginalized, one begins to wonder even about one’s own sense of things. Yet there is a *pattern* to the lives of boundary leaders. The crucial role they play in the social ecology includes five distinctive characteristics. Knowing them doesn’t make the journey easier; but perhaps less lonely. On the next pages, we spell them out.





Embracing complexity of persons and systems

Boundary leaders are aware of their apparent weaknesses and strengths – they have to be, because they are deeply engaged with other people and aware of the challenges and complexity of life in the real world. They live *into* that complexity, and know that one cannot reduce reality to any one aspect of it. But to do that requires certain strengths, and it exposes one’s own personal weaknesses.

It’s not surprising, then, that many boundary leaders are religious or deeply spiritual. Being open to complexity without being overwhelmed by it means, to use David Bohm’s term, to live in dialogue with the ‘unlimited.’ That’s actually very unsettling! It forces one to be sensitive to conflict, tension, and turmoil, and it may even push one towards unexpected personal transformation. This is common in boundary leadership.

Of course, many kinds of leaders, even those in traditional roles within ‘safe’ boundaries or definitions of themselves and their work, experience times of doubt; and of surprise at their ability actually to do what is expected of them. This is not what marks a boundary leader. Boundary leaders face the same challenges as others in this respect. What marks a boundary leader is that they experience something distinctive – something that goes beyond the normal demands of leadership – for two main reasons.

One we have already pointed to: it is how they read reality, not like a state or bureaucracy, but in its full complexity, with all of its unsettling aspects. Another has to do with how they experience themselves: as participating in the lives of a body of people who are active in working for the emergence of a new social whole (they are not ‘loners’).

As we have said before, boundary leaders thus see beyond their particular organization or movement. In doing so, they grasp a larger whole including, very importantly, everything that lies in between ‘normal’ boundaries or fixed borders – think of refugees, marginalized people, undocumented immigrants, those who are unemployed, abandoned or orphaned children, abused women, and so on. That’s actually where a great many people find themselves, and where health is at great risk.

This often also makes a boundary leader’s own organization highly nervous (‘Hey! Get back in here where you are supposed to be; pay attention to the problems of this organization/institution, not problems outside of our boundaries!’). What’s more, boundary leaders, like those who do the work of community organizing in real neighborhoods, *know* or *feel* they are vulnerable because the formal structures that may employ them repeatedly find it hard to understand the more complicated work they are doing, which goes beyond ‘deliverables’ and ‘measurable outcomes.’

All of this comes with embracing the complexity of persons and systems.

“Boundary leaders see beyond their particular organization or movement and, in doing so, they grasp a larger whole that includes – very importantly! – everything that lies in-between ‘normal’ boundaries or fixed borders.”



Living with misunderstanding

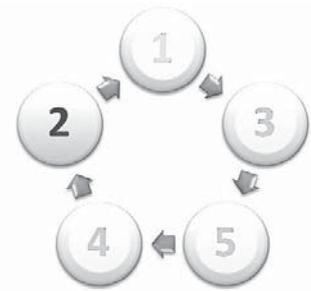
So boundary leaders – *because* of their role in the boundary zones – are often misunderstood by their organizational structure or profession. They commonly feel marginalized, invisible, under-valued, or even endangered professionally. The way they work and where they undertake their work simply bursts the bounds of standard role and job expectations. This means that their accountability and even allegiance to their institution or organization is likely to be suspect, precisely when they ignore its boundaries or succeed in crossing them.

And boundary leaders can't help doing that when they see that is necessary. They could not possibly be a good boundary leader without living this way! The organisations and institutions of boundary leaders, by contrast, as we have said, tend to set boundaries and to police them. They create lines of command and accountability, and of reward and approval, which are defined in terms of those boundaries.

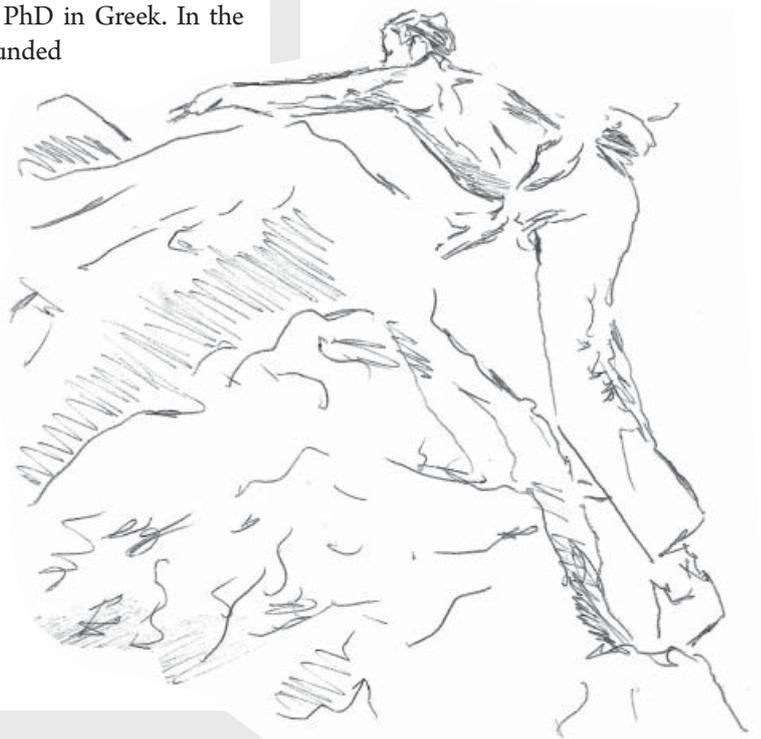
Boundary leaders thus have complicated work journeys, and quite frequently they have complicated job histories that may appear curious, or worrying, to those on more traditional paths. Not surprisingly, then, boundary leaders may even be regarded as misfits or rebels. Of course, in one sense, *they are rebels*, at least if one understood by that what Albert Camus (who wrote an influential book on this called 'The Rebel') meant. Camus was aware that rebellion has destructive potential. Yet, properly understood, rebellion is really much more about a creative drive. What others may think is rebellion, is actually an action aimed at transcending a present pattern, one that is hurting people or unable to move into a more hopeful future. As Martin Luther King Jr. crisply commented, nobody well-adjusted ever changed anything!

A good example of a boundary leader whom others saw as a 'dangerous' rebel was Clarence Jordan, an agriculturist with a PhD in Greek. In the 1940s, at a time when this was just not done, he founded a communal farm in South Georgia in the USA, where black and white people could live, work and campaign against racism. He did this as an expression of his particular reading of his religious texts. He knew them, in their original Greek language, and he saw that they were about a new order of life trying to break into the hurtful social reality he actually lived in – one full of radical injustice and racism that seemed unchangeable. 'Normal' white Southerners could not grasp what he thought he was doing or why, and some even attacked the farm.

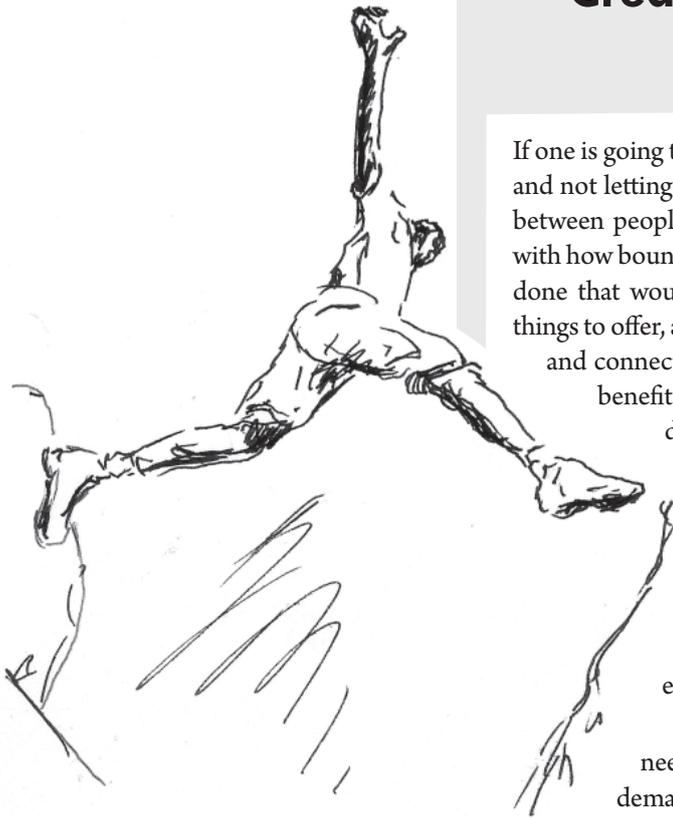
But those who see the need for such a dialogue have entered into the world inhabited by boundary leader personalities, and they understand well that they are going to have to live with serious misunderstanding.



“Boundary leaders, when they see it as necessary for the sake of the whole, can't help ignoring or crossing the boundaries that their institutions or organisations set around them. They have to learn to live with misunderstanding. As Martin Luther King Jr. crisply commented, nobody well-adjusted ever changed anything.”



Creating bridges and keeping them open



If one is going to cross boundaries, with the aim of holding on to the whole and not letting any part go, then one is also going to have to build bridges between people who live within their boundaries. Not only does that fit with how boundary leaders think and act, it's also how one gets many things done that would be impossible otherwise. It links people with different things to offer, and it connects energies that need to be connected. The links and connections that people then have can be used by them to mutual benefit. In technical language, we would say that boundary leaders develop *bridging social capital*.

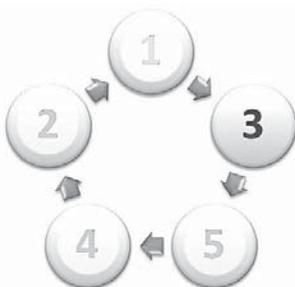
Sometimes creating the necessary bridges is like laying a pathway across a perilous chasm – people often prefer to stay within their boundaries rather than look for bridges to others; or maybe they fear who will come across that bridge to threaten their comfort. For the same reasons, once one has created a useful and meaningful bridge, it takes effort to keep the bridge open.

The effort, courage and persistence a boundary leader needs to be able to create bridges and keep them open can be demanding. Surprisingly often, carrying this psychological and emotional cost is made easier for many people through their faith or spirituality, which gives them strength to pursue a larger vision and support along the way. It gives them energy to move across boundaries and build bridges for others to cross as well.

Generating new bridging social capital is why boundary leaders are so useful to the social whole. But calling it a 'bridge' might be too formal. Maybe rocks sticking out in a rushing stream is a better image. A boundary leader knows how to help others step across, how to support them, how to point out where the unstable stones are that will dump them in the stream.

Boundary leaders are usually good at this role, first, because of their own complex personal journeys, second, because they know how to navigate the difficulties of community relationships. They are also able to see things emerging that are hard for those with more fixed lenses and literal minds to see. And because of their vulnerability, they know a lot about organizational behavior and its dangers, so they tend to be nimble, resilient and flexible. They are frequently described by themselves and others as visionary or imaginative – they not only see what has happened before, what is happening now, and what has not yet happened. But, critically, they also see differently. And that is often very useful!

“Creating bridges between different people, organization and institutions in service of the well-being of all, and then keeping them open despite all the difficulties, is typical of boundary leadership.”



There is a cost

Because boundary leaders usually spread themselves across many relevant bridges, they also experience a 'shadow' side – they have very broad networks of relationships, but that means the relationships are often relatively thin. There is a cost. The crucial role of holding widely scattered people together means boundary leaders can and do suffer from a lack of safe, deep, personal relationships. What they invest in building and holding open bridges also comes at a personal cost of felt vulnerability and marginalization.

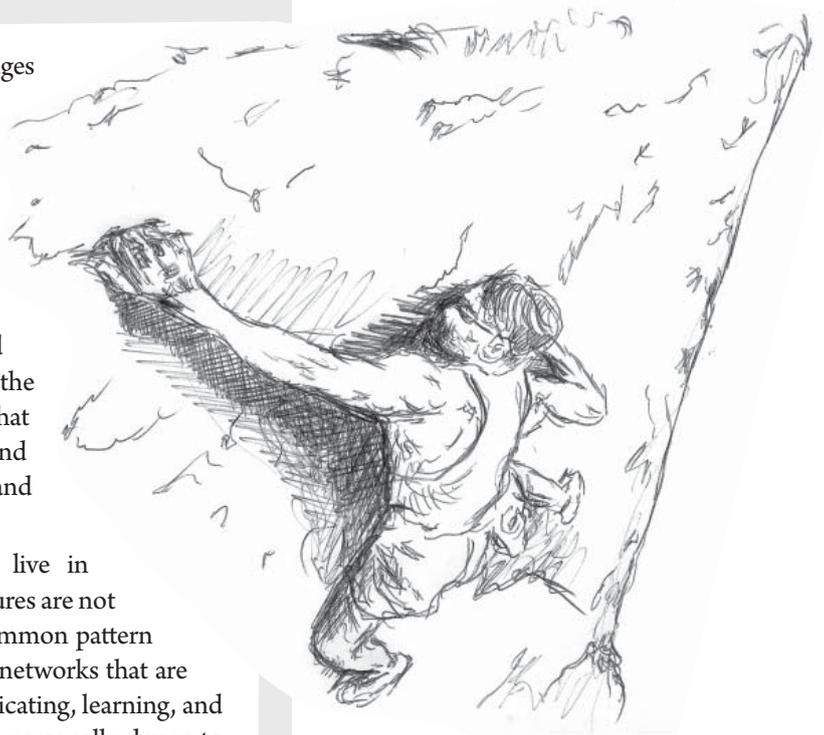
Engendering webs of transformation

If boundary leaders typically create bridges that connect people, organisations and institutions, then they don't stop there. Again typically, they also try to build new structures that will enable to this to keep happening, so that what is gained in the process is not lost again too quickly. More than this, however, it's in their nature to want to develop structures that can grow and develop in ways that really help transform the social whole over the long haul, sustainably. That means working hard to keep those people and groups together who share a common vision and aim for the well-being of all.

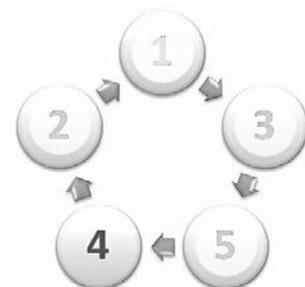
In other words, boundary leaders do live in structures of their own kind. But these structures are not rigid, or set within fixed boundaries. The common pattern of boundary leaders is to move and work in networks that are adapted for the tasks of organizing, communicating, learning, and engaging in social change. Similarly, they are personally drawn to those kinds of networks where participatory social knowledge is alive to the unlimited, transformational energy that creates powerful and unpredictable bonding social capital, ways of staying in solidarity with one another over time. These kinds of structures, then, are more social, and they feel more like **webs of transformation**.

Often boundary leaders say that they feel they have more powerful bonds with an odd assortment of people they find in their boundary networks, than they do with their formal colleagues in the organization or institution for where they are employed or have their 'normal' identity. They intuitively recognize people in other organisations or institutions (or outside any) who are also boundary leaders like themselves. So they form unorthodox social bonds in the boundary zones, which work like magnets to hold together what would otherwise be unlikely groups of people. Over time, such webs of transformation produce powerful energies and actions, capable of doing on a larger scale what no one person or group can do on their own.

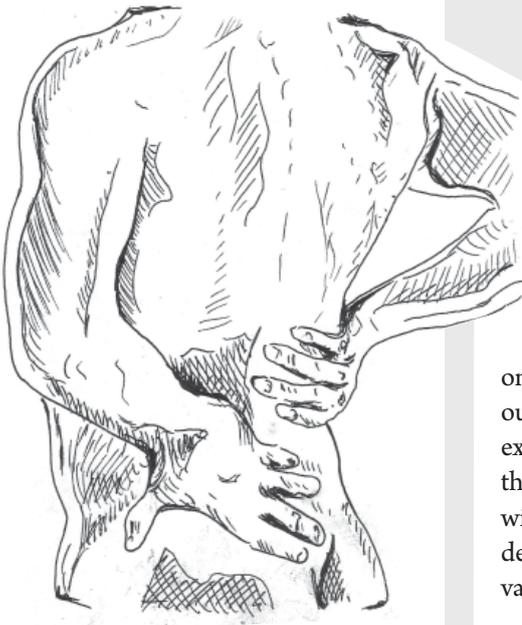
This is how boundary leaders help systems gain many efficiencies, by aligning and connecting assets that already exist but that are, for many reasons, otherwise inaccessible or invisible.



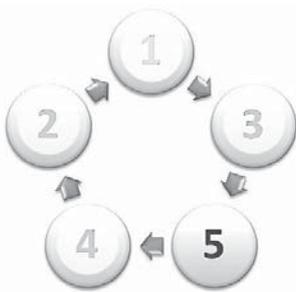
“Often boundary leaders have more powerful bonds with the odd assortment of people they find in their boundary networks – their ‘webs of transformation’ – than they do with their formal colleagues in the organization or institution for where they are employed or have their ‘normal’ identity.”



Holding the negative valence



‘Holding the negative valence’ refers to the attitude that boundary leaders have towards the unrealistic expectations, fears and negative reactions that people have about them and what they do. They ‘hold’ it all together despite the negativity, with the hope of helping all see the positive transformation that is possible. 》



Much that is found in boundary zones is broken, the debris of destructive social, political and economic processes that have left people hurt, dehumanized, depressed or damaged. Fear and negativity may thus dominate. A boundary leader seeking transformation towards greater well-being, and coming into such an environment, might act as a lightning rod attracting unrealistic or distorted expectations.

This kind of situation is familiar to therapists working in the one-on-one relationship of counselor and client, and they are trained to look out for it. They learn how to deal with a person’s heightened hopes or false expectations, which comes from their anxiety and desperation to be free of the fear and negativity that seem to govern their lives. They also learn to deal with a person’s anger when they don’t meet those expectations or trigger a defense mechanism. Psychologists refer to this skill as ‘holding the negative valence.’

The same sensitivity is needed at community or social level, especially where people face lots of conflict or uncertainty. That kind of sensitivity is also characteristic of boundary leaders. And boundary leaders frequently do find themselves in the middle of negative valence, not only because of a community’s fears and expectations, but also because those whose stability and comfort is threatened by what they are doing react against what they do. Even then, boundary leaders see the social whole as generally positive, and so they still hold this ‘negative valence,’ waiting for the time when the positive reasons for their actions become visible to others. That sounds much easier than it is in practice, of course, especially if you are the one in the middle of the negativity!

Boundary leaders such as Kotze, King, Jordan, and Chandrasekar actually do far more than *hold* the negative valence. By avoiding swimming in negative racism and the competitive violence common in the broken zones within which they moved, they actively seek to *turn it around*. Against the negative valence, boundary leaders hold open a *positive* valence until it can be seen and experienced by others, first at small, then at larger scales. What they are trying to do is pull together scattered and broken parts toward a stable center of a new, emerging whole.

Not everyone appreciates this, naturally. Kotze’s growing critique of the international economic system that for long made Apartheid durable is one example, and it lost him many affluent supporters. Martin Luther King’s move from Dexter Avenue Baptist Church onto the streets and alongside sanitation workers, poor whites, and war-torn Vietnamese, disturbed some of his community, exposing him to additional vulnerabilities and stresses.

Unlike therapists, few boundary leaders are trained to hold the negative valence, so they often experience personal vulnerability. Trained or not, however, they keep going, drawn by the positive valences necessary and vital to the way life creates new social wholes. The movement to which they give themselves thus transforms them at the same time.

SOCIAL EMBODIMENT

Boundary leaders are deeply focused on social realities. So it is no surprise that they are continually aware of what is going on in social life, and always searching for ways to impact on social life by placing themselves – their bodies as well as their minds – into the midst of it. As one useful example of how this may play itself out, let's look at what it could mean for health in our contemporary political and economic context.



The most basic social commitment (for health & well-being)

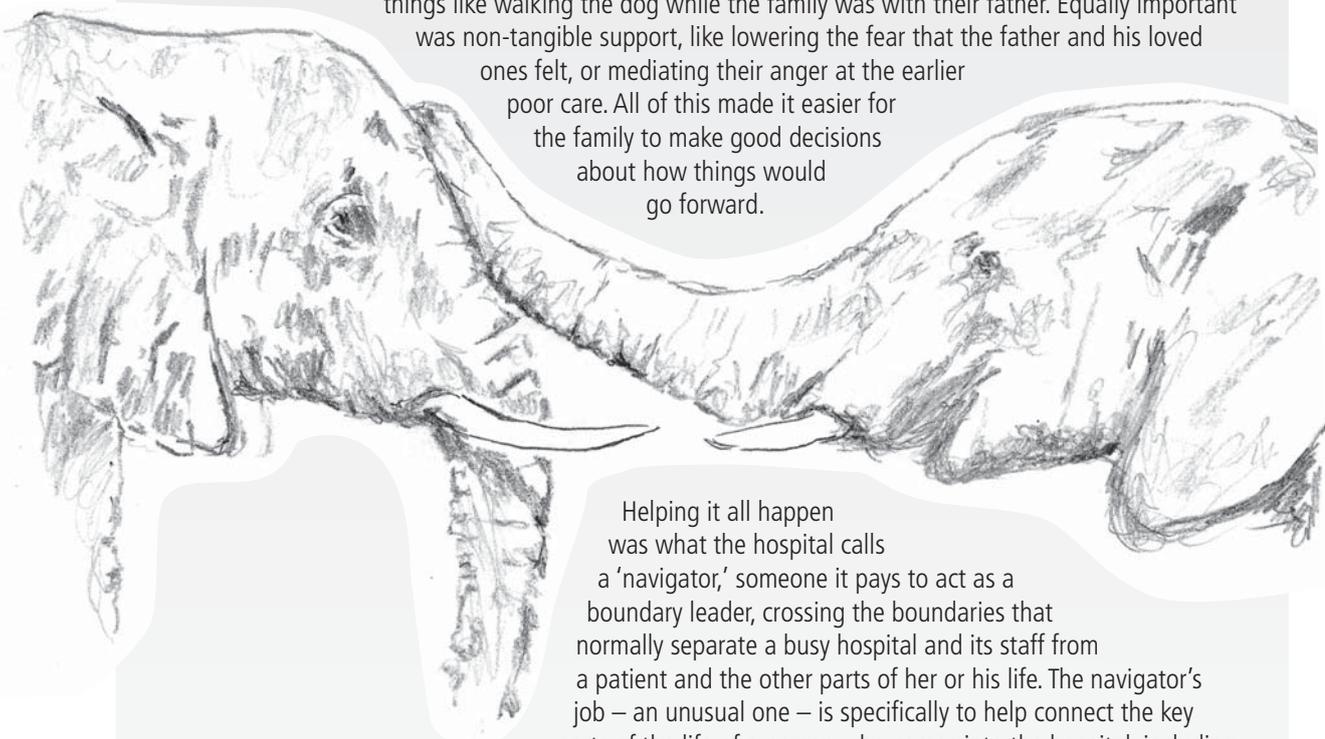
We have talked about boundary leaders as ‘participating’ in the social reality of which they are part. They stand ‘in’ the water, they don’t just ‘talk about’ water. Their focus is on people, communities, social relationships, and how they are hurt or healed. Communication – the ability to enter into dialogue with others in ways that create and sustain relationships – is crucial to their life and work. To use a technical term, they are involved first and foremost in ‘**communicative action**.’ That’s different from ‘instrumental’ action, which instead treats people as things to be used or misused for other purposes or for the interests of others – like a state bureaucracy’s interest in control, or a business’s interest in the profits of its shareholders. The first social commitment of a boundary leader is thus usually to the well-being of all, even if the place in which they act begins with the lack of well-being in one particular community or society. Think of Nelson Mandela. He is recognized across the world for his commitment to freedom and justice for *all*, even though the place where he lived out that commitment is only one part of Africa.

BOUNDARY LEADERSHIP

It helps the whole system heal ...

Boundary leaders help systems gain many efficiencies by aligning and connecting assets that already exist, many otherwise inaccessible or invisible. A simple, small example is about a family whose father, after developing eleven bedsores in a poorly run nursing home, was admitted to the Methodist Extended Care hospital facility in Memphis. What would normally be a nothing more than a pure medical intervention in most cases, became something much more in this case.

First, this hospital has a Faith and Health office. It helped connect the father to the pastor of his home church, an experienced chaplain. The chaplain, in turn, served a congregation organized into care teams – its understanding of its faith makes this seem natural. The pastor and congregational care team were able to step in, providing important support to the patient and his family, including helpful, tangible things like walking the dog while the family was with their father. Equally important was non-tangible support, like lowering the fear that the father and his loved ones felt, or mediating their anger at the earlier poor care. All of this made it easier for the family to make good decisions about how things would go forward.



Helping it all happen was what the hospital calls a 'navigator,' someone it pays to act as a boundary leader, crossing the boundaries that normally separate a busy hospital and its staff from a patient and the other parts of her or his life. The navigator's job – an unusual one – is specifically to help connect the key parts of the life of a person who comes into the hospital, including

mobilizing available religious and other health assets outside the hospital as part of this patient's care. The navigator seeks to bring all these parts into alignment for the benefit of the patient.

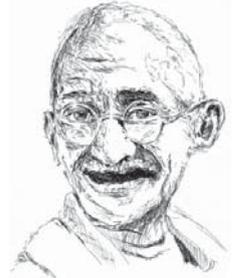
Here we are *not* describing a way for the hospital to outsource its legitimate responsibilities – it did not shirk the material costs of helping all these alignments happen. In any case, if it tried to do that simply to avoid costs by pushing its responsibilities onto the pastor, congregation or community, it would soon collapse. People, for good reasons, would not trust the hospital. Nor would the hospital's key problem – how to deliver health care efficiently, effectively and sustainably in the long run – be solved. The alignment we are describing is not about a social contract, but about a human necessity, especially where health systems and health policies are in crisis. Another benefit from the boundary leadership role we see here is that everyone grows smarter about what's actually going on, where the deeper problems lie, and who might help deal with them.

Finally, in Memphis (probably in many other places around the world), most patients coming into an emergency room have also recently attended some house of worship or place where people congregate. It might be important, then, to understand what *that* congregation or 'faith-forming entity' knows about health, what motivates their health-seeking choices and behavior, what kind of providers they turn to, and under what circumstances. In short, boundary leaders help one system learn from another, gaining new synergistic intelligence, by building a web of trusted relationships across the boundary zones that otherwise keep them apart.

Thinking about systems

'I claim that human mind or human society is not divided into watertight compartments called social, political and religious. All act and react upon one another. ... The difference between what we do and what we are capable of doing would suffice to solve most of the world's problems.'

– Mahatma Gandhi



Communities live within societies under systems of power and control, whether economic, political or even cultural (think of the things we think or have to do because of what the government, corporations or the media say, and so on).

These larger systems are real and we can't avoid them. Yet they often seem to hinder rather than help us. They come to us from outside our communities, but they run through and exert a powerful influence over community life.

Paying attention to these systems does not add to the complexity we must face but, rather, it *reveals* it. Systems may appear to be beyond our control, but in fact, they are a large part of what needs to be transformed to have any deep, enduring impact on the lives of people and communities. We can stick with what we already do, but perhaps the right question to ask ourselves is Gandhi's:

What are we *capable of doing* when confronted by systems?

Nevertheless, and yet ... it is *also* possible to shape our local actions to blend with those of many other leaders like us who are moving as best and resolutely as they can toward another, kinder, more fitting social and political and economic fabric.



Seeing the systems we are in



Some examples: of 'large scale drivers' that show how systems impact on us:

- employment gives people dignity, but unemployment is a major contributing factor to mental illness
- financial accountability helps people trust those who lead them, yet fraud and corruption takes money away from the poor or those whom leaders should be serving
- fair distribution of wealth enhances our ability to live together, but inequality creates a huge sense of injustice and anger, destabilizing communities and societies
- gender justice strengthens relationships between men and women, while gender discrimination plays a key role in the disproportionate health burden and violence that women and children bear
- government programmes that actively target those whose need is greatest create healthier societies, while policies that primarily serve elite interests do the opposite

Surely community leaders have enough to do locally without assuming responsibility for the huge overarching social and political systems around us? Why then bother with them in a Barefoot Guide for leaders?

It would be irresponsible to not name these **large scale drivers**, especially political and economic, of our times. After all, they are not weather or gravity. They are shaped in ways that reflect complex patterns of human choice at social scale – the result of human action, they are not written in stone. They reflect 'what people were capable of doing' in the past. What happens to these large-scale social systems in the future will, in part, reflect what we are capable of doing now.

We do not *have* to choose a posture of denial or delusion, self-imposed ignorance, naiveté, passivity or apathy. We need *not* be victims, even when it is not within our individual or local control to fix large scale social, political and economic rules to bring them into line with our greatest hopes or grandest vision.

It is said that as long as 'they' can get us to ask the wrong questions, it doesn't matter what our answer is. As long as 'they' can make us feel we do not need to think about the larger scale phenomena that shape our community's prospects, 'they' benefit from our passivity. In each place and time the question of who 'they' are has to be answered locally. Though there are always particular, often changing, groups and persons who benefit from the injustices and inequities of large scale social systems, the real issue is what makes for unjust politics and an iniquitous economy?

Possibly our best labours will only cushion the blows and bruises from choices made by more powerful others elsewhere. We may trap ourselves through our own naiveté or incomplete analysis. We may have little means to engage the powers who make the big decisions.

But we are not powerless because of that. As we deal with local challenges and opportunities, we *can* consciously learn language and logic from others in other places that help us develop a way of thinking about these systems and their impact on us. We *could* begin building a scaffolding to build our understanding of something new and more life-giving out of our humble and small efforts.



That hopeful vision is not likely to happen, however, if we ignore the larger scale phenomenon shaping, limiting and sometimes promoting the life of our community. We need to get to grips with what is happening out there or we will always be its victim. One small chapter is barely a beginning of that scaffolding of thought – yet beginning to think through it is hugely important.



In the gaps of systems

We visited the impressive Ndola General Hospital In Ndola, Zambia, to conduct a pilot study on religious health assets; it was a complex like many other such hospitals in regions experiencing great economic change.

The first surprise was that the parking lot was almost empty. Beyond that, however, was a gate onto a road to the back of the hospital. Here pickup trucks regularly exited. Passengers already in the back were joined by others waiting outside. They chanted and prayed as they drove away. What we were seeing? It turned out that the people on the trucks were family and friends fetching the body of someone who had died. Why so many? Because HIV was hitting hard. Though the hospital had a maternity ward, it processed death more than it delivered life.

A second surprise. In the huge, main reception area, two people waited. No-one was attending. The wards above were mostly empty. Again, what were we seeing? Ah, said our host, 'user fees' had been introduced as a condition, at that time, for international financial loans to the government. But in Zambia about two thirds of the population lives on less than 1 US Dollar per day, and few could pay even what seemed insignificant to an economist. Households had to decide between traveling to the hospital and feeding a baby. Usually the baby won.

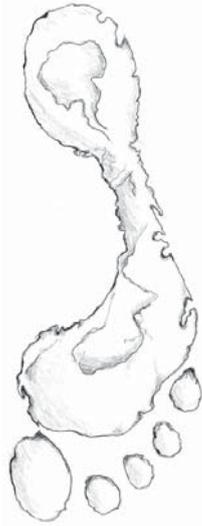
A third surprise: we found a separate door into this main building where lots of people moved in and out, a complete contrast from the rest of the hospital. Oh, said our host, this is the entrance for privately insured patients whose fees were covered – corporate employees, government officials, expatriates, tourists. They received full, high quality care .only steps away from those who received none at all. Nobody involved in any part of this story was heartless or mean. What was going on?

The previous evening we had been in a poor, sub-economic 'compound a few miles from the hospital. We sat' in a church with gaping split pine walls roughly wired together, patchy plastic sheet roofing flapping in the wind, crude benches and a dirt floor. It also had an imposing set of electronic musical instruments by the low stage. The place rocked with song and praise, with preaching as vibrant as the hospital

'I believe that our very survival depends upon us becoming better systems thinkers.'

- Margaret J. Wheatley





reception area was lifeless. Though many present, mostly younger, were unemployed, and almost a quarter HIV infected, the religious messages, punctuated by amens, hallelujahs and ululations, were of hope and assurance. And not just in the 'world to come.'

Woven into the service were frank words about bodily care, safe relationships, compassion, and the need to express one's own agency against the threat of death or the devil.

These worshippers seemed fully aware of how the ills of the social system in which they had to live affected everything in their lives. Despite this, they lived in the gaps of the system with hope, with some agency, and with greater potential to help shape their future than they would have had by simply giving up.

Citizens of social systems

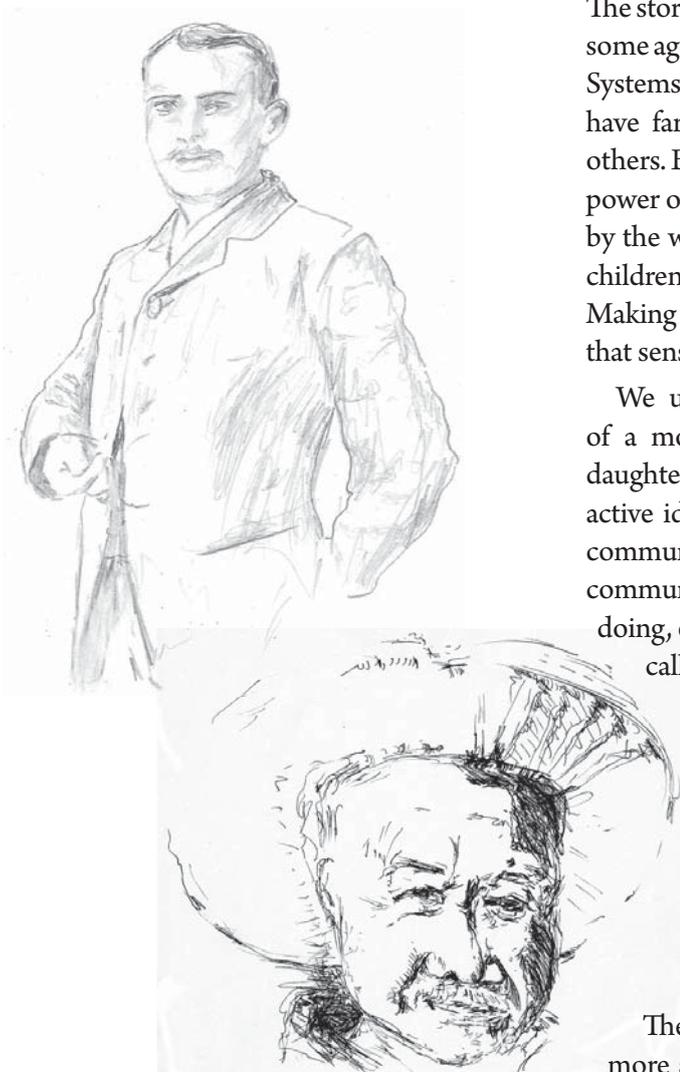
The story of Ndola, its hospital and small congregations filled with some agency, hope and great resilience is also a story of citizenship. Systems are made by people, not by magic. Of course, some people have far more power, knowledge and material resources than others. But none of the humans involved, no matter their apparent power or lack of it, are entirely able to act as if they are unaffected by the whole complex system. The business executive and street children are all citizens in a complex and connected social system. Making sense of that connectedness, and then acting in light of that sense, is part of the real work of boundary leaders.

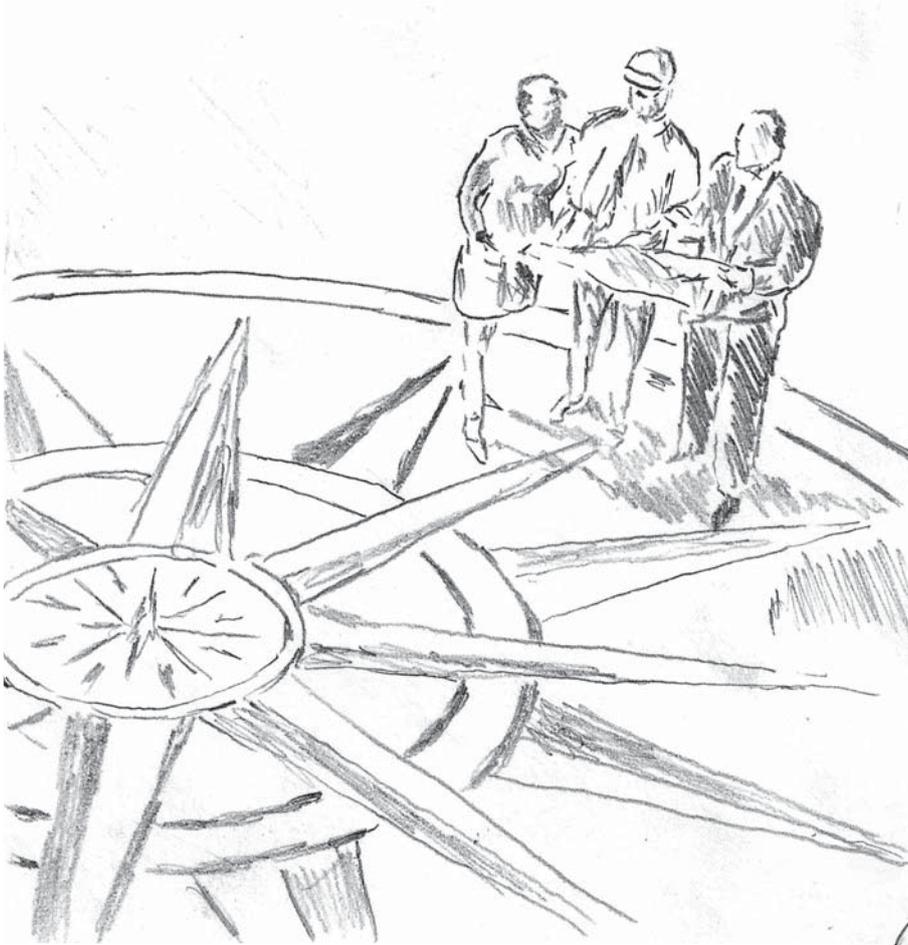
We use many words to describe people: patient, member of a mosque, neighbor, believer, nurse, youth, family, father, daughter, ancestor. How about *citizen*? The idea of a citizen is an active identity in which the action is mainly communicative. A community is a thing in which communication happens. A citizen communicates. If 'citizen' were a verb it would be all about talking, doing, expressing in ways that build up the social body, the thing called a public.

It is painfully obvious that all citizens do not have the same means to do citizen work! Even in societies with open, fair, just habits of elections. After all, voting is just one way of communicating. We have many others: graffiti, talking at the bus station, writing letters and publishing letters, preaching, teaching, showing up at a protest, or giving one's time to care for another.

A 'system' is not quite the same thing as a 'community.'

The organizations and institutions in a system tend to think more about instrumental logic than communicative or people logic. Local people tend to talk; institutions tend to design instruments that do specific things. Both ways of thinking are okay, but it helps to realize that human beings responsible for





‘If ‘citizen’ were a verb it would be all about talking, doing, expressing in ways that build up the social body, the thing called a public.’

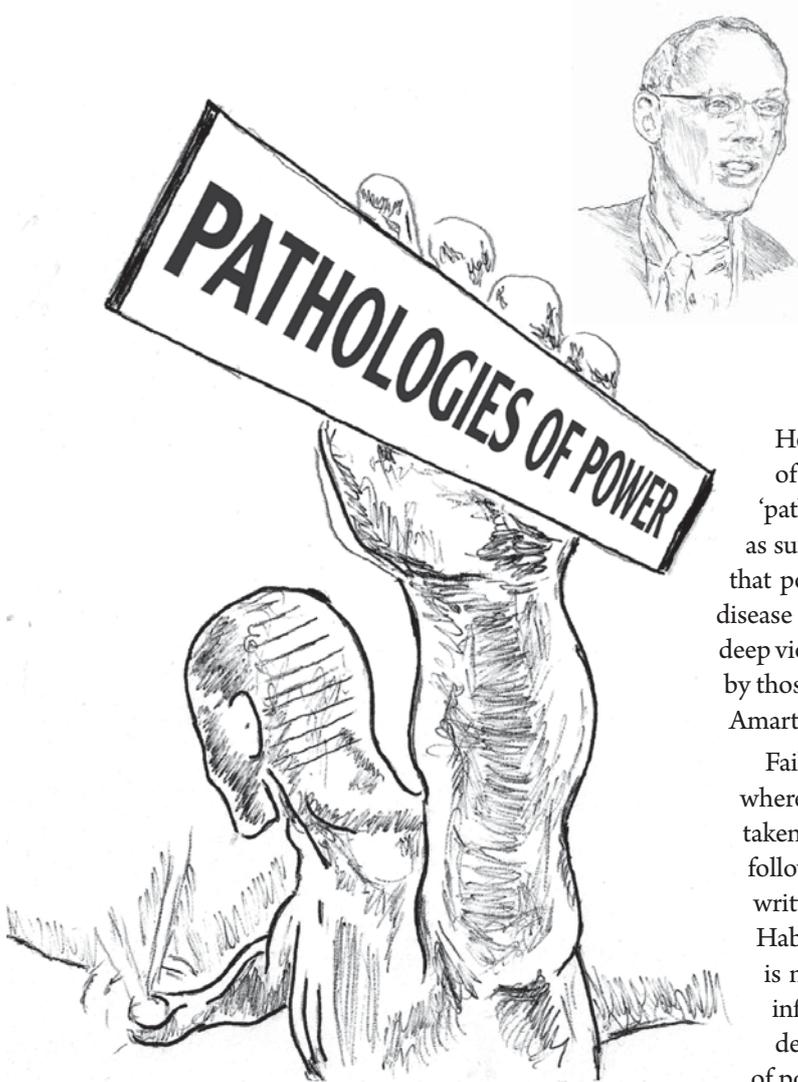
institutions tend to think of instruments. In some legal systems corporations are treated as if they are citizens, but they are not *actually* persons and certainly do not *see* like persons. As James Scott helped us see earlier (in the chapter on boundary leadership), how you see can be very limited. It is ‘seeing like a state’ or, today, seeing like a business (or maybe seeing like an organized religion, too!). The problem is that if you see only in the way most useful to your particular kind of instrumental work, you are highly likely to miss or forget that there are other ways of seeing the same thing. Scott wrote about how hard it was for a state to ‘see’ the full life of the forest, but he could have easily been describing how hard it is for an institution to see the full life of the community.

What can one do about this?

First, think about how *you* see. If you are a leader of something, chances are you see in ways that might be instrumentally useful to that organization. You might need to broaden your own way of seeing! And then you can begin to borrow others’ eyes to see the community reality in more than one way.

Secondly, think about *you are seen*, by those in other organizations and governmental agencies. You can see like a Boundary Leader, seeing in multiple perspectives, using different lenses. As you grow beyond being trapped into only one, you can free others in the system to see, too.





The health of individuals is a dependable sign of the health of the body politic. It shows what Paul Farmer calls 'pathologies of power.' And it shows the resilient vitalities of power, too!

Health is a very good indicator of the skewed nature of social realities. It shows up what Paul Farmer calls 'pathologies of power' – its dysfunction. For example, as surely as we know that clouds produce rain, we know that poor people carry an extraordinarily high burden of disease and ill health. The economic system often inflicts deep violence to their bodies and lives, but it's largely unseen by those who are *not* poor. Nobel Prize winning economist Amartya Sen calls this 'a kind of quiet brutality.'

Failure of governance might be part of this, especially where available resources are misapplied, or simply taken by powerful elites. Systems operate in patterns that follow rules, including some important ones that are not written. This includes economic markets that, as Jürgen Habermas notes, are essentially 'deaf to information that is not expressed in the language of price.' So it misses information important to the lives of the poor. That deafness is why Paul Farmer speaks of the 'pathologies' of power. Power can be mean, even brutal, even when it is merely deaf and blind.

Why does this matter to us? This Barefoot Guides come from the practical attempt by many people in many places to find ways to live with the pathologies of power. It is just not enough to simply analyse those pathologies or illnesses of society, and describe how bad it is for so many people in so many part of the world. We have power, too! Our danger is letting the deafness of pathology power keep us from hearing our own vitality. Our challenge is how to build on what people have and do that enables them to survive and, even flourish.

So we insist there are *vitalities of power*, too.

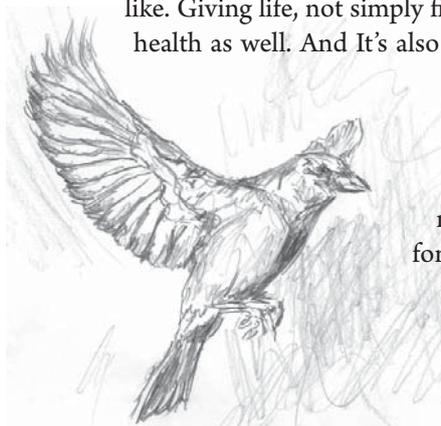
That's the reason for talking about 'assets,' 'causes of life,' 'strengths of people who congregate,' 'marks of boundary leadership,' and the like. Giving life, not simply fighting death, is the true heart of public health as well. And It's also the heart of faith or religion which we refuse to not see, not hear. Listen to the wellsprings of moral action and intention, especially among those many people, some of whom we have named, that trace histories of struggle for freedom, justice and the good of all.



Amartya Sen



Jürgen Habermas



asking why children don't have shoes...

Challenging systems

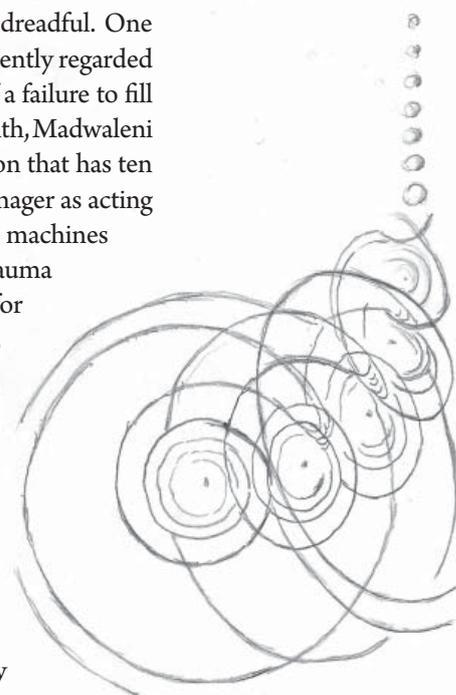
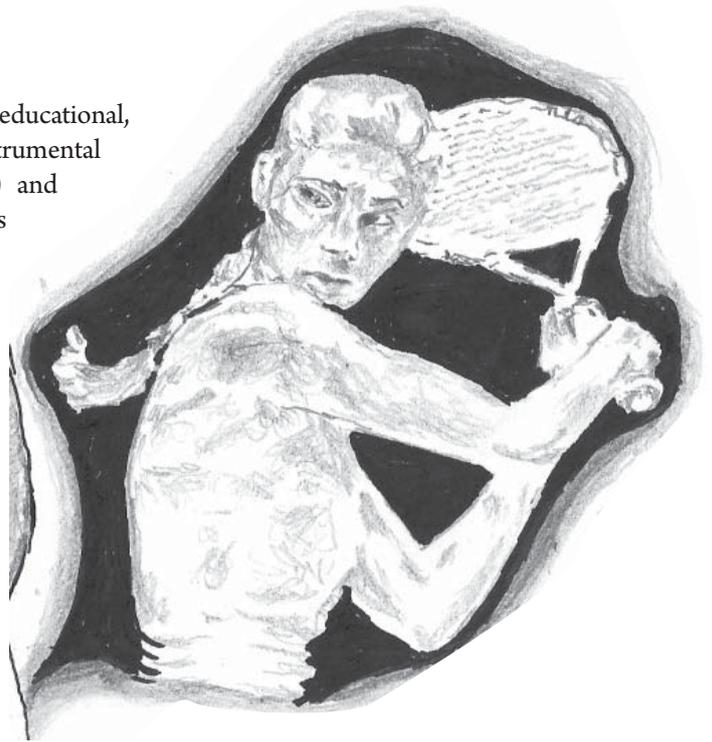
Anyone working in any kind of system – political, economic, educational, religious or whatever – faces a permanent tension between instrumental purposes (to meet the needs or demands of the system) and communicative action (to respect the dignity, relationships and lifeworld of persons). No administrator of a healthcare facility wants the reception rooms to be empty, or the back doors to be filled with wailing mourners like those the gates of Ndola General Hospital. No real doctor wants a patient to suffer or die. Both, however, have to work with the systems that make up social life, including those that determine how power is shared or money is used, and both have to come to terms with how to do that under imperfect, sometimes even hostile, conditions.

Being both a person with a job to do and a citizen is often a real challenge. Having the job may require making a system work as well as one can, rather like an emergency room nurse tends to children with bleeding feet from walking on stones. It is the right thing to do, but being a citizen may mean challenging the system, asking why the kids don't have shoes. Every citizen has the obligation to see the missing shoes. Every citizen must ask *why* and then *why not?* That is exactly why it often requires some courage rooted in faith to be a citizen.

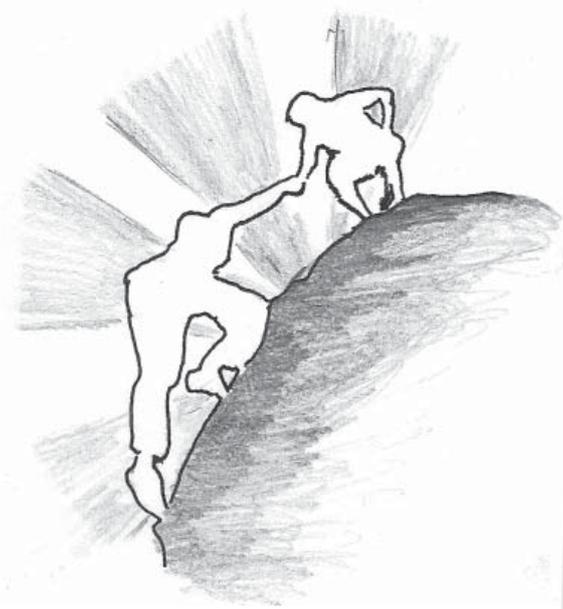
Dr Siva Pillay, a man with impeccable anti-Apartheid struggle credentials and experience in governance, is Superintendent General of a provincial Health Department in South Africa. He has battled microbiological viruses throughout his career. Now, called 'Dr Clean-up,' he tries to root out another kind of virus: fraud and corruption, the effects of which are dreadful. One example: rural Madwaleni Hospital, a 180-bed facility until recently regarded internationally as doing exemplary work. Now it is a victim of a failure to fill critical posts. Because of the problems in the Department of Health, Madwaleni has ended up with one doctor instead of 14, a maternity section that has ten instead of 42 nurses, no clinical manager, a deputy nursing manager as acting head of the hospital, and no head of administration. Its x-ray machines have either been condemned or broken. Emergency and trauma cases, including complex pregnancies, must wait a long time for an ambulance which transports them to Mthatha Hospital, 100km away.

Dr Pillay simply says, 'Everything is going haywire. Thieves have hijacked the process. All the gains we made are slowly being reversed. We are bleeding everywhere.' And he notes that he also battles resistance to his investigations of fraud and corruption from the highest levels, with three attempts on his life to date. Asked if he was not afraid of dying, he said: 'I am a Buddhist, I am not afraid of dying.'

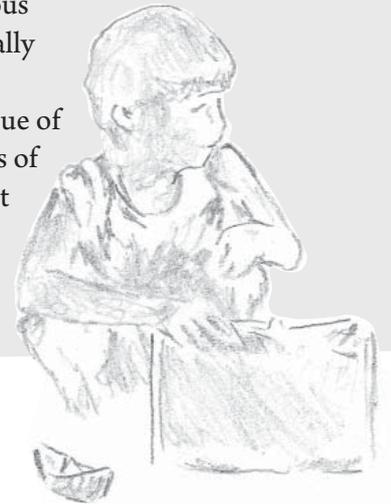
Whatever happens to Madwaleni Hospital, Siva Pillay understands that he is not just a doctor but a citizen who has a responsibility to challenge systems when they go wrong, and help put them right when he can.



Re-imagining the



Thinking about the health of the public is really another way of imagining a world that is whole and healed, free of unjust hurt and unfair inequity and filled with people, communities and societies that allow people to live a full and fulfilled life. It's also a way of grasping what this Barefoot Guide on 'mobilizing religious health assets for transformation' is really about, of understanding why we have placed health at the centre. What is true of health is also true of the deepest roots of religious imagining which, in different ways for different traditions, aims at a fulfilled life in a healed and whole society and world.



1

Religious leaders who are close to their communities and good public health practitioners know that health is more than a commodity in a market economy, and that having better knowledge or more powerful science is not enough. They are aware that disparities in health status among population groups are unjust and inequitable, as often as not a result of preventable, avoidable, unfair conditions and policies. These disparities are interconnected, they feed on each other, and go down through generations. All of this means citizens end up with a lower capacity for full participation in society. It's a global challenge. Taking up this challenge, Fabienne Peter says, means 'not so much a new public health as a return to the historical commitments of public health to social justice.' One could say the same for many religious traditions too

2

Talking about justice or equity does not necessarily change the social conditions that produce them, of course. Language is easily co-opted. We don't necessarily mean the same thing when we talk of 'poverty alleviation' or 'equity.' For example, if we focus on delivering medicines to people who are poor because they can't afford them without addressing the conditions that make them poor and damages their health in the first place, we will not change their health status much at all over time. Similarly, if we just pay attention to the delivery of health care, and ignore the agency of those people for whom health is intended, then we turn them, in effect, into a passive recipients of care, consumers of health. Instead, we should be strengthening citizenship – growing the capacity of people to have greater say in what happens to them and their communities, becoming agents of health and well-being.

3

For the 2000 World Development Report, participatory 'Consultations with the Poor' were conducted by local organizations with more than 60,000 poor people in sixty countries. What did they say? The Report says that they expressed 'an overwhelming feeling of powerlessness,' 'mostly negative experiences with governments,' and 'mixed feelings' about non-governmental organisation (NGO's), 'preferring the dependability of their own local networks.' If poor people distrust their governments and are hardly enthusiastic about NGOs or other external agents, then we know that thinking about how to change the structural and systemic conditions of poverty, alienation, and marginalization is going to be hard, no question. Clearly it won't happen overnight, nor will it happen easily. Still, we can see that it is healthier for people and communities to take a full part in decisions about their own health, and it is supportive of the necessary citizenship to encourage people's initiatives. That, at least, is what public health practitioners and religious leaders can be held accountable for.

health of the public

We have also said that we cannot avoid economy and politics. Like the double helix of our DNA gene code, they make up a key part of the language of life, continually shaping each other in an indivisible dance. Any person's action in a particular role (in a religious institution, a health facility, an NGO, etc.) will be constrained by the systemic imperatives at work in that context or particular social environment. Every actor will be faced with systemic distortions that obstruct the goal of health for all in a healthy political economy.

What does this mean for re-imagining the health of the public? No doubt you will have your own ideas about that. Here are some worth thinking about.

'You don't have to know where you are to be there, but if you want to go somewhere else, the first thing you need is to know where you are!'

– Bill Foegel



The World Development Reports shows that one cannot simply listen to people or record what they say. One has to pay attention to their freedom and dignity, and this again brings in the question of justice in health. The practice of public health rests on a moral vision, not just on science or technology. One significant criterion to determine whether or not a health system is just is how seriously it considers what *all citizens* experience as a threat to or restriction on their being and, in the same way, what *they* find generative or life-giving. It's about giving full to their knowledge of their own existence, and their own capacity to survive or thrive. Many of the ideas in this Guide are based on that understanding.

4

This means, allowing for the unevenness of power, finding ways to mediate between those 'above' who are run and work in the systems that govern our lives, and the experience and wisdom of those who are 'below,' who are affected by systems. The aim is mutual reciprocity, or what a basic religious insight says: 'do unto others as you would have done unto you.' It's not just about personal relationships but about social ones. It means searching for and insisting upon structures that help us live well with, and for, others, which would require us to build institutions that serve justice. That's not just an idea. It's a practical project. We can, as we have in Chapter Five, talk about 'reciprocity,' 'quality of life,' or 'decent care' or 'trust' as crucial to health and well-being. Separated from conceptions of justice, however, these ideas are likely to betray the very thing they seek.

5

A purely formal view of justice is expressed in the idea of a contract. A contract is governed by procedural rules, managed by thousands of legal experts, and focused only on 'what?' and 'why?' We suggest that this is insufficient. In principle and in practice, justice must rest on the idea of reciprocity in relationships with others. The question that really matters is 'who?' The 'who' here is, first and foremost, the human person. We are human because we have the imaginative capacity to act, to effect what happens in the world, with others. As Paul Ricoeur's puts it, 'With the decrease of the power of acting, experienced as a decrease of the effort of existing, the reign of suffering, properly speaking, commences.' To understand this means changing how we think about public health, or any other, interventions. The most obvious, but radical, implication is to direct efforts, resources, money, and institutional priorities towards enhancing the power of acting. It is for this reason that this Guide works with ideas of assets and agency, and the notion of the leading causes of life.

6



Changing our standards of accountability



'Medical science is in its innermost core and being a social science,' and politics is best understood as *'medicine in the largest sense,'* said Dr Rudolf Virchow, a famous physician in the 1800's and a hero of public health, who showed us it is hard for anyone to be truly healthy in an unhealthy society.

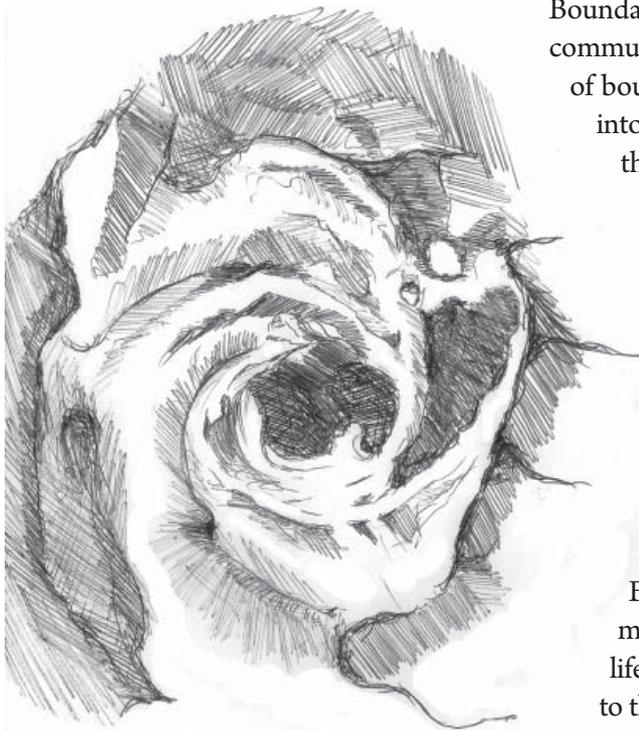
It is a very uncomfortable fact that most of the leaders we admire for advancing the mercy, justice and health of their societies measured their lives in tears and bruises, if not blood. We admire the fruits of their life, but fear the price. Sometimes social political systems fail to be just because they don't know

any better; the powerful have not noticed the suffering, have not realized it could be otherwise. More common is that those with power fear there is really not enough to go around and they choose quite consciously to protect their privileges and the well-being of *their* children over against the hopes of somebody else's children. They don't see because they don't want to see.

There are certainly places and times when scarcity is real. But Boundary Leaders, equipped with tools for discovering and making visible assets and vitalities challenge the blindness created by fears. Boundary leaders use their whole lives to make visible the life of the community. Living without fear in the boundary zone the full lives of boundary leaders bring the causes of life into view and then into focus like a lens. Both Vincent Van Gogh and Galileo were thought to be crazy for the way they described the heavens.

Everyone knew that the stars were tiny little dots on a fixed canvas. Van Gogh saw them (accurately) as wildly vibrant and ablaze as he painted in 'starry nights.' He died unthanked for his vision. Likewise Galileo saw the stars in motion, and said so. This suggested dimensions of complexity in the universe that decentered the little world views of the powerful elites of his time, so he died in detention.

The artist and scientist are accountable for the gift of vision, helping their contemporaries see the truth. Boundary leaders do not work with paint or light, but they must be accountable for helping their communities see the life, vitality and assets of the social body. They are accountable to the profound role of citizen of a great whole.



Deep accountability



*'For the hardest problems, the problems that would not give way without long looks into the universe's bowels, physicists reserved words like **deep**.'*

– James Gleick, *Chaos: Making a New Science*

In the realm of the terminally blue, it's not
It's not who you are, it's what you do. And in
The land of the marginally free, it's not how you
Look, it's what you see.

– John Kilzer, *Red Blue Jeans*



What is true for the universe is also true for our life together on Earth. One of the very hardest problems we face is that of building a world in which full health and well-being is there for everyone, and that includes the earth that sustains us. That's what we are 'accountable' for. When we think of *deep* accountability, we are thinking about all of the vital elements that are in this Barefoot Guide – remembering what the past has given us, seeing religious health assets, focusing on the causes of life and strengths of people who gather, exercising boundary leadership, and building systems that are just. In this last chapter we open up further the question of just what 'deep accountability' might mean.

What makes accountability ‘deep’?

Accountability is a good thing. But on its own it is not enough.

Everyone who cares wants to see leaders, organisations and institutions being accountable for what they say and do. But usually what that means is quite limited. It mostly refers to explaining why one made a decision, how one spent some money, or whether or not one carried out a policy properly, and so on. So what makes accountability ‘deep’?

First, the challenges we have been dealing with in public health – which are also relevant across all spheres of our life together, including issues of poverty and inequality – are, as Gleick says above, among the hardest problems, those that force us to take long looks at what is going on in our society. Acting to deal with the problems is important, and many people do jump into action. But that is not enough for the hardest problems, the ones that seem to evade easy resolution. We need to reflect deeply, to find better theories to help us along. In so doing we can become more accountable to the deeper truths of being human.

Second, better theories should enable better practice, otherwise they are not worth the bother. The Barefoot Guides 1 and 2 also deal with the kind of accountability that naturally arises out of honest action learning from experience, without which accountability risks becoming an alienating monitoring function. Linking learning to accountability also facilitates forgiveness for wrongs or mistakes. Good theory helps one take up responsibility, to be able to give a thoughtful account for how we use our influence and live our lives. For that to happen, it must help us grasp the deep complexity of life. It must enable us to have respect for life’s many forms, to cope with the turbulence it contains, to be sensitive to the variety of ways in which human relationships matter, and to bear the weight of our decisions over time.

Third, in this Guide we have defined health as ‘comprehensive *well-being*,’ and we have linked that, drawing on the work of Amartya Sen, to the idea of development as ‘*freedom*.’ We have also connected it to Paul Ricoeur’s understanding of *justice*, rooted in an understanding of the self as always affected by and responsible to the other. Deep accountability will always keep those three dimensions of human life in focus – well-being, freedom and justice – aware that they cannot ultimately be separated.



Deep accountability is clearly not easy. Organisations and institutions—including religious ones—tend to look after their own interests or stick to their limited view. They protect their boundaries and find it hard to incorporate or support boundary-crossing thinkers. Many prefer the comfort of familiar language and logic. They don’t often feel any need for wider accountability. Yet contemporary social life is also marked by many new, expanding organisational forms that seek to be deeply accountable. That needs to be encouraged.



‘Blended intelligence’: Jean the navigator

From his office, the Senior Vice President for Faith and Health at Methodist Healthcare in Memphis could clearly see across to an eight-story public housing unit. Living there for more than eight decades is a woman who, high school incomplete, married, birthed, outlived her husband, and watched her children leave. Surviving mostly on bare public assistance, she was coming to the end of her days. The hospital had a lengthy record of her ever more complex medical conditions. Many of her readmissions – for things like taking medication off schedule, falling while bathing, being unable on her own to care for a foot wound – could have been addressed, even prevented, by non-clinical means. There had to be a better way, he thought.

Long a member of a small Baptist congregation, this woman had visits from her prayer group, and sometimes her pastor, but all were thwarted by the practical barriers created by the medical care system for someone with so little means. This particular hospital has begun to follow a different theory, in which it is only one component in a larger complex of religious assets that might care for this one woman. Viewing things less like a state or a bureaucratic medical provider, and more like the religious health asset it is, the hospital began to see the possibility of building wider webs of human trust with others in the community. It had to change in some crucial ways – not in its clinical competence, but in its ways of connecting to others. The key is a web of trust.

The hospital, only one node in that web, has had to work hard to gain trust – and to keep it. Marketing slogans and great science was not enough. It began to build relationships that people *would* trust. It employed people like Jean to be a paid ‘navigator.’ Like those who have to find their way across an ocean whose end they do not see or control, Jean set out to follow a path that took her into this woman’s apartment.

Not barging in, she was helped by the pastor who cares for the woman and trusts Jean. Noticing the others around this woman – the prayer group, the pastor, the informal network of residents in block – Jean could spend her time, paid for by the hospital, aligning and animating other human assets and networks beyond the hospital, assembling a team of volunteers, that would not otherwise have come together, who cared and could now actively care for the woman. This care-giving ‘team,’ loosely but effectively aligned yet working as a social whole, does a very remarkable thing. It creates a continuum of care that can help her with bathing, general wound dressing, taking medication correctly and on schedule, and getting her to the hospital when she needs to be there – not too late to help.

Jean connects what was otherwise disconnected. She helps break the barriers that make institutional spaces like a hospital strange and threatening. She invites into the shared work of hospitality those who were not just unwelcome, but invisible. She helps facilitate a web of trust that supports this woman’s life journey. It sounds magical, but it is not. It is entirely natural in this sense: the new, more inclusive order Jean helps create reflects the nature of life: its capacity for new connections, deeper coherence, more relevant agency, greater generativity and embodied hope.

In the same way that one would be accountable for withholding evidence-based treatment, a health leader who knows all this and does not work with that natural flow of life should also be held accountable. What one is accountable for now, however, is not so simple. Trust, relationships, connections and networks are not the same as X-rays, medications, heart by-pass techniques, nursing protocols and so on – they are much harder to control, and they are much more fluid, volatile and multi-layered realities. They are complex, and to be accountable for them means understanding how to live with complexity.



Blended intelligence:
one that integrates
a wide variety
of information -
community wisdom,
clinical data streams,
academic research,
and the best practice
knowledge from local
and international
partners - to enable
better practices.



Thinking about complexity

Complex challenges are ones where, in principle and not just because of ignorance, you can't be sure how things will develop. They are full of unpredictability – you can't draw a straight line from problems to answers (we call them 'non-linear'). Health science and development practice, though, tend to work with a predictable, linear approach: identify the problem → decide on a solution → apply the solution → problem solved.

If transmission of HIV is the problem, a handful of ways to stop the virus being transmitted are proposed (don't have sex, use a condom, don't use unsterilized needles, take a drug, and so on). But HIV is a complex matter. It also involves relationships, trust, shame, stigma, cultural values, deeply rooted ways of behaving that hard to change, suspicion about those who make profits from treating it, and more. Dealing successfully with HIV is not just about a drug, or scientific ignorance. It means having to come to terms with its full complexity, and developing a deeper standard of accountability that is more adequate to life.

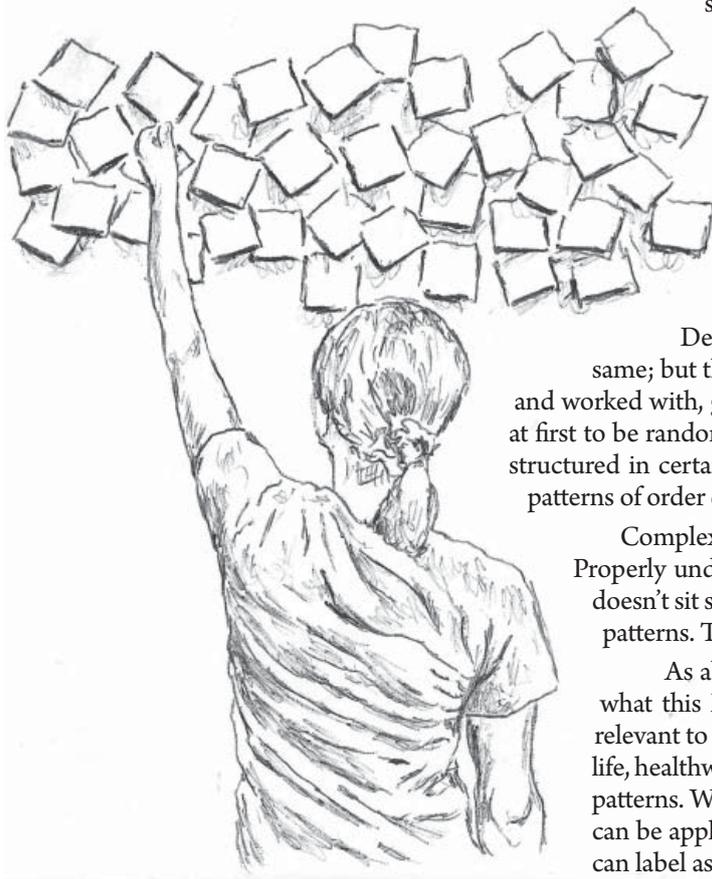
How then does one do that without getting completely lost or overwhelmed?

Well, it's not *all* unpredictable or irregular. The science of complexity – in nature or human society – looks for patterns.

Details change all the time, and the patterns never look *exactly* the same; but they do repeat themselves. Those patterns can be seen, understood and worked with, giving us a better sense of what we are dealing with. What seems at first to be random or mere chance turns out to have a certain kind of order, to be structured in certain ways. In fact, that's a way to describe life – the emergence of patterns of order despite the millions of things that should make it impossible!

Complexity, it turns out, is about generative patterns of order and of life. Properly understood, complexity is the friend of accountable leadership. Life doesn't sit still, and to grasp it properly means understanding those generative patterns. That's what we mean by 'deep' accountability.

As abstract as this all sounds, this is a rather precise way of describing what this Barefoot Guide is about – to point to some generative patterns relevant to the health of the public. Ideas like religious health assets, causes of life, healthworlds, congregational strengths, and boundary leadership are such patterns. We think they can be found in contexts everywhere. If so, then they can be applied to mobilizing our energies and resources (including those we can label as 'religious' health assets), developing our ideas, and strengthening our practice; all for the sake of the well-being of all.



The patterns we sketch in this Guide offer one framing set of ideas that call us towards deeper accountability for the health of the public, including people who lead religious institutions, groups or movements concerned about the well-being of all. You could use other words to express these ideas, and maybe there are better ones - like *bophelo* - in various languages. But the ideas remain, and they are based on powerful insights and knowledge from many people in many parts of the world over a long time.



Priceless – Webs of trust

The web of trust Jean the hospital ‘navigator’ helped build may be the most important ‘intangible’ asset one could want to have – for almost any activity that is generative of life in the face of the forces of death. Trust is priceless. Besides being essential to effective, sustainable and productive work with people, it cannot be given a price – it is not a commodity. You either earn it by your way of being and relating, when it is enormously powerful; or you don’t have it, then something critical has been lost.

Think again of the story of *Masangane* in Chapter Four. This remarkable community-based organization lives because of trust. That’s how it began. The Reverend Mgcoyi, like many other faith leaders who care for local communities, had become increasingly distressed by the devastating effects of AIDS on the people he served as a Moravian pastor. Anguished by the visible pain, and motivated by the hope his faith proclaimed, he was clear that preaching, praying, and visiting the ill and the bereaved was simply not enough. So he gathered a small team around him to begin *Masangane*.

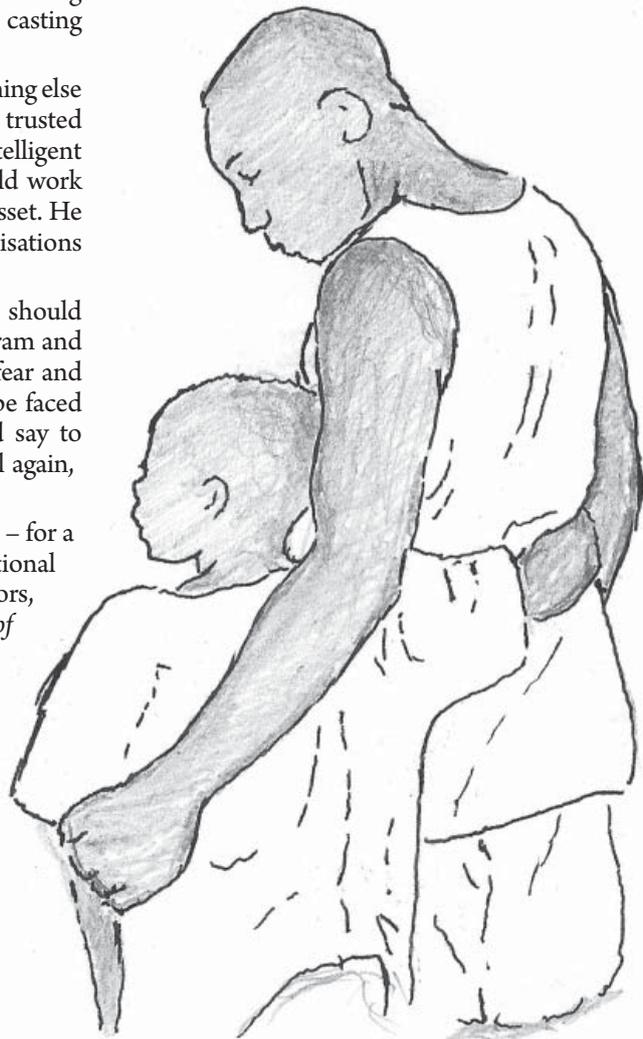
Why would others trust his intentions, though? Many religious leaders, unfortunately, condemned those with HIV, seeing it as a punishment for their (sexual) ‘sin.’ Some even pushed them out of their congregations, rejecting them. Well, thought Mgcoyi, we are going to do the exact opposite – and that’s the reason for the name *masangane*, which means ‘let us embrace.’ This first step, folding people *into* a congregation and community instead of casting them *out*, began to build a basis for trust.

Reverend Mgcoyi, as a boundary leader, offered something else too. Through his congregations, he had immediate and trusted access to communities in which they existed. He was intelligent enough to know that his position, if used properly, could work towards breaking stigma and turn religion into a health asset. He was thus able to gain the trust of *other* people and organisations that *Masangane* needed.

A second step was to decide that *Masangane* workers should as far as possible themselves be beneficiaries of the program and willing openly to share that they are HIV positive. The fear and stigma in the community and the wider society would be faced head on, but even more important, the workers could say to others, ‘See, I was dying and now I am healthy, beautiful again, and alive – you can trust what we are saying!’

The programme had to have the help of others though – for a trained nurse, financial support from sympathetic international churches, proposal and report writing skills, local doctors, and many others over time. It had to build a *wider web of trust* to be able to do its own work properly. And it had to make sure all these other people, organisations or institutions would trust that it was doing the work it claimed to be doing.

That’s a lot of trust to build and maintain! It requires a high level of accountability. In fact, to keep on holding that trust, with people who need its help, and with people who help it, *Masangane* has to live out of a deep accountability for the fullness of the life of those for whom it exists. That web of trust is literally priceless.



Paying attention to the social whole



Health and well-being cannot be simply about individuals. It has a great deal to do with our social reality too. Human beings are fundamentally social creatures. Every important choice we make is affected by others and has effects upon others.



Think about it: even if most major illnesses have specific causes, they are all social in various ways as well. Avian flu is a threat in the context of commercial chicken production; HIV is more likely in a fractured family structure or where there is gender inequality; smoking is cynically promoted using mass persuasion media aimed at the young; obesity is not just about bad food choices but also hidden economic and social conditions; violence is patterned, gendered, and located in gross disparities; most depression is deeply shaped by social and economic dynamics that affect emotional fitness for the journey of a person's life.



Each of these phenomena is social *before* it is personal, each is personal *in the context* of a social reality. Health is not merely a state of being, but a journey that integrates our social and personal lives from the day we are born. That journey is never apart from the journeys of others. So accountability means more than fulfilling rights and responsibilities for the needs or demands of the moment. It means taking a lifespan view, looking up and down the life journey people are on, even if only to ensure a smooth, good passage along the way.



Then accountability means shifting from a focus on the quality of an intervention in one place, to the best possible alignment with other people and institutions who care about advancing the quality of life for the whole – individuals, their families, and the communities that hold them – over a lifespan. The key question then becomes this: what advances the quality of life over the long haul, sustainably? That's a very high standard of accountability. Religion, as part of this and a key factor in many people's journey, should really then also be about informing a life journey in ways that enhance the well-being of the persons and societies within which they exist.



What kind of religion and what kind of health science or knowledge makes that more likely? What will support those common passions and enable the choices that lead to life? Those are guiding questions for what we call 'deep accountability.' It is the kind of accountability that is responsible, ultimately, to the totality of life together. This is because life, and not simply death, is at stake. This needs boundary leaders who are capable of moving across the divides of language, status, training, position, and spheres of life. People who see health as embodied in a larger, more vital social whole. People who can imagine not just healing past and present wounds but who can also nurture the conditions in which social life, whatever its turbulence, might expand to transform the present and generate the life that comes next.





The
Barefoot
Guide

to mobilizing
religious
health
assets
for
transformation



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Credits:

- P14: Quotes of Jonas Salk taken from <http://www.epidemicofhealth.org>.
- p97: The Leadership Competencies mindmap is partially adapted from Kate Wright et al, 'Competency Development in Public Health Leadership,' *American Journal of Public Health*, 2000, 90: 8, p1202ff.