When Religion and Health Align

Mobilising Religious Health Assets for Transformation

James R Cochrane, Barbara Schmid and Teresa Cutts (*editors*)
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Chapter Five

Boundary Leaders: Seeing and Leading in the Midst of the Whole

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The overarching goal of this paper is to advance thinking about leadership at the boundaries of faith and health. Gunderson speaks about this in terms of boundary leadership, which he describes as the capacity to ‘think, lead, and hope at the level of the whole system’ (2004:11). However, he does not address the ability ‘to see the self in the whole.’ Yet if a boundary leader sees the whole and its many parts, it is also critical—and this is my key claim—to perceive him or herself as one of those parts, to develop reflective capacities we can define in terms of the ‘contextual self,’ self-awareness, and ‘seeing our seeing’ (Gray 2008:68). Because this expands what we know about leadership, I shall also raise questions and pose considerations about forming, training, and developing leaders able to demonstrate this reflective capacity.

The experiences and model upon which I draw arise from the Institute for Public Health and Faith Collaborations (Kegler 2007). An initiative of the Interfaith Health Program (IHP) at Emory University, the Institute prepares teams of religious and public health leaders to address community scale conditions that perpetuate health disparities through systems change thinking, essential to solving ‘complex, interdependent, and messy’ public health problems such as safe water, HIV/AIDS, teen pregnancy, gender-based violence, and chronic diseases (Turning Point 2005:9). As the Institute curriculum has shaped my hypothesis considerably, I provide some background information on it. But the main focus of the paper is on what it means to see oneself in the whole as a critical aspect of boundary leadership. It develops this theme by exploring the general literature of leadership as well as seminal authors on formation/education underpinning this focus on the ability to see the self thus. I turn first to the Institute curriculum.

¹ This work would not have been possible without Gary Gunderson’s creative and insightful naming and mining of boundary leadership, Brad Gray’s extraordinary transformational leadership development, ARHAP’s respectful, supportive and generative collegial environment, and Fred Smith’s inspiring and empowering teaching and belief in human beings.
Institute for Public Health and Faith Collaborations

The Institute came about as a response to a 2002 request made by the Centers for Disease Control and Prevention (CDC), to the Interfaith Health Program, for the development of training that mobilised the strengths of the faith community together with public health. Work that informed the structure and content of the curriculum included Gunderson’s (2004) preliminary research on boundary leadership, a synthesis of collaborative leadership literature (Larson et al. 2002), community change models from public health (Institute of Medicine 2003), organisational and systems change knowledge, and best practices in leadership development.

The overarching aim of the Institute is to develop boundary leadership for community transformation in the elimination of health disparities, using a unique multi-sector, team-based leadership development model to train teams of religious and public health leaders from their respective communities. Evaluating the short term impact of the Institute, Kegler (2007) found significant growth in participant knowledge and skills in understanding the role of boundary leaders in community systems change.

Two design elements link the development of the individual leader with community change. One is the core design scaffolding which provides a structure for sequential application and integration of the learning at three levels—individual, team/organisation, and community. Over the course of the four days, activities direct individuals and/or the team to apply what they are learning to impact health disparities at each of these levels. David Kolb’s (1984) cycle of experiential learning is also used to build cognitive awareness and ability linking leadership awareness of self and team to understanding factors associated with community scale determinants of health. This includes getting participants and teams to consider their leadership role in dealing with the challenges inherent to the systems level change they are seeking, seeing themselves and their role in their community context, asking that they claim responsibility for that, and then developing an individual and team covenant for a half generation (ten year) vision and a plan for community transformation.

The key question I wish in particular to explore here is why boundary leaders capable of bringing about community transformation must take into account and see themselves as part of the whole system.

Recognising the Systems Nature of Health Challenges

First, it is important to clarify what is meant by the term ‘whole system’ in the context of the claim that leaders on the boundary of faith and health must see themselves in the midst of ‘the whole.’ I shall draw in particular on the works of Robert Kegan (1994), Bradley Gray (2008), and Sharon Daloz Parks (2005).
Parks, in her inspiring account of Ronald Heifetz’s leadership course at Harvard, offers the image of the chess board: ‘Leadership for today’s world requires enlarging one’s capacity to see the whole board, as in a chess match—to see the complex, often volatile interdependence among the multiple systems that constitute the new commons’ (2005:3). For those leading organisations, the perimeter of the whole is often not at the edges of the organisation itself, but beyond the organisation. For those leading in a community across and between the boundaries of faith and health structures, the perimeter of the whole can be extensive, in a state of flux, and comprised of many players.

Enlarging ones capacity to see and understand what constitutes ‘the whole’ is not a new idea. Research into the relationship between religion and health has demonstrated that some non-Western cultures have concepts in which the realities of both religion and health are contained, a conceptual framework rather different from that typically employed in the United States and Europe (ARHAP 2006). Researchers of the African Religious Health Assets Programme (ARHAP) who conducted participatory inquiry workshops in Lesotho discovered early on that community members did not have language for distinct entities of religion and health in their lives (Germond & Cochrane 2010). The ARHAP team then adopted a term from Sesotho, the predominant language in Lesotho, to address the issue. This is *bophelo*, which conveys the meaning of a whole, integrated self and in the largest sense, a ‘fully healthy society.’ This was then generalised by introducing a useful bridging conceptual framework, that of the ‘healthworld’, a term for describing the complex reality that shapes our perception of well-being (See the chapters by Germond & Cochrane, and by Lucy Gilson in this collection). Thus, I base my argument on the view that the whole is a system of systems that are interconnected and anything but static.

Today, in a variety of disciplines, there is an emergence of concepts that speak to a dynamic and interdependent quality of structures. Some of these are social networks, bonding and bridging social capital, social cohesion, social body, social integration, and webs of transformation. Increasingly, understanding the dynamic interdependent relationships amongst the parts of the whole is as important as seeing the whole itself. This relational dynamic is the core of Peter Senge’s (1990) contribution to systems thinking, or the *Fifth Discipline* as he calls it, the ‘antidote’ to the helplessness leaders feel in the face of complexity. Though originating in the organisational development and management world, his ideas have had widespread influence in other disciplines.

Senge and colleagues (2005) have continued to advance systems thinking even further in ways that also add to an understanding of the whole. They describe the whole as represented in the part, and understand a part not simply as a mechanistic, unrelated component but one with a holographic identity intimately related to the whole. Our human bodies represent this exquisitely. The nature of the relationships
amongst the parts of the whole system is highly relevant to the claim in this paper—that leaders see themselves as part of a community strategy to improve health.

One can see an expanding capacity and a deepening curiosity for recognising the dynamic connectivity in life. Robert Kegan, a developmental psychologist, speaks to this cognitive ability and maintains that there is a ‘pattern repeated in our structures of knowing—differentiation always precedes integration’ (1994:326). Though he references individual human development, one can see this dynamic mirrored historically in the capacity of collective human consciousness. Humans and our cultures are moving from a highly differentiated way of seeing the world to an integrating way of seeing and understanding the whole nature of life. The widespread adoption of systems thinking as a fifth discipline, the recognition of the concept of bophelo, and the development of ideas around healthworlds are all indicative of this movement and push us to think critically about leadership in the context of whole systems.

Language found in more recent public health and medical literature reflects similar systems and holistic thinking applied to understanding the nature of the health challenges of the 21st century—‘complex, interdependent, and messy’ (Turning Point 2005:9), ‘wicked problems’ (Kreuter 2004:441), ‘chaos theory’ and ‘complex adaptive systems’ (Resnicow 2008:1382), a ‘syndemics orientation’ (Milstein 2006:1), and ‘multilevel complexity and heterogeneity’ (Heng 2008:1581). Scholars and practitioners from a variety of disciplines are trying to create new terminologies and new concepts for understanding the emerging realisation of our interconnections and the complexity of whole systems. Ronald Heifetz (1994), in Leadership Without Easy Answers, speaks of adaptive challenges, that is situations and problem that cannot be solved using existing, predominantly technical knowledge, but requiring new knowledge and new ways of organizing human effort that may call for new roles and critical shifts in the balance of power.

Health disparities are multifaceted and derive from the interplay of complex systems. Heifetz’s and others insights about complexity and the challenge of systemically driven problems provide compelling grounds for particular leadership qualities.

In response to the recognised complexity of health challenges described above, a number of conceptual models and interventions have been developed to map the multiplicity of social conditions that influence health and to link their complex causal relationships. Most notable are the World Health Organization’s work on social determinants of health (WHO 2007), the CDC framework on the social environment and health (Anderson et al. 2003), the work of Nancy Krieger (2000) and other social epidemiologists, the Millennium Development Goals, and the common feature now in chronic disease prevention grant making that requires environmental and policy change strategies in the interventions.
Boundary leaders who serve at the intersection of faith and health, often in the commons, must draw upon this way of thinking and seeing to respond effectively to the challenges of health disparities. While we have increasingly better maps and language for the complexity of health inequities, we lack sufficient understanding of how to prepare, form, and develop leaders with the capacity to tackle these ‘complex, interdependent, messy’ public health problems.

**Leadership that Sees the Self in the Whole**

Having laid the groundwork for understanding the context that I suggest requires a particular kind of leadership, I turn now to examine more closely this capacity—to see self in the midst of the whole system. I begin with a case example of leaders who recognised the need intentionally to take themselves and their relationships into account.

A group of leaders of the Families and Youth 2000 collaborative in Pennsylvania, attempting to meet the complex needs of families in their community, see themselves as part of the problem and part of the solution (Rogers & Ronsheim, 1998). Over the course of more than seven years, leaders representing four African American churches, a neighborhood health centre, a church-based grassroots community organisation, and a counselling and therapy agency, learned together and began to reshape institutional relationships in their monthly meetings.

They identified the issues facing them as collaborating leaders—culture, control, race, and trust—and described the implications of these issues on their work:

> We recognise that these issues reside within us, as individuals, within each of the seven sites of the collaborative, and within the collaborative as a whole. The same issues have emerged repeatedly as the collaborative and its members have interacted with groups and institutions outside the collaborative. These issues play a major role in shaping public policy, congressional decisions, and world issues. (Rogers & Ronsheim 1998:108)

Their willingness to see and transform patterns of relating at the individual, organisational, and community levels over time had an impact. Across different systems and within institutional partnerships new kinds of resources were leveraged that supported a more expansive continuum of care for the families served in the East End of Pittsburgh.

The cornerstone of most leadership development programs is a session dedicated to a self-assessment inventory or personality profile. The starting point of developing oneself as a leader is: ‘Leader know thyself.’ A few examples illustrate this: Turning Point’s Leadership Development National Excellence Collaborative (2005) highlights self-reflection as the leadership practice at the heart of their curriculum. In the domain of faith-based community development, Bryan Myers
emphasises the need for leaders to be ‘ruthlessly self-aware’ (1999:158). Robert Linthicum (2006) takes this a step further when he suggests a sustained cycle of reflection and action to generate levels of increasingly substantive action; this leads over time to the deepest level of insight, the ability to recognise one’s complicity in the oppressive conditions that one seeks to change. In a course at Harvard called ‘Exercising Leadership: Mobilizing Group Resources,’ Heifetz uses the metaphor of ‘getting on the balcony’ to describe the practice of seeing what is really going on, seeing the patterns, and seeing the self as leader in those patterns (Parks 2005:52-53).

Instead of being overwhelming, seeing this dynamic interdependence of the whole of reality is a relief and yields new insights about effective actions that are liberating and less likely to reinforce the status quo and patterns of dominance. Transformation at many levels becomes possible when in the midst of seeing one ‘discovers a new relationship between self and the world’ (Parks 2005:70).

Robert Kegan (1994) is interested in what is required to meet the demands of modern and post-modern life. In his work, he employs a constructive developmental approach in a ‘subject-object’ theory to explain how humans develop and construct meaning. In this theory, he addresses capacities of self-awareness or consciousness that enable people to see themselves as subject and/or as object in the context of their life experiences and context.

Kegan’s work has informed Heifetz’s approach to leadership development and is important to this paper for two reasons. First, his emphasis on the current social and cultural demands we face and his questions about our ‘fitness’ to meet those demands are quite relevant to the role of a boundary leader exercising leadership in the complex public space of communities. Second, the ability to see ‘self as object’ makes possible a leader’s critical awareness of self and the embedded social context within which he or she leads.

The claim made in this paper is that one leads more effectively if one can see one’s part. When self is seen as object, one is able to see the relational dimensions of systems within which selves exist. With that knowledge, one can more successfully attend to the nature of human and structural relational contexts within which he or she exercises power.

Reverend Kirsten Peachey, a graduate of the Institute, has a wide lens vision of faith and health partnerships that exist throughout the city of Chicago. At a meeting in June 2009, she demonstrated the ability, as Heifetz would say, to ‘see from the balcony’ and then engage on the dance floor while integrating this view. She and her co-leader of the Center for Faith and Community Health Transformation were invited to be in dialogue with a coalition of Jewish agencies, rabbis, and advocates. The purpose of the meeting was to discover potential common ground and ways that developing faith and health partnership relationships in the city could include the Jewish community.
At one point in the meeting, during an energetic discussion about language, specifically the use of the word ‘faith,’ Reverend Peachey responded to the group’s claim that this word was not meaningful to them: ‘We understand that we have not done the work to prepare the way for the partnership relationship’ (author’s personal notes). Her response came from critically reflecting on ways that her own religious location, biases, and language, perhaps institutionalised in the Center, might limit the potential relationship field by excluding others. On the spot, she recognised herself as part of the problem (object) but remained in the engagement as part of the solution (subject). This can and most likely did have an impact on trust and power relations across the groups represented in the room. A boundary leader such as Reverend Peachey, hoping for change at the level of the whole, attentively and courageously attends to seeing self in the multi-dimensional whole.

Scholars and practitioners in the broad field of organisational development have been critical interpreters of the new reality of the 21st century and developers of pragmatic conceptual tools for leaders facing today’s challenges. Leaders at the intersection of faith and health, tackling the seemingly intractable, complex, systemic factors underlying health inequities, can benefit from these contributions. Understanding complexity, the interdependent and relational nature of reality, and the role of one’s self in the midst of that whole are vital to boundary leadership.

**Liberative Pedagogy**

Having built the case for the community whole-system context of leadership and how essential it is for leaders to see themselves as part of that context, I turn now to explore approaches germane to the training and formation of boundary leaders. Here Paulo Freire, Thomas Groome, and Mary Elizabeth Moore each provide important pedagogical insights relevant to preparing leaders capable of tackling social, systemic factors that undergird health disparities. Their work makes a distinct contribution to thinking about how emerging and practicing leaders can acquire or develop the skills to see themselves as part of the whole system.

Paulo Freire’s (1970) focus on critical thinking, ‘conscientisation,’ is congruent with the leadership capacity needed for the kind of social analysis that ignites systems change. Freire was deeply committed to releasing the oppressed through praxis education. Though Freire’s direct application of this approach was literacy education, his vision was the social and political means for the oppressed to become fully human.

Once the individual selves become the subject of their seeing and learning, they can and must take on a different level of responsibility for the social circumstances of their life. Through the dialogic approach to education, those who have been oppressed also ‘discover themselves to be “hosts” of the oppressor’ and are then able to ‘contribute to the
midwifery of their liberating pedagogy’ (Freire 1970:48). Teacher and
learners simultaneously become the objects of their own learning as
subjects, and agents of transformation. Freire’s path to liberation has
important implications for leadership at the level of the whole and seeing
self in the midst of that whole.

Like Freire, Groome (1980), is committed to dialogue centred
education as a means to promote human freedom. Groome’s ‘shared
Christian praxis’ is distinguished by its critical engagement with the
Christian story and vision in community as well as deep reflection into what
he calls ‘present action.’ The foundational beginning point of shared
Christian praxis, present action, is of the ‘whole human engagement
in the world’ (1980:184). This centre of embodied learning, Groome
says, ‘includes what we are doing physically, emotionally, intellectually,
and spiritually as we live on personal, interpersonal, and social levels’
(1980:185). Groome’s view of the comprehensive nature of reality and
of being human is where he situates critical reflection. For him this
consists of the lived and past socio-cultural context of self, others in
group dialogue, the lived and historical Christian story, and the vision
that emerges from that story. He locates the learner-practitioner in the
context of a dynamic whole system.

Mary Elizabeth Moore, a well-known religious educator, also sees the
comprehensive nature of reality as context for learning and teaching
and emphasises a commitment to what she calls ‘organic teaching’ and
‘organic theology’ (1998:2-3). This is a commitment to a ‘dream for the
art of teaching to be practiced in such an organic way that people are
connected with themselves, with one another, with social systems, with the
earth, and with transcendent reality’ (1998:2). The integrative, holistic
nature of Moore’s approach to education is grounded in process theology
and affirms the effort in this paper to locate questions of leadership in
the context of whole systems.

Moore (1998) places liberative teaching, specifically Freire’s
conscientising method, in a re-forming dialogue with process theology.
Liberative education, as understood by Moore, entails ‘opening our
eyes to those realities that we have denied, opening our ears to those
voices who wish to name their own realities, and opening our hearts to
receive others and to enter partnerships with them in their struggles

Moore finds that the purpose of education in conscientisation has
much in common with process theology and yet has insights about
ways the engagement expands the liberative teaching form. A process
approach would require defining social problems in ways that take into
consideration how complex, interdependent, and changing the realities
of life actually are. This means allowing room for different kinds of
voices and meaning, for ‘tentativeness,’ for views that are incomplete
or partial, and for multiple action strategies. For Moore, all elements of
creation must be seen and named—the earth, climate, and geography as integral to the ‘web of social relationships’ (1998:186).

These three educators share a number of core philosophical threads: the priority of freeing persons to a full, authentic life, and the necessity of a critical engagement with the learner-defined, larger social and ecological reality of their world. Critical thinking approaches and consideration of the social environment as essential to the context for learning, back us into taking into account the liberatory needs of the leaders themselves. This mutuality points to including leaders as part of the whole system being necessary for the health of all, both community and leader.

**ANALYSIS**

The conceptual terrain covered in this paper is broad and as complex as the human and structural challenges it seeks to engage. As the goals are to add clarity to particular characteristics of leaders and to expand knowledge of how to prepare and train leaders, to focus the analysis I will further use the lenses of leadership capacity and of educational methods.

There are at least three threads of ideas critical to the kind of leadership needed for self and community transformation. The first is a kind of self-consciousness that enables leaders to see more clearly the ways in which their personal strengths, challenges, and actions contribute to building liberative social structures or reinforcing oppressive ones. Leaders with this capacity take opportunities to foster this for others and for themselves. Many of the authors cited characterise this as the need to ‘risk seeing.’ Walter Wink (1992) speaks to a kind of seeing capable of dismantling self-preserving understandings of the world we create.

The second thread of ideas critical to boundary leadership is the relational nature of being. This relational dynamic now permeates systems thinking and is becoming more common in the health sciences with emerging research into the social determinants of health that reveals the complex interrelationships between individuals, communities, cultures, and institutions. The biblical vision of *shalom* embodies wholeness, a connectedness within creation based on a bi-directional relationship of mutuality and interdependence (Brueggemann 1982:15). As one cannot be free or healthy at the expense of another’s freedom or health, so leaders are not separate from the whole system.

Relationality and interdependence are linked to the third critical idea—scale and complexity. Douglas Ronsheim and colleagues are aware that the ways they relate as individual leaders have implications for how their organisations serve families as well as larger resource flow issues dictated by the macro-level influence of social policies. A social determinants of health model, particularly as expressed in the WHO commission’s framework (2007), best represents the complexity of social forces and structures that influence health. The Institute design, which
uses a social determinants approach, embeds the covenant an individual makes within the creation of a shared team covenant; these covenants in turn give rise to the shared vision that guides the team’s community change strategies. An additional characteristic of this complexity is the changing, fluid nature of reality. This dimension is addressed in Heifetz’s views on adaptive leadership and challenges.

Having sketched the three key points regarding the nature of transformational leadership, let me now consider the educational methods that address these leadership issues.

What promise does the Institute, and liberative teaching, hold for advancing the preparation of leaders? The most obvious is experiential learning and praxis-based education. The kind of critical thinking and analysis that drives praxis-based education is essential for looking beyond superficial technical solutions to the complexities that undergird health disparities. In addition, liberative education is built on a philosophy that supports human becoming—needed for both the oppressed and oppressors—and assists in dismantling unconscious complicity.

Another promise is team-based leadership development or shared praxis. Seeing self in the context of the whole system and community can be experienced directly in this kind of learning environment. Groome’s shared praxis is consistent with this kind of dynamic learning in community. When a learning experience begins with an individual personality profile that is then applied in the context of interactions with other leaders, it is much easier to build the capacity to see self as object in relationship. Similarly, learning and seeing that happens at the depth of the kind of communal lament that is required in the face of health disparities is more likely to occur through shared praxis (on communal lament in the face of health disparities, see Emilie Townes 1998:24). Moreover, learning with multiple local sectoral representation on a team provides a more direct means of working with a larger and more complex conceptual map of factors influencing health outcomes.

Similarly, it is also essential for a curriculum scaffolding to include learning explicitly integrated at multiple levels: self, team and other leaders, organisations, and community and society. Like team-based learning, this makes it possible for critical awareness of self in the midst of the whole to be developed.

Another method relevant to the leadership capacity in question is found in how the Institute curriculum is constructed around a set of core, shared values. Team learning activities are explicitly linked to one of these values. Having this common understanding of the meaning of their shared commitments creates a learning environment that fosters the trust and risk necessary for a truly transformational vision and action. It makes possible risking seeing, the uncovering of biases and delusional assumptions, a journey of communal lament, and healing of history—all essential thresholds for reimagining the future rather than recreating what we already have.
The examination undertaken in this paper affirms, even with an obvious bias, aspects of the Institute curriculum that contribute to building the leadership capacity in question. Despite this contribution and the strength of the support from liberative teaching, there is, however, still no easy or simple way forward for a number of reasons. The development of this kind of higher order consciousness rarely happens in a semester and for only a few in a yearlong leadership development program; for many it is a lifelong process. Further, the ability to see oneself as part of the whole system, while an essential quality, is not the only leadership quality needed for tackling the embedded, systemic social determinants of health. It is apparent too that Kegan’s (1994) central question, ‘Are we preparing leaders for the actual curriculum of life?’ needs further attention by educators. While we do know more about what challenges leaders face than how to engage those challenges, the concept of seeing self in the midst of the whole system is a capacity that does hold promise for meeting those challenges.

I propose two issues for further consideration. One is derived from reflecting on the work of Rogers & Ronsheim (1998) and their colleagues in Pittsburgh. Ronsheim and at least one other leader in the collaborative come from a pastoral counselling background. They are creatively applying a therapeutic, systems thinking approach derived from their pastoral counselling training to the socio-political environment occupied by their organisations. As a result, they appear to be able to leverage deeper levels of systems change around some of the issues relevant and critical to health disparities—race and power. I recommend exploring ways of building an integrative bridge between human development and therapeutic ways of thinking on the one hand, and more macro socio-political approaches to community change on the other. Both may be vital to understanding and forming boundary leadership capable of community transformation.

The second issue takes the form of a question and a challenge for additional thinking. Seeing self as object, as part of community transformation, requires moving beyond self. Though beyond the scope of this paper and my expertise, the question is this: how do we understand the unique contribution religion or spirituality makes when leaders are able to exercise this kind of self-transcendence?

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