When Religion and Health Align

Mobilising Religious Health Assets for Transformation

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Boundary Leadership is an approach to leading and influencing human systems that embodies a different way of seeing the edges, boundaries, gaps and discontinuities, as well as the social wholes, in which people live. This different way of seeing is useful in times such as ours that seem filled with anxiety about apparent disorder or discontinuity. And, I will argue, it is highly relevant for leaders who seek to mobilise religious health assets for transformation.

Boundary leadership emerged as an idea in the early 1990s in the work of the Interfaith Health Program (IHP) at The Carter Center in Atlanta (see Gunderson 1999, Gunderson & Pray 2006). It was a way of describing the work of people who, largely outside and away from the institutional centres of power, lend their lives to improving health in the community, like public health field workers or clergy in smaller congregations. During interviews, people I call boundary leaders often described themselves in relatively pejorative terms—as being on the margins and hence marginalised and unappreciated. Working on the edges between the disciplines of faith and health, however, the IHP regarded precisely those margins as places of positive ferment. Here one is closer to the leadership that needs to emerge to be adequate to the public challenges of health, for the power centres are poorly adapted to navigating the discontinuities so visible in health.

Boundary leadership adopts a view of discontinuity much like that of the great physician, Jonas Salk, who thought that life moved constantly, if not steadily, through states of discontinuity. In Survival of the Wisest, Salk (1973:68ff.) observed that the human species had relatively few behaviours that were as hardwired as even highly evolved social species such as lions. Their colouring, feet, teeth, and social proclivities and behaviours are perfectly adapted for life in the African grasslands, as any Zebra prey comes to learn. Humans are not particularly well adapted physically for much, being slow, awkward, weak and naked. But they can
talk, think abstractly, imagine something new, and plan its embodiment. They are thus capable of social adaptations that allow them to fit into, even thrive, in many environments. Humans, Salk understood, held this positive adaptive power in their cultures, not in their genes. Culture may often not be quick to turn, but it is remarkably malleable and adaptable, even if in a process filled with anxiety and stress. Salk thought that it might even be possible for the human species to be wise enough to choose social patterns more fitting to what we now understand to be a closed environment on a limited planet, very different from the open grasslands in Africa where our journey as humans may well have begun.

Salk drew two curves that suggest successive cultural eras, one gently sloping up to a gap (era A), followed by another sloping away (era B). He suggested that a species such as ours finds ways and means to thrive in one era that may be quite different than behaviours fit for the next, noting that we currently live in the discontinuity between eras. In some sense, we always live between two eras, but some discontinuities offer up a greater challenge than others do. The greater the difference between eras, the more profound is the instability, the less clear the unknown path from one to the other. The gap between eras is not just empty time, but a point of inflection in which the path might bend away from the old toward life fit for the new (Salk 1973:16ff.).

Boundary leadership regards discontinuities as open space in which leadership is possible in ways different from times dominated by stable systems. Instability here is a good thing; it signals a broken-openness within which new things might find life. The point of inflection in Salk’s diagram, where one pattern in human communities changes into another, is turbulent, complex and uncertain. It can be an anxious time, even for those more likely to thrive in the new pattern than the old. The reality is that, beyond the present time, multiple futures compete for attention. Past and present experience, events and actions shape the momentum, trajectory, friction, viscosity, velocity of future
alternatives—all descriptors of change and motion. Boundary leadership likes motion, not stability. It views the fact that we are not hardwired into fixed behaviours as good news.

Alternative futures are determined by a critical mass of boundary leaders who create new patterns of hope, fear and confidence. It is hard to know what that critical mass is but, like other tipping points, it may be smaller than one might expect, given the catalytic role boundary leaders play between eras. If (a big if) their patterns of hope are adapted to reality, they endure and become the basis for new stable relationships. These, in turn, become the scaffolding for fresh institutions, systems and culture. The relationships make possible innovations and efficiencies reflecting multiple intelligences that are needed to perceive the path toward hope and survival. In the most nitty-gritty kind of way, they help the human community be ‘fit’ for the future or, as Jonas Salk would say, fit for life.

This logic was present when, in 2002, the Centers for Disease Control and Prevention (CDC) entered into a cooperative agreement with the IHP to develop a leadership training program that came to be known as the Institute for Faith and the Health of the Public (described by Mimi Kiser elsewhere in this volume). For example, forty-nine individuals in nine teams from Memphis were trained in three different offerings of the Institute. Many of these individuals, if not their teams, continue today to play significant roles in the unfolding pattern of faith and health work in Memphis—including the author, who (ironically for a boundary leader) holds a central positional role in one of the largest institutions in the region, Methodist LeBonheur Healthcare. It also is fair to view the growth of the Congregational Health Network in Memphis, explored elsewhere in this volume by Teresa Cutts, as a reflection and embodiment of the idea of boundary leadership.

This brief essay explores the way that boundary leadership, an idea built for discontinuity, now needs to be radicalised to resist being tamed to serve the interests of traditional, positional leaders, including those interested in the determinants of the health of such a complex form of life as a ‘public’. Public health, as a field of inquiry, proudly discovers and explains linear patterns and consequences, and has good tools for doing so. Nevertheless, this is not radical enough to explain the fluid and often non-linear dynamics of social reality. We are touching here on complexity theory, sometimes known as chaos theory (the classic introduction remains Gleick 1988), which takes seriously the non-linear nature of much of our reality, including the way health works. The language of causes, determinants, vectors and predictors are so Newtonian—better for bouncing balls than human systems in discontinuity. In a world upset at any moment by volcanoes, fissures a mile under the ocean, and evolving viruses, we need language better fit for discontinuity. My early volume on boundary leadership (let us call it BL 1.0) did not recognise this sufficiently, even if it was implicit.
BL 1.0 was born as an idea in the upland Piedmont region of Atlanta, Georgia, in an academic working environment of a Presidential Center. The image of the boundary zone was drawn from the vast tidal marshes of Glynn on the Georgia coast where every day the tides flow in and out (and up and down by nine or ten feet), feeding a wildly rich zone of life. It was an image that recognised the in-betweenness of boundaries, their character as places of great emergent vitality: places not marginal, but seminal, the zone where life emerges.

The problem of BL 1.0 was not inadequate conceptualisation of skills and behaviours. Boundary Leadership has always used a borrowed tool chest, turning familiar leadership tools toward different purposes than many have thought possible, the difference being in seeing what to use the tools for. For instance, BL 1.0 borrowed heavily from the forward thinking conceptualisation by Wright et al (2000) of ‘transformational competencies’ developed under the auspices of the Public Health Leadership Institute. Boundary Leadership took one more step, beyond the still parochial identity of ‘public health’ leadership, to declare boundary zones generally as the home for a new way of leading.

It turned out, however, that the language, if not the idea, of boundary leadership was capable of being tamed, to the point of turning a borderland fox into an institutional poodle. Someone in a classic ‘command, control and manipulate’ leadership role like an academic dean might be heard to describe themselves as a boundary leader, though mostly their job is to patrol boundaries and screen anything that threatens what is within them. Just as boundary leadership could borrow tools for more radical purposes, so could boundary leadership be harnessed for more traditional aims. The same tools can be used for opposite purposes depending on the lifeworld, or healthworld (Germond & Cochrane 2010), of those doing the talking and exercising power.

We need a model of a Boundary Leader 2.0, one marked by a conceptualisation of boundaries less easy to tame and more fit for the radical turbulence of our current discontinuities. The model may be said to be emerging from the mud of the Mississippi Delta in the city of Memphis, a site on that great river which drains 42% of the North American continent. This is a gritty land, fraught with deep historical and material burdens, in which many remain caught in gross disparities that have shaped generations and threaten those to come. Despite massive investments in health in the region, the overall health profile of the city’s population, with the deep inequalities it depicts, barely changes.
A discontinuity in this pattern would be very welcome indeed.

The photograph of a river here was taken by the author in 2008 near Jacksonville, Florida. From above the river looks like a kind of a line and it often serves as a boundary. The image becomes a useful metaphor for Boundary Leadership 2.0, as long as one begins fully to understand the nature of the liquid flow we call ‘a river.’

Between Memphis, Tennessee and West Memphis, Arkansas, a liquid mile away, the Mississippi meanders in much the same way. John Barry, in *Rising Tide* (1998: 38), describes the Mississippi thus:

> It roils. It follows no set course. Its waters and currents are not uniform. Rather, it moves south in layers and whorls, like an uncoiling rope made up of multitude of discrete fibers, each one following an independent and unpredictable path, each one separately and together snapping like a whip. It never has one current, one velocity. Even when the river is not in flood, one can sometimes see the surface in one spot one or two feet higher than the surface close by, while the water swirls about, as if trying to devour itself. Eddies of gigantic dimensions can develop, sometimes accompanied by great spiraling holes in the water.

Liquid reality is far more complex than the land through which it flows. And the complexity of human ecologies, including that linked to health, goes far beyond any river. In the Mississippi Delta, four major streams of health disparities are visible even to the naked eye: in the lives of frail elders; among vulnerable mothers and their even more vulnerable babies; among those living with predictable and preventable conditions such as diabetes (usually way too early in their lifespan); and in the traumas of those finding themselves tangled in emotional stresses severe enough to be disabling. These profound disparities are wicked tangles of conditions that are carried like debris on a river at flood. The cost to the lives of those caught directly in the currents, and to the existence of institutions in the path of the flood, can barely begin to be measured in currency, in ‘disability adjusted life years’, or in other such indicators. Each type of condition that marks the population of Memphis has its specialised analyses, its own programme guilds, and its own alternate futures, but they all flow in a common social channel that actually offers up a dynamic spray of possibilities for doing things differently in ways that may actually change the health profile of the city.

To hijack Barry’s description of the river, it is just as accurate to say that *disparities* move ‘in layers and whorls, like an uncoiling rope made up of multitude of discrete fibres, each one following an independent and unpredictable path, each one separately and together snapping like a whip.’ Although moving in wicked tangles, disparities do not evince one current or one velocity. In fact, they have no set course—they are a fluid discontinuity—and, seen differently, they open up space for the life work of boundary leaders who, wisely, would align living assets in ways that nurture emergent patterns of life. This way of thinking about
BL 2.0 extends the classic understanding of the public health field as the work of creating conditions favourable to health. Even trying and failing at work relevant to the demands of the next era is better than failing to be fit for it at all.

The four streams of health disparities mentioned, coursing at flood level through the Delta, are different from each other. Yet they share common social aetiologies. Unsurprisingly, many individuals and groups share more than one, sometimes all four conditions, over their lifespan. Because each of the conditions is currently analyzed by and served by professionals whose career takes shape primarily within the boundaries of only one of them, this tends to hide another critical fact—that the multiple trajectories of individuals and groups who experience the conditions depend on a common web of social assets and on how well those assets are shaped by and aligned with each other.

It is not obvious to a person working in paediatrics that they have any stake in understanding the social assets that are encountered by someone working in geriatrics; but clearly, they do. It is the work of boundary leaders to move into the turbulent flood that marks the field of health with a view to aligning these various strands and, given the way health is shaped by social and historical conditions (inequitably), recognizing the congruent need to align common community assets for mercy and justice (usually known in the health fields as ‘access’ and ‘health status change’, respectively). Boundary Leadership 2.0 is equipped for a more radical turbulence, still valuing vital in-between-ness, but also being comfortable with the disturbance, fluidity, and discontinuity that academic deans might find harder to tame.

Boundary Leadership 2.0 is informed by Zygmunt Bauman’s (2000:2) description of modern reality as ‘liquid’—defined more as in motion than not, it does not easily hold its shape nor fix space and time. BL 2.0 emphasises that human phenomena are not just in motion, but turbulent. That metaphor is instructive and important. Turbulence has a rich descriptive language emerging out of the study of liquid and gaseous flows (air moving over an aircraft wing, or liquid through a pipe). Researchers of turbulence focus on the edges between moving fluids or gases and the surfaces that constrain them, paying special attention to how and when the flow changes from a smooth (or ‘laminar’) state into a turbulent one (Moin & Kim 1997). The critical shifts occur on the edges. Boundary leaders, at home in fluid social environments, appreciate this expanded vocabulary, especially recognition of turbulence as a potentially positive attribute of moving phenomena, and the attention given to those edges.

BL 2.0 is also influenced by David Bohm’s (2002) confidence that discontinuity is tolerable because of what he calls an ‘implicate order’ driving large-scale adaptive change. Although any one life, family, city or people (or galaxy, for that matter) may well end, the greater flow of life moves toward a more complex, even beautiful, ordered whole. That
is the decisive point, the guiding paradigm, for 2.0 boundary leaders. But BL 2.0 also notes, as Bohm fails to do, that the implicate flow is far from even or regular, and that disorder shows surprising capacity to fight back against the obvious direction of order.

Certainly, in the Mississippi Delta region it is impossible to describe even a short span of decades without accounting for constant reversals against all logic and decency. Current reality is not made of the remnants of that which has not yet emerged into order, but is a conflict in real time, between forces that seem to need religious language to capture accurately the pathos of the struggle. Kreuter et al. (2004) once described some public health challenges as ‘wicked’ in their complexity, apologizing for the moral overtones. Susan Thistlethwaite, in a keynote speech to the IHP National Meeting in Atlanta in February, 2004 (personal experience), asked him to retract the apology, insisting that the full resonance of ‘wicked’ was actually appropriate in the face of disparities that need not be intractable, but that nevertheless persisted across generations.

BL 2.0 does not fear, but neither does it deny, that the boundary zones are contested and conflicted. With Bohm (2002), it appreciates that knowledge on the edge of the ultimate can only be known by going there, not alone but by seeking ‘participatory knowing’. In my earlier work on boundary leadership (BL 1.0, see Gunderson & Pray 2006), I identified a typology of felt strengths and weaknesses that many boundary leaders working in communities identified with including, for instance, having very broad networks of very thin relationships, leaving them feeling often lonely despite a thick contact list.

Reflecting neither a strength nor weakness, this is a functional expression of their way of life on the boundaries. BL 2.0 continues to stress such predictable life stresses (and rewards); they come with living and working in and on the boundaries, but they also deepen and broaden the mysteries of life. Participatory knowing is how we explore the bigger mysteries in which we move. Those working to improve the health of the public find plenty of mystery in the turbulent edges of work on the boundaries of health, faith, mercy, and justice. By radicalizing the turbulent nature of the boundary zones, BL 2.0 makes them even less predictable. That life cannot be known or described from the banks of the river (or the dean’s office suite), but only by participating in the turbulent. Again, the Mississippi River warns us about what that means. Thus, Barry (1998:26) describes the journey of one of the seminal Mississippi engineers who went down into, not across, the river, to find the truth of its liquid reality:

> Without light, Eads could not see the river. He felt it. The bottom sucked at him while the current embraced him in darkness and silence. The current also buffeted, whipped, bullied, pulled. A diver had to lean against it, push against it. Unlike the wind, it never let up. He later
wrote: ‘... I found the bed of the river, for at least three feet in depth, a moving mass and so unstable that, in endeavoring to find a footing on it beneath my feet, my feet penetrated through it until I could feel, although standing erect, the sand pushing past my hands driven by a current apparently as swift and rapid as that on the surface.’

Boundary Leaders move through places as filled with turbulence as any river.

The final move from BL 1.0 to BL 2.0 is the surprising discovery that the turbulence of human actions and systems holds inside organisational life as much as in community life. Coterminal, then, with the emerging ideas of BL 2.0 is another earlier conceptual framework, that of the Leading Causes of Life to which I refer below (Gunderson & Pray 2007). This confluence of concepts has had the effect of emphasizing the role that boundary leaders play in changing organisational life, just as BL 1.0 had emphasised change in realigning community assets. The fact that I work most days on the seventh floor of one of the larger faith-based hospital systems in the United States, responsible for relationships between the formal healthcare system and the surrounding communities for whom its services are intended, accounts for this dawning realisation.

The work of aligning assets is only fully grasped as the work of generative life in all its dimensions. Assets, whether they appear as solid institutions or liquid networks, are all social and alive. The institutions are liquid, too, while the networks have form. In teasing them all into new alignments, boundary leaders offer those in community, as well as those inside their organisational environs, a way to seek health and seek life simultaneously—or better, as essentially the same thing. BL 2.0 is a concept that helps leaders be accountable to the possibility of living their lives in the service of life.

For those working in the context of health, this helps clarify many possibilities, even as it takes away the false comfort of the walls formed by guilds, disciplines and logos. Health organisations—when aligned with community partners—have much more to work with than their tool chest of service lines and categorical programs; they can work with life and the can do so systematically, in a planful manner, intelligently. But the greatest health challenges require leaders to use blended intelligences that complement disease knowledge with life knowledge. Normal healthcare deals poorly with the majority of health challenges: the chronic conditions managed over time outside the walls and reach of medical professionals, the many recoveries people pass through (relational, physical), the many transitions they undergo (pregnancy, adolescence and the great life passages of job loss, retirement, marriage and the loss of marriage and the end of one’s life).

How can leaders work on the edge of such ultimate wonders? Life leadership begins by understanding that life processes are different from death processes, which are relatively simple: something breaks,
wears down, gets run over, or fails, for lack of fundamental needs (food, water, shelter, raw medical care). Life adapts, moves, chooses with a rich array of social strategies. Life’s adaptive vitality can be described in five concept-words that prevent leaders from collapsing into premature simplicity, so that they can be accountable for leading toward generative life. They are, once more:

**Connection.** Humans thrive in highly complex social connections—and in some way we die when our connections are filled with friction and fear. BL 2.0 health leaders build systems that connect patients to those that care, unite employees into webs of meaningful work and earn the trust of their communities.

**Coherence.** Humans live into and through meaning, which is held in story and symbol, not just data (but much stronger when the data support a true story!). BL 2.0 leaders’ whole lives are narratives—beyond just what they say. So is the life of the organisation they lead more than just what it says, and one can diagnostically ask of the work of any leader or institution: is it a story of life or primarily of instrumental survival?

**Agency.** Even in the most turbulent human crises, people choose—this and not that, now and not later—move, and act. A patient and family that feel their capacity to act can be agents in their own lives. Leaders, employees and physicians—even amid truly incoherent times and situations—can still act out of values that point toward life. And they can form and implement strategies that focus vital decisions.

**Generativity/Blessing.** We measure time in generations because each one generates the life of the next, just as it receives life from those who have gone before. Leaders alive to the flow of life across generations see the life of their organisation and community as part of a transgenerational whole, which opens decisions that serve those coming later.

**Hope.** Every health discipline knows that hope is responsible for profound variation in the efficacy of pills and programs. Alive to hope in their own lives, BL 2.0 leaders help their organisations and communities see the way forward without fear; allowing choices and commitments that serve life.

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