

“A Case Study on Holistic Health Development”

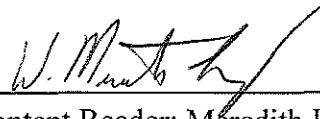
by

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Global Health as an international development field has seen great accomplishments throughout the proceeding century. For this century, new challenges have arisen such as HIV/AIDS, globalization, and health disparities; so too must our responses change. This paper will deal with Leadership and its need to adapt to the problems at hand. Because of the complex and interdependent nature of the current global health challenges a new form of leadership will be required. I will explore throughout this work the response that future leaders should take while examining the implications of a holistic health framework.

I think that the majority of health problems facing the field of Global Health are non-technical or adaptive. Ronald Heifetz's work on adaptive leadership sheds light on how to approach problems that are complex and interdependent. He draws several distinctions between problems that are technical versus adaptive. He describes technical problems as requiring the leader to define the problem and to provide the solution. The situation differs for adaptive leadership, first by identifying the adaptive challenge and then by framing the key questions and issues. Framing the key issues supposes that others must weigh in and problem solve before the issue can be addressed or overcome (Heifetz p128). When problems are non-technical or adaptive, a relational form of leadership is required because no single authority exists. These problems force us to address issues such as values and world view while collectively trying to make sense of the problem. These types of leadership challenges are amendable only by participation of all stakeholders.

Wilfred Drath has also outlined a concept of leadership as a community process, rather than an individual endeavor. "Instead of getting leadership by starting with some

kind of leader, what if you got leadership by starting with a community or workgroup or organization of people making sense and meaning of their work together?" (Drath) This questioning of leadership obviously blurs the line between leaders and followers in global health development. More importantly, this idea creates space for the two way learning that should take place in development projects. This type of learning is required so that communities can make sense of constructs such as social justice.

Health is a word that only has meaning within a societal context. Holistic health is relational in its construction of health within a relationship to self, community, and environment. Meredith Long describes holistic health as peace with creation, including its Creator (Health, Healing, and God's Kingdom). A holistic health framework provides leaders with avenues into spiritual competence and thereby access into some resources that are needed when confronting adaptive problems. Holistic health is not constrained by material or technical problems, but rather it has the ability to transform world views.

Holistic health opens the leadership perspective to a greater view of how to address adaptive problems. Adaptive problems, such as the exploitation of women as a result of a sex industry, require the assessment of how life is valued within that context. Who is responsible to lead such a massive undertaking such as changing cultural beliefs? How do we grapple with adaptive problems in global health?

This paper is a case study that draws distinctions between cases in their approach to answer some of these questions. The format of this paper will consist of four case studies. The contrast of these cases, and the manner in which they are portrayed, will shed light on how development should be approached. Each case is unique in the questions that it raises, yet they all overlap in a fashion that will convince the reader of

the need for value-based leadership. Two of the cases will address issues from a program level. I will present a positive and a negative case, each will point to either the presence or need for holistic development that comprehends adaptive problems. The remaining two cases are stories from an individual level that beg questions of how world view affects the sustainability of leadership.

Millions Saved or Opportunities Lost?

As Public Health students we are confronted with case studies and arguments that are often paradoxical in their assertions. We are instructed to look for a root cause of disease, but are often forced to study interventions that fall short of this mandate.

My evaluation of this case calls for an entire shift in paradigm. The paradigm represented in this case has limited good for the future, and is not holistic in its evaluation of the program. I will shift the context so that moral implications can be included when assessing this case. I will argue that though the program may have prevented some incidences of HIV transmission, it hardly constitutes a victory to be celebrated.

Ruth Levine, in her book, Millions Saved Proven Success in Global Health, sets out on a noble task to identify and advocate for global health work. The book produces 17 case studies of successes ranging from “Eradicating Smallpox” to “Curbing Tobacco Use in Poland.” My criticism rests not on Mrs. Levine’s intentions or her efforts, but rather on a greater concern of how we define success in Global health. I will address a specific case from her book as one example of the paradoxical messages we students often face.

The case is “Preventing HIV/AIDS and Sexually Transmitted Infections in Thailand.” The current need to address HIV globally will be considered assumed. The fact that in the early 1990’s, Thailand realized its responsibility to address the problem

must be highlighted. The case shows that the epidemiological work, centering on sentinel groups, proves the fact that Thailand was in a position to respond to the problem. Two measures of HIV case incidence rate increases were cited concerning the countries risk factors for an epidemic. These were a spike in the incidence of HIV in both prostitutes and military conscripts.

Levine's summary of the intervention:

In 1991, the National AIDS committee led by Thailand's prime minister implemented the "100 percent condom program," in which all sex workers in brothels were required to use condoms with clients. Health officials provided boxes of condoms free of charge, and local police held meetings with brothel owners and sex workers, despite the illegality of prostitution. Men seeking treatment for sexually transmitted infections (STIs) were asked to name the brothel they had used, and health officials would then visit the establishment to provide more information. (Levine pg 23)

From her conclusion, she is honest about her reservations regarding her case. It was this sense of reservation that first called my attention to the paradoxical nature of including the case in a book on global health victories.

The Thai experience in preventing the spread of HIV provides no blueprint for other countries, particularly those where the starting conditions may be very different. But it does suggest that major changes in deeply entrenched behaviors can be effected through targeted strategies, and it highlights the courage of political leaders who take risk to improve the public's health (Levine Page 29)

My concern is that she is commending this case for changing the wrong "deeply entrenched behavior" and misusing the "targeted strategies." It is paradoxical because on the one hand, if you say you can change deeply held behaviors, who decides what ones to go after? The political risk also mentioned here gives me pause to consider the controversial nature of the intervention.

So the "deeply entrenched behavior" that Levine is heralding is the use of condoms with sex workers. The "targeted strategies" were distribution of free condoms to

sex workers, with follow-up and continued surveillance from the public health workforce. And the “political risk” that she so admires was that the prime minister agreed to this program, which virtually subsidizes prostitution.

Levine outlines four points that she felt were crucial for making the 100 percent condom policy work. First, the sex industry is relatively structured. The Thai Government has had data on the industry since the 1960’s. Second, she listed the well run national health system which had the complement of “trained health workers, epidemiologists, and statisticians.” Third, she credits the cross sector collaboration of health authorities, provincial governors, and police. Finally, she credits the political and financial support of the prime minister. (Levine pg 28)

Prostitution was characterized in this case by the man who is credited for doing most of the epidemiological work for the program. Levine quotes Dr. Wiwat Rojanapithayakorn, former director of the Regional Office in Communicable Disease Control in Thailand’s Ratchaburi province, as saying “It is not possible to stop people from having sex with sex workers, so the most important thing is to make sure that sex is safe.” This quote is used to demonstrate that the root cause or risk factors for HIV, prostitution, were dismissed. I think it is a public health failure when the moral implications of our interventions are not considered. Further, it is a shame that the exploitation of women is considered the status quo.

Levine acknowledges the “political risk” by saying that investing in such interventions would clearly be interpreted as condoning the sex industry. However, it appears to me that no hazard was taken politically in view of the nature and history of the sex industry in Thailand. The government had no desire to address prostitution as the

problem and had in fact subsidized the industry. Condoms were given to the prostitutes at “their regular health checks in government-run clinics . . . (Levine pg 24).”

What I am trying to articulate is that there was clearly a laissez faire political culture concerning prostitution. What allowed for this culture to develop? What made prostitution so prevalent? Why not address these root causes rather than solely discuss transmission. One could ask questions regarding the status of women, women’s levels of education, their access to cash, and Thailand’s economic situation. There are multiple other levels of prevention, but sadly the case demonstrates a morally shortsighted approach.

I am frustrated by the fact that Levine equivocates regarding the merits of prevention throughout her presentation of the case, as this quote demonstrates:

The success of the strategy in slowing HIV transmission is due, at least in part, to the sheer scale and level of organization of the sex industry in Thailand, and the popularity of commercial sex among a wide cross-section of Thai men in the early years of the epidemic. However, Thailand’s public health officials acknowledge that the program has done little to encourage men and women in Thailand to use condoms in casual but noncommercial sex (Levine pg 28).

In an effort to not simplify the case, I must say that the prevention of HIV is not an easily distilled problem. The success of this program however was shortsighted, at best. The source of the problem is not the condom use of sex workers but rather that a society sustains such an industry. There are many different levels of attack on this problem but this case, which is being heralded as a successful approach, simply addresses transmission of HIV. The case does not even mention the underlying root causes that allow AIDS to be endemic.

What concerns me here is that we call a success a program which in hindsight only put a band-aid on Thailand’s gaping and expanding wound, HIV/AIDS. Sex and

morality is a politically risky topic, mainly because people are afraid to make value judgments. Another fearful reality from the case that bolsters this concern for proper value of human life is about the trafficking of women.

Although condom use reportedly remains very high among sex workers, there are also concerns about new sex workers, trafficked into Thailand from nearby countries. For these women access to health care, information, training, and even condoms may be limited (Levine pg 29).

Migration is known to be a risk factor for HIV, compounded by commercial sex work.

We should be outraged over issues such as poverty and the status of women, not diverted by policies or programs that simply addressed narrow views of these global problems. I argue that we must attack the even more “deeply entrenched beliefs” of prostitution and examine how the sex industry erodes a society’s dignity. The adaptive problem facing the Thailand society is the status of women

Jamkhed, Comprehensive Rural Development Project

The concern of the status of women is a broad development issue that is cross cutting in its implications for interventions. The Thailand case of a stable sex industry is a tangible example of the injustices that spring from the exploitation of women. Women are exploited in relation to cultural practices and values in other parts of the world as well. This case will focus on how a husband and wife team, Dr. and Dr. Arole, were able to address the condition of women in rural India. Listen to their sympathetic voices for the plight of women in India.

One sensitive and accurate indicator of the development of a society or a nation is the status of its women and children. In most countries of the world, women and children are exploited both socially and economically. Rural women, who live in abject poverty, bear the burden of childbearing and child rearing. Women have to do back-breaking work in the fields as well as in the households. Worse still, these tasks are performed under severe social restrictions and oppression which keep women and female children the most nutritionally deprived and deny them

access to education. They have little or no decision-making power or self-esteem, even when they are the main wage earners (Arole p 14).

We will consider the Arole's value based leadership as a model for how holistic health development should be undertaken. It has its roots in the value of human life and social justice. From its inception, this case was championed by locals, thus providing it a participatory structure throughout its history. The case, however, will be limited to "The Mahila Vikas Mandal," which means, women's development organization (WDO).

Doctors Mabelle and Rajanikant Arole had a true concern for the rural poor of India and began a practice in the village of Jamkhed in 1970. From this practice sprung the Comprehensive Rural Health Project. Their curative efforts were quickly overwhelmed by the great health needs of the villages. Because of their public health training they realized that strategies that addressed primary causes and health promotion would be the only way that they could abate some of the need for curative medicine. They began by training village health workers. The village health worker program mushroomed into many other development programs of which the WDO is only one example.

The Aroles brought a sense of equity, empowerment and integration that sustained their work in comprehensive health development. The WDO was born out of the community's identification of the need for such a group. The group was sustained through the self-interest inherent to the betterment of family health and income for the women involved. The groups were a place for the women to be heard, a place to share information, and a group for action.

These groups struggled to accomplish many things for their respective communities. They did income generation projects through financing programs, at the

formal and informal level. They enjoyed greater voice through their collectivization. They brought healing to themselves and each other by the solidarity that comes from group membership. They did literacy education for themselves and young girls for remediation in schools. They did health education on topics such as oral re-hydration solutions for children suffering from diarrhea. The Jamkhed example of WDO provides the women of the community redemption at the level of relationship to self, to others, and to the environment.

At the individual level, the groups were able to enhance the participants' sense of worth by giving them a sense of belonging. Additionally, the women had enhanced efficacy once confidence was built with successful group ventures into areas like health and income generation. The informal credit scheme that they adopted allowed them to undertake business ventures. These women were able to feel empowered to the point of entrepreneurs, because of the confidence that the group provided.

The WDO also helped restore the women's relationships at the community level. The women were able to band together to have greater political voice. Their political education campaign allowed them greater understanding of their legal rights, as well. This gave women great access to legal recourse, when previously oppression had been the prevailing status quo. This group solidarity moved them towards development issues that women face and made them a more visible stakeholder in policy development. Therefore, the women gained political voice for the first time.

The women began to use their voice in the communities to effect change. Because they were now educated about their rights they were empowered to stand up for

them. This testimony of a village woman reflects the sense of empowerment felt by the members of the WDO.

When men go to get a loan of five hundred rupees, they come back with only three hundred. They bribe the officials, or so they say, and they spend some money for their own entertainment. In the end, it is us women who have to work hard to pay back these loans. Now we know all this is not necessary. We walk to the bank so that we do not have to spend bus fare. We know exactly what is required and submit the necessary documents. We go as a group and the official is forced to give us the certificates without a bribe. We bring the money home and use it for the benefit of the family (Arole p194).

From a holistic standpoint, the WDO effected change at the environmental relationship level as well. The WDO did this by confronting major cultural practices, values, and beliefs. The status of women was the heart of the problem. By educating women, giving them access to health information, and providing income generation activities, the women's status rose.

Government officials from outside of Jamkhed noticed the difference. The WDO received a national award for work it had done in reforestation. The social forest department officer commented regarding the distinctions that he noticed in Jamkhed. He said, "You know, working in Jamkhed block is different from other blocks. People have a sense of justice here. They talk about right and wrong (Arole p 196)."

The Aroles are stopping short of nothing but health for all; they understand that to accomplish such goals, health programs must be comprehensive in their scope and reach. Their programs adapted to the problems and the solutions that the communities encountered together. Their leadership was based in moral values and social justice, for the marginalized, in this case, the women and children of rural India.

Frustrated Efforts

How does one's world view act to motivate or sustain involvement in leadership?

This negative case illustrates that when one's world view is frustrated, the result can be manifested anger and despair. In this case, disappointment erodes the sustainability of leadership. This case brings out the fact that some worldviews are constrained by disappointment, while others are hopeful for redemption.

For frame of reference, I will compare two systems that construct worldviews. An open system is one that allows for contributions and intervention from extra system forces. A closed system is a system constrained by its material resources. These two different systems can also have valuation or economic underpinnings. An open system is a system where a positive sum gain exists. Inversely a closed system is a one where a zero sum gain exists. I will regard an open system perspective as allowing for the redemptive powers of the Divine to transform reality.

The question for this negative case is "does hopelessness end in anger and despair?" As a case, I will refer to Katherine A. Dettwyler's deeply personal anthropologic work on malnutrition in Mali entitled, Dancing Skeletons Life and Death in West Africa. Dettwyler's honesty and openness about her own personal shortcomings should be identified as great work to advance sincere thought about the ethical dilemmas of global health. I applaud her courage to tell such a narrative, a story that seems like a catharsis for the deep wounds that she suffered while witnessing countless indignities to humanity in Mali.

I will talk about how she reacted to a situation and how she later processed her disappointment. This information will give us insight into her worldview and her perspective on global health. I will focus in on chapter 12 of her book entitled, "Dancing

Skeletons.” The chapter stage is set by Dettwyler’s use of a quote that seems to demonstrate her closed system philosophy. She quotes Henry Beston, “For a moment of night we have a glimpse of ourselves and of our world islanded in its stream of stars-... (Dettwyler p139).” I read this quote to mean that the world is alone, an “island,” and thus a closed system.

Dettwyler is an archetype for a materially constrained worldview because of her background in physical anthropology. Her eyes are capable of seeing the level of malnutrition in the village without recourse to instruments. In her honesty, Dettwyler realizes that it is her failure to turn off this limited perspective that separates her from others. She says regarding her ability to quickly assess health status, “The flipside, though, is that there’s no way to turn off this ability, to just see what other people see, to not be struck by the physical condition of the people who surround you (Dettwyler p140).”

Physical conditions are not the only requisite for health and they should not be the sole criteria for a successful program evaluation. In this case, the villagers were celebrating progress, but that joy was tainted, for Dettwyler by her world view.

The chapter tells of how she attended a party in the village of Macina, to celebrate its graduation from a CARE project. CARE had been working there in a number of different project areas in an effort to reduce childhood morbidity and mortality. The project was centered on clean drinking water. The project was complemented by work in oral re-hydration solutions, birth hygiene, tetanus immunizations for pregnant women, and sanitation efforts. The village had set up a great celebration to commemorate its graduation of the program.

But because of Dettwyler's limited perspective, one of a system of zero sum gain, she was disturbed when the children of the village began to dance. She interprets their energy expense, dancing, as an opportunity cost for growth and health. She loses heart and she recounts, "What's wrong with this picture? Suddenly, it dawned on me. The children – dancing with abandon, smiles on their faces- looked like dancing skeletons" (Dettwyler p 142)

Her response was, "I fled, in anger and horror, pushing my way past the dignified government men... I left chairs overturned in my wake. Hot tears coursed down my cheeks. . ." (Dettwyler p 143). Here, she reacts to an event that she believes on a deep level to be an injustice. She thinks, "How can these people be celebrating, when in fact they are malnourished?" Her anger is based on a limited definition of health, a definition that excludes spiritual health.

The chapter goes on to tell us that even after her initial reaction of shock, she still maintains a view that is fatalistic. Following the incident at the party, an argument with a coworker about her reasons for leaving included phrases like, "What difference will it make?" "It's not enough," and "...then you're just wasting everyone's time, money, and energy." Her argument also includes macro level determinants that the CARE program fails to address, but ultimately she is dealing with her own evaluation of their efforts. This is a questioning of her ability to sustain her personal involvement in the struggles of Mali's development.

The question is then how do we grapple with tragedy? These boys whose nutritional status render them as mere skeletons in the eyes of Dettwyler, how *should* they be perceived? She is looking at their physical depravity only, and overlooking their

spiritual wellbeing. This view has stark contrast to the fact that the children are happily dancing. How can we learn to dance with people and surrender our limited perspectives? I fear that we will continue to lose heart when our only evaluation criteria are purely physical. I posit that we will continue to be hopeless without a belief in redemption. Therefore, I suggest we look beyond material constraints and incorporate perspectives that include metaphysical definitions of health.

I agree that injustice, such as malnourishment, should call us to respond. However, we must not allow the negative and tragic components of the problem to frustrate our hope for the world's redemption. Our hopes must be steadfast in their origins and sustained in the face of tragedy. Dettwyler sees this tragedy of malnourished boys and responds according to her physical or materially constrained notion of the world. She does not embrace redemption, which in this situation is the tension between tragedy and the hope of victory. With a redemptive perspective, progress is evaluated on an eternal scale.

It is more hopeful and more sustainable for leadership to view the system in which we work as an open system that can produce positive sum gains. This world view is not constrained by opportunity cost, but is based on the serenity that anticipates God's redemption of humankind. This case underscores the need for spiritual competence in leadership.

Mission Doctor

I want to recount a story of personal courage that demonstrates what it means to take heart even in the face of tragedy. This story illustrates how an open system world view allows for transformative hope. It is a personal story of how the patient/doctor

relationship can be reciprocal in its healing. It demonstrates how hope and faith can be sustained in the face of the global TB epidemic.

I interviewed, Dr. John Boldt, because I personally admired his positive leadership presence. Dr. Boldt is a Christian physician, who practices pulmonary medicine in Ecuador. He was born a son of a Doctor and therefore early in his life he identified with science and man's need for medicine. He considers work in a developing country as honoring to God's concern for the poor. His international work flourished in July of 1993, when as a missionary with HCJB World Radio Ministries, and in conjunction with HCJB's Hospital Vozandes, he founded a TB clinic in Quito, Ecuador. His founding of the TB clinic is exemplary of initiative in leadership.

Sustained leadership is needed because TB is a deadly world problem. The Kaiser Family Foundation has global TB figures showing 1,693,051 deaths for the year 2004. For that same year they report that 14,602,353 people are living with TB. Another alarming number is the number of new cases of TB for that respective year at 8,918,203. TB is an infectious disease that developed countries have managed to control, however, it is a disease that is a component of the health-poverty cycle of developing countries. Endemic TB is a sign of material deprivation and poverty.

TB is medically curable, which makes subsequent deaths from TB heartbreaking. That grief is compounded by the fact that poverty and lack of proper medical care are breeding grounds for a more fatal version of TB. Multi drug resistant TB (MDRTB) is when the TB bacteria have mutated and become resistant to medications. This means that the normal course of medicine can no longer kill the bacteria.

Ecuador's prevalence for MDRTB is among the highest in Latin America. Dr. Boldt says, "What is frustrating is that with proper treatment and management, the disease is curable but with improper management and treatment the disease mutates into an incurable disease (Boldt)."

This makes MDRTB a grave prognosis in all countries, especially developing ones. In a study of MDRTB patients being treated in the USA, "Fully 46 percent of our patients with treatment failure or relapses died (Goble et al.)." This is a sad fact of MDRTB, for in juxtaposition, the normal TB patients in the US enjoy a near 100% cure rate.

In the interview, Dr Boldt volunteered a story that illustrated why he was able to sustain his work in spite of the harsh realities of TB in Ecuador. Dr. Boldt remembered a MDRTB patient named Juan. Juan made an eternal impression on Dr. Boldt, which served to undergird his faith in a transformative open system world view.

Juan's story is one of a patient who was compliant and faithful to the heavy regiment of treatment for MDRTB. He underwent many rounds of intensive chemotherapy. Juan's contact with Dr. Boldt and the mission hospital staff compelled him to realize the difference in what motivated their work. He began to attend a weekly Bible study lead by Dr. Boldt. Dr. Boldt built an extensive relationship with Juan as they struggled to treat his MDRTB. After bouts of improvements and regressions it was understood that the TB was not responding to the medication. Dr. Boldt felt the sharp inadequacy of science and the bitter grief of the imminent loss of his patient.

However this is not the end of the story, because redemption and healing fall on a different continuum when you consider an open system world view. This is a story that

demonstrates transformation of paradigm. Dr. Boldt remembers the joy he felt when Juan said to him, “Don’t worry that I can’t be physically cured, I have found peace with God and that is the treatment that has prepared me to die (Boldt).”

What is important to remember here is that Dr. Boldt told this story regarding his motivation to work. He is saying, “Look how redemption has reinforced my efforts.” He was at the point of despair and a patient ministered God’s love to him. Dr. Boldt’s world view allowed his heart to be open to the two-way healing of spiritual health. Having a patient express confidence and gratitude before death, proved to be a wellspring of encouragement. It is a demonstration of faith that calls us to attention. Dr. Boldt is able to confront death with a patient in a way that brings meaning to both of their respective lives.

Spiritual health is not bound by material deprivation. Faith matters, and in this case despite tragedy, Dr. Boldt is actually encouraged that Juan has found meaning in his life. Helping Juan deal with his death brought dignity to Dr. Boldt’s work. Being able to relate through faith brought healing to Dr. Boldt’s broken heart. Sharing a metaphysical faith in a transcendence of death bestows hope to Dr. Boldt amidst the attack of the Global TB epidemic.

This case is not only an example of good palliative care on the part of Dr. Boldt, but it also illustrates the importance of spiritual health in the context of treating the whole person. Spiritual health provides hope and encouragement to patients where physical health cannot.

Dr. Boldt has found a sustainable call for his work. He is motivated by faith that is antientropic, he does not think his efforts are in vain. The value for his work comes

from his faith in God and his belief that God cares for all things. He embraces a perspective that keeps an eye open for the emerging redemption that is only possible with an open system world view. This belief propels him to continue to treat the next TB patient, no matter how grave the prognosis.

Conclusion

We have seen in these cases that easy answers are not often afforded in global health development. When the definition of health is merely the absence of disease, the subsequent interventions are technical in their approach to ameliorate morbidity. As our understanding of the interdependent nature of health has progressed we are forced to confront the sustainability of both the outcomes and the delivery of interventions. Emerging concepts such as relational development and participatory methods have been considered as formal ways to incorporate moral value and social justice in the work of holistic health development. These methods place balance on power differentials between stakeholders, as well as allow for reciprocity in the restoration of relationships.

The need for such restoration was shown in the case entitled, "Frustrated Efforts." Dettwyler was estranged from the people she was serving because of her limited world view. The gap that divergent world views produce was then mended in the example entitled, "Mission Doctor." Dr. Boldt and Juan bore witness to the healing that comes from shared faith in a loving God.

Dr. Boldt's value based leadership was consistent with the Arole's concern for the poor and marginalized. The case, "Jamkhed Comprehensive Rural Development Project," illustrated that the redemption of women was predicated on a more just position in society. The Aroles were able to do this because they did not avoid the tough questions required to confront adaptive challenges. They sought to address root problems but in

doing so could only make headway once all stakeholders understood the implications of their limited world view. This meaning making was brought about because they fostered an environment of leadership as a process of participation by all members of society. In contrast, we saw from the case, “Millions Saved or Opportunities Lost?” that when the moral implications and the roots of problem are avoided that the situation will continue to fester.

Leadership does not take place in a vacuum. The idea for this paper sprang from the need to understand how to apply my public health training in the international development field. One avenue in the development field is within organizations that support the concept of Holistic health. Julie Berger did research on the organizational distinctions of religious NGO’s that defines the service dimensions of their work. Berger says regarding RNGO’s:

...most are concerned with the practical expressions of their religious beliefs and consider themselves duty bound to be a source of positive change in society. It is this sense of duty, or mission, which is rooted in and often defined by a particular religious or spiritual orientation. Although phrased somewhat differently, all religions command to “Love thy neighbor as thyself” – an exhortation which calls believers to look outside of themselves, to recognize the needs of others and, most importantly, to act. (Berger pg32-33)

Listen to Berger’s clear voice as an advocate for RNGO’s specific function, when she says they, “represent a unique concern with the spiritual and moral capacities of those they seek to serve – capacities at the root of people’s ability to transform their own condition and that of those around them (Burger pg37).” The capacities of the poor deserve attention when considering adaptive challenges. This paper has intended to draw attention to the fact that all people have value to add to the development of Global Health.

Unfortunately, in the West we give preeminence to material value and physical health at the exclusion of spiritual competence.

This paper addressed a concept of health that comes from the Biblical notion of Shalom or peace. The concept of health is accorded to right relationship with God and His creation. "Central to a holistic view of people is a deeply felt regard for their worth and potential (Long, Intro Soc Change)." Interventions to address adaptive problems require a belief in the potential of all stakeholders to make sense of the problem solution.

Long's idea of Holistic health as relational is in accord with perspectives such as Ronald J. Sider, a professor of theology at Palmer Theological Seminary in Pennsylvania. Sider said, "Persons are not just souls, or not just complex material machines. They're some profound mix of spiritual and material. The only way to get the most effective transformation is to work at every aspect of the person" (Boston Globe, Klein). This holistic health perspective therefore forces leadership to exam its spiritual competence.

I have learned that leadership is not a necessarily haughty or exalted position but rather it can be approached with humility. Now I better understand my personal responsibility as a leader in the Global Health community as described by Drath.

In other words, the individual is still there, as responsible and accountable and authorized as ever before. But this is an individual with an idea of participating in leadership-not creating leadership-and this feels more like being in service to the community(Robert Greenleaf) than it does like taking charge of the community. Such a leader may feel more humble about being a leader, maybe less likely to arrogate power and privilege, since leadership is understood not as something the individual brought to the position, rather as something the position brought to the individual. (Drath)

I believe that this foundation of humility will allow me to realize when my limited worldview must be amended in the process of leadership. I hope that the organization of which I am a part of will be able to learn from and adapt with the people we serve.

I also think that future leaders should be exposed to works such as those of Gary R. Gunderson, the Director of the Interfaith Health Program at the Emory School of Public Health. In his book, Boundary Leaders, Leadership Skills for People of Faith, he addresses public health workers who are working in the heat of adaptive leadership.

A boundary leader's spiritual competence rests on the ability to recognize God in the moment of surprise. There is something deeply spiritual in a mature expectation of the new, the unexpected, the unanticipated. This capacity is rooted in reverence for the capacity of the system to create amid shattered pieces. (Gunderson p131)

The competence to address shattered pieces is needed when confronting adaptive problems. I personally gather encouragement from the thought that God does indeed have concern for our plight, and what is even better is that He is actively redeeming the situation. My holistic definition of health informs my value based leadership. I have compassion for the broken pieces and tragic realities of Global Health, fueling my aspiration to work within a community of leadership.

Through this paper I have learned that value based leadership should be characterized by obligations toward the Divine and others, by a belief in transformative capacities, and a concern for justice and reconciliation. The cases have provided me with encouragement that these values can be incorporated into interventions. Berger has demonstrated that this work is being done in the RINGO sector. Drath has provided a leadership style based on participation that produces a form of humility, which resonates with my passion to see change. Heifetz has given us the permission to ask tough

questions rather than believing we already have all the answers. Finally Long's work in explaining holistic health affirms my sensibilities regarding the importance of faith and healing. It is my hope that this paper has also caused you to examine how your definition of both health and leadership affect your participation in Global Health.

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