RESOURCES FOR MODULE 2:

RELIGIOUS HEALTH ASSETS: SEEING & LEADING DIFFERENTLY

[WORKING WITH STRENGTHS]

What You Will & Won't Find Here

We do not cover the many writings on religion, religiosity, faith and/or spirituality in relation to health you can find. What we offer is material that expressly defines and articulates the concept of ***'religious health assets'****—the focus of this module.*

The origin of the concept, its development, and its application are closely linked to key contributors to this module, and many of the references are to their or their colleagues writings. These are supplemented by others that enrich, expand on, or otherwise describe what is meant by 'religious health assets'.

A secondary focus is on ***'boundary leadership'****. Also originating from key contributors to this module, it is key to how one most effectively identifies, leverages, or otherwise works with religious health assets in communities or institutions.*

The references include the following (in order):

- **A general text on 'religion/health'** *that* guides this module and a **Core text** on the *theory* lying behind it. p2
- A freely downloadable "**Barefoot Guide**" to *the* core text. p2
- 'What we have to work with ...: *p3-5*
  - '**On religious health assets** p3-4
  - **'On mapping religious health assets'** p4-5
  - '**On understanding 'healthworlds'** p5
- '**Boundary leadership'** p6-7
- **Additional resources** (supplementary) p7-11
- **Summary Distillation** of Key Concepts *(Briefing Note)* p12
- **Quick Access & Concept Introduction Videos** – list for module p14
- **Contents** of the general text, i.e., the *Handbook on Religion and Health: Pathways for a Turbulent Future* p15

All items are ***annotated*** *— this should help you determine whether or not you want to reference or use them.*

Items are marked as follows (those central to any full understanding of 'religious health assets' and 'boundary leadership' are highlighted in bold black)...

KEY

Bold black	- seminal readings (key concepts and theories)
Bold grey	- accessible, easy reading (to key concepts and theories)
Black	- additional resources (for class assignments, essays, research purposes)
Grey	- supplementary materials (incl. films, novels, websites, etc.)

Seminal Works

➡ GENERAL TEXT ON RELIGION/HEALTH

Cochrane JR, Gunderson GR, Cutts T, eds. *Handbook on religion and health: Pathways for a turbulent future.* Edward Elgar; 2024.

> "This *Handbook* arrives at a pivotal inflection point. [...] A disturbing mix of mistrust, apathy, and antipathy has clouded human interaction. [...] only by strengthening the human spirit [...] can we transcend these times and promote the adaptability, resilience, and regeneration needed to advance the future of public health. [Here] the editors are joined by several dozen similarly visionary authors to leverage a broad and fundamental paradigm shift for public health, to move beyond 'just resisting death to enhancing life' [to embrace instead] the comprehensive human assets model of the 'leading causes of life' [to] advance common goals, build non-traditional partnerships, promote basic spiritual and religious literacy for an increasingly diverse nation, and increase attention to innovative models for research, systems, and equity. [...] Re-building public health after the pandemic fundamentally means "encouraging the heart" as part of striving for a 'new normal.' [It] is the time for public health leaders to spark 'an epidemic of life' [...] to turn 'no hope' to 'new hope.'"
>
> - ***Afterword*, Howard Koh**
> Harvey V. Fineberg Professor of the Practice of Public Health Leadership
> Harvard T. H. Chan School of Public Health and the Harvard Kennedy School

➡ CORE TEXT (Modules 1 & 2) – Formal + Illustrated

*These two complementary texts, the main resource for the ideas at the heart of this module, are referenced more than once below. The **first**, a formal academic work, introduces the ideas in full. The **second**, freely downloadable, is based on the book, making it very accessible in simplified (but not dumbed-down) form, using evocative illustrations — ideal for classroom and teaching purposes, or for quick reference.*

Gunderson GR, Cochrane JR. *Religion and the health of the public: Shifting the paradigm.* Palgrave MacMillan; 2012.

> A comprehensive theoretical framework for understanding and working on the interface of religion and public health, drawing on global health history and practice. Calling for 'deep accountability' by health and religious leaders, it deals with 'the embodied religious mind', religious health assets, 'leading cause of life', boundary leadership, congregate strengths, and a healthy political economy, offering vital resources for increasing mutual understanding and focusing constructive cooperation in service of healthy societies.

Barefoot guide #3: *Mobilizing religious health assets for transformation.* The Barefoot Collective, 2012.

> [free download at: https://www.barefootguide.org/barefoot-guide-3---transforming-health-systems.html].

PART 1 • 'What we have to work with' – RELIGIOUS HEALTH ASSETS

- ***On "Religious Health Assets" (RHAs)***

The concept of RHAs integrates and applies several established approaches to community-based participatory research (CBPR) including asset-based community development (ABCD), 'appreciative inquiry', 'dialogical action', and 'rapid rural appraisal'. The readings, from its founders, detail the theory, practice, role & significance of RHAs, and related ideas like the 'human capabilities approach', 'spiritual capacities', and notions of 'legibility/illegibility'.

1. **'Religious health assets: What religion brings to the health of the public.' In: Gunderson GR, Cochrane JR. *Religion and the health of the public: Shifting the paradigm*. Palgrave MacMillan; 2012, pp. 41-58.**

   A culmination of research done over many years in Africa and the USA in particular, by the authors and their collaborators, beginning with the development of the concept and its application for the WHO in the face of HIV and AIDS in Zambia and Lesotho as well as separate research carried out in South Africa and Memphis, Tennessee, this explains the idea of religious health assets and its use (from 'Core text', p2).

2. **'What we have to work with: Mobilizing religious health assets.' In: Barefoot guide #3: *Mobilizing religious health assets for transformation*. Barefoot Collective, 2012, pp. 33-46. [free download at: https://www.barefootguide.org/barefoot-guide-3---transforming-health-systems.html].**

   Based on the book by Gunderson & Cochrane ('Core text', p2), this highly accessible yet conceptually rich guide introduces the idea, and mapping, of 'religious health assets' (with evocative illustrations by Teboho [Cagn] Cochrane).

3. **Gunderson GR, Cochrane JR. 'People who congregate: Building on Strengths.' In: *Religion and the health of the public: Shifting the paradigm*. Palgrave MacMillan; 2012, pp. 114-135 (Ch.6).**

   This chapter summarizes and extends Gunderson's earlier seminal work, *Deeply Woven Roots*, on eight strengths of congregations that contribute to their ability to play significant roles in health and well-being (see item 5 below).

4. **'Strengths of people who come together.' In: *Barefoot guide #3: Mobilizing religious health assets for transformation*. Barefoot Collective, 2012, pp. 75-84. [free download at: https://www.barefootguide.org/barefoot-guide-3---transforming-health-systems.html].**

   Highly accessible, based on the book by Gunderson & Cochrane (see 'Core text', p2).

5. **Gunderson GR. *Deeply woven roots: Improving the quality of life in your community*. Fortress Press; 1997.**

   This influential work describes how congregations, religious leaders, and concerned individuals can and do take practical steps to improve the health of their communities. It suggests that congregations are uniquely positioned to "feed the roots" that build and sustain community life in addressing such problems as violence, substance abuse, housing, nutrition, and public health. Eight 'strengths of congregations' are discussed: the strength to accompany, to convene, to connect, to tell stories, to give sanctuary, to bless, to pray, and to endure—all capable of bringing to bear singular powers that are available to people of faith in nurturing community life at its roots.

6. **Cutts T. The Memphis model: ARHAP theory comes to ground in the Congregational Health Network. In: Cochrane JR, Schmid B, Cutts T, eds. *When religion and health align: Mobilizing religious health assets for transformation*. Cluster Publications; 2010:193-209.**

Discusses the logic and design of an RHA approach, emphasizing the importance of working with existing community assets for health, in building the Congregational Health Network at Methodist LeBonheur Healthcare (MLH) in Memphis, TN, a patient-centered care network of (eventually) over 600 local congregations partnering in a covenant with MLH. The 'Memphis model' attracted the attention of the Obama White House and became nationally known for its approach, design and positive outcomes.

7. **Cochrane JR, Schmid B, Cutts T, eds. *When religion and health align: Mobilising religious health assets for transformation*. Cluster Publications; 2011.**

From a conference held in Cape Town with prominent international authors, the volume includes chapters on participatory inquiry in religion/health (see item 9 below) and others on the paradigm shift in global health, boundary leadership, case studies around HIV and AIDS, the role of faith-related organizations, the 'Memphis model' of faith/-health partnerships (see item 6 above), and 'faith at the table' of social transformation in public health.

8. **Cochrane JR. A model of integral development: Assessing and working with religious health assets. In: ter Haar G, ed. *Religion and development: Ways of transforming the world*. Hurst & Co.; Columbia University Press; 2011:231-252.**

Focusing on public health and recognizing that health, broadly understood, is a key variable as a measure of poverty and an indication of development, the article considers the role and potential of religious assets, material and non-material, including the agency of the human persons who think, make choices, behave and act in ways more often than not deeply connected to a particular religious worldview.

- ***On 'Mapping' RHAs***

1. **de Gruchy S, Cochrane JR, Olivier J, Matimelo S. Participatory inquiry on the interface between religion and public health: What does it achieve and what not? In: Cochrane JR, Schmid B, Cutts T, eds. *When religion and health align: Mobilizing religious health assets for transformation*. Cluster Publications; 2011:43-61.**

The definitive essay on religious health assets, networks and agency as understood and mapped at community level, using a highly innovative mix of integrated methods, in research carried out for the WHO. Includes an outline of the theoretical framework that governed the methods used, a step-by-step summary of the toolset, and a discussion of the nature of the research data that results from the use of the toolset, including what it can and cannot achieve. An essential companion to mapping RHAs.

2. **Cutts TF, Gunderson GR. Implications for public health systems and clinical practitioners: Strengths of congregations, religious health assets and Leading Causes of Life. In: Oman D, ed. *Why religion and spirituality matter for public health: Evidence, implications, and resources*. Springer International Publishing; 2018:323-340.**

This chapter sketches the historical background of the role of religious, public health and health system partnerships in improving health at community scale, from ending infectious disease epidemics to improving the health of the vulnerable, situating recent efforts against more than a century of public health practice. It describes the roles of public health professionals in fostering community partnerships between religious organizations and health systems and, drawing on case studies in Memphis and North Carolina, outlines seven key principles for religion/health partnerships drawing on the 'strengths of congregations', 'religious health assets', and 'Leading Causes of Life'.

3. **Cutts T, King R, Kesmarki M, et al. Community asset mapping: Integrating and engaging community and health systems. In: Cutts T, Cochrane JR, eds. *Stakeholder health: Insights into new systems of health*. Stakeholder Health Press; 2016:73-95:chap 6.**

> This chapter describes the history and specifications of select asset-based mapping methodologies, existing mapping tools, as well as their potential integration into the federally mandated Community Health Needs Assessments (CHNAs). It explores the potential use of mapping findings to build, nurture and enhance community health improvement efforts, and key strategies and considerations in use of these processes, with case studies to illustrate how asset mapping can help build meaningful clinical-community partnerships with health systems.

4. **African Religious Health Assets Programme.** ***Appreciating assets: The contribution of religion to Universal Access in Africa*****. 2006. October.**

> For three years research was carried out in Zambia and Lesotho for the World Health Organization by a consortium of scholars and graduate students from three universities in South Africa and Emory University in the USA, which produced the definitive, and most thorough exploration and analysis of the notion of tangible and intangible religious health assets as they appear in the life of local communities, including its implications for formal health systems.

5. **Olivier J, Cochrane JR, de Gruchy S, Wodon Q. Mapping religious community health assets and initiatives: Lessons from Zambia and Lesotho.** ***Mapping, cost, and reach to the poor of faith-inspired health care providers in sub-Saharan Africa: Strengthening the evidence for faith-inspired health engagement in Africa*****. World Bank; 2012:52-61.**

> A key goal in research in Zambia and Lesotho, commissioned by the World Health Organization (WHO), to understand the role of religion in the health-seeking strategies of local communities, and to map both the formal and informal HIV and AIDS initiatives in the process. was to go beyond standard quantitative measures (such as GIS mapping), towards a participatory community engagement model that qualitatively sought out local perspectives on the value and function of the mapped entities for the communities themselves. The model developed for the purpose, since used elsewhere, is described here, and key lessons outlined, including the challenges and strategies of mapping 'informal' community-level responses and initiatives.

- ***On understanding "Healthworlds"***

1. **Germond P, Cochrane JR. Healthworlds: Conceptualizing landscapes of health and healing.** ***Sociology*****. April 2010;44(2):307-324.**

> How people think about health and illness is not only multifaceted and conceptually complex; it leads to equally complex choices and behaviours in relation to healing. Stimulated by fieldwork in southern Africa and drawing on the idea of lifeworlds as developed principally by Jürgen Habermas, the notion of healthworlds (a conceptual innovation original to the authors) is introduced, explained and developed as a distinctive 'region' of the lifeworld defined by a particular *telos*, of comprehensive well-being, a lifeworld without dysfunction. A key analytical tool, it addresses the empirical complexity of health beliefs (including religious ones) and behaviours, and illuminates possibilities for improving health practice and outcomes.

2. Gilson L. The relevance of healthworlds to health system thinking about access. In: Cochrane JR, Schmid B, Cutts T, eds. *When religion and health align: Mobilising religious health assets for transformation*. Cluster Publications; 2011:164-177.

> From the perspective of a leading international health policy and systems researcher, the chapter elaborates on access, and considers the idea of 'healthworld' in relation to access and barriers to the delivery of healthcare, especially as regards questions of acceptability and trust, with implications for health systems in general.

PART 2 • BOUNDARY LEADERSHIP

1. **Gunderson GR. *Boundary leaders: Leadership skills for people of faith*. Fortress; 2004.**

   Not just for people of faith but anyone, this book defines and describes a pattern of life and leadership common among innovative, risk-ready people who find themselves living in the insecurity of the complex and contested space we can call boundary zones. Boundary leaders, they are found among those working in the heart of racism, AIDS, intractable public health catastrophes, and grinding poverty—but also in any and every institution or community where new ideas and a capacity to build transformative webs of relations turn out to be vital. Leadership able to cope with deep and stormy waters means being willing to live and learn with integrity 'at the boundaries', and it has profound implications for leadership at any and every level.

2. **'Boundary leadership: Embodying complexity in turbulence.' In: Gunderson GR, Cochrane JR. *Religion and the health of the public: Shifting the paradigm*. Palgrave MacMillan; 2012, pp. 136-157.**

   Extending Gunderson's original book on boundary leaders, this chapter outlines five key characteristics of boundary leaders: embracing the complexity of persons and systems; living with misunderstanding; creating bridges and keeping them open; engendering webs of transformation; and 'holding the negative valence'.

3. **'Boundary Leadership.' In: Barefoot guide #3: Mobilizing religious *health assets for transformation*. Barefoot Collective, 2012, pp. 85-100. [free download at: https://www.barefootguide.org/barefoot-guide-3---transforming-health-systems.html].**

   Based on the book by Gunderson & Cochrane (item 1 above), this concept

4. Barefoot guide #6: *Generative leadership: Releasing life in a turbulent world.* Barefoot Collective, 2019. [free download at: https://www.barefootguide.org/barefoot-guide-6---generative-leadership.html]

   Less about skills, techniques, or tools, and more about a different set of capabilities, this accessible manual aims at what one sees life doing even in the most hopeless situations. Curious about how life finds a way for the people, families, neighborhoods and natural systems, it is not about a new 'model' of leadership but about what it means to participate in generative, life-giving and life-enhancing leadership.

5. Cutts TF, Gunderson GR, Proeschold-Bell RJ, Swift R. The Life of Leaders: An Intensive Health Program for Clergy. *Journal of Religion and Health*. 2012;51:1317–1324. doi:10.1007/s10943-010-9436-6

   Clergy suffer from chronic disease rates higher than those of nonclergy. Health interventions for clergy are needed. Life of Leaders is a one, consisting of a two-day retreat of a comprehensive executive physical and leadership development process. Guiding principles include a focus on personal assets, multidisciplinary, integrated care, and an emphasis on the contexts of ministry for the poor and community leadership. Consistent with calls to intervene on clergy health across multiple ecological levels, Life of Leaders has potential for congregational and religious denominational change.

6. Taylor CT, Pearlstein SL, Stein MB. A tale of two systems: Testing a positive and negative valence systems framework to understand social disconnection across anxiety and depressive disorders. *J Affect Disord*. 2020; 266:207-214. doi:10.1016/j.jad.2020.01.041

   Studying how normative social connections develop and flourish, this article shares the results of testing both a positive and negative valence systems framework in relation to the social disconnection that is a common and pernicious, yet insufficiently addressed, feature of anxiety and depressive disorders.

7. **Gunderson, GR. Theogenerative life and practice. In: Cochrane JR, Gunderson GR, Cutts T, eds. *Handbook on religion and health: Pathways for a turbulent future*. Edward Elgar; 2024:97-112.**

> Health is one way people talk about their lives, and faith is another, not separate. But religion can be dangerous, so Gunderson evokes what he calls 'theogenerative practice', linked to boundary leadership. To add '*theo*', 'god' by any name, is to refer to an active agent in forming the character and choices made by people of faith that leads them to give themselves to generative work and practice in the first place. This, in turn, requires a 'mature' faith expressed in capacities for good that disrupt the status quo in favour of mercy and justice while drawing on 'relevant' science, measured by its capacity to extend mercy and justice through what it helps make possible. Theogenerative practice, crucially, is marked by humility not preachiness, curiosity not certainty, wonder not pride, and awe before mystery, as well as generosity. It informs 'competent practices' in public health and works as 'civic muscle' where it is needed.

8. Long KNG, Gregg RJ, VanderWeele TJ, Oman D, Laird LD. Boundary crossing: Meaningfully engaging religious traditions and religious institutions in public health. *Religions*. 2019;10(412):1-8. doi:10.3390/rel10070412

> This commentary outlines three challenges that impede more substantive engagement with religion and spirituality from the public health perspective: the controversial aspects of religion, the perception of religion as a private matter, and limited academic space for coursework on religion and spirituality within public health training. It offers a series of recommendations to foster better scholarship and praxis at the crossroads of public health, religion, and spirituality: forming interdisciplinary teams, engaging a wider body of literature, building relationships with faith-inspired colleagues and communities, and considering the goals and ends of communities we serve.

9. Wheatley MJ. *Leadership and the new science: Discovering order in a chaotic world*. 3rd ed. Berrett-Koehler Publishers; 2006.

> As 'old' as it is, Wheatley's contribution to the meaning of leadership in a complex world and social reality remains potent. For her relationships are what matters in life, a vast web of interconnections where cooperation and participation are required. This expanded edition provides examples of how non-linear networks and self-organizing systems are flourishing in the modern world in the midst of turbulence. She describes her book as a collection of intriguing maps, much like those used by the early explorers in search of new lands, enticing but not fully revealing, pointing in certain directions, illuminating landmarks, warning of dangers, but elusive enough to encourage others to explore and discover: "It's time to realize that we will never cope with this new world using our old maps. It is \our fundamental way of interpreting the world—our worldview—that must change. Only such a shift can give us the capacity to understand what's going on, and to respond wisely."

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* Additional resources *

— Specialized, helpful for essays and/or researchers —

MORE ON RELIGIOUS HEALTH ASSETS

1. Schmid B, Cochrane JR, Olivier J. Understanding religious health assets: Health as a lens on religion and development. In: Swart I, Rocher H, Green S, Erasmus J, eds. *Religion and social development in post-apartheid South Africa: Perspectives for critical engagement*. SUN Press; 2009:137-152.

> Considers the role of religious entities in social development, with public health and population health as the lens. Focusing on 'the health of the poor' (whom Paul Farmer, called the 'mine-shaft canaries of society'), it argues that what happens to them

affects all, including those objectively 'better-off'. In this regard, particular attention is given to the assets that religious groups bring to public health.

2. Foot J, Hopkins T. A glass half-full: How an asset approach can improve community health and well-being. 2009. *Improvement and Development Agency's Healthy Communities Programme, UK.* https://www.local.gov.uk/sites/default/files/documents/glass-half-full-how-asset-3db.pdf

   Concerned about the health gap between socio economic groups and resulting inequalities in life expectancy, illness and health and wellbeing, this official publication opens the door to new ways of thinking about and improving health and of responding to ill-health. Its first part makes the case that, besides needs and problems, marginalized communities also have social, cultural and material assets that, when identified and mobilized, can help them overcome the health challenges they face. The second part offers practitioners and politicians who apply the principles of community-driven development to challenge health inequalities, a set of coherent and structured techniques for putting asset principles and values into practice.

3. Glasgow Centre for Population Health. Asset based approaches for health improvement: redressing the balance. 2011. *Concepts Series*. https://www.gcph.co.uk/latest/publications/200-concepts-series-9-asset-based-approaches-for-health-improvement [*download*]

   Presents current evidence and thinking on asset-based approaches for health improvement, the background and rationale for these approaches, and the practical challenges of adopting these approaches in reality.

4. Cochrane JR. Religion in the health of migrant communities: Cultural assets or medical deficits? *Journal of Ethnic and Migration Studies*. May 2006;32(4):715-736. International Conference on Health and Migration (Oxford University, Queens University, University of Cape Town).

   Through a case study on local governance in South Africa – which highlights the complexities of migration, the impact this has on an already complex context of health care policy and provision, and the reality of compromised personal, familial and communal environments and weak support structures -- this article reassesses the importance of 'religious health assets' in understanding and responding to local contexts of health and health provision.

5. Kretzmann JP, McKnight JL. *Building communities from the inside out: A path toward finding and mobilizing a community's assets*. ACTA Publications; 1993.

   The famous grounding text on asset-based community development (ABCD), it outlines in simple, 'neighbourhood-friendly' terms what local communities can do for their own journey in asset-based development—rediscovering and mapping their assets, combining and mobilizing them as rediscovered strengths for stronger, more self-reliant communities—and how "outsiders" can contribute sensitively and effectively to the process of asset-based development.

MORE ON RELIGION/FAITH & HEALTH

[The *Handbook on Religion and Health: Pathways for a Turbulent Future* reflects on the current state of the field and its future, with chapters on 'health for all', 'the health of the whole', and narratives 'from the ground', as well as challenging standard categories and concepts in the field. A seminal work from leaders in the field, it is a basic text for understanding the relationship of religion/faith to community, public, population and planetary health and its future. Below are selected chapters of particular relevance for the module with, at the end of this document, a full *table of contents*.]

1. **Bersagel Braley M, 'Scanning a moving field: Religion and health,' in Cochrane JR, Gunderson GR, Cutts T, eds. *Handbook on religion and health: Pathways for a turbulent future*. Edward Elgar; 2024, pp. 31–46.**

   > A superb scan and analysis of major texts on three contemporary approaches to religion and health, including works edited, inter alia, by Harold Koenig, Doug Oman, Ellen Idler, and Dorothea Lüddeckens. It raises important questions not just about what we know but what we don't and need to know. The goal is to take the pulse of a maturing field of study by asking how its questions have evolved in an age that continues to resist, in practice if not in discourse, the binary of religious and secular.

2. **Oman D, ed. *Why religion and spirituality matter for public health: Evidence, implications, and resources*. Springer International; 2018.**

   > Reviews the exploding religion/spirituality (R/S) and health literature from a population health perspective, emphasizing the distinctive Public Health concern for promoting health and preventing disease in societies, nations, and communities, as well as individuals. Part I reviews mainstream biomedical and social scientific theory and evidence on R/S-health relations. In Part II, practitioners describe how attending to R/S factors enhances the work of clinicians and community health practitioners. Part III offers diverse short chapters by faculty who teach R/S-health connections in Schools of Public Health. It concludes with international and global perspectives.

3. **Cutts T, 'Religiosity/spirituality, mental health, substance abuse: Implications for population health,' in Cochrane JR, Gunderson GR, Cutts T, eds. *Handbook on religion and health: Pathways for a turbulent future*. Edward Elgar; 2024, pp. 62–77.**

   > Recent large-scale reviews uncover a favourable impact of aspects of R/S on both physical and mental health but tend to relate to individual models of care. Cutts emphasises what faith-based and health system partnerships can do to reduce disparities and promote mental and physical health at population health level, with a focus on integrating community-based care and health system clinical care and medicine with population health screenings, prevention and treatment for depression, anxiety, suicide prevention, substance abuse and adverse childhood events (ACES), as they intertwine with poverty, to build resilience

4. **Cochrane JR, 'Grounding religion and spirituality,' in Cochrane JR, Gunderson GR, Cutts T, eds. *Handbook on religion and health: Pathways for a turbulent future*. Edward Elgar; 2024, pp. 16–30.**

   > What enables us to experience 'religion' or 'spirituality' at all in the first place? Noting how diverse, even contradictory, particular religions or spiritualities are, how ambiguous in their impact, the chapter pursues this question by distinguishing the 'kernel' (what evokes religion/spirituality in us) from the 'husk' (its particular expressions in our life), locating the key to an answer in our 'creative freedom' and our unavoidable 'moral responsibility' for what we intend with our lives in the world.

MORE ON RELIGION & SPIRIT

1. Idler EL, ed. *Religion as a social determinant of public health: interdisciplinary inquiries*. Oxford University Press; 2014.

   > Religious institutions and public health institutions seek to improve the well-being of their communities, sometimes with aligned interests, but other times at odds. This book is the first to explore the intersection of these two social institutions.

2. Idler EL, Jalloh MF, Cochrane JR, Blevins J. Religion as a social force in health: Complexities and contradictions. *British Medical Journal*. 2023;(382):e076817. (doi: 10.1136/bmj-2023-076817)

> Discusses how durable partnerships with religious bodies can contribute to better population health outcomes, including the benefits and tensions this brings.

3. Long KNG, Gregg RJ, VanderWeele TJ, Oman D, Laird LD. Boundary crossing: Meaningfully engaging religious traditions and religious institutions in public health. *Religions*. 2019;10(412):1-8. doi:10.3390/rel10070412

> Outlines three challenges that impede more substantive engagement with religion and spirituality from the public health perspective: the controversial aspects of religion, the perception of religion as a private matter, and limited academic space for coursework around religion and spirituality within public health training. Recommendations include: forming interdisciplinary teams, engaging a wider body of literature, building relationships with faith-inspired colleagues and communities, and considering the goals and ends of communities we serve.

4. McGaughey DR, Cochrane JR. *The human spirit: Groundwork*. SUN Press; 2017.

> A collaborative work and valuable source for understanding the underpinnings of the concept of spirituality, the authors undertake the "audacious" task of reformulating how we think about Spirit. Focusing on 'our creative freedom', they deal with human capacities, the mind/brain issue, causality, free will, morality, consciousness, and beauty—asking what it means to be human and why that matters.

5. WHO Faith Network. See: https://www.who.int/groups/who-faith-network

ON PARTICULAR VIEWS FROM RELIGIONS/FAITH-TRADITIONS

1. **Interfaith America — Case Studies: Engaging Religious Diversity in Health Fields**

> Written in partnership with health fields faculty, medical practitioners, and bio-ethics students, these case studies describe real-life scenarios from health care settings in which religious identity plays a significant role.
> https://www.interfaithamerica.org/resources/case-studies-health-faith/

2. Idler EL, ed. *Religion as a social determinant of public health: Interdisciplinary inquiries*. Oxford University Press; 2014.

> A seminal work that explores the intersection of religious institutions and public health institutions in their common interest in the well-being of their communities, showing how potent religion often is as a social determinant of health. Of particular interest are Part I, which describes religious practices of ordinary people in several major faith traditions that provide daily, weekly, annual, and life course streams of influence on the body, mind, and spirit, and Part V, which looks at religion's role in addressing the ongoing epidemic threats of HIV/AIDS, pandemic influenza, and Alzheimer's disease.

3. Carr M, Sorajjakool S, Bursey E, eds, *World religions for healthcare professionals* (3rd Edition), Routledge; 2023.

> This helpful volume introduces healthcare students and professionals to a wide range of health beliefs and practices in nine major world religions, offering an insider's view on the religion's historical development and key beliefs and practices, including ideas of health, sickness, death, and dying. Introductory chapters consider the broad context of patient care in pluralistic society and explore one's personal orientation to others from different religions, paying attention, too, to appropriate professional boundaries. A new chapter, arising from the COVID-19 pandemic, considers the morally appropriate balance required when personal faith conflict with public health needs.

ON TEACHING

1. Cochrane, Cagn. *The unmeasurable heart: How to inspire a love of learning*. Unpublished, 2024. Available at: https://www.dropbox.com/scl/fi/701x00hes70l5z4ktarww/Unmeasurable-Heart.pdf?rlkey=u9eyvodmdk00d5c4fnxmkkr7o&st=xsri735n&dl=0

   > A potent story, it begins thus: "In all the metrics and measurements, on all the scales and statistics, in all the figures and charts and spreadsheets in all the world, Sophia shows up as a success. She has all the right attributes and does everything she is supposed to. She has grit, she has drive, she has ambition, she has discipline and diligence. She learns harder and faster than any of her peers, she listens, she comes on time, she is polite, she goes to the best schools and gets the best grades, and she ends up looking good on everyone's books, including her parents, her teachers, her schools, and her country. And yet she kills herself. This, I think, is what happens when you measure the wrong thing."

2. hooks b. *Teaching to transgress: Education as the practice of freedom*. Taylor & Francis; 2014.

   > How can we rethink teaching practices in the age of multiculturalism? What do we do about teachers who do not want to teach, and students who do not want to learn? How should we deal with racism and sexism in the classroom? Teaching to Transgress combines a practical knowledge of the classroom with a deeply felt connection to the world of emotions and feelings. A rare book about teachers and students it dares to raise critical questions about eras and rage, grief and reconciliation, and the future of teaching itself. "To educate as the practice of freedom", writes bell hooks, "is a way of teaching that anyone can learn."

OF SPECIAL GENERAL INTEREST

1. Graeber D, Wengrow D. *The dawn of everything: A new history of humanity*. Farrar, Straus and Giroux; 2021.

   > Written by a leading anthropologist and a renowned archaeologist, this extraordinary, norm-shattering picture of the astonishing diversity of how human societies arose over thousands of years, from the Palaeolithic to the Enlightenment, tears open one-dimensional views of a struggle between hierarchical and egalitarian values and practices. It is included here because it has significant implications for understanding of what was, and is, possible for us in thinking about public health and religion in relation to our most intractable ideas about hierarchy and equity. It raises the question of how we recover and exercise our capacities for flexibility and political creativity.

ON THE NEXT PAGE IS A 'BRIEFING NOTE'
THAT DISTILLS ALL THE CONCEPTS WE HAVE INTRODUCED.

This 'Briefing Note' summarizes a keynote address (see page 4, Cochrane JR, *Fundamental evaluation criteria in the medicine of the 21st Century*) given in Bayreuth, Germany, to some 16 universities and leaders of health systems (such as the UK's NHS) who, given fundamental shifts in demography, training, science, technology, and financing, were meeting after five years of research on what priorities would be needed in medicine in the 21st Century.

SUMMARY DISTILLATION OF KEY CONCEPTS IN RELATION TO 21st CENTURY HEALTHCARE

['Leading Cause of Life'/'Health Assets'/'Healthworlds'/ 'Boundary Leadership'/'Deep Accountability']

LCLI

Briefing Note

Evaluation criteria for priorities in medicine in the 21st Century: Leading causes of life

Key Messages

Transcending the limits of the science of pathology is the future.
An over-emphasis on needs, deficits, threats and pathology is a fault line.

The 'leading causes of life' is a promising lens for rethinking health.
This shift in language, with its implications for practice and research, offers a compelling framework for innovation.

Community assets for health, tangible and intangible, are key.
Health is a lifespan journey of individuals in communities who hold assets for their health that can and should be leveraged.

Understanding healthworlds helps avoid intervention failures.
The agency of health seekers, linked to their ways of seeing health and illness, is a crucial part of a healthy system.

'Boundary leadership' is crucial to enable innovation across silos.
Such leadership embraces complexity, and is willing to risk for the sake of the health of the whole.

Fully responsive/responsible health systems show 'deep accountability'.
Internal accountability for health services must be linked to external accountability to all relevant stakeholders, which requires trust and trustworthiness.

While huge strides have been made in the last century to understand and combat the various pathologies that threaten human health and life, **we have hardly begun to understand and encourage the processes that enable, sustain and enhance that life and its quality in the first place**.

A framework moving from the "leading causes of death" to the "leading causes of life" is the new, cutting-edge future of health science and practice – we see it in many new programmes that are rethinking health systems and re-imagining health care and its culture around the world. From it flow criteria for evaluating how we build the medical and health care systems of the 21st Century.

Here the "leading causes of life", a **shift in language with practical implications**, is a means to balance the overwhelming stress on needs, deficits, threats and pathology, while inspiring new research and break-through knowledge. Its elements, and related ideas on health assets, healthworlds, boundary leadership, and deep accountability, are outlined below.

Originating in work done in Africa for the World Health Organization[1], these ideas are also being concretely applied to health systems in Memphis[2] and North Carolina, and have fed into the USA Stakeholder Health[3] collaboration. Five key, interlinked 'leading causes of life' are advanced, each backed by substantive existing knowledge[4]:

LEADING CAUSES OF LIFE

Coherence – a meaningful story informing how we make sense of our life journey, and of how we care for it, and for those around us.

Connection – the complex social relationships and connections to one another by which we find life, building communities of various kinds to enable us to adapt to changing threats and opportunities.

Agency – having the will and the resourcefulness to act, expressing the full range of capabilities we have as human beings.

Intergenerativity – being affirmed from one generation to another, encouraged, strengthened and inspired in how we shape our lives by key individuals and valued groups or communities.

Hope – being able to imagine a different, healthier future and finding the energy to do something to try to bring it into being.

Extended Health Systems for Complex Patients in Complex Neighborhoods

Investigating and applying the full implications of a 'life', or generative, perspective on health systems of the future also implies rethinking how we conceive of what we mean by a health system:

- A fully adequate health system will take into account the lifespan journey of health across generations.
- Facilities (hospitals, clinics, etc.) will rethink their mission, practice, and accounting to include, say, the 30 days before, and the 30 days after, patients arrive at their doors.
- Because this clearly exceeds what facilities alone can do, it means entering into trustworthy partnerships with all relevant stakeholders beyond their walls, in communities.
- Then connections, agency, other assets, the healthworlds people live by, and boundary leadership matter.

Briefing Note on Evaluation Criteria for Medicine in the 21st Century: Leading Causes of Life

HEALTH ASSETS

Health assets extend well beyond visible, formal services, and include *tangible* and *intangible* resources and energies in communities that should be made visible and leveraged more effectively for greater individual and population health.

Because formal health systems, private or public, cannot and never will meet all the demands and needs, paying attention to the full range of assets available 'beyond the walls' of the facility, including community strengths, is of obvious consequence.

Crucially, intangible factors are also of considerable import for the effectiveness and efficiency of any service or intervention. Trust is one such; so are credibility, motivation, compassion, mentoring, accompaniment and more. Hard to measure, all nonetheless bear upon whether or not available health care is accessed, regarded as acceptable, or properly utilized, and on their affordability: how direct and indirect costs are carried and shared.

HEALTH-WORLDS

Agency, active engagement in using or leveraging an asset, is essential – and it belongs to provider and health-seeker.

Medical and health care providers and professionals largely see agency as residing with them. Yet durably effective interventions, at individual, community or public level, must also account for the agency of the health seeker. Here the world of the health seeker's individual or communal construction of health and illness and their etiology – their 'healthworld'[5] – often plays a key role in behaviour and choices.

Because the reception of interventions or services impacts on their utility and value, it is unhelpful – perhaps counter-productive – simply to insist on the agency, or power, of the health provider over the health seeker. Trust and credibility are won not by force, but by intelligent encounter.

BOUNDARY LEADER-SHIP

Boundary leadership nurtures innovation and transformation for the sake of the whole and the well-being of all.

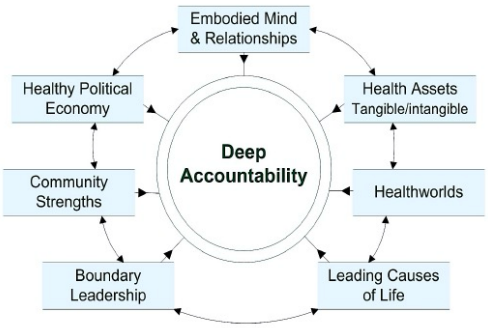
It means embracing complexity, moving beyond inflexible silos of practice and thought, being willing to risk the hopeful, looking for connections and greater coherence, nurturing the agency of others.

DEEP ACCOUNT-ABILITY

Deep accountability, beyond normal internal ('vertical') accountability protocols of health facilities or formal systems, takes proper account of all stakeholders through effective, durable forms of external ('horizontal') accountability.

This includes all involved in the journey of health, taking the complexity of that journey into account. The language of health assets, healthworlds and causes of life, and the patterns and processes they describe, helps describe that complexity. Best understood not in the light of a theory of disease, but in the context of a living person in a social system that is itself alive, it involves a 'blended intelligence' able to work with an ensemble of practices, each distinct but all impacting on the others [6].

An ensemble of interlinked practices



To learn more ...

[1] African Religious Health Assets Programme. (2006). Appreciating assets: the contribution of religion to Universal Access in Africa. Cape Town: ARHAP, Report for the WHO.
[2] Cutts, T. (2010). The Memphis model: ARHAP theory comes to ground in the Congregational Health Network. In J. R. Cochrane, B. Schmid & T. Cutts (Eds.), When religion and health align: mobilizing religious health assets for transformation (pp. 193-209). Cluster Publications.
[3] Health Systems Learning Group. (2013). Strategic investment in shared outcomes: transformative partnerships between health systems and communities. Washington DC: Health & Human Services/Robert Wood Johnson Foundation Leadership Summit.
[4] Gunderson, G. R. & Cochrane, J. R. (2012). Religion and the health of the public: shifting the paradigm. New York: Palgrave MacMillan. For a more narrative discussion, see also Gunderson, G. R. & Pray, L. (2006). Leading causes of life. Memphis, TN: The Center of Excellence in Faith and Health, Methodist Le Bonheur Healthcare.
[5] Germond, P. & Cochrane, J. R. (2010). Healthworlds: conceptualizing landscapes of health and healing. *Sociology*, 44(2), 307-324.
[6] Barefoot Guide #3 (basic, illustrated, covers all concepts): http://www.barefootguide.org/barefoot-guide-3.html

VIDEOS

— TEACHING AIDS FOR THE MODULE —

Three kinds of video aids are provided.

1. **Playbook Videos** (PBV), usually short, accompany and help explain some exercises that may otherwise not be clear enough for animateurs (teachers, facilitators, etc.).

2. **Quick Access Videos** (QAV), about 30-60 seconds, very briefly introduce specific concepts as a supplement text to the section and the items listed in the Resource file for the module.

3. **Concept Explanation Videos** (CIV), more substantial and roughly 3-5 minutes, are designed to help both the animateur and the learner gain a sense of particular concepts specific to the theoretical frameworks that inform the module (these are either original or used in an unusual way).

There is also ONE important *audio file*
for a "Primer exercise" for the whole module
in response to a question about the concept:
"Why 'Religious Health Assets'?"
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Video #	***Session title***	***Use for …***
CEV #1	"Why Faith Matters"	Introductory section (p16)
CEV #2	"Making a RHA Matrix"	Guidelines, some background (p23)
CEV #3	"Healthworlds"	"Meaning & Medicine" exercise (p32)

QAV #1	"FaithHealth History"	*Timeline* exercise (p21)
AUDIO	"Why 'religious health assets'?	Used for Primer exercise (P18)

NOTE: THE VIDEOS ARE LIKELY TO CHANGE OVER TIME AS THEY ARE IMPROVED

VIDEOS ARE WORK-IN-PROGRESS

Supplement - Contents of Handbook on Religion & Health

Cochrane JR, Gunderson GR, Cutts T, eds. *Handbook on religion and health: Pathways for a turbulent future*. Edward Elgar; 2024.

Intro: On (what was known as) religion and health [*James R. Cochrane, Teresa Cutts, & Gary R. Gunderson*]

PART I: 'RELIGION/HEALTH': SCOPING THE FIELD
1 Grounding "religion" and "spirituality [*James R. Cochrane*]
2 Scanning a moving field: religion and health [*Matthew Bersagel Braley*]
3 Religion among the social determinants of health: Micro-, meso-, and macro views [*Ellen Idler*]
4 Religiosity/spirituality, mental health, substance abuse: Implications for population health [*Teresa Cutts*]
5 Hoist by our own petard: backing slowly out of religion and development advocacy [*Jill Olivier*]
6 Theogenerative life and practice [*Gary R. Gunderson*]

PART II: PLANETARY HEALTH – "HEALTH OF THE WHOLE"
7 Spirituality, health, and ecology: Co-liberation, the climate movement, and the quest for planetary health [*Tobias Müller & Thandeka Cochrane*]
8 Interrelationship of religion and spirit in health, well-being, and equity [*Somava Saha*]
9 Bio-ethics for a whole planet [*Gerald R. Winslow*]
10 Infrastructures of hope: What will it take to build planetary health [*Geordan Shannon & Jeremy Lauer*]
11 Point of inflection: Epidemic of health [*Heather Wood Ion*]

PART III: 'HEALTH FOR ALL'
12 Health, interreligious action, and solidarity [*Katherine Marshall*]
13 Global health and religion [*Christoph Benn*]
14 Life and health of the public: A field in motion [*Kevin Barnett*]
15 The place of human rights and the people's health movement [*Leslie London*]
16 Faith-based health justice: What are the options? [*Ville Päivänsalo*]

PART IV: RELIGION/HEALTH FROM THE GROUND
17 Gendering religion and health: Women's religio-cultural vulnerability [*Beverley Haddad*
18 A founding moment: How members of religious congregations became AIDS activists [*Philippe Denis*]
19 Lifting the veil I – reflecting on Covid-19 in Africa [*Elias Kifon Bongmba*]
20 Lifting the veil II—religion at the intersection of food security, health and well-being: From the field [*Craig Stewart and Nadine Bowers Du Toit*]
21 Religion, spirituality, and interpersonal violence [*Naiema Taliep, Sandy Lazarus, & Marcellino Jonas*]

PART V: NEW LANGUAGE, NEW VIEW
22 Disingenuous narratives, cognitive myopia: A neuroscientist's view [*Paul Laurienti*
23 Meshworks, entanglements, and healthworlds [*Thandeka Cochrane*]
24 The ought that lies within [*Bastienne Klein*]
25 Communities emerging their potentials of faith and health [*Daniel C. Taylor*]
26 Searching for the spiritual sources of shared stewardship: Where can we find the courage to stay human in dehumanizing times? [*Bobby Milstein, Ella Auchincloss, & Jane Erickson*]
27 Positive deviance: New parables for healthy communities [*Arvind Singhal*]

PART VI BEYOND THE STREAM: RETHINKING KEY METAPHORS
28 The watershed of life: A river runs through it [Gary R. Gunderson, Teresa Cutts, & James R. Cochrane]

Afterword #1: A new knowledge for a new world [*Corey D. B. Walker*]
Afterword #2: Integrating and reimagining health and spirituality – a call for leadership [*Howard K. Koh*]