

Exploring Inner & Outer Geographies

A joint public health expedition with Namibia's African Public Health Leadership Initiative

A case study by DeeDee Yates for

INNER WORK *for*
SOCIAL CHANGE



Fetzer Institute



SYNERGOS

Building trust works

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The Inner Work for Social Change Project

Synergos and the Fetzer Institute began the project on Inner Work for Social Change in 2018 to demonstrate how Inner Work and Bridging Leadership can make social action towards a better world more effective. Through six commissioned case studies and in dialogue with thought leaders, development practitioners, and others, the project aims to spark a global conversation on how reflective practices can make social action more aware, more ethically attuned, and more sustainable.



Within the project, *inner work* is any form of reflective practice that increases awareness of self, others, and the systems in which complex social problems arise. Inner work is core to *bridging leadership*, which is the capacity and will to build trust and tap the fullest contributions of diverse stakeholders, helping them to come together across divides to work in concert for the common good.

About this case study

This case study looks back at the African Public Health Leadership Initiative (APHLI) implemented in Namibia from 2008–2013. The study used archival documentation including introductory interviews, workshop reports, and progress reports, in particular, a midterm progress evaluation conducted in 2010. In-depth interviews were conducted with seven individuals closely involved in the project.

The study investigates key episodes and events, as reflected through the memories, perceptions and experiences of key participants. It uses a modified most significant change methodology to tease out the critical components of the project, with specific reference to personal transformation as a grounding element for social transformation.



Prelude: Who are you? Who are we?

Namibia is a large semi-arid country of 2.4 million people¹ (2011 Census projections) spread over 824,000 square kilometers, scattered with the remnants of early geological upheavals and ancient human habitation, and the relics of 15th century sea explorers. It offers a fragile environment for pastoralists and hunter-gatherers, with subsistence farming following the few perennial rivers and the flood plains in the central northern regions. Bounded by two ancient deserts, crisscrossed with the tracks of diamond miners and early traders, colonized by Germany, ruled by South Africa after World War 1, it is now enjoying the benefits of independence achieved in 1990 after a 55-year freedom struggle.



Synergos staff member on a learning journey in maternity ward

In 2008, 18 years after independence, individuals were still living within their personal histories of segregation, discrimination, racism, violence and trauma. Entrenched gender inequality had resulted in high levels of gender-based violence. Inherited structural poverty and income inequality contributed to high levels of violent crime. In addition, Namibia was in the throes of the HIV epidemic, with prevalence rates above 20%, stigma and discrimination still apparent, and public access to life-saving treatment only just being rolled out. Adult and infant mortality were high, and multiple funerals over the weekend the norm.

This potentially toxic mix meant that violence, discrimination, serial bereavement, pain, and injury were common, with associated personal and familial trauma. This is the setting for the African Public Health Leadership Initiative (APHLI, also referred to as “the Initiative”) (2008–2013), which aimed to strengthen the leadership and systems of the country’s Ministry of Health and Social Services (MOHSS also referred to as “the Ministry”) by realigning stakeholder groups to focus capacity, unlock potential, and untangle complex systems.²

Before leaders in a complex system can attend to fixing elements of the system, they must first understand and address the multitude of personal narratives shaping patterns of behavior. As the Truth and Reconciliation Commission in South Africa showed, hidden hurts and trauma will continue to influence current behavior. In *The Book of Forgiving*, Desmond Tutu wrote, “Many people are disconnected from their feelings and their own experiences. This is often a result of old suffering.”³ In order to make progress in the outer realm of the health system, some personal Inner Work was required.

Kasee Ithana’s⁴ role as the project coordinator of the African Public Health Leadership Initiative in Namibia was to hold the space, provide leadership, and offer coaching and mentoring. She worked with senior leaders of the Ministry within the newly formed Leadership Development Forum (LDF, also referred to as “the Forum”) and later within the regional delivery units (RDUs, also referred to as the “delivery units”).

Many personal histories, particularly in post-conflict countries, contain some painful elements of oppression, racism, sexual violence, abandonment, or exploitation. Kasee's challenge was to design activities that acknowledged this reality, gently enabling participants to trust, show empathy, and undertake action.

“The Leadership Development Forum was an interesting group. The Ministry was developing its five-year strategy and there was little common ground and common understanding on which to build this strategy,” she says. The personal transformation and subsequent growth in group cohesion and trust within the Leadership Forum and delivery units form the basis for the Namibian case study.



Synergos photo

The trust walk

Who are you?

This was the question Kasee was asked most often as she led the APHLI from 2008 to 2012. At this stage, Namibia had emerged from a long struggle for independence, achieved in 1990, and a new country was being shaped. It did not have a Truth and Reconciliation process like South Africa to reconcile itself with the atrocities of the past. As a result, the historical divisions between people (whether of race, ethnicity, language, political affiliations, or gender) were glossed over. An individual's identity was often cast in simplistic terms: Owambo or Herero; English or Afrikaans, male or female, SWAPO or not, local or foreigner, a returned exile or a resident.

Kasee was something of a mystery. She looked like a Namibian – like some quite prominent Namibians – but her surname was that of an outsider, and she had not been seen in Namibian professional circles. Answering “I am Kasee Ithana-Mhoney” did not answer the deep query of participants' persistent question: “Who are you?” She realized she was being asked about her kinship, her affiliations, her ties, and her community. Even after affirming her family connections, her schooling in Namibia, the names of her cousins, people remained skeptical since she did not carry herself like a typical woman from Namibia.

It may be this position as an insider with an outsider lens that enabled her to interact with the Forum and project participants the way she did, listening and understanding the different levels of conversation that were going on simultaneously.

But it was something else as well; she was authentic. Asked how she got to that place, she replies, “I had the opportunity to deal with my own issues. When I went to work in the Free State in 1998 for nine years, soon after democracy in South Africa, I had to ask and answer tough questions every day. I rock up and am fully present. I listen and do not dismiss anything as being unnecessary. I just allow.”

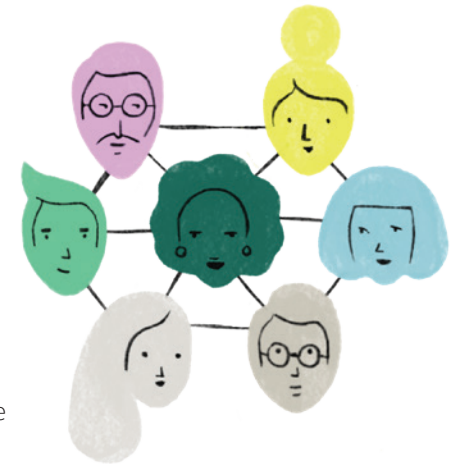
The pleniplain: An introduction

This case study looks back at the African Public Health Leadership Initiative (APHLI) implemented in Namibia from 2008–2013. It incorporates the perspectives, experiences, and memories of team members, harvested from their responses to questions on what the project meant to them, what has stayed with them, what was achieved, and what they believe were the critical ingredients in the process. It draws on literature from that period and documentation available on the project.⁵ The study investigates key episodes and events in the project, as reflected through interviews with seven of the participants. It uses a modified most significant change methodology to tease out the critical components of the project, with specific reference to personal transformation as a grounding element for social transformation.

The Initiative in Namibia arose in part due to interest at the Bill and Melinda Gates Foundation in developing and testing innovative models to improve the performance of public health systems in developing countries, particularly in Africa. In response to this interest, in 2007, a consortium of three complementary organizations – McKinsey and Company, the Presencing Institute, and Synergos – conceived the Initiative in Namibia. These organizations envisioned the project as an approach designed to shift the attitudes, values, and relationships that underpin the way individuals, teams, and sectors operate within the health system. The aim of the four-year project was to strengthen the leadership and systems of Namibia’s Ministry of Health and Social Services. After some start-up adjustments, the three organizations worked in a complementary fashion to achieve this goal with funds from the Gates Foundation.

In such a situation, a web of strong relationships is necessary to mobilize a response, requiring a focused and committed community for action. Generating such a dynamic team approach is neither easy nor optional; it is central to starting and sustaining the work and must begin where the individual members are. Under the leadership and direction of Len LeRoux, Synergos’ Director in Namibia at that time, the Initiative worked intensively with a group of leaders from the Ministry, allowing them to review and renew their personal values before galvanizing action for improved health service delivery.

The Initiative recognized in its actions, if not in its original documentation, that changing a complex system required the personal transformation of its leaders and the leadership dynamics. There was also an implicit realization that taking action bravely is itself a source of further inspiration. As Cornel West says, “Hope is more the consequence of action than its cause. As the experience of the spectator favors fatalism, so the experience of the agent produces hope.”⁶



The external architecture of the Initiative relied on the strong relationship and trust among the three implementing partners: McKinsey and Company, the Presencing Institute, and Synergos. Likewise, the project’s achievements depended on the trust that accrued among the participants. Breaking down the ubiquitous us and them barriers of gender, ethnicity, politics, or bureaucracy, helped build causeways of understanding and trust. This in turn smoothed the road for innovation and action.

The concept of strength in unity and alliances is not new, of course. Epango ri urea ouzeu (Herero proverb, meaning “alliance conquers all troubles”). But forming alliances is not always easy and the sands may shift as individual concerns or prejudices threaten the cooperation. Those who take leadership roles within an alliance may have to overcome suspicion before they can enable a sense of collective ownership, capacity, and commitment. APHLI operated in a dynamic system with various interacting parts – the individual with his or her history, intra-group dynamics, Namibian post-independence culture, and the Health Ministry’s strengths and challenges. The current case study seeks to explore how the project addressed these distinct elements to embolden individuals and encourage teams that could galvanize change within the health system.

The outer geography: Namibia circa 2008

Pressures: Namibian health system

The Initiative took place during a time of significant changes and pressures within the Ministry and the health sector generally. These included the rollout of life saving anti-retroviral therapy (ART) for HIV in the public health sector, changes in leadership at the Ministry, the health sector strategic review, and the government of Namibia's emphasis on performance and management improvements.



District Hospital ambulance transporting patients

During the first decade of the 21st century, Namibia experienced the full impact of the HIV epidemic. HIV/AIDS, at 22% prevalence in 2002, was one of the main causes of the rise in maternal and infant and child mortality. It also brought about a decrease in life expectancy, which in 2002 in Namibia was only 54 years of age. AIDS-related diseases were the main cause of death. Maternal mortality rates were 449 per 100,000 live births in 2006–7, almost double the rate recorded in 1992. By 2010, HIV prevalence had dropped to 18% and deaths had decreased by half, thanks to the introduction of ART and its rollout in public health facilities in 2003.

HIV/AIDS had weakened the human capacity of the health system while simultaneously putting increasingly greater strain on its workload. The nationwide rollout of ART in August 2003 and the rapid expansion of efforts to prevent mother-to-child transmission improved life expectancy and quality, but did not diminish the workload of health personnel.

Women and children were subjected in different ways to the confluence of poverty, poor health, and HIV. Stunting in children under five rose from 24% in 2000 to 29% in 2006. A report on child nutrition suggested that 80% of the households in Namibia experienced factors that undermined their capacity to maintain the nutritional status of children and most likely the family unit as a whole. Between 2000 and 2006, Namibians had decreased access to food of sufficient quality.⁷ Sub-standard maternal health and baby care continued to plague Namibia well into the second decade of the new millennium. Newspapers repeatedly reported on the shortage of skilled health workers and cases of negligence by health care professionals.⁸

Burnout among the leaders and health care providers was both a cause and a result of this situation. People at all levels in the health system experienced emotional and physical exhaustion and felt unable to meet the constant demands for more and better outputs. Lack of teamwork, poor performance, and decreased productivity ensued. Local development partners recognized this situation and put efforts into caring for the carer. “The work involves giving of ourselves to others – our

attention, caring, emotional support, and love. If we don't get some of this back or find opportunities for personal renewal and replenishment, we will eventually feel emotionally exhausted and empty inside."⁹

Navigating a way through: Cultivating hope

I was appointed at a time of crisis in the Ministry.¹⁰ People were burned out and struggling to survive. The health institutions were always embedded in some crisis and had to be fire brigades. Individuals would be sent here or sent there but had little ability to control the situation; they did not feel like masters of their own destiny. The prime minister introduced the idea (of the Initiative) to me and the timing seemed perfect. We would concentrate on the soft side of the Ministry. I was an agriculturalist, not a medical person. But I was open to leadership and management and knew health was a particularly people-oriented system. The project boosted my interest because I was surrounded with trained people with resources and skills, evidenced by the facilitators. I feel it was a blessing to have the opportunity to work with this team. I knew I could never be bigger than my team (Kahijoro Kahure, then permanent secretary at the Ministry of Health and Social Services).

At the outset of the Initiative, Synergos staff conducted 90-minute interviews with a number of Ministry directors and senior management in order to determine the perceived leadership needs. The interviews were personal as well as professional, touching upon feelings, experiences, fears, and concerns. A number of common elements flow through these early interviews and dialogues. The four most common refrains were:

- Poor communication between units or directorates (national and regional) and between service units (directorates) and upper management
- Little sense of direction or of contributing to a common vision
- Lack of sufficient motivation, recognition, and controls resulting in demoralized clinic and facility personnel
- A sense of mistrust amongst and within teams.

The transcripts of these early interviews describe individuals being parachuted into posts outside their own region or into posts that others were expecting to occupy. According to one regional director, "My arrival pushed out other aspiring directors." Some went so far as to suggest that elements in the team tried to undermine their confidence and ability to complete tasks successfully.

The participants in the Initiative reported a lack of trust among colleagues with frequent back-biting and jockeying for position. According to another regional director, "The teamwork is missing. We are divided and fragmented and have this baggage of cliques is our history. We have not attempted to make and have a shared vision, which is blocking us from seeing people as individuals."

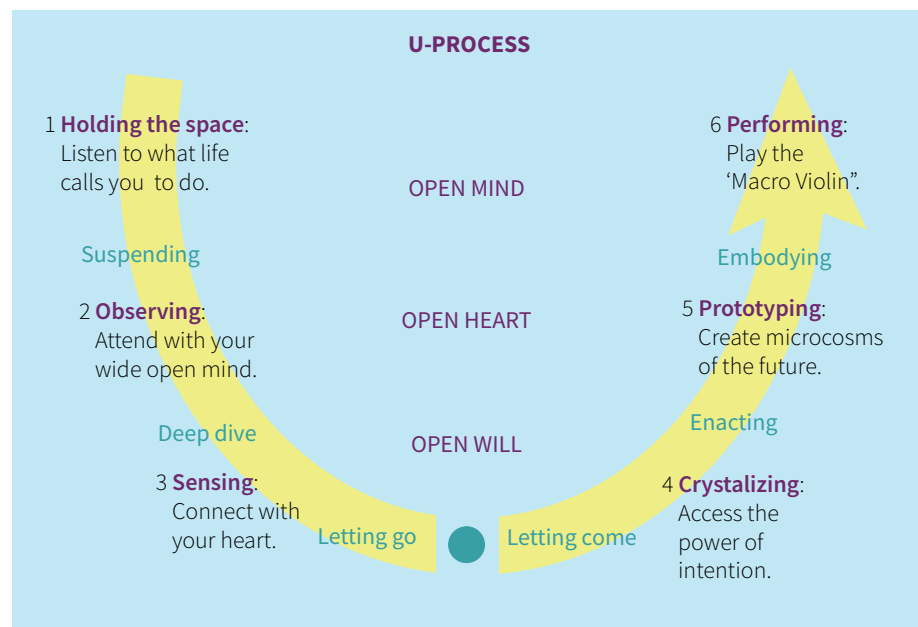
The transcripts also reveal how for many individuals their spiritual foundations provided strength and courage. The participants had attended previous leadership and team workshops and meetings, but felt nothing had happened. Nothing had changed. The Initiative was shaped to value an individual's deepest beliefs, to recognize individual responsibility, to create ties among a diverse group, and to galvanize action for common cause. Though not articulated in any documents, the APHLI seemed to grasp intrinsically that action in itself can generate hope. "In the absence of a better alternative, acting for hope beats sceptical spectatorship every time."¹¹

Alliance for mountain building

The alliance of the three implementing partners – McKinsey and Company, the Presencing Institute and Synergos – was itself both a challenge and a strength. Establishing roles and focus areas was time-consuming but the resultant team proved to be complementary and deft. McKinsey compiled and presented data in fresh ways; Presencing brought its Theory U practice; and Synergos facilitated and managed the entire project, refining its concept of Bridging Leadership along the way.

Starting in March 2008, McKinsey led the initial health system assessment, an in-depth analysis of the state of the Namibian public health system. Run in partnership with the Ministry, the health system assessment measured performance

Figure 1: The U-process



using data collected through extensive fieldwork, literature reviews, and analysis. The McKinsey “data deck” was a thorough and impressive compilation of this data. The subsequent report was used in developing the Ministry’s strategic plan. The use of data and data visualization became a hallmark of the Initiative.

The Presencing Institute brought the Theory U design to the Initiative. Acknowledging the role of emotions (the heart) and linking the heart, the mind, and the will is central to the Theory U process. It enables people throughout organizations to take a critical look at themselves and their organization without fear.¹² Theory U provided the framework for “movements” that generated a journey for change and was central throughout the life of the project. The human-centered process helped participants respond to the human experience behind the statistics and data. Importantly, it provided for concrete actions and appropriate responses, characterized by “will.”

Consecutive workshops applied the Theory U with both the LDF at national level and the RDUs at regional level. Participants from both groups recalled the Theory U as a central feature of their experience of the Initiative.

At this time, Synergos was further developing its concept of Bridging Leadership, designed to develop the type of leadership that is appropriate in multi-stakeholder processes that address social inequity and bring about social change. Following this approach in the Initiative, Synergos assembled key leaders, facilitated their identification of problems within the system, created opportunities for constructive dialogue and recognition of a common purpose, and provided mentoring. This encouraged and created a safe space for thinking, reflecting, and acting without the anxiety of criticism or the fear of failure. Both Synergos and the Presencing Institute provided skilled facilitators at different times for leadership workshops, which was critical to the achievements of the project.

Project landscape and launch

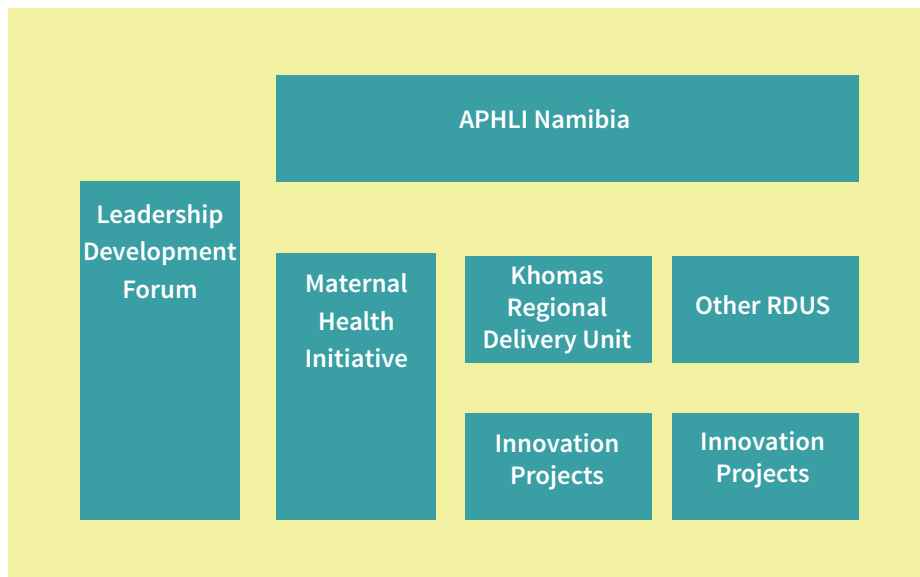
The Initiative developed organically and was responsive to opportunities and requests from the Ministry. Its primary activity was the establishment of the Maternal Health Initiative (MHI), which in turn generated the RDUs, first in the Khomas Region, where the capital Windhoek is located, and then in other regions. The LDF, not envisioned in the original project plan, was a response to a request from the permanent secretary. The members of the LDF led the MHI, then initiated and energized the RDUs.

The chronology of the APHLI illustrates the speed with which different activities were conceptualized and then implemented; starting with the LDF, next the launching of the MHI, then the establishment of the Khomas Delivery Unit to drive the MHI, and finally the formation of other RDUs.

Leadership Development Forum

The LDF grew out of a suggestion from the permanent secretary of the Ministry of Health (the chief executive officer of the Ministry), who requested a team-building exercise for his top leadership cohort. The Forum focused on leadership and

Figure 2: Elements of the APHLI



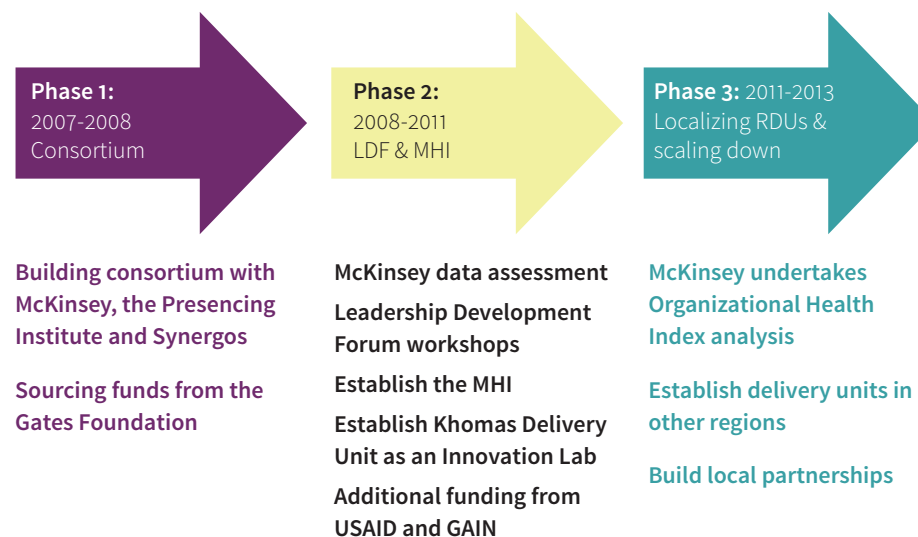
management skills for 24 of the Ministry’s senior tier, including the permanent secretary, two undersecretaries, six national directors, and 13 regional directors. In 2008, the Initiative held the first of six workshops for the Forum based on Theory U. Workshops lasted between three and five days and took place approximately quarterly. Attendance was always high, and the permanent secretary was present to some extent at every workshop. The intensity, creativity, and iterative nature of those workshops and subsequent interactions were key to the project’s success, evidenced partially in its members’ ongoing participation at national level and in the delivery units.

Maternal Health Initiative and the Khomas Regional Delivery Unit

Based on the results of the McKinsey assessment and with encouragement from the permanent secretary and the deputy permanent secretary, maternal health became the focus of the APHLI. The MHI began in early 2009, with a group of 21 women and two men drawn from government, nongovernmental organizations and the private sector. The inclusion of public sector, private sector, and civil society was itself quite unique, an idea later replicated in the Namibian Alliance for Improved Nutrition (NAFIN), which is also supported by Synergos.

To drive the MHI and to act as a quality improvement hub, a regional delivery unit was established at the end of 2009 in the Khomas Region. The Khomas Delivery Unit engaged multiple stakeholders such as the University of Namibia, the Red Cross, Development Aid People to People, and the Midwives Forum to build consensus and drive quality improvements and innovation. Again, the private sector was

Figure 3: Chronology of the APHLI



mobilized to assist. The project facilitated the linkages between and among different organizations and sectors, resulting in a variety of community health initiatives. Bertha Katjivena, then the Hardap regional director and now a deputy executive director in the Ministry, was a committed member of the Forum and provided consistent direction to the delivery unit. She remembers, “The project broke down work boundaries. People whose voice I had never heard before, could even chair a meeting. We found people who could think out of the box and they developed the delivery unit to drive the change.”

The establishment and work of the delivery unit was considered one of the Initiative’s most significant achievements. Based on a careful assessment of the data, the Khomas Delivery Unit launched nine maternal health innovation projects. These included the broadcast of interactive radio programs, the rollout of antenatal care services from two hospitals to 13 clinics, and the provision of additional clinic space by procuring and equipping renovated shipping containers.

With the backing and support of the regional directors who had participated in the Forum, other delivery units were established in other regions. At least some of these showed equal promise, drive, and ability, harnessing multiple organizations to achieve a common vision. In the Erongo Region on the cool Atlantic coast, the Swakopmund town council provided land, the private sector assisted with obtaining and converting a shipping container, and eventually another antenatal clinic was available to the women in the informal township known somewhat affectionately as the DRC. A similar process occurred in the Omaheke Region with the creation of a maternity shelter, where women could wait in relative comfort for their delivery date to ensure a safe facility birth.

Commitment and engagement from the Ministry of Health leadership was a key factor in the Initiative’s successful launch of the MHI and later the RDUs. Another key factor was credible, skilled facilitation that prompted greater personal reflection and growing self-awareness, indicative of Inner Work.

A woman in a white shirt is pointing at a large table with handwritten data. The table has columns for 'RESPONSE TIME (MIN) (A.MB)', 'NUMBER OF NO SHOWS (A.MB)', 'NUMBER OF DRIVERS ABSENT FROM SHIFTS', 'NUMBER OF DRIVERS LATE FOR SHIFTS', 'NUMBER OF PATIENTS TRANSPORTED BY BUS 1 (Clinics)', 'NUMBER OF PATIENTS TRANSPORTED BY BUS 2 (Hospitals)', 'NUMBER OF PATIENTS TRANSPORTED BY AMBULANCE (FROM CLINICS)', 'NUMBER OF BUS 1 ROUNDS COMPLETED', 'NUMBER OF HEALTH FACILITY CALLS RECEIVED', 'NUMBER OF CALLS FROM PUBLIC', and 'NUMBER OF VEHICLES OPERATIONAL'. The data is organized into columns with some cells containing numbers and others with dashes or symbols.

	20	24	18				
NUMBER OF PATIENTS TRANSPORTED BY BUS 1 (Clinics)	28	46	79	60	66		
NUMBER OF PATIENTS TRANSPORTED BY BUS 2 (Hospitals)	62	93	99	36			
NUMBER OF PATIENTS TRANSPORTED BY AMBULANCE (FROM CLINICS)					2		
NUMBER OF BUS 1 ROUNDS COMPLETED	2/4	1/4	1/4				
NUMBER OF HEALTH FACILITY CALLS RECEIVED	79	49	59	37			
NUMBER OF CALLS FROM PUBLIC	5	1	6	5			
NUMBER OF VEHICLES OPERATIONAL	5	6	6	6			

Ambulance unit staff member capturing data for dashboard

The inner geography: The Leadership Development Forum

This case study reveals the three spheres of awareness – self-awareness, external awareness, and group accountability – that catalyzed the APHLI in Namibia between 2008 and 2013 and contributed to the ability of the RDUs to address maternal mortality. The participation of the senior leadership was repeatedly reported as being very positive and seminal to the project, encouraging engagement and commitment. The personal growth of individuals and the modeling and creation of a positive group dynamic within the LDF and the delivery units are arguably the most important long-term benefits of the Initiative.

As the chief executive officer of the Ministry at the time, Kahijoro Kahuure explains,

The team at the Ministry had technical and clinical capacity but were not necessarily managers. They worked in silos. People in silos don't recognize the importance of linkages. You can't work alone. Real improvement will be people-centered improvement. When we started recognizing people, people's needs and their personhood, this cascaded down to better service for our patients. How you treat people matters at all levels. As one participant said, "Patients are our constituency."

The activities of the Initiative, especially of the Forum, allowed a group of Ministry officials to see each other – regardless of differences – as respected individuals, not as “them.” This vision was then extended to the wider health sector, allowing leaders to see patients not as them but as one of us. This re-categorization and re-framing is a critical movement in Inner Work. The head of the Khomas Delivery Unit, Ms. Katjivena, explained, “We needed to address the rift, to get out of the ‘us’ and ‘them’ situation and build bridges.” This focus on a small group of leaders helped to build a bridge across the divides of old injuries to the possibility of reconciliation and trust within the LDF. In one of the introductory interviews, a director noted that “we lumped together people who spoke the language (Afrikaans) with a people who committed atrocities.”

The APHLI conceived this process as that of Bridging Leadership. According to Synergos, Bridging Leadership is the capacity to build trust and tap the fullest contributions of diverse stakeholders, helping them to work as partners. It aims to create and sustain effective working relationships among stakeholders whose collective input is needed to make progress on a given social challenge. By “bridging” different perspectives and opinions, groups can find a common agenda that addresses solutions to social and economic problems.

In 2011, when the ministry conducted an Organizational Health Index (OHI) survey with the assistance of McKinsey and Synergos, the results demonstrated improvements as seen in the table below.

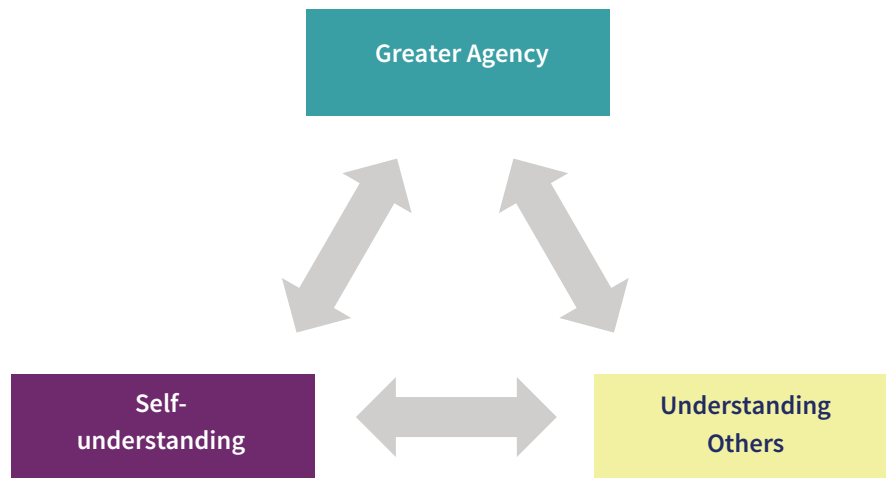
Table 1: Elements of the APHLI

OHI element	Positive rating (%)	
	2008	2011
Direction, clear and compelling vision	39	60
Capacity for innovation and learning	37	52
Leadership	54	66

These data suggest an increase in agency within the MOHSS team, as represented in Figure 4. This sense of agency was built on a foundation of improved understanding of self and of others. Two members interviewed within RDUs commented on the freedom they saw manifest through the process. “The program was not bound by your position at work” and “We all had an equal voice and the work barriers were broken down.”

While change was evident at various levels, Dr. Norbert Foster’s account of his involvement in the Initiative demonstrates that change is not always easy to sustain.

Figure 4: Elements of the change



Dr. Foster was the deputy permanent secretary in the Ministry at the time and he had this to say:

I see a number of vital contributions made by APHLI. These include the leadership development and the Index survey (which were mutually supportive). The Regional Delivery Units were also a result of the APHLI. They were very promising, achieved empowerment of the regions and produced important short-term momentum. But since their staffing was never formally embedded in the Ministry's structure, they could not last, although, in my capacity as chair of the ministerial restructuring group at the time, I had pushed for these units to be formally integrated into the concept templates for the reformed regional and district structures. There was thus no system to accommodate and sustain these regional units. Also, this project aspect stopped at the regional level and did not go down to the health districts. For maximum effectiveness and sustainability, it would have been important to plow through the key levels of the health system.

At that stage, motivation in the ministry was especially low, a perception which was strongly substantiated by the Index survey results. The national level engagement that the APHLI facilitated was a critical component. The Presencing Institute's Theory U approach to the change process helped the national and regional directors better understand the change process and also gel as a team. We were still operating with historical legacies from colonialism and from the struggle. In addition, there were elements of entrenched professional divisions, and also ethnic divisions. There was a huge need for reconciliation. In this respect I can say that Kasee was instrumental in moderating that key piece of the project. She was a very able facilitator. The series of workshop retreats over the course of about 18 months got everyone on the same page. That level of intensity and also the time intervals in-between sessions were very necessary for the success of the process. I don't think there had been anything like this process before in the ministry, or since. The spin offs have been lasting – a strong team, an organizational culture shift, better communication, and removing silos. This is actually huge.

Today, with a new group of managers rising through the levels, there are still issues of personal and group transformation to be addressed. We also continue to see effects of stigma and discrimination, gender violence, and communication issues that need to be tackled. There thus is much room and work to further stretch the boundaries.

Dr. Norbert Foster, then deputy permanent secretary in the Ministry of Health and Social Services

Key strata: Hearts, minds and a common will

Linking mind and heart was already embedded in the Theory U process and in the LDF workshop activities. Personal reflection and self-awareness were the building blocks of the Forum. Participants' stories reveal different, though related, touch points: a deep self-awareness, a sensitive external awareness, greater personal and team will, and ownership of the problem. Case study interviews suggest a pattern

Baby's Story

Baby Kanguvi is a senior health officer in Omaheke Region in eastern Namibia on the edge of the Kalahari Desert. When the Initiative was getting underway she was a nurse in the region. She recalls that the then regional director, the chief medical officer, and a senior registered nurse attended a meeting in Windhoek (the LDF). When they returned to Gobabis they described the operations of RDUs. Next, a multisectoral group of dynamic individuals in Omaheke Region was pulled together and the first Omaheke RDU was established. Kasee Ithana came and took the members of the new unit through the Theory U process. Ms. Kanguvi explains:

The Theory U process and the sensing journey training were very good because you immerse yourself in the problem. You go in and try to put yourself aside and see the situation as a community member. The Theory U helped us as nurses – it changed our attitude. We went through this training and it had an impact on our lives. You become more sensitive to what's around you, for example the patient. You see what's really happening to others. You realize health care is not just a routine task; you need to consider what you are really doing. We blame policies when it is us. Once you go through the training you start seeing things differently. You see your own responsibility and even beyond.

Let me give you an example. The clinic needs a thermometer. The thermometer could be found in the pharmacy, but the person who liaises between the clinic and the pharmacy doesn't fully realize or see the urgency. After the Theory U, even if you are an admin officer, you understood your role and wanted to do extra to get things done. Even if you were only responsible for a vehicle you would start to realize that this car is needed to contribute to the health of our nation. In the RDU, members were from different divisions like finance, HR and primary health care. Everyone was in, so they could all contribute and have the know-how and the understanding to direct resources where they were needed.

Kasee was our main facilitator and she has that character trait of seeing the whole group and each individual in the group as important. She encourages everyone to participate. She valued everybody who had a stake in the program and made sure they were able to participate. The problem in health is that you have a section to deal with, but do not necessarily see the whole. Kasee helped us see the whole. It was reflection, reflection and more reflection. We took action, we started new things, and then were able to reflect and course-correct if needed.

Theory U training helped open people's doors. "We started having an open-door policy – being available to help each other and being less concerned about position and hierarchy. We were no longer in our corner alone, only speaking when asked. We changed so all of us felt we could speak up and say what was needed. People took initiative without waiting for a meeting or a command. You start seeing. You remove the old specs and put on the new specs. We did lots of team building – to help others, to bring people along with you."

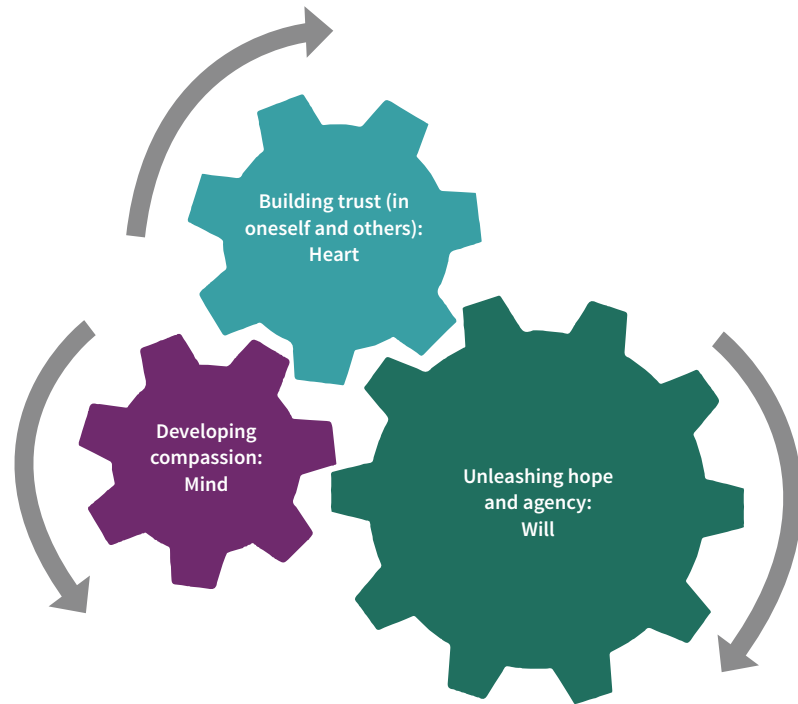
The division had already identified that hospital delivery of babies was low, and they wanted to find out why women were delivering outside facilities. Some women preferred to deliver in Windhoek or at home with traditional birth attendants. So, the delivery unit decided to take this as their key challenge to address. "We put our heads together to figure out how to address this," said Baby Kanguvi. "The only place to come was in Gobabis and people had no accommodation. So, we brainstormed and thought of a shelter. We started lobbying the UN and others to support a shelter. We did get funding and built the maternity shelter. It is still going strong, despite challenges. We did it in such a way that it could be a community project, not state owned but municipality owned. The Ministry of Health refers clients there at 36 weeks."

Ms. Kanguvi is still with the Ministry of Health and is still in Omaheke as a senior health officer. She says, "The project helped me to grow as a person. It even helped me at home. The way I was doing it was as if I were alone, as if we were all there alone. Now we are sitting like a family, deciding together. Before I would never let my child correct me, but from what I learned and the experience in the team, I know everybody has a meaningful contribution to make and can have a positive impact."

The lasting impact on the ministry is not so evident. "The delivery unit started to slow down and by 2017 was quiet. We tried to start up in 2018, but it is not the same energy as before. Everyone is quiet and no one is pushing for meetings. Before, everyone was there, learned how the system works, and tried to help find a solution. We still have a community radio where we give health talks using other stakeholders. But now it is highly reliant on one person or one position, instead of being a team like we used to. Levels of help and support have fallen off and others are not so willing to help you."

Reflecting on the lasting impact of the Theory U training, Ms. Kanguvi says, "Unfortunately now most of them have retired and we don't get things done. People don't understand it the way we understood it. What we really need now is to be revived so we can have that same spirit."

Figure 5: Connecting the cogs



of developing trust, warmth and empathy for others through listening, genuine feedback and reflection. This was mirrored in the training of RDUs. The importance of personal and common will engendered by the training can be seen in the reflection below by one of the RDU members.

The case study participants have a fairly uniform understanding of the central components of the Initiative: building trust in oneself, nurturing trust in the team, and then translating that trust into concrete actions based on an analysis and ownership of the challenges. The Initiative addressed these three interconnected cogs of heart, mind and will. Each was necessary, but none was sufficient. It was the recognition of the interconnectedness of the three that was critical. Indeed, as explained by neuroscientist Dr. Doty in *Into the Magic Shop*:

Techniques for eliminating distraction and journeying inward can increase focus and help us make decisions more quickly, but without wisdom and insight (opening the heart) the techniques can result in self-absorption, narcissism and isolation. Our journey is not meant to be an inward journey alone, but an outward journey of connection as well.

Building trust in the group

When the Initiative began its work in Namibia, mistrust was a pervasive characteristic of the health system and even of society. Trust begins with understanding and accepting yourself and your past so that you can be fully present in the group. In the Namibian context of gender and historical racial inequality, the ability of the Forum workshops to build a sense of trust in a diverse group so quickly was impressive.

Reflecting back on the experience, Bertha Katjivena, now deputy executive director of the Ministry said, “We needed to get over our fear of being called to the minister’s office. Our problem was a situation of ‘them’ and ‘us’. We needed to address the rift and build bridges between the national and regional programs, and within the national directorates. The Initiative was not bound by the work you did or restricted by your position. We used first names, not titles or surnames.” This is very significant given the bureaucracy and hierarchies common in government and the initial levels of mistrust.

The LDF workshops had broken down the fear of hierarchy and had established trust between senior team members. A nurse leading the RDU in Erongo remembered, “I wasn’t criticized, I could call anytime, I could reach out – even to the permanent secretary.” In a fairly traditional and hierarchical society, expunging these often gender-related status norms required bold and different approaches. According to a 2013 study on Bridging Leadership, the Initiative

- Brought people together and created connectivit
- Contributed to an attitude change and culture shift with a new way working
- Allowed for self-evaluation, exploration, criticism, and the acceptance of advic
- Encouraged members to be open to external advice and advice from colleagues
- Encouraged members to question the health system and their own role within it.

The eagle and the butterfly

Denise was a nurse. Through the APHLI she was appointed as the coordinator of one of the RDUs, bringing an end to the normal hierarchy common in ministries, including the Ministry of Health. She was “tossed in and had to swim” given various lifelines. “I never felt alone or lost,” she said. The facilitator training that she attended helped her get out of her boxed-in view of herself as a nurse.

Exercises such as the Journey of Life where each person reflected on and plotted her own story and narrative – both the highlights and the low points in her life - enabled Denise to see herself as a problem solver, as part of the solution, not detached from it. Seeing how she had overcome problems in her own life gave her the courage to address problems in the workplace, no longer just identifying a problem but owning it as a shared problem and rallying the forces to solve it.

The process helped me get out of the box. And stay out of the box. We had to identify what animal we were. I was a butterfly because I was emerging. Later I was an eagle, I could fly. I never went back into the box. I still use these principles in my job. The principle of Be the Change. Don't be afraid to initiate. This created a permanent change in me, not necessarily in the system.

An evaluation of the Initiative commissioned in 2010 reported that it had successfully mitigated the top-down approach characteristic of the public health system. Here's how one member of the Forum described the new approach: “The Forum lets us sit down on the same floor around the same fire, and lets us hold hands and talk about stories and see what happened ... the approach is to put everyone at the same level ... we realize we are just human beings, the same. The ranks are there ... so what? We can still communicate and work together as human beings.”

Working with leaders in the health system, from the most prominent – the permanent secretary or chief executive officer – through regional directors to clinic heads

increased the Ministry's morale and enhanced trust, leading to better internal and external communication.

Developing compassion: The mind

Some interesting recent research suggests that a compassionate act may be based as much on cognition as on emotion. Robert Sapolsky, in his excellent synthesis *Behave: Human Behavior at its Best and Worst*, summarizes this as feeling someone's pain versus understanding someone's pain – the latter being more likely to result in a compassionate act. Cognition has to do this heavy lifting.

Tools for awakening a deep awareness of others included exercises called stakeholder shoes and sensing journeys. These activities allowed individuals to take on the personas of others for a day, experiencing fully and deeply the human reality within their own health care system. People across the Ministry's bureaucracy experienced the health system from new angles: as a pregnant woman waiting for eight hours to be seen; as a husband standing in a queue for his wife's medicine; as a mother walking to the clinic before dawn to be first in line, ensuring she will at least be seen that day and not sent home. These experiences gave participants a richer understanding of the challenges faced by Namibians seeking health care. The data took on a face and a feel.

Denise, a nurse in Erongo at the time, commented, “Sometimes you are blinded by the things you see every day. You need those fresh eyes. We went out to see for ourselves. It was a way to open minds by not relying on assumptions. The sensing journey put a mirror up, so we could look at ourselves (nurses) from the other side. You take the person out into the field and then they can re-enter with new eyes.”

Cognition and compassion were first elicited through a data analysis of the larger health system, then deepened by experiential learning through personal exposure to the health system.

Unleashing agency and hope: The will

Accountability and agency, courage and commitment – the leadership team fostered all of these qualities. This constituted recognizing personal and group responsibility. In a major shift, the group was able to focus on innovation and opportunities, without fear of failure or blame.

A sense of agency developed through the workshops as the team owned the problems within the health system and felt free to innovate in a safe space where failing was acceptable. Staff members in junior positions, who were previously unable to initiate action or challenge their seniors, reported having more open communication, allowing for increased participation at all levels of seniority. Denise's story illustrates the change.

Some Forum members spoke of the difficulty of maintaining the momentum generated at workshops. Although these meetings had generated new ideas and left members feeling excited, many members found that they “became the same person again” when they returned to their offices. Others reflected that although maintaining momentum once back at the office was challenging, it was nevertheless happening. They attributed their ability to maintain momentum to the fact that they had seen the reality on the ground through sensing journeys, had reviewed their place within the system, and now saw themselves as agents of change.

Many of the positive shifts appear to have been generated through the demonstration of quick wins, the modeling of leadership behavior, and the simple provision of time for participants to reflect, think, and create their own dynamic.

Participants attributed the ability to act and respond and to manifest agency and will to the changing culture of communication, trust, and openness. At the same time, it is possible that having a shared goal contributed to breaking down the old Us/Them dichotomy, bringing to the fore a new Us – one that operates with a shared vision.

Key approaches: What worked?

What specific activities and approaches did the Initiative use to build trust, compassion and agency? What captured people's imagination and what do participants remember and value, looking back at the Initiative? During the interviews, participants reflected appreciatively on the methods used in the LDF workshops. One or two methods – such as learning or sensing journeys – were mentioned repeatedly as being particularly efficacious and memorable. Other approaches that participants in the Forum or delivery units found valuable and memorable are listed below:

- Operating within a safe space
- A sense of belonging to a group where one is respected
- Personal histories and reflections
- Reflective solo walks and dialogue walks
- Workshops and meetings held in unusual places
- Rooms laid out in unusual ways – often in a circle with no desks
- Upending hierarchies by using first names and having new leaders
- Check-ins and check-outs which engage people's feelings
- Metaphors and activities which engage people's imagination and creativity
- Sensing journeys to deeply experience another's perspective.

There is a large body of evidence concerning leadership development, including public health leadership and leadership in post-conflict settings. What is less readily available is literature on and models of readiness and the capacity to benefit from leadership opportunities. This case study posits that self-reflection and trust building are such prerequisites. As the second and youngest secretary-general of the United Nations, Dag Hammarskjold, wrote in his journals: “The more faithfully you listen to the voice within you, the better you will hear what is sounding outside. And only he who listens can speak. Is this the starting point towards the union of your two dreams – to be allowed in clarity of mind to mirror life and in purity of heart to mold it?” The Theory U approach to the change process addresses this connection to the real self and to the other.

Table 1: Tools for the trip

Destination	How to get there	Tools used in the APHLI Namibia	Cross-cutting practices
Trust in colleagues	<ul style="list-style-type: none"> Humanize the other Address structural inequalities (ethnicity, gender, and hierarchies) 	<ul style="list-style-type: none"> Check-ins Reflective dialogues Use first names Dialogue walks 	Inner work, nuanced and sensitive facilitation, Theory U, metaphors, operating in a safe space
Compunction and urgency	<ul style="list-style-type: none"> Confrontation with data Develop compassion 	<ul style="list-style-type: none"> Extensive data review Sensing journeys 	
Sense of personal agency	<ul style="list-style-type: none"> Address past histories Take on leadership functions 	<ul style="list-style-type: none"> Journey of life/river of life Local models of leadership 	

The stories and interviews coalesce around three particularly significant approaches:

- Sensitive facilitation from someone with an insider/outsider angle
- A liminal experience such as that provided by the five-day workshop at the Waterberg Plateau
- The use of the sensing journey and other novel mind-opening approaches.

Broadening the horizons: Facilitation

Creating the necessary environment for a trusting community depended on who facilitated the process and how. At some early stages in the project, there was mistrust of the outsiders. Participants remember thinking, “Is this foreign led? Whom here can I trust?” For some of the early team members, this period lacked “an African voice” and too much time and energy may have been spent on building relationships within the team.

To succeed, the project needed to have an insider with outside experiences to facilitate the process. The project director in Synergos provided that. As Kasee explains, “We had to allow the apartheid legacy to emerge and be addressed, so we could begin to relate to each other as human beings. I was the listening ear, attentive and affirming.” The Inner Work that Kasee had done in her own life was an essential ingredient of the work she did with the APHLI. In turn, the participants incorporated this Inner Work into their interactions with the Namibian health system.

In post-apartheid Namibia, trust between different ethnic groups, political affiliates, social groups, work cadres, and even men and women was low and hard to establish. As Kasee said, “We have a history where you can’t trust each other.”



Safe and healthy delivery

As a facilitator, Kasee had to set the tone for the trust and space needed for any Inner Work to develop. “When people asked, ‘Who are you?’ they were not asking for my name. They wanted to know my kinship, my community, my ties and my affiliations. I come fully each time.” The facilitator’s self-awareness gave her a more complete awareness of others in the room.

We needed to create the container where people could open up to share and then deal with their inner struggles, struggles that were blocking their performance. I challenged the people to consider what they wanted to take from the past and what they wanted to leave behind. Being a Christian helped me and in turn the process helped me to make more use of my faith – to combine the personal and the professional parts of life, to become integrated.

Kasee Ithana

Kasee and the other facilitators from Synergos and the Presencing Institute came highly skilled and self-aware. Kasee brought both her Christian beliefs and her professional theoretical scaffolding to the APHLI, engaging others in reflective practice. She was clear about who she was and what she believed and was able to help others connect with fundamental beliefs about themselves and their context.

Interviewees commented on how the project facilitation helped integrate the personal and the public, their inner and their outer selves. Providing an opportunity and some tools for people to reflect upon their own lives, what has happened to them, what is important to them, and what they want to do and how they want to be is both an ancient and an innovative way to ground public health work. Self-understanding is a critical first step toward a better understanding of others and in turn toward a better understanding of how systems function. As Blaise Pascal said, “One must know oneself. If this does not serve to discover truth, it at least serves as a rule of life, and there is nothing better.”

Liminal experiences: Waterberg

Waterberg Plateau or Oueverumue, the “narrow gate,” is a high sandstone mountain with rock cliffs built up of petrified dunes. The high plateau is preserved today thanks to ancient tectonic processes lifting up the Damara Mountains, covering over the more ancient Karoo rocks, and thus protecting the Waterberg from erosion. The underlying geology of sandy soil and soft stone absorbs water, which then runs off underground and emerges later as springs. In 1904, the Herero paramount chief, Samuel Maharero, under pressure from his people to act against German colonial encroachment on their land and cattle, gave orders to rise up. There followed a series of skirmishes in which the Herero were largely successful. General von Trotha was brought in to take



Namibia's Waterberg plateau.

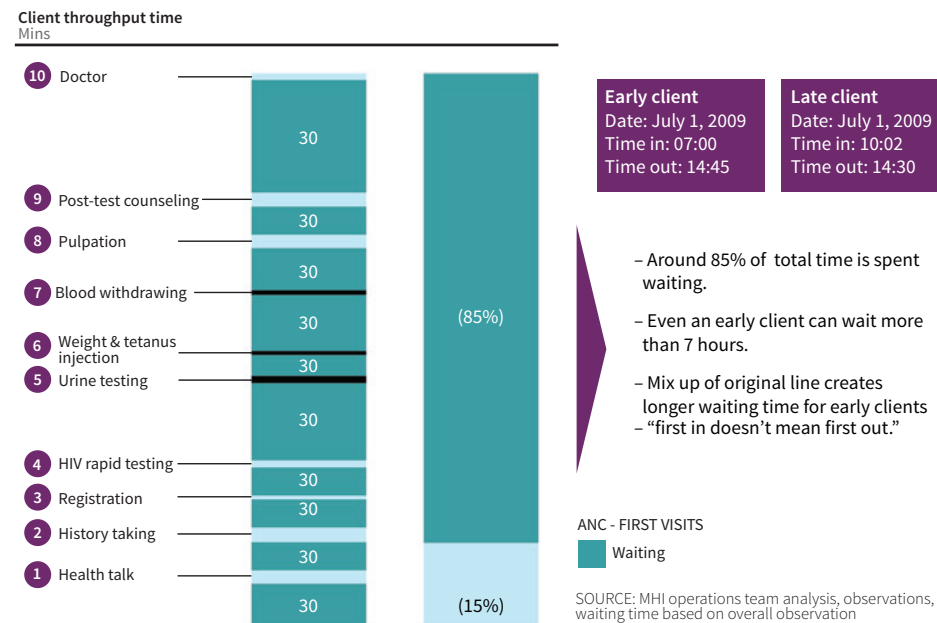
command of the German forces and his troops fought back fiercely. The Hereros retreated to Waterberg and in August 1904, it was the scene of a major battle between the Germans and the Hereros. On August 11th, fighting was heavy and on August 12th, rather than surrender to the invading forces, the Herero people retreated eastwards and began a long and dangerous trek that took them to what is now Botswana. Thousands died during the battles and thousands more died of starvation and thirst during the trek, or from drinking water from wells poisoned by the German forces. The Waterberg Plateau is now a nature reserve, recognized for its natural and unique beauty, as well as for its historical significance in Namibia's early struggle for freedom.

The narrow gate of the Waterberg became a broadening experience for the LDF participants, and the protected plateau a safe space to begin forming as a unit. This expansion of heart and will was enabled by exposure to the unusual – an unusual venue for a government workshop, an unusual presentation of data through installments tucked away in corners throughout the resort, and unusual team activities that provoked laughter and camaraderie. As one participant recalled, “We learned through play.”

All respondents mentioned the importance of this initial workshop in building a trusting, cohesive group. The activities were new and fresh for the participants. The current deputy executive director recalls: “When I was told to go on a solo walk to talk to myself, I said to myself, ‘Kasee is crazy.’ But the Waterberg environment was perfect and very calming.” People were taken out of their ordinary setting and schedules. The three- to five-day workshops included a number of new approaches, moving people outside their normal conception of professional leadership training:

- **Landscapes** – small installations spread around the venue with detailed pictorial, graphic, and written information on different aspects of the health system
- **World-café** – small group discussions
- **Four direction reflection** – building, literally, a vision of the health system with clay and other construction materials
- **Dialogue or solo walks** – guided conversations individually or in pairs
- **Journaling** – reflective practices.
- **Outdoors exercises** – team building, trust building, fun physical activities.

Figure 6: Katutura Hospital: 85% of time is spent waiting at ANC clinic



The legacy we want to leave behind is of a visionary team, cohesive and united, committed to its work, dedicated to the vision of the MOHSS, engaging the community and responsive to their needs, thereby improving the wellbeing of all Namibians, increasing the quality of life and of life expectancy.

The Leadership Development Forum, Aug. 2008

Subsequent LDF workshops and the later RDU training sessions used similar approaches. But it is often to this first workshop that respondents refer. This initial group formation was critical for the project as it set the tone for the months and years ahead – embodying trust in the team, unleashing untapped creativity, and accepting personal responsibility.

Sensing journeys: Metaphors and shoes

In order to expand the participants' understanding of the inner working of health provision in Namibia, the APHLI team facilitated learning or sensing journeys to give a human face to the data that had been presented. These provided the texture to the graphs and tables. Individuals were sent into the health system as clients and beneficiaries for a full day, to walk in another's shoes and to be immersed in the entire experience, giving place and voice to those whose voices are often not heard.

Ms. Kanguvi from Omaheke remembers that during the sensing journeys they found long lines of pregnant women sitting outside, even in the rain, on cement blocks. Once inside, the health facility had only two rooms for deliveries and one of those was used for antenatal care. Expectant moms waiting to deliver sat on the

The experience: Alicky and Denise

Alicky, hired by Synergos to assist the regional teams, was herself tasked with taking on the role of a pregnant woman waiting for her first antenatal consultation. She waited for most of the day on the long hard benches of the antenatal clinic. She watched the mothers, some far advanced in their pregnancies, sit and wait and wait. When it was eventually her turn to see the nurse, she was never even offered a pregnancy test. Reporting back to the group elicited a firm commitment to have a pregnancy test as a standard operating procedure put in place so that women would not have to wait unnecessarily.

Denise is now a health information officer in the region. "My attitude and my approach have changed. I used to have a difficult relationship with my sister. I try to see things from her perspective now. That looks like a small thing, but it works." For her the sensing journeys and other tools provided a mirror by which she could see herself and her nurse colleagues using the eyes of a client. "You forget that the client is a person with emotions and problems." Using introspection activities, reflective practices and journaling allowed the individuals to understand themselves better and in turn to have greater understanding for their clients.

backless bench outside the room. "With the Theory U training we felt the difficulties of everyone, and the problems within the community, and we took that upon ourselves."

A pharmacist was sent out to wait in line as a husband collecting his wife's medicine. On his return, the group remembers his saying, "I will never forget that those people in a line are people with their own problems." A finance manager came back from a sensing journey determined to improve the benches used by pregnant women.

This theme was repeated in the different workshops, helping to open up the mind and the heart, allowing the leaders to experience others as full individuals with their own realistic and reasonable demands. As with many of the workshop activities, participants engaged with their bodies as well as their minds, in one instance removing their shoes, as illustrated in the photo below.



An APHLI participant accompanies a patient to a clinic appointment as part of a sensing journey.

The methodologies used at the workshops for the Forum and for the delivery units moved beyond formulas to tap into individuals' deeper beliefs and experiences. One activity explored the different words and expressions from local languages around leadership and interrogated the values embedded in each. Another workshop dealt with questions of the human heart: Who am I? (Identity) Where am I from? (Heritage) Why am I here? (Purpose) What can I do? (Potential) Where am I going? (Destiny). These and other activities grounded the experience of the group in ongoing personal reflection, deepening both the individual's self-awareness and an enhanced group awareness.

Walking in the other person's shoes helped people across the bureaucracy of the Ministry to experience the health system from new angles – as a pregnant woman waiting for eight hours to be seen; as a husband standing in a queue for his wife's medicine; as a mother walking to the clinic before dawn to be first in line, ensuring she will at least be seen that day and not sent home. In so doing, they developed a richer understanding of the challenges faced by Namibians seeking health care, and the data took on a face and a feel.



Walking in their shoes: activity from the leadership forum

What happened next? Roadblocks and potholes

The initial project officially ended in 2012, with some regional activities continuing into 2014. The APHLI struggled to survive the change in leadership in the Ministry, the climate of diminishing funds, and the decentralization of the initiatives to RDUs.

The participants recognized the value of having their top political and civil service leaders as drivers of the project. They felt that their participation allowed benefits to cascade down. “Everyone was on board. We broke down bureaucracy and created new channels” (member of the delivery unit). This approach, however, is vulnerable to changes in leadership. People work within a vast bureaucracy that may not nurture personal transformation. When the permanent secretary was transferred to another

ministry, the project lost its champion. As pressures mounted on the Ministry and staff were transferred or left, some of the original team spirit dissolved.

The APHLI had not sufficiently embedded the practices to ensure the system would retain them. The current deputy executive director has approached Synergos to provide leadership training for more people in the Ministry using some of the approaches of the Initiative. She reports that the earlier project did not reach far enough into the system with its training, and wants all cadres to be involved moving forward. “We needed to take the practices all the way down to middle management. We need to ensure everyone is touched so it becomes part of the system. The APHLI built the team, but we mustn’t end there. We needed to go all the way down. This did not cascade down to have teams everywhere” (Forum member).

The establishment of RDUs was considered a major accomplishment of the Initiative. The units created some healthy competition between regions, according to some respondents, and helped motivate and mobilize initiatives. Although the MHI and the delivery units brought certain rapid changes to the health system, including a decrease in maternal waiting time, increased efficiency in a Khomas Region ambulance service and additional clinics, these gains were not consistently sustained. Seven years later, the delivery units are no longer functioning. The project was not able to leverage the cohesion and solidarity of the Forum to maintain high levels of performance and systemic change.

Peak experiences need grounding in everyday systems in order to be fully realized and supported in action. Some of the structures that were established, such as delivery units, survived for a while in some places but not in others. Other facilities, such as a clinic, took time to be established but are now thriving. What is clear from the individuals interviewed for this case study is that seven years later many have stayed the course and articulate the transformation in their own lives, and how it enriched workplace and personal relationships.



Synergos photo

A patient waits outside a new container clinic.

Conclusion

The APHLI had some significant achievements during its lifetime, while funding was most readily available, and the frequency and intensity of engagement was high. The project contributed to the wider changes and successes of the health system, such as the decentralization of antenatal services and decrease in maternal mortality.

The case study confirms findings from other health leadership development projects that coalesce around the value of personal change and team motivation. The Initiative is a prime example of such a process and led to positive changes in individuals and, to a lesser extent, in the health system. The Initiative took these tenets further and engaged a team of people over 18 months, exposing them to fun, creative, challenging exercises and activities to open their hearts, activate their minds, and energize their actions. The Namibian case study points to some well-established types of practice that can be integrated into the development setting – practices that facilitate more trust, more compassion, more agency, more solidarity.

Self-reflection and building trust in a team are common currency in many leadership and quality improvement initiatives. The findings from this case study are consistent with other health leadership initiatives in which leadership workshops improve communication and collaboration and even lead to improved familial relations. The ideas are also currency in many continuous quality improvement initiatives wherein members of the team collect data and reflect on ways to increase efficiencies or improve quality, relying on ethics, integrity, and trust as essential ingredients.

The project used and developed methodologies that addressed greater self-awareness and group cohesion, leading to strong mobilization for action. Given the country and the constituencies, this was a personal and transformative experience for the participants, and has had a lasting impact on their lives. In its approaches the APHLI was able to build trust that in turn enabled action. Ten years after the Theory U process, participants still recall highlights and can trace its impact on their own lives. The project did not articulate an approach of personal transformation,

reconciliation and hope, yet it perhaps inadvertently filled that purpose with the LDF and subsequent work with the RDUs.

The actual benefits to the health system are not as evident or as long lasting. A number of explanations for this are possible, including the complex and dynamic nature of the health system, the drop in funding, and the light touch of the project compared to the weight of a health system bureaucracy. Given more time and resources, it is possible that the methodologies would have been more embedded in the system and more far reaching. Sufficient time is needed to erode poor practices and build up layers of positive new ones. APHLI did not have that time, but was nonetheless able to begin a shift of attitudes and practices.



Patients using the new transport bus



Annex: People interviewed and interview questions

People interviewed

Individual	Position at time of APHLI	Position at time of interview	Type of interview
Len Le Roux	Synergos, Country Director	Synergos Regional Director	Introductory
Kasee Ithana	Synergos, Project Coordinator	Synergos Country Director	Multiple in-person
Alina Imbili	Synergos staff based in Erongo Region	MoE Teacher	In-person
Kahijoro Kahuure	MOHSS Permanent Secretary	Retired	In-person
Bertha Katjivena	MOHSS Regional Director for Khomas and National Director Planning	MOHSS Deputy Executive Director	In-person
Norbert Foster	MOHSS deputy permanent secretary	Director I-Tech	In-person
Denise Boois	MOHSS Erongo RDU Coordinator	MOHSS Health Information Officer, Erongo Region	In-person
Baby Kanguvi	MOHSS RDU Coordinator Omaheke Region	MOHSS Senior Health Officer, Omaheke Region	Phone interview

Interview questions

The interviews lasted between one to two hours. All but one were face-to-face interviews and focused on five basic questions:

- What was your role in the project and type of involvement?
- What was of most significance?
- What were the key achievements?
- What facilitated these achievements?
- Are there any sustainable or lasting results from the project – for individuals or for systems/organizations?

Three of those interviewed are still with the Ministry of Health and Social Services in leadership capacities, one person has retired, one person is now directing an international health partner, and one has returned to teaching. In each case, people were recalling what was most significant to them, and reflecting on what they remembered from the project.

Notes

¹ 2011 CENSUS Projections

² Roy Steiner and John D'Agata eds, *Harnessing the Power of Collective Learning; Feedback, Accountability and Constituent Voice in Rural Development* (Routledge, 2016).

³ Desmond and Mpho Tuto, *Book of Forgiving* (London: William Collins, 2014), 111.

⁴ Although a number of personnel provided exceptional leadership and facilitation, and leadership direction to the project, Kasee's role is highlighted as somehow both representative and unique.

⁵ Two case studies have been published on the role of Bridging Leadership in the APHLI. See appendix.

⁶ David Cole, "Have Human Rights Failed? A Review of Kathryn Sikkink Evidence for Hope: Making Human Rights Work in the 21st Century." *New York Review of Books* LXVI, no. 7 (May 8, 2019): 50 (quoting from West, Cornel and Roberto Mangabeira. *The Future of American Progressivism: An Initiative for Political and Economic Reform* (Beacon: 1999), 50.

⁷ Namibia Alliance for Improved Nutrition (NAFIN), *Malnutrition in Namibia*, NAFIN (Windhoek), 10–12.

⁸ Ombudsman, *Baseline Report on Human Rights in Namibia* (Namibia, 2013), 173-174

⁹ Lucy Steinitz, *The Way We Care* (Namibia: Family Health International, 2009), 122.

¹⁰ Kahijoro Kahure, an agriculturalist, was appointed as permanent secretary to the MOHSS in 2007.

¹¹ Cole, "Have Human Rights Failed?", 50.

¹² The Theory U, co-developed by Otto Scharmer, is represented as a U shape that moves from the left-hand side of the U to the right-hand side of the U. An individual will have to open their mind to new ideas first and they must not be obstructed by thoughts and emotions. //presencing.org

¹³ Possibly names DRC as a result of the poor conditions in the informal settlement, suggesting those of the Democratic Republic of Congo.

¹⁴ Material supplied by Synergos.

¹⁵ James Doty, *Into the Magic Shop* (London: Yellow Kite, 2016).

¹⁶ Anna Davies, *African Public Health Leadership Initiative: A Story from Namibia* (Windhoek: Synergos), 19.

¹⁷ ICF Macro, *Outcome Evaluation of the African Public Health Leadership and Systems Innovation Initiative* (Windhoek: 2010), 11.

¹⁸ Robert Sapolsky, "Feeling Someone's Pain, Understanding Someone's Pain, Alleviating Someone's Pain," in *Behave: The Biology of Humans at Our Best and Our Worse* (London: The Bodley Head, 2017), 520–552.

¹⁹ ICF Macro, *Outcome Evaluation*, 12.

²⁰ Robert Sapolsky, "Feeling Someone's Pain", 627.

²¹ See for instance *The Intersection of Good Governance and Better Public Health: Professionalizing Leadership and Management in Ceará, Brazil*. Cambridge, MA: Management Sciences for Health. http://www1.msh.org/projects/lms/Documents/upload/Ceara_Intersection_Governance.pdf) and *Building Skills While Tackling Real Challenges: A Pilot Leadership Development Program in Guinea*. Cambridge, MA: Author. http://www1.msh.org/projects/lms/Documents/upload/Guinea_Evaluation_Notes1.pdf)

²² Dag Hammarskjöld, *Markings* (New York: Vintage, 2006), 13.

²³ Pascal, Blaise, *Pensées* (Dutton, 1958).

²⁴ Adapted from Marion Wallace, *A History of Namibia* (Jacana Media: South Africa, 2011), 161–168 reflecting information presented to participants at the Waterberg workshop.

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Acknowledgments

Synergos expresses deep gratitude to the case writer, DeeDee Yates, for her diligent work in conducting the research, interviews, and writing to produce this case study. We are especially grateful to the individuals who contributed the stories and insights that form the basis of the case study: Len Le Roux, Kasee Ithana, Alina Imbili, Kahijoro Kahuure, Bertha Katjivena, Norbert Foster, Denise Boois, and Baby Kanguvi. Their stories and examples are what give this case study its meaning and practical application.

At Synergos, Len Le Roux and Kasee Ithana were very helpful in providing access to historical project documents, in fact checking, and reading drafts. Thanks to the Synergos Namibia Team for their support.

The Inner Work for Social Change project would not have been possible without the vision and support of the Fetzer Institute. Synergos is immensely grateful for their partnership in making this project a reality, even and especially as the world navigates tumultuous times. A special thanks to Bob Boisture, Kurian Thomas, Gillian Gonda, Amy Ferguson, and Jenny Smith.

We would also like to thank the core team of the Inner Work for Social Change Project, including Len le Roux, Kathryn Uhl, Shirley Pendlebury, Derek Schwabe, Swati Chaudhary, Constance Monatla, and Marina Poudret.

Sue Davidoff and Shirley Pendlebury ran a three-day writing workshop for the case writers.

This project has been powered by the combined brilliance of its advisory team, including Bruno Vercken, Daniel Groody, Emmanuel Garza, Ernesto Gariloa, Gretchen Ki Steidle, Mark Gerzon, Sue Davidoff, and Vijay Shankar Kathan. The advisory team enriched and invigorated the dialogue on inner work for social change, and gave insightful feedback on the case studies in progress.

About the author

DeeDee Yates lives in Namibia. Since 1985 she has been engaged with projects addressing child development and HIV prevention and care in Southern and Eastern Africa. She works with bi-lateral and multi-lateral organizations, governments, philanthropic institutions, civil society, and faith-based organizations to buttress family, faith and community responses to support vulnerable children and adolescents. She is married to the Rev Mike Yates. They have two children and a granddaughter.

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3 East 54th Street

New York, NY 10022, USA

Telephone: +1(646) 963-2100

Email: collaborate@synergos.org

www.synergos.org

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