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Matthew Bersagel Braley

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Date

More than Just Health:  
Theo-ethical Reflection as a Religious Health Asset

By

Matthew Bersagel Braley  
Doctor of Philosophy

Graduate Division of Religion  
Ethics and Society

---

Elizabeth M. Bounds, Ph.D.  
Advisor

---

Peter J. Brown, Ph.D.  
Committee Member

---

Ellen Ott Marshall, Ph.D.  
Committee Member

---

Steven M. Tipton, Ph.D.  
Committee Member

Accepted:

---

Lisa A. Tedesco, Ph.D.  
Dean of the James T. Laney School of Graduate Studies

---

Date

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By

Matthew Bersagel Braley  
B.A., Luther College, 1997  
M.A.R.T., United Theological Seminary of the Twin Cities, 2003

Advisor: Elizabeth Bounds, Doctor of Philosophy

An abstract of  
a dissertation submitted to the Faculty of the  
James T. Laney School of Graduate Studies of Emory University  
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## **Abstract**

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By Matthew Bersagel Braley

In this dissertation, I examine the recent turn on the part of global health leaders to religious entities as allies in the response to the HIV pandemic. A cursory survey of this turn highlights how global health leaders have used the language of religious health assets to revalue the activities of religious entities. But a closer examination of this revaluation reveals how it obscures an important dimension of religious participation, namely, critical theo-ethical reflection.

In the first part, I analyze changing understandings among global health policymakers, funders, and practitioners of the value of Christian religious entities. This analysis shows how the HIV pandemic has both intensified tensions between religion and global health and served as a catalyst for a renewed interest in the relationship between religion and health.

The second part draws on the work of James Gustafson and Lisa Sowle Cahill to recover and expand a form of participatory theology that renders visible the distinctive role of critical theo-ethical reflection in the interpretation and response to complex social issues like those animating global health.

In the third part, I offer a historical and contemporary case study to highlight how processes of theo-ethical reflection have affected and been affected by participation in global health conversations, suggesting the possibility of processes of theo-ethical reflection as a religious health asset.

I conclude by pointing toward the institutional commitments and arrangements necessary for recognizing theo-ethical reflection as a religious health asset and supporting a mutually generative encounter between Christian ethicists and persons responsible for setting the policies and priorities of global health.

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## Acknowledgments

As many others have observed in more eloquent prose than I can offer here, it is deeply gratifying and humbling to acknowledge, however inadequately, one's debt of gratitude to those without whom this dissertation would not be possible.

In 2006, three years after entering the Graduate Division of Religion, I began to understand why Emory University was the place—perhaps the only place—where I could carry out research at the intersections of Christian social ethics, global health, and African studies. The resources in “my own backyard” including a culture supportive of interdisciplinary collaboration have given the dissertation a distinctively Emory character. Fellowship opportunities through the Institute for Comparative and International Studies, the Religion, Conflict, and Peacebuilding Collaborative, and, most notably, the Center for Health, Culture and Society, afforded me both the time and space to follow, literally and figuratively, where the questions animating the complex relationships between religion and global health lead. Given the financial climate in which much of this dissertation research took place, I am especially grateful to the Graduate Division of Religion and the Laney Graduate School for their encouragement and generous funding for domestic and international professional development opportunities, including three trips to South Africa to participate in conversations at the intersection of religion and public health.

My ARHAP conversation partners and colleagues I am now privileged to call friends are a direct result of these trips and Emory's institutional commitments to religion as an important part of any discussion, including public health. I am especially grateful for the ARHAPIans in South Africa. I want to acknowledge in particular, though, the generosity of Jim Cochrane, Barbara Schmid, Jill Olivier, Sinatra Matimelo, and the late Steve de Gruchy whose intellectual generosity was more than matched by the deep hospitality they extended to me during my time in South Africa. ARHAP's collaborative model of engaged scholarship and the friendships that sustain it have come to define, for me, not only what is possible with regards to scholarship for social change, but what is necessary for resisting cultured despair. I hope that this dissertation can in some small way honor this unique group and, as they would be sure to remind me, Masangane and the many other diverse communities their work is intended to serve. A special thanks to Renate Cochrane and Barbara who went out of their way to introduce me to the work of the Masangane program and to the remarkable persons who carry on this work day in and day out.

Closer to home, I have found among Emory's faculty four teacher-scholars who recognize the value of their own careers first and foremost in the work of their students and in the institutional spaces they cultivate for others. Ellen Ott Marshall graciously agreed to serve on the committee part way through the writing, offering in her own writings and equanimous spirit a witness to the possibilities of Christian participation in the public sphere and a way of making James Gustafson current again. Through various opportunities including teaching assistantships, coursework, and book indexing, Steve Tipton has nurtured in me an appreciation for the complexity of institutions, the thick, religiously resonant narratives that sustain them, and, most importantly, how we are re-bound (*religare*) together in and through them, God-willing, for the common good. Peter Brown has found again and again just the right ways to encourage me in my exploration of global health. This dissertation emerges in many respects from his tireless efforts to keep the humanities, social sciences, and natural sciences in conversation with one another, in a word, to practice *university*. He continues to serve as a model for me of the discipline and humility it requires to participate well in interdisciplinary conversations.

I wish I could claim from the start that I possessed the necessary self-awareness and intellectual maturity to discern the type of advisor most fitting for my project, temperament, and way of seeing the world. I have discovered in each phase—from conceptualization to writing to revising—just how fitting Liz Bounds has been for this project and my development as a scholar.

She has prepared me, in ways that I could not have anticipated when I arrived at Emory, for a life of service that is fully of mind, body, and spirit, and for an approach to teaching that extends the classroom to recognize the learning taking place betwixt and between, hither and thither.

The presence of two other Emory faculty can be felt in this dissertation. Jon Gunnemann's interpretive approach has served as my "primer" for understanding the task of Christian ethics and his careful, responsive approach to facilitating student-learning in seminars stands in as the "impossible possibility" each time I enter the classroom as a facilitator. His personal concern for my well-being and that of my family was especially appreciated as we made the transition from the Upper Midwest to the South—a transition he knows well.

I cannot help but wonder how this dissertation would have been different with the guidance of Nancy Eiesland, who passed away during the early stages of writing. I do know that it is stronger because of her insistence in her scholarship and in her life on keeping alert to how both our theologies and sociologies can disrupt conventional wisdom about health and reveal in the process new ways of being members one another of the body of Christ.

Of course, one does not enter doctoral studies without preparation nor without mentors who live out an academic vocation in ways both inspiring and encouraging. Rosetta Ross and Paul Capetz of United Theological Seminary of the Twin Cities introduced me to the work of H. Richard Niebuhr and James Gustafson in rigorous seminars that mirrored the intellectual demands of Ph.D. coursework and proved formative for my understanding of theological reflection expressed in this dissertation. Their efforts to hold me accountable in the words I write and the deeds I do provided me with anchors and toeholds as I found my way into and back out of the crevasse between activism and the academy.

One of the benefits of being in a large graduate program over a long period of time is ongoing exposure to the creativity and vitality of fellow students, who will always in some sense share an origin story with one another. I am grateful for the many friendships that have sustained and, at times, revitalized my spirit. I am indebted, in particular, to three friends who have endured patiently—well beyond the usual term limits of a dissertation writing group—the slow coagulation of my thinking in this dissertation. Amy Levad, John Senior, and Katy Shroust, whether or not they have memories long enough to recall, constituted my dissertation writing group. I think it is clear to all involved that I gained much more from this endeavor than I was able to offer. All three have shown me what it means to be a clear thinker and writer. The many ways in which my writing and thinking continues to protest this call for clarity is certainly not for lack of persistence on their part. A special thank you to Katy and her family who have been our Georgia family since our arrival at Emory in 2003. A fourth, honorary member of the writing group deserves acknowledgment as well. Conversations with Letitia Campbell about religion, development, health, Africa, and anything else connected, however tangentially, have provided many a welcome reminder of why I went into all of this in the first place.

When Kari agreed to live the questions with me almost twelve years ago, I am fairly certain that she did not expect to live the particular question at the heart of this dissertation—certainly not for this long. She knows this dissertation not as an argument but as an extension of who I am, or, more accurately, who I seek to become. She has listened generously and often to my doubts and despair, offering in return unconditional love and abiding faith in me, come what may. Our two children, Nora and Matea, born during the research and writing of this dissertation, remind us daily of what it means to participate—to be fully present—in the patterns and processes of interdependence so essential to human being and human flourishing.

Finally, I offer thanks to my mom who, without having to read a single word, forged the initial pathways that made the thinking in this dissertation possible, and more importantly, made sure that I knew, without a doubt, that the appropriate response to suffering is not pity or despair but a life lived in gratitude to God and service to others.

I dedicate this dissertation to Moses Bagaiga and to the many others whose lives ended not because of the limits of modern medicine, but because of the limits of our empathy.

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## CHAPTER ONE

### INTRODUCTION

*You see, we – faith and health – have been together a very long time. Health is not only freedom from suffering and illness, but according to your Constitution: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” These words enshrine the fundamental reason you are here and suggest something of what we share in our commitment to the world, together. Perhaps it would be good for us to include the recognition that there is an intrinsic relationship between God and humankind, which can be acknowledged as “spiritual well-being”? Perhaps one day this notion of well-being can be included in the WHO definition of health?*

Archbishop Desmond Tutu<sup>1</sup>

### I. INTRODUCTION

The best I can recall, I first learned about AIDS in the low-ceilinged basement fellowship hall of the United Methodist church in which I grew up. The chairs were arranged in rows facing the stage we used for the annual cabaret, a youth-led variety show and fundraiser for our summer mission trips. My memory of the presentation that night has faded over the past two decades, leaving only a vague sense of having learned the “facts” of HIV transmission. No, you cannot get AIDS by shaking hands with an infected person, or using a public toilet, or swimming in a public pool or... Laying out the facts was one way in which my church broke the silence, dispelling many fears surrounding the disease as it seized the U.S. imagination in the late 1980s and early ‘90s.

The uniqueness of this experience, like many of the other details, was lost on me that night and for the next decade or so. It came back to me suddenly on a Wednesday

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<sup>1</sup> Desmond Mpilo Tutu, "Address by Reverend Desmond Mpilo Tutu," in *Sixty-first World Health Assembly* (Geneva: World Health Organization, 2008), [http://www.who.int/mediacentre/events/2008/wha61/desmond\\_mpilo\\_tutu\\_speech/en/index.html](http://www.who.int/mediacentre/events/2008/wha61/desmond_mpilo_tutu_speech/en/index.html).

night in the fall of 2007 while sitting in a lecture hall at Emory University. The course was simply called AIDS: Public Health Implications. I had enrolled in it as a part of an interdisciplinary fellowship year sponsored by the Center for Global Health, Culture, and Society. For two semesters I had the opportunity to sit in on the global health conversation as conducted within the professional education of future public health practitioners.

The course covered the virology, epidemiology, and history of the AIDS epidemic and was co-taught by one of the foremost medical researchers in the field and a respected social epidemiologist, both of whom had significant field experience in sub-Saharan Africa. This particular night, however, featured a guest speaker, an Atlanta community member who was HIV positive.

He had contracted the virus as a young, gay man in rural Georgia. Raised in a theologically conservative, evangelical Christian community, he experienced HIV as a punishment for his sins as a homosexual. Already marginalized by his identity as a gay man, his status as HIV positive made reconciliation with his faith community and his family—all devout Christians—impossible.

His story of alienation and pain has become for many in the public health community the conventional wisdom about the relationship between Christianity and AIDS in America. Christianity served as a cultural barrier to effective AIDS education, prevention, and treatment.<sup>2</sup> No effort was made that night or any other night during the course to offer a counter-narrative about the involvement of Christian communities in AIDS hospice care or the efforts of global Christian communions to combat stigma and

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<sup>2</sup> See, for example, the dominant images of Christianity in Renata Simone et al., *The Age of AIDS*, (Alexandria, Va.: PBS Home Video, 2006).

discrimination against persons living with HIV and AIDS. As he spoke to the lecture hall full of aspiring public health professionals, I was cognizant that this may be the most personal story they will hear about Christianity and AIDS—in effect, a testimonial.

My church was by no means an outspoken advocate on behalf of persons living with HIV and AIDS. But on that particular evening it is possible to see the intentional effort to educate a room full of youth about HIV as a positive contribution to the work of public health. The congregation had created space in a church basement for education about HIV as a *health* issue potentially affecting our neighbors, co-workers, and even members of our church community. In this sense, the church had become a *religious health asset*, “an asset located [in] or held by a religious entity that can be leveraged for the purposes of development of public health.”<sup>3</sup> The suggestion that a church could be a religious health asset in the fight against AIDS in America stands in stark contrast to the painful story shared by the guest speaker in the AIDS course. Indeed, the story told by the guest speaks directly to the way in which churches, from the perspective of public health, can be a health liability, creating barriers to effective care for persons living with HIV and AIDS.

What accounts for the difference between my experience and that of the guest speaker? In overly simplified socio-historical terms, our experiences seem to reflect the internal differentiation of Christianity in the United States.<sup>4</sup> Churches with a family

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<sup>3</sup> African Religious Health Assets Programme, “Appreciating Assets: The Contribution of Religion to Universal Access in Africa,” *Report for the World Health Organization* (2006), 39. The language of assets permeates the dissertation, specifically as it is developed within the research of the African Religious Health Assets Program (ARHAP), but also as a general question about how religion is valued within the late modern or postmodern context of the twenty-first century. Both senses of the term are developed more fully in the remainder of this chapter and in the discussion of the turn to religion in chapter three.

<sup>4</sup>Robert Wuthnow’s restructuring argument offers the most accurate picture of this differentiation, at least with regards to the diminished role of denominations as predictors of theological liberalism and conservatism. So, for example, my experience in a northern urban United Methodist church may vary

resemblance to my home church—theologically liberal, northern, urban—are health assets; churches like that of the guest speaker—theologically conservative, southern, rural—are health liabilities.

While an oversimplification, this is a part of the story insofar as it signals the plurality of Christianities with which public health practitioners and policymakers must contend. In this sense, it is not surprising that the diverse and complex beliefs and practices of Christians and their institutions are manifest in public health at times as assets and at times as liabilities. Christianity is not monolithic.

While this may be stating the obvious, the implications of this statement may be less obvious, at least from the perspective of public or global health leaders strategizing in real-time how to work with community institutions—churches, para-church and faith-based organizations, religiously affiliated hospitals, etc.—in a response to a pandemic. Are these leaders equipped to parse the dense and diverse Christian landscape in a way that can accurately predict which institutions are likely to be assets and which are more likely to be liabilities to public health? Should these leaders be expected to do such parsing when articulating policies about partnering with community groups to meet the public health needs of citizens?

The two stories suggest the initial motivating questions for this dissertation: why, in retrospect, does my experience stand out as a counter-argument to the conventional wisdom about Christian participation in the response to the emerging U.S. HIV pandemic in the late 1980s and early 1990s? Why did the guest speaker’s account of Christianity

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considerably from someone else’s experience in a southern, rural United Methodist church. Robert Wuthnow, *The Restructuring of American Religion: Society and Faith since World War II* (Princeton, NJ: Princeton University Press, 1988).

and AIDS go uncontested in a lecture hall filled with aspiring public health professionals, among whom at least some were practicing Christians?

As the research progressed and my direct involvement in conversations at the intersections of religion and public health intensified, it became clear just how much Christian engagement in the HIV pandemic has served as a touchstone for the broader conversation about the relationship between religion and global health. So while significant attention will be paid to the specific involvement of religious entities in the HIV pandemic, the guiding question for this dissertation might be better articulated as what is the value of Christianity to global health? The dissertation attends to the descriptive and normative dimensions of this question. Descriptively, I examine changing understandings among global health policymakers, funders, and practitioners of the value of Christian religious entities to global health. Normatively, I explore arguments for why global health leaders should value the participation of Christian religious entities in global health conversations and programs.

The descriptive task includes analysis of how the HIV pandemic has both intensified tensions between religion and global health and served as a catalyst for a renewed interest in the relationship between religion and health. As a result of the association between religion and stigmatizing practices, Christian theologians and ethicists have entered the HIV debates as apologists, offering the themes of love, inclusivity, and justice in the Christian tradition as a counterweight to Christian practices of stigmatization and marginalization, supported by claims of divine retribution.<sup>5</sup> The

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<sup>5</sup> As examples of this type of theological engagement, see Donald Messer, *Breaking the Conspiracy of Silence: Christian Churches and the Global AIDS Crisis* (Minneapolis, MN: Fortress Press, 2004); Maria Cimperman, *When God's People Have HIV/AIDS: An Approach to Ethics* (Maryknoll, NY: Orbis Books, 2005).



concern about stigma has, in many global health and religious circles, come to define the relationship between religion and public health for the past twenty-five years. Today, the tension around HIV and AIDS animating many of the early encounters between religious and global health leaders persists, but I show that a clear turn to religion as a vital partner in the response to AIDS has taken place.

A cursory survey of the recent turn to Christian religious entities as potential allies in the response to HIV highlights how global health leaders have used the language of religious health assets to revalue the activities of religious entities. But a closer examination of this revaluation reveals how the global health appropriation of the current religious health assets framework may obscure important dimensions of religious participation. As part of the normative task, this dissertation renders visible one of these important dimensions: critical theo-ethical reflection. Critical theo-ethical reflection is a key dimension of Christian presence and participation and, as such should be understood by global health leaders as a distinctive health asset held by Christian religious entities. The limits and possibilities of incorporating theo-ethical reflection in global health conversations are explored through two case studies as well as theoretical constructs drawn from Christian theological ethics.

The remainder of this introduction begins to problematize the reductionist accounts of religion and theology that underpin much of the recent enthusiasm for partnerships between religious communities and global health organizations. Such problematizing, however, is not intended as an end in itself, but as a way into conversations, both historical and theoretical, that raise the possibility of nonreductionist,

or at least less reductionist ways of valuing theo-ethical insights and the practices they sustain in the face of twenty-first century global health challenges.

The development of a more expansive account of the value of Christian participation in global health is important for at least two reasons. First, a more expansive account captures with greater sophistication and accuracy the dialogical character of Christian participation in seminal late-twentieth-century global health conversations. The case study of the Christian Medical Commission and the primary health care movement (chapter six) illumines this dialogical character and the value of theo-ethical reflection in this conversation. While this may be important to scholars helping to fuel the recent surge in interest in global health history as well as scholars concerned with distinguishing mission studies from the emerging academic study of religion in international development,<sup>6</sup> it also has bearing on contemporary debates in global health, given the concomitant recommitment to primary health care as a priority and renewed interest in religious entities as partners in global health initiatives. The CMC and primary health care history suggest the participation of Christian theologians *as theologians* in global health conversations has, in the past, been mutually generative and been catalytic for paradigm shifts. At a minimum, this history invites self-reflection among global health leaders on the dynamics that facilitate paradigm shifts in how health is conceptualized.

The development of a less reductionistic account of Christian participation in global health is also important for Christian theologians and ethicists working to extend

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<sup>6</sup> Examples of scholars advocating the importance of history public health and global health include Theodore Brown and Elizabeth Fee. For brief statements of their positions see Theodore M. Brown and Elizabeth Fee, "A Role for Public Health History," *American Journal of Public Health* 94, no. 11 (2004); Theodore M. Brown, "The Value of History to Public Health," *American Journal of Public Health* 96, no. 2 (2006). For emerging interest in religion and international development as distinct from mission studies, see the American Academy of Religion's Religion and International Development Group established in 2010.

the insights of the liberal theological tradition into a twenty-first century that is neither the “Christian Century” nor a post-Christian century.<sup>7</sup> Global health has become in the twenty-first century one of the primary arenas in which fundamental questions about human being and human flourishing are being contested. Sustained liberal theological reflection on human being and human flourishing necessitates engagement with global health, in part, then, to understand better the threats to human being and human flourishing, but in part because of the praxiological obligations such theological reflection generates—obligations that cannot be understood independent of the theological framings and motivations that gave rise to them. For Christian theologians and ethicists to acquiesce either to accounts of health and human flourishing or to the value of Christian participation in global health that do not sufficiently account for the place of theo-ethical reflection is, it would seem, to jettison the very dynamic that has sustained the reform impulse of the liberal theological enterprise.

Minimally, the absence of theologians as participants in global health conversations should provoke questions—among theologians and global health leaders—about the relationship between scientific descriptions of the determinants of human health and normative arguments about what constitutes human flourishing. This is not to suggest that theology or a particular theology provides the ground for global health, rather it is a reminder that definitions of health and conceptions of human flourishing that orient global health priorities and drive flows of resources are arguments about what it means to

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<sup>7</sup> For an authoritative, historical account of the shifting place of liberal theologians in relation to the wider U.S. society, see Gary J. Dorrien, *The Making of American Liberal Theology: Imagining Progressive Religion, 1805-1900* (Louisville, Ky: Westminster John Knox Press, 2001); *The Making of American Liberal Theology 2: Idealism, Realism, and Modernity, 1900 - 1950* (Louisville, Ky: Westminster John Knox Press, 2003); *Soul in Society: The Making and Renewal of Social Christianity* (Minneapolis, MN: Fortress Press, 1995).

be human. As such, these arguments require attention to the question why *this* particular vision of human flourishing? Answers to this question are always provisional, revisited by each generation as it seeks to integrate advances in human knowledge (e.g., the virological understanding of HIV) with both shared and contested visions of human being. Given this, one of the important tasks to which liberal theological ethics, in particular, can contribute is the development of a theory of the value of theo-ethical reflection that is sensitive to both dimensions of this ongoing, integrative process. An argument for why theologians and ethicists working in the liberal theological tradition are particularly well-positioned to make this contribution will be worked out more fully in my engagement with the work of James Gustafson and Lisa Sowle Cahill in chapter four.

## II. AS THE GLOBAL HEALTH WORLD TURNS

The turn to religious entities as allies in the response to HIV, while recognized widely as an improvement over a previous era characterized by if not outright hostility, at least the perception of tension between religious entities and global health, highlights descriptive, normative, and formative tasks of Christian ethics. The turn to religion requires clarification about what the participation of religious communities and leaders looks like in global health policy debates and programs dominated by evidence-based science. To what in religion are global health leaders turning, exactly? *Do religious entities contribute anything distinctive to the global HIV response?* If so, what is the nature of this contribution?

A turn to religion in and of itself does not necessarily answer this question. I understand the turn to religion as predicated on a two-part movement on the part of global health leaders. The first part involves the recognition by global health leaders that, on the one hand, reversing the pandemic will require unprecedented cooperation and material support among all sectors of society, including the religious sectors, and, on the other hand, religion remains a powerful lens through which health and the meaning of illness are viewed in countries most affected by HIV. This recognition leads to the second part of the movement in which global health leaders actively pursue partnerships with religious entities at all levels, from the community (e.g., traditional healers) to the national (e.g., Christian Health Associations), to the global (e.g., Lutheran World Federation).

Both parts of this two-part movement can be understood as establishing the relevance of religious entities in the response to HIV. But to move from recognizing religion's relevance to engaging religious entities as allies requires an additional step. The turn to religious entities as allies requires revaluing religious entities in a particular way that is compatible with and useful for global health policies and programs. One of the emerging frameworks for articulating the value of religious entities is the religious health assets framework.

Religious health assets is a concept coined by the African Religious Health Assets Program (ARHAP), an international, transdisciplinary collaboration of scholars and practitioners in religion and public health. Founded in 2002, ARHAP (now known as the International Religious Health Assets Program to better reflect both an expanded context for the research and expanded geographic representation among group members), seeks

to understand better the intersection of religious entities and public health. The group formed as part of the response to a consensus among a range of academics and professionals in religion and public health that very little research had been done on the relationship between religion and public health.

Two questions drove their research: (1) how much were religious entities having an impact on health? and (2) what was the nature of this impact? Importantly, ARHAP distinguished this work from the preoccupation in the religion and health literature with “individual experiences of health and spirituality.” ARHAP’s focus has been on the impact of religion on public and global health, or health at the community and population-level, and not directly on individual experiences of health.<sup>8</sup>

For the moment, this brief introduction to ARHAP and the concept of religious health assets is sufficient for setting up what ARHAP provocatively identifies as the “bounded field of unknowing” in which this dissertation is situated. To be situated this way is to stand as a researcher in an “uncomfortable place...between professional (and often secular and biomedical) public health perspectives and that of the ‘the religious.’”<sup>9</sup> In this sense it is bounded by the various discourses and practices that constitute different disciplinary ways of knowing, but the very boundedness gives way to “unknowing”—when viewed through the lens of health, the boundedness exposes how these disciplinary ways of knowing and professional ways of being and doing fail, in and of themselves, to articulate the polyvalent experience of health. A fuller description of the religious health

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<sup>8</sup> Jill Olivier, James R. Cochrane, and Barbara Schmid, " ARHAP Bibliography: Working in a Bounded Field of Unknowing," (Cape Town: ARHAP, 2006)., 8. ARHAP also made explicit that this was scholarship for social change: “The results of this research could then be used to support religious health interventions and increase the understanding of religion’s role in health in order for better policy-making at a national and regional level.” Ibid.

<sup>9</sup> Ibid.

assets framework and the work of ARHAP is provided below in the section “Clarifying the Terms” and in chapter three.

When I began formulating my ideas about religion and global health, especially within the context of the HIV pandemic in sub-Saharan Africa, I didn’t know just how bounded the field I was entering was (nor how unknowing I was). I was sensitive to how Christian communities might learn better ways of providing antiretroviral treatment (ARVs) to persons living with HIV and AIDS—to become what I would later recognize with the help of ARHAP, a health asset to global health. By integrating the latest innovations in HIV programs, I speculated, Christian communities would be confronted with the inadequacies of their HIV response, a response that tended to focus on prevention, hospice care, and AIDS orphans. The availability of treatment, and later the proven effectiveness of delivering treatment at the level of community clinics, raised for me theo-ethical questions about how Christian communities committed to love and justice might expand their response to include treatment. Specifically, I was interested in developing an ethic of decent care to guide Christian involvement in the millennial commitment to rapidly scale-up access to ARVs—an ethic that might help guide an “HIV-competent church.”<sup>10</sup>

These concerns are reflected in what follows. However, after spending the past four years involved in formal and informal conversations about the relationship between religion, theology, and global health—including as a member of ARHAP—I began to recognize an equally urgent task: clarifying for global health policymakers and practitioners how Christianity has been and continues to be a vital partner in realizing the

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<sup>10</sup> For examples of this type of work, see Ted Karpf et al., eds., *Restoring Hope: Decent Care in the Midst of HIV/AIDS* (New York: Palgrave Macmillan, 2008); Sue Parry, *Beacons of Hope: HIV Competent Churches: A Framework for Action* (Geneva: WCC Publications, 2008).

goal of “health for all.”<sup>11</sup> In courses at Rollins School of Public Health, religion and public health colloquia in South Africa, and interdisciplinary faculty seminars convened at Emory University, I began to refine this task. While the primary audience is global health leaders and practitioners who recognize at a basic level the value of partnering with religious entities, the secondary audience is Christian ethicists and religious leaders who are or would like to be involved with global health issues. The dissertation provides a way forward – or, better, a way toward one another—for each of these audiences, including practical suggestions for what is necessary for both audiences if partnerships are to be cultivated that recognize the value of theo-ethical reflection as a health asset.

As chapter three demonstrates, religion is recognized as a partner—a necessary one, even—in the response to pressing global health issues like HIV. But from the perspective of global health, it is a vital partner precisely because of the ways in which its assets can be leveraged to scale-up existing global health programs. Partnerships with religious entities are formed on the basis of selective engagement with dimensions of religion that are supportive of existing practices in global health and easily transposable into the existing moral logics of global health. In this way, the use of the religious health assets framework to revalue Christian participation in global health may serve, ultimately, to legitimate, albeit in a more sophisticated key, a reductionist view of religion within global health, effectively erasing the distinctiveness of religious participation. Partnership forged largely on the basis of this limited understanding of how religion is a health asset, I argue, is to miss one of the most “vital” assets of religious activity: theo-ethical reflection.

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<sup>11</sup> “Health for all!” was the rallying cry invoked during the primary health care movement in the 1970s. See Joy E. Lawn et al., “Alma-Ata: Rebirth and Revision 1: Alma-Ata 30 Years On: Revolutionary, Relevant, and Time to Revitalise,” *The Lancet* 372, no. 9642 (2008).



Current analysis and appreciation of the turn to religion and the cultivation of partnerships with religious entities is being done largely without reference to the processes of theo-ethical reflection out of which commitments to health and human flourishing, an omission conspicuous in its absence.<sup>12</sup> As an example, the most comprehensive study of religion as a health asset in sub-Saharan Africa focuses on “the contribution of faith-based organizations (FBOs), institutions, and networks to the health of vulnerable populations in resource-poor areas of sub-Saharan Africa (SSA)... identif[ying] key areas for investment that would accelerate, scale up and sustain access to effective services, and/or encourage policy and resource advocacy among and in African countries.”<sup>13</sup> The value of religion in the quote above is rendered primarily in language that largely ignores theological framings, motivations, and responses to existing global health practices and policies.

This is not to suggest that those carrying out the studies do not pay attention to the implicit and explicit theologies at work in these partnerships. Indeed, the authors of the study evidence in other venues a heightened sensitivity to theological discourse in the HIV pandemic.<sup>14</sup> Yet the findings of this report, commissioned by the Bill and Melinda Gates Foundation, suggest that those reading the reports are most interested in religious entities’ capacity to scale-up, provide effective services, and serve as an advocate for resources, and that discussions of theology are best reserved for academic religion and

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<sup>12</sup> Additional examples as well as the reasons for ignoring theological framings of health or rejecting theological claims about AIDS will be detailed in chapter two.

<sup>13</sup> Barbara Schmid et al., "The Contribution of Religious Entities to Health in Sub-Saharan Africa (Study Commissioned by Bill and Melinda Gates Foundation)," (Cape Town: African Religious Health Assets Programme, 2008), 9

<sup>14</sup> See Barbara Schmid, "AIDS Discourses in the Church: What We Say and What We Do," *Journal of Theology for Southern Africa* 125(2006); Jill Olivier, "Where Does the Christian Stand? Considering a Public Discourse of Hope in the Context of HIV/AIDS in South Africa," *Journal of Theology for Southern Africa* 126(2006).

theology journals. The case studies in chapters five and six suggest that this way of valuing religion does not adequately attend to the distinctive contribution religious entities can make to the broader global health commitments to human flourishing, nor does it attend to the ways in which persons integrate experiences of suffering and health with theologically resonant understandings of human being.

### III. STATEMENT OF THE PROBLEM

To state the problem of this dissertation succinctly: In its current form, **the turn to religion as a health asset has effectively rendered processes of critical, theo-ethical reflection irrelevant.** As a result, the primary participation of religious entities—whether manifest in the activities of religious leaders at the global health table or among local religious entities—is restricted to *informing* and *conforming*. Religious leaders become *informants* in global health circles, sharing what they know about the beliefs and practices of a particular religious community and how best to work with communities to make global health policies more effective. Religious leaders also *conform* to the best practices as outlined by global health professionals, adapting first-order religious language to support the evidence-based programs promoted by global health professionals.<sup>15</sup> A dissertation focused on describing the ways in which religion informs and conforms to global health would make an important contribution to current debates about the viability of religious entities as allies in global health, adding texture and context to the many white papers developed by foundations, international governmental

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<sup>15</sup> See, for example, Parry, *Beacons of Hope: HIV Competent Churches: A Framework for Action*.

organizations, nongovernmental organizations, and governments. As a Christian ethicist, however, an emphasis on these two activities fails to account for what I understand to be at the heart of religious activity in the world: *transforming* existing structures, institutions, and practices that act as limits to the full expression of the kin-dom of God.

The constructive dimension of this dissertation suggests that a turn to religion can and should take account of processes of theo-ethical reflection as a constitutive dimension of Christian participation in global health and a distinctive health asset of religious entities, that a full account of how Christians participate in global health goes beyond what is currently expressed in the language of assets—tangible or intangible. Without explicit engagement with theo-ethical reflection, the current turn to religion remains partial, limited by an instrumental view of religion that does not accurately describe nor adequately anticipate the potential of religion as a health asset.

#### **IV. STATEMENT OF THE THESIS**

A turn to religion that recognizes, engages, and values theo-ethical reflection as a religious health asset can be a catalyst for a more fully participatory global health that better reflects in its policies and practices the actual ways persons experience and make sense of health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”<sup>16</sup>

My exploration of this statement proceeds in three stages. The first stage is to both acknowledge and problematize the turn to religion as it is currently taking place

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<sup>16</sup> This is the definition of health enshrined in the Constitution of the World Health Organization. See World Health Organization, "Constitution," in *Basic Documents* (Geneva: World Health Organization, 1986).

within global health circles. The first part of this dissertation shows the movement from an adversarial relationship with religious entities in the response to HIV to one in which religious entities are perceived as allies by global health leaders.

If, as I argue in chapter three, a turn to religion has been predicated largely on understanding religion as a particular type of health asset, then the work ahead, from a global health standpoint, consists primarily of: 1) aligning the assets of religious entities with existing and emerging programs and strategies in the response to HIV and AIDS; 2) developing a working lexicon and mediating structures for persons working at the intersection of religion and health; 3) reflecting on the actual practice of transdisciplinary research projects, including the identification of the precise nature of persistent stumbling blocks in conversations and partnerships between religious and global health leaders (e.g., different epistemological starting points); and 4) finding new ways to operationalize religion, both as a cultural determinant of health and, especially with regards to intangible religious health assets, as a value-added in global health (e.g., developing metrics for the impact of hope on health outcomes). All of this work is important, necessary, and currently underway in a variety of settings including my home institution, Emory University and among the ARHAP network.

In presenting evidence of the turn to religious entities, however, I raise questions about the limits of a turn to religious entities as allies, especially a turn predicated primarily on the revaluing of religious entities in terms of the health assets they possess. Thus, in the second stage of the argument I employ resources from my own formation in the liberal theological tradition to gain critical leverage on the current, limited view of the health assets religious entities possess. Specifically, in chapter four, I develop an account

of theological participation that updates James Gustafson's notion of the participant theologian in light of his more recent work on the place of theology in interdisciplinary intersections and Lisa Sowle Cahill's call for a participatory theological bioethic. The concept of the participant theologian that emerges from the integration of Gustafson and Cahill calls into question the sufficiency of accounts of the value of religion that dismiss processes of theo-ethical reflection and suggests the necessary theoretical parameters for valuing theo-ethical reflection.

Conscious that this theoretical approach is best reserved for academic journals in theology and therefore unlikely in itself to convince global health leaders of the value of theo-ethical reflection, I turn in the third stage to case studies to demonstrate how attention to processes of theo-ethical reflection has been and can still be a catalyst for rethinking existing global health priorities, policies, and programs.

In order to understand the need for both the theoretical approach and the evidence from the case studies, it is useful to provide a sense of the larger context in which the partnerships between religious entities and global health organizations are being forged. In the next section, I will locate the particular claims about the value of theo-ethical reflection in global health in the broader debates about the relevance and desirability of religious participation in the public sphere.

## **V. SEPARATE BUT NOT EQUAL: RELIGION AND HEALTH IN A DIFFERENTIATED WORLD**

The particular stories of Christianity and AIDS narrated above and the general story of religion and global health make sense only within the larger story of modernity

in which the “thesis of the differentiation and emancipation of the secular spheres from religious institutions and norms remains valid.”<sup>17</sup> The differentiation of religion and health can be seen as emblematic of these larger forces that characterize the modern world.

Since the Enlightenment, the practice of Western medicine has become increasingly identified with the natural sciences, rendering the earlier notion of the “healing arts” quaint.<sup>18</sup> The medicalization/secularization process also included institutional differentiation. The idea of a hospital as a distinct institution in society specifically for the treatment and care of sick persons and staffed primarily by trained medical professionals emerges in the wake of the Enlightenment.<sup>19</sup> While many modern hospitals retain connections—including financial ones—to the religious orders or denominations that founded them, the hospitals themselves are understood primarily as medical centers.<sup>20</sup> The hospital as medical center rather than almshouse, way station, or temple for healing highlights the degree to which, in modern institutions, at least, scientific understandings of illness and health can and do operate independent of explicit

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<sup>17</sup> José Casanova, *Public Religions in the Modern World* (Chicago: University of Chicago Press, 1994), 6.

<sup>18</sup> While it is beyond the scope of this dissertation to detail the socio-historical processes that account for this shift in the practice of medicine and the increasing differentiation between religion and health, historians of medicine note the rise of scientific medicine in the nineteenth century, professionalization of doctors in the early twentieth century, and the predominance of clinical science and medical research in the late twentieth century. Today’s push for evidence-based medicine is consistent with this trajectory. For a comprehensive and accessible account of these changes, see Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity*, First American ed. (New York: W.W. Norton & Co., 1998).

<sup>19</sup> For a history of this differentiation, see Guenter B. Risse, *Mending Bodies, Saving Souls : A History of Hospitals* (New York: Oxford University Press, 1999). From the time of the First Council of Nicaea in 325, hospitals were constructed in towns with cathedrals as part of a Christian commitment to care for the poor, the sick, and the stranger. Medieval monasteries included a commons, housing for the monks, a worship space, and an infirmary, forming a quadrangle the interior of which was understood as sanctuary.

<sup>20</sup> Even among hospitals that identify their religious heritage in current mission statement, the link between religion and the medical care provided is best understood as motivational. The religious heritage, including the concepts of human dignity found therein, motivates the hospital’s commitment to meeting the medical needs of the community it serves. Religious heritage, however, does not alter assumptions about the authority of scientific medicine.

religious understandings of the causes of suffering, the path to healing, or concerns about salvation.

This dissertation begins with the observation that within the differentiated context of the early twenty-first century, leaders in the global health field have made a conscious effort to engage religious leaders and religious communities as “vital partners”<sup>21</sup> in carrying out global health policies and programming. These partnerships and the urgency with which they are pursued suggests that both the assumptions regarding religion, and, consequently, some of the assumptions regarding religion and health have been shifting.

This shift is not a return to ancient Greece and the temples of healing in which the healer-God Asclepius combined surgical techniques with guidance from the deity—though examples of this type of relationship can be found throughout the world today, including recent and well-funded inquiries into the relationship of prayer and healing.<sup>22</sup> That is, while many of the processes identified with modernity have contributed to the structural differentiation of religion and health, individuals continue to resist this differentiation in their beliefs about health and their health-seeking behaviors. The differentiation is not totalizing. And this is not only true at the individual level or with regards to what might be considered private beliefs and health-seeking practices. José Casanova argues persuasively that the assumption of religion as thoroughly differentiated from secular spheres remains valid only when qualified by “the emergence of new

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<sup>21</sup> World Health Organization, "Faith-Based Groups: Vital Partners in the Battle against AIDS," in *The '3 x 5' Target Newsletter* (Geneva: World Health Organization, 2004).

<sup>22</sup> See, for example, J. M. M. Aviles, "Intercessory Prayer and Cardiovascular Disease Progression in a Coronary Care Unit Population: A Randomized Controlled Trial," *Mayo Clinic Proceedings* 76, no. 12 (2001); F. Ikedo, "The Effects of Prayer, Relaxation Technique During General Anesthesia on Recovery Outcomes Following Cardiac Surgery," *Complementary Therapies in Clinical Practice* 13, no. 2 (2007). For a critical, philosophical assessment of these types of studies, see D. D. Turner, "Just Another Drug? A Philosophical Assessment of Randomised Controlled Studies on Intercessory Prayer," *Journal of Medical Ethics* 32, no. 8 (2006).

historical developments which, at least qualitatively, amount to a certain reversal of what appeared to be secular trends.”<sup>23</sup> Casanova identifies these new historical developments as part of the “deprivatization” of religion:

Religions throughout the world are entering the public sphere and the arena of political contestation not only to defend their traditional turf, as they have done in the past, but also to participate in the very struggles to define and set the modern boundaries between the private and public spheres, between system and life-world, between legality and morality, between individual and society, between family, civil society, and state, between nations, states, civilizations, and the world system.<sup>24</sup>

Global health policies and programming I take to be one sector of the public sphere Casanova is describing.

The increasing participation of religious leaders and communities in conversations about and activities related to global health issues, then, may be seen as further evidence in support of Casanova’s differentiation-yet-deprivatization thesis. Casanova’s basic thesis makes intelligible the starting point for this dissertation: the turn to religion taking place within the global health public sphere. This dissertation engages in a level of analysis that speaks most directly to dimensions of the public sphere in which religion and global health interact. The analysis does not include a thoroughgoing account for individual-level health-seeking behaviors or the particular beliefs and practices of individuals or communities, though I do draw in the case studies on examples of such.

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<sup>23</sup> Casanova, *Public Religions in the Modern World*, 6.

<sup>24</sup> *Ibid.*



The increasingly visible participation of religious actors in global health forums such as the World Health Assembly supports Casanova's sense of the increasing publicity of religion in the modern world. (Indeed, religious actors have become welcome, vital, sought after partners in global health as chapter three will make clear.) For Casanova, such public expressions of religion suggest that within a differentiated world certain forms of public religious expression have earned the distinction of being both "viable" and "desirable." A viable expression of public religion is one that is "not intrinsically incompatible with differentiated modern structures." A desirable expression of public religion is one that "may actually contribute to strengthening the public sphere of modern civil society."<sup>25</sup> Within global health a similar criteria is at work. The turn to religion within global health implies a turn to religious entities, that are both *viable* and *desirable* from the standpoint of global health. What types of encounters are possible within those parameters?

When global health recognizes and engages religion, it usually does so in one of three ways: 1) as an *aspect* of well-being; 2) as a *cultural determinant* of health; and, 3) as a partner in the response to the social determinants of health. As an aspect of well-being, religion signals a category overlooked, or perhaps subsumed by the other aspects of well-being. Religion appears in global health discourse and even among religious

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<sup>25</sup> Ibid., 7-8. For Casanova the criteria of viability and desirability may lead to a secularization theory "complex enough to account for the historical 'contingency' that there may be legitimate forms of 'public' religion in the modern world, which have a political role to play which is not necessarily that of 'positive' societal integration; that there may be forms of 'public' religion which do not necessarily endanger modern functional differentiation; and that there may be forms of 'public' religion which allow for the privatization of religion and for the pluralism of subjective religious beliefs." *Public Religions in the Modern World.*, 39.

leaders as spiritual well-being, and, like mental and social well-being, challenges physicalist notions of illness and cure.<sup>26</sup>

But adding spiritual as an aspect of well-being serves primarily to enlarge the diagnostic lens, not to alter the light passing through the lens. Adding spiritual simply means global health folks need to pay attention to more questions about the potential cause of an illness. Whereas the inclusion of mental and social well-being necessitated additional diagnostic methods from psychology and psychiatry as well as sociology and social work, it is less clear as to what methods the spiritual dimension might lead.

Religion is also recognized as a *cultural* determinant of health. Global health practitioners recognize the importance of paying attention to the cultural context, including religious beliefs and practices, that shape individual understandings of health and exert influence on health-seeking behaviors. For example, whether or not a community endorses the practice of male circumcision has been shown to affect rates of HIV infection.<sup>27</sup> Religious practice is interpreted in this situation as a determinant of health outcomes, such that altering the practice would likely lead to a different outcome.

The third way in which global health recognizes and engages religion is as a potential ally in the fight to mitigate the social determinants of health. Social

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<sup>26</sup> Debates about whether or not spiritual is a necessary addition to the definition of health have been going on in the WHO since the 1980s. Does spiritual add anything not covered by mental and social well-being? Isn't a tired soul really just clinically depressed? Aren't persons who experience alienation from others, including transcendent others, really just socially maladjusted? That these debates have been given prominence in the WHO suggests that spiritual well-being may be a category unto itself. That the classic definition of health remains officially un-amended from its 1946 iteration in the Preamble to the WHO Constitution suggests that consensus on what spiritual well-being entails is hard to come by. The definition remains unchanged today, despite a general consensus emerging in the 1980s that health includes a spiritual component. See World Health Organization, *Preamble to the Constitution of the World Health Organization* (New York: World Health Organization, 1946). <http://www.who.int/library/collections/historical/en/index3.html>

<sup>27</sup> See Natasha Larke, "Male Circumcision, HIV, and Sexually Transmitted Infections: A Review," *British Journal of Nursing* 19, no. 10 (2010).

determinants refers to “the conditions into which people are born, grow, live, work and age” with heightened attention to how these conditions are affected by “the distribution of money, power, and resources at global, national, and local levels.”<sup>28</sup> The commitments of religious communities to provide care for those marginalized by existing social structures, religious articulations about the common good, or religious practices of charitable giving are all seen as conducive to a focus in global health on the social determinants of health.

These three forms of recognizing and engaging religion provide insight into the perceived *value* of religion to global health in the early twenty-first century. But what are the implications of this way of valuing religion? And how does the context of differentiation circumscribe discourse about which parts of religion add value to global health policies and programs?

I will argue in this dissertation that even though the trend within the global health public sphere at the level of the World Health Organization is towards the recognition of enduring public forms of religion—as exemplified by intentional efforts to include religious leaders in global health strategy sessions—the criteria of viability and desirability impose limits on religion that ultimately render religion *qua* religion irrelevant. The value of religious beliefs and practices are *recognized* and *engaged* but only when they take forms that do not challenge the epistemological grounds of global health, or more broadly the differentiation of modern structures. When religious beliefs or practices do challenge the epistemological grounds of global health, they may still be recognized but as an obstacle to be overcome. Neither the former nor the latter require

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<sup>28</sup> CSDH, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health: Final Report of the Commission on Social Determinants of Health* (Geneva: World Health Organization, 2008). [http://www.who.int/social\\_determinants/thecommission/finalreport/en/index.html](http://www.who.int/social_determinants/thecommission/finalreport/en/index.html)

global health leaders to come to terms with “religious opinions as *reasonably expected disagreement*.”<sup>29</sup>

I contend that the value of religion is circumscribed by definitions of viability and desirability generated largely within the modernist discourse of global health. This discourse privileges scientific positivism, evidence-based inquiry, and utilitarian moral reasoning. And these forms of privilege impose limits on how the value of religion is conceptualized by global health leaders and consequently how religious actors participate in conversations about global health policies and partnerships in global health programming. As a result of these limits the current turn to religion gives the *appearance* of what Casanova observes as the “changing boundaries between differentiated spheres,” but ultimately, I argue, fails to account for the full range of “possible structural roles religion may have within those differentiated spheres,” and, more to the point, “the role it [religion] may have in challenging the boundaries themselves.”<sup>30</sup>

That is, even within (and perhaps, in part, because of) the institutional differentiation characterizing the early twenty-first century, a turn to religious entities as allies that recognizes theo-ethical reflection as a distinctive contribution of religious leaders and communities represents an expansion of the current structural role that religion has come to play in recent global health initiatives. To support this expanded structural role, a clearer and more compelling account of how theo-ethical reflection is a health asset is necessary.

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<sup>29</sup> Italics in original. Jürgen Habermas, "Religion in the Public Sphere," *European Journal of Philosophy* 14, no. 1 (2006), 15.

<sup>30</sup> Casanova, *Public Religions in the Modern World*, 7.

## VI. NOT SEPARATE, BUT EQUAL

It is important to note that the turn to religion among global health leaders both confirms and complicates Casanova's differentiation-yet-deprivatization argument. The arena of global health is populated by a diverse array of participants from community health workers who have never traveled beyond their community to globe-trotting policy wonks whose concept of community relates more to profession than place. Global health by definition pulls these diverse participants together in an effort to promote better health outcomes in populations. The differentiation-yet-deprivatization argument best describes the trajectory leading to organizations like the WHO, arguably a first-world institution constituted, in part, by representatives from the two-thirds world. That is, the institutional logic of the WHO emerges primarily from a trajectory consistent with modern conceits from Western science and history that privilege certain rational modes of inquiry. For many communities, especially those whose history includes complex negotiations with colonial institutions and their legacies, differentiation remains inconsistent and deprivatization misleading, since the privatization of religion is less extensive, if it has occurred at all.<sup>31</sup>

So, while the differentiation between religion and health retains salience among policymakers and global health elites (e.g., those working for the World Health Organization), at the community level, it is not always possible to tease out distinctions between religion and health. Indeed, as Paul Germond and Sepetla Matimelo discovered while researching the relationship between religion and health in Lesotho, the distinction

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<sup>31</sup> Recent scholarly projects have taken issue with depictions of secularity as a singular phenomenon, advocating instead for an understanding of secularisms—though much of this conversation takes the West as its starting point. See, for example, Craig Calhoun, Mark Juergensmeyer, and Jonathan VanAntwerpen, eds., *Rethinking Secularism* (New York: Oxford University Press, 2011).

does not always make socio-linguistic sense. Instead, the Basotho people use the term *bophelo*, which Germond, Matimelo, and James Cochrane loosely translated as healthworld, to capture concepts related to well-being, human flourishing, and what is often meant by the term religion. The concept does not differentiate between spirit, mind, and body, nor does it suggest a distinction between individual and community well-being.<sup>32</sup>

Some of the implications of this way of understanding well-being can be seen in what public health workers recognize as plural health-seeking strategies in response to illness.<sup>33</sup> For example, an individual may go to the clinic to confirm their HIV-positive status, take the clinic card to a traditional herbalist for a customized remedy that may or may not include processes of divination, and return home to offer ritual sacrifices to ancestors. And then on Sunday, head to the Zionist church to participate in a faith-healing service.<sup>34</sup>

The example of *bophelo* helps focus my use of the terms religion and health. I do not directly engage questions raised by concepts like *bophelo* about contexts in which religion and health appear to be undifferentiated. Rather, to restate my central concern, I am interested in whether or not it is possible for processes of theo-ethical reflection to be recognized and appreciated as a health asset in public discursive spaces that have

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<sup>32</sup> Paul Germond, Sepetla Molapo, and Tandi Reilly, "The (Singular) Health System and the Plurality of Healthworlds" (paper presented at the ARHAP International Colloquium, Cape Town, South Africa, March 13-16, 2007); James R. Cochrane, "Seeing Healthworlds Differently," *Religion and Theology* 14, no. 1 (2007).

<sup>33</sup> This is not limited to the Basotho, of course. When confronted with illness, many persons do not limit their pursuit of healing to the standards of care legitimated within the practice of Western medicine. It is not clear that combining health-seeking strategies necessarily reflects ontological assumptions about the world, as *bophelo* seems to, or practical resignation—"well, it certainly can't hurt to try prayer, acupuncture., etc."

<sup>34</sup> Jonny Steinberg depicts the fluidity of these plural health-seeking strategies in his engaging account of the HIV pandemic in a rural community in South Africa. See Jonny Steinberg, *Sizwe's Test: A Young Man's Journey through Africa's AIDS Epidemic* (New York: Simon & Schuster, 2008).

emerged as a result of modern processes of differentiation, such as global health policy debates. The turn to religion observed in this dissertation, I contend, does not signal a substantive shift in the logic of this differentiation in any significant way. The turn to religion shifts attention to the possibilities for partnerships between global health and religion, but it does not fundamentally challenge the assumptions of a differentiated world. Indeed the recent, explicit turn to religion as an ally in global health only makes sense within the modern context of differentiation. That is, the institutional differentiation of health and religion gives global health something to turn to that is perceived as somehow other than global health. In contexts where this differentiation is less pronounced, the example of *bophelo* above, there is, in a sense, nothing to turn to since it is all of a piece.

The problematic in this dissertation arises in part because global health tacks back and forth among contexts that exhibit varying degrees of institutional differentiation. Global health practitioners may work in communities with largely undifferentiated healthworlds, but often make policy in highly differentiated settings with clear separation between the scientific evidence-base and other types of claims. Given my own training in a liberal theological tradition that assumes a context of differentiation, and my concern for the implications of this assumption for the limits and possibility of theology, the constructive response in this dissertation is focused on the latter. In order to understand how this focus affects the claims possible within this dissertation, it is necessary to clarify the use of four terms: global health, religion, religious health assets, and theo-ethical reflection.

## **VII. CLARIFYING THE TERMS: GLOBAL HEALTH, RELIGION, RELIGION, HEALTH ASSETS, THEO-ETHICAL REFLECTION**

One of the challenges inherent in an interdisciplinary dissertation is to develop working definitions of key terms that are both meaningful within a discipline and recognizable to those in other disciplines. How are global health, religion, and theology being used in various settings? When global health leaders refer to religion, do they mean the same thing as when theologians invoke the term? When Christians talk about health, do they assume the WHO definition? Do they distinguish between public health and clinical medicine? Or between public health in the U.S. context and global health? That these terms require separate definitions is, in large part, reflective of the differentiated context described above. Differentiation introduces problems of definition as the practices of religion and health take place largely in separate institutions with, if not mutually exclusive, at least distinguishable moral logics.

The following offers working definitions of four terms central to this dissertation. A full history of the varied and contested use of these terms within their respective disciplines is beyond the scope of this dissertation, though some of the debates will be recognizable to theologians, religion scholars, and public health professionals. The working definitions emerge from my own formal training in the liberal theological tradition and Christian social ethics as well as my experiences participating in intentionally interdisciplinary conversations with global health and religious professionals, theologians, and religious studies scholars.



## GLOBAL HEALTH

In recent years, the term global health has come to replace what was commonly known as international health in the late nineteenth and early twentieth centuries.<sup>35</sup> Whereas international health focused primarily on “the control of epidemics across the boundaries of nations,” global health implies a concern for “the health needs of the people of the whole planet above the concerns of particular nations.”<sup>36</sup> One of the practical implications of this shift is an expanded sense of who the actors are in global health. Nation-states are still an important component of the global health system, but increasingly so, too, are philanthropic foundations, international nongovernmental organizations, transnational corporations, pop culture celebrities, the media.<sup>37</sup> In describing the turn of global health toward religion, I intend this expansive understanding of the “who” of global health. The particular ways in which several of these institutions have turned to religion is taken up below in chapter three.

While there has been a proliferation of institutions which have taken up the global health banner, the World Health Organization (WHO) remains symbolically and structurally the center of the global health field; the themes of its annual reports consistently shape discussions in the international and national policy arena as well as the curriculum revisions in public health professional schools. The definition of health enshrined in the WHO constitution has now become the conventional wisdom: “*Health is*

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<sup>35</sup> For evidence of the increasing frequency of the term global health, see James E. Banta, "From International Health to Global Health," *Journal of Community Health* 26(2001).

<sup>36</sup> Theodore M. Brown, Marcos Cueto, and Elizabeth Fee, "The World Health Organization and the Transition From "International" To "Global" Public Health," *American Journal of Public Health* 96, no. 1 (January 2006), 62.

<sup>37</sup> *Ibid.*

*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*"<sup>38</sup> While this definition reflects a more holistic conception of health, drawing on a variety of disciplines including psychology and sociology to understand well-being, the definition of health and the measurement of well-being continue to privilege a scientific understanding of the world.<sup>39</sup> Such privileging can admit a "metaphysical entity that cannot be proven or disproved but that nevertheless is believed to interact" with human beings, but only as descriptive data—for example, statements *about* religious beliefs and practices that affect health outcomes—and not as normative claims about the nature of well-being itself.<sup>40</sup>

## RELIGION

Religion will be used generally in this dissertation to refer to "a wide variety of comprehensive systems of sacred beliefs and practices, usually (but not always) issuing in religious institutions, groups or organizations that range from fluid to codified, popular to formal, centralized to decentralized, communal to institutional."<sup>41</sup> This is the working definition employed by the African Religious Health Assets Program (ARHAP) in their

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<sup>38</sup> World Health Organization, *Preamble to the Constitution of the World Health Organization*.

<sup>39</sup> As Bishop Desmond Tutu's words imply at the outset of this chapter, the current definition is not as expansive as it could be. It does not include spiritual well-being, despite periodic attempts at the World Health Assembly to revise the definition to include some acknowledgment of the connection between one's spiritual well-being and one's overall health. The terms of the debate about whether and how to include spiritual well-being within the WHO framework are indicative of the types of challenges inherent in the turn to religion, including the pressure to operationalize well-being. The challenge to operationalizing well-being need not be exclusive to disciplines such as theology, psychology, for example, may also resist global health policies that reduce mental health to a measurable set of inputs and outcomes. For a discussion of these debates, see James S. Larson, "The World Health Organization's Definition of Health: Social Versus Spiritual Health," *Social Indicators Research* 38, no. 2 (1996).

<sup>40</sup> See, for example, Christoph Benn's distinction between the scientific and religious frameworks for understanding both the virology, prevention, and treatment of HIV in sub-Saharan Africa. Christoph Benn, "The Influence of Cultural and Religious Frameworks on the Future Course of the HIV/AIDS Pandemic," *Journal of Theology for Southern Africa* 113(2002), especially 6-7.

<sup>41</sup> African Religious Health Assets Programme, "Appreciating Assets: The Contribution of Religion to Universal Access in Africa," (Research Report for the World Health Organization, 2006), 38.

reports to the World Health Organization and other global health institutions. The definition is generous enough to include institutions at all levels—from traditional, local African healers to the global Catholic Church—as conduits for systems of sacred beliefs and practices. The definition is also practical in that it reflects how religion is used in formal and informal global health discourse (e.g., at conferences, in white papers, in policies, and in academic publications).<sup>42</sup>

This latter point raises an important qualification. When religion is referenced in health literature, it is usually an answer to the question: what is religion *doing* in a particular context to promote or hinder the global health agenda? It is rarely discussed in terms of how religious beliefs and practices related to health and human flourishing might *constructively* critique assumptions contained within health policies and practices, themselves. So, for example, religion is understood as an independent variable in which the dependent variable is health outcomes. Whether explained in psychological, anthropological, or sociological terms, the concern is for how specific religious beliefs and practices impact health outcomes.<sup>43</sup>

So while the distinguishing feature of religion is captured in the above definition by the descriptor *sacred* with reference to beliefs and practices, from a global health

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<sup>42</sup> The related concept of a *religious entity* underscores the range of “regular” and “amorphous” forms religion takes in the world, and seeks to avoid the narrower, though much more recognizable, term faith-based organization. Traditional African healers are religious entities, but not faith-based organizations. Though much of the dissertation focuses on entities that would conform to the popular understanding of faith-based organizations, the turn to religion in global health can and does include a turn to religious entities such as traditional African healers. Public health efforts in South Africa to partner with traditional African healers in the treatment of HIV exemplify this claim about the broader interpretation of the turn to religion then is offered in this dissertation.

<sup>43</sup> For a general review of various ways religion is understood in relation to health, see Jill Olivier et al., “ARHAP Literature Review: Working in a Bounded Field of Unknowing,” (2006). For examples of how religion is studied as an explanatory variable see Harold G. Koenig and Harvey Jay Cohen, *The Link between Religion and Health: Psychoneuroimmunology and the Faith Factor* (Oxford: Oxford University Press, 2002).

perspective, such a descriptor matters primarily to signify a category of beliefs and practices that stand in contrast with the epistemological basis and evidence-base on which scientific claims and practices rest.

An example of this is a sacred belief or practice that admits to some degree what Christoph Benn described as a “metaphysical entity that cannot be proven or disproved but that nevertheless is believed to interact” with human beings and cannot be integrated into global health discourse without first expanding the epistemological boundaries of science-based global health.<sup>44</sup> At first glance, recent efforts to study the relationship between prayer and healing or religious participation and health suggest a willingness to expand the epistemological boundaries, at least at the level of individual health outcomes. However, these efforts are predicated on an initial reduction of religion to an operationalizable variable, a mechanism that can be isolated in terms of causality or correlationality. One way to think about this is that even when religious beliefs are not granted explanatory status by medical professionals, for example as viable etiologies of disease transmission, the beliefs remain viable “data” for social scientists attempting to understand the correlation of religious participation and health outcomes or religious beliefs and reduced HIV prevalence.<sup>45</sup> The dissertation probes the forms of engagement that have come to characterize global health partnerships with religion in part to

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<sup>44</sup> See, for example, Christoph Benn’s distinction between the scientific and religious frameworks for understanding both the virology, prevention, and treatment of HIV in sub-Saharan Africa. Benn, “The Influence of Cultural and Religious Frameworks on the Future Course of the HIV/AIDS Pandemic.”, especially 6-7.

<sup>45</sup> Robert C. Garner, “Safe Sects? Dynamic Religion and AIDS in South Africa,” *The Journal of Modern African Studies* 38, no. 1 (2000).

determine whether such scientific understandings of religion limits what is possible in partnerships between global health and religion.<sup>46</sup>

### *RELIGIOUS HEALTH ASSETS*<sup>47</sup>

Religious Health Assets (RHAs) are defined as “an asset located in or held by a religious entity that can be leveraged for the purposes of development of public health.”<sup>48</sup>

In an attempt to clarify different kinds of religious health assets (RHAs) observed throughout sub-Saharan Africa, ARHAP distinguishes between *tangible* and *intangible* assets.<sup>49</sup> ARHAP defines tangible assets as: “The more visible and most studied religious health assets, including facilities, personnel, and activities, sometimes resembling those of secular entities.”<sup>50</sup> Tangible assets include such things as church buildings, denominational networks, lay care workers, etc. In sub-Saharan Africa, the tangible

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<sup>46</sup> For a recent example of how religious studies scholars, social scientists, and development practitioners are paying attention to the ideas and not just the institutions of religion in economic development partnerships, see Gerrie ter Haar, ed. *Religion and Development: Ways of Transforming the World* (New York: Columbia University Press, 2011).

<sup>47</sup> The language of religious health assets owes a debt to the field of community-based assets development, particularly as understood in the work of John Kretzmann and John McKnight. ARHAP summarizes their use of Kretzmann and McKnight as follows: “[Community-based assets development] takes as its starting point the concern that people and their communities should not be viewed in the first instance in terms of deficits that hamper their development, and that needs analysis is thus not the best first step in determining appropriate development interventions. Instead, the view is on the assets that people have and that they leverage (even to survive), which may be further mobilised or strengthened for development, thereby empowering communities by beginning from what they know and do and building on that.” Olivier et al., “ARHAP Literature Review: Working in a Bounded Field of Unknowing,” 11. See also, John Kretzmann and John McKnight, *Building Communities from the Inside Out: A Path toward Finding and Mobilizing a Community's Assets* (Chicago: ACTA Publications, 1993); *Asset-Based Strategies for Community Development* (Chicago: Asset-Based Development Institute of Northwestern University, 2002).

<sup>48</sup> The definition can be found under “religious health asset” in the glossary of African Religious Health Assets Programme, “Appreciating Assets.”

<sup>49</sup> The distinction between tangible and intangible health assets is a source of considerable debate within ARHAP. The discussion presented here takes its cue from one of the initial matrices presented by ARHAP to explore the utility of the distinction. My proposal in this dissertation for a mutually generative encounter between religion and global health engages this distinction by focusing on Christian theo-ethical reflection as a religious health asset. See chapter three below for a matrix representing ARHAP’s intangible and tangible religious health assets.

<sup>50</sup> See “tangible assets” in the glossary of African Religious Health Assets Programme, “Appreciating Assets.”

RHAs most visible to public health systems are church-affiliated hospitals and clinics as well as the national-level Christian Health Associations common in many countries.

While the concept of tangible religious health assets has gained purchase among global health leaders, the central question of this dissertation is intimately related to the less well understood (and, correlatively, less well-documented) concept of an intangible religious health asset. That is, to ask whether religion make a *distinctive* contribution to global health requires some attention to dimensions of religion or assets of religious entities that cannot simply be replicated by non-religious entities, such as a secular nongovernmental organization. If there is a distinctive contribution it is likely to emerge, at least in part, from something like an intangible asset.

ARHAP identifies intangible religious health assets as the “volitional, motivational and mobilising capacities that are rooted in vital affective, symbolic and relational dimensions of religious faith, belief, behaviour and ties.”<sup>51</sup> This intangible dimension has proven much more difficult to operationalize in ARHAP research, yet it remains at the heart of an inquiry into the impact (positive and negative) religious entities have had in the response to HIV.

What exactly the concept of intangible religious health asset refers to remains elusive—and not only for public health folks. For sociologists of religion and theologians involved in ARHAP projects mapping the religious health assets in communities, questions remain about what counts as an intangible asset, how to determine its presence in a community, how to measure its impact, etc.<sup>52</sup> In part, it is a problem of

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<sup>51</sup> ARHAP, *Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho*, Report to the World Health Organization, 2007, 40.

<sup>52</sup> ARHAP, "Appreciating Assets: Mapping, Understanding, Translating, and Engaging Religious Health Assets in Zambia and Lesotho," (Report to the World Health Organization, 2006), 25

operationalizing theologically resonant concepts like hope. For example, if eschatological visions of a better world, a beloved community, or the great bye-and-bye emerge from various theologies of hope within the Christian tradition, do these theologies (and the practices they generate) suggest distinctive responses to HIV, perhaps even responses yet unimagined by global health actors?

Chapter two shows how tensions between religious entities and global health often have a theological framing, for example, theological framings of disease as punishment. This suggests that the distinctive contribution of intangible dimensions of religion may be recognizable to global health, though primarily as something akin to a religious health liability. But can distinctive theological framings be understood as a health asset equally, if not more important than, other tangible assets? This dissertation presents a theoretical argument and case studies that suggest this is possible.

### *THEO-ETHICAL REFLECTION*

In the post-9/11 world, there appears to be a standing invitation for partnerships predicated on the notion that religion is an asset to be leveraged, or minimally, that efforts to better understand religious beliefs and practices are necessary for work in a variety of fields including international relations, economic development, and global health. Scholars and religious leaders contribute to social issues by describing, explaining, or analyzing the beliefs and practices of various religious communities. In a phrase, it is an invitation to *say something about religion*. It is not, however, an invitation to “say something theological,” a distinction James Gustafson highlighted in his seminal essay by the same name. The challenge to “say something theological” remains for those of us who stand in the liberal Protestant theological tradition. Or more precisely, in a

“post-(Reinhold) Niebuhrian world,” the challenge persists to say something theological that can still be heard in and affect the priorities of various formal assemblies of power—from the World Health Assembly to the Congress to the research university quadrangle.<sup>53</sup>

In Christian theological ethics this challenge has been understood as one of the fundamental paradoxes of faith. H. Richard Niebuhr describes it as the paradox of external and internal histories, or the “two-aspect theory of history.” For Niebuhr the paradox is constitutive of Christianity, allowing Christians to “understand how revelation can be in history and yet not identifiable with miraculous events as visible to an external observer and how events that are revelatory in our history, sources of unconquerable certainty for us, can yet be analyzed in profane fashion by the observer.”<sup>54</sup> More recently, debates within religious studies have attempted to name, if not resolve, the methodological challenges such a paradox poses to the study of religion, particularly given doubts about the degree to which a scholar can perform the phenomenological suspension of judgment in the study of religious beliefs and practices in one’s own confessional tradition, let alone another’s tradition.<sup>55</sup>

The problem of internal and external histories and the so-called “insider/outsider” dilemma it gives rise to in the study of religion suggest a deeper and wider context for the concerns of this dissertation. So, for example, theological claims about health and human flourishing can be seen as authoritative but only as part of a history internal to a particular faith tradition. This does not mean such theological claims cannot impact the practice of

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<sup>53</sup> The phrase “post-Niebuhrian world” suggests that the context in which Reinhold Niebuhr functioned as a public theologian can no longer be assumed. For an analysis of this change, see Dorrien, *Soul in Society: The Making and Renewal of Social Christianity*.

<sup>54</sup> H. Richard Niebuhr, *The Meaning of Revelation* (New York: Macmillan Publishing Company, 1941; repr., 1967), 82

<sup>55</sup> Russell T. McCutcheon, ed. *The Insider/Outsider Problem in the Study of Religion: A Reader* (New York: Cassell, 1999).



global health, but the impact is limited by their status as confessional statements. That is, the theological claims can be informative, shedding light on why a particular faith tradition might endorse a specific health-seeking behavior, for example. In this way, such claims can affect how a global health campaign is marketed or implemented. But this is to understand theology as something that has been done, rather than a doing—to focus on the outcome of the theological reflection rather than the ongoing process of correlating lived experience with the responses of faith traditions to the nature of human being and flourishing. Robert Kinast extends this understanding of theological reflection to include the practices it generates. The task of theological reflection is, according to Kinast, “to allow the reality of theology to come through its distinct form, namely, experience correlated with tradition for the sake of praxis.”<sup>56</sup>

Though I am sympathetic to this understanding of theological reflection, what I point toward in this dissertation, and the theoretical sources I draw on, suggest a process that is better conceptualized as *theo-ethical reflection*. Douglas Ottati’s recent articulation of the relationship between theology and ethics shows why this emphasis is appropriate for the interdisciplinary and inter-axiological context of this dissertation.<sup>57</sup> Ottati explains:

Important elements of ethics are not determined by theology alone. Other disciplines, many of them empirical, go into interpreting circumstances calling for moral action... . Again, in addition to theology, our estimates of human possibilities and limits are responsive to philosophical perspectives,

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<sup>56</sup> Robert Kinast, *What Are They Saying About Theological Reflection?* (Mahwah, NJ: Paulist Press, 2000), 3.

<sup>57</sup> Inter-axiological is an awkward phrase, but it is intended as a descriptor for contexts, like global health, in which implicit and explicit descriptive and normative accounts of human being are present but valued by differently by different participants.

interpretations of biological bases for agency, and so on, not to mention insights garnered from biographies and novels. Multiple lines of reflection contribute to our understandings of moral norms such as fairness, justice, and care for the weak and dependent.<sup>58</sup>

On this reading, the general correlational method of theological reflection, articulated in the above quote by Kinast, requires some refining. The broad category of experience must include descriptions of human experience as mediated through other disciplinary lenses. Similarly, any practices generated must be accountable not only to the descriptive knowledge generated by other disciplines, including any limits on enacting the practices themselves, but also to the variety of moral languages that are used to justify or reject certain practices. And, I would fill in Ottati's "and so on" with attention to how social and institutional locations can circumscribe the arena of moral action. Taken together, these constitute the interpretive task of *theo-ethical* reflection. So what does it mean, then, to say something *theo-ethically*? James Gustafson's famous response to the invitation from his colleagues to "say something theological" provides an initial clue.

Gustafson asserts that "To say something theological is to say something about how things really and ultimately are."<sup>59</sup> Theology as ontology is, he admits, the "most troublesome" aspect of the "theological enterprise."<sup>60</sup> Throughout this dissertation

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<sup>58</sup> Douglas F. Ottati, "How Can Theological Ethics Be Christian?," *Journal of the Society of Christian Ethics* 31, no. 2 (2011), 16.

<sup>59</sup> James M. Gustafson, "Say Something Theological!," in *Moral Discernment in the Christian Life: Essays in Theological Ethics*, ed. Theo A. Boer and Paul E. Capetz (Louisville: Westminster John Knox Press, 2007), 90

<sup>60</sup> *Ibid.*, 91 A less troublesome way of saying something theological is to limit the implications of theological discourse to religious confessional communities—to say how things really are from the perspective and for the purposes of a living, historically conditioned faith tradition. Gustafson identifies this as one of the two senses two in which saying something theological is also saying some religious: "to speak from a religious tradition, while also being open to its alteration and revision." *Ibid.*, 89

theology is intended in this “most troublesome” way. But this is a more modest claim than it might appear.

For Gustafson theological speech is also religious speech inasmuch as what we say “about the ultimate power is moved and informed by piety,” or the religious affections of dependence, gratitude, obligation, remorse, a sense of possibility, and a sense of direction. Taken together, then, theology is the form human response takes to “*the power that induces piety.*”<sup>61</sup> And it is in the process of reflecting on and responding to God, or “the power that brings all things into being, sustains them and bears down on them, and creates the conditions of possibility for newness and renewal,” that we come to discover something about the way things really are. Importantly for the task of Christian ethics, reflection on the power that induces piety as well as the form of the human response leads to Gustafson’s practical moral question: “What is God, the divine governance, enabling and requiring us to be and to do?”<sup>62</sup>

To determine whether or not such reflection and response might have something to say about current practices of global health is complicated by the context of differentiation that has made possible the modern global health system. It became increasingly clear to me that when I attempted to say something theological, about what it means to be finite human beings, for example, it was heard not as an insight into the human condition (an ontological claim in any sense), but as a form of ethnographic data about what some humans believe. In this sense, to say something theological in a conversation about global health is simply to reveal something about the theologian. In

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<sup>61</sup> Ibid., 89.

<sup>62</sup> Ibid., 97.

contrast, to say something scientific is to say something about the way the world really is, and not about the scientist or the one making the claim.

This dissertation does not fully reconcile the differences in these two types of claims, for example by defending theological claims as legitimate claims about the way the world really is or by de-masking scientific claims as self-expressions of the scientist making the claims. Instead, as my statement of the thesis above indicates, I take a more pragmatic approach: giving voice to others who have said something theological and been heard within global health circles. In this way, I demonstrate how processes of theo-ethical reflection have had an impact on global health paradigms. Admittedly, this strategy already accepts the epistemological premises of global health: the demand to provide evidence of the effect of theology on global health, or, to make theology relevant. But given the modern context of differentiation, the recent history of actual and perceived tensions between religious entities and global health in the response to AIDS, and my primary audience, this is a necessary starting point.

By providing evidence of this effect, I hope to justify space within global health for religious leaders and Christian ethicists to be recognized not only as assets to be leveraged but also as “participant theologians,” whose processes of critical theo-ethical reflection are a health asset because of the mutually generative conversation about health and human flourishing they help to create, clarify, and sustain. A participant theologian, according to Gustafson, is a theologian that is active “in the shaping of events and in the development and reordering of institutions,” a partner who “brings to bear the insight and wisdom of the Christian community’s long historical reflection about the chief ends of man [*sic*]” in order to transform “the processes of public opinion formation” about issues

that impact human flourishing.<sup>63</sup> The participant theologian is a consistent practitioner and facilitator of processes of theo-ethical reflection.

The potential value of theo-ethical reflection is shown in several ways throughout this dissertation, as the chapter outline below describes. But I also endeavor to show the value of theo-ethical reflection by employing theo-ethical reflection as the method in this dissertation. This method takes the general form articulated by Kinast as “experience correlated with tradition for the sake of praxis.”<sup>64</sup>

Jon Gunnemann’s method of interpretive Christian ethics shows more specifically how I understand “experience” in this general form. Gunnemann locates the Christian ethicist at the intersection of four mutually interpreting elements of moral judgment: moral reasoning and forms of moral language, theological and quasi-theological beliefs, empirical evidence, and social and institutional location. The emphasis in this method is on the descriptive and interpretive tasks, rather than the normative task of Christian ethics. The method requires the Christian ethicist to spend significant time describing and interpreting what is going on in complex social phenomena prior to making any normative claims. The four elements provide an analytical structure for this interpretation, highlighting where disagreements do and might occur.<sup>65</sup> For example,

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<sup>63</sup> "The Theologian as Prophet, Preserver, or Participant," in *Theology and Christian Ethics* (Philadelphia: United Church Press, 1974), 84

<sup>64</sup> Kinast, *What Are They Saying About Theological Reflection?*, 3.

<sup>65</sup> I am indebted to Jon Gunnemann for introducing me to and showing me the potential of this interpretive method of Christian ethics. Gunnemann used the four elements of moral judgment in his introduction to Christian ethics courses at the Candler School of Theology, Emory University. Gunnemann’s interpretive method is an adaptation James Gustafson’s argument in James Gustafson, "Context Versus Principles: A Misplaced Debate in Christian Ethics," *The Harvard Theological Review* 58, no. 2 (1965). For Gunnemann one of the primary tasks of the Christian ethicist is to clarify the location of moral disagreement. Others have developed versions of this interpretive framework though with different emphases. For example, Ralph Potter’s “four elements of moral reasoning” seeks to limit the task of the Christian ethicist to the ethical reasoning element and focuses on moral judgment, rather than locating disagreement. Potter’s method is articulated succinctly in Ralph Potter, "The Logic of Moral Argument," in *Toward a Discipline of Social Ethics: Essays in Honor of Walter George Muelder*, ed. Paul Deats, Jr. (Boston: Boston

persons analyzing a complex social phenomenon may disagree on the empirical evidence. This is one of the more obvious disagreements within academic disciplines. But disagreements may also be caused by differences in institutional and social locations that inform one's interpretation of the morally relevant dimensions of a phenomenon. Individuals may privilege certain moral languages over others (e.g., utilitarian over deontological) or prioritize particular theological commitments as key to understanding a phenomenon (e.g., interpreting a phenomenon as the result of original sin). Methodologically, the interpretive task requires the Christian ethicist to pay attention to all of these possibilities when doing theo-ethical reflection, discerning in the process which elements are most salient and offering a justification for why.

To talk about theo-ethical reflection as a health asset raises fundamental questions about what counts as theological. It is beyond the scope of this dissertation to map the full topography of these debates. However, given the concern in this dissertation for the turn to religion's insufficient attention and often outright hostility to what I understand to be the theological, it is necessary to work with a method of doing theo-ethical reflection that, one, stands a chance of getting to the global health table, and two, has something theological to say that can be heard in global health circles.

For these reasons, the method of doing theo-ethical reflection in this dissertation emerges from and is informed by actual participation in interdisciplinary projects, that is to say, it is *rooted* in the *context* of interdisciplinary dialogue and praxis related to religion and global health. As such, the method of theo-ethical reflection in the

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University Press, 1972). The four elements of moral reasoning have also been developed in the interpretive sociology of Steven Tipton, especially in his analysis of the structures of four different "styles of ethical evaluation." See Steve Tipton, "Social Differentiation and Moral Pluralism," in *Meaning and Modernity: Religion, Polity, and Self*, ed. Richard Madsen, et al. (Berkeley: University of California Press, 2002).

dissertation is oriented by the goal of articulating an understanding of health and human flourishing that attends with greater sensitivity to the complex and diverse human experience of suffering and illness. That is, theo-ethical reflection is undertaken with the goal of saying something about the way things really are—even though such statements are understood as provisional and incomplete.<sup>66</sup>

This context is animated by all four of Gunnemann's elements of interpretation. To describe what is going on in this context (experience) is to pay attention to how these four elements mutually interpret one another. So, for example, an interpretation of the antiretroviral treatment debates necessarily requires paying attention to the ways in which policymakers (institutional role) assess the cost-effectiveness of ARVs (empirical evidence) and draws on utilitarianism (moral language) to justify policy decisions. The fourth element—theological or quasi-theological worldviews—may not be as visible in this particular example, but it is often present and even determinative in some sense of the other three elements. This is, in part, what a method of interpretive Christian ethics helps to clarify.

In Kinast's model, the correlation of the experience or context with a religious tradition often takes place with reference to a particular confessional community. Denominations or church study groups carry out theo-ethical reflection for the purposes of guiding a particular community's response to the situation. While it is certainly possible to approach the topic of this dissertation from well-defined confessional histories

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<sup>66</sup> I am aware that one of the critiques most often leveled against theology done in a liberal key is its apparent desire to be relevant, connoting an acquiescence to agendas shaped by the powers of the world rather than the narrative of the Christian tradition. In this sense, some might see rootedness as double-speak for relevance, or the need to be liked. As described in more detail in the chapters on Gustafson and the Christian Medical Commission, the particular form of theo-ethical reflection I advocate acts as a rebuttal to the critique of relevance. For an example of this critique, see the work of Stanley Hauerwas. Stanley Hauerwas, *The Hauerwas Reader*, ed. John Berkman and Michael G. Cartwright (Durham, NC: Duke University Press, 2001).

and commitments, I have elected to focus more broadly on the liberal theological tradition for two reasons.

The first reason for this broader approach is that my formal disciplinary training in Christian theology and ethics has taken place largely in liberal, ecumenical Protestant institutions in the United States. As a Christian social ethicist within the Protestant, liberal theological tradition, I take as constitutive of any definition of Christianity a commitment minimally to raising questions about how our apprehension of God as an active presence in the world informs our engagement with existing structures of the world and how human understanding of the world informs theo-ethical claims. As a practicing Christian, my institutional location has moved from the United Methodism of my youth to the Lutheranism of my college years to the intentionally ecumenical United Church of Christ seminary. (And while I am not Catholic, my current faculty position is at a Franciscan university that has integrated the Catholic tradition into its new core curriculum.) These different contexts have provided to varying degrees the catechesis for my understanding of the Christian tradition such that I cannot claim with any authority to speak as a Lutheran, Methodist, or Reform theo-ethicist.

As will be made explicit in chapter four, my extensive use of Gustafson mediates the Calvinist tradition in a particular way that has proven over time influential in my theo-ethical thinking, especially with regards to theocentricism / theological naturalism, and in this way gives direction to my processes of theo-ethical reflection and shape to my theo-ethical claims. But this influence has been done with very little exposure to the liturgies of the Reform tradition or sustained participation in Reform congregations. Rather my initial commitments to the broader liberal theological tradition were formed



through participation in United Methodist service-oriented youth groups, Lutheran peace and justice focused summer camps, and as a young adult delegate to the National Council of Churches, each of which manifest in various ways the legacy of a twentieth-century social Christianity more explicitly than any particular confessional identity. This leads to the second reason why I have focused more broadly on the liberal theological tradition rather than a specific confessional tradition.

The second reason for this broader approach to tradition has to do with sociological arguments about the “restructuring” of religion, at least in the U.S. context. Confessional commitments or denominational identities retain less salience in the twenty-first century than they did (or at least were perceived to) in previous decades. To wit, while different streams of the Christian tradition continue to convey something about the persons who swim in them, these persons swim in other streams as well. As Robert Wuthnow argues, denominational identity is often less telling than a liberal or conservative disposition, as manifest in theological, social, and political commitments. So, for example, liberal Lutherans, Calvinists, and Catholics are likely to share more in common with one another than they do with their conservative counterparts who confess the same creeds and follow the same liturgies.<sup>67</sup> Anecdotally, this has been my own experience in the various ecumenical contexts described above. While I do not find it possible to speak authentically as a denominationally specific Christian ethicist, I also do not find it accurate to speak of the Christian tradition without distinctions. By identifying the liberal theological tradition as the “tradition” in my theo-ethical reflection I intend to signal a basic stance toward modern ways of knowing about the world that I believe is

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<sup>67</sup> Wuthnow, *The Restructuring of American Religion: Society and Faith since World War II*.

supported by groups of Christians within a variety of denominations even as it is opposed by others.

The third moment in Kinast's general mode of theological reflection, praxis, is informed by the description and interpretation of experience or context and by resources from within the liberal theological tradition. In the argument below, the participant theologian is one such resource from the tradition that suggests the shape of the response, in this case, efforts to create spaces of transdisciplinary praxis among religious and global health actors. This response, or the praxis moment of theo-ethical reflection, is not conceived of as an end, but as the catalyst for re-describing and re-interpreting the context. That is, the method of theo-ethical reflection is characterized as a cycle, or perhaps better, as a spiral. Each moment of praxis reveals the limits and possibilities of the previous, provisional descriptions as well as the correlations with elements of the Christian tradition, moving at times towards and at times away from theo-ethical claims that can be heard by others as ontological claims, as saying something about how the world really is.

The following chapter outline shows how this method of theo-ethical reflection is carried out in the dissertation.

## **VIII. CHAPTER OUTLINE**

### *CHAPTER TWO – Chronic Tension in a Diachronic Pandemic: Religious Morality in an HIV-Infected World*

The turn to religious entities as allies suggests a time when religious entities were not sought out as partners. Chapter two situates the turn to religion within a longer history

of tensions—actual and perceived—animating the relationship between religious entities and global health organizations. The global response to the HIV pandemic is used as a lens for understanding these tensions. The first half of this chapter provides background on the scope and scale of the HIV pandemic. Though not intended as a comprehensive history of the pandemic, the snapshot of the current pandemic helps locate the changes taking place in the relationships among religious entities and global health institutions within the unique context of a chronic pandemic. The second half of the chapter focuses on a stigmatization of persons affected by HIV and AIDS as a particular examples of how theo-ethical commitments have functioned as a health liability in the global response to AIDS.

*CHAPTER THREE – Appreciating Religion as a Health Asset: The Turn to Religion in an HIV-Infected World*

Chapter three provides a review of the literature in which a turn to religious entities as allies can be clearly seen. Two related reasons for this turn are discussed: the recognition of religion as relevant and the identification of religion as a health asset. As in chapter two, the contemporary response to the HIV pandemic is employed as a lens through which the intentional turn to religion can be observed. Drawing from the academic and gray literature—governmental reports, white papers, and meeting notes—as well as my own participation in structured interdisciplinary religion and public health conversations, I show that the partnerships being cultivated between religion and public health are predicated on a re-assessment of the potential value of certain religious activity.

After showing the reasons for the turn to religion, the second half of the chapter evaluates the viability of the concept of religious health assets as justification for the turn to religion, asking does the religious health assets framework capture fully the activity of religious entities in response to HIV and AIDS?

*CHAPTER FOUR – The Possibility of Theo-Ethical Participation: Participant Theologians in the Intersections*<sup>68</sup>

While the turn to the intentional engagement of global health with religious communities is welcome in many ways, it remains from the perspective of Christian ethics. Chapter four draws on the liberal theological tradition, especially as expressed in the work of James Gustafson and the feminist Catholic theological ethics of Lisa Sowle Cahill. Using Gustafson and Cahill I develop an account of the participant theologian that can serve as a conceptual bridge for understanding theo-ethical reflection as a religious health asset.

The recognition of religious health assets that have been the catalyst for new partnerships are necessary but not sufficient for understanding the distinctive contribution religious entities might make to global health. To understand this distinctive contribution more fully, I argue, requires attention to what I call *the persistence of the theological*. While Gustafson's work does not attend specifically to the global response to HIV or global health, his analysis of the possible relationships among theological and nontheological disciplines focuses attention on what I refer to as the persistence of theo-ethical reflection in complex, interdisciplinary phenomena. Cahill's participatory

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<sup>68</sup> Portions of chapters four and five were published previously in an abridged form and are reprinted here with the permission of the author. For the original publication, see Matthew Bersagel Braley, "Checking Vitals: The Theological (Im)Pulse of Christian Leadership in Global Health," *Practical Matters*, no. 4 (Spring 2011), <http://www.practicalmatters.org>.

theological bioethics expands and deepens Gustafson's understanding of participation to make more explicit the role of theologians in public conversations beyond the academy. The goal of this chapter, then, is relatively modest: to locate global health in an interdisciplinary intersection in which processes of theo-ethical reflection might persist. Gustafson and Cahill help to clarify for global health actors the limits and possibilities for a broader and deeper engagement with processes of theo-ethical reflection and the claims they generate.

*CHAPTER FIVE –Participatory Theo-ethical Reflection in an HIV-Infected World: A Contemporary Case Study of the Masangane Integrated HIV Treatment Program*

Chapter five focuses on the Masangane AIDS Treatment Program as a contemporary case study of the process theo-ethical reflection in an organizational setting. The case study illustrates the multiple ways in which religious entities are health assets. By describing the role of theo-ethical reflection in the activities of Masangane, I raise the possibility of theo-ethical reflection as an important health asset. In its geographical and historical locations as well as its evolution from an orphan care program to a treatment and advocacy program, Masangane reflects, refracts, and interacts with many of the global “forces, connections, and imaginations” affecting the global response to AIDS.<sup>69</sup> As such, the case study provides a unique lens through which to see the ongoing process of theo-ethical reflection in an HIV-infected world. Masangane's theo-ethical framing of its work, articulated variously as a “theology seeking justice” and

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<sup>69</sup> Michael Burawoy et al., eds., *Global Ethnography: Forces, Connections, and Imaginations in a Postmodern World* (Berkeley and Los Angeles: University of California, 2000).

“theology of abundant life,” highlight, at the programmatic level, one way in which processes of theo-ethical reflection can be understood as vital health assets.

*CHAPTER SIX – The Recovery of Participant Theologians in Global Health History: A Case Study of the Christian Medical Commission*

In chapter six, I focus on the theological backstory of the Christian Medical Commission and the primary health care movement in order to show how participant theologians have, in the past, facilitated processes of theo-ethical reflection that led to new paradigms in global health. Whereas the Masangane case study was singular in its focus on the HIV pandemic, the story of the CMC provides evidence of theo-ethical reflection as a health asset to global health more generally. As such, the case study offers critical leverage on the limited understanding of partnership in the current turn to religion in which theo-ethical reflection is rendered unintelligible, irrelevant, or immeasurable (both in the theological sense of ineffability and the public health understanding of metrics). The story of the CMC suggests that a robust turn to religious entities as allies—one that acknowledges theo-ethical reflection as a vital health asset—may surface the theological and philosophical visions animating global health’s commitment to health for all, and, in the process, reveal the limits of current global health approaches.

*CHAPTER SEVEN – Theo-ethical Reflection as a Religious Health Asset: Implications for Participant Theologians and Global Health Leaders in Transdisciplinary Space*

In the concluding chapter, I point towards the implications for global health of acknowledging theo-ethical reflection as a vital and vitalizing health asset and to the implications for “my” particular location as a Christian ethicist. Specifically, I explore

some of the institutional changes necessary in order to prepare the next generation of Christian theologians, ethicists, and members of faith communities for participation in global health conversations—that is, to become participant theologians.

## **IX. A NOTE ON SOURCES**

Theo-ethical reflection involves decisions about sources. The interpretive approach to Christian ethics highlights the many possible sources that can inform the description of what is going on in any given social phenomena. I draw on formal Christian theo-ethical reflection on health and secondary analysis of international and global health in order to contextualize the processes of theo-ethical reflection taking place in Masangane and the CMC. These sources are necessary but not sufficient for describing the practical dimensions of theo-ethical participation that this dissertation points toward.

Thus, for the purposes of this dissertation, I have selected sources that in some way show the *process* of theo-ethical reflection over time in institutions. The sources that have been most helpful in understanding these processes in the two case studies include: evaluative reports, internal organizational memos, organizational archives, and participant observation. This, of course, is not an exhaustive list of the possible sources for showing the process of theo-ethical reflection over time. (Indeed, in earlier conceptions of this project, I envisioned semi-structured interviews with Masangane and CMC leaders as an emic source for understanding the processes of theo-ethical in these organizations. I remain committed to this approach for future iterations of the argument in this dissertation.) However, I view my selection of these sources as consistent with a

Christian ethics that pays attention to the texture of meso-level institutions, a texture that is often smoothed out when Christian ethicists rely primarily on theological and philosophical texts, scripture, or secondary macro-level analysis (e.g., in order to substantiate normative claims about global justice). Specifically, the reports, memos, and other organizational documents show the institutions reconciling, however provisionally, the commitments emerging in their theo-ethical reflection and the practical constraints and possibilities of institutional activity in complex webs of social activity. In this way, these sources show how religious entities more broadly, and not just churches, function as communities of theologically inflected moral discernment. These sources, thus, offer important insights into theo-ethical reflection as an ongoing discernment of the appropriate, or fitting, response to patterns and processes in which we participate.

Part of this discernment about the appropriate response entails sensitivity to the levels at which theo-ethical reflection is taking place. In this dissertation, processes of theo-ethical reflection can be seen at the level of global health policy (e.g., the role of the Christian Medical Commission in the primary health care movement) and on the ground in the design and implementation of programs (e.g., the particular shape and content of the Masangane treatment program). Christian ethicists working on issues related to global health, I submit, need to be able to move between these levels and recognize how these different levels affect differently the interpretive task. (Here, it is useful to recall one of the four elements of Gunnemann's interpretive approach, namely, the social and institutional location quadrant.)

Why is this agility on the part of Christian ethicists necessary? Because Christian theo-ethical reflection is, in large part, a process for naming and responding to the various



sources in our midst that frustrate attempts to respond to what God “is enabling and requiring us to do.” Two particularly relevant sources of this frustration are: 1) unjust or poorly conceived policies that intentionally or unintentionally limit access to the resources necessary for human flourishing, and 2) good policies poorly realized in the programs designed to implement them. Responsible Christian ethicists who attend with sensitivity to the relationship between the ideal visions of the Church and the practical realities of church life are obligated, and arguably, well-positioned, to engage constructively and critically with these sources of frustration.

In addition to the methodological choices about the modes of inquiry that are important for describing what is going on, theo-ethical reflection requires choices that provide some limits to what is being described. It is, of course, not possible to describe every possible religious entity involved in the response to HIV or to document the participation of religious entities throughout the history of global health. I have chosen to focus on two organizations that already share many of the assumptions of the liberal theological tradition, at least with regards to their willingness to work largely from within the scientific paradigms endorsed by global health practitioners. I have chosen to focus on these types of organizations in order to make my analysis more precise, to clarify the obstacles to viewing theo-ethical reflection as a health asset.

The CMC and Masangane are engaged constructively in global health activities. This makes the organizations more difficult to dismiss on the grounds of their resistance or objection to global health programs, and as a result, raises more pointedly questions about the distinctiveness of theo-ethical reflection in these organizations, specifically, and in complex interdisciplinary conversations, more generally. I have selected these

organizations in order to intentionally bracket the many other substantive questions that inevitably arise when doing comparative theo-ethical reflection. Many other organizations with a diverse range of theo-ethical commitments are engaged in global health and the response to HIV. Some of this diversity is represented in chapters two and three. The diverse range of theo-ethical commitments represented within the Christian tradition emerges from both the substantive traditions within Christianity as well as the moves these traditions privilege with regards to what constitutes theo-ethical reflection. For the purposes of this dissertation, however, attention to this much broader range of theo-ethical commitments would distract from my modest attempt to describe processes of theo-ethical reflection that give rise to mutually generative conversations among religious and global health leaders.

It is entirely possible to read the stories of Masangane and CMC without identifying these organizations explicitly as communities of theologically resonant moral discernment. But this is to miss something I understand as vital and distinctive in their identities as Christian entities. The force of my argument derives in part from recognizing the disconnect between a willingness to recognize more readily theo-ethical reflection as a constitutive dimension of stigma and discrimination (chapter two) and the inability to recognize theo-ethical reflection as a constitutive dimension of constructive responses to HIV. In order to overcome this disconnect, I have brought forward a variety of sources that show religious entities thinking theologically together about their participation in global health, sources that are constitutive of the interpretive approach to theo-ethical reflection described above, and sources that I believe encourage Christian ethicists to get closer to the ground in their interpretation of complex social phenomena.

Often, global health policy and priorities are determined by reports and the limited interpretation of value they afford. I have attempted to tease these limits out in chapters two and three by highlighting the shift in global health discourse effected by the development of the religious health assets framework. To do this, I have turned in chapter three to commissioned reports on the role of religious entities as assets in global health, juxtaposing the discourse reflected in these reports with both explicitly theo-ethical reflection carried out by Christian theologians and ethicists and with secondary social scientific evidence of the value of religious entities in the response to HIV in sub-Saharan Africa.

In chapter five I describe the changes in the Masangane program as an outcome of processes of theo-ethical reflection on the availability of antiretroviral treatment. This description necessarily entails locating the Masangane program in the broader global health response to AIDS—the context in which the processes of theo-ethical reflection are taking place. For these reasons, I draw on epidemiological data of the pandemic (globally and in South Africa), evaluative reports of innovative treatment programs, and social scientific analysis of the determinants of health in a rural, African context. A description of these changes in Masangane also requires attention to both how the services Masangane offers have changed and how these changes are justified. Since my on-site field research in South Africa was limited to two brief trips in 2007 and 2008 and since Masangane is a relatively low-profile, faith-based organization, my ability to document these changes is dependent largely on access to informal memoranda of key leaders and various organizational documents, including revised constitutions and reports to donors, as well as secondary analysis of the interviews and focus groups that constitute

the ARHAP case study on Masangane as a religious health asset. Drawing this variety of sources together yields a picture of the Masangane program not only as one of the many potential religious allies involved in the global response to HIV, but as a community of theo-ethical discernment. The former is documented in the language of global health reports (some of which are referenced in chapter five). Those types of reports privilege a certain interpretation of the value of Masangane, obscuring other potentially valid, less reductionistic interpretations of Masangane's value. By framing Masangane as a community of theo-ethical discernment and not just as a HIV treatment program, however, I read organizational documents theo-ethically, paying particular attention to the framings and motivations for the work in which they are engaged.

In chapter six I draw on organizational archival sources including notes, minutes, and proceedings from the meetings that led to the formation of the Christian Medical Commission, as well as analytical sources that reflect on the impact of those meetings. Organizational minutes are rarely viewed as theo-ethical sources, but they can be one of the most important places for "observing" processes of thinking theologically together, especially historical processes. That is, I view these historical documents much like an ethnographer might view participant observation of a church debating changes to its social policies. Since I was not present at these meetings, I have relied on others who were to help me understand various dynamics at play in these meetings, as well as the larger historical context in which these meetings took place. What these particular historical, organizational sources have afforded me is a theo-ethical vantage point on the global health debates taking place in the 1970s that, once recognized as a valid vantage point, must be incorporated into the larger story of how religion and global health have

influenced one another. In this sense, archival materials of organizations thinking theologically together become important resources for doing contemporary theo-ethical reflection on the limits and possibilities of global health turning to religious entities as partners. Other scholars may want to push back even further, historically, to understand the dynamics—including previous examples of processes of theo-ethical reflection—that led to the Tübingen consultations. But for the moment, the focus on these types of sources raises the profile of the theo-ethical backstory of the primary health care debates in the 1970s in ways that are less obvious when the story of the CMC is told primarily from the perspective of global health and the achievements at Alma Ata.

In making explicit the range of sources contained in the following argument, I intend to signal my commitment to viewing Christian theo-ethical reflection as a process that takes place outside of the church walls as well as within and that attending to such non-church processes has methodological implications both for doing Christian theo-ethical reflection and for describing processes of theo-ethical reflection being done by others. For example, describing these processes requires paying attention to framings, motivations, and practices of theo-ethical praxis as manifest in a variety of less recognizable theo-ethical discursive forms including internal memos, external evaluations, informal histories, and formal reports to funders.

This type of close reading of organizational documents and histories set within the larger web of institutional life animating the modern world is consistent with the methodological spirit of Gustafson's approach to Christian ethics (e.g., his early work as an ethical consultant for Standard Oil) and Cahill's contemporary engagement with the praxis of collaborative social networks (see chapter four). That is, the organization or

network itself can be understood as both a particular kind of argument about the way the world should be and a specific space in which that argument is continually being negotiated for internal as well as external audiences. Christian ethics sensitive to the ways in which modern institutional life responds to complex social phenomena in an already-not-yet secular world do well to be alert to the processes of theo-ethical reflection just below the surface of many of the contemporary debates about the way the world should be. In this way, Christian ethicists might complement “the insight and wisdom of the Christian community’s long historical reflection about the chief ends of [human being],”<sup>70</sup> with an nuanced analysis of the forms this insight and wisdom assume in modern institutions.

## X. CONCLUSION

An important claim, suggested by the notion of a participant theologian, is that theologians and Christian ethicists are experts in their own right about the human condition and that this expertise is not limited in its applicability to the formation of confessional faith communities. Rather, the discipline of theological ethics and the practice of critical theo-ethical reflection it promotes can name experiences in ways that open up new possibilities for understanding perennial questions about the nature of being human. In this way, theo-ethical reflection can be a source of *reform*.<sup>71</sup> That is, it is more

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<sup>70</sup> Gustafson, “The Theologian as Prophet, Preserver, or Participant,” 84.

<sup>71</sup> In previous work I have employed the following definition of reform, the tenets of which are applicable here as well: “(1) creating space within existing structures, institutions, relationships, etc., for possibilities beyond the status quo; (2) linking criticism of current practices with viable alternatives (coextensive); (3) identifying, and responding to, the negative *and* positive impact of self-interest on all relationships; (4) continually renegotiating relationship networks to more accurately reflect the injustices experienced and the justice being pursued.” Reform may include complete rejection of current structures or policies if the impact of the rejection can be mitigated by other structures or policies of equal or greater potential for

than just securing an invitation to the table based on some notion of tokenism or religio-political correctness. To be tolerated is not the goal, rather it is to be actively engaged as a co-participant. This, I take, is what it means to embrace the intellectual and social responsibility of being a participant theologian, to see oneself as “one partner among many in the human conversation that will give some determination to the ways in which men [*sic*] use their technical and political powers, their resources and talents in the development of history and society towards humane ends.”<sup>72</sup> My use of *theo-ethical* reflection suggests that this participation is contingent upon the theologian’s capacity to engage with, in Ottati’s phrases, the “other disciplines” that inform the limits and possibilities of moral action and the “multiple lines of reflection [that] contribute to our understandings of moral norms.”<sup>73</sup>

While I find Gustafson’s notion of the participant theologian persuasive as a possible correction to the marginalized role of professional theologians in current global health conversations, the evidence in this dissertation suggests a need to expand his

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justice, sustainability, and participation. See Matthew Bersagel Braley, "Towards the Sources in Our Midst: Exploring the Use of Ethical Sources in the Commitment to Global Justice" (master's thesis, United Theological Seminary of the Twin Cities, 2003), 73

<sup>72</sup> James M. Gustafson, *Theology and Christian Ethics* (Philadelphia: United Church Press, 1974), 85

<sup>73</sup> Ottati, "How Can Theological Ethics Be Christian?," 16. Recent projects in practical theology can appear to collapse the distinction between *theo-ethical* reflection and practical theology. Certainly both approaches draw on other disciplines to help understand various contexts for praxis. I maintain that the distinction may be most important with regards to audience. In this dissertation, global health leaders are one of the primary audiences. Practical theology is often directed at, if not particular confessional communities, a Christian audience. I appreciate practical theology’s emphasis on religious social practices and the inversion of classical theological ways of knowing it achieves, but see the impact of practical theology as more limited when it is transposed into broader, non-explicitly religious discursive spaces, such as the global health policy arena. Jennifer Ayres’s practical theology of Christian social witness offers a compelling argument for a practical theological method that begins in social analysis for reasons complementary to those articulated by Ottati about the need to engage other modes of analysis. Ayres explains an “[e]mphasis upon social analysis keeps the practice grounded and responds to activists’ wariness about seemingly abstract processes of thought. ... If we’re to begin with theological concepts and then seek to apply them to experience and our understandings of social structures, we might actually miss some of the new questions being posed by experience and social analysis to Christian faith.” see Jennifer Ryan Ayres, "with an Urgency Born of This Hope...': A Constructive Practical Theology of Reformed Christian Social Witness Practice" (PhD dissertation, Emory University, 2007), 211-212

notion of participant theologian beyond that of academically trained theologians or publicly recognized religious leaders, or at least to encourage theologians to participate in conversations beyond the academy and the church. Gustafson's concept of participant theologian and later work on interdisciplinary discourse has the effect, I argue, of circumscribing an arena in which only a certain type of participant theologian is admitted, namely the professional or academic theologian. As a response to this limitation, I draw on Lisa Sowle Cahill's participatory theological bioethic to expand and deepen the notion of participant theologian in ways that strengthen the concept as a conceptual bridge for the re-evaluation of the value of religious entities in global health discourse. For Cahill, participatory theological ethics can only be done by participating in collaborative networks focused on social justice. The potential of this type of participatory theological ethics is illustrated in the two case studies. The Masangane case study in chapter five and the Christian Medical Commission story in chapter six suggest that a concept of participant theologian limited to professional theologians or established public religious leaders obscures the efforts of many others actively engaged in theologically informed critiques of, or theo-ethical reflection on, global health programming in their communities.

James Cochrane, in *Circles of Dignity*, a work that predates but in many respects presages his pioneering work at the intersection of religion and global health, develops a method for engaging with the local wisdom of communities, including the "incipient theologies" that reflect "hard-won experience" and provide insight into the relationship of their theological reflection and the particular context in which that reflection has "transformative potential." Consistent with the insights of liberation theology, he argues:



“Local communities—particularly those on the margins of the center of power in society—possess a theologically and socially relevant wisdom about their situation and context. . . . [This wisdom] gives us insight into what otherwise remains unseen about ourselves, our theories, power relations, and society.”<sup>74</sup>

Perhaps not surprisingly, this emphasis on the wisdom of local communities has a family resemblance to the community-oriented health programs that became popular in global health around the same time liberation theology was finding a foothold in academic and activist circles. Half a century later, liberation themes remain one of the strongest bridges between theology and global health.<sup>75</sup> A review of theo-ethical reflection within the context of HIV/AIDS in chapter three as well as engagement with Lisa Sowle Cahill’s proposal for a participatory theological bioethics in chapter four show the tensile strength of this bridge. By expanding Gustafson’s notion of participant theologian to include all those who think theologically, this dissertation shows how intentional and sustained theo-ethical reflection in and around global health institutions can facilitate ways of understanding human being and human flourishing that affect the priorities of global health.

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<sup>74</sup> James R. Cochrane, *Circles of Dignity: Community Wisdom and Theological Reflection* (Minneapolis: Augsburg Fortress, 1999), 21-22. For Cochrane, “incipient theology” refers to theological reflection done by “ordinary believers, believers who are untrained in the formal canon or history of theological method” but who, when they reflect on their faith, “engage in the task of theology in a provisional way, gathering an as yet untested wisdom about the meaning of their faith.” *Ibid.*, 22.

<sup>75</sup> The link between liberation theology and global health is exemplified most clearly by the broad influence of the medical doctor and anthropologist Paul Farmer’s work on academic theologians and religious communities. It is debatable in Farmer’s work whether liberation theology acts as a starting point for his tireless efforts to overcome the effects of structural violence on the world’s destitute or whether he finds liberation theology a convenient and powerful ally in his Sisyphean task—the latter an ironic fulfillment of the Marxian roots of liberation theology. For Paul Farmer’s use of liberation theology see Paul Farmer, *Infections and Inequalities: The Modern Plagues*, 2nd ed. (Berkeley, CA: University of California Press, 2001); *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (Berkeley: University of California Press, 2005). For the engagement of Christian theologians with the work of Paul Farmer, see Cimperman, *When God's People Have HIV/AIDS*.

To create space for participant theologians and theo-ethical reflection in twenty-first-century global health conversations requires some groundwork. The invitation to “give some determination” to the ways global health is practiced is not forthcoming—for professional or lay theologians, alike. I begin some of this groundwork in this dissertation. I begin this work in the hope that global health policymakers might recognize in their own history as well as in the specific, contemporary responses to HIV the way those who approach health theologically have encouraged global health leaders to reevaluate their current policies. In what ways, for example, do current global health approaches to HIV expand or limit the possibilities of human flourishing?

I hope that the success or failure of the argument of this dissertation will be determined largely by two criteria: (1) whether or not I have presented compelling evidence to global health policymakers for paying attention to those saying something theological about the human experience of illness and health and (2) whether or not Christian ethicists recognize in the argument a responsibility to enter more fully into the global health fray, conscious of their role as *participant* theologians. To live into this role, I submit, involves cultivating both a greater attentiveness to the ways in which those outside of the academy are co-participants in processes of theo-ethical reflection and a greater competence for engaging the complex, interdisciplinary arena of global health policy and programming.

I also begin from a particular and limited location. My formal disciplinary training in Christian theology and ethics has taken place largely in liberal Protestant institutions in the United States. As noted above, as a Christian social ethicist within the Protestant, liberal theological tradition, I take as constitutive of any definition of

Christianity a commitment minimally to raising questions about how our apprehension of God as an active presence in the world informs our engagement with existing structures of the world. That the modern context of differentiation affects the modes of engagement possible (and, arguably, our apprehension of God as well) is a starting point, not an ending point. Indeed, as Gary Dorrien characterizes the legacy of liberal social Christianity in the U.S. context, “its willingness to address the intellectual, political, and moral dilemmas” of modernity is its “chief distinguishing characteristic.”<sup>76</sup> It is what makes the concept of a participant theologian intelligible, even necessary. Thus, while the argument below addresses global health folks directly, it also raises important questions about how Christian ethicists—how I—understand the nature of their (my) responsibility to address the “intellectual, political, and moral dilemmas” generated by the global health concerns dominating the early twenty-first century.

In this commitment to upholding my responsibility, I recognize with Bishop Tutu not only the enormity of the challenges ahead, but also a kinship with all those engaged in the work of global health:

You are the guardians of the dream of ‘Health for All.’ You have the opportunity and responsibility to lead the world into a healthy place. You are the enactors of justice: justice in the distribution of a country's wealth for health; justice to meet the Millennium Development Goals; justice to save the lives of your people and enable them to prosper and build healthy nations! God is watching. The people are waiting. You are commissioned to go to wipe the tears away from all faces

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<sup>76</sup> Dorrien, *Soul in Society: The Making and Renewal of Social Christianity*, vii.

and bring forth lives filled with strength, and purpose which will make for peace.<sup>77</sup>

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<sup>77</sup> Tutu, "Address by Reverend Desmond Mpilo Tutu."

## CHAPTER TWO

### Chronic Tension, Diachronic Pandemic:

#### Religious Morality in an HIV-Infected World

*We believe there is a close relationship between globalization, moral decay, and the high infection rate of HIV and AIDS. Deterioration of human ethical code [sic] leads to sexual immorality such as the homosexual acts and sodomy deplored by this statement.*

Bishops of the Evangelical Lutheran Church in Tanzania<sup>78</sup>

### I. INTRODUCTION

The Bukoba Statement by the Bishops of the Evangelical Lutheran Church in Tanzania articulated a response to what they perceived to be two urgent challenges facing their church and the wider society: globalization and troubling trends in human sexuality. The statement emerged from a weeklong spiritual retreat and represents, in the language of this dissertation, a process of theo-ethical reflection.<sup>79</sup> While acknowledging the good intentions of churches and governments to fight the AIDS pandemic, the Bishops argue that these intentions are thwarted by a Western-driven globalization. Specifically, the Bishops see globalization as a process promoting the widespread adoption of the West's perceived sexual immorality, including tolerance of promiscuity and homosexuality. They conclude by drawing a causal arrow from globalization through sexual immorality to AIDS: "By and large, globalization...contributes to the ethical erosion of our national

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<sup>78</sup> Bishops of the ELCT, "The Bukoba Statement," (Bukoba, TZ: Evangelical Lutheran Church in Tanzania, 2004).

<sup>79</sup> The Bishops allude to this process in the Preamble to the statement: "We are aware of our duties to pray for, teach, discipline and forewarn the community of faith in our nation and the larger community worldwide. In the face of many other issues facing our society, we have decided to give a conscientious statement on a few critical challenges facing the church and society." Ibid.

culture. The rapid upsurge of reckless and irresponsible human sexual behavior indicates that the governmental and non-governmental efforts to control HIV and AIDS have not adequately addressed the problem.’’<sup>80</sup>

I begin with this particular example to show how theo-ethical reflection within religious communities can create tension in the response to AIDS. The statement reveals how this tension is both related to the process of theo-ethical reflection and the claims this reflection gives rise to. The first, and more obvious, is the tension created by the *claims* generated by theo-ethical reflection. The statement draws on the Christian tradition, including scripture, to analyze lived experience in a globalizing, HIV-infected world. The outcome of this reflection process—linking HIV to “disordered” sexualities and disordering sexual behaviors—provides theo-ethical cover for viewing persons living with HIV and AIDS as consciously immoral and thus responsible for their own suffering. This, in turn, serves to reinforce and may give rise to conditions within which stigmatizing persons living with HIV and AIDS is theologically warranted and institutionally supported.

The second reason I chose to lead with this example is because it suggests how the *process* of theo-ethical reflection can give rise to tension and foster suspicion among global health actors of the distinctive contribution of religious entities. The ELCT is involved in and supports efforts to fight the HIV pandemic, as the statement attests. Yet its processes of theo-ethical reflection are done without the presence of persons living with HIV and AIDS or representatives from global health. This raises questions about the relevance and credibility of the claims generated, questions that will be addressed more

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<sup>80</sup> Ibid.

fully in chapter four. This chapter takes up the more obvious, first reason: claims by religious entities that create friction in the global response to HIV. The initial section of this chapter provides a basic overview of the AIDS pandemic today. Though not intended as a comprehensive history of the pandemic, this overview is necessary to understand the context in which friction points between religious entities and global health institutions in the response to HIV and AIDS have arisen. In the second part of the chapter, I turn to a particular friction point, focusing on a well-documented issue involving religious claims: the role of religious entities in promoting or reinforcing stigma and discrimination against persons living with HIV and AIDS.

An examination of this friction points reveals good reasons for global health leaders to view religious entities as a potential health liability. As the next chapter shows, global health leaders have also begun to articulate good reasons for viewing religious entities as a potential health asset. These two chapters, taken together, show how the discourse about the possibility of religious entities as health assets emerges as a direct response to the specific ways in which religious entities have been health liabilities. The two chapters also help to clarify why any new framework for valuing religious entities as allies in global health must be sensitive to the ways religious entities have been and continue to be health liabilities. The tensions persist even as global health leaders embrace a more expansive and nuanced understanding of religious participation in the response to HIV.

## II. Scope and Scale-Up: The HIV Pandemic Today

AIDS is taboo for many different, often culturally specific reasons across the globe. But it is the enduring urgency of the crisis, the sense of a chronic pandemic, that reveals the inadequacy not only of existing paradigms and practices in public health and medicine but also, at a more fundamental level, conceptions of health, healing, and the requirements for human flourishing.

Nearly thirty years and thirty million deaths<sup>81</sup> after Atlanta hosted the first international AIDS conference, governments across the globe continue to struggle with what has been described as modernity's "single greatest reversal in human development."<sup>82</sup> In some countries in sub-Saharan Africa where the virus is hyperendemic,<sup>83</sup> gains in life expectancy have been reversed as a result of HIV.<sup>84</sup> Dreams of human flourishing—even survival—have been deferred once again, despite unprecedented political and economic efforts to respond to the virus and its society-wide impact.

At the half-way point of the global campaign to secure universal access to HIV prevention, treatment, care, and support, a 2008 UNAIDS report offered a sobering

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<sup>81</sup> As of 2009, an estimated 30 million persons have died of HIV-related causes, while an additional 33 million are living with the HIV. UNAIDS, "Global Report: UNAIDS Report on the Global AIDS Epidemic (2010)," (Geneva: UNAIDS, 2010), 23.

<sup>82</sup> UNDP, "Human Development Report: International Cooperation at a Crossroads (Summary)," (New York: United Nations Development Programme, 2005), 17.

<sup>83</sup> Endemic refers to a disease that is found constantly in a population, as opposed to epidemic, which suggests a disease that is sporadically present or fluctuating with regards to prevalence rates. Hyperendemic denotes a disease that is found constantly *and at high rates* in a population. While HIV is often described as an epidemic, its long duration and sustained high prevalence rates in sub-Saharan Africa suggest hyperendemic is a more accurate descriptor. UNAIDS defines hyperendemic more precisely as "an adjective used to qualify a generalized epidemic that exhibits a sustained high prevalence that is typically 15% or higher among pregnant women attending antenatal clinics." See UNAIDS, "Terminology Guidelines," (2011), <http://www.unaids.org>.

<sup>84</sup> For example, in South Africa, between 1990 and 2007, life expectancy dropped from 62 to 50 years, largely as a result of HIV-related deaths. "SA Life Expectancy Decreases," *Mail & Guardian*, November 19 2009. <http://mg.co.za/article/2009-11-19-sa-life-expectancy-decreases>



assessment of the pandemic's persistence: "Without a substantial strengthening and acceleration of the HIV response, many countries will not achieve universal access to HIV prevention, treatment, care and support by 2010 or begin to reverse the epidemic by 2015."<sup>85</sup> The latest data available estimates the number of persons—adults and children—living with HIV at 34 million, women over the age of fifteen account for half of all adults living with HIV (approximately 15 million women). 3.4 million children under 15 years old are infected, with an additional 16.6 million children orphaned as a result of AIDS-related deaths.<sup>86</sup> In 2007, alone, of the 60 million persons whose lives ended, over 2 million persons died because of AIDS. One virus, one-thirtieth of all deaths worldwide. Though not the leading cause of death across all ages, in the three decades since it was first identified, it has become among men and women age 30-44, the leading cause of death, globally, accounting for nearly one million deaths—a fact, in itself, that lends support to claims since its discovery that HIV is exceptional.<sup>87</sup>

### **III. Chronic Pandemic: The Paradox of Prevalence**

So much of the rhetoric about the virus itself as well as its spread highlights its exceptionalism. This is no less the case when it comes to the global response. In part, this is because the availability of antiretroviral treatment has shifted the focus on HIV from

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<sup>85</sup> "2008 Report on the Global AIDS Epidemic," (Geneva: UNAIDS, 2008), 27.

<sup>86</sup> These statistics reflect the most recent data available from UNAIDS, UNICEF, and WHO, "Global HIV/AIDS Response: Epidemic Update and Health Sector Progress Towards Universal Access: Progress Report 2011," (Geneva: UNAIDS, 2011). The report is available at <http://www.unAIDS.org> UNAIDS defines orphans as a child under 18 years old who has lost one or both of their parents. While this can be delineated further to account for maternal, paternal, and dual orphans, estimates reflect the general definition of orphan.

<sup>87</sup> Statistics come from the World Health Organization's Global Burden of Disease project, available at [http://www.who.int/gho/mortality\\_burden\\_disease/regions/en/index.html](http://www.who.int/gho/mortality_burden_disease/regions/en/index.html)

being an acute infection to being a chronic disease. It is a *chronic pandemic*, in a sense, demanding both the epidemiological tools used to understand virulent infectious disease transmission and the paradigms of chronic care management used to treat non-infectious diseases such as diabetes over the course of a lifetime. Moreover, it requires chronic care management in parts of the world that have until recently been disproportionately burdened by acute infectious diseases—diseases that tend to kill relatively quickly or are treatable.<sup>88</sup>

Resources for chronic care are a luxury for countries preoccupied with fighting acute infections like malaria, cholera, and many other diseases that once plagued the entire globe, but were recast in the last century under the somewhat misleading umbrella “tropical medicine.”<sup>89</sup> Many of the countries devastated by the HIV pandemic are also countries that have health systems ill-prepared for managing a complex chronic disease.<sup>90</sup> Given these factors it is not surprising that language often dismissed as hyperbole names accurately the scope and scale of the challenges ahead: “The decision of the global community to push towards universal access to HIV prevention, treatment, care, and support represents a moral commitment of historic proportions. Never before has the

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<sup>88</sup> Global health studies have increasingly focused on the shifting burden of disease in under-resourced health systems across the globe. Chronic diseases, including cancer, have begun to demand greater health care resources, even as the prevalence of infectious diseases remains high in many regions. See Ama de-Graft Aikins et al., “Tackling Africa’s Chronic Disease Burden: From the Local to the Global,” *Globalization and Health* 6, no. 5 (2010), <http://www.globalizationandhealth.com/content/6/1/5>.

<sup>89</sup> The term has a long history, but can be misleading since it connotes the study of diseases in regions of the globe that bear a disproportionate amount of certain infectious diseases, and not necessarily diseases endemic to tropical climate zones. For example, The American Society of Tropical Medicine and Hygiene defines its current mission broadly as the promotion of “global health through the prevention and control of infectious and other diseases that disproportionately afflict the global poor.” See <http://www.astmh.org>

<sup>90</sup> Health systems as well as global health programs, more generally, have evolved along particular trajectories that reflect the intersection of the specific disease burden of a population and the availability and distribution of health-related resources. The relationship between the burden of disease and a health system in any given locality is, of course, more complex than this suggests. History, politics, socio-economic factors (e.g., so-called diseases of poverty), patterns of industrialization, migration, etc., all affect this relationship.

world attempted, on such a large scale, to bring broad-based chronic disease management to resource-limited settings."<sup>91</sup>

A chronic pandemic represents something of a paradox. Declines in the incidence rates, or the rates of infection in a population each year, do not necessarily result in declining prevalence rates, or the total rate of infection in a given population. While over time declining incidence rates should begin to positively affect prevalence rates, in the short and medium term, greater access to antiretroviral treatments means more persons living with HIV and AIDS for longer periods of time. As a result, prevalence rates can actually increase even when incidence rates decrease—the prevalence paradox. Prevalence rates, especially in southern Africa, have been rising steadily over the past decade and only now have begun to stabilize, though still at hyperendemic rates.<sup>92</sup>

Moreover, since prevalence rates reflect a ratio of infected persons to total population, even a declining prevalence rate does not always correlate with a decrease in the total *number* of persons living with HIV and AIDS. For example, prevalence rates that had been rising since 1990 began to level off around 2000 and then decline in the last five years, yet the number of persons living with HIV and AIDS has continued to rise. As noted above, in 2010 an estimated 34 million persons were infected with HIV—more

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<sup>91</sup> UNAIDS, "UNAIDS2008."

<sup>92</sup> An epidemic is considered "generalized" in a population when it infects more than 1% of the population. In many countries in southern Africa, the prevalence rate is close to 5%. South Africa illustrates the prevalence paradox and will be discussed in greater detail in chapter three below. While the epidemic is spoken of as a global pandemic, the variation between and within countries in prevalence and incidence rates, primary modes of transmission, access to antiretroviral treatment, among other things makes HIV "an amalgam of an almost infinite number of individual epidemics." Ibid., 27. As a result a snapshot of the global pandemic can be misleading. In all regions, "national epidemics continu[e] to expand even as the overall regional HIV incidence stabilizes." Ibid., 8. Given this variation, UNAIDS and other global AIDS organizations have begun rejecting one-size-fits-all approaches in favor of a "know your epidemic" approach at the country level.

than three times as many persons than in 1990, and almost 20% higher than in 2000.<sup>93</sup>

Aware of these numbers and the future they portend, Peter Piot, then-director of UNAIDS, insisted twenty-five years after the identification of HIV that the global health community begin planning for the next twenty-five years of the pandemic. HIV was not going away any time soon.<sup>94</sup>

Despite advances in prevention, care, and treatment, the pandemic persists. Benchmarks for achieving universal access to treatment have come and gone, unmet. Hope for a vaccine, once talked about as imminent, wavers with each clinical trial failure. It is not surprising, then, that some leaders within the international donor community and HIV and AIDS experts themselves have begun to question the unprecedented amount of resources directed towards HIV programs.

For example, Daniel Halperin in a New Year's op-ed piece for the *New York Times* attempted to put the HIV "plague in perspective." Halperin, a senior research scientist at the Harvard School of Public Health and past USAID HIV prevention adviser in southern Africa, argues for greater equity in the allocation of global health resources. While AIDS is a global health priority, so too are safe-water projects. Yet in 2007 the United States spending on safe-water projects in Africa was about 1% of what it spent on AIDS programs in Africa.<sup>95</sup> The need to scale-up safe-water projects is arguably greater

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<sup>93</sup> UNAIDS, UNICEF, and WHO, "Global HIV/AIDS Response: Epidemic Update and Health Sector Progress Towards Universal Access: Progress Report 2011." Estimates for 2010 range from 31.6 to 35.2 million. For a discussion of how estimates of the epidemic are made, see UNAIDS, "AIDS Epidemic Update," (Geneva: Joint United Nations Programme on HIV/AIDS and the World Health Organization, 2009), especially 12-13.

<sup>94</sup> Peter Piot, "Closing Address," in *XVI International AIDS Conference* (Toronto, Canada 2006).

<sup>95</sup> In 2007, the United States spent close to 3 billion dollars on AIDS programs in Africa compared to 30 million on "traditional safe-water projects." Daniel Halperin, "Putting a Plague in Perspective," *New York Times*, January 1, 2008.

than the need for HIV treatment scale-up, raising questions about why a global fund for safe water does not exist.<sup>96</sup>

Debates about global health priorities are nothing new. Indeed, criticism of the global response to HIV may feel like déjà-vu to those familiar with the emergence of the global health field in the late-twentieth century. Earlier eras of global, or what was then called international, health were focused on “control of epidemics across the boundaries between nations.”<sup>97</sup> “International” captured, on the one hand, how diseases could not be understood as bounded within the often arbitrary lines serving as national borders, and on the other hand, how coordinated responses to single-disease epidemics primarily involved the governments of sovereign nation-states. Health historians suggest that “global health” refers to a “consideration of the health needs of the people of the whole planet above the concerns of particular nations.” It also signals an expansion of the types of actors involved in health including nongovernmental organizations, media, foundations, and corporations.<sup>98</sup> Both the broader concern and the diversification of participants pushed global health toward more integrated approaches to health that called into question public health programming focused on single diseases as a medical or public health problem to be solved. Changing understandings of health and healing in tandem with the shifting geopolitical landscape led in the 1960s and 1970s to a greater emphasis on strengthening rural health infrastructure across the globe.<sup>99</sup>

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<sup>96</sup> In 2002, an estimated 1.7 million deaths were associated with diseases related to unsafe water, roughly the same number of deaths attributed to HIV in 2010. World Health Organization, "The World Health Report 2002: Reducing Risks, Promoting Health Life," (Geneva: World Health Organization, 2002).

<sup>97</sup> Brown, Cueto, and Fee, "The World Health Organization and the Transition From "International" To "Global" Public Health," 62.

<sup>98</sup> *Ibid.*

<sup>99</sup> *Ibid.*, 66.

Today, the particular dynamics of HIV transmission and treatment in a community as well as the disease's resistance to conventional public health and medical interventions have been a catalyst for refocusing thinking at the WHO and elsewhere on the need to strengthen health systems and intersectoral cooperation, recalling themes from the 1960s and 1970s that had been more muted in the intervening years.<sup>100</sup> Health system strengthening involves all sectors of society, not just health professionals. And in most, if not all cases, building a strong, sustainable health system capable of meeting the needs of its citizens requires resources beyond the borders of any one nation-state.

The need to coordinate the efforts of all sectors within societies and across nation-states in order to shore up health systems struggling to meet the demands of the HIV pandemic is one significant reason why the HIV work of local and transnational religious entities has become increasingly visible to global health leaders. As the next chapter details, global health institutions are seeking to partner with religious entities in carrying out specific HIV and AIDS prevention and treatment programs. But to create viable partnerships, global health institutions must find ways to overcome actual and perceived tensions with religious entities.

#### **IV. Religion and HIV: New Forms, Old Tensions**

The following sections analyzes one of the most prominent friction points involving religious claims: stigmatization and discrimination against persons living with HIV and AIDS. This friction points suggests the theo-ethical roots of the tension between

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<sup>100</sup> World Health Organization, "The World Health Report 2000 - Health Systems: Improving Performance," (Geneva: World Health Organization, 2000).

religious entities and global health. For example, stigmatizing and discriminatory practices derive from particular theo-ethical renderings of what is natural in human sexual relations. That stigmatizing and discrimination are linked to theo-ethical reflection on HIV clarifies a distinctive dimension of Christian participation in global health that must be analyzed as part of any effort on the part of global health to engage religious entities. The analysis below shows how theo-ethical reflection can have a detrimental impact on global health and its beneficiaries in both direct and indirect ways, and in this way makes a preliminary case for why theo-ethical reflection matters and why global health leaders need to pay attention to it.

Stigma often serves as the one place in the public health literature where religion makes an appearance.<sup>101</sup> The reigning assumption in the early years of the pandemic was that the sexual ethics of Christianity as well as other world religions was incompatible with many public health initiatives.<sup>102</sup> Global health leaders' concerns about the stigmatizing practices of religion<sup>103</sup> (e.g., denial of communion to PLWHA) have often been legitimate. There have been religious pronouncements about HIV and AIDS as punishment from God, along with exclusions based on religious morality. Major Christian organizations have been relatively slow to respond adequately (or even at all) to

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<sup>101</sup> Olivier et al., " ARHAP Literature Review: Working in a Bounded Field of Unknowing," 45.

<sup>102</sup> While the HIV pandemic has given rise to the particular issue of condom usage, the religio-moral dynamics of stigma can be found in other pandemics as well. See, for example, the contentious socio-religious histories of leprosy, bubonic plague, and syphilis as detailed in Peter Lewis Allen, *Wages of Sin: Sex and Disease, Past and Present* (Chicago: University of Chicago Press, 2000).

<sup>103</sup> Drawing on the conceptualization of stigma by Link and Phelan (2001), Parker and Birdsall define stigma as "that part of identity that has to do with prejudice—the setting apart of individuals or groups through the attachment of heightened negative perceptions and values." Though they distinguish between stigma (ideas about others) and discrimination ("direct enactment of stigma" or acting upon the ideas), they suggest that as the "social expression of negative attitudes and beliefs" stigma informs "processes of rejection, isolation, marginalization and harm to others." Warren Parker and Karen Birdsall, "HIV/AIDS, Stigma and Faith-Based Organizations: A Review," (Centre for AIDS Development, Research and Evaluation (CADRE), 2005), 5.

the scale of the pandemic. According to this literature, religious entities are visible largely because of the ways their beliefs and practices have given rise to or amplified negative moral interpretations of HIV and AIDS.

As an infectious disease transmitted primarily through sexual contact, HIV is especially susceptible to religiously infused stigma. As James Cochrane has observed, religion often contributes to stigma through its “taboos, sanctions, and silences” about sexuality.<sup>104</sup> Several studies of levels of HIV awareness and education have confirmed that even when knowledge of HIV transmission pathways are high, “perceptions of morality were linked to promiscuity, moral transgression, choosing to engage in ‘bad’ behaviour, and punishment from God.”<sup>105</sup>

Though stigma does not require an explicit theodicy, instances of stigmatization are particularly susceptible to background assumptions about why persons suffer disease and illness. The story of Job comes to mind here as the *locus classicus* of the questions that arise when one suffers. But so, too, the question to Jesus about culpability in a child’s blindness—who sinned, the child or the parents? The religious framing of the theodicy question remains remarkably resilient, much to the dismay of many—though not all—health professionals.<sup>106</sup> HIV’s distinctive etiology and modes of transmission make it especially susceptible to theodical interpretations—religious and secular.<sup>107</sup>

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<sup>104</sup> Ibid., 12.

<sup>105</sup> Ibid., 6. See also Kate Winskell et al., “Making Sense of Abstinence: Social Representations in Young Africans’ HIV-Related Narratives from Six Countries,” *Culture, Health & Sexuality* 13, no. 8 (2011); Daniel Jordan Smith, “Youth, Sin and Sex in Nigeria: Christianity and HIV/AIDS-Related Beliefs and Behaviour among Rural-Urban Migrants,” *Culture, Health & Sexuality* 6, no. 5 (2004).

<sup>106</sup> In theorizing about the various punishment theories of HIV, Loretta Kopelman notes that among some health professionals, the frame HIV as punishment retains salience. Loretta M. Kopelman, “If HIV/AIDS Is Punishment, Who Is Bad?,” *Journal of Medicine and Philosophy* 27, no. 2 (2002).

<sup>107</sup> Ibid.



For Loretta Kopelman, the theodicy of AIDS falls under the broader understanding of disease as punishment. For Kopelman, punishment theory holds that “being bad or doing bad things can directly cause disease, and when it does, blame should be placed on those who get sick.”<sup>108</sup> She distinguishes four forms of the theory, or two kinds of two kinds: religious non-modified, religious modified, secular non-modified, and secular modified. Religious and secular are differentiated by the absence or presence of a God or transcendent being inflicting punishment. In its secular form, disease is not a punishment from God, but it is still a result of morally suspect life choices. In public health parlance such choices are categorized as risk behaviors. The focus here is not on a “causal concept of responsibility,” rather culpability is rendered in moral terms.<sup>109</sup>

Punishment theories of disease provide an account of different understandings of why certain persons and not others become ill. As African theologian Tinyiko Maluleke observes, “AIDS represents the frightening world of chaos, disorder and non-meaning from which we hoped our faith had delivered us... . The AIDS pandemic recreates for us the frightening world of the earlier church where we do not control the elements.”<sup>110</sup> The punishment theory of disease offers order and meaning, and in the process shows the pathway from theo-ethical interpretations of illness to stigma.

Stigma often leads to specific acts of discrimination. PLWHA are especially vulnerable to the social and psychological isolation of living with a disease attributed to the thwarting of God’s intentions or a break with the natural harmony of the world

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<sup>108</sup> "If HIV/AIDS Is Punishment, Who Is Bad?," in *Ethics & AIDS in Africa: The Challenge to Our Thinking*, ed. Anton A. van Niekerk and Loretta M. Kopelman (Claremont, South Africa: David Philip, 2005), 209.

<sup>109</sup> *Ibid.*, 210.

<sup>110</sup> Quoted in Parker and Birdsall, "HIV/AIDS, Stigma and Faith-Based Organizations: A Review," 15.

around them. PLWHA who seek out Western medicine and join support groups risk alienation from their families, kinship networks, and the cultural web that helps them make sense of the world. Given these consequences and risks, it is not surprising that global health professionals are wary of those who understand the HIV pandemic as a punishment for moral or spiritual transgressions. Stigma is a recurring and prominent theme in the major intergovernmental reports on the pandemic and one of the primary locations where religion is named explicitly.<sup>111</sup>

The logic is straightforward: stigmatization disempowers PLWHA by placing them “outside” of the community. As outsiders they face various forms of discrimination, including denial of employment, health care, etc. The punishment theory effectively provides moral cover for this logical sequence by locating blame on the individual—or an associate of the individual—who has sinned (religious) or engaged in risky behaviors (secular).

For pastor and scholar Peter Mageto, this moral cover is rooted in the longer history of Christian churches in Africa, especially the correlation of “sex, disease, and conversion” at the heart of the colonial missionary encounter with African traditional conceptions of morality.<sup>112</sup> As the most recent manifestation of this correlation, HIV/AIDS reinforces a “victim theology” in which Christian teachings emphasize “heavenly rewards at the expense of responsible living in the now and here.”<sup>113</sup> Mageto argues that churches conceptualize HIV as an incurable, sexual disease “sent against

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<sup>111</sup> In the UNAIDS strategy *Getting to Zero*, one of the few references to faith-based organizations reads: “Strengthen faith-based organizations in expanding their pivotal role in the community; in integrating HIV prevention, care and support; and in steadily addressing stigma and discrimination.” See UNAIDS, “Getting to Zero: 2011-2015 Strategy,” (Geneva 2010), 47

<sup>112</sup> Peter Mageto, *Victim Theology: A Critical Look at the Church's Response to AIDS* (Bloomington, IN: AuthorHouse, 2006), xv.

<sup>113</sup> *Ibid.*

homosexuals and / or prostitutes,” and in so doing obscure “major co-factors such as migrant labor, poverty, freedom, equality, and health care for all.”<sup>114</sup> As a result, churches overemphasize conversion to Christianity and a particular form of Christian living as the most effective “remedy for both sexual sin (deviant behavior) and divine retribution over a committed sin.”<sup>115</sup> Conversion is a response to the notion that HIV threatens the “rational order of creation” and requires something other than a medical prescription. However, as a result of the church’s overemphasis on conversion, the “church’s theological teachings on sexuality, disease, conversion, sin, suffering, and the practices of care and counseling remain judgmental, condemnatory, and victimizing.”<sup>116</sup>

Yet the empirical question of whether religious entities contribute to or mitigate stigma remains an open one. The lack of empirical research has given a disproportionate authority to anecdotal evidence of stigmatizing practices among religious entities. Recent research, however, has attempted to fill this gap in the literature. As may be expected, the research suggests that religious entities both exacerbate and reduce stigma. Local context matters. Religious networks matter. Politics matter.<sup>117</sup>

Reducing stigma of PLWHA is seen as the best way to mitigate explicit acts of discrimination. Many Christian theologians and ethicists have articulated alternative, constructive theologies of inclusion in response to stigmatizing practices. For example, Elias Bongmba, invoking the theological concept of the *imago dei*, exhorts Christian

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<sup>114</sup> Ibid., xvi.

<sup>115</sup> Ibid., xv.

<sup>116</sup> Ibid., xvi.

<sup>117</sup> In their review of the role of faith-based organizations and stigma, Parker and Birdsall offer an analysis of several factors that shape the FBO response to HIV/AIDS: attitudinal and conceptual (e.g., doctrinal positions on sexuality), societal (e.g., nature of religious moral authority in a given society); and political and structural (e.g., degree of collaboration between government and religious entities). See Table 1. Factors that shape the role of FBOs in relation to HIV/AIDS in Parker and Birdsall, "HIV/AIDS, Stigma and Faith-Based Organizations: A Review," 14.

denominations to break the silence and make the connection between stigmatizing theologies and discriminatory practices: “Discrimination diminishes a person’s dignity, ignores, and disrespects the *imago dei*. It creates boundaries on grounds that are unscientific and irrational. Stigmatization and discrimination destroy proximity to the other, an important relational component of intersubjective relations.”<sup>118</sup> Constructive theologies, like that offered by Bongmba, push back against punishment theories of disease and reveal Christian themes supportive of global health priorities and programs.

So what does this mean? I explore in chapter three how the recognition of this ambivalence about religion and stigma has been a critical dimension of the degree of willingness of global leaders to turn to religion. That is, a clearer sense of what religions are doing on the ground in sub-Saharan Africa as well as the amplification of inclusive theologies has provided the justification global health leaders needed not only to invite religious leaders more fully into the conversation about appropriate HIV and AIDS policy, but also to seek out partnerships with specific religious entities (from traditional healers to local churches to global communions) providing a wide range of HIV services.

The efforts currently underway to foreground ways religious entities mitigate stigma, including the theo-ethical framings and motivations that are especially apt for combating stigma and discrimination, suggest that a previous era in which the default mode was one of suspicion or tension may be giving way to an era in which global health leaders recognize publicly the potential of religious entities as a health asset. But this recognition is possible in part because of the increased attention to documenting what religious entities actually do—that is, the empirical evidence offers a compelling, though

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<sup>118</sup> Elias K. Bongmba, *Facing a Pandemic: The African Church and the Crisis of AIDS* (Waco, Texas: Baylor University Press, 2007), 122.

much more complicated story of the intersection of religious practices with global health policies and programs—and in part because of the increasingly vocal participation of Christian theologians and ethicists in responding to the problem of stigmatization.

This represents what I understand to be the limits of partnerships between religious entities and global health leaders. Partnerships are forged largely on instrumental grounds, when global health leaders recognize the way religion might support existing research. But any partnerships that emerge from the current coincidence of empirical evidence and theo-ethical commitments are then highly contingent and give a false impression that deeper tensions between scientific reasoning and theological reflection have been resolved.

## **V. CONCLUSION**

The friction point of stigma suggests that any revaluing of religious entities as a health asset cannot overlook processes of theo-ethical reflection as a critical dimension of what religious entities actually do. Given the active and passive role of religion in encouraging and exacerbating the stigmatization of persons affected by HIV, global health leaders have good reason to be suspicious of partnering with religious entities in the global response to HIV. Yet, the practical demands of scaling-up the global response to HIV and the failure of existing policies to reverse the now-chronic pandemic has served as a catalyst for revaluing the contribution of religious entities. To do so, global health leaders have had to come to terms with and find ways to mitigate the various ways in which religious entities can create tension in the response to HIV.

The limited success of existing health prevention and promotion strategies has contributed to a greater willingness on the part of global health leaders to parse the religious landscape more carefully.<sup>119</sup> Tensions, while real, do not tell the whole story. Rather than dismissing religion entirely, the next chapter documents the work of global health leaders to identify specific religious communities supportive of secular global health policies and programs—to seek an evidence base of what religious entities are actually doing to respond to AIDS, including the articulation of constructive theo-ethical responses to stigma.

The following chapter shows this pragmatic, selective turn to religious entities as allies and analyzes the influential role of an emerging assets-based framework in supporting this turn. By focusing attention on how the specific health-related activities of religious entities contribute to global health, this assets-based framework has provided global health leaders with a conceptual tool and helped to generate an evidence-base for revaluing religious entities as more than a source of tension in the global health response to HIV.

The HIV pandemic continues in the next chapter to serve as the context in which the persistent questions about the distinctive contributions of religious entities to global health can be seen in bold relief. But as subsequent chapters show, greater attention to the role of religious entities in the response to AIDS surfaces longstanding debates about the status of and relationship between theo-ethical and scientific claims more generally.

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<sup>119</sup> Recall the three global health realizations noted in the introduction: 1) reversing the pandemic will require unprecedented cooperation among all sectors of society; 2) religion remains powerful lens through which health and the meaning of illness are viewed in countries most affected by HIV; and 3) religious entities hold various *health assets*.

## CHAPTER THREE

### Appreciating Religion as a Health Asset:

#### The Turn to Religion in an HIV-Infected World

*We have a unique presence and reach within communities. We have unique structures and programmes that are already in place. We are available. We are reliable. And we are sustainable. We were there long before AIDS came and we will still be there when AIDS goes away.*

Rev. Canon Gideon Byamugisha<sup>120</sup>

### I. Introduction

The 2008 International AIDS Conference in Mexico City began with a gathering of people witnessing an evocative religious ritual. Reverend Mark Hanson, presiding Bishop of the Evangelical Lutheran Church in America and President of its global communion, the Lutheran World Federation, knelt down to wash the feet of two women living with the human immunodeficiency virus, or HIV. The act, carried out in front of hundreds who had gathered for an ecumenical discussion on the theme, “Faith in Action Now,” rendered dramaturgically the participants’ regret over the failure of Christian churches throughout the world to respond compassionately and courageously in an HIV-infected world.<sup>121</sup>

For many at the pre-conference as well as the many more attending the seventeenth International AIDS conference, it was a powerful and necessary image of the church penitent. For others, however, it was an image that had already been overplayed.

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<sup>120</sup>World Health Organization, "Faith-Based Groups: Vital Partners in the Battle against AIDS," 3.

<sup>121</sup> "Elca Presiding Bishop Washes Feet of HIV-Positive Women," *ELCA News Service*, August 4, 2008.

Yes, many churches had been slow to respond in the early years of the pandemic. But that initial hesitation had been more than matched by the zeal with which religious organizations had embraced and, at times, led the global response to HIV. The existence of a pre-conference event specifically for religious communities in and of itself suggested a formal recognition of what had been for years informal networks of religious leaders and communities providing support for persons and communities affected by HIV and AIDS.

Yet the suggestion that churches had not been sufficiently involved in the global response to HIV and AIDS must have seemed a bit strange to those who stuck around past the pre-conference. The workshops and presentations that constituted the much larger gathering of biologists, social scientists, community leaders, and dignitaries were animated by discussions of religion and the role of faith-based organizations in the response to AIDS, particularly as global health organizations and nation-states worked together to meet the Millennium Development Goals' ambitious—and behind schedule—plan for universal access to antiretroviral drugs by 2015. A special faith-themed pre-conference hardly seemed necessary.<sup>122</sup>

Among global health leaders, the turn to religious entities as an ally—and not an obstacle—in the response to HIV had already taken place. And among religious leaders—Hanson's own Lutheran communion, in particular—the turn *of* religion to global health organizations that could help them meet the pressing needs of PLWHA was well under way, as evidenced by denomination-specific publications and church-wide

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<sup>122</sup> For a description of the footwashing and the preconference event, see “ELCA Presiding Bishop Washes Feet of HIV-Positive Women,” press release, *ELCA News Service* (August 4, 2008), <http://www.elca.org>.



units focused on AIDS as well as the explosion of ecumenical meetings and workshops on the practical dimensions of scaling-up access to antiretroviral treatment.

Bishop Hanson was not the first religious leader to be featured so prominently at the International AIDS conference. Four years earlier on the stage of the fiftieth International AIDS conference held in Bangkok in 2004, Reverend Canon Gideon Byamugisha gave voice to the potential of religious entities as allies in global health. Byamugisha became the first religious leaders to ascend to the plenary dais of the International AIDS conference. Reading from a statement of commitment signed by heads of African Protestant churches in the run-up to the conference, Byamugisha made clear that the churches and church networks have significant potential to be an asset to global health in the response to HIV and AIDS. He noted that the All Africa Conference of Churches (AACC) represents over 140 million Christians in Africa. If, as AACC leaders resolved, every congregation becomes a “centre for health, healing, and treatment” and all faith-affiliated health facilities “havens of compassion,” then those 140 million Christians become part of the frontline response to the pandemic.<sup>123</sup> Churches and their networks, in this framework, become health assets—increasingly valuable assets—as ambitious global health targets for rolling out AIDS treatment come and go unmet.<sup>124</sup>

This does not imply that religion is an unmitigated good for global health; Byamugisha recognizes the friction points described in chapter two: “Some of us are still

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<sup>123</sup> "Faith-Based Groups: Vital Partners in the Battle against AIDS," 4.

<sup>124</sup> For example, by World AIDS Day, December 2005, the WHO's 3x5 initiative fell significantly short of its ambitious goal of enrolling three million persons in low and middle-income countries on ARVs by 2005. By 2005 approximately one million new patients had been enrolled in ARV treatment programs. See UNAIDS, "AIDS Epidemic Update," [http://www.unaids.org/en/HIV\\_data/epi2006/default.asp](http://www.unaids.org/en/HIV_data/epi2006/default.asp).

preaching condemnatory and stigmatizing sermons and approaches to HIV/AIDS.”<sup>125</sup>

However, it does suggest the practical reasons why partnerships between Christian entities and global health organizations have increased in the past decade. In this chapter, I review the reasons for this emerging consensus among global leaders that religion can be a health asset.

In the time between Byamugisha’s bold claims from the plenary dais to Hanson’s footwashing, a growing body of empirical research emerged that documents the activities of religious entities in the global response to HIV<sup>126</sup>—that is, research that shows what religious entities are actually doing. The first part of this chapter reviews this research, focusing especially on the literature published between 2006 – 2010, delimited geographically to sub-Saharan Africa and virologically to HIV.<sup>127</sup>

Simultaneously, formal theo-ethical reflection on the HIV pandemic and the global response to it has burgeoned in the past ten years, dominating much of the writing by African Christian theologians as well as non-African Christian theologians and ethicists that feature Africa prominently in their own work. The second part of this chapter reviews the themes in this theo-ethical work. Taken together, the two literature reviews suggest a qualitatively different starting point for engaging questions about the positive role of religion in the HIV pandemic than was possible a decade ago.

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<sup>125</sup> World Health Organization, "Faith-Based Groups: Vital Partners in the Battle against AIDS," 3.

<sup>126</sup> For one of the most comprehensive listing of works related to religion and HIV, see the bibliography created by the Collaborative for HIV and AIDS, Religion and Theology (CHART). The publicly accessible bibliography includes over 2000 entries contributed by various scholars and is accessible at <http://chart.ukzn.ac.za/>.

<sup>127</sup> I have chosen to limit the literature review to these years for two reasons. One, in 2006, global health interest in moving from anecdotal evidence to mapping the role of religious entities in health increased, as evidenced by the reports below as well as the uptick in the number and diversity of studies being published. Two, ARHAP completed a comprehensive review and annotated bibliography of the existing literature prior to 2006. See Olivier et al., " ARHAP Literature Review: Working in a Bounded Field of Unknowing."; Olivier, Cochrane, and Schmid, " ARHAP Bibliography: Working in a Bounded Field of Unknowing."

Out of this surge in both the scientific and theo-ethical literature on HIV and religion, the concept of religious health assets has emerged as one of the primary frameworks used to understand why and how religious entities are being revalued as both *relevant* to global health and *desirable* as allies.<sup>128</sup> A religious health asset, most basically, is “an asset located [in] or held by a religious entity that can be leveraged for the purposes of development of public health.”<sup>129</sup>

Drawing specifically on the origins and current research of the African Religious Health Assets Program (ARHAP), the third part of this chapter explains the concept of religious health assets and explores how it has been used to: (1) get a clearer picture of what religious entities are doing; (2) justify greater attention to religion on the part of global health actors; and (3) articulate in language accessible to global health the value of religious entities.

After showing how the concept of religious health assets was developed and deployed, I offer in the concluding section a critical appreciation for the religious health assets approach as a foundation for partnerships between religious entities and global health institutions in the response to HIV and AIDS. While recognizing that the health assets religious entities hold are necessary for success in preventing the spread of HIV and caring for those already affected, I suggest that the current understanding and use of religious health assets by global health actors fails to account for the potential of critical, theo-ethical reflection as one of the most distinctive religious health assets. This lack of recognition, as the next chapter argues, has as much to do with the inability of

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<sup>128</sup> Though Robert Garner is focused specifically on HIV and Pentecostalism in South Africa, I find his conceptualization of the terms relevance and ally useful helpful for naming broad themes in the literature. See Robert C. Garner, "Religion in the AIDS Crisis: Irrelevance, Adversary, or Ally?," *AIDS Analysis Africa* 10, no. 6-7 (1999); Garner, "Safe Sects?."

<sup>129</sup> African Religious Health Assets Programme, "Appreciating Assets," 39.

theologians and ethicists to articulate the value of theo-ethical reflection in purportedly nontheological contexts as it does with any limitations on the part of global health.

## II. Religious Entities as Relevant

There are now a significant number of correlational studies focused on understanding how religious entities affect persons and communities impacted by HIV and AIDS in sub-Saharan Africa. Empirical studies and arguments published range across fields (and their subfields) as diverse as community psychology, sociology, public health, anthropology, medicine, nursing, sexuality studies, law, and, even, conservation biology.<sup>130</sup> This work suggests that many scholars in diverse fields now assume that religious entities are relevant—or, minimally, that determining whether or not religious entities are relevant is a legitimate part of the research agenda.

Typical framings of these studies read as follows:

“Churches have attracted controversy for how they have dealt with AIDS: they have been criticized for moral stigmatism, yet lauded for their charitable works.”<sup>131</sup>

“Increasingly faith-based organizations are being asked to participate in HIV prevention and care activities. ... The study highlights differences in messages between mainstream and Pentecostal Christians and Muslims. ... Public health organizations and policy-

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<sup>130</sup> Stephen M. Awoyemi, "The Role of Religion in the HIV/AIDS Intervention in Africa: A Possible Model for Conservation Biology. Editorial," *Conservation Biology* 22, no. 4 (2008).

<sup>131</sup> Mark Krakauer and Jodie Newbery, "Churches' Responses to HIV/AIDS in Two South African Communities," *Journal of the International Association of Physicians in AIDS Care* 6, no. 1 (2007), 27.

makers should be aware of these denominational differences as they engage with religious institutions and leaders in HIV prevention and care.”<sup>132</sup>

“Religion shapes everyday beliefs and activities, but few studies have examined its associations with attitudes about HIV. . . . Research results highlight the influence of religious beliefs on HIV-related stigma and willingness to disclose, and should help inform HIV-education outreach for religious groups.”<sup>133</sup>

The empirical studies at both the individual and organizational level are often correlational, falling into categories familiar to the global health audience: prevention, care, and treatment. Representative research questions focused on the individual include: Is there a correlation between religious affiliation and engagement in risk behaviors associated with HIV transmission?<sup>134</sup> How does religious participation affect dynamics related to disclosing one’s positive status?<sup>135</sup> Do persons on antiretroviral treatment benefit from church participation?<sup>136</sup>

Representative research questions focused on religious organizations include correlational studies, for example, What is the relationship between faith-based

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<sup>132</sup> D. N. Ucheaga and K. A. Hartwig, "Religious Leaders' Response to AIDS in Nigeria," *Global Public Health* 5, no. 6 (2010), 611

<sup>133</sup> James Zou et al., "Religion and HIV in Tanzania: Influence of Religious Beliefs on HIV Stigma, Disclosure, and Treatment Attitudes," *BMC Public Health* 9, no. 75 (2009), 46

<sup>134</sup> S. O. Gyimah et al., "Religion, HIV/AIDS and Sexual Risk-Taking among Men in Ghana," *Journal of Biosocial Science* 42, no. 4 (2010).

<sup>135</sup> Robin Root, "Religious Participation and HIV-Disclosure Rationales among People Living with HIV/AIDS in Rural Swaziland," *African Journal of AIDS Research* 8, no. 3 (2009). Suzanne Maman et al., "The Role of Religion in HIV-Positive Women's Disclosure Experiences and Coping Strategies in Kinshasa, Democratic Republic of Congo," *Social Science & Medicine* 68, no. 5 (2009). Neville Miller and D. L. Rubin, "Factors Leading to Self-Disclosure of a Positive HIV Diagnosis in Nairobi, Kenya: People Living with HIV/AIDS in the Sub-Sahara," *Qualitative health research* 17, no. 5 (2007).

<sup>136</sup> Stephen T. Carpenter, "What Perceived Benefits Do HIV Positive Patients on Anti-Retroviral Therapy Derive from Participation in a Local Church?: The Experience of Patients at Valley Trust ARV Centre, Kwazulu-Natal" (master's thesis, St Augustine College of South Africa, 2007).

organizations and HIV-related stigma?,<sup>137</sup> as well as what might be described as primarily descriptive studies. The latter seek to describe what specifically religious entities are doing in response to HIV.<sup>138</sup>

Framed in these ways, the goal of the research is, largely, to clarify for global health practitioners and policymakers the ambiguity about the role of religion. Through its identification of specific features of religious practices and beliefs that affect the health of, and health-related strategies employed by, persons living in communities impacted by pandemic HIV, the research sheds light on the various ways religious entities contribute to and create obstacles for global health. The results of both the descriptive and correlational studies do not necessarily resolve the ambiguity of religious relevance to global health, however. While some studies suggest that religious participation correlates positively with HIV prevention measures,<sup>139</sup> other studies suggest that socioeconomic factors account for much of this correlation, rendering religious participation largely insignificant,<sup>140</sup> while still others note it is both/and.<sup>141</sup> Similarly, at the organizational level, studies provide evidence both of religious entities' active

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<sup>137</sup> Erasmus Otolok-Tanga et al., "Examining the Actions of Faith-Based Organisations and Their Influence on HIV/AIDS-Related Stigma: A Case Study of Uganda," *African Health Sciences* 7, no. 1 (2007).

<sup>138</sup> Krakauer and Newbery, "Churches' Responses to HIV/AIDS in Two South African Communities." Katherine Marshall and Lucy Keough, "Faith Communities Engage the HIV/AIDS Crisis: Lessons Learned and Paths Forward," in *Berkley Center Religious Literacy Series* (Washington, D.C.: Berkley Center for Religion, Peace, and World Affairs, Georgetown University, 2007); R. J. Vitillo, "Faith-Based Responses to the Global HIV Pandemic: Exceptional Engagement in a Major Public Health Emergency. Special Report," *Journal of Medicine and the Person* 7, no. Journal Article (2009); Philippe Denis, "The Church's Impact on HIV Prevention and Mitigation in South Africa: Reflections of a Historian," *Journal of Theology for Southern Africa* 134, no. Journal Article (2009); Eva S. Bazant and Marc Boulay, "Factors Associated with Religious Congregation Members' Support to People Living with HIV/AIDS in Kumasi, Ghana," *AIDS and Behaviour* 11, no. 6 (2007); Victor Agadjanian and Soma Sen, "Promises and Challenges of Faith-Based AIDS Care and Support in Mozambique," *American Journal of Public Health* 97, no. 2 (2007).

<sup>139</sup> G. J. Wagner et al., "Factors Associated with Condom Use among HIV Clients in Stable Relationships with Partners at Varying Risk for HIV in Uganda," *AIDS and Behavior* 14, no. 5 (2010).

<sup>140</sup> Gyimah et al., "Religion, HIV/AIDS and Sexual Risk-Taking among Men in Ghana."

<sup>141</sup> Jo Sadgrove, "'Keeping up Appearances': Sex and Religion Amongst University Students in Uganda," *Journal of Religion in Africa - Religion en Afrique* 37, no. 1 (2007).

involvement in providing direct assistance to PLWHA<sup>142</sup> and religious entities largely absent from the provision of direct assistance.<sup>143</sup> These differences in findings simply underscore what for many scholars in religious studies is a commonplace: religious entities are not all the same. While this may be stating the obvious, it also serves as an important cautionary note as faith-based and secular global health leaders increasingly tout the “untapped” potential of religion to scale-up the response to HIV.<sup>144</sup>

Policymakers do not have the luxury of attending to all of these differences. Tension will always exist between the particularity of these correlational and descriptive studies and the necessary generality of a policy framework for engaging religious entities in the response to HIV. What emerges from these studies, though, is a constellation of explicitly and nonexplicitly religious activities worth paying attention to in global health discussions. This constellation includes religious discourse about HIV and PLWHA (e.g., messages from the pulpit about HIV-related stigma) and spiritual support for coping with HIV/AIDS. It also includes attention to broader religious commitments and the activities through which they are enacted that impact the experience of PLWHA and the response of communities affected by HIV. For example, paying attention to the discourses on

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<sup>142</sup> Denis, "The Church's Impact on HIV Prevention and Mitigation in South Africa: Reflections of a Historian." Denis notes three main areas in which the churches in South Africa have contributed: home-based care, orphan care, and ARV treatment.

<sup>143</sup> Agadjanian and Sen, "Promises and Challenges of Faith-Based AIDS Care and Support in Mozambique."

<sup>144</sup> Tearfund, *Faith Untapped: Why Churches Can Play a Crucial Role in Tackling HIV and AIDS in Africa* (Teddington, UK: Tearfund, 2006). Sara Woldehanna et al., "Faith in Action: Examining the Role of FBOs in Addressing HIV-AIDS," (Washington, D.C.: Global Health Council, 2005). World Health Organization, "Faith-Based Groups: Vital Partners in the Battle against AIDS."

gender at play in religious entities can illumine the challenges religious leaders face in generating consistent messages about gender equality and HIV-prevention messages.<sup>145</sup>

These activities are in addition to the less distinctively religious activities such as providing a building in which voluntary counseling and testing can be offered or visiting the homes of PLWHA. In many places throughout Africa these less distinctively religious activities may be provided exclusively by religious entities due to the absence of public health infrastructure. Arguably, though, there is nothing about these activities that sets them apart as distinctively religious activities. To clarify, the framings and motivations for offering the church building for voluntary counseling and testing may be distinctively religious, but the activity itself could, presumably, be carried out by a nonreligious entity as well.<sup>146</sup> Contrast this with religiously inflected messaging about the inclusion or exclusion of PLWHA from communion, for example.

From the standpoint of global health, all of these activities are relevant. They suggest the potential of religious entities to complement, reinforce, or otherwise support two of the major global health goals in the response to AIDS: reducing stigma for PLWHA and increasing adherence to antiretroviral treatment regimens. For example, Boulay et al. analyze survey data from a stigma reduction program in Ghana involving national and local religious leaders and conclude that “attitudes related to a punitive response to PLHA both improved over time and were positively associated with exposure

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<sup>145</sup> Elisabeth Eriksson et al., "Ambivalence, Silence and Gender Differences in Church Leaders' HIV-Prevention Messages to Young People in Kwazulu-Natal, South Africa," *Culture, Health & Sexuality* 12, no. 1 (2010).

<sup>146</sup> A case study of an “AIDS-sensitive church” in South Africa illustrates this point. The authors conclude that the church as a support network provides an important mechanism in resource-poor communities (i.e., those without sufficient public health infrastructure) for coping with the pandemic. What is not clear from this study is whether the importance of this mechanism is its distinctive religious character or simply its presence in the absence of other alternatives. See R. L. Miller, "A Rock in a Weary Land: AIDS, South Africa, and the Church," *Social Work in Public Health* 24, no. 1/2 (2009).



to the program's campaign."<sup>147</sup> With regards to increasing adherence, Watt et al. show that despite the persistence of stigma and the lack of church support for PLWHA, prayer practices supported adherence.<sup>148</sup> In less direct ways, Perry et al. identify through a phenomenological study the important role of "faith, spirituality, fatalism, and hope" in Ghanaian women's "construction of the phenomenon of living with HIV/AIDS."<sup>149</sup> Religious leaders, practices, and meaning-making processes are, according to these studies, worth paying attention to.

This brief literature review of recent empirical studies on religion's relevance to the HIV pandemic can be read as both a cause and effect of the emerging consensus among global health leaders that religious entities are an important partner. The evidence base generated by these studies show in scientific language specific ways religion is relevant to global health (cause), even as the existing and emerging partnerships between global health and religious entities legitimate a research agenda animated by questions about the precise nature of religion's relevance (effect).

With regards to the latter, a cluster of publications emerged in the mid-2000s from intergovernmental organizations<sup>150</sup> as well as religiously affiliated nongovernmental

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<sup>147</sup> Marc Boulay, Ian Tweedie, and Emmanuel Fiagbey, "The Effectiveness of a National Communication Campaign Using Religious Leaders to Reduce HIV-Related Stigma in Ghana," *African Journal of AIDS Research* 7, no. 1 (2008), 133.

<sup>148</sup> Melissa H. Watt et al., "Missed Opportunities for Religious Organizations to Support People Living with HIV/AIDS: Findings from Tanzania," *AIDS Patient Care and STDs* 23, no. 5 (2009).

<sup>149</sup> Tonya E. Perry, Denise Davis-Maye, and Durrenda N. Onolehemhen, "Faith, Spirituality, Fatalism and Hope: Ghanaian Women Coping in the Face of HIV/AIDS," *Journal of HIV/AIDS & Social Services* 6, no. 4 (2007), 37.

<sup>150</sup> UNAIDS, "Partnership with Faith-Based Organizations: UNAIDS Strategic Framework," (Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS), 2009); Gary Bandy et al., "Building from Common Foundations: The World Health Organization and Faith-Based Organizations in Primary Healthcare," (Geneva: Geneva Global and Department of HIV/AIDS of the WHO, 2007); Todd Ferguson et al., "Report on the Global Consultation on Decent Care," (Geneva: World Health Organization, 2006); Woldehanna et al., "Faith in Action."; World Health Organization, "Faith-Based Groups: Vital Partners in the Battle against AIDS." World Bank, "Concept Note," in *HIV and AIDS Workshop for Faith-Based Organisations and National AIDS Councils* (Accra, Ghana: World Bank, 2004); Edward C. Green, "Faith Based

organizations.<sup>151</sup> These publications, in the form of reports, strategic plans, and consultations, focused on resources religious entities can, and in some cases already do, contribute to the global health response to HIV. The documents tend to flatten the distinction between religious entities and other nongovernmental organizations. For example, while noting the “prophetic role of faith” as an important form of discursive activism that religious entities can contribute, the report on the “Global Assessment and Strategy Session on Faith Communities Accessing Resources to Respond to HIV/AIDS” concludes that the obstacles to partnership tend to be the result of asymmetries of information and resources—in both directions. On the one hand, global health organizations are not aware of the significant resources religious entities possess, and, on the other hand, religious entities are not aware of, nor equipped to take advantage of, the resources global health organizations can offer.<sup>152</sup> Framed this way, the problem is largely about building the capacity of religious entities, including the capacity to monitor and evaluate their own programs to satisfy the requirements of global donors, and creating

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Organizations Contributions to HIV Prevention," (Washington DC: US Agency for International Development (USAID) and The Synergy Project TvT Associates, Harvard Centre for Population and Development Studies., 2003).

<sup>151</sup> William L. Sachs, *Empowered by Faith: Collaborating with Faith-Based Organisations to Confront HIV/AIDS* (Arlington, VA.: Family Health International (FHI)/USAID Bureau for Global Health Office of HIV/AIDS, 2007); Marshall and Keough, "Faith Communities Engage the HIV/AIDS Crisis: Lessons Learned and Paths Forward."; Ecumenical Pharmaceutical Network and World Council of Churches, "HIV and AIDS Treatment- FBOs Getting Involved," *Contact*, October - December 2007 2007; Tearfund, *Faith Untapped: Why Churches Can Play a Crucial Role in Tackling HIV and AIDS in Africa*; N. Taylor, "Working Together? Challenges and Opportunities for International Development Agencies and the Church in the Response to AIDS in Africa," in *HIV and AIDS Briefing Paper 7* (Teddington, UK: Tearfund, 2006); Steven Lux and Kristine Greenaway, "Scaling up Effective Partnerships: A Guide to Working with Faith-Based Organizations in the Response to HIV and AIDS," (Geneva: Ecumenical Advocacy Alliance, 2006); Sara Speicher, "Final Report" (paper presented at the Global Assessment and Strategy Session on Faith Communities Accessing Resources to Respond to HIV/AIDS, Geneva, Switzerland, January 18-20 2005); Andrew Doupe, "Partnerships between Churches and People Living with HIV/AIDS Organizations," (Geneva: World Council of Churches, 2005).

<sup>152</sup> Speicher, "Final Report". This major consultation included representatives from twenty faith-based organizations and most of the major global health funders, including the WHO, UNAIDS, UNICEF, the World Bank, the Department for International Development (UK), and the Global Fund to Fight AIDS, Tuberculosis, and Malaria.

access points for integrating religious entities into existing funding mechanisms, such as the Country Coordinating Mechanism, a national-level government entity through which most of the major global health funding flows to particular countries.

Not insignificantly, these reports coincided with financial and moral support for the rapid scale-up to make access to antiretroviral treatments universally available. In light of this, the recognition of the relevance of religious entities appears to be linked to the strategic interests of global health. That is, when the practical demands of the scale-up necessitated more resources than were available within the existing global health system, the potential value of religious entities increased. This is, I contend, one of the factors leading to what I have described in this dissertation as a turn toward religious entities as allies. These reports have served as a catalyst for the empirical research described above.

It is important to note that even when empirical studies show that religion may be a nonfactor, the tenor of the conclusions drawn imply that religious entities could (and should) remain relevant. After concluding that “sexual practices of committed church youths might be similar to those of youths in wider society,” Chidi Nweneka concludes: “More might be achieved by a more pro-active engagement of the church in young people’s sexual and reproductive health matters.”<sup>153</sup>

This example suggests that with regards to prevention, at least, researchers have become more sympathetic to a positive role for religious entities in the global health response, or, minimally, are willing to give religion the benefit of the doubt. Edward Green and Alison Ruark’s critical response to the Berkley Center report “Faith

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<sup>153</sup> Chidi V. Nweneka, "Sexual Practices of Church Youths in the Era of HIV/AIDS: Playing the Ostrich," *AIDS Care* 19, no. 8 (2007), 966.

Communities Engage the HIV Crisis”<sup>154</sup> suggests one interpretation of this increasing sympathy. Green and Ruark argue that the report’s focus on religious entities’ emphasis on care and compassion obscures the focus on sexual responsibility within faith communities.<sup>155</sup> Green and Ruark suggest in this and other writings that, from a global health perspective, religiously inflected messages about sexual responsibility can have a bigger epidemiological impact in the response to HIV than the care and treatment programs.<sup>156</sup>

Certainly the coincidence of theologically resonant conservative sexual ethics and effective global health prevention strategies gives pause to global health leaders who may be quick to dismiss religious involvement in the response to HIV. This pause should include reflection on the part of global health leaders about the precise nature of their relationship to religious entities and their normative claims. For example, are there other global health commitments that are threatened by an instrumental use of a theo-ethically

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<sup>154</sup> Marshall and Keough, "Faith Communities Engage the HIV/AIDS Crisis: Lessons Learned and Paths Forward."

<sup>155</sup> Edward C. Green and Allison Herling Ruark, "AIDS and the Churches: Getting the Story Right," *First Things*, no. 182 (2008).

<sup>156</sup> See also E. Green and Allison Herling, "The ABC Approach to Preventing the Sexual Transmission of HIV: Common Questions and Answers," (Christian Connections for International Health, 2007); Edward C. Green, "The Impact of Religious Health Organisations in Promoting HIV/AIDS Prevention," in *The AIDS Crisis in Developing Countries*, ed. E. C. Green (Westport: Praeger Publishers, 2003); Edward C. Green et al., "Uganda's HIV Prevention Success: The Role of Sexual Behaviour Change and the National Response," *AIDS and Behaviour* 10, no. 4 (2006). That major reports have ignored this dimension, I would argue, reflects the lingering effects of the perceived and actual tension between religious entities and global health documented in chapter two. That such now-prominent public health personalities as Green are advocating this dimension of religious activity has, I believe, less to do with a moral conversion to more conservative sexual values and more to do with a pragmatic response to what, not without controversy, have been recognized as key success stories in the response to HIV, namely, the religious support for the A and B of the ABC (Abstain, Be faithful, use Condoms) approach popularized in Uganda: . For an analysis of the ABC approach in Uganda and Green’s pivotal role see Helen Epstein, *The Invisible Cure: Africa, the West, and the Fight against AIDS* (New York: Farrar, Straus and Giroux, 2007). See, especially, chapter eleven, “God and the Fight against AIDS.” Epstein argues that Green, though himself a self-described liberal, became a darling of the Bush administration’s response to AIDS because of the empirical evidence base he had been developing about the greater impact of abstinence and faithfulness when compared to condom use in reducing HIV prevalence rates. Green’s rise to prominence, and a Harvard fellowship, Epstein notes was due, in no small part, to the support of conservative Christians and the influence they had in Bush-era policy responses to HIV.

conservative sexual ethic, even if such an ethic supports programs with a greater epidemiological impact?

Without dismissing this coincidence as an important part of the turn to religious entities as partners, the following section explores another plausible explanation for the increasing sympathy of global health to religious entities: the surge of feminist and liberationist theo-ethical reflection on HIV as a social justice issue and its convergence with global health's attention to the social determinants of health.

### III. Theo-ethical Reflection for an HIV-Competent Church

In a 2008 review of African Christian theological responses to the HIV pandemic, Martha Fredericks concludes: "Within pastoral care, within liturgy, within Biblical studies and within systematic theology most efforts are geared towards combating the stigma and affirming the dignity of all people, especially people living with HIV and AIDS."<sup>157</sup> With a few notable exceptions, she notes, these efforts did not begin in earnest until the turn of the Millennium<sup>158</sup> —two decades after the first cases of HIV had been

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<sup>157</sup> Martha T. Frederiks, "HIV and AIDS: Mapping Theological Responses," *Exchange: Journal of Missiological and Ecumenical Research* 37, no. 1 (2008), 22.

<sup>158</sup> Frederiks notes an important Roman Catholic Bishops' pastoral letter in 1989 as one of the earliest theological responses, but relative silence throughout the 1990s. Speculating about the reasons for this silence, she suggests that the HIV pandemic was largely overshadowed by the urgency of other African socio-political events including the Rwandan genocide and the end of Apartheid in South Africa. *Ibid.* The latter and the complexity of the ensuing transition have been cited elsewhere as part of the explanation for HIV flying somewhat below the radar during the Mandela administration, though his efforts since leaving office have sought to rectify this inattention. For the Bishops' pastoral letter see The Catholic Bishops of Uganda, "Message on the AIDS Epidemic: To the Clergy, the Religious and All People of God, to Men and Women of Good Will: Peace and God's Blessing," *African Ecclesial Review* 31, no. 5 (1989). For discussion of the HIV epidemic in South Africa's transition to democracy, including a sympathetic critique of the Mandela administration's relatively muted response to HIV, see S.S. Abdool Karim and Q. Abdool Karim, eds., *HIV/AIDS in South Africa* (Cambridge: Cambridge University Press, 2005). For an example of the work Mandela has done through his foundation since being in public office see Medicins sans Frontières, "Implementing HIV/AIDS Services Including ART in a Rural Resource-Poor Setting: *Siyaphila*

reported and years after the fear of HIV had taken hold of the African public's imagination.<sup>159</sup>

What accounts for this silence and subsequent surge? Among the many possible factors, I contend that one important factor was the reframing of HIV as an issue of social justice affecting *all* persons in a society. This last qualifying phrase is important given the earlier history of AIDS activism in the U.S. and elsewhere that focused primarily on the impact of the pandemic on the rights of gay men, IV drug users, and others who are often labeled as marginal to society. Circumscribed by moral-behaviorist and moral-deviancy paradigms, the first decades of HIV required a prophetic response that most church communions were ill-equipped to articulate, much less follow-through on, given the unresolved—often unasked at the time—theological and moral questions related to homosexuality.<sup>160</sup>

Despite the fact that many of these questions remain unresolved, or tenuously resolved, in Christian communions, church involvement in the HIV response—from local AIDS ministries to global ecumenical programs—is now often taken for granted. What has changed is the public face of AIDS. The poster child for AIDS is now, literally, a

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*La Programme-- Lusikisiki, Eastern Cape (Activity Report 2003-2004),*" (Medecins sans Frontières; Nelson Mandela Foundation, 2005).

<sup>159</sup> My first encounter with these fears came in 1995 while studying at the University of Dar es Salaam in Tanzania. Within the first month of my arrival, I attended a campus sanctioned performance in the main auditorium that was part morality play and part public health education campaign about the dangers of HIV. A few weeks later Tanzanian students responded to my plans for a proposed trip to Uganda with parental concern, echoing the widespread perception at the time that Uganda was one of the centers of the pandemic.

<sup>160</sup> One notable exception to this is a collection of essays published by the National Council of Churches (USA). The volume draws, importantly, on the experiences of members of the Metropolitan Community Churches, the first LGBTQ positive ministry with an ecclesial structure, and a member of the NCCCUSA. See Letty M. Russell, *The Church with AIDS: Renewal in the Midst of Crisis* (Louisville: Westminster/John Knox Press, 1990).

child, usually an African child.<sup>161</sup> Or, it is a married African woman whose husband has multiple concurrent partners.<sup>162</sup> As the perceived moral culpability of those affected and infected by HIV has lessened, the involvement of churches has intensified. AIDS has been mainstreamed and, as a result, churches have found ways into the response that were not available or acceptable in the earlier years. The initial rush by churches to build orphanages specifically for children who lost parents to AIDS exemplifies this shift.<sup>163</sup>

The link between HIV and other currents in the global justice movement has taken place against the backdrop of highly publicized global initiatives to mitigate inequalities across a variety of issues linked to human flourishing (e.g., the Millennium Development Goals).<sup>164</sup> As such, access to AIDS care and treatment became one of the

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<sup>161</sup> For the prominence of images of African children in reports on AIDS, see UNAIDS, "Universal Access to HIV Prevention, Treatment, Care and Support: From Countries to Regions to the High Level Meeting on AIDS and Beyond," (Geneva: UNAIDS, 2011). accessed February 10, 2012 at [http://www.unAIDS.org/en/media/unAIDS/contentassets/documents/document/2011/2011\\_UA\\_roadmap\\_en.pdf](http://www.unAIDS.org/en/media/unAIDS/contentassets/documents/document/2011/2011_UA_roadmap_en.pdf)

<sup>162</sup> For Helen Epstein's argument about the initially unappreciated role of concurrent partnering in the Ugandan HIV epidemic, see Epstein, *The Invisible Cure: Africa, the West, and the Fight against AIDS*. Despite the emphasis on male infidelity, at least one study, drawing on large-scale Demographic and Health Surveys, finds that in a significant percentage of sero-discordant couples (30-40%), women are the one infected. The implication is that women are also involved in relationships outside of their monogamous partnerships more frequently than self-reports indicate. The study does not account for the reasons for this, but it does suggest that the predominant public focus on the vulnerability of women may not account sufficiently for the powerful dynamics of the concurrency models. Damien De Walque, "Sero-Discordant Couples in Five African Countries: Implications for Prevention Strategies," *Population and Development Review* 33, no. 3 (2007). This is in no way to suggest that the focus on women is not justified nor that the dynamics of patriarchy have not had a disproportionate impact on women's health. Rather, I include this study as a reminder of a phenomenon familiar to those who study heart disease. Assumptions about who is most at risk can drive research that unintentionally excludes other populations. In the case of heart disease, most studies have been conducted on men, despite the recent evidence that heart disease ranks as the number one cause of death for women in the United States. See Jane E. Brody, "Women Struggle for Parity of the Heart," *New York Times*, April 12, 2005; Denise Grady, "In Heart Disease, the Focus Shifts to Women," *New York Times*, April 18, 2006.

<sup>163</sup> While in recent years this strategy has been modified to respond to concerns both about the economic feasibility and the socio-psychological impact of orphanages compared to family care models, the moral framing of the orphan issue remains consistent. For a description of this shift see <http://www.avert.org> Avert has been involved in HIV work since 1986, serving as a research repository, advocacy service, and community project supporter.

<sup>164</sup> Goal six of the eight original Millennium Development Goals is "Combat HIV/AIDS, malaria, and other diseases." The description reads: "AIDS has become the leading cause of premature death in sub-Saharan Africa and the fourth largest killer worldwide. ... Though new drug treatments prolong life, there is no cure

litmus tests for a much broader global development agenda. Persons and communities affected by HIV/AIDS are still seen as marginals, but now their marginality is linked more explicitly to global structural injustices that could not be reduced as easily to the agency of the persons afflicted. Ironically, it seems, the recasting of PLWHA as innocent victims, and thus, in some sense characterized by limited agency—that is, victims of structural injustices—coincides with more intentional and sustained Christian involvement in the response, including theo-ethical reflection on the inherent dignity and agency of PLWHA.

James Keenan, who has been one of the most consistent and long-standing contributors to Catholic ethical debates about HIV, signals the more expansive understanding of social justice in his substitution of “social instability” for marginalization as the key concept for understanding the social dynamics of HIV.

Keenan argues

instability, not marginalization, is what frightens the rest of the world, and HIV/AIDS breeds specifically where there is social instability... . We find persons infected or at risk to the virus not simply among marginalized people, but rather as vulnerable persons precisely because their lives and their social settings lack the stability needed to live safely in a time of HIV/AIDS.<sup>165</sup>

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for AIDS, and prevention efforts must be intensified in every region of the world if the target is to be reached.” United Nations, “The Millennium Development Goals Report, 2005,” (New York: United Nations, 2005).

<sup>165</sup> Keenan and Jon Fuller introduce the concept of instability as a more accurate representation than marginalization of the context in which HIV/AIDS thrives: James Keenan, “Four of the Tasks for Theological Ethics in a Time of HIV/AIDS,” *Concilium: International Journal for Theology*, no. 3 “AIDS” (2007), 69.



This does not suggest that social instability *causes* HIV, but it does suggest that instability in social structures (e.g., high unemployment rates, labor force migration) have an effect on who is vulnerable to diseases like HIV.<sup>166</sup>

The relatively recent adoption of the phrase “the Church has AIDS,” or its theologically provocative rendering, “the Body of Christ has AIDS,” captures this broader understanding of shared vulnerability and the ongoing obligations of solidarity it evokes, serving as an indictment of both the earlier insensitivities and narrow ecclesiologies of Christian churches in the U.S. (Did the church not have AIDS when gay men, IV drug users, and prostitutes were identified as the primary vector for HIV?) and the too little, perhaps too late support of Western Christians responding to the severity of the pandemic in Africa.<sup>167</sup> This is not to diminish the courage and importance of recent theo-ethical reflection on HIV. Indeed, the shift from the West to the global South (and even from the U.S. West—San Francisco—to the U.S. South—Atlanta)<sup>168</sup> as the epidemiological and symbolic epicenter of the disease calls forth prophetic critiques appropriate to the context.

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<sup>166</sup> Helen Schneider offers a nuanced discussion of this in the context of the controversy over the Mbeki administration’s initial embrace of the claims by dissident scientists about the socio-political determinants of HIV. In many ways the justified public outrage over the impact of this stance on the availability of treatment in South Africa had the effect of obscuring important social dynamics in the pandemic, many of which are now considered an important focus for effective treatment campaigns. See Helen Schneider and Didier Fassin, "Denial and Defiance: A Socio-Political Analysis of AIDS in South Africa," *AIDS* 16(2002).  
<sup>167</sup> For an exploration of the implications of metaphors like “the body of Christ has AIDS” see Adriaan S. van Klinken, "When the Body of Christ Has AIDS: A Theological Metaphor for Global Solidarity in Light of HIV and AIDS," *International Journal of Public Theology* 4, no. 4 (2010).

<sup>168</sup> The relocation of the NAMES Project Foundation (the curator for The AIDS Memorial Quilt) from San Francisco to Atlanta in 2002 reflects symbolically the changing demographics of AIDS in the United States. In broad cultural terms, San Francisco represents the cultural capital for many in the gay community, while Atlanta has, in recent years, served as a similar cultural capital for African Americans. According to the most recent Center for Disease Control data, while “men who have sex with men,” or MSM—the CDC category—continue to be the most affected by HIV, regardless of race, African Americans bear the largest burden of disease. African Americans account for 44% of the incidence rate (new infections) in the U.S., despite representing only 14% of the population. Viral Hepatitis National Center for HIV/AIDS, STD, and TB Prevention, "HIV in the United States," (Atlanta: Centers for Disease Control and Prevention, 2011), <http://www.cdc.gov/HIV/resources/factsheets/PDF/us.pdf>.

For example, much of the theo-ethical reflection on HIV among African theologians has been focused on the impact of patriarchy or other gender-related concerns in African cultural and social systems.<sup>169</sup> The necessity of this type of reflection emerges, among other things, from the disproportionate impact of HIV on heterosexual women in Africa, disease transmission trends driven by practices of concurrency among heterosexual partners, and the gendered social ecology of labor migration, mining, and prostitution.

The courage of this type of theo-ethical critique is all the more noteworthy given the patriarchal structures of the churches in which most of these theologians are themselves located. That is to say, the theologians are engaged simultaneously in critique of the broader culture and the ways in which their own religious institutions legitimate, reify, and/or refract the oppressive practices and beliefs of the broader culture. African theologians, more so than many theologians in the West, pose their theo-ethical critiques

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<sup>169</sup> Examples of this focus on gender and patriarchy in theo-ethical reflection on AIDS include Augustine Musopole, *Spirituality, Sexuality and HIV/AIDS in Malawi: Theological Strategies for Behaviour Change* (Zomba: Kachere Series, 2007); Christina Landman, "A Theology for the Older, Female HIV-Infected Body," *Exchange: Journal of Missiological and Ecumenical Research* 37, no. 1 (2008); Teresia M. Hinga et al., *Women, Religion and HIV/AIDS in Africa: Responding to Ethical and Theological Challenges* (Pietermaritzburg: Cluster, 2008); Denise M. Ackermann, "'Deep in the Flesh' Women, Bodies and HIV/AIDS: A Feminist Ethical Perspective," in *Women, Religion and HIV/AIDS in Africa: Responding to Ethical and Theological Challenges*, ed. Teresia M. Hinga, et al. (Pietermaritzburg: Cluster, 2008); Lilian Siwila, "Care-Giving in Times of HIV and AIDS, When Hospitality Is a Threat to African Women's Lives: A Gendered Theological Examination of the Theology of Hospitality," *Journal of Constructive Theology* 13, no. 1 (2007); Isabel Apawo Phiri, Beverley Haddad, and Madipoane Masenya, *African Women, HIV/AIDS and Faith Communities* (Pietermaritzburg: Cluster, 2003); Mary Jo Iozzio et al., *Calling for Justice Throughout the World: Catholic Women Theologians on the HIV/AIDS Pandemic* (New York: Continuum International Publishing Group, 2009); Beverley Haddad, "Surviving the HIV and AIDS Epidemic in South Africa: Women Living and Dying, Theologising and Being Theologised," *Journal of Theology for Southern Africa*, no. 131 (2008); Gillian Margaret Paterson, "Escaping the Gender Trap: Unravelling Patriarchy in a Time of AIDS," *Concilium: International Journal for Theology*, no. 3 "AIDS" (2007); Augustine C. Musopole, "Christic Realism and AIDS: Theological Strategy for Behavior Change," *Theologies and Cultures* 4, no. 2 (2007).

of the role of patriarchy in the HIV pandemic as immanent critics, with all the attendant risks of this position.<sup>170</sup>

This emphasis on gender justice is one of the ways in which HIV has been linked to other currents in theo-ethical reflection. By foregrounding gender in the HIV pandemic, Christian theologians are able to bring the full force of a (relatively) more stable and recognizable feminist theo-ethical discourse to bear on the pandemic. As a result, this theo-ethical reflection responds directly to one of the recognized social determinants of the pandemic: gender inequity.

Similarly, theo-ethical reflection that frames the pandemic as an issue of health care justice or even more broadly as part of the global justice movement—and more often than not this framing includes attention to gender—draws on various liberationist theological discourses that have become in the past forty years one of the primary, though never uncontested, modes of doing contextual theology, especially among theologians in or expressing solidarity with the global South.

The general themes in both the feminist and liberationist theo-ethical reflection on HIV are familiar and include solidarity,<sup>171</sup> embodied theologies,<sup>172</sup> vulnerability,<sup>173</sup> life-

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<sup>170</sup> African American womanist theologians can also be seen as immanent critics in relation to concerns about the health impact on women of patriarchy, heterosexism, and discourses about masculinity in Black churches in the U.S. See Emilie M. Townes, *Breaking the Fine Rain of Death: African American Health Issues and a Womanist Ethic of Care* (New York: Continuum, 1998), especially chapter six, “And All the Colored Folks Is Cursed: The Impact of HIV/AIDS on African Americans.”

<sup>171</sup> Bertrand Lebouché et al., “Religion in the AIDS Crisis: Irrelevance, Adversary, or Ally? The Case of the Catholic Church,” in *Applied Ethics in a World Church: The Padua Conference*, ed. Linda Hogan (Maryknoll: Orbis Books, 2008); Thinandavha Derrick Mashau, “Where and When It Hurts Most: The Theology of Hope and Accompaniment in the Context of HIV and AIDS in Marriage and Family Life,” *Exchange: Journal of Missiological and Ecumenical Research* 37, no. 1 (2008); Cimperman, *When God's People Have HIV/AIDS*.

<sup>172</sup> Landman, “A Theology for the Older, Female HIV-Infected Body.”

<sup>173</sup> Evelyn Wakhusama, “Abused and Infected with HIV: A Call for a Communal Response,” in *Women, Religion and HIV/AIDS in Africa: Responding to Ethical and Theological Challenges*, ed. Teresia M. Hinga, et al. (Pietermaritzburg: Cluster, 2008); Fulata L. Moyo, “Sex, Gender, Power and HIV/AIDS in Malawi: Threats and Challenges to Women Being Church,” in *On Being Church: African Women's Voices*

affirming theologies,<sup>174</sup> and recognition of the inherent dignity of all persons.<sup>175</sup> These general themes manifest themselves in particular ways: through proposals for the greater inclusion of persons living with AIDS, (or GIPA), in care, treatment, and policy discussions;<sup>176</sup> articulation of and advocacy for decent care criteria;<sup>177</sup> enactment or calls for enactment of nondiscrimination policies in churches and national constitutions;<sup>178</sup> and revisions of seminary curricula<sup>179</sup> and ecumenical programs<sup>180</sup> for an HIV-competent church.

In outlining the four important tasks for theological ethicists in the response to AIDS, Keenan credits Lisa Sowle Cahill, whose work is taken up in the next chapter, with helping to sensitize theological ethicists to “issues of power and distribution of resources” in their reflection, and, importantly, action, on the pandemic.<sup>181</sup> More provocatively, Steve de Gruchy sees in the origins of public health and the contemporary work of global health a commitment to social justice that offers a better reflection of the Social Gospel than the versions offered up by theologians. Theologians should, de

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*and Visions*, ed. Isabel Apawo Phiri and Sarojini Nadar (Geneva: World Council of Churches, 2005); Kari Hartwig, "Confronting Religion, AIDS and Gender in Tanzania: Church Leaders at the Crossroads," *Journal of Constructive Theology* 12, no. 2 (2006).

<sup>174</sup> Haddad, "Surviving the HIV and AIDS Epidemic in South Africa: Women Living and Dying, Theologising and Being Theologised."; Isabel Apawo Phiri, "Life-Affirming African Theological Reflection on HIV and AIDS," *Concilium: International Journal for Theology*, no. 3 "AIDS" (2007); Denise M. Ackermann, "From Mere Existence to Tenacious Endurance," in *African Women, Religion, and Health: Essays in Honour of Mercy Amba Ewudziwa Oduyoye*, ed. Isabel Apawo Phiri and Sarojini Nadar (Maryknoll: Orbis, 2006).

<sup>175</sup> Karpf et al., eds., *Restoring Hope: Decent Care in the Midst of HIV/AIDS*; Bongmba, *Facing a Pandemic*; Johan Bouwer, "Human Dignity and HIV/AIDS," *Scriptura* 95, no. 2 (2007).

<sup>176</sup> Margaret Farley, "Prophetic Discourse in a Time of AIDS," in *HIV Prevention: A Global Theological Conversation*, ed. Gillian Paterson (Geneva: Ecumenical Advocacy Alliance, 2009).

<sup>177</sup> Karpf et al., eds., *Restoring Hope: Decent Care in the Midst of HIV/AIDS*.

<sup>178</sup> Bongmba, *Facing a Pandemic*.

<sup>179</sup> Musa W. Dube, ed. *HIV/AIDS and the Curriculum: Methods of Integrating HIV/AIDS in Theological Programmes* (Geneva: WCC Publications, 2003).

<sup>180</sup> Parry, *Beacons of Hope: HIV Competent Churches: A Framework for Action*.

<sup>181</sup> He locates this work in his second task: "Concepts, language, and advocacy regarding prevention and access to treatment." Keenan, "Four of the Tasks for Theological Ethics in a Time of HIV/AIDS," 66.

Gruchy argues, look to global health in order to “relearn our mother tongue,” to relearn what he understands to be the critical link between theology and social justice.<sup>182</sup>

The linking of HIV to broader social justice concerns has increased the potential points of contact between global health and religious entities. And, in general, these additional points of contact involve less friction than the points of contact highlighted in the previous chapter. That is, feminist and liberationist theo-ethical reflection on HIV as a social justice issue aligns well with social determinants of health approaches currently en vogue in global health. Feminist and liberationist critiques serve, then, to legitimate many of the existing programs and themes generated by the social determinants framework such as advocating for greater equity for women, combating stigma and discrimination in order to mitigate the effects of social exclusion, and addressing global economic inequality and disparities in access to and conditions of employment.<sup>183</sup>

This is not to say that tensions do not remain, nor that these additional points of contact were not present in the earlier years of the pandemic. But the literature review does show how the surge in theo-ethical reflection on AIDS has a particular feminist and liberationist bent to it that is more amenable to the current global health emphasis on the social determinants of health and, as such, may have helped to render religious entities more immediately visible and desirable as allies.

In both the review of the empirical evidence and the theo-ethical reflection, I have sought in broad brush strokes to add color to what is not a black and white story of global health’s turn to religious entities as partners in the response to AIDS. The claims in the

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<sup>182</sup> Steve de Gruchy, "Re-Learning Our Mother Tongue? Theology in Dialogue with Public Health," *Religion & Theology* 14, no. 1/2 (2007).

<sup>183</sup> For a comprehensive discussion of the social determinants of health framework in global health see CSDH, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health: Final Report of the Commission on Social Determinants of Health*.

above literature reviews are intended to be modest, but sufficient enough to indicate that something of consequence has changed in the relationship between global health and religion. At minimum, the two literature reviews suggest a qualitatively different starting point for engaging questions about the positive role of religion in the HIV pandemic than was possible a decade ago. Religious beliefs and activities, including theo-ethical reflection, are relevant, on the one hand, because of their interface with the broader social determinants of health (indirect), and, on the other hand, because of their function as a possible determinant of health (direct).

One influential attempt to understand this different starting point and articulate the direct and indirect relevance of religion to global health leaders has come from the African Religious Health Assets Program, or ARHAP.

#### **IV. Religious Entities as Desirable: Religion as a Health Asset**

ARHAP is an international, interdisciplinary group of scholars and practitioners interested in the intersection of religion and public health.<sup>184</sup> Borne out of a December 2002 meeting at the Carter Center in Atlanta, Georgia to discuss a “global religious health assets initiative,” ARHAP has sought “to address the general paucity of studies on faith-based organizations working in health.”<sup>185</sup> The initial founders of ARHAP included liberationist theologians, sociologists of religion conversant in critical theory, U.S.-based

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<sup>184</sup> ARHAP was relaunched in 2011 as IRHAP, International Religious Health Assets Program, a reflection of the expanding geographic scope of its work. Though not evident in the name change, the re-launch also identifies several new areas of research, including health systems strengthening. Many of the same institutions continue to provide support, including my home institution, Emory University. However, its primary home—the administrative and operational “hub”—shifted from the Department of Religious Studies Department to the School of Public Health and Family Medicine at the University of Cape Town. Since the research for this dissertation took place before 2011, I will use ARHAP when referencing this research collaboration. For a more detailed explanation of the evolution from ARHAP to IRHAP see <http://www.arhap.uct.ac.za>

<sup>185</sup> African Religious Health Assets Programme, "Appreciating Assets," 23.

global health economists working on health-system strengthening in African contexts, and directors of faith and health initiatives in the U.S. These participants shared a general understanding that “the secularization thesis is in crucial aspects invalid; that humans have the capacity to exercise their own agency in dealing with their health; and that an assets-based approach is most appropriate for research in this field,” though their reasons for participating may have been framed in discipline-specific language.<sup>186</sup> The founders also shared a vision of extending the benefits of public health to all persons, especially those who are currently underserved, and an appreciation, grounded in their practical understanding of the complexity of global health issues, for the difficulty of making this vision a reality.<sup>187</sup>

Among its stated objectives, ARHAP includes mapping the field of religion and public health in Africa; developing “conceptual frameworks, analytical tools, and measures that will adequately define and capture religious health assets from African perspectives” and generating an evidence-base with the potential to influence health policy decisions and resource allocation.<sup>188</sup> In order to attend to these objectives, ARHAP researchers have conducted large-scale literature reviews,<sup>189</sup> designed original case study

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<sup>186</sup> Olivier et al., " ARHAP Literature Review: Working in a Bounded Field of Unknowing," 8.

<sup>187</sup> ARHAP builds on the longer history of the Interfaith Health Program, a program of the Carter Center now housed at Emory University. Supported by the prominent epidemiologist, William Foege, who served as the Centers for Disease Control Director (1977-1983) and the Carter Center’s first director (1986-1992), the Interfaith Health Program was founded in 1991. The vision of extending public health to all persons can be seen in Foege’s work on “closing the gap.” Some of the roots of the assets and agency focus of ARHAP can be seen in Foege’s concept of “reverse epidemiology,” a concept that encourages a focus on what Gary Gunderson and Teresa Cutts have more recently described as the “leading causes of life” or vitality as opposed to a pathological approach focused on the leading causes of mortality and morbidity. See, respectively, William H. Foege, Robert W. Amler, and Craig C. White, "Closing the Gap," *JAMA: The Journal of the American Medical Association* 254, no. 10 (1985); Gary R Gunderson and Teresa F. Cutts, "Decent Care for Life," in *Restoring Hope: Decent Care in the Midst of HIV/AIDS*, ed. Ted Karpf, et al. (New York: Palgrave Macmillan, 2008).

<sup>188</sup> African Religious Health Assets Programme, "Appreciating Assets."

<sup>189</sup> Olivier, Cochrane, and Schmid, " ARHAP Bibliography: Working in a Bounded Field of Unknowing."

research on the nature of religious health assets,<sup>190</sup> and adapted participatory inquiry research tools.<sup>191</sup> As a result of this work, ARHAP has become one of the primary interlocutors for major global health players including private foundations, international governmental organizations, and religious nongovernmental organizations.<sup>192</sup>

In one of its initial projects, ARHAP developed, piloted, and refined a participatory inquiry tool known as PIRHANA, or Participatory Inquiry into Religious Health Assets, Networks, and Agency. PIRHANA, a participatory, inductive, appreciative suite of research tools, was designed specifically to document the wide range of religious entities that are or have the potential to contribute to health and wellbeing. Researchers, contracted by the World Health Organization, conducted sixteen workshops in Lesotho and Zambia using the PIRHANA toolset to facilitate community as well as regional conversations about health, wellbeing, religion, and religious entities.

While entities like Christian Health Associations or church-affiliated hospitals have long been recognized by global health organizations and national governments, the community maps generated by the PIRHANA workshops highlight the ubiquity and diversity of religious entities responding to HIV.<sup>193</sup> The workshops, conducted over a nine-month period in 2005-2006, included 358 participants. The resulting report,

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<sup>190</sup> Liz Thomas et al., “‘Let Us Embrace’: The Role and Significance of an Integrated Faith-Based Initiative for HIV and AIDS,” (Eastern Cape, South Africa: African Religious Health Assets Programme, 2006); African Religious Health Assets Programme, “Appreciating Assets.”

<sup>191</sup> African Religious Health Assets Programme, “Appreciating Assets,” 23.

<sup>192</sup> For the Gates Foundation, Tearfund, and the World Health Organization, respectively, see Schmid et al., “The Contribution of Religious Entities to Health in Sub-Saharan Africa (Study Commissioned by Bill and Melinda Gates Foundation).”; B. Haddad, J. Olivier, and S. De Gruchy, “The Potential and Perils of Partnership: Christian Religious Entities and Collaborative Stakeholders Responding to HIV and AIDS in Kenya, Malawi and the DRC,” (African Religious Health Assets Programme (ARHAP), 2008); African Religious Health Assets Programme, “Appreciating Assets.”

<sup>193</sup> The PIRHANA suite of tools was developed using insights from other well-established participatory methods, namely Participatory Rural Appraisal and Participatory Learning and Action. For an overview of the PIRHANA workshops and the specific data generated by the process, see chapter two and Appendix F in ARHAP, “Appreciating Assets: Mapping, Understanding, Translating, and Engaging Religious Health Assets in Zambia and Lesotho.”



*Appreciating Assets: Mapping, Understanding, Translating, and Engaging Religious Health Assets in Zambia and Lesotho*, was presented to a global health gathering at the National Cathedral in Washington, D.C. in 2007, legitimating ARHAP's role in the emerging conversation on religion and global health.

The starting point for the ARHAP conversation is the inseparability of religion and wellbeing in the everyday lives of Africans. The epitaph for the WHO report pithily reads "religion is so overwhelmingly significant in the African search for wellbeing, so deeply woven in the rhythms of everyday life, and so deeply entwined in African values, attitudes, perspectives and decision-making frameworks that the inability to understand religion leads to an inability to understand people's lives."<sup>194</sup> Thus, making religious entities involved in formal and informal health initiatives "visible" to global health institutions is a concrete way in which ARHAP makes good on its broader commitment to understand people's lives *as the people themselves understand them*. As a natural extension of this commitment, ARHAP's methodological approach values "what people already know, in their own context" and reflects the epistemological priorities of "knowledge drawn from 'the underside' of the world."<sup>195</sup> It is these two priorities that

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<sup>194</sup> Ibid., 1. ARHAP, drawing on Jürgen Habermas's concept of lifeworld, has coined the term "healthworld" as a way of capturing the experiential and linguistic inseparability of the religion and wellbeing in many African contexts. For the original research out of which the concept of healthworld emerged, see Paul Germond and Sepetia Molapo, "In Search of Bophelo in a Time of AIDS: Seeking a Coherence of Economies of Health and Economies of Salvation," *Journal of Theology for Southern Africa* 126(2006); Germond, Molapo, and Reilly, "The (Singular) Health System and the Plurality of Healthworlds".

<sup>195</sup> James R. Cochrane, "A Model of Integral Development: Assessing and Working with Religious Health Assets," in *Religion and Development: Ways of Transforming the World*, ed. Gerrie ter Haar (New York: Columbia University Press, 2011), 238. The antecedents of this commitment are worked out more fully in James Cochrane's earlier work on "incipient theology," a concept that emerges from his participatory research on theological reflection in indigenous South African groups. See Cochrane, *Circles of Dignity: Community Wisdom and Theological Reflection*.

give rise to the community assets-based approach signaled by the concept religious health assets.<sup>196</sup>

Cochrane offers this justification for assets-based thinking as a corrective to other approaches in global health:

First, it captures the basic idea that assets carry value and may be leveraged to create greater value. *Needs*, by contrast, imply that we are seeking to identify and overcome what is found to be lacking. Another common concept, *resources*, as distinct from assets, is more passive; they are there to be *used* rather than leveraged and grown. ‘Assets’ suggest a stronger agency in the local context, and prompt us to identify what is already there to work with, rather than beginning with lack or need - concepts that emphasize outside agency, even undermine local agency.

External resources are obviously important, but policy, usually driven ‘from above,’ and therefore inherently oriented toward prioritising external resources, might be better served by an approach that mobilizes existing internal *assets, strengths and capabilities*. This works simultaneously against ingrained habits of dependency and disabling gift giving or patronage, derived largely from generations of colonialism that have been hard to break. Constraints must also be taken seriously, but not as determining.<sup>197</sup>

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<sup>196</sup> ARHAP locates the concept of religious health assets in the broader conversation about community assets-based development, specifically as found in the research of John Kretzmann and John McKnight. See Kretzmann and McKnight, *Building Communities from the Inside Out; Asset-Based Strategies*.

<sup>197</sup> James R. Cochrane, "Religion in the Health of Migrant Communities: Asset or Deficit?," *Journal of Ethnic & Migration Studies* 32, no. 4 (2006), 733.

Given this background, religious health assets, specifically, are “an asset located in or held by a religious entity that can be leveraged for the purposes of development or public health.”<sup>198</sup>

The subtitle of the WHO report cited above suggests that the turn to religious entities as a health asset follows a sequence or an order of knowledge: mapping, understanding, translating, and engaging religious health assets. The sequence supports the double meaning of the report’s title *Appreciating Assets*. In order to *appreciate* the contribution of religion to, in this case, universal access to HIV treatment, care, and prevention, it is necessary to get a sense of what forms religion takes on the ground in a community (mapping) and how community members relate to the diverse religious expressions and entities around them (understanding).

The second sense of *appreciate* comes from economics. In order to increase the value of religious health assets for the specific purposes of global health programs, it is necessary to develop a framework for rendering intelligible specific religious health assets (RHAs) to public health policy makers and practitioners (translating) and to identify a set of practices capable of integrating RHAs (engaging) in public health programs.<sup>199</sup>

The initial research in Lesotho and Zambia made visible approximately 500 entities that were in some way religious or connected to religious organizations, a number that reflects, since 2000, an increasingly “strong local commitment to be more effective in the area of HIV/AIDS.”<sup>200</sup> Community members recognized these entities for their contribution to the HIV response and wellbeing, more generally, through both tangible

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<sup>198</sup> See the “Glossary” in African Religious Health Assets Programme, “Appreciating Assets.”

<sup>199</sup> *Ibid.*, 1.

<sup>200</sup> *Ibid.*, 2.

and intangible factors. Tangible factors included compassionate care, material support, and health provision; while intangible factors included spiritual encouragement, knowledge giving, and moral formation.<sup>201</sup> As the recent literature reviewed above illustrates, both tangible and intangible factors have become variables in a wide range of studies.

Tangible factors, or what ARHAP identifies as tangible religious health assets, may not differ much from health assets held by other entities such as secular nongovernmental organizations. Nonreligious entities also provide facilities and personnel, material and social support, and preventative and curative healthcare services. The case study of the Masangane Integrated HIV Treatment Program presented in chapter five helps to show just how much overlap there is between the tangible assets of faith-based treatment programs and programs run by groups like Doctors without Borders. But ARHAP research also highlights intangible religious health assets.

But ARHAP research also highlights intangible religious health assets. These assets are defined as “volitional, motivational and mobilizing capacities that are rooted in vital affective, symbolic, and relational dimensions of religious faith, belief, behavior, and ties.”<sup>202</sup> Specific examples include local knowledge, trust, hope, and resilience. While the definition of intangible religious health assets offers distinction from tangible religious health assets, parsing the terms in a way that links intangible assets specifically to religion has proven more elusive in the research. (Again, the Masangane case study helps to illustrate this challenge.) The examples of local knowledge, trust, hope, and resilience may be assets that are explicitly animated by the “vital affective, symbolic, and

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<sup>201</sup> Ibid., 3.

<sup>202</sup> Ibid., 39.

relational dimensions of religious faith,” but they may also be found in vital affective, symbolic, and relational dimensions of community life, in general.

To illustrate further, in arguing for the potential distinctiveness of a faith-based response to healthcare provision, ARHAP highlights the concept of “respectful treatment.” Respectful treatment was identified by public health researchers in South Africa as one of the fundamental concerns of those in South Africa served by the primary care system. Respectful treatment refers to “positive attitudes / behaviors, thoroughness and technical competence, as well as well as institutions that support fair treatment.”<sup>203</sup> While the ARHAP concept of intangible health assets helps to focus attention on this dimension of healthcare and offers support that this is one of the important health assets held by religious entities, further research is necessary in order to support any claims about the distinctiveness of religious entities to cultivate an ethos of respectful treatment.<sup>204</sup>

Table 1 represents an attempt to further clarify the type of health assets religious entities hold. It is not intended as an exhaustive list, rather it captures what has surfaced in the four major published research projects to date and the various conversations surrounding these projects. The tangible and intangible distinction continues to be a

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<sup>203</sup> Qtd. in Barbara Schmid et al., "The Contribution of Religious Entities to Health in Sub-Saharan Africa," (Cape Town: African Religious Health Assets Programme (ARHAP), 2008), 35. For the original research see Lucy Gilson, Natasha Palmer, and Helen Schneider, "Trust and Health Worker Performance: Exploring a Conceptual Framework Using South African Evidence," *Social Science & Medicine* 61, no. 7 (2005).

<sup>204</sup> One interesting example of the role of religious entities in cultivating an ethos of respectful treatment can be seen in the WHO's efforts to locate the concept of decent care in the religio-moral commitments of the world's religions. This effort shows the particularity of religious beliefs and how they might support specific criteria for decent care (e.g., an emphasis on the dignity and agency of persons living with HIV). In the end, though, the decent care discussion begins in global health and seeks out legitimacy in religious traditions, calling into question, again, the possibility of distinctive, critical contribution of religious entities. For the edited volume that emerged from the WHO's conversation about decent care, see Ted Karpf et al., *Restoring Hope: Decent Care in the Midst of HIV/AIDS* (New York: Palgrave Macmillan, 2008).

**Table 1. Religious Health Assets**

<b>Religious Health Assets</b>	<b>Intangible</b>	<ul style="list-style-type: none"> <li>• Prayer</li> <li>• Resilience</li> <li>• Health-seeking behavior</li> <li>• Motivation</li> <li>• Responsibility</li> <li>• Relationship: caregiver and patient</li> <li>• Advocacy/prophetic</li> <li>• Resistance – physical and/or structural/political</li> </ul>	<ul style="list-style-type: none"> <li>• Individual (sense of meaning)</li> <li>• Belonging (human/divine)</li> <li>• Access to power/energy</li> <li>• Trust/distrust</li> <li>• Faith-hope-love</li> <li>• Sacred space in a polluting world (AIC)</li> <li>• Time</li> <li>• Emplotment (story)</li> </ul>
	<b>Tangible</b>	<ul style="list-style-type: none"> <li>• Infrastructure</li> <li>• Hospitals – beds, etc.</li> <li>• Clinics</li> <li>• Dispensaries</li> <li>• Training – para-medical</li> <li>• Hospices</li> <li>• Funding/development agencies</li> <li>• Holistic support</li> <li>• Hospital chaplains</li> <li>• Faith healers</li> <li>• Traditional healers</li> <li>• Care groups</li> <li>NGO/FBO – “projects”</li> </ul>	<ul style="list-style-type: none"> <li>• Manyano and other fellowships</li> <li>• Choir</li> <li>• Education</li> <li>• Sacraments/rituals</li> <li>• Rites of passage (accompanying)</li> <li>• Funerals</li> <li>• Network/connections</li> <li>• Leadership skills</li> <li>• Presences in the “Bundu” (on the margins)</li> <li>• Boundaries (normative)</li> </ul>
		<b>Direct</b>	<b>Indirect</b>
<b>Health Outcomes</b>			

*Source:* Reproduced with permission from Schmid et al., “The Contribution of Religious Entities to Health in Sub-Saharan Africa, Study Commissioned by Bill and Melinda Gates Foundation, (Cape Town: African Religious Health Assets Programme), 185

source of debate within ARHAP as well in its conversations with public health

collaborators. In these discussions, tangible, direct assets represent the least complicated

conceptual bridge between public health and religion and the starting point for conversations about “scaling up” the response to HIV and AIDS.<sup>205</sup>

Given the definition of a religious health asset as something that can be leveraged or grown for the purposes of global health and the global health emphasis on technical solutions, aligning resources, and capacity-building, it is not surprising that the tangible assets are seen as the most obvious starting point in the conversation. As Dr. Hermann Reuter of Doctors without Borders argues, stigma would no longer be a problem if all persons had convenient, affordable access to counseling, testing, support groups, and treatment. For Reuter, stigma is largely the result of social structural inequality in the health system.<sup>206</sup> Religious entities can help mitigate this inequality by providing additional sites for counseling, funding for wider distribution of ARVs, and organizing support groups—tangible assets—and following Reuter’s logic, may help to reduce stigma.

Of course, theologically resonant messages combating stigma may also be helpful, as the literature review above indicated.<sup>207</sup> ARHAP research certainly bears this out, shedding light on the role of intangibles like employment, or the sense an individual has of being part of community’s story. While it is difficult to translate—let alone leverage and grow—the sense of employment individuals associate with their participation in a religious community, it is no less vital. That is, stigma depends on individuals experiencing a particular relationship to the dominant, meaning-making

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<sup>205</sup> For examples of this debate within ARHAP, see James R. Cochrane, Barbara Schmid, and Teresa F. Cutts, eds., *When Religion and Health Align: Mobilizing Religious Health Assets for Transformation* (Pietermaritzburg: Cluster Publications, 2011).

<sup>206</sup> Dr. Hermann Reuter, who initiated the first rural HIV ARV treatment program in South Africa, features prominently in Jonny Steinberg’s account of the response to HIV in South Africa. See Steinberg, *Sizwe's Test: A Young Man's Journey through Africa's AIDS Epidemic*.

<sup>207</sup> See especially Boulay, Tweedie, and Fiagbey, "The Effectiveness of a National Communication Campaign Using Religious Leaders to Reduce HIV-Related Stigma in Ghana."

narratives in their culture. The *Appreciating Assets* report shows the both / and character of the assets approach, suggesting that overcoming stigma requires addressing social structural inequalities and cultivating space in which PLWHA remain full participants in the stories told about them and their experience of suffering. Like tangible health assets, however, questions remain as to whether (and how) the character of the intangible religious health assets held by religious entities differs from similar assets held by nonreligious entities.

Despite the ongoing conversation about the exact nature of religious health assets, the analytical distinction between intangible and tangible helps to clarify the problem at the very heart of the renewed interest in religion in global health: do religious entities contribute anything distinctive to global health? If so, what is it (and can it be operationalized)? Additional mapping studies carried out by ARHAP hint at the distinctive contribution of religious entities but do not fully work out in their published reports for global health audiences what, specifically, this consists of. The focus in these reports tends to be on tangible assets, and, to some degree, intangible direct assets (e.g., advocacy/prophetic role of religious entities). Intangible, indirect assets, by their very nature, are more difficult to operationalize; although, as the larger corpus of scholarship produced by ARHAP participants attests, these types of assets are a critical dimension of how ARHAP understands the value of religious entities.<sup>208</sup> The focus in this dissertation on theo-ethical reflection as a religious health asset can be read as an attempt to

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<sup>208</sup> See, for example, Steve de Gruchy, "The Value of Religion in Religious Health Assets" (paper presented at the ARHAP International Colloquium, Cape Town, South Africa, March 13-16, 2007); Christoffer H. Grundmann, "Health Assets of Religious Practices and Convictions: The Impact of the Immaterial" (paper presented at the ARHAP International Colloquium, Cape Town, South Africa, March 13-16, 2007). De Gruchy, reflecting on the *Appreciating Assets* report for the WHO identifies one of the values religion offers is an interpretive framework for health and wellbeing, or what the researchers came to call the individual's "healthworld." The healthworld encompasses many of the assets located in the indirect, intangible quadrant of the matrix above.



understand this apparent dissonance and whether or not it can be overcome. If theo-ethical reflection is a religious health asset, is it best described as an intangible, indirect asset? If so, can, theo-ethical reflection be talked about within global health circles in any meaningful way?

The mapping work pioneered by ARHAP has gained the attention of major global health funders including the Bill and Melinda Gates Foundation. A few short months after the WHO report debuted, the Gates Foundation sought ARHAP's assistance for a "landscape study." The study, conducted from June 2007 to September 2008, had two purposes: (1) to provide an overview of the "contribution of faith-based organizations... to the health of vulnerable populations in resource-poor areas of [sub-Saharan Africa]" and (2) "to identify key areas for investment that would accelerate, scale-up, and sustain access to effective services, and/or encourage policy and resource advocacy among and in African countries."<sup>209</sup> The objectives show the seriousness with which global health funders took both senses of *appreciating* assets described in the earlier WHO report.

The first part of the study included a desk review of the current literature on the health-related work being done by religious entities in ten countries throughout Africa. Though not intended to be representative of all of Africa, the first part of the study offers the most comprehensive overview to date of the "range of conditions that were found in countries with differing faith traditions and health systems" throughout Africa.<sup>210</sup>

The second part of the study drilled down with case studies on three countries: Uganda, Zambia, and Mali. The selection of these particular countries was driven by two

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<sup>209</sup> Schmid et al., "The Contribution of Religious Entities to Health in Sub-Saharan Africa (Study Commissioned by Bill and Melinda Gates Foundation)."

<sup>210</sup> "The Contribution of Religious Entities to Health in Sub-Saharan Africa," 16.

factors: (1) the value of presenting the internal diversity of Africa, especially with regards to religion and health systems and (2) extant relationships with key stakeholders.

For the purposes of this dissertation, two important claims supported by the report are especially relevant. The first relevant claim emerging from the Gates Foundation landscaping study involves the role of religious entities in promoting the public health agenda. Religious entities, the first key finding indicates, “make a significant and unique contribution to health services.”<sup>211</sup> That this contribution is underutilized is a thread that runs throughout the report and the larger ARHAP corpus, as is the related theme that this underutilization is largely the result of the need for greater awareness of what religious entities are actually doing on the ground. The logic is straightforward: greater awareness of what (and where) religious entities are contributing to public health will result in greater utilization of religious entities in the response to public health challenges.<sup>212</sup>

The value of religious entities in this claim is their utility for the current work of public health. Greater knowledge of what religious entities are doing will allow public health actors to utilize them more effectively in scaling-up specific components of the global response to HIV. Accurate mapping of what religious entities are doing, what is actually going on, on the ground, is important and necessary work, especially given the report’s documentation of the diverse range and uneven quality of religious entities’ contribution to global health. Religious entities, to restate one of the more obvious conclusions from the literature review above, are not monolithic.

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<sup>211</sup> "The Contribution of Religious Entities to Health in Sub-Saharan Africa (Study Commissioned by Bill and Melinda Gates Foundation)," 174.

<sup>212</sup> For an application of this logic, see Gerard Clarke, "Faith Matters: Faith-Based Organisations, Civil Society and International Development," *Journal of International Development* 18, no. 6 (2006).

Global health strategies for engaging religious entities are by necessity, however, blunt instruments, attempting by design to capture generalizations about religion as a way of orienting persons in global health to the distinctive challenges they might face in working with faith-based organizations.<sup>213</sup> While these strategies formally acknowledge religious pluralism both across and within faith traditions, global strategic frameworks and policies do not often permit the level of nuance the ARHAP mapping work suggests is necessary for a closer alignment between what religious entities are actually doing in particular socio-cultural contexts and what is possible in a specific country's health system.<sup>214</sup> It is precisely ARHAP's attentiveness to this type of interrelation between the particular religious landscape of a country (i.e., a significant dimension of the socio-cultural context) and a country's health system, then, that gives rise to a second, arguably more provocative, claim in the Gates Foundation study.

The second claim, derived largely from the desk review, relates to the resilience of religious entities in resource-poor areas. Despite lack of access to the formal health system and many other resources considered vital to the promotion of health and human flourishing (e.g., clean drinking water), religious entities have persisted in providing a range of health-related services. The implication of this claim is that global health policymakers might do well to learn more about what accounts for this resilience:

It is a great pity that more is not known about these FBOs, their

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<sup>213</sup> Lux and Greenaway, "Scaling up Effective Partnerships."; UNAIDS, "Partnership with Faith-Based Organizations: UNAIDS Strategic Framework."

<sup>214</sup> In a research project by Tearfund, , ARHAP explored in greater detail this process of alignment with national health systems as well as the global health donor networks in which they are increasingly enmeshed. As ARHAP relaunches as IRHAP in 2011, the focus on health-system strengthening has emerged as one of the priorities for future research. See Haddad, Olivier, and De Gruchy, "The Potential and Perils of Partnership: Christian Religious Entities and Collaborative Stakeholders Responding to HIV and AIDS in Kenya, Malawi and the DRC."

survival strategies, their resilience and intention to make a difference. Not only for purposes of policy or planning, but because something might be there to be learned of an integral intention to care and to act in response to need—in adverse circumstances—which could be translated to the broader aim of making health services work for those who need them most.<sup>215</sup>

The second part of this claim introduces a bolder claim about the involvement of religious entities in global health. The evidence presented in this chapter offers a counterpoint to the conventional wisdom in global health about the involvement of religious entities (see chapter two), but, so far, this counterpoint has largely consisted of showing how religious entities might be useful to global health. Arguably, the literature review offered in the first part of this chapter does not move much beyond viewing religious entities in terms of resources, in the particular way Cochrane parses this term above.

To suggest that global health actors might do well to engage religious entities “because something might be there to be learned... which could be translated to the broader aim of making health services work for those who need them most” takes the argument a step further. It implies that religious entities are well-positioned to offer critical, constructive proposals for doing global health better. This, I would argue, entails a recognition on the part of global health actors of the *agency* of religious entities, or the capacity of religious entities to effect change within global health circles, and highlights Cochrane’s subtle, but hardly semantic, distinction between resources and assets.

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<sup>215</sup> Schmid et al., "The Contribution of Religious Entities to Health in Sub-Saharan Africa (Study Commissioned by Bill and Melinda Gates Foundation)," 93.

The report, itself, does not fully work out the implications of, in the language of this dissertation, the generative potential of religious entities. The research study did not generate data that could answer substantively the reasons for the resilience of these religious entities in resource-poor areas or how this might differ from other types of institutions. The report concludes with a general claim, however, based on the three case studies, that faith-based services “do have a different ethos” that leads to “valued services to marginalized groups.”<sup>216</sup>

The report identifies an “integral intention to care and act in response to need” as constitutive of religious entities and seems to imply that this is what accounts for their resilience, or the value-added recognized by marginalized groups. But to support a more robust claim about what accounts for the resilience of religious entities, I contend, requires research beyond what was collected for this particular report.<sup>217</sup> For example, historical and qualitative research guided by questions related to mission effectiveness, comparative organizational culture and ethos, social ecology, or a theology of institutions may help to further substantiate general claims about how, specifically, the resilience of religious entities can be distinguished from other entities involved in the provision of healthcare.

ARHAP is interested in these and other similar questions as one way to further refine the religious health assets concept, especially its intangible dimensions.<sup>218</sup> But to

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<sup>216</sup> Ibid, 175.

<sup>217</sup> As the report indicates, the literature review is limited by the type of research that is currently available. Most of the secondary data is derived from literature by and for global health policymakers and funders involved in the response to HIV. As such, it focuses on measurement and evaluation of programs to satisfy donor requirements for accountability and efficacy.

<sup>218</sup> See for examples of this interest, James R. Cochrane, "Fire from above, Fire from Below': Health, Justice and the Persistence of the Sacred," *Theoria*, no. 116 (2008); de Gruchy, "Re-Learning Our Mother Tongue? Theology in Dialogue with Public Health."; Barbara Schmid, "The Faith-Based Factor: What Value Does Religion Add to Health Services," (African Religious Health Assets Program, 2006); Olivier,

date, its largest visible impact in global health circles has been the documentation and systematic analysis of the role religious entities are playing in the response to HIV. From the outside looking in, this impact appears largely attributable to the unique way in which ARHAP has pulled together empirical evidence to create a theoretical framework that is recognizable to global health actors and a methodological approach that is immediately useful in global health. That is, even without further refinement of the assets model, ARHAP has made a compelling case to global health that religious entities are not only relevant, but often desirable as partners in the response to HIV and other health crises because of the assets they hold.

But how then does the feminist and liberation theo-ethical reflection on display in the literature review above fit into this model? Are theo-ethical framings of the dignity of persons living with HIV and AIDS or the sensitivity it engenders to the structural violence threatening this dignity intangible religious health assets? What about theo-ethical motivations for solidarity with PLWHA? The ARHAP assets matrix appears to make room for such possibilities, especially as intangible assets—indirect and direct (e.g., the connection between solidarity and advocacy/prophetic). But it is less clear in the actual reports commissioned by global health institutions how such intangible assets are valued.

In the conclusion I will work to clarify the relationship of theo-ethical reflection to the religious health assets framework. But this chapter provides a preliminary step: by keeping the empirical evidence and the theo-ethical arguments in close proximity in this chapter, I am suggesting that the predominance in recent years of feminist and liberative

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"Where Does the Christian Stand? Considering a Public Discourse of Hope in the Context of HIV/AIDS in South Africa."; Steve de Gruchy, "Editorial: Doing Theology in a Time of AIDS," *Journal of Theology for Southern Africa* 125(2006).

theo-ethical arguments for an HIV-competent church has helped make smooth the way for global health actors to recognize empirical evidence for the full range of assets religious entities hold. The following section raises a concern that in making smooth the way, theo-ethical reflection can, itself, become just another form of empirical evidence to be leveraged by global health, and, in the process, lose its critical, generative potential.

## **V. RELIGIOUS HEALTH ASSETS: A CRITICAL APPRECIATION**

The turn to religion may, in reality, only be a turn to religious entities and their value in scaling-up or otherwise mitigating the logistical demands and resource scarcity in the response to HIV. From the perspective of the WHO or Gates that may be all that is necessary—perhaps even all that is possible. Yet, this dissertation argues that the turn to religion constitutes more than merely recognizing and then aligning the assets of religious entities with existing policies and commitments in the global health sector.

Religious entities are rarely empty shells—even an abandoned church building may still evoke certain histories, events, cultural practices in a community, etc. Neither are religious entities perfect embodiments of doctrines, beliefs, etc. Relationships between, in the language of ARHAP, the tangible and intangible assets are complex and dynamic, seldom captured by the language of capacity-building or monitoring and evaluation templates. Thus, attempts to render religion intelligible in global health-speak threaten to obscure important activities that are constitutive of religious entities, including processes of theo-ethical reflection on human flourishing.

From the perspective of global health, research describing the religious health assets of a community—even intangible assets like a theology of hope—now become “data” for use in making existing global health policies related to HIV and AIDS more effective. How, for example, can religious health assets be leveraged in order to scale-up the provision of treatments more quickly? Similarly, attempts to gain more accurate knowledge of a community’s religious beliefs and practices are seen as part of the overall commitment to sensitivity among global health professionals to cultural particularity and existing social institutions in designing interventions and responses. Understood as “data” in this sense, effectiveness in global health policies is determined by the degree to which any given health intervention succeeds in generating improved health outcomes for a given population while, at the same time, minimizing the cultural impact of a health policy.

Yet it is also the case that religious entities have turned to global health institutions for assistance in living out their theo-ethical commitments to more inclusive and appropriate responses to PLWHA in and near their communities. For example, recognizing their lack of staffing and resources for effectively monitoring and evaluating the diverse and rapidly increasing number of church-affiliated HIV programs, Christian communions have requested the UNAIDS and WHO monitoring and evaluation toolkit be distributed more widely to church networks. Similarly, with an increasing amount of global HIV funding being funneled directly to nation-states through what are known as Country Coordinating Mechanisms (CCMs), churches interested in scaling-up their own programs increasingly rely on assistance from global health institutions to gain access to



and successfully navigate the complicated national-level grant proposal and reporting processes.<sup>219</sup>

This practical dimension of the turn of religious entities to global health institutions serves a legitimating function as well. Against the backdrop of Bishop Hanson's dramaturgical foot-washing at the International AIDS Conference (described above), successful integration into secular global health networks moves communities of faith beyond the penitential posture in which their participation as partners remains probationary. Penitence, though necessary, is ultimately an insufficient posture for moving from the paradigm of religion and health in tension to religion as an active ally to global health.

Why is it not sufficient? Because religious entities offer more than tangible health assets to be leveraged for greater effectiveness or aligned for increased efficiency. And they offer more than intangible health assets such as hope and trust to be operationalized in various public health programs. Religious entities provide institutional space in which persons and communities think together theologically about the limits of existing practices and programs of global health as well as the theoretical justifications for the programs. That is, religious entities cultivate theo-ethical reflection on what it means to flourish as human beings in the context of real-world constraints.

From a public health perspective, I can understand the risk of engaging in theo-ethical reflection with religious leaders and members of faith communities. The discussion of stigma illustrates how theo-ethical reflection in religious entities has been done both formally and informally in ways that can have a negative impact on health

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<sup>219</sup> For discussions about how global health institutions can assist religious entities in accessing global donor resources, see Speicher, "Final Report".

outcomes and limit human flourishing. Here the contribution of theology to further stigmatization is recognized, if not always understood, by global health leaders. This is certainly one way in which religious entities have offered something distinctive to the conversation about HIV, but such distinctive contributions offer a strong argument against any turning to religion as an ally.

But even these negative contributions can be a catalyst for more direct engagement with the processes of theo-ethical reflection taking place among religious entities. For example, countering a religious argument that stigmatizes may require developing an immanent critique of the theology that supports such stigmatization, and then offering a constructive theological proposal for inclusivity.<sup>220</sup> Stigmatization, as this chapter shows, is clearly not the only response to emerge from theological reflection on the HIV pandemic. Religious leaders can be exhorted to invoke the “prophetic voice of faith” on behalf of those affected by HIV, calling on religious entities “to advocate for appropriate and inclusive HIV and AIDS responses.”<sup>221</sup>

Yet the encouragement for the prophetic voice of faith rings hollow if religious entities are merely asked to transpose the language of prevention and treatment into a theological key. While it can be a form of confession for denouncing theologies of exclusion, the prophetic voice of faith runs the risk of merely amplifying existing best practices in the global health response to AIDS. To be sure, this amplification is necessary and welcome. Yet, something of the power religions claim is lost when religious leaders mistake *conforming* to existing global health practices for the more

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<sup>220</sup> For the use of immanent critique as a strategy for engaging in conversations involving competing comprehensive visions of the good, see Jeffrey Stout, *Democracy and Tradition* (Princeton: Princeton University Press, 2003). For a representative theological proposal, see Messer, *Breaking the Conspiracy of Silence*.

<sup>221</sup> Speicher, "Final Report".

difficult task of articulating and enacting theo-ethical commitments capable of *transforming* the practices, themselves. To borrow from Christian ethicist James Gustafson's analysis of the varieties of forms of moral discourse in medicine, global health policy and practices that fail to account for ethical critiques, including theo-ethical critiques, "easily degenerate into satisfaction with the merely possible, with assumed values and procedures, with the domination of the economic or institutional considerations."<sup>222</sup> This, I understand, is what that seemingly offhand remark quoted above from the Gates Foundation landscaping study ultimately points to: religious entities as potential leaders in developing global health programs and policies that attend with sensitivity to the healthcare needs of those at the margins.<sup>223</sup>

Religious entities—or, better, the “right” religious entities—have been invited to the global health table, but it remains unclear whether they sit at the table as equals or as subordinates. The evidence from this chapter suggests that the movement toward religion as an ally in the response to HIV is taking place largely on terms set by the secular global health community. That is, despite the initial development of the religious health assets language by theologians and religion scholars, the global health discourse about religion's value circumscribes the contributions of religion to global health within an existing set of best practices in the HIV response. In this way, religious health assets—tangible and intangible—become valuable if they can be rendered intelligible and

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<sup>222</sup> James Gustafson, "Moral Discourse About Medicine: A Variety of Forms," *The Journal of Medicine and Philosophy* 15(1990), 141

<sup>223</sup> "It is a great pity that more is not known about these FBOs, their survival strategies, their resilience and intention to make a difference. Not only for purposes of policy or planning, but because something might be there to be learned of an integral intention to care and to act in response to need—in adverse circumstances—which could be translated to the broader aim of making health services work for those who need them most." Schmid et al., "The Contribution of Religious Entities to Health in Sub-Saharan Africa (Study Commissioned by Bill and Melinda Gates Foundation)," 93.

appreciated using the existing lexicon and logic of global health. As a result, the primary activity of religious entities in partnerships with global health institutions is limited to *conforming* their practices to the best practices of HIV programs. Religious entities become valuable, become an asset to be valued, then, not for the processes of theo-ethical reflection they encourage, but for the *outcome* of their theo-ethical reflection.

## VI. CONCLUSION

This chapter has shown that religious entities are actively involved in the response to HIV, and that this involvement takes diverse forms. Beyond describing some of these forms, this chapter has examined how the framework of religious health assets has served as a catalyst for increasing attention to the positive role of religious entities in the response to HIV. The language and logic of religious health assets serves to clarify, from the perspective of global health, particular ways religion adds value to global health programs and why partnerships should be cultivated. Yet, this chapter also raises the possibility of the framework as a source of immanent critique about the reduction of religion to a measurable set of health assets. Critical theo-ethical reflection on global health appears to be a largely unexamined religious health asset, even as global health leaders depend on religious entities to have taken on self-critical theo-ethical reflection prior to any participation in global health conversations. But the most distinctive value of religion as a health asset may exist precisely in its potential to critically engage the fundamental assumptions and best practices of HIV prevention, treatment, and care, specifically, and global health, more generally.

Theo-ethical reflection, as conceptualized in this dissertation, is an attempt, as Gustafson says, “to say something about how things really and ultimately are.”<sup>224</sup> This is consistent with James Cochrane and Gary Gunderson’s recent articulation of the function of religious discourse and religious imagination. Gunderson and Cochrane, both founding members of ARHAP, highlight the contribution of religious entities to global health in terms of religious imagination, underscoring the priority of the *processes* of theo-ethical reflection that give rise not only to certain dispositions towards the health and wellbeing of others but also to ways of thinking about public health challenges.

Drawing on the historical evidence of the role of a clergyperson’s local knowledge in helping to understand the water-borne transmission of cholera, more recent historical research into the role of the Christian Medical Commission in the promotion of primary health care, and the surprising eradication of smallpox, Cochrane and Gunderson argue that two of the most important religious health assets are religious discourse and religious imagination, what they understand to be a part of the “religious mind.” The religious mind “includes discursive practices and human imagination as they are shaped by religion” such that they “shift language and conceptual frameworks through the capacity of the human mind to reflect on ‘what is’ (actuality) and imagine ‘what is not yet’ (possibility).”<sup>225</sup> And importantly, the religious mind is manifest in action resulting from the process of reflecting and imagining. They argue for these as assets because religious discourse is “often closely conformed to actual conditions in local communities, [and] enables early identification of crises” and because the “religious imagination, often

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<sup>224</sup> Gustafson, "Say Something Theological!.", 90.

<sup>225</sup> Gary R. Gunderson and James R. Cochrane, *Religion and the Health of the Public* (New York: Palgrave Macmillan, 2012). This book will not be published until after this dissertation is deposited, so page numbers for selected quotes are not available. The quotes in this section are all from the unpublished manuscript Chapter Two: “Public Health and the Religious Mind: Connections and Disconnections.”

deeply sensitive to the lure of new possibilities and their embodiment, enables existing paradigms to be transcended.”<sup>226</sup>

Theo-ethical reflection, at its best, should be “closely conformed to actual conditions in local communities” and articulate eschatological visions that pull communities through existing paradigms and towards a more fuller realization of the kingdom of God. Importantly, in this dissertation, I understand processes of theo-ethical reflection as giving sustained, critical attention not only to religious discourse and imagination but also to other discourses and imaginaries as well.<sup>227</sup> That this has proven valuable in the past as a catalyst for new paradigms in global health is acknowledged by Cochrane and Gunderson, even as they wrestle with the causes of what they identify in the twenty-first century as “fractures across disciplines and fields” that have “evolved into distance and separate practices.”<sup>228</sup>

The causes of this fracturing are complex, a result of changes in the practice of global health, the dynamism of a global religious landscape, transformations in the global political economy, among others. Many of these changes are implied in what follows, but it is beyond the scope of this dissertation and my training to analyze them with the sophistication they deserve. Instead, I focus in the next chapter on developing a theoretical and normative argument for reintegrating theo-ethical thinking into the analysis of complex phenomena. This argument derives in part from the liberal, Protestant theo-ethical tradition as articulated in the work of James Gustafson and, in

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<sup>226</sup> Ibid.

<sup>227</sup> For example, discourses related to global health could include biomedical, human rights, public health, gender, economic development, and traditional African religious discourses. For a discussion of these various discourses in the HIV pandemic, see Schmid, "AIDS Discourses in the Church: What We Say and What We Do."; Gill Seidel, "The Competing Discourses of HIV/AIDS in Sub-Saharan Africa: Discourses of Rights and Empowerment Vs. Discourses of Control and Exclusion," *Social Science and Medicine* 36, no. 3 (1993).

<sup>228</sup> Gunderson and Cochrane, *Religion and the Health of the Public*.

part, from the feminist Catholic praxis articulated by Lisa Sowle Cahill. My reading of James Gustafson's account of the value of theo-ethical reflection and Lisa Sowle Cahill's proposal for a participatory theological bioethics in the next chapter offers what I understand to be a robust theoretical starting point for ARHAP's proposal for a "renewed integrative paradigm"<sup>229</sup> that is transdisciplinary, sensitive to the interrelation of multiple contexts, and collaborative.<sup>230</sup> Gustafson's theoretical account of the challenges of and possibilities for incorporating theo-ethical reflection into purportedly nontheological contexts and Cahill's extension of this account to include participation of theologians in social movements and activist networks are used as the hermeneutics for analyzing two case studies in religion and global health. The two case studies were selected because of their centrality to ARHAP's initial and ongoing claims about religious health assets as well as the emerging consensus among global health leaders about the need to integrate religious entities more fully into global health programming and policymaking.

The first case study shows how theo-ethical reflection functions as an intangible religious health asset in many of the conventional ways described in this chapter, including the motivations and framings for engagement in the response to HIV, yet it also shows how processes of theo-ethical reflection can add a distinctive layer to existing global health programs. The second case study shows how processes of theo-ethical reflection can lead to significant changes in global health policies and priorities when taken seriously by global health leaders.

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<sup>229</sup> Ibid.

<sup>230</sup> Cochrane identifies these three attributes as constitutive of ARHAP's commitment to "defining complexity as the real." See Cochrane, "A Model of Integral Development: Assessing and Working with Religious Health Assets," 240-241.

## CHAPTER FOUR

### THE POSSIBILITY OF THEO-ETHICAL PARTICIPATION: PARTICIPANT THEOLOGIAN IN THE INTERSECTIONS

#### I. INTRODUCTION

This chapter turns first to the work of James Gustafson in order to explore what I refer to as the persistence of the theo-ethical in complex, interdisciplinary phenomena. While his work does not attend specifically to the global response to HIV or global health, his analysis of the possible relationships among theological and nontheological disciplines focuses attention on epistemological, communicative, and practical questions animating the turn to religious entities as a health asset. The goal of this chapter, then, is relatively modest: to explore a theoretical lens that could help clarify how theo-ethical reflection can be recognized as a religious health asset.

Adjusting the fit of this lens, however, is a twofold task. It requires persuading two audiences, Christian theologians and ethicists and global health leaders, each with their own specific set of concerns about whether and how theological and nontheological disciplines should relate. In the first section of the chapter, I review Gustafson's recent works (*Intersections* and *An Examined Faith*) as a direct response to the concerns of the first audience.

As a rigorous defense of the liberal theological tradition, these works argue, on the one hand, for the necessity (arguably, ontological in Gustafson) of theologians and Christian ethicists to participate in and be informed by conversations with nontheological



others about the patterns and processes of the world. And, on the other hand, these works describe the limits, including the limited possibilities, of theo-ethical claims in these conversations. The moves he makes in these works are consistent with the trajectory of the liberal theological project, even as the limits he places on theo-ethical claims become more restrictive over time.<sup>231</sup>

Whether one agrees with his position or the premises of the liberal theological tradition more generally, his arguments resonate with long-standing and on-going debates within Christian theological ethics about the task of theology in a post-Enlightenment world.<sup>232</sup> Much of the theo-ethical reflection represented in the literature review in chapter three demonstrates the seriousness with which many Christian theologians and ethicists, including those who identify explicitly as feminist or liberationist Christians, already take the basic tenets of the liberal theological tradition, at least insofar as it requires engagement with current knowledge generated in non-explicitly theological disciplines such as the social and natural sciences. I turn to Gustafson as a conversation partner because he provides both a rigorous and comprehensive defense of the persistence of other disciplinary knowledge in processes of theo-ethical reflection and a careful analysis of the alternatives. What is less clear in his more recent work is what, if

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<sup>231</sup> The degree to which the theological must be accountable to other ways of knowing reflects two mutually reinforcing aspects of Gustafson's later career: an intensification, or at least more explicit statement, of his own commitment to theological naturalism and his sustained participation in intentional, structured interdisciplinary conversations.

<sup>232</sup> For essays that provide an overview of these debates see Ottati, "How Can Theological Ethics Be Christian?"; James M. Gustafson, "A Retrospective Interpretation of American Religious Ethics, 1948-1998," *Journal of Religious Ethics* 25(1997); Douglas F. Ottati, "Christian Theology and Other Disciplines," *The Journal of Religion* 64, no. 2 (1984); William Schweiker, "On the Future of Religious Ethics: Keeping Religious Ethics Religious and Ethical," *Journal of the American Academy of Religion* 74, no. 1 (2006); Gary Dorrien, "Truth Claims: The Future of Postliberal Theology," *Christian Century*, July 18, 2001.

anything, the appropriate contribution of theological ethics is to the interdisciplinary interpretation of complex phenomena.

The argument of this dissertation hinges on global health leaders recognizing theo-ethical reflection as a vital religious health asset. As such, a necessary first step is to make more explicit to *Christian theologians and ethicists* the contribution of theological ethics and processes of theo-ethical reflection to interdisciplinary intersections such as the one represented by global health. In this way, theologians and ethicists might be better equipped to carry Gustafson's project through to one of its logical, though largely underdeveloped, conclusions: engaging in processes of theo-ethical reflection that can "expand the received information by interpreting it from a different perspective."<sup>233</sup> Greater self-awareness on the part of theologians and ethicists about the limits and possibilities for their engagement with and expansion of the global health conversation is a necessary step if processes of theo-ethical reflection are to be recognized and respected by global health leaders.

Persuading global health leaders about the persistence of the theo-ethical and the potential for theo-ethical reflection as a health asset requires both demonstrating that theologians and ethicists take seriously the claims about the world generated by nontheological ways of knowing, including modes of inquiry employed in the practices of global health to discern and respond to the patterns and processes of disease transmission, and demonstrating the value-added contribution of theo-ethical reflection. From the perspective of global health leaders, the premises of the liberal theological tradition are a necessary, but not sufficient reason for taking seriously the claims of

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<sup>233</sup> James M. Gustafson, *An Examined Faith: The Grace of Self-Doubt* (Minneapolis, MN: Fortress Press, 2004), 82.

theology. It is necessary insofar as theologians and ethicists are expected by global health leaders to take seriously the nontheological ways of knowing employed by global health and the evidence-base this generates. It is insufficient, as noted above in relation to theological ethicists, because Gustafson's interpretation of the epistemological moves necessary for continuing the project of liberal theology do not in themselves offer a robust constructive proposal for what theo-ethical reflection might *contribute to* nontheological ways of knowing about the world, or more specifically, global health.<sup>234</sup>

I employ two moves to address this insufficiency, particularly as understood from the perspective of global health leaders. That is, I attempt to answer why should global health take theo-ethical reflection seriously? The first move is to recover within Gustafson's work the theoretical concept of the participant theologian. The second move, employs the work of Lisa Sowle Cahill's participatory theological bioethic to expand and deepen the concept of the participant theologian, an expansion and deepening that I argue renders the participant theologian more visible to global health leaders, and ultimately, raises the profile of theo-ethical reflection as a vital religious health asset.

While critics have interpreted Gustafson's yoking of theo-ethical claims to scientific accounts of the world as rendering the presence of theologians and theo-ethical reflection superfluous,<sup>235</sup> the second part of this chapter explores some of Gustafson's earlier work in order to recover dimensions of his understanding of participation that are

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<sup>234</sup> The clearest statement of what theology actually does in conversation with nontheological accounts of what is going on can be found towards the end of *An Examined Faith*: "The major contribution of theology and ethics in interactions with scientific and other secular accounts is to expand the received information by interpreting it from a different perspective." Ibid., 82. I attend to this statement in the discussion below.

<sup>235</sup> In a theological analysis of the perceived differences among humans animals, Stanley Hauerwas and John Berkman disclose this concern deeper fear that seems to be driving it: "On the issue of the relationship between humans and other animals, Gustafson's critique employs broadly scientific criteria. This is shown by the types of appeals made and, more generally, by his view that scientific criteria may lead to the doing away altogether with Christianity in the future." Stanley Hauerwas and John Berkman, "The Chief End of All Flesh," *Theology Today* 49, no. 2 (1992), 198, fn 5.

best read as continuous with his explicit discussions of interdisciplinarity in his later works.<sup>236</sup> By focusing on his notion of the participant theologian, I argue that Gustafson's own work provides critical leverage for understanding a more robust role for theologians in interdisciplinary contexts and, by extension, a more expansive understanding of religion as a health asset. His complex, theocentric understanding of participation, I suggest, leads, on the one hand, to a clearer mandate for how theologians and ethicists should engage in global health conversations, and, on the other hand, to processes of theo-ethical reflection that can be appreciated by global health leaders as a vital religious health asset.

Finally, I initiate in this chapter a conversation about the limits of Gustafson's notion of experts that has implications for who he envisions at the intersections of interdisciplinary conversations. For example, does his approach to interdisciplinarity assume a culture of professionalism that effectively limits whose theo-ethical reflection counts and which sources of scientific knowledge are legitimate. The short answer is yes, but that a critical appreciation of his work and the context in which he was doing this work can both account for the limitations and point to the type of constructive work needed to overcome these limitations. I turn to Lisa Sowle Cahill's proposal for a participatory theological bioethics as an example of this constructive work. Specifically, Cahill offers an account of why theological ethicists should be active participants in

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<sup>236</sup> Interestingly, Stanley Hauerwas, one of Gustafson's students and most consistent sparring partners, identified in an early response to *Ethics from a Theocentric Perspective* the importance of participation as a continuity between Gustafson's earlier and later writings. Hauerwas admits the centrality of the notion of participation had not been apparent to him until he began to wrestle with what he perceived as Gustafson's shift away from a particularist historicism. Hauerwas notes "Gustafson's rather innocent use of 'participate' as a notion to govern Christian behavior in the world becomes a full-scale theory in his later work. I must confess I had not noticed before reading for this essay how significant the notion of 'participation' is for understanding Gustafson's general perspective." Stanley Hauerwas, "Time and History in Theological Ethics: The Work of James Gustafson," *Journal of Religious Ethics* 13, no. 1 (1985), 20, fn 2.

groups and networks working for social justice. In this way, Cahill extends and deepens Gustafson's understanding of participation.

## II. THE PERSISTENCE OF JAMES GUSTAFSON

In *An Examined Faith: The Grace of Self-Doubt*, James Gustafson rehearses one of the theo-ethical claims at the heart of his theological naturalism: "Because God is the ultimate ordering power, Christians, like all others, willy-nilly participate in the ordering of social and political life and human interventions into nature."<sup>237</sup> "Willy-nilly participate" is an ontological claim in a theocentric world. If, as Gustafson famously concluded in his *magnum opus*, *Ethics from a Theocentric Perspective*, God is "the power that brings all things into being, sustains them and bears down on them, and creates the conditions of possibility for newness and renewal,"<sup>238</sup> then human being in its most fundamental expression is participation in the "patterns and processes of interdependence"<sup>239</sup> God creates and sustains.

Participation as an ontological claim "grounds our vocation to discern what God is enabling and requiring us to be and to do."<sup>240</sup> That is, for Gustafson, participation holds together descriptive and normative moments, discernment of what is going on and what our appropriate (fitting) response should be: "The task of ethics is to use knowledge and intelligence to discern, under the inexorable conditions of finitude, how we are to relate ourselves and all things in a manner appropriate to our and their relations to God. It is to seek how to participate in nature and society, in history and culture, and in the ordering of

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<sup>237</sup> Gustafson, *An Examined Faith: The Grace of Self-Doubt*, 88

<sup>238</sup> James M. Gustafson, *Ethics from a Theocentric Perspective. Vol.2, Ethics and Theology* (Chicago; London: University of Chicago Press, 1984), 322.

<sup>239</sup> *Ibid.*, 321.

<sup>240</sup> *Ibid.*

ourselves so that human life is in the service of God.”<sup>241</sup> Importantly, for Gustafson (and as shown below, his critics), the modes of knowing to which humans turn to discern what form participation might take in a given context—the “manner appropriate” for life “in the service of God”— are many and diverse, no less so for Christians than for others.<sup>242</sup>

That nontheological descriptions of the “patterns and processes of interdependence” in which human beings participate might have theological implications is what, for many, makes Gustafson, despite his protestations, a contemporary example of H. Richard Niebuhr’s “Christ of Culture” type—explicitly, in Gustafson’s more recent works, a culture constituted more and more by debates within the natural sciences.<sup>243</sup> If, as Gustafson claims, “the human processes of discernment are no different among Christians than they are among other men [*sic*],”<sup>244</sup> then what difference does a theological perspective, much less a Christian one, make?

Gustafson’s claim can be seen as derivative of Niebuhr’s “two aspect theory of history.” Niebuhr, Gustafson’s teacher, describes the two-aspect theory of history as a paradox of faith in which for Christians an internal and external history exist simultaneously. The paradox describes how Christians can “understand how revelation can be in history and yet not identifiable with miraculous events as visible to an external

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<sup>241</sup> Ibid., 321-22.

<sup>242</sup> Reformed historical theologian, and Gustafson student, Douglas Ottati reminded members of the Society of Christian Ethics that this “respect for the arts and sciences” has been an important, though not always practiced, part of the Reformed Christian tradition since its earliest articulation in Calvin. See Ottati, “How Can Theological Ethics Be Christian?”

<sup>243</sup> Critics of Gustafson and the larger trajectory of liberal theology argue that such theologizing exhibits a misplaced fidelity to the Enlightenment project. Gustafson has spent much of the past three decades defending the project of liberal theology, particularly as articulated in Ernest Troeltsch. And, in many ways, Gustafson’s recent work on interdisciplinarity can be read as an attempt to shore up the tradition of liberal theology against its detractors, at least insofar as liberal theology takes seriously the various nontheological descriptions and interpretations of phenomena. For a clarifying exchange between Gustafson and his critics on this point see James M. Gustafson et al., “Doubting Theology,” *Christian Century*, June 29 2004.

<sup>244</sup> James M. Gustafson, “Moral Discernment in Christian Life,” in *Moral Discernment in the Christian Life: Essays in Theological Ethics*, ed. Theo A. Boer and Paul E. Capetz, *Library of Theological Ethics* (Louisville: Westminster John Knox Press, 2007), 33.

observer and how events that are revelatory in our history, sources of unconquerable certainty for us, can yet be analyzed in profane fashion by the observer.”<sup>245</sup> By holding theo-ethical claims—Christian or otherwise—accountable to descriptive accounts of culture, including scientific renderings of the “patterns and processes of interdependence,” Gustafson comes, at worst, perilously close to leaving religion behind.<sup>246</sup> Cries of “naturalism” from Gustafson’s critics refer not only to general epistemological concerns about conflating the “is” and “ought” in ethical discourse but also to specific concerns within Christian theological ethics about the authority of revelation or other forms of distinctively Christian knowledge.

In two of his more recent works, *Intersections* and *An Examined Faith*, Gustafson addresses these concerns, first, by critiquing ways theologians claim a privileged position in conversations with the sciences, and, second, with a typology of the alternatives within theological ethics for resolving cognitive dissonance in these conversations. In both works, his theological naturalism is developed through a distinctive blend of epistemic humility, analytical rigor, and academic cantankerousness that opens up a way for talking about the limits and possibilities for theologians and ethicists in the “intersections” of disciplinary traffic. Importantly, these two works stop short of offering fully worked out substantive proposals for theological contributions to different intersections, concentrating instead on the methodological moves that give rise to, and are necessary to sustain, his form of theological naturalism.

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<sup>245</sup> Niebuhr, *The Meaning of Revelation*., 82

<sup>246</sup> Gustafson’s earlier works drew out the implications of both Troeltsch and H. Richard Niebuhr to expand the sphere of influence of the social sciences on Christian theology. Gustafson’s later focus on bioethics and environmental ethics has, I contend, granted similar influence to the natural sciences. For a critique of the implications for such extensive qualifications of religious claims, see Jeffrey Stout, *Ethics after Babel: The Languages of Morals and Their Discontents* (Boston: Beacon Press, 1988).

The following section provides an overview of Gustafson's own position on the relationship between theo-ethical and "scientific and historical accounts of how things really are."<sup>247</sup> As Jon Gunnemann observes, Gustafson remains committed to an "ontological realism" in his work. Though never with the degree of certitude we might prefer, Gustafson believes we can know something of the world, "that there is a world to be known." For Gustafson, a commitment to ontological realism orders the priorities of the theological ethicist. As Gunnemann notes, in Gustafson "a major portion of the theological and ethical task is to come to know that world, our place of habitation."<sup>248</sup>

In *Intersections* and *An Examined Faith*, the onto-theological and ethical claims about participation are rendered as disciplinary "intersections."<sup>249</sup> That is, to participate in "patterns and processes of interdependence" is to stand at an intersection of disciplinary "traffic" in order to discern what is going on. Intersection—like participation—simply is.<sup>250</sup> When we ask with H. Richard Niebuhr the first question in ethics: what is going on?, our answer as theological ethicists depends, even when we are not necessarily aware

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<sup>247</sup> James M. Gustafson, *Intersections: Science, Theology, and Ethics* (Cleveland, OH: Pilgrim Press, 1996), xvi.

<sup>248</sup> Jon P. Gunnemann, "Thinking Theologically About the Economic," in *Christian Ethics: Problems and Prospects*, ed. Lisa Sowle Cahill and James Childress (Cleveland, OH: Pilgrim Press, 1996), 316.

<sup>249</sup> These two works emerge out of his intentional, structured participation in interdisciplinary dialogue at Emory University. His participation in these dialogues, described in the introductions to his most recent works, suggest with greater specificity the way the sciences delimit the theological and ethical claims he is willing to make. For critics, however, this only confirms Gustafson slide into the "Christ of culture" type and, consequently, away from the "theological." The challenge of this dissertation, in general, and this section, specifically, is to shine a light on the persistence of the theo-ethical in Gustafson. Whether the persistence of the theo-ethical in Gustafson is persuasive or not to readers depends, in part, on whether one reads his more recent work as a form of the narrative of decline or, as I argue, the working out of his central, consistent theological commitments within the actual context and practice of interdisciplinary inquiry and discourse. Can he, as one of his most famous lectures asks, still "Say Something Theological"? If so, on what grounds? See Gustafson, "Say Something Theological!."

<sup>250</sup> In Gustafson's words, "The intersections simply are—they exist." *Intersections: Science, Theology, and Ethics*, xiii.



of it, on overlapping descriptions from nontheological and theological disciplines.<sup>251</sup> For example, the phenomenon of the human being is an intersection, informed by descriptions, interpretations, and evaluations from the natural sciences, humanities, social sciences, and theological studies.<sup>252</sup>

Intersections are busy. Yet, he observes in the claims many theologians and Christian ethicists make for the “independence and privilege” of theology and ethics that the traffic tends to flow in one direction, “from the theology or ethical theory to an account of the subject to which it is applied or is interpreted by it.”<sup>253</sup> In *Intersections*, he distinguishes his own form of theological naturalism and the limits it imposes upon his theological claims from three ways in which others claim a right-of-way for theology in a given intersection. In what follows, I present an overview of the alternatives Gustafson identifies to his own position.

### III. THE INSISTENCE OF THE THEO-ETHICAL

Gustafson identifies three ways in which theology exercises authority at various intersections. Theology may (1) replace, (2) add to, or (3) filter the descriptions and interpretations offered by nontheological disciplines. All three ways run counter to Gustafson’s theological naturalism and the type of participation it requires of theologians and ethicists.

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<sup>251</sup> Indeed a large part of the Christian ethical task in a Gustafsonian key is to make explicit how the use of nontheological descriptions affects the process of moral discernment. See especially *An Examined Faith*.

<sup>252</sup> Gustafson’s work provides a general method for doing theo-ethical reflection that can then illuminate what is possible at the intersection of religion and global health.

<sup>253</sup> Gustafson, *Intersections: Science, Theology, and Ethics.*, xvii

According to Gustafson, *replacement* is the strongest claim of theological privilege, and the one which stands in starkest contrast to theological naturalism. It is the claim that the “special revelation” of theology is, in itself, sufficient for describing, explaining, and interpreting events and phenomena: “The revelation is independent from other knowledge and other modes of knowing. It can be applied to events and phenomena to give them a different explanation, to direct human action, and to indicate the ultimate outcome of all things.”<sup>254</sup> The most obvious manifestation of this is “creationist science,” with its biblically based rejection of evolution. The biblical story of creation *replaces* accounts of the genesis of life from different disciplines. The claim of special revelation, however, takes more subtle forms as well.

Normative claims such as the priority of love in Christian ethics also privilege the special revelation in scripture and tradition: “nothing informed by any sciences or other perspectives can change the independent authority of love as the central norm of Christianity.” (2) The first example, consistent with the logic of biblical literalism, uses the Bible as an encyclopedia containing specific knowledge about all phenomena, while the second example interprets and evaluates complex phenomena using principles identified within the biblical and broader Christian narrative. If, for example, “love constitutes the defining feature of Christian ethics,” then how does this understanding direct our action in political, military, or economic affairs? (2). Though distinct, both forms of the this claim of privilege emphasize the uniqueness and authority of what is revealed in the scriptures and in the particular history of Christianity, and both trade on the idea that traffic flows one way at the intersection.

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<sup>254</sup> Ibid., 1-2. All parenthetical page references in this section refer to *Intersections*. All other references will be cited in the footnotes.

The privilege of theology can also be observed in claims about the insufficiency of descriptions and explanations from nontheological disciplines. In this way, theology exercises the second form of authority; it *adds to* the inevitably limited knowledge generated by the other domains of inquiry. This is not the typical “God of the gaps” argument. That is, the insufficiency of other disciplines cannot be overcome by increasing knowledge within those disciplines. The “privilege” of theology in this claim is that it is “a *more comprehensive way* to interpret events... . [Theology and theological ethics] enlarge what is relevant in understanding more comprehensively the depth or ultimate “meaning” of the events and phenomena, explained in nontheological terms” (2). The advance of science, noble as it may be for gaining knowledge about the way the world works, will, from the standpoint of theology, always be hamstrung by varying degrees of reductionism. As an example, Gustafson cites the difference between describing death and dying as biological and physiological processes rather than theological events. Biology and physiology can account for diverse *causes* of death, but “they do not address the dimensions of meaning, ultimacy, and breadth of context that humans experience in dying or in relation to others” (2). That theology does address these dimensions is what might be called a kerygmatic claim.

The privilege of theology as more comprehensive than other ways of knowing is primarily a theo-ontological claim. The world has been redeemed through God’s action in Christ. A redeemed world is one in which “hope and the possibility of redemption always lie beyond the starkness of tragedy,” beyond our experience of the world as a tragic place (3). Theo-ontologically, then, we “stress the possibilities of good coming out of evil, of openness within apparent restraints and restrictions of possibilities” not only because it

provides a soothing balm for cultured despair, but because we can do no other in a redeemed world.<sup>255</sup>

The contrast with love, in the example above, is subtle, but illuminating. Love may have priority of place as *the* Christian principle ordering forms of Christian participation in all spheres of life. But such priority is a theological and ethical claim about how Christians should order their lives (and by extension the analytical frame they should employ to evaluate whether or not different forms of activity are loving). It is not, ultimately, an ontological claim about how the world actually is. Rather, love (*agape*) is understood as the special revelation of the Christian tradition, specifically in the person of Jesus Christ, and in this way offers a corrective to the way the world is, or at least the fallen world is.<sup>256</sup>

A third and final claim for the privilege of theology and the unidirectional flow of traffic at the intersections rests on an assumption that, when all is said and done, phenomena are best understood in light of the religious and moral issues they relate to. Theology acts as the *filter* through which all interpretations of phenomena must pass. Religious and moral issues are deemed to be the most critical and “thus the concepts, metaphors, and narratives of these approaches or disciplines ought to override the

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<sup>255</sup> Given the theological influence on the founders of ARHAP, a particularly relevant example of this form of theological privilege is the work of Jürgen Moltmann. In a clear statement of the ontological implications of his theology of hope, Moltmann suggests that “Faith in God the Creator cannot be reconciled with the apocalyptic expectation of a total *annihilatio mundi*. What accords with this faith is the expectation and active anticipation of the *transformatio mundi*. ... Anyone who believes in the God who created being out of nothing, also believes in the God who gives life to the dead. His faith makes him prepared to withstand annihilation, even when there is nothing left to hope for, human speaking.” Qtd. in *Intersections*, 113. Originally published in Jürgen Moltmann, *God in Creation: An Ecological Doctrine of Creation: The Gifford Lectures 1984-1985* (London: SCM, 1985), 80.

<sup>256</sup> I emphasize the fallen world only because it is possible to read this another way, such that Christ revealed the way the world really is by collapsing in his homoousious the very distinction between the already and not-yet, an incarnational eschatology, so to speak, where the vision of the kingdom of God is realized in the presence of Christ on earth. But ultimately I think this does the same work as saying the unique understanding of love revealed in the Christian tradition is understood as an alternative to world as we can know it through observation—scientific, historical, or otherwise.

interpretations of others, subordinate the functions of others to the theological or ethical interpretation, or integrate them into a coherent theological or ethical framework because of their preeminent importance” (3). Complementarity between theological and nontheological descriptions of reality is possible, according to this line of thinking; there may be coherence between physical theories about an open universe and faith in a God who “makes all things new” (3-4). But given paradigm shifts in scientific understandings of the world, such coherence is ultimately unstable, threatened at all times by the potential for cognitive dissonance in the face of new scientific knowledge.<sup>257</sup>

Theo-ethical claims about human freedom, for example, may be threatened by evidence of determinism in nontheological fields. To mitigate the threat, “this freedom has to be defined and defended in such a way that inferences drawn from biopsychology or genetics do not qualify the necessary capacity for full personal responsibility for actions” (4). The privilege of theology, here, Gustafson suggests, is its prerogative to act as a filter, selectively incorporating other forms of knowledge so as to minimize the risk to core theological commitments.<sup>258</sup>

Theological naturalism, however, posits that theology can genuinely learn about the world from the world, itself. Claims for theological privilege at the intersections often lead to what Gustafson provocatively identified as the “sectarian temptation” in his early work, the temptation to isolate Christianity “from taking seriously the wider world of science and culture” and limit “the participation of Christians in the ambiguities of moral

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<sup>257</sup> This can be contrasted with the notion of consilience popularized by sociobiologist E.O. Wilson. Consilience posits that there is a unity to all knowledge. See Edward O. Wilson, *Consilience: The Unity of Knowledge* (New York: Alfred A. Knopf, Inc., 1998).

<sup>258</sup> An example from practical theology might be preachers who avoid the so-called “texts of terror,” biblical texts that are difficult to reconcile with core Christian commitments or worldviews.

and social life in the patterns of interdependence in the world.”<sup>259</sup> That theologians stand in busy intersections is a given. The three ways of exercising theological privilege do not contest this. That theologians *should* be included at these intersections is also, according to Gustafson, a given. Again, this is not disputed. In fact, if anything, it is underscored by the claims for theological privilege.

Each of the three ways theology exercises authority suggest justifications for why theologians should, or need to, be in the intersections. For example, accounts from other disciplines may be insufficient or partial, disordered, or, simply, false. These forms of justification enforce one-way traffic at the intersections: theology should—must—be in the intersections because of the truth it offers whether as replacement for, addition to, or filter of descriptions from other disciplines. (Each of these three ways of reasoning provide a pathway for arguing that theo-ethical reflection is a, if not *the*, distinctive, religious health asset, but I pursue a different route for reasons that will be made clear below.)

According to these ways of reasoning, the possibility of theologians being “informed and even altered by concepts, information, and theories that they meet at particular intersections” is not a justification (4). But this, of course, is exactly the justification theological naturalists turn to. For Gustafson the traffic at the intersections “goes both ways,” (xvi) though the effort he expends to defend theological naturalism against claims of theological privilege leaves little room for developing his own

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<sup>259</sup> James M. Gustafson, "The Sectarian Temptation," in *Moral Discernment in the Christian Life: Essays in Theological Reflection*, ed. Theo A. Boer and Paul E. Capetz (Louisville: Westminster John Knox Press, 2007), 144.

constructive proposal for how theology ought to affect nontheological descriptions and interpretations of phenomena.<sup>260</sup>

Instead, Gustafson is content to “alert theological ethicists and their audiences to practices of their craft ... in the context of the diverse contributions that many academic disciplines make to the field” (143-44). To that end, he concludes by identifying eight themes in his analysis of how theological ethics relates to other disciplines. These eight themes form the basis for his discussion of the strategies of rejection, absorption, and accommodation in *An Examined Faith* (described below). The eight themes are, briefly: (1) other academic disciplines do not affect theological ethics, (2) academic disciplines affect the substance and content of theological ethics, (3) theological ethics revises or otherwise gives meaning to information given by other disciplines, (4) disciplines provide the descriptive premises to theo-ethical principles are applied, (5) disciplines translate theo-ethical claims into nontheological language to make the claims intelligible to nontheological audiences, (6) theological ethics draws on the authority of other disciplines to shore up theo-ethical claims, (7) theological ethicists use other disciplines as tools for immanent critique of the claims from within those disciplines that are not consonant with the theo-ethical claims, and, finally, (8) theological ethics seeks coherence “*between theological and ethical premises and what is taken in, how it is interpreted, and how it is applied*” (136-143).

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<sup>260</sup> Even some of Gustafson’s more sympathetic critics decry what amounts to an unsubstantiated claim for two-way traffic in the intersections: “[N]owhere in either ‘The Sectarian Temptation,’ or *An Examined Faith* does Gustafson even consider the possibility that science may need to make adjustments, even small ones, in light of theology.” Todd David Whitmore, Todd David Whitmore, “Crossing the Road: The Case for Ethnographic Fieldwork in Christian Ethics,” *Journal of the Society of Christian Ethics* 27, no. 2 (2007), 279.

*Intersections* leaves unanswered the question of how traffic at the intersections might flow *both* ways. What, from Gustafson's perspective, is the appropriate form of theo-ethical persistence in the intersections? Having stripped theological ethics of the ways in which it claims privilege in interdisciplinary conversations, is theological ethics relegated to a largely responsive stance, reacting to the descriptive premises crisscrossing the intersection from other disciplines? The eight themes listed above are framed largely in terms of how theological ethics relates to other disciplines. That is, the themes do not address how other disciplines relate to theological ethics. Can theological ethics act back upon these disciplines in intelligible or meaningful ways with both descriptive and normative premises of its own, or at least partially its own, and in the process redirect the traffic at the intersections?

The next section turns to his most recent monograph, *An Examined Faith: The Grace of Self-Doubt*, for answers to these questions. *An Examined Faith* continues the conversation started in *Intersections*, and, in the end, I argue, offers a modest claim for the persistence of theo-ethical reflection as a generative activity in the intersections of disciplinary traffic. This modest claim will likely not satisfy Gustafson's critics, but it is sufficient to preserve the necessary theoretical space for identifying theo-ethical reflection as a potential religious health asset. *An Examined Faith* also opens a conceptual portal back into some of his earlier work, a key component of which is the concept of the participant theologian, discussed further below.



#### IV. THE CHEAP GRACE OF SELF-DOUBT

In *An Examined Faith: The Grace of Self-Doubt*, Gustafson focuses his attention less on the justifications for theological privilege in the intersections and more on the strategies theologians use to respond to cognitive dissonance generated in the intersections. While retaining some of the polemic against claims for the “independence and privilege” of theology, he explores in greater detail the diverse ways in which theologians and ethicists make use of scientific and other natural explanations in day-to-day theological reflection, ethical analysis, decision-making, and pastoral care. That there may be tension or cognitive dissonance between claims from theological and nontheological descriptions or interpretations is, for him, a catalyst for clearer thinking about the causes of the dissonance, rather than an indictment of the incommensurability of the different modes of knowing, or a concession that cognitive dissonance is all we have.

To facilitate clearer thinking, Gustafson posits three ideal types for analyzing how theologians, in particular, overcome cognitive dissonance in the intersections: (1) absorption, (2) rejection, and (3) accommodation. His evaluation of the limits of these three types suggests criteria for how much and in what ways science *should* determine the limits of theological statements. The three types also indicate how epistemological choices give rise to different forms of participation, or different kinds of participant theologians, each in their own way an expression of theological persistence.

The first strategy he notes is rejection.<sup>261</sup> Theology and science are incommensurable for one of two reasons: (1) truth is relative in the postmodern world, and science and theology each present a truth that is appropriate to the kind of truth each pursues, or, (2) there is only one truth and theology has it. To borrow an analogy from laboratory science, the former implies that theology and science proclaim truths that are reliable, though they make no claims on one another for accuracy. The latter, however, locates reliability and accuracy of truth claims solely within the domain of theology. Both forms of rejection accept cognitive dissonance as the status quo.

For Gustafson these positions are untenable on normative grounds (e.g., cognitive dissonance should not be the status quo) and descriptively inaccurate. In the interpretation of events, humans rely on a variety of forms of knowledge, often without respect for the disciplinary boundaries cognitive dissonance presumes. This is not merely an indication of the ascendancy of pragmatism, but a recognition that human understanding of actions and events, let alone their meaning, has been deeply influenced by the interaction of different theological and nontheological lines of inquiry.<sup>262</sup>

Gustafson's identifies a second strategy as absorption. Epistemologically, theology *interprets* the reality as *described* by science—theology absorbs science. Scientific theories and explanations, then, determine the theological significance of an event. To illustrate this strategy, Gustafson uses an anecdote from the Reformed theologian John Calvin about lactating women. Empirical differences among women with the ability to lactate and those without are, for Calvin, suggestive of God's will (6-

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<sup>261</sup> Gustafson, *An Examined Faith: The Grace of Self-Doubt*. See especially 40-44. All parenthetical page references in this section refer to *An Examined Faith*. Additional references will be cited in the footnotes.

<sup>262</sup> For example, one does not have to be a full-blown scientific positivist to accept scientific explanations of events such as gravity that constrain daily living.

7). The order of inquiry is important here, especially as a contrast to the second form of rejection noted above. The absorption strategy relies on scientific description to understand the natural law, whereas the fundamentalism of the second rejection strategy described above begins with a revealed order and seeks evidence of it in the world around.<sup>263</sup>

The third strategy, accommodation, can be seen as a continuum.<sup>264</sup>

Accommodation strategies begin with the premise that theological and nontheological discourse describe the same phenomenon and that there are varying degrees of compatibility between the accounts. At the far left on the continuum, scientific explanation impacts religious claims to such a degree that religious claims must be reworked to accommodate the new scientific knowledge.<sup>265</sup> On the far right of the continuum, science provides data for making better, more precise use of extant ethical principles. In the first case, science provides a test for the efficacy of religious symbolism:

Symbols of the religious tradition are “primordial readings of human experience and the human position within the natural and social world.” The test of the tradition is its revelatory power with reference to human experience. Whether the

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<sup>263</sup> Pat Robertson exemplifies the second rejection strategy when interpreting the events of 9/11 or the 2010 Haiti earthquake. Rather than determine theological reflection, the tragedies confirmed—and were conformed to—a static theo-ethical worldview in which God punishes whole societies for particular immoral beliefs (e.g., Voodoo in Haiti) or practices (e.g., homosexuality in the U.S.). For an analysis of Robertson’s theo-ethical reflection on Haiti, see Anthea Butler et al., “Biblical’ Disaster in Haiti: Pat Robertson and the Curse of Unyielding Ignorance,” *Religion Dispatches* (January 15, 2010).

<sup>264</sup> Gustafson himself does not use the language of continuum, however, I have found it useful in understanding the relationships among what he identifies as left-leaning, centrist, and right-leaning strategies.

<sup>265</sup> Again, though not explicit, I believe Gustafson uses “left-leaning” to signal the strategy’s affinity with the extreme form of philosophical and theological liberalism in which religion is completely derivative of all other forms of knowledge. This might be variously understood as a thoroughgoing theological naturalism or as a version of the classic statement of the “Christ of culture” in H. Richard Niebuhr, *Christ and Culture* (New York: Harper and Row, 1951).

religious tradition “is enhanced or rendered obsolete when juxtaposed to science is...dependent upon whether the symbol seems to render adequately what accounts as *significant* human experience, inclusive of science.”<sup>266</sup>

The challenge, consistent with Gustafson’s concern throughout his argument, is the abstract level at which these kinds of arguments are made. The left-leaning accommodationists accept natural science explanations of nature and human experience as well as the mythic interpretation of religious symbols. The contrast with the above anecdote from Calvin is subtle, but important. For Calvin, there is no mythical interpretation. The empirical evidence and the theological interpretation are understood literally.

The right-leaning accommodationist maintains the “authority and autonomy” of theology and ethics, while accepting the limits scientific research imposes on ethical choices (45). So, for example, theologians in this camp make use of scientific advances to help clarify the application of specific theo-ethical principles. Debates among Christian biomedical ethicists here as well as other versions of applied ethics are particularly relevant. For example, in order to answer the question about whether or not stem cell research is justifiable from the perspective of Christian theological ethics, right-leaning accommodationists engage with the most current scientific research in order to identify with greater precision the application of previously derived theo-ethical principles.<sup>267</sup>

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<sup>266</sup> Gustafson, *An Examined Faith: The Grace of Self-Doubt*, 48. The internal quotes reference the work of Philip Hefner, Gustafson’s representative of left-leaning accommodationists. See Philip Hefner, *The Human Factor: Evolution, Culture, and Religion* (Minneapolis: Fortress Press, 1993).

<sup>267</sup> Gustafson, himself, does not explicitly discuss the right-leaning accommodationist position. My discussion here is derived from his contrast with left-leaning accommodationists. See *An Examined Faith*, 45.

A centrist position exists on the accommodation continuum, between the right-leaning and left-leaning accommodationists. The centrist position might best be characterized as “aggregative disciplinarity.” The upshot is that different disciplines add different pieces to our understanding of the same phenomenon. The aggregation of these disciplinary contributions yields the most complete description of an event. Gustafson notes, however, that in these accounts, theology and philosophy as synthesizing disciplines are often accorded the status of first among equals.<sup>268</sup>

The centrist position comes closest to Gustafson’s own commitments and fidelity to the enduring legacy of the liberal theological tradition.<sup>269</sup> But he makes one final move, one that is if not definitive, at least suggestive of the form of participation for theologians engaged in the intersection of global health. For Gustafson, “the major contribution of theology and ethics in interaction with scientific and other secular accounts is to expand the received information by interpreting it from a different perspective” (82.) The meaning of events is neither the sum of its respective parts, nor is it captured fully by the synthesizing processes of theologians and philosophers. Rather, the meaning of events emerges out of the mutually generative interaction among all those who participate in the intersections. Accommodation, he argues, involves determining the meaning of an intersection by “maximiz[ing] coherence and minimiz[ing] incoherence”

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<sup>268</sup> Recall from the previous section, theology as a more comprehensive way of knowing is the second privilege of theology he notes in *Intersections*.

<sup>269</sup> He summarizes the legacy of the liberal theological project as a concern for what is theologically permissible given that “Christian life and thought exist in a context in which historical and cultural relativism are deeply embedded; in which other historical religious traditions and secularism are materials not only to be addressed intellectually, but also in our personal experience and that of our neighbors and our families; in which various sciences interpret nature, events, and experiences that are present in religious thought and life.” *An Examined Faith*, 78. Though this may be closest to his position, he does not articulate his own normative resolution of the issues raised in *An Examined Faith*. In responding to critics, he explains the primary purpose of the book in primarily descriptive, analytical terms. Gustafson et al., “Doubting Theology.”

(83). Importantly, this generative interaction does not lead to a full integration in which “one party grants that the perspective of the other is comprehensive and sufficient to explain and exhaust the meaning of the other” (83). His resistance to this type of integration and the privileging it engenders is clear in *Intersections*. As a result, the primary virtue in the epistemological space created at the intersections is humility, or “the grace of self-doubt,” on the part of all who stand in the intersections, but especially the theologians.<sup>270</sup> To rehearse the coda from *Intersections*, “theologians can provide critical perspectives on the contributions of others, but they are also open to critical examination from the perspectives and work of others. Theology and theological ethics have no grounds on which to be critics of other fields if they do not permit work from other fields to be critical of them. They should be undefensively open to justifiable revisions as they and other disciplines intersect on common interests or problems.”<sup>271</sup>

So who is left to direct the traffic at the intersections, then? What does the persistence of the theo-ethical reflection look like after Gustafson?<sup>272</sup> At the end of *An Examined Faith*, he moves from analytical to “polemical and hortatory” discourse. This

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<sup>270</sup> Given the influence of Jürgen Habermas on the founders of ARHAP, it is relevant to point out that in recent writings Habermas has come close to this position in his articulation of the role of “complementary learning processes” in the public sphere. While complementary learning processes still require religious persons to translate their religious claims into language accessible to the nonreligious, it requires reciprocity on the part of nonreligious persons—and not merely as a form of civility. Complementary learning processes enjoin nonreligious persons to be open to the *normative* truth content in religious claims that may illuminate issues or aspects of other traditions that have hitherto been obscured, forgotten, dismissed, or dominated. See Habermas, “Religion in the Public Sphere.”

<sup>271</sup> Gustafson, *Intersections: Science, Theology, and Ethics*, 147.

<sup>272</sup> Critics of *An Examined Faith* suggest that at the end of the day the limits Gustafson’s theological naturalism obligates him to impose on the uniqueness of Christian theological claims under the participant theologian merely a participant, and not a theologian, certainly not a Christian theologian: “One wonders on what grounds Gustafson would allow any uniquely Christian claims to determine Christian theology. The chief effect of these portions of the book is to emphasize the growing gulf between what Christians are required to proclaim about God and what Gustafson now believes is intellectually permissible. In the end, the persuasiveness of the book will depend largely on whether the reader agrees with Gustafson that there is no avoiding the concerns and methods of liberal theology.” Matthew Rose, “An Examined Faith: The Grace of Self-Doubt,” *First Things: A Monthly Journal of Religion & Public Life*, no. 151 (2005), 54-55. See also Whitmore, “Crossing the Road: The Case for Ethnographic Fieldwork in Christian Ethics.”

discourse is intended to “make a case for [his] standpoint for contemporary Christian theology, ethics, preaching, and pastoral care” (78). It is not much more than a standpoint. That is, he does not offer in this volume a comprehensive, constructive proposal for how exactly theo-ethical reflection persists in the intersections. While in *Intersections* he was concerned primarily with defending theological naturalism from its Christian despisers, *An Examined Faith* engages more sympathetically, though still immanently, in critique of particular theological strategies. It is intended as a call for greater self-awareness among theologians and religionists about “how much traditional religious discourse has been altered by historical and contemporary sciences and other secular interpretations of the world” (92). Greater self-awareness through careful, critical dissection of the strategies theologians employ in interdisciplinary conversations is, as readers of Gustafson know, one of the hallmarks of his lifelong commitment to maintaining a Christian ethics as a rigorous academic discipline.

Yet in calling for greater awareness, he maintains discursive space for the persistence of theo-ethical claims, even though these claims are highly qualified. Here, Gustafson defaults to Calvin to explain, though not ground, the persistence and necessity of theo-ethical reflection: “Whenever we come upon these matters [e.g., arts and sciences] in secular writers, let the admirable light of truth shining in them teach us that the mind of man [*sic*] though fallen and perverted from its wholeness, is nevertheless clothed and ornamented with God’s excellent gifts. If we regard the Spirit of God as the sole foundation of truth, we shall neither reject the truth itself, nor despise it wherever it shall appear, unless we dishonor the Spirit of God” (7).<sup>273</sup> From a theocentric perspective,

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<sup>273</sup> Original quote from John Calvin, “Science as God’s Gift,” *Institutes*, Bk. 2. Importantly, Gustafson does not see quoting Calvin as sufficient reason for taking the sciences seriously. Rather, the quote demonstrates

the ontological realism Jon Gunnemann notes in Gustafson, is also theological realism.<sup>274</sup>

When we discern something of the patterns and processes of interdependence in the world we are, from a theocentric perspective, discerning something—though always in the form of a revisable hypothesis—about God, even when we employ putatively nontheological language and categories.<sup>275</sup>

On the basis of *An Examined Faith* and *Intersections*, alone, it is difficult to support a robust claim for the contribution of theo-ethical reflection in the intersections, since so much of the ink is devoted to either defending his theological naturalism<sup>276</sup> or exposing the weaknesses of other ways theological ethics relates to various nontheological disciplines. The claim is there, I believe, but it has to be teased out from the fine-grained analysis of the options Gustafson sees theologians exercising as “practices of their craft.”<sup>277</sup> In many ways, the claim about the contribution of theo-ethical reflection is there as a penumbra, created by the light of his earlier work being directed toward the methodological challenges of relating theological ethics to the descriptive premises of other disciplines.

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how from the beginning the Reformed tradition is shot through from the beginning with an openness to the diverse, nontheological sources in our midst as sites for God’s self-disclosure. This is consistent with Gustafson’s overall theocentric perspective as captured most succinctly in the Latin phrase, *solī Deo Gloria* (to God, alone, glory).

<sup>274</sup> Gunnemann, "Thinking Theologically About the Economic."

<sup>275</sup> Though Gustafson’s demand for precise analysis resists the collapse of all categories into theological categories, the theocentric perspective does suggest that in some way all forms of inquiry are theological in nature, since all inquiry sheds light on the patterns and processes of interdependence in which we exist.

<sup>276</sup> He concludes *Intersections* with this strong endorsement of theological naturalism as the only viable alternative: “One may, or may not, like to think that theological ethics are ‘naturalistic’ in some strong or weak sense, that the morality which emerges or follows from a theological ethics is heavily dependent upon various descriptive premises used. But the weight of analyses in this books is that they do, whether one wishes to admit it or not.” Gustafson, *Intersections: Science, Theology, and Ethics*, 145.

<sup>277</sup> *Ibid.*, 144.



## V. GUSTAFSON'S PARTICIPANT THEOLOGIAN IN THE INTERSECTIONS

I understand Gustafson's sustained attention on interdisciplinarity in *An Examined Faith* (and *Intersections*) to be continuous with his more substantive theological claims in earlier works.<sup>278</sup> Demonstrating this continuity forms part of the argument for how Gustafson's layered understanding of participation might serve to support the constructive proposal in this dissertation for viewing theo-ethical reflection as a religious health asset.

Introducing a collection of writings from the first phase of Gustafson's career (roughly the 1960s and early 1970s), Charles Swezey articulates the general effect, if not the substance, of theological persistence in Gustafson's thought: "The presumption is that theological convictions will affect the analysis in a significant although not unique way; the analysis of human existence may be qualified, modified, or intensified, but it will not

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<sup>278</sup> J. M. Gustafson, *Ethics from a Theocentric Perspective Vol. 1, Theology and Ethics* (Chicago: University of Chicago Press, 1981); Gustafson, *Ethics from a Theocentric Perspective. Vol.2, Ethics and Theology*. Gustafson's shift away from constructive theological proposals in *Intersections* and *An Examined Faith* can be explained, in part, biographically (or institutionally), something he, himself, acknowledges in the preface to *Intersections*. Reflecting on the shift from the kind of theo-ethical work he was engaged in first at Yale and then at the University of Chicago to the more intentional, institutionally supported interdisciplinarity of his work as the Robert W. Woodruff Professor of Comparative Studies and Religion at Emory University, he writes: "The materials about which I have to think about as a theological ethicist are denser, more diverse, and more complex. ... [T]he Emory work in effect makes me move into them less from the standard route of theological ethics. Now I tend to meet the theological and ethical materials from the panorama of academic fields. Indeed, I have formed a deep conviction that theologians and ethicists ought to think most seriously about matters not often attended to in their various professional guilds." See *Intersections*, x. For critics of his work, such confessions only confirm the increasing the distance between his thoughts and Christian theological ethics. However, for others, myself included, such confessions name aloud the challenges confronting those who continue to do constructive work in the liberal theological tradition. One hope for this dissertation is to demonstrate the distinctive ways in which liberal theology remains a vital source for responding to the complex challenges of global health in the twenty-first century. However, I do not take my primary audience to be critics of Gustafson's work, specifically, or others who dismiss the premises of liberal theology. I do address concerns about the limits of Gustafson's relevance. See, for example, my discussion below of Kevin O'Brien's proposal for an ethics of biodiversity.

be erased.”<sup>279</sup> The two volumes of *Ethics from a Theocentric Perspective* develop this presumption in more substantive directions, though the force of his argument is directed at various forms of anthropocentrism infecting Christian theological ethics. As such, the impact of his constructive proposal for a theocentric ethic was felt most profoundly *within* theological and Christian ethical conversations, even though many of the chapters, especially in the second volume, reflect a sophisticated engagement with nontheological sources.

How might theology qualify, modify, or intensify other ways of knowing? How is it both “significant,” yet not unique? Gustafson suggests an answer in his proposal for the theologian as participant.

Gustafson’s “participant theologian” is presented as an alternative that is both between and beyond two ideal-types found in abundance in the Christian tradition: the “theologian as preserver” and the “theologian as prophet.”<sup>280</sup> The theologian as prophet, briefly, is a social critic who “stands with and for God over against the existing society and culture, over against the spiritual and moral ethos of his [*sic*] time and place.”<sup>281</sup> Importantly, the theologian as prophet employs theology to make “independent judgments about the spiritual and moral health of the society,” leveraging his or her authority as “God’s appointed” representative to decry the ways in which societies have

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<sup>279</sup> Italics in original. See Charles Swezey’s “Introduction” in Gustafson, *Theology and Christian Ethics*, 15.

<sup>280</sup> “The Theologian as Prophet, Preserver, or Participant,” 84. While he suggests that examples of the preserver and prophetic types are prevalent throughout the sweep of Christian history, he does not find examples of the participant type. For him it is an ideal-type in the most literal way. Though I have no evidence to suggest Gustafson was or was not familiar with the Christian Medical Commission, given the origin story retold in chapter five, I suspect that Gustafson would recognize in the work of early participants at Tübingen as well as the later work of the CMC if not the presence of participant theologians, at least kindred spirits.

<sup>281</sup> *Ibid.*, 75.

become “estranged from God.”<sup>282</sup> Combining both lament and indignation at the state of the world—inevitable as it may be given the fallenness of the created world—the theologian as prophet finds an audience in faith communities that see themselves as exemplars of obedience to God’s will (e.g., the monastic ideal) or as the vanguard tasked with ushering in a new epoch more closely aligned with God’s will (e.g., apocalypticism).<sup>283</sup>

The theologian as preserver, on the other hand, sees in society the gradual emergence of the kingdom of God, a consonance rather than dissonance between the existing structures of the world and God’s will. The preserver’s passion is channeled into defending the status quo. Contrary to the prophet, the preserver’s greatest fear is “the thought of revolution and radical change, not the embedded evils in the historical past.”<sup>284</sup> Gustafson is short on examples for the preserver, but imagines the preserver as one who would defend the relationship between Christian liberty and free markets as reflective of the divine ordering.<sup>285</sup> The theologian as preserver cleaves to an idealized vision of the historical church in which the church exercised greater authority over all domains of human activity. Defense against efforts to further undermine any remaining authority as well as efforts to reassert authority that has been lost preoccupy the preserver, whereas the prophet sees corruption all the way down, rejecting any notion of a historical church that offered a closer approximation of the kingdom of God.

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<sup>282</sup> Ibid., 75.

<sup>283</sup> Ibid., 79. See also H. Richard Niebuhr’s “Christ against culture” ideal type in *Christ and Culture* and Max Weber’s discussion of the “ethics of ultimate ends” see Max Weber, “Politics as Vocation,” in *From Max Weber: Essays in Sociology*, ed. H.H. Gerth and C. Wright Mills (New York: Oxford University Press, 1946), 77-128.

<sup>284</sup> Gustafson, “The Theologian as Prophet, Preserver, or Participant,” 83.

<sup>285</sup> Normative readings of Weber’s *Protestant Ethic and the Spirit of Capitalism* come to mind here.

Gustafson is quick to point out that these are exaggerations, proposed for heuristic purposes. Even in the brief description above, this is clear. Certainly some theologians who operate in the prophetic key draw on both eschatology and memory to assert visions of societies reconciled to God. But Gustafson's distinction between the modes of social action the different ideal-types legitimate is helpful, especially as he works to develop a constructive alternative within the liberal theological tradition.

The participant theologian, in contrast to both the preserver and prophet, is a reformer, actively engaged in "the shaping of events and in the development of and reordering of institutions" without being predisposed to either "the condemnation of the existing state of affairs" (prophetic) or "to whole-hearted support of them" (preserver).<sup>286</sup> Two extended quotes suggest how the activities of the participant theologian reveal the *significant-yet-not-unique* character of the theological in "political, educational, and other processes that have an impact on the course of human development."<sup>287</sup>

While the theological naturalism Gustafson defends in *Intersections*—the necessity of theology learning from the world—delimits the theologian's participation and the kind of theo-ethical claims that are possible, it does not render the theologian obsolete. The participant theologian

is one partner among many in the human conversation that will give some determination to the ways in which men [*sic*] use their technical and political powers, their resources and talents in the development of history and society toward humane ends. ... While he thinks and speaks from a perspective that is theologically informed and shaped, he does not announce it as the truth. Rather,

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<sup>286</sup> Gustafson, "The Theologian as Prophet, Preserver, or Participant," 84.

<sup>287</sup> *Ibid.*, 84.

he recognizes its limitations with reference to things that need to be known and done and its relativity and partiality that need to be corrected by others.<sup>288</sup>

The character of participation, or the disposition of the participant theologian, is epistemic humility. Such a disposition acts as a corrective to the direction of the one-way traffic Gustafson critiques in *Intersections*. But it does not reverse the direction of the traffic; epistemic humility is not the same as absolute epistemic deference to knowledge generated by nontheological domains of inquiry.<sup>289</sup>

It is not absolute deference because the participant theologian brings her own “specialized knowledge and discipline of thought to bear in the interactions of perspectives, technical knowledge, moral beliefs and opinions, out of which come the convictions and actions that shape the future.”<sup>290</sup> The *significance* emerges from the theologian’s articulation of

what the primary purposes of human existence in community and history are, about what the qualities of life ought to be, about what values are in accord with God’s activity and intention for his [*sic*] creation. . . . He [*sic*] brings to bear the insight and wisdom of the Christian community’s long historical reflection about the chief ends of man.<sup>291</sup>

Thus, the importance of theo-ethical reflection persists—the participant theologian “speak[s] meaningfully and clearly from his perspective”—even as the participant theologian nurtures “a capacity to listen to and understand other points of view, to

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<sup>288</sup> Ibid., 84-85.

<sup>289</sup> For a nuanced interpretation of how the challenge of balancing of epistemic humility and theological claims informs Christian participation in the public square, see Ellen Ott Marshall, *Christians in the Public Square: Faith That Transforms Politics* (Nashville: Abington Press, 2008)., especially chapter three, “Theological Humility.”

<sup>290</sup> Gustafson, “The Theologian as Prophet, Preserver, or Participant,” 84.

<sup>291</sup> Ibid., 84.

comprehend the basic options thrust up by political, technological, and scientific developments.”<sup>292</sup> In this way, processes of theo-ethical reflection (and the participant theologian) are persistent but not overly insistent, so to speak, retaining “the grace of self-doubt,” to borrow from the first-order religious language of Gustafson’s most recent monograph.<sup>293</sup> The participant theologian is also consistent. Though an alternative to the preserver and prophet ideal-types, the participant theologian draws from what has always constituted the best of what the theological discipline has to offer, including “imagination, critical reflection, and historical awareness.”<sup>294</sup>

The radical openness, or theological humility, of Gustafson’s work mitigates against *a priori* claims for what the persistence of theo-ethical reflection will look like in a particular intersection. Admittedly, his basic theocentric premise that “God will be God” may be cause for cultured despair among theologians and nontheologians, alike—if God will be God, then why bother participating? As a result, the theologian who stands in the intersection proclaiming “God will be God” is likely to appear as little more than Chicken Little. Yet, for Gustafson, such theocentric statements are intended as catalytic not paralytic. That God will be God is an invitation to understand better what, or how, God is being in a given intersection, and to the best of our abilities as finite beings to respond appropriately.

Gustafson’s participant theologian, then, is the earthen vessel carrying a theocentric understanding of participation to the global health table. And while for some, the defense of theological naturalism in *Intersections* can leave the impression that the presence of a theologian at the global health table, while less problematic than previously

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<sup>292</sup> Ibid., 84-85.

<sup>293</sup> Gustafson, *An Examined Faith: The Grace of Self-Doubt*.

<sup>294</sup> “The Theologian as Prophet, Preserver, or Participant,” 84.

assumed, may ultimately be superfluous—for example, the theological is coextensive with the nontheological to such a degree that its persistence is rendered unnecessary. Gustafson’s participant theologian stands in the intersection and resists such a conclusion in her claim to bring to the table specialized knowledge and discipline of thought about the ends of human being. And while, in itself, it may not represent a robust claim for a mutually generative encounter in the intersections, it does at least suggest that a mutually generative communicative praxis may be possible.<sup>295</sup>

Gustafson’s understanding of participation goes a long way to fulfilling the first part of the twofold task identified in the introduction to this chapter: making a case to theologians and ethicists about participation in intersections. However, I contend that the persistence of the theological remains underdeveloped in his work, even when *Intersections* and *An Examined Faith* are seen as continuous with his understanding of the participant theologian. In part, I think that this is a result of the kinds of conversations in which he has been involved, especially in his later career. Meta-interdisciplinary conversations in which his role is one of facilitator, of helping to direct the traffic generated largely by other disciplines, may not be a moment for rigorous defenses of the contribution of theo-ethical reflection.<sup>296</sup>

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<sup>295</sup> I employ Gustafson as a theoretical resource for understanding the limits and possibilities of a mutually generative communicative praxis within the expert culture of global health policymaking. This is not to say that the praxis is limited to the policy level, only to name what liberation and feminist critics of Gustafson have already pointed out: he focuses most of his attention on so-called “expert culture.” In this dissertation, however, such a focus is seen as a necessary complement to other dimensions of the turn to religion that privilege the voices of those marginalized by current global health policies. I contend that in many ways the latter is seen as an acceptable and expected, and therefore, manageable form of religious presence in global health discourse.

<sup>296</sup> It is certainly my experience in the religion and public health faculty seminars, structured dialogues, and workshops at Emory and in South Africa that participants tend to tolerate descriptive religious claims and to avoid the normative theological statements about health and healing.

Admittedly, the participant theologian is an ideal-type, but in his development of the concept and its continuity with his later writing on interdisciplinary intersections, Gustafson shows his preference for a particular type of participant theologian, one that bears a striking resemblance to Gustafson, himself. That is, based on the above discussion, the participant theologian is an academically trained, professional theologian engaged at the intersections of disciplinary traffic within a research university—preferably a university with an attached school of theology. What Gustafson offers is a theoretical argument for how these participant theologians can be recognized as experts *within* expert culture. The argument trades on the institutional logics animating the culture of a research university, namely analytical rigor and discipline-specific standards of peer review. For Gustafson, the primary task is to demonstrate that theo-ethical reflection adheres to these standards and exhibits this rigor, largely by taking with the utmost seriousness the evidence generated by nontheological disciplines.

This is important work, and, ultimately, I argue, necessary to engage the expert culture dominating global health policymaking circles. Indeed, I chose Gustafson as a conversation partner for this reason. But with such a narrow focus, this type of argument cannot fully account for the claims, both theological and otherwise, generated beyond the intersections of an academic quadrangle.

Global health and theology both move back and forth between the academy and other types of communities. Gustafson's theocentric participant theologian has the theoretical potential to move back and forth, as my recovery of his earlier work was intended to show. That is, one imagines that the participant theologian capable of contributing to global health conversations something about the ends of human being



does so in part out of her reflection on how persons other than professional theologians and church doctors define these ends.

This I take to be the point made by James Cochrane in his proposal for paying attention to “incipient theology.” Cochrane makes a strong case for how “local communities—particularly those on the margins of the center of power in society—possess a theologically and socially relevant wisdom about their situation and context. ... giv[ing] us insight into what otherwise remains unseen about ourselves, our theories, power relations, and society.”<sup>297</sup> For Cochrane, “incipient theology” refers to theological reflection done by “ordinary believers, believers who are untrained in the formal canon or history of theological method” but who, when they reflect on their faith, “engage in the task of theology in a provisional way, gathering an as yet untested wisdom about the meaning of their faith.”<sup>298</sup> While officially located in the academy as a sociologist of religion, Cochrane’s methodological approach is informed by a liberation praxis and critical theory. As such, his theoretical, and arguably theo-ethical, reflection emerges from the social movements and activist networks that have animated South African public life in the recent past, including the role of religion in the Apartheid movement.<sup>299</sup>

I do not think this type of theo-ethical reflection is necessarily incompatible with Gustafson’s more limited notion of the participant theologian. Gustafson provides

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<sup>297</sup> Cochrane, *Circles of Dignity: Community Wisdom and Theological Reflection*, 21-22.

<sup>298</sup> *Ibid.*, 22.

<sup>299</sup> Cochrane was an active participant in the Apartheid movement and helped to organize a national conference on religion in South African public life. His current focus on public health and the HIV pandemic similarly reflects sensitivity to the pressing social concerns of the context in which he is theoretical work is located. For an example of his work in promoting and furthering the religion and public life conversation, see James R. Cochrane and Bastienne Klein, eds., *Sameness and Difference: Problems and Potentials in South African Civil Society* (Washington, D.C.: Philosophy and Values, 2000). For his leadership in the anti-Apartheid movement see James R. Cochrane, "Damned If You Do, Damned If You Don't: Rereading the Public Theology of the Christian Institute for the Contemporary Practitioner," in *Christian in Public: Aims, Methodologies and Issues in Public Theology*, ed. Len Hansen, *Beyers Naude Centre Series on Public Theology, Stellenbosch University* (Stellenbosch: SUN Press, 2007).

glimpses of a participant theologian engaging beyond the interdisciplinary academic debates. Indeed, his reflections on his first consulting job as an ethicist suggest that Gustafson sees this engagement as a necessary correction to abstract theoretical debates among ethicists. He was hired to do a policy analysis for Standard Oil to determine whether cost reductions could be achieved without a negative impact on the workers. As part of the analysis he read company reports, but also interviewed personnel who held various positions in the company. For Gustafson this methodological approach was a constitutive element of social ethics, a way of addressing the “huge gap between theory, quantified information, and the role obligations of persons.”<sup>300</sup> What I find most instructive in this anecdote is the emphasis on a methodological approach in Christian ethics that pays attention to the “role obligations of persons,” or how institutional location influences processes of moral discernment. This insight can be seen as compatible with, perhaps even a necessary complement to, feminist and liberationist theo-ethical reflection that emphasizes the importance of social location on processes of moral discernment. Such methodological affinities, however, do not necessarily suggest theological agreement.

Towards the end of *An Examined Faith*, Gustafson makes his rejection of liberation theologies explicit, and places the theodicy question squarely in the laps of liberation theologians

By drawing selectively from the Bible, one can make an *ideal* theological case and a *normative* ethical case that those who are faithful to God should prefer the poor.

... If God prefers the poor, is the destitution, the deprivation, the pain and

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<sup>300</sup> For his re-telling of the Standard Oil anecdote see Gustafson, *An Examined Faith: The Grace of Self-Doubt*, viii.

suffering of those millions whose plight draws our compassion due only to the human fault—sin? Or is much of the outcome of historical and natural conflicts and forces beyond the capacity of any individual human, or any government, or any nongovernmental organization, to alleviate, not to mention eliminate? If God prefers the poor, is God impotent to fulfill that preference?<sup>301</sup>

It is important to note that his rejection is predicated largely on an unwillingness to let eschatological theo-ethical visions stand in for what he sees as the historical and natural (e.g., caused by what insurance agents refer to as “acts of God”) reality of suffering. In a typical Gustafsonian distinction, he argues: “It is clearly the Christian mission to prefer the poor and oppressed. But if that is the purpose of the Almighty, the Almighty is not Almighty. God may be love, but love is not God; love is not omnipotent—unless we proclaim the eschatological solution of a final reign of love and justice, unfortunately not realizable in the tragedies of historical life.”<sup>302</sup>

Such candor—Gustafson himself does not shy away from a self description as a Christian stoic<sup>303</sup>—is, I would argue, the consequence of inevitable tensions Gustafson surfaces by holding the descriptive and normative tasks of theology so closely together. The easy way out is to limit theological discourse to one or the other. But given the commitments outlined above in the analysis of *Intersections* and *An Examined Faith*, this is clearly not possible. Theo-ethical reflection is accountable to all modes of human inquiry. Theo-ethical reflection takes place in the intersections, and theologians are not only informed but also formed by the social scientific and natural scientific traffic flowing in these intersections.

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<sup>301</sup> Ibid., 104-105.

<sup>302</sup> Ibid., 105.

<sup>303</sup> Ibid., 106.

But these commitments, I submit, have had the practical effect of stifling some of the impetus for widening the circle of participating theologians that might be possible in Gustafson. This happens in two ways. First, few persons outside of academia or other expert arenas (e.g., thinktanks, policymaking bodies) stand in intersections defined by such a high level of analytical rigor. Academic theologians, then, are positioned to participate in conversations about the latest advances in knowledge about what contributes to or limits human flourishing in ways that others engaged in theo-ethical reflection may not have access to. A second way in which the participant theologian has been circumscribed in Gustafson can be seen in his rejection on theocentric grounds of normative liberationist claims about God siding with the oppressed. That is, his rejection on theological grounds is read as a rejection of both the ethical commitments and methodological approaches such claims legitimate. Yet, the incipient theology articulated by Cochrane above suggests other forms of the participant theologian are rendered visible *because* of the ethical commitments and methodological approaches liberation theology demands.

Kevin O'Brien argues convincingly, along these same lines, that Gustafson's theocentric perspective and liberation perspectives are not mutually exclusive. He proposes an alternative reading in his use of Gustafson to develop an ethics of biodiversity. O'Brien distinguishes between the substantive claims of theological naturalism and a more open-ended "methodological naturalism" in Gustafson's work: "Methodological naturalism is based on the idea that our theological and ethical commitments emerge from our understanding of the world and its processes."<sup>304</sup> For

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<sup>304</sup> Kevin O'Brien, "An Ethics of Biodiversity: Moral Theology, Ecology, and Environmentalism" (PhD dissertation, Emory University, 2006), 34

O'Brien, it is possible to embrace Gustafson's methodological naturalism without coming to the same theological conclusions.

In particular, O'Brien worries that Gustafson's "decentering of human beings" in his dismissal of liberation theology on theocentric, if not social, anthropological, or pastoral, grounds, "can have the unintended consequence of distracting us from the very real needs of human beings, particularly in oppressed and struggling communities."<sup>305</sup>

O'Brien proposes a "naturalistic stance in solidarity with liberation" as his way of recognizing that the theological disagreement between Gustafson and representatives of liberation theology such as Leonardo Boff do not preclude ethical agreement:

Naturalism leaves plenty of room for evidence that human individuals and communities are uplifted by a commitment to the 'the least among us,' and therefore does not by any means contradict a commitment to oppose oppression in human communities. Gustafson therefore fundamentally disagrees with Leonardo Boff insofar as the latter claims that God takes the side of the poor and oppressed, but they agree that it is the duty of Christians to do so.<sup>306</sup>

The difference is in what legitimates this duty. For Boff and other liberation theologians, it is a theo-ontological claim about the already-not-yet realization of an eschatological hope that leads to solidarity with the least privileged. For Gustafson, it is recognition of the powers that bear down on *all* of us—though in varying degree and kind—that evokes a sense of shared dependence and mutual obligation in our human relations.

O'Brien's endorsement of methodological naturalism serves as a reminder of just how profound Gustafson's sense of moral ambiguity is, and how this sense gives rise to

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<sup>305</sup> Ibid., 76.

<sup>306</sup> Ibid., 88.

an equally profound commitment to epistemic humility in making substantive theological claims.<sup>307</sup> Human finitude always compromises the ability to understand the “world and its processes,” and, according to the logic of naturalism—theological or methodological—works to consistently undermine the certitude with which theo-ethical statements are made. (Perhaps in this way, Gustafson is not so different than the “ordinary believers” Cochrane imagines engaging in the “task of theology in a provisional way, gathering an as yet untested wisdom about the meaning of their faith.”)<sup>308</sup>

And this, I take to be the crux of the matter for Gustafson. The defiant “God will be God!” that concludes *An Examined Faith* is in defiance of those who claim to know the “Almighty’s purposes.” The “self-assured religious huckersterism of American Protestant television preachers” and the righteous certitude of proclaiming God’s preference for the poor are equally indictable on this point, according to Gustafson.<sup>309</sup> By holding Christians accountable in their theo-ethical reflection to the “social ambiguities and tragedies inherent in the movements of history and nature that are beyond human control,” Gustafson resists, on the one hand, the temptation to provide theological cover for individual and institutional sins as scapegoats, and on the other hand, an overly optimistic theological account of human agency. In so doing, he trades in the “assurances of cosmic hope” for “attention to the small possibilities for tiny improvements in the

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<sup>307</sup> In reflecting on what he believes to be a kind of Christian stoicism in Lincoln’s second inaugural address, Gustafson rehearses the relationship between his profound sense of moral ambiguity and the epistemic humility it requires when making theological claims: “The ambiguities of every aspect of actions and events are never eradicated by hope, or even by commitments to the times and places when significantly better conditions are possible because of a Christian preference for the poor.” Gustafson, *An Examined Faith: The Grace of Self-Doubt*, 109.

<sup>308</sup> Cochrane, *Circles of Dignity: Community Wisdom and Theological Reflection*, 22.

<sup>309</sup> Gustafson, *An Examined Faith: The Grace of Self-Doubt*, 107.

complexities of individual, interpersonal, and public life.”<sup>310</sup> And he resigns himself to the only theological claim he believes capable of avoiding the anthropocentrism in both projectionist and neoorthodox theologies. That is, his claim, with Lincoln, that the “Almighty has his [*sic*] own purposes” pushes back against both the desire to reconcile the “harsh but unavoidable outcomes” of life with who or what humans prefer God to be as well as attempts to reveal, in a Barthian key, God’s intention for human being.

I do not read this defiance and resignation as an indication that Gustafson endorses disengagement borne of cultured despair or that it serves to distract from the actual suffering of marginalized persons and communities—though I can certainly sympathize with those who might wish for a clearer articulation of Gustafson’s motivation for staying engaged and responsive to the tragedy and suffering he is so quick to remind readers is a defining part of a God-created world. While O’Brien worries about the unintended consequences for marginalized communities of de-centering humans in Gustafson’s theological naturalism, I contend, on the contrary, that Gustafson’s theocentric perspective effectively renders center and marginality *theologically* inconsequential but *ethically* significant. That is, Gustafson’s refusal to place God on the side of any particular group or subset of the human population has the effect of *sharpening* the focus of the ethical lens on how *human responses* to the powers that bear down and sustain us have resulted in marginalization and instability. In this way, it is possible to read Gustafson’s theocentrism as preserving for *all* persons a “strong hint of some modest hope for a better life,”<sup>311</sup> the hint emerging more appropriately out of the

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<sup>310</sup> Ibid., 107.

<sup>311</sup> Ibid., 106.

actual potential of human moral relations rather than the potential actualization of theological visions.

The hope, however modest, is present because the theological statement God will be God and the anthropological statement that humans will be humans are not corollaries. Humans are finite and mutable, even if the starkness of Gustafson's vision of human progress and pessimism about social change suggests an incremental mutability. Human purposes, at least as manifest in individual actions and social structures are knowable to a greater extent than that of the Almighty. Because of this, participant theologians, informed by diverse modes of inquiry similarly animated by the quest to know something about human being, are driven not to fatalism, but rather to the task of discerning responsibly the "modest newness of life" present within the "historical crucifixions" that affect "conditions of possibility for change."<sup>312</sup>

Gustafson, in the end, stops short of articulating the specific directions in which processes of theo-ethical reflection might expand the information received at the intersections of human flourishing—phenomena constitutive of global health. Without this direction, and in the absence of examples or evidence of participant theologians, global health leaders are likely to dismiss, or more likely, ignore, such a theoretical defense of the value of theo-ethical reflection as a religious health asset, much less a vital one. The argument above, though, is a necessary first step.

The first part of the twofold task begun in this chapter was to make more explicit *to Christian theologians and ethicists* the theoretical and methodological limits and possibilities for their engagement with and expansion of the global health conversation. If

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<sup>312</sup> Ibid., 108.



Gustafson's proposal for theo-ethical participation in interdisciplinary contexts is to be seen as a viable model for Christian theologians and ethicists engaged with global health, it is necessary to respond to and anticipate theological critiques from liberationist perspectives, as I have tried to do briefly above. Such a response is all the more important given both the liberation frame, itself, employed by the majority of Christian ethicists and moral theologians responding to the HIV pandemic, and the role this frame has played in exposing the affinities between the social determinants of health and the social ethical concerns of Christian theologians and ethicists—what I argued in the previous chapter was a key factor in legitimating the turn of global health to religious entities as allies (see chapter three).

But Gustafson's proposal for theo-ethical participation pushes for something more than recognition of these affinities. It presses an acknowledgment of the *process* of theo-ethical reflection as compelling in and of itself on grounds other than the perceived consonance of global health commitments and *outcomes* of selective theo-ethical commitments. In the language of this dissertation, it shows the process of theo-ethical reflection to be a potential health asset to global health leaders because of the theo-ethicist's careful attention to the locations and conditions in which the "modest newness of life" can flourish. In this way theo-ethical reflection done by participant theologians is both responsive to the existing conditions and responsible to "the insight and wisdom of the Christian community's long historical reflection about the chief ends of [humans]."<sup>313</sup> In a word, theo-ethical reflection is generative.

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<sup>313</sup> "The Theologian as Prophet, Preserver, or Participant," 84.

Two concerns militate against using Gustafson's concept of participant theologian, alone, to fulfill the second part of the twofold task begun in this chapter. If the second, admittedly more difficult, task is to persuade global health leaders to take seriously the persistence of the theological in the turn to religion, and by turns, recognize theo-ethical reflection as a vital religious health asset, then something more than a resolution of theological debates internal to Christianity (e.g., O'Brien's "naturalistic stance in solidarity with liberation" or my own argument above) is needed to render the participant theologian visible to global health leaders. Both concerns are present, though not thoroughly addressed, in the analysis of Gustafson above. The first concern has to do with the insularity of the conversations in which he is involved. The second, related, concern has to do with to theoretical abstractness of his argument.

To mitigate these concerns, I turn in the next section of this chapter to Lisa Sowle Cahill, a Catholic ethicist who has shown that feminist, liberationist ethics carried out in a Gustafsonian key is not only possible, but also necessary for correcting two trends in Western bioethics: the thinning of theologically resonant language and the hyper-medicalization (and marketization) of health.<sup>314</sup> Cahill's feminist-liberationist inflected participatory theological bioethic, I argue, usefully expands and deepens, rather than undermines, Gustafson's notion of the participant theologian. The expansion comes from paying attention to the actual processes and impact of theo-ethical reflection taking place in global health intersections beyond the university quadrangle, widening the circle of who counts as a participant theologian and the range of sources recognizable as essential for understanding human being and human flourishing. The deepening comes from

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<sup>314</sup> Lisa Sowle Cahill, "James M. Gustafson and Catholic Theological Ethics," *Journal of Moral Theology* 1, no. 1 (2012). For the respect her work on the HIV pandemic as a social justice issue has engendered among her peers, see Keenan, "Four of the Tasks for Theological Ethics in a Time of HIV/AIDS."

Cahill's willingness to name explicitly the goal of theo-ethical participatory discourse as "the creation of connective practices among interlocutors in order that shared social practices may be transformed in light of religiously inspired... visions and values."<sup>315</sup> In the conclusion, I return to this more expansive, deeper concept of participant theologian as (1) the key conceptual bridge for recognizing theo-ethical reflection as a vital religious health asset and (2) a catalyst for reimagining the intersection of religion and global health as a transdisciplinary space animated by theologians and global health actors committed to co-literacy in, and not merely translation between, one another's epistemic communities.<sup>316</sup>

## **VI. Feminist, Liberationist Christian Ethics in a Gustafsonian Key: Lisa Sowle Cahill and Participatory Theological Bioethics**

In a recent summary of the Protestant Gustafson's significant impact on more than a generation of moral theologians and Catholic ethicists (the latter term, itself, due in part to his influence), Lisa Sowle Cahill writes

Many diverge from both their mentor's vision of the Almighty, and from his estimate of the prospects for social change. Nevertheless, Catholics true to Gustafson's insistence that theological-ethical claims be backed by good reasons, not just by theologies detached from the real conditions of life, take seriously the

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<sup>315</sup> Lisa Sowle Cahill, *Theological Bioethics: Participation, Justice, Change*, ed. James F. Keenan, Moral Traditions Series (Washington, D.C.: Georgetown University Press, 2005), 38.

<sup>316</sup> For an extended discussion of the problems of translation between religion and public health, see James R. Cochrane, "The Language That Difference Makes: Translating Religion and Health," *Practical Matters*, no. 4 (2011), <http://www.practicalmattersjournal.org>.

problems posed when “the facts” are juxtaposed to Christian expectations of human sanctification and political transformation.<sup>317</sup>

As a Gustafson student, her own work reflects this sympathetic, yet critical engagement with his central themes.

Her recent proposal for a participatory theological bioethic can be seen most readily as taking up the challenge Gustafson’s low “estimate of the prospects for social change” poses for ethicists like Cahill who reimagine the *telos* of theological bioethics as the co-creation of a “global social network” mobilized to overcome existing disparities in health and inequities in healthcare.<sup>318</sup> For her, the theo-ethicist as participant operates in a decidedly activist mode to “strengthen already existing practices ‘on the ground’ and broaden and deepen the vocabulary of solidarity and care of neighbor.”<sup>319</sup> Given the concerns Gustafson raises about the *theological* warrant often given for this type of engagement with marginalized communities, it is important to note that from the outset Cahill carefully locates her warrant not in an explicitly theological claim about God’s preferences, but in the preferential option for the poor that emanates from “the New Testament depiction of Jesus’ healing ministry to society’s outcast.”<sup>320</sup> It is a moral warrant for Christian communities conceived of as communities of moral discernment.<sup>321</sup>

From this moral warrant, Cahill builds a case for a twenty-first century bioethic that “must in every case be social ethics, not just as theory but as engagement.”<sup>322</sup> What this means, briefly, is that bioethics must take as its primary orientation the questions of

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<sup>317</sup> Cahill, "James M. Gustafson and Catholic Theological Ethics," 115.

<sup>318</sup> *Theological Bioethics*, 3.

<sup>319</sup> *Ibid.*, 24.

<sup>320</sup> *Ibid.*, 1.

<sup>321</sup> For Gustafson’s understanding of the Christian community as a community of moral discernment, see Gustafson, "Moral Discernment in Christian Life," 25-40.

<sup>322</sup> Cahill, *Theological Bioethics*, 2.

distributive justice animating conversations about the social determinants of health—economically and politically determined access to health care resources, environmentally and socially determined burdens of disease, etc. Cahill’s endorsement and promotion of a health care reform agenda “guided by the priority of the preferential option for the poor within an ethics of the common good”<sup>323</sup> aligns well with the agenda and logic of global health institutions, even as it challenges the narrow focus of Western bioethics. For example, the community and population focus of global health is more amenable to conceptions of the common good than the clinical setting out of which much of the Western bioethical canon has emerged—a canon that influenced and was influenced by Gustafson. Similarly, the rebranding of international health as global health has come about in part because of the simultaneous recognition, on the one hand, of an expansive notion of the global community that more accurately depicts the globalized pathways along which disease and disease response travel, and, on the other hand, that vast areas of this global community have limited access to health care resources and share disproportionately the burden of disease.<sup>324</sup> In this sense, a preferential option for those at the margins of health care systems is built into the architecture of a global health system as an epidemiological as much as an ethical mandate.

Against this backdrop, *theological* bioethics has an important role to play, according to Cahill. She argues that theological bioethics contributes both to the analysis and amelioration of socially determined health problems. With regards to the former, she exhorts theological bioethicists to *bring to* the public and political bioethical square, not

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<sup>323</sup> Ibid., 252.

<sup>324</sup> For a historical discussion of the role of the WHO in mainstreaming the term “global health” as a pragmatic survival strategy, see Theodore M. Brown, Marcos Cueto, and Elizabeth Fee, “The World Health Organization and the Transition From “International” To “Global” Public Health,” *American Journal of Public Health* 96, no. 1 (2006).

bracket, the thick narratives from their confessional, traditioned reflection on the ends of human being and the dimensions of human flourishing:

Because they deal in the elemental human experiences of birth, life, death, and suffering, the biomedical arts provide an opportunity for larger questions of meaning and even transcendence. Religious themes and imagery can be helpful in articulating these concerns and addressing them in an imaginative, provocative, and perhaps ultimately transformative way. Religious symbolism may be grounded in particular communities and their experiences of God and community, but perhaps it can also mediate a sensibility of transcendence and ultimacy that is achingly latent in the ethical conflicts, tragedies, and triumphs that are unavoidable in biomedicine.<sup>325</sup>

Such exhortation eloquently captures Gustafson's emphasis on the role of theology in "expanding the received information" at the intersections of interdisciplinary traffic. The analytical power and direction of the expansion emanates, Cahill believes, from the capacity of theological bioethicists to surface, name, or otherwise remind health care professionals and bioethicists of the existential dimension that is "achingly latent" in the modern practice of the biomedical *arts*, yet achingly present in persons affected by illness.

That this analytical power has become largely unrecognizable in bioethics is, for Cahill, symptomatic of the general trajectory in bioethics away from substantive arguments between persons formed in communities with distinctive and consequential anthropologies, ecclesiologies, etc., and towards the formal rationality and procedural

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<sup>325</sup> Cahill, *Theological Bioethics*, 42.

logics regnant in science, the market, and liberalism.<sup>326</sup> As a result of this trajectory, or thinning of bioethics, Cahill argues theology has “lost its power to identify, expose, and challenge social problems stemming from the misuse of medicine and technology.”<sup>327</sup> Reclaiming this power requires first exposing the fallacy that absent theological discourse, the bioethical public sphere operates value-neutral. That is, part of what hampers theological ethicists is the false opposition between substantive, normative, epistemically tribalistic theological discourse and the purportedly formal, descriptive, epistemically universal scientific or policy discourse about health and human flourishing. By calling out science, technology, the market, and liberal political theories as “value traditions,” complete with internally contested moral arguments about the good and goods these traditions promote, Cahill seeks to legitimate the inclusion of theological bioethicists as spokespersons for other, equally valid, value traditions.

At stake, here, is, in part, the continuing relevance of the prophetic mode of theological discourse. The capacity of theological bioethicists to engage meaningfully, and with a degree of political efficacy, in critiquing the injustice of existing health systems hinges, for Cahill, on the recovery of a “religiously distinctive prophetic voice”

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<sup>326</sup> This critical reading of the history of bioethics can be read as a microcosm of the broader debates taking place at the time in religious studies about the appropriate role of religion in the public sphere. These debates continue to set the agenda for many high-profile theologians, ethicists, and philosophers. For Cahill’s historical review of how these debates affect bioethics, see chapter one, “Theologians and Bioethics: Some History and a Proposal,” in *Ibid.*, 13-23. For examples of the wider conversation in which this history is situated, see Habermas, “Religion in the Public Sphere.”; Stout, *Democracy and Tradition*. James Childress offers a counter argument that calls into question Cahill’s narrative of decline regarding the participation of religious ethicists in policy debates. For Childress this narrative is based on a myth that overstates the degree of influence religious ethicists had on the field of bioethics. That is, for Childress, there is no decline in influence because there never was a substantive influence. My dissertation only indirectly addresses this tension between Childress and Cahill’s historical account of the field of bioethics. I say indirectly because the historical evidence marshaled in the case study of the Christian Medical Commission suggests that in global health, at least, theologians and ethicists did at one time have a significant impact. See James F. Childress, “Religion, Theology, and Bioethics,” in *The Nature and Prospects of Bioethics: Interdisciplinary Perspectives*, ed. Frank G. Miller, John C. Fletcher, and James M. Humber (Totowa, New Jersey: Humana Press, 2003).

<sup>327</sup> Cahill, *Theological Bioethics*, 18.

that can “enter into policy debates as an energetic adversary of the liberal consensus.”<sup>328</sup> Despite the pugilistic undertone, this is not a retreat into confessional corners out of which theologians come out swinging; it does suggest, however, that pulling punches, that is, always translating theological convictions into nontheological language, has had a detrimental effect, undermining the ability of theological bioethicists to make “common cause” and negotiate a “common language with all who are similarly committed to health care justice.”<sup>329</sup> Common cause and common language are particular instantiations of an ethic of the common good that is continually being negotiated, as opposed to a common good constituted by universal principles waiting to be discovered once and for all.

Theological bioethicists should, Cahill argues, enter into this negotiation with others as full participants, committed to the dialogical nature of the common good, where “engagement rather than completion fulfills the meaning of the common good, as a network of historical relationships in which everyone continually participates in the practices relevant to their well-being.”<sup>330</sup> The common good according to this line of argument may never be more than a temporary consensus animated by a provisional set of “middle axioms,” a concept she exhumes from mid-twentieth century Protestant ecumenical debates.<sup>331</sup> Still, such a consensus, she believes, is a marked improvement

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<sup>328</sup> Ibid., 18.

<sup>329</sup> Ibid., 18.

<sup>330</sup> Ibid., 254.

<sup>331</sup> The concept, despite being much maligned in the mid-twentieth century, has experienced something of a renaissance in recent years, notably among theologians and Christian ethicists whose articulation of the constructive role of religion in the public sphere emerges from their practical involvement in public policy debates and civil society movements. See, for example, Charles Villa-Vicencio, *A Theology of Reconstruction: Nation-Building and Human Rights* (Cambridge: Cambridge University Press, 1992). These recent recoveries are consistent with earlier attempts to highlight the potential value of the concept outside of the intramural ecumenical debates in which it was first coined. See John C. Bennett, *Christian Ethics and Social Policy* (New York: Scribner and Sons, 1956). Bennett conceives middle axioms as “more concrete than a universal ethical principle and less specific than a program that includes legislation and political strategy,” 77. For the original articulation of middle axioms by Oldham, see J. H. Oldham and



over the current state of affairs, since middle axioms emerge inductively from the *interaction* among the rich teleological narratives, symbols, and practices of diverse value traditions—faith-based or otherwise—and the pressing social problems of the day.

Cahill’s summary of two different interpretations of middle axioms helps to clarify this last point:

While it is generally agreed that middle axioms are supposed to negotiate the distance between Christian ideals and social realities, some have understood this to occur by means of deduction from more general to more concrete judgments; others, including Oldham, see middle axioms as indicating more a process of interaction between Christian values and social problems, with the church endorsing positions that seem the best available at the time.<sup>332</sup>

Cahill favors the latter interpretation. Middle axioms, for her, thus serve as a “theoretical niche” in which theological bioethicists can express the process of negotiating “among Christian values, social realities, local contexts, and [the] global interconnectedness of societies and faith traditions.”<sup>333</sup> In a fully participatory public sphere, middle axioms help to legitimate and provide direction for cooperative social action across diverse value traditions.

Cahill’s recovery of middle axioms provides a clue to her understanding of both the underappreciated analytical power of theological bioethics and its potential to effect social transformation. Middle axioms suggest one important way theological bioethicists can re-enter the public debates as theological bioethicists. Theological bioethicists both

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W.A. Visser’t Hooft, *Church, Community, and State*, vol. 1, *The Church and Its Function in Society* (London: George Allen and Unwin, 1937)

<sup>332</sup> Cahill, *Theological Bioethics*, 46.

<sup>333</sup> *Ibid.*, 47.

contribute to the generation of middle axioms and facilitate their implementation in particular programs that address social injustice. In one of her boldest statements, and one that suggests the contours of her praxiological divergence from Gustafson, she claims: “Theological bioethics can *alleviate* the social conditions that create these problems.”<sup>334</sup> How does theological bioethics alleviate social conditions that impact health? It is one thing to highlight the role theological bioethics can play in “widening the moral imaginations” represented in the public sphere.<sup>335</sup> It is quite another to say that theological bioethics can *alleviate* unjust social conditions.

In this move, Cahill is not merely calling attention to moral discourse as a form of action. She is proposing a new mode of moral discourse: participatory discourse.

Participatory discourse builds on the four modes of moral discourse Gustafson identified in Christian theo-ethical reflection on social problems, including biomedicine.

Gustafson’s four modes are the modes in which theo-ethicist might participate, that is, the modes are those of a participant theologian. So it is important to understand why they do not constitute a participatory mode in the way Cahill intends. To understand the distinctiveness of Cahill’s fifth mode and how it supports her bold claim above, it is necessary, first, to provide an overview of Gustafson’s four modes.<sup>336</sup>

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<sup>334</sup> Ibid., 5. Italics not in the original.

<sup>335</sup> Ibid., 2.

<sup>336</sup> Gustafson explicated the four modes of moral discourse in three places. The first was the Stob Lectures at Calvin College, the second was in a philosophy and medicine journal, and the third a section in *Intersections*. The overview here draws primarily on the second location for two reasons: 1) the Stob Lectures are directed primarily at a Christian audience whereas the philosophy and medicine journal addresses the implications of these forms for a broader audience and 2) the *Journal of Medicine and Philosophy* article complements the theological focus in Cahill’s own summary in which she draws exclusively on the Stob Lectures and *Intersections*. See Gustafson, “Moral Discourse About Medicine.” For a published version of the Stob Lectures, see James M. Gustafson, *Varieties of Moral Discourse: Prophetic, Narrative, Ethical, and Policy* (Calvin College and Seminary, 1988).

The four discourses Gustafson identifies in medicine are ethical, prophetic, narrative, and policy. Each discourse, he argues, “is prompted... [by] a sense that something is awry.” Though each discourse defaults to “data, information, sources of insight and concepts that are judged to be appropriate to the location or arena in which some wrong is intuited or perceived.”<sup>337</sup> As is common in Gustafson, the four modes are identified for analytical purposes, with the full recognition that the different modes interpenetrate one another. The main value of the analysis is to provide clarification on the interdependent relationship between where one locates a moral problem and the type of discourse employed for responding to it.

Ethical discourse in medicine draws on moral philosophy and theology to “decide how one ought to act in a particular circumstances” (129). Concepts and typical conflicts in moral philosophy and theology frame the problem, for example, as a conflict between rights and duties or a clarification of the agency and autonomy of a patient. The discourse lends itself to a casuistic approach in which the principles from moral philosophy or theology are applied to a specific case and compared to other similar cases. The range of actions possible are limited by the empirical data received from the medical sciences, primarily. The goal is to mitigate the risk of engaging in relatively clear forms of unethical behavior.

Gustafson breaks the second form of discourse, prophetic, into two types.<sup>338</sup> The first is indictment. Indictment is most readily apparent in the prophetic books of the Hebrew scriptures like Jeremiah (hence, jeremiad). The purpose of prophetic discourse as indictment is to expose evil in existing system. Prophetic indictment does not require

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<sup>337</sup> Gustafson, "Moral Discourse About Medicine," 127. All parenthetical page references in this section refer to “Moral Discourse About Medicine.”

<sup>338</sup> For his discussion of the prophetic, see especially *Ibid.*, 130-136

analytically precise language, but relies instead on metaphor to evoke an impassioned response from its hearers. The second type of prophetic discourse is utopian.

Characterized by visions and eschatological appeals, the utopian type offers a critique of the current system through its articulation of the contours of a better future. The utopian, for example, imagines a world without cancer and marshals the rhetoric of crusade to inspire those who hear it to action in co-creating that world. Such rhetoric is not constrained by what is realistic in the moment, for example, the limits suggested by natural science; rather, it evokes a sense of hope based on what might be possible, limited only by our imagination. The prophetic mode often makes use of Gustafson's third type, narrative, in order to give form to this imagination.

Narrative discourse emerges from our membership in moral communities whose "outlooks, values, and visions" are "shaped by their stories," the formative narratives that give clues to what it means to be a virtuous person (137). Like the prophetic, narrative discourse locates moral choices in a broader social context, yet "stay[s] close to experience" (139). Whereas Gustafson sees the capacity to abstract from experience as the primary analytical power of ethical discourse, staying close to experience and asking questions about the larger economic, social, or political context of moral choices, for example, in clinical medicine, allows the storyteller to retain "affective and descriptive overtones" deemed important to the interpretation of any given case (137).

Finally, Gustafson discusses policy discourse. Policy discourse, like the political arena, is defined by what is possible. Of particular importance in this form of discourse is the institutional location of the policymaker. Policy discourse shows the complex structures of accountability that constrain institutional leaders or others who bear

responsibility for demonstrating the effectiveness and efficiency of a particular choice. Ethical discourse about what ought to be can be retained, but in the end, policy discourse expresses how “enabling and limiting conditions ground possible courses of action” (141). That is, unlike the other three discourses, policy discourse, prioritizes the question of “what is” over the question of “what ought to be” — “what resources are available or can be accumulated? What proper interests compete for these resources? What personnel and institutional arrangements are necessary?” (140).

As noted at the outset, Gustafson argues that in and of itself, no single discourse is sufficient. The abstractions and preconceived categories of ethical discourse fail to account for the larger social context in which medical moral decisions are made and, by emphasizing precision and rationality, give the false impression of certitude or moral decision without remainder.<sup>339</sup> Prophetic discourse, while evocative in its critical rhetoric, gives little actual guidance in how to proceed. Narrative discourse begs the question of which narratives should be employed and on what grounds. And, finally, policy discourse focused only on what is, risks reifying the status quo, “degenerat[ing] into satisfaction with the merely possible, with assumed values and procedures, with the domination of the economic or institutional considerations” (141).

Viewed more narrowly as modes of theological moral discourse, the four modes suggest a contrast between what Cahill calls “neutral language in public and strong theological language in community.”<sup>340</sup> Policy and to some extent ethical discourse trade

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<sup>339</sup> In other writings, Gustafson eloquently captures the inhumanity of such certitude in his description of ethical decisions as a “mournful act.” He is critical of moral philosophers for whom “there are not genuine moral dilemmas; [for whom] fully good reasons can be given for every particular choice. There is, in such views, never an occasion for remorse when the well-reasoned choice is made.” *Ethics from a Theocentric Perspective Vol. 1, Theology and Ethics*, 19.

<sup>340</sup> Cahill, *Theological Bioethics*, 37.

largely in the former, while prophetic and narrative discourse depend heavily on the latter. The implication she sees in this contrast is that theologians operating in policy and ethical modes bear the burden of translation in order to be heard in public, whereas the prophetic and narrative modes express theological speech as theological speech, though its intelligibility is limited to the particular community from which it emerges.

She, true to the interpenetration of these modes Gustafson emphasizes, rejects this implication: “If a ‘public’ theological participant suggests a symbol, value, or principle from his or her specific tradition, the suggestion may resonate with aspects of the experiences and traditions of other participants, either distinctive or common, leading to agreement on certain values, bonds, practices, and decisions, even in the public realm.”<sup>341</sup> In this way, theological language acts to “tip sensibilities in a certain direction,” hopefully towards a “better understanding of the human condition and more humane, just, and beneficent practices and policies of biomedicine.”<sup>342</sup> For Cahill, the power of this theological language to impact others in a given discursive space is not only in the language itself, but also in the practices of engagement that theological language intimates. The emphasis in Gustafson’s four modes on “concepts, principles, stories, and statements,”<sup>343</sup> she argues, does not sufficiently attend to the relationship between theological language and practices of engagement, nor do they point much beyond the discursive activity of expanding the received information or widening the moral imaginations.<sup>344</sup> That is, the four discursive modes do not seem to legitimate Cahill’s bold

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<sup>341</sup> Ibid., 38.

<sup>342</sup> Ibid., 38.

<sup>343</sup> Ibid., 38.

<sup>344</sup> Cahill explains this insufficiency: “Biomedicine, ethics, policy, religion and theology engage one another in the public sphere in many more and deeper ways than the display of rational, verbal argumentation by individual spokespersons. Practices, institutions, and issue-oriented activism also make

claim that theological bioethics can *alleviate* the social conditions that contribute to human suffering. For this reason, Cahill proposes a fifth mode of moral discourse: participatory discourse.<sup>345</sup>

## VII. Do, Don't Just Say, Something Theological

Theological ethics as participatory discourse privileges dispositions toward connectivity and relationship-building, whereas the other modes of discourse tend to promote either dispositions of over-against and set-apartness or generic equivalencies among theologians engaged in public bioethical debates. As a result, Cahill argues, participatory theological bioethics must seek not only to advocate for, but also to “instantiate” connective practices that can nourish and sustain commitments to a more just health care system.<sup>346</sup> In the public sphere, this instantiation takes place when “religious traditions and theologies join with other communities of meaning and value,” connecting the processes and outcomes of theo-ethical reflection to “the practices and

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up the dialectical common space where bioethics is negotiated as theory, policy, and implementation." Ibid., 34.

<sup>345</sup> The policy mode may come closest to alleviating the social conditions that lead to suffering, since policies can have a direct impact on access to goods, protecting rights, etc. And certainly Gustafson might want to remind Cahill of his work with Standard Oil. The policy adopted by Standard Oil reflected a concern for fairness over against efficiency. As a result of this, jobs were saved. (The extent to which theo-ethical reflection as opposed to social ethical analysis was involved in this is unclear from Gustafson's telling. Though perhaps he would not have drawn too bright of a line between the two in the 1950s.) See footnote above for Standard Oil anecdote. But, in the end, Gustafson's discussion of the policy discourse does not, by itself, reflect the level of engagement exhibited in the Standard Oil study, and there is no indication that this policy discourse draws on the insights from the grassroots activism Cahill wants theological bioethicists to engage. A parallel illustration from my own experience may be useful for clarification here. As a delegate to the National Council of Churches in 2000, I was involved in conversations about a new initiative identified as the “Decade to Overcome Poverty.” The idea going forward was for member churches to facilitate conversations about U.S. poverty policies, but no effort was made to include persons living in poverty in the conversations. I worry, with Cahill, that without the complement of a more robust participatory mode of discourse, a focus on policy discourse in global health is susceptible to the same narrow understanding of who should be at the table.

<sup>346</sup> Cahill, *Theological Bioethics*, 12.

movements in civil society that can have a subversive or revolutionary impact on liberalism, science, and the market.”<sup>347</sup> Importantly, though, these movements are not sought after the agenda has been fully set. Instantiating coalitions of convenience is not the goal; rather, participating in “real-world coalitions around shared purposes and goals” is conceived of dialogically such that theological bioethics affects and is affected by the act of participating in the real-world coalition.<sup>348</sup>

Unlike the other four discourses, the persuasiveness of participatory discourse is not in its rational cohesion (ethical), evocation of a better world (prophetic), articulation of a formative story (narrative), nor its effectiveness within an existing set of constraints (policy)—though it includes all of these to some degree. The persuasiveness of theology in the participatory mode is located instead in its “power to allude to or induce a shared sphere of behavior, oriented by shared concerns and goals, and its power to constitute relations of empathy and interdependence among the ‘arguers.’”<sup>349</sup> Recalling Gustafson’s image of intersection, Cahill’s participatory theological bioethicist is not tasked so much with directing the traffic as with helping to create a round-about, a new pattern of interaction, or traffic flow, that imagines the right-of-way among interlocutors in less adversarial terms.

Importantly, for Cahill, the location of this round-about (my image, not hers) is not in the academic quadrangle or in the official corridors of power. The route to reclaiming a public role for theological bioethics is through participation in the local and

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<sup>347</sup> Ibid., 39.

<sup>348</sup> Ibid., 39.

<sup>349</sup> Ibid., 38.



global social movements and networks calling for greater justice in health care.<sup>350</sup> By participating in those movements, she believes theological bioethicists can re-discover both the courage to invoke religious symbols and language in public arenas and the deep resonance of theological speech with health care as one of the most fundamental dimensions of social justice. This rediscovery amplifies while simultaneously modifying the prophetic and narrative modes of discourse so that theology enters into public debates in a “provocative and critical, yet dialogical way.”<sup>351</sup>

This route to re-entering the public square helps to explain Cahill’s optimistic appraisal of the theologian’s ability to alleviate social conditions. By engaging directly in the movements and networks working to bring about greater justice in health care, theologians become scholars for social change in word and deed. As such, they begin to instantiate their hope for change in their own theo-ethical praxis, co-participating in the articulation of, advocacy for, and struggles to enact real-world alternatives to the status quo in health care systems.

The participant theologian emerging from Cahill is one who not only brings the distinctive language and symbols of religion and theology to the policy table or public debate, but one who also brings herself as an active, engaged participant in the struggle to bring about the changes mandated by her and her community’s theo-ethical language and symbols. This engagement, necessarily, places her in circles where the “truth and viability” of theo-ethical proposals are evaluated in light of their capacity to bring about

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<sup>350</sup> Cahill’s account of the loss of public influence of theological bioethicists is a narrative of decline that begins with the influential role of the first generation—Paul Ramsey, Richard McCormick, and Gustafson, as exemplars—and gradually gives way in the second generation to “a thin, secular, philosophical discourse that excludes and demeans theology and that is incapable of a truly prophetic or transforming contribution to health care, health policy, or research ethics.” *Ibid.*, 23.

<sup>351</sup> *Ibid.*, 43.

“transformative practices that join together with other movements in human solidarity, empower ‘the poor,’ and motivate the powerful to change.”<sup>352</sup> Rational argument and coherence remain important elements of this truth, but these can never be the only elements. To understand why not is to circle back to my original claim that Cahill extends and deepens Gustafson’s earlier concept of the participant theologian.

The intersections in which Gustafson’s theologians participate are not necessarily limited to interdisciplinary conversations among experts, though this is clearly the context for *An Examined Faith* and *Intersections*. Gustafson, himself, does not point to other locations in which his theoretical argument might find purchase, though he does acknowledge the limits of these “meta-approaches.”<sup>353</sup> Cahill, I contend, does exactly this. Recall from above that one of the hallmarks of Gustafson’s Catholic students, including Cahill, is a commitment to theo-ethical claims responsive to the “real conditions of life” and informed by “the facts.”<sup>354</sup> Gustafson focuses on the description of these real conditions of life within the specialized disciplines of the academy. But, clearly, scientific claims are not the only place where one might be confronted by the facts about human being and the conditions for human flourishing. Moreover, as Gustafson’s own analysis of the limits of the policy mode of discourse suggests, one of the most important reasons for engaging in multiple modes of moral discourse is to illumine truths about human being that are neither divorced absolutely from the empirical evidence, nor dependent solely on this evidence for their recognition as truth.

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<sup>352</sup> Ibid., 2.

<sup>353</sup> Gustafson, himself, seems to acknowledge as much in his brief critique of “meta-approaches” to conversations about disciplinary intersections. Meta-approaches that operate at high levels of abstraction too easily devolve into what he refers to as intellectual gridlock—“ideology versus ideology, or epistemological theories against each other”—avoiding “the more complex, fine-grained analysis and bypass[ing] both specific issues of contention and specific possibilities of complementarity.” Gustafson, *Intersections: Science, Theology, and Ethics*, 131 and 133, respectively.

<sup>354</sup> Cahill, “James M. Gustafson and Catholic Theological Ethics,” 115.

Cahill extends Gustafson by making explicit another context in which the truths about human being and human flourishing are being redescribed: civil society movements and activist networks for health care justice. Of course, neither context exists in isolation. Social movements are informed by academic advances, and, perhaps, less obviously, the reverse is true. The status of HIV as both a pandemic and social movement described throughout this dissertation shows this bi-directionality. Antiretroviral drug breakthroughs spur activism for greater access, even as activism for greater access reorients research agendas (and their funding sources) in multiple disciplines.

Cahill also deepens the concept of participant theologian by emphasizing its praxiological dimension. Presumably, a participant theologian in the Gustafson mold would be aware of the sociological and anthropological studies of social movements related to health care. Such studies would be a part of the traffic at the intersections. In this way, the theologian could be said to participate in the conversation and be informed by perspectives other than theology. But Cahill's feminist sensibilities militate against this type of discursive participation as sufficient. Her claim about the capacity of theological bioethics to alleviate unjust social conditions is predicated on a "theological bioethics [that] is not just about talk."<sup>355</sup> It is about *doing*, not just saying, something theological. Active involvement in the practices of these social movements gives rise to and qualifies the theo-ethical claims that are possible,<sup>356</sup> but it also serves to instantiate

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<sup>355</sup> *Theological Bioethics*, 2.

<sup>356</sup> Articulating the praxiological imperative in bioethics, Cahill writes "Activism and theory are interdependent, and this has implications for the way bioethics should be conceived theoretically today. Theological bioethics must incorporate the fact of mobilization around health care issues into bioethical theory and into a reconceptualization of the 'field' of bioethics and its 'public voice.'" *Ibid.*, 4.

the type of collaborative, participatory social action that she understands as essential to realizing a “more just and compassionate sharing of global health resources.”<sup>357</sup>

Cahill extends and deepens Gustafson’s participant theologian through her normative reconceptualization of what participation should look like in bioethics. By exhorting theological bioethicists to participate in collaborative social action, she suggests one way that participant theologians may be rendered more visible in public. With this increased visibility, I contend, Cahill’s participant theologian is better positioned to move between the multiple contexts in which the response to the HIV pandemic and other global health issues are negotiated. That is, theological bioethicists are not likely, in the near future, to gain a seat at the global health policy table on the merits of their theological arguments about human being. Rather, their presence at the global health policy table is much more likely to be legitimated on the basis of their active participation in social movements for global health justice.

## VIII. CONCLUSION

Gaining a seat is one thing, being heard is quite another. Thus, what I have tried to show in the first half of this chapter are some of the preconditions for being heard. Gustafson’s insistence on epistemic humility and the seriousness that he believes theology must take the descriptive insights from other disciplines serve the participant theologian well while at the global health table. In part, this is because it demonstrates competency in the empirical evidence so essential to global health programs, and, in part,

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<sup>357</sup> Ibid., 254.

this is because it acknowledges the very real institutional constraints within which global health leaders work (see policy discourse discussion above).

In the second part of this chapter, I have shown in the work of Cahill deepens and expands the concept of the participant theologian in ways that I believe strengthen the concept as a conceptual bridge between the empirical turn to religion as a health asset documented in the previous chapter and the larger claim in this dissertation that theo-ethical reflection is one of the most distinctive and vital religious health assets. To test the strength of this conceptual bridge, I turn in the next two chapters to two case studies.

The case studies show participant theologians in action and suggest their role in helping theo-ethical reflection to persist in interdisciplinary conversations oriented to particular problems on the ground. Without examples or evidence of participant theologians, global health leaders are unlikely to cross the conceptual bridge I have constructed in this chapter and recognize the value of theo-ethical reflection as a religious health asset, much less a vital one. How, global health leaders should legitimately ask, do processes of theo-ethical reflection better inform global health conversations about the patterns and processes of interdependence that constitute health and human flourishing?

The two case studies in the following chapters are intended to show what an answer to this question might look like, and in the process help complete the second part of the twofold task begun in this chapter: persuading global health leaders to take seriously the persistence of the theo-ethical in the turn to religion, and by turns, recognize theo-ethical reflection as a vital religious health asset. The contemporary case of an integrated HIV treatment program in South Africa and the historical case of the Christian Medical Commission each offer insights into how participant theologians have

contributed to nontheological ways of knowing about and acting in the world in the late twentieth and early twenty-first centuries. Both case studies show how theo-ethical reflection is affected by the advances made in global health and raise the possibility of theo-ethical reflection affecting global health policies and programs. In both cases, theo-ethical reflection is recognizable as a religious health asset, highlighting the possibility of an encounter between religion and global health that is characterized by mutual generativity.

## CHAPTER FIVE

### PARTICIPATORY THEO-ETHICAL REFLECTION IN AN HIV-INFECTED WORLD:

#### A CONTEMPORARY CASE STUDY OF THE MASANGANE INTEGRATED HIV TREATMENT PROGRAM

What emerges is a horrifying picture of a society that is being ruptured and buckled into an antithesis of the humane, just, and dignifying society millions struggled for and continue to strive toward.

Hein Marais, *Buckling: The Impact of AIDS in South Africa*<sup>358</sup>

What I can say is, ha, when you walk through that door you feel welcome and loved dearly. That to me shows [Masangane] is a church organization.

Masangane Client<sup>359</sup>

So by what we are doing at Masangane and the church we are in that mission of Jesus Christ; that we must come close to people, love each other and not segregate from each other just because one of us has a certain condition.

Masangane Client<sup>360</sup>

## I. INTRODUCTION

This chapter focuses on the Masangane AIDS Treatment Program, a faith-based integrated care program of the Moravian Church. Chapter five focuses on the Masangane AIDS Treatment Program as a contemporary case study of the process theo-ethical reflection in an organizational setting. The case study illustrates the multiple ways in which religious entities are health assets. By describing below the role of theo-ethical reflection in the activities of Masangane, I raise the possibility of theo-ethical reflection

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<sup>358</sup> Hein Marais, *Buckling: The Impact of AIDS in South Africa* as quoted in Thomas et al., “Let Us Embrace,” 8.

<sup>359</sup> *Ibid.*, 46.

<sup>360</sup> *Ibid.*, 46.

as an important health asset. In its geographical and historical locations as well as its evolution from an orphan care program to a treatment and advocacy program, Masangane reflects, refracts, and interacts with many of the global “forces, connections, and imaginations” affecting the global response to AIDS.<sup>361</sup> As such, the case study provides a unique lens through which to see the ongoing process of theo-ethical reflection in an HIV-infected world. Masangane’s theo-ethical framing of its work, articulated variously as a “theology seeking justice” and “theology of abundant life,” highlight, at the programmatic level, one way in which processes of theo-ethical reflection can be understood as a vital health asset. As such, the case study provides a unique lens through which to examine the role of theo-ethical reflection as a potential religious health asset in an HIV-infected world.

A close reading of the evolution of Masangane from a home-based and orphan care program to an integrated AIDS treatment program is intended to show how processes of theo-ethical reflection were affected by changes in the global health response to HIV, specifically with regards to the scientific *and* social advances made in the provision of antiretroviral treatment. In this way, the evolution of Masangane surfaces the value of both Gustafson’s call for theological ethicists to engage with the traffic coming from nontheological experts and Cahill’s exhortation to a participatory theological bioethic grounded in collaborative social action.

In the first section I provide a brief overview of the epidemiological context in which Masangane emerges. Masangane came to being in an area of the world with one of the highest HIV prevalence rates and in local communities that reflect and refract many

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<sup>361</sup> Michael Burawoy et al., eds., *Global Ethnography: Forces, Connections, and Imaginations in a Postmodern World* (Berkeley and Los Angeles: University of California, 2000).



of the broader social determinants of health that have complicated the response to HIV, including economically motivated labor migration, limited access to primary healthcare, and politically fraught attempts to address the lingering effects of Apartheid. The second section narrates the shift from a home-based and orphan care program to a treatment program, focusing on the influential role of Doctors without Borders in this shift. Finally, in the third section, I analyze the theo-ethical commitments that emerged as part of the framing and motivation for this shift.

## **II. Locating Masangane in an HIV-Infected World: Epidemiological and Socio-economic Contexts**

In its biennial report on the state of the AIDS epidemic in South Africa, “The Demographic Impact of HIV/AIDS in South Africa: National and Provincial Indicators for 2006,” the Actuarial Society of South Africa presents sobering evidence of the epidemic’s unabated assault on the peoples of South Africa.<sup>362</sup> Of the approximately 48 million people living in South Africa, 11% are infected with HIV (~ 5.4 million). An incomprehensible 71% of all deaths for persons 15-49 are due to AIDS and an estimated 1.8 million persons in South Africa have become victims of the pandemic.

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<sup>362</sup> Medical Research Council, *The Demographic Impact of HIV/AIDS in South Africa: National and Provincial Indicators for 2006*, (2003), <http://www.mrc.ac.za>. The report uses evidence from the Actuarial Society of South Africa’s 2003 AIDS and Demographic model to project epidemiological data for 2006. Though actual numbers and percentages may vary with the different methods used, the statistics below reflect a reasonably accurate estimate of prevalence and incidence rates in South Africa. For example, three recent reports by the Medical Research Council, the Actuarial Society of South Africa, and UNAIDS/WHO estimate the number of deaths per year due to HIV as 336,000, 345,640, and 350,000, respectively. A variety of sources offer HIV statistics, each employing different methods including modeling, household surveys, antenatal clinic surveys, and morbidity reports. For a useful discussion of several recent statistical reports, the methods used, and the limitations of each, see “South Africa HIV & AIDS Statistics,” Avert, <http://www.avert.org/south-africa-HIV-AIDS-statistics.htm>.

Despite international attention and signs of a shift away from the controversial AIDS policies of the post-Apartheid governments,<sup>363</sup> incidence rates (i.e., the number of new infections each year) continue to overwhelm a health system suffering from staff shortages, drug supply disruptions, and emerging threats from drug-resistant tuberculosis. Even if the 1400 new infections each day could be prevented, the ARV rollout and demand for universal access to treatment will likely keep prevalence rates (i.e., the number of persons in a given population at one time infected with HIV) high for the foreseeable future.<sup>364</sup> From the perspective of the health system, it is a tragic irony of the ARV scale-up: the more treatment is made available, the longer PLWHA will require health sector resources—including complex and expensive second-line treatments.<sup>365</sup> In a brief sixteen-year span (1990 – 2006) the chance of a fifteen-year old reaching the age of 60 in South Africa has been reduced by almost half.<sup>366</sup>

At the population level in South Africa, an 11.8% prevalence rate remains one of the highest in the world. Yet, as with most public health issues, population level prevalence rates mask the distribution of the burden of disease within a country. In South Africa's nine provinces, prevalence rates range from 1.9% in the Western Cape (where Cape Town is located) to 16.5% in KwaZulu-Natal (largely constituted by the lands of the Zulu kingdom on the Eastern side of the country). Similar distribution patterns are

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<sup>363</sup> According to one model, over 370,000 lives (including children born with HIV) were lost because of policies that prevented a “feasible and timely program” to be implemented in South Africa.” See Pride Chigwedere et al., “Estimating the Lost Benefits of Antiretroviral Drug Use in South Africa,” *Journal of Acquired Immune Deficiency Syndrome* 49, no. 4 (2008), 412.

<sup>364</sup> Bisola Ojikutu, Chris Jack, and Gita Ramjee, “Provision of Antiretroviral Therapy in South Africa: Unique Challenges and Remaining Obstacles,” *The Journal of Infectious Diseases* 196, no. s3 (2007).

<sup>365</sup> Recall here the paradox of prevalence discussed in chapter two above.

<sup>366</sup> In 1990, 29% of 15-year olds would not reach age 60. By 2006, the mortality rate had increased to 56%, largely due to the HIV pandemic. In that same time period, life expectancy had plummeted from a modest 63 to 51 in a country that by many indicators was considered middle income. Actuarial Society of South Africa, Summary of Biennial Report on the State of the South African HIV/AIDS Epidemic, (2006), <http://www.doh.gov.za/docs/reports/2006/summary.html>.

evident in antenatal clinic surveys, which have been taken annually since 1990, when prevalence was estimated at 0.8%. In 2006, KwaZulu-Natal reported an estimated 39.1% of pregnant women attending clinics for antenatal care were HIV positive. 1000 kilometers away in the Western Cape, 15.2% of pregnant women had contracted the HIV virus.<sup>367</sup>

The main clinic of the Masangane program is located in Matatiele, an urban development that straddles the provincial boundary between KwaZulu-Natal and Eastern Cape. Under Apartheid, Matatiele was designated for white South Africans, while the surrounding Transkei “homelands” were designated for Black South Africans many of whom had been forcibly resettled under Apartheid. Indeed, whether Matatiele falls under the jurisdiction of the Eastern Cape or KwaZulu-Natal provincial health authorities has been a heated topic of local politics in recent years.<sup>368</sup> Though the Eastern Cape prevalence rate places the province in the middle of the pack compared to its provincial peers (29% among antenatal attendees in 2006; 8.9% in the general population), the province is among the poorest in South Africa and its health system acknowledged as severely limited in its capacity to meet the basic needs of its residents.<sup>369</sup> These challenges are compounded by the almost exclusive reliance on the public health system

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<sup>367</sup> As prevalence rates in all of the provinces have continued to rise, the distribution of the burden of disease has remained largely consistent. So, for example, while considerably lower than other provinces, the Western Cape rate still represents a doubling since the initial 1990 surveys. See Rob Noble, "South Africa: HIV & AIDS Statistics," <http://www.avert.org/safricastats.htm>.

<sup>368</sup> In 2000, Matatiele was designated as one of sixteen “cross-boundary municipalities” as a way of recognizing that its magisterial (or district-level) governments were located in both the Eastern Cape and KwaZulu-Natal. In 2005, Matatiele was formally reassigned to the Eastern Cape province. In anticipation of the 2009 general elections, residents of Matatiele have demanded reincorporation into KwaZulu-Natal. Further details on the dispute can be found in the background section of a 2006 case before the Constitutional Court of South Africa, *Matatiele Municipality and Others v President of the Republic of South Africa and Others (1) (CCT73/05) [2006] ZACC 2; 2006 (5) BCLR 622 (CC) (27 February 2006)*

<sup>369</sup> Thomas et al., “Let Us Embrace,” 10.

for care provision.<sup>370</sup> (As a result there is significant resistance among many in Matatiele to provincial lines being redrawn to relocate Matatiele in the Eastern Cape.) In both provinces high prevalence rates among women ages 15-49 have earned KwaZulu-Natal and Eastern Cape notoriety as the provinces with the two highest rates of orphanhood (19.8% and 18.1%, respectively).<sup>371</sup>

The socio-political geography of HIV and AIDS is further complicated in Matatiele by two factors: proximity to the Lesotho border and the history of labor migration. The relationship between movements of peoples and disease has long been of interest to public health practitioners and historians. Of particular interest in South Africa has been the relationship between work in the mines and the spread of sexually-transmitted diseases.<sup>372</sup>

For generations, men have traveled to and from Johannesburg to earn wages beyond what was possible in the rural areas. And there is consensus in the public health community that “population mobility, and labour migration in particular, has played an important role in the spread of HIV/AIDS, particularly in South Africa.”<sup>373</sup> Opportunities for employment in the cities and mines, however, did not trickle down to rural areas like Matatiele. Unemployment rates in the Eastern Cape, itself, continue to hover around

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<sup>370</sup> According to a 2004 study, dependence on the public health system is high across the country-- 85% of the population relies on the public health system. In the Eastern Cape this dependence is even greater at 90.3%. Study cited Ibid., 10.

<sup>371</sup> Study cited Ibid., 10.

<sup>372</sup> In the 1940s, Sydney Kark, a pioneer in South Africa's community-oriented primary care (COPC) movement, harnessed the insights of epidemiology and community health to draw causal arrows between mineworkers returning to rural homelands and the spread of syphilis. And in the twenty-first century, researchers have once again turned—though tragically late in the epidemic—to Kark's fundamental insights to understand epidemiological patterns in the HIV pandemic. In 2003, the *International Journal of Epidemiology* reprinted Kark's article along with contemporary commentary. The reprint of this article reflects a growing interest in global health history, though the immediate catalyst for the reprise is clearly the HIV pandemic. See Sidney L. Kark, "The Social Pathology of Syphilis in Africans," *International Journal of Epidemiology* 32(2003).

<sup>373</sup> Landon Myer, Chelsea Morroni, and Ezra S. Susser, "Commentary: The Social Pathology of the HIV/AIDS Pandemic," *International Journal of Epidemiology* 32(2003), 190.

40%.<sup>374</sup> In the waning years of the twentieth century, after years of retrenchment by the companies operating mines near Johannesburg (“City of Gold”), young men in the Eastern Cape once again headed to the mines and other urban areas in search of employment—just as the HIV pandemic was gaining momentum.<sup>375</sup>

The Basotho (the people of Lesotho) constitute a significant percentage of the population in Matatiele. Many more Basotho commute to Matatiele for goods, medical services, and regional transportation. A mere 20 kilometers distant, Matatiele is for many Basotho the closest town. The upshot: even in the wake of the South African government’s ARV rollout in late 2003, Basotho who do not have South African citizenship are not eligible for treatment programs operated by public health hospitals and clinics.<sup>376</sup>

The treatment component of the Masangane Program emerged in this context, enrolling its first clients in 2003. At the time it was the only denominationally affiliated treatment program in the Eastern Cape, and one of only a few treatment programs available in this region.<sup>377</sup> Today, the day-to-day activities of the Masangane Integrated

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<sup>374</sup> The 40% figure collates data from three years: 2005 (43.6%), 2006 (36.9%), and 2007 (42.9%). The figure is based on an expanded definition of unemployment that includes the category “discouraged work-seekers,” or those who are able and willing to work but have given up hope that they will find a job. The *expanded* definition can be compared to the *strict* definition which omits this category. According to the strict definition, unemployment is around 25% in the Eastern Cape. Statistics are taken from South African Institute of Race Relations, a research and policy organization, and can be accessed at <http://www.sairr.org.za>. Given the global recession in 2008 – 2009 and its disproportionate impact on primary commodity prices (i.e., many of South Africa’s mine-related exports), it is likely that these rates will rise in the foreseeable future.

<sup>375</sup> The South African mining industry workforce is predominantly made up of migrants from rural areas within the country as well as neighboring countries such as Lesotho. According to one researcher, in 1997, 95% of the 350,000 male mining workers were migrants. See Catherine Campbell, “Migrancy, Masculine Identities and AIDS: The Psychosocial Context of HIV Transmission on the South African Gold Mines,” *Social Science & Medicine* 45, no. 2 (1997), 273.

<sup>376</sup> Lesotho also has a national treatment program. But for many living near the border on the slopes of the Drakensberg mountain range, the trip to Matatiele is much more convenient.

<sup>377</sup> The Catholic Church had active treatment programs in neighboring Kwa-Zulu Natal, but no Masangane was the first such faith-based program in the Eastern Cape, a predominantly Christian province with a

HIV Treatment Program are carried out largely by volunteer and stipended treatment volunteers and counselors, affiliated medical professionals including a private doctor and a public health nurse, a driver, and a salaried office manager. The story in this chapter is about the processes of theo-ethical reflection that facilitated the shift to embrace an integrated treatment program. While this story includes many of those who carry out the day-to-day activities, my focus is on the persons most responsible for setting the vision for and articulating the current mission of Masangane. These persons include most prominently a local Bishop in the Moravian Church, a German Lutheran pastor living in South Africa, and a doctor with *Medicins sans Frontières*. But the processes of theo-ethical reflection in which these persons were involved included many others who serve in an advisory capacity or as members of the organization's board, including various local pastors and members of Moravian congregations and representatives from the Lutheran Church of South Africa, the umbrella communion with which the Moravian Church in South Africa is affiliated.

The following section describes the evolution of the Masangane program in order to show the motivations for expanding its program to include treatment.

### **III. EVOLUTION OF THE MASANGANE PROGRAM**

#### *Origin Story: Masangane as Caregiver*

Masangane did not begin as a treatment program. In 1996, despite the increasing availability of ARVs in the United States and Western Europe, the response to persons

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history linked strongly to Methodism and other denominations that bear a family resemblance (e.g., the Moravians). Thomas et al., "Let Us Embrace," 10.

living with HIV and AIDS (PLWHA) in South Africa consisted primarily of home-based care, combating stigma, prevention education, and providing material and social support for family members. It was around these strategies that the initial work of Masangane lived out the meaning of its name. Masangane is an *isiXhosa* word translated as “let us embrace.”

Not surprisingly, perhaps, the initial catalyst for this church-affiliated health service for persons living with HIV was a woman who stood at the intersection of religious service and health provision. Sister Jabu Sikhonje, a Moravian and a matron at the regional tuberculosis hospital in Pietermaritzburg, recognized the acute shortage of HIV-specific healthcare workers in rural South Africa and envisioned an equip and send program for members of her congregation.<sup>378</sup> Congregation members would be trained in home-based care techniques as well as general HIV education, and then sent to rural areas as complements to the severely understaffed and overstretched formal public health system.

During the first several years of its existence, Masangane operated largely as a loose network of concerned individuals affiliated with the Moravian Church and guided by the Treatment Action Campaign (TAC), the leading advocacy group for PLWHA in South Africa. In 2001, the institutionalization of the program began to accelerate. With the appointment of Reverend Ntombentsha Matinisi, the first Xhosa woman pastor in the South African Moravian Church, to a congregation within the Masangane catchment area, a new dimension of the program began to take shape.

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<sup>378</sup> Ibid., 16-17.

As coordinator of the Masangane program in the Maluti mountains, Reverend Matinisi focused on AIDS orphans and the unique constellation of needs animating these children's lives, not the least of which was funding for school uniforms and fees. The focus on orphans and child-headed households was consistent with trends among other religious communities in South Africa as well as the global donor networks that provided substantial support for these programs.

At the same time, care for orphans did not represent a fundamental break from the conventional wisdom—reified in the mortality rates—that contracting HIV in Africa was a death sentence. The role of healthcare workers (religious or otherwise) remained primarily palliative. The web of care had expanded to include surviving family members of persons who had succumbed to the virus; yet, in fundamental ways, a person *dying* of AIDS rather than a person *living* with HIV and AIDS remained the focus. Death with dignity was the goal; AIDS, in medical-speak, remained an acute rather than chronic disease.<sup>379</sup>

Death with dignity proved an elusive goal, however, running up against, among other things, the conventional wisdom propagated by members of the established health infrastructure in the Eastern Cape. In a 2001 report to one of the early German funders of Masangane, Rev. Matinisi describes the socio-religious landscape in which Masangane was trying to carve out space: “My great worry is the discriminating attitude of the people. The point of view of the nurses in our hospitals is horrid. They treat the AIDS patients as if they were lepers. Many don't even administer medication because ‘You are dying anyway.’ Many Christian nurses refuse to care for AIDS patients. ‘This is your

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<sup>379</sup> A focus on palliative care here could be conceived broadly as helping infected persons and their dependents cope with death. Similarly, it is possible to speak of death with dignity as including foreknowledge of the care one's dependents will receive after a parent's death.



punishment. Go home and die.”<sup>380</sup> Prior to (and, as will be show below, even subsequent to) the roll-out of ARVs, the lives of PLWHA were deemed unworthy of medical attention, a waste of already scarce resources. The juxtaposition of the medical and religio-moral dimensions of HIV at the turn of the twenty-first century is striking in its blunt evaluation of the worth of individual human lives.

Taken by itself such a determination seems to betray the fundamental principles of medical ethics, most notably, the principle of beneficence. Yet, in the pre-ARV, resource-strapped health system of South Africa, such medical triage was perceived as a necessity, perhaps even an obligation of justice given the need to balance the medical needs of persons not infected with HIV. Stripped down to the utilitarian calculus upon which both health policy and service delivery often rest, the response of professional health workers observed by Matinisi may appear “rational,” despite the tragic medical and social implications for PLWHA. But Matinisi’s observation suggests that arguments from a rationed care perspective mask deeper ambiguities about the meaning of the HIV pandemic for rural communities throughout South Africa. The realization that those who shared her faith could use their professional status as a means for meting out divine justice suggests that denial of care for PLWHA cannot be explained solely in terms of a tragic, but necessary cost-benefit analysis.<sup>381</sup>

### *Community Health: Masangane and Doctors without Borders*

Yet, as chapter three details, the millennial winds of change were blowing strong in the global health community. The Millennium Development Goals signaled a

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<sup>380</sup> Ntombentsha Matinisi, "Breaking the Silence in the Churches," *Informationsbrief* (2001), 3.

<sup>381</sup> Recall the brief discussion of Kopelman’s theory of disease as punishment in chapter two above.

willingness on the part of nation-states to prioritize universal access to antiretroviral treatment.<sup>382</sup> Pressure from HIV activists within South Africa, especially the efforts of the Treatment Action Campaign, had generated international outrage at the continued resistance of the Mbeki government and his much-ridiculed Minister of Health, Manto Tshabalala-Msimang, to the mainstream virological understanding of AIDS and its correlate antiretroviral treatment.<sup>383</sup>

Though it is easy to single out South Africa for its medically heterodox views on the etiology of HIV and AIDS, it is important to note that even among those who shared the “orthodox” views of disease transmission, prevention, and treatment (e.g., WHO), a global consensus had not been reached on how best to deliver ARVs in communities with high prevalence rates and limited access to the formal health system. Prominent nongovernmental organizations like *Medicins Sans Frontiers* (MSF) had begun pilot studies as early as April 2000 on the effectiveness of non-ARV treatment programs in communities with high prevalence rates and poor health services. And, then, in May 2001, MSF began distributing ARVs in Khayelitsha, a sprawling, yet densely packed township on the outskirts of Cape Town. This seminal study called into doubt assumptions about the futility of treatment programs in resource-poor urban communities in Africa.<sup>384</sup>

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<sup>382</sup> Goal number six, for example, deals explicitly with combating HIV and AIDS through treatment as well as prevention—Millennium Development Goal #6: Combating HIV/AIDS, Malaria and Other Diseases.

<sup>383</sup> For an analysis of the history of the political conflict over AIDS treatment, see Nawaal Deane, “The Political History of AIDS Treatment,” in *HIV/AIDS in South Africa*, ed. S.S. Abdool Karim and Q. Abdool Karim (Cambridge: Cambridge University Press, 2005).

<sup>384</sup> Nomi C. Levy, Rebecca A. Miksad, and Oliver T. Fein, “From Treatment to Prevention: The Interplay between HIV/AIDS Treatment Availability and HIV/AIDS Prevention Programming in Khayelitsha, South Africa,” *Journal of Urban Health* 82, no. 3 (September 2005). Paul Farmer and his *Partners in Health* colleagues have deconstructed similar assumptions about the effectiveness of treating multi-drug resistant and extreme-drug resistant forms of tuberculosis in impoverished communities. See, for example, Farmer, *Infections and Inequalities*. Both sets of studies expose questionable assumptions about the relationship

The MSF Khayelitsha study was a critical first step in demonstrating to health officials that “ARV medical management could be introduced effectively through existing governmental medical care structures in resource-poor settings to a highly stigmatized and underserved patient population.”<sup>385</sup> It offered one of the first empirical rays of hope that universal access to treatment could be more than political rhetoric. Yet, the success of the Khayelitsha program begged questions about the potential effectiveness of treatment programs located far from cosmopolitan urban centers and their attendant health resources.

Despite the intentions of MSF, Khayelitsha remained dependent on doctors as the primary coordinators of the treatment program. For a radical scale-up of treatment with the potential to reach even the most remote areas of the country, the doctor dependency would have to be overcome, or at least mitigated. There simply were not enough doctors in the country. For Hermann Reuter, one of the main doctors involved in the Khayelitsha study, and the man responsible for piloting MSF’s first rural treatment program (Lusikisiki), the doctor dependency was grounded in an ARV paradigm that grew out of the world of clinical trials and all the trappings of tertiary-care institutions:

You have four or five doctors, all of them with highly specialized training,

hovering around one patient. Four or five doctors to a patient: how can you deal

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between socio-economic status and treatment compliance, as well as facile (and insulting) equations of ascriptive identities and expected behaviors. In 2001, Andrew Natsios, then head of the U.S. Agency for International Development, offered the following explanation for not investing heavily in highly-regimented ARV treatment programs in Africa: “people do not know what watches and clocks are. They do not use Western means for telling time. They use the sun.” Quoted in Steinberg, *Sizwe's Test: A Young Man's Journey through Africa's AIDS Epidemic*, 84-85. For evaluations of the initial study in Khayelitsha see David Coetzee et al., “Outcomes after Two Years of Providing Antiretroviral Treatment in Khayelitsha, South Africa,” *AIDS* 18, no. 6 (2004); Jean-Michel Tassie et al., “Highly Active Antiretroviral Therapy in Resource-Poor Settings: The Experience of Medecins Sans Frontières,” *AIDS* 17, no. 13 (2003).

<sup>385</sup> Levy, Miksad, and Fein, “From Treatment to Prevention: The Interplay between HIV/AIDS Treatment Availability and HIV/AIDS Prevention Programming in Khayelitsha, South Africa,” 503.

with an epidemic that way? ... ARVs are the most significant intervention since [oral rehydration therapy]. And it's also a primary health-care intervention. No fancy machines, no organ transplants. You just need a nurse. And frankly, you don't even need that.<sup>386</sup>

ARVs as primary health care was a radical concept. As journalist Jonny Steinberg elucidates in his conversations with Reuter, it was *the* concept in which the commitment to universal access must be grounded if it was to move from rhetoric to reality. Importantly, as the quote above implies, the implications of ARVs as primary health care extended beyond the formal health sector. Steinberg writes, "the project's [Lusikisiki] assumption was that treatment would only work if animated by a social movement of laypeople and antiretroviral users."<sup>387</sup> It is a truism that gives a distinctive texture to the global AIDS response and its local expressions: a pandemic and a social movement.<sup>388</sup>

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<sup>386</sup> Quoted in Steinberg, *Sizwe's Test: A Young Man's Journey through Africa's AIDS Epidemic*, 84-85. The healthcare personnel crisis is deep and broad in South Africa. According to recent estimates, South Africa has approximately 18,000 doctors in the public sector, leaving it well short of the WHO's recommend ratio of doctors to population. South African would need three times as many doctors to meet the WHO's standard of 8 doctors for every 10,000 people. Despite promises of an "occupation specific disbursement" to raise salaries of doctors, protests by doctors in May 2009 exposed the extent of the anger and the potential increase of health professionals leaving the country—already a significant factor at its current rate in the underperformance of the health system. See South African Press Agency, "SA State Hospitals in Crisis," *Mail & Guardian*, May 24, 2009.

<sup>387</sup> Steinberg, *Sizwe's Test: A Young Man's Journey through Africa's AIDS Epidemic*, 85. Steinberg's thorough account of the Lusikisiki program was, serendipitously, published during the course of writing this chapter. The parallels between the two programs are many, but I thought it was important to include separate discussions of each of the programs as a way of highlighting the role of theology in Masangane. The MSF Lusikisiki program is not a religious entity and makes no explicit theological claims about the nature of its HIV program.

<sup>388</sup> Such a truism recalls the emphasis of liberation theologians. To wit, the critical role of ARV users and their network of informal care providers in successful treatment programs embodies a form of *conscientization*. Though Reuter himself does not draw explicitly on liberation theology, Paul Farmer, a kindred spirit who shares many of his commitments to seeing ARVs as a primary health care intervention, does. See, for example, Farmer, *Infections and Inequalities; Pathologies of Power: Health, Human Rights, and the New War on the Poor*.

In 2002, Lusikisiki, located in the Eastern Cape (approximately 200 km from the main Masangane clinic) was identified by MSF, the Nelson Mandela Foundation, and the Eastern Cape Provincial government as an ideal site for “developing and testing a model of HIV service delivery that would be appropriate to rural populations in South Africa.”<sup>389</sup> Citing its “deep rural nature, high HIV prevalence and history of underdevelopment” as well as the severity of the “human resource crisis” in rural South Africa, the Lusikisiki program had the potential to offer insights into the specific challenges of scaling-up antiretroviral treatment.<sup>390</sup>

As point person for MSF in Lusikisiki, Reuter faced a daunting task.<sup>391</sup> The entire population of the subdistrict (approximately 150,000) depends upon, at any given time, the services of fewer than ten physicians—a doctor-to-patient ratio *fourteen times* greater than the national average—and a nursing pool in which almost half of all positions are unfilled.<sup>392</sup> Against this backdrop, the commitment to involving laypeople in a primary-care oriented approach is striking in its pragmatism as much as its ideology, an insight not lost on the policymakers at the World Health Organization.<sup>393</sup>

The Lusikisiki program was organized around three interrelated strategies: “decentralization to primary health care, task shifting within services, and strong community support.”<sup>394</sup> The provision of ARVs at the community clinic level

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<sup>389</sup> Médecins sans Frontières, “Achieving and Sustaining Universal Access to Antiretrovirals in Rural Areas: The Primary Health Care Approach to HIV Services in Lusikisiki, Eastern Cape,” (Cape Town 2006), 3.

<sup>390</sup> Ibid.

<sup>391</sup> For a particularly compelling portrait of “Dr. Hermann” see the work of South African journalist, Jonny Steinberg. Steinberg, *Sizwe's Test: A Young Man's Journey through Africa's AIDS Epidemic*.

<sup>392</sup> Martha Bedelu et al., “Implementing Antiretroviral Therapy in Rural Communities: The Lusikisiki Model of Decentralized HIV/AIDS Care,” *The Journal of Infectious Diseases* 196, no. s3 (2007), S464

<sup>393</sup> See World Health Organization, “Taking Stock: Health Worker Shortages and the Response to AIDS,” WHO/HIV/2006.05(2006), <http://www.who.int/HIV/pub/advocacy/tr/en/index.html>.

<sup>394</sup> Bedelu et al., “Implementing Antiretroviral Therapy in Rural Communities: The Lusikisiki Model of Decentralized HIV/AIDS Care,” S465.

(decentralization) resulted in a near doubling of clinic-based services in the first two years of the program, yet the number of professional nurses remained unchanged.<sup>395</sup> The successful decentralization of the treatment program required rethinking the traditional roles of health workers in HIV and AIDS care (task-shifting). Reflecting the logic of subsidiarity, the Lusikisiki program operated according to a belief that an appropriately trained and supervised cohort (army?) of community health workers and primary care nurses were the key to sustainable treatment programs in rural areas.

Task-shifting, however, was more than a restructuring of medical responsibilities in the community. By introducing several new roles in the provision of service, including prominent roles for adherence counselors, pharmacist's assistants, and support groups, the Lusikisiki program was intended to broaden the base of community support. On one level this broadening takes place simply through the employment of a larger percentage of the community in the provision of services. At another level, though, the intentional efforts and explicit responsibilities of the local health workers to reach out to those underserved by the formal health system served as a catalyst for reinterpreting the meaning of HIV in the community at-large, a reinterpretation that could not ignore the existential and practical implications of HIV as a chronic rather than acute illness.

The shift to viewing HIV as a chronic rather than an acute disease was a medical triumph, but it retains, and perhaps even exacerbates, conditions in which stigma finds a foothold. As Sizwe Magadla, the protagonist in Steinberg's account of "a young man's journey through the African AIDS epidemic," reflects: "I do not like those pills. . . . To take them every day is a reminder that your blood is dirty. Especially that big yellow pill,

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<sup>395</sup> In 2004, 30 professional nurses provided services for 16,465 clients. Two years later, the same number of professional nurses served 28,191 clients. See *Ibid.*, S465.

that huge rugby ball pill. If I had to take that pill every day it would be close to the end for me. It would just remind me that I am dying.”<sup>396</sup> For Reuter, the association of infection with contamination, or “dirt in one’s blood,” can only be ruptured by an HIV response that privileges disclosure over confidentiality:

We in MSF have a very different attitude to confidentiality compared to the health department. The health department was saying you must not write on people’s clinic cards that they are HIV-positive. Everything must be a big secret. We are saying, unless people disclose they are not going to deal with AIDS. If it’s a big secret you are trying to hide from everybody, you will not be able to deal with it.<sup>397</sup>

Such a bold approach may risk disrupting long-standing relational webs as well as cultural systems that have been formative for PLWHA, but for Reuter it is worth the risk.

Reflecting upon the resistance by Sizwe and others in his village to testing and therefore confirming their sero-status, Reuter concludes without apology: “If he [Sizwe] goes to test and he tests positive, then yes, the people in his community will know, and he will make some enemies. But the friends he makes will be more important than the enemies. The people testing positive develop meaningful relationships, the sort of relationships they have never had before.”<sup>398</sup> The antidote to social death is predicated on disrupting the former webs of relationship that have served to stigmatize PLWHA and creating new relationships in which one’s sero-status is a source of connection rather than contamination.

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<sup>396</sup> Steinberg, *Sizwe's Test: A Young Man's Journey through Africa's AIDS Epidemic*, 298.

<sup>397</sup> *Ibid.*, 88.

<sup>398</sup> *Ibid.*, 88.

From the perspective of Reuter and MSF, adherence counselors and support groups are as important, if not more so, as improving access to and the quality of local clinics (e.g., by ensuring that all persons live within a reasonable walking distance of HIV-specific health information and resources). The adherence counselors, largely absent from other ARV treatment programs in South Africa, became the cornerstone of both the Lusikisiki and Masangane approaches: preparing individuals for treatment, creating safe space in support groups for candid discussions of the biological as well as social experience of illness, keeping track of persons who default on treatment, and collecting data essential for building an epidemiological model of the pandemic from the ground-up.<sup>399</sup>

The use of counselors, many of whom were HIV positive themselves, expanded the capacity of the treatment program even as it improved other measures of effectiveness, such as “loss-to-follow-up” (LTFU) rates. While mortality rates were comparable among those who initiated treatment at hospitals and clinics affiliated with the Lusikisiki program, LTFU was dramatically lower in the MSF-sponsored study. A mere 2% in the Lusikisiki program were unaccounted for after starting treatment compared to 19% of those who were enrolled in programs through the hospital.<sup>400</sup> LTFU has become a significant measure of effectiveness in the HIV response.<sup>401</sup> As ARVs become more widely available, concerns about drug-resistance have become more urgent.

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<sup>399</sup> Bedelu et al., "Implementing Antiretroviral Therapy in Rural Communities: The Lusikisiki Model of Decentralized HIV/AIDS Care," S465. Bedelu et al. provide a useful table comparing the traditional roles of health staff in HIV/AIDS care and those of the Lusikisiki program health staff. Of particular note is the absence or underutilization of adherence counselors, support groups, PLWHA, and pharmacist's assistants in the “traditional” model. See Table 1, S465.

<sup>400</sup> Ibid., S467.

<sup>401</sup> See Sydney Rosen, Matthew P. Fox, and Christopher J. Gill, "Patient Retention in Antiretroviral Therapy Programs in Sub-Saharan Africa: A Systematic Review," *PLoS Medicine* 4, no. 10 (2007), [www.plosmedicine.org](http://www.plosmedicine.org).



The fact that the Lusikisiki program demonstrated a much better capacity for following-up is significant in large part because fears of widespread drug resistance often go hand in hand with critiques of decentralization and task-shifting.

MSF demonstrated in Lusikisiki that a treatment program in an under-resourced, rural community was possible. It was possible when fundamental assumptions about treatment protocol for HIV and AIDS were called into question. It was possible when the lives of persons affected by HIV and AIDS were cared for as fellow human beings.

*Embracing Medicine: Masangane as an Integrated Treatment Program*

For the Reverend Fikile McGoyi of the Eastern Cape, the justice and care work of MSF came to resonate with the best of Christian prophetic and pastoral traditions, challenging Christian communities to recalibrate existing HIV and AIDS programs in light of shifting medical and political realities. In 2002, the same year that Dr. Reuter was moving from Khayelitsha to Lusikisiki, Masangane co-founder and German Lutheran pastor, the Reverend Renate Cochrane, invited Mgcoyi to Cape Town to visit the treatment program run by MSF and the Treatment Action Campaign (TAC) in Khayelitsha. Mgcoyi, who had been working with Masangane in his capacity as a trusted dean in the Moravian Church, retired school principal, and local chief in the Eastern Cape, was in 2002 serving as the director of Masangane. McGoyi observed firsthand in Khayelitsha the successful provision of purportedly out-of-reach antiretroviral treatment to persons living at the margins of the formal health system. He returned home to the Transkei “convinced that treatment was available,”<sup>402</sup> and that Masangane had a role to play in bringing this treatment to the Eastern Cape. Upon his return, Mgcoyi accompanied

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<sup>402</sup> Renate Cochrane, co-founder of Masangane, e-mail message to author, June 1, 2009.

a critically ill mother to a private clinic near Queenstown. Using funds from the Lutheran Church in Germany, Mgcoyi paid for the doctor consultation and the treatment regimen.<sup>403</sup>

The medical effects of ARVs are nothing short of miraculous when observed firsthand by persons affected by HIV. Within weeks of starting treatment, persons whose CD4 counts placed them as close to death's door as possible without going through it are up walking, gaining weight, and fighting off the opportunistic infections that are often the cause of death among HIV-infected persons. The so-called "Lazarus effect" can go a long way toward dispelling the conventional fatalism about HIV.

Yet such dramatic physical evidence of healing introduces its own challenges, particularly in rural South Africa where persons seeking treatment negotiate the meaning of illness within a plurality of complementary and conflicting healthworlds<sup>404</sup>—from the healthworlds of the herbalists and diviners at the heart of African traditional religions to those of the secular and religious medical "missionaries" and their descendants that dominate the formal health system. For Rev. Mgcoyi's parishioners, his close proximity to the mother living with HIV and his association with the church led to speculation that he—and not the ARVs—was the source of the healing power.<sup>405</sup> This is an ongoing

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<sup>403</sup> At the time, the triple combination of antiretrovirals was not available yet available in the Eastern Cape, but "double therapy" was. While not ideal, double therapy was enough to prolong and improve the patient's life.

<sup>404</sup> The concept healthworld is adopted from the ARHAP research in Lesotho. Healthworld is the loose translation of *bophelo*, a term used by the Basotho people to capture all things related to well-being and human flourishing. Importantly, healthworld refers to an interpretation of human flourishing that does not differentiate between spirit, mind, and body. Here I am using healthworld primarily to signal the way in which an individual's understanding of the etiology and pathology of illness and/or suffering affects, though not necessarily in a relationship of strict correspondence, the health-seeking behaviors the individual pursues. For a fuller discussion of the concept of healthworld and its importance for the ARHAP theoretical framework, see Germond and Molapo, "In Search of Bophelo in a Time of AIDS: Seeking a Coherence of Economies of Health and Economies of Salvation."; Cochrane, "Seeing Healthworlds Differently."

<sup>405</sup> Renate Cochrane, co-founder of Masangane, e-mail message to author, June 1, 2009.

challenge for Masangane and for other programs providing drug treatment as a response to illness in a cultural context animated by plural healthworlds and the diverse health-seeking strategies they legitimate, though it is a challenge Masangane tries to meet with educational workshops about HIV and ARVs, individual counseling and testing, support groups, and the witness of its client success stories.<sup>406</sup>

For the Masangane program, however, the success of its first foray into the emerging world of highly active antiretroviral treatment (HAART) led to a different kind of negotiation: With the unavailability of treatment no longer an excuse for focusing primarily on prevention, education, care, and support, should (and could) Masangane expand its services, yet again? The “should” was not difficult to answer. Securing treatment for PLWHA in rural areas, a population dismissed as untreatable by not only the South African government but also by the wider global health sector, was a natural progression for a program grounded in a “theology seeking justice” for those at the margins of society.<sup>407</sup> If treatment was available, then, McGoyi and other pastors affiliated with Masangane argued, it should be available to all, regardless of geographic location, income level, race, or other marker around which South African society was stratified. Unlike its previous expansion into the care of orphans, a treatment program required medical expertise. It also required reliable and substantial funding sources given the risks associated with intermittent treatment and the costs of ongoing treatment.

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<sup>406</sup> Jonny Steinberg documents similar stories that emerged as part of the response to the Lusikisiki program and the wider distribution of ARVs in the region. Steinberg focused in particular on the presumption that it was the faith healers, e.g., leaders in the African Zionist Churches, who cured PLWHA, even those on ARV treatment. See Steinberg, *Sizwe's Test: A Young Man's Journey through Africa's AIDS Epidemic.*, especially 186-189.

<sup>407</sup> Thomas et al., “Let Us Embrace,” 16.

In 2002, ARVs were not available through the public health system in South Africa. A treatment program would, initially, function completely independent of the government, though it would still have to comply with government regulations regarding qualified personnel for administering tests, dispensing drugs, etc. Whereas previously Masangane staff had often acted as a kind of shadow social workforce helping “clients”<sup>408</sup> and their families access different aspects of the existing welfare state to which they were entitled—for example, disability grants, foster-care grants, and old-age grants—treatment services would have to be self-sustaining, operating outside of the formal public health system, at least in the short term.

The primary goal, recognized broadly by those familiar with Masangane, was “To save lives – and to do so in rural areas.”<sup>409</sup> But like the Lusikisiki program, an important corollary was the witness the program provided to the possibility of treatment in rural areas. For Dr. Stefanie Jellouschek, a volunteer with the Treatment Action Campaign (TAC) and MSF, and one of the main consultants for the initial start-up of Masangane’s treatment program, Masangane could be a catalyst for improved HIV treatment throughout South Africa: “If we manage to create a programme that can show that it is possible to treat people responsibly and successfully even in rural areas, it will also serve as a model for other organizations and work towards a roll-out of an ARV programme in the public sector. Thus, its benefits will go far beyond the MASANGANE individuals

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<sup>408</sup> The Masangane program identifies persons enrolled in the treatment program as “clients” rather than patients or some other designation. For consistency and out of respect for what was a conscious decision to acknowledge the agency of persons seeking health services—as opposed to the relationship of dependency signaled by the appellation “patient”—I will retain the use of “clients” throughout when referring to persons in the Masangane program.

<sup>409</sup> Ibid.

who will directly get access to ARVs.”<sup>410</sup> The “good” of the program could extend outward from clinical to community health and all the way up to public health. For example, individuals associated with Masangane benefit directly from their enrollment in a treatment program (clinical health good), additional community organizations see the success of Masangane and seek to emulate it (community health good), and based on the growing number of successful treatment programs, public health policymakers begin to rethink fundamental assumptions about scaling-up treatment in rural areas (public health good).

Masangane’s potential as a multi-level good foregrounds HIV treatment as a unique combination of social movement and pandemic response. Masangane’s decision to initiate a treatment program required a new understanding of its role as an advocate for PLWHA. Previously for Masangane, advocacy was understood as connecting persons to parts of a system that exists but may be inaccessible for a variety of reasons. It was advocacy on behalf of persons who were dying but still deserving of government assistance for themselves and for their families.

With a treatment program, though, advocacy involved a more critical stance towards the government. The very existence of a nongovernmental treatment program was an act of defiance against the government’s public and persistent denial of the virological origins of HIV. A treatment program reflects more than a disagreement among health experts about disease etiology. It is a political statement.

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<sup>410</sup> Stefanie Jellouschek, "Untitled [Evaluation of Masangane Program]," (University of Cape Town: IRHAP arcHIVes, 2003), 5. This document represents a consulting memorandum from Dr. Stefanie Jellouschek to the Masangane Board. It is held by IRHAP at the University of Cape Town as part of the background materials collected for the original ARHAP case study on Masangane. This document and other similar background materials were made available to me by the ARHAP staff on a visit to South Africa in August 2007. A special thanks to Barbara Schmid, then-ARHAP program coordinator, for orienting me to these materials.

The government denial of the link between the human immunodeficiency *virus* and Acquired Immune Deficiency *Syndrome* betrays a more fundamental resistance to what was perceived by South African political leaders as the most recent version of colonialism: the pernicious influence and propagation of Western pharmaceutical companies in South Africa, and in sub-Saharan Africa more generally.<sup>411</sup> Thus the decision to initiate a treatment program at Masangane involved a conscious decision to stand up and publicly embrace those citizens whose health needs were not being met by the government, and to do so with resources provided through a global network of “Western” ngos and colonial-era church communions. Importantly this form of advocacy was intended as both a moral and evidence-based catalyst for an expanded public ARV roll-out, and not as a substitute for government health services.<sup>412</sup>

With regards to an evidence-base, Masangane (and Lusikisiki) demonstrated that it was possible to provide ARVs to PLWHA in rural South Africa. Indeed, it was not only possible, but the remarkable success of the program suggested that the model was more effective than many ARV programs in parts of the world with stronger health systems, better qualified health workers, and longer histories of administering treatment programs.<sup>413</sup> After a yearlong discussion about whether or not to begin a treatment

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<sup>411</sup> It is beyond the scope of this dissertation to explore the connections between the government’s health policy and the ideological commitments of its leaders, exemplified most clearly in President Thabo Mbeki’s version of pan-Africanism. For a discussion of these connections, see Deane, “The Political History of AIDS Treatment.”

<sup>412</sup> The Masangane treatment program, like the orphan care program, was a response to a specific and pressing need in the community at a particular time. It was necessitated by the unavailability of ARVs in the public health system. It was assumed that once ARVs were made widely accessible through the existing public health system, Masangane would reassess its role in the provision of treatment. As detailed below, the nationwide roll-out of ARVs has led Masangane to evaluate how it can complement, rather than stand out against, the public health effort.

<sup>413</sup> Ojikutu, Jack, and Ramjee, “Provision of Antiretroviral Therapy in South Africa: Unique Challenges and Remaining Obstacles.”; Bisola Ojikutu, “The Realities of Antiretroviral Therapy Rollout: Overcoming Challenges to Successful Programmatic Implementation,” *Journal of Infectious Diseases* 196, no. 3 (2007).

program, Masangane embraced more fully its role as a prophetic, yet pragmatic partner in the response to HIV: the government could do more and *here is how*.

In a June 2003 memorandum, Dr. Jellouschek, who was the main consultant to Masangane from MSF, outlined the basic requirements for a treatment program at Masangane. Education, broadly understood, had been a cornerstone of the early services offered by Masangane. Early education efforts focused on understanding the biomedical aspects of the virus as well as its social and phenomenological (e.g., how the illness is experienced by the sufferer) dimensions. Biomedical education, as an early constitution detailed, included dissemination of up-to-date information to “all members of our [Moravian] congregations about the nature of the HIV / AIDS disease and the ways of transmission” as well as “HIV-wellness management.”<sup>414</sup> Education to address the social and phenomenological dimensions of HIV was seen as both a way of combating stigma, or “breaking the silence around AIDS” and as a proclamation of a Christian love that is “NOT condemnatory.”<sup>415</sup>

With a treatment program, the education focus would take on even greater importance as volunteers and staff learned how ARVs worked including the signs and

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<sup>414</sup> Masangane Moravian AIDS Programme, "Constitution [A]," (Masangane Moravian AIDS Programme, Undated), 1.

<sup>415</sup> "Constitution [B]," (Masangane Moravian AIDS Programme, Undated), 1. Emphasis in original. The commitment to a non-condemnatory witness to the love of Christ and to removing the stigma around AIDS by “breaking the silence” and encouraging conversation about it in churches were both categorized under the heading “Spiritual Education” in what appears to be the original constitution. The phrase “breaking the silence” has been widely employed by church members and communions as shorthand for the particular responsibility of the churches to make amends for their earlier complicity in creating a culture of shame around the pandemic. With regards to the Masangane project, specifically, see Matinisi, "Breaking the Silence in the Churches." The Lutheran World Federation, one of the global communions that has led the way in the most recent stages of the HIV response and of which the Moravian Church in South Africa is a member, the language of “conversion” is used to describe the church’s need to listen “to the wisdom of those with HIV [so that the church] can repent for its past failures to love those it shunned.” Here the problem of silence is understood as a failure not only to speak about HIV but also to listen to those affected by HIV. See LWF, "Lutheran World Federation Action Plan for Responding to HIV/AIDS Pandemic: Compassion, Conversion, Care," (2002), 2. See also Donald E. Messer, *Breaking the Conspiracy of Silence: Christian Churches and the Global AIDS Crisis* (Minneapolis: Augsburg Fortress, 2004).

seriousness of various side effects. Though, ultimately, the lay health workers that constitute Masangane are not qualified (nor expected) to respond medically to Masangane “clients,” they do comprise an early warning system for the medical personnel in whose care patients are formally enrolled. In this sense, the lay health workers retain their responsibilities as “connectors”—connecting PLWHA to an existing, even if nascent and limited, array of services and network of service providers in the community. So how did the program work?

The treatment program began with a modest goal of providing treatment and care for 30 – 40 PLWHA in the Eastern Cape during 2003, its inaugural year. In order to address upfront the gaps between the numbers of persons needing treatment and the capacity of Masangane to provide treatment, a selection mechanism was established. The selection mechanism included four types of criteria: clinical, biological, social, and reliability. Social criteria refers broadly to factors that might influence an individual’s participation in a treatment program. Factors that fall under social criteria include: degree of readiness to commit to lifelong treatment, explicit desire to live longer, willingness to disclose status to closest friends or family, a commitment to safer sexual practices, openness to on-going counseling and home visits by Masangane staff, and agreement to participate in a support group.<sup>416</sup> Assessment of whether or not a person meets the social criteria was carried out, initially, by the congregational liaison.

Initially, Masangane drew on members of local Moravian congregations to help identify potential clients. Eventually, the hope was to have a volunteer from each congregation who would function as a liaison to Masangane. The liaisons would

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<sup>416</sup> Jellouschek, "Untitled [Evaluation of Masangane Program]."



recommend potential clients to the central treatment preparedness committee. Liaisons were not expected to evaluate the clinical (e.g., symptoms) status of potential clients. Instead, the liaisons focused on social criteria.

The assessment was informal, functioning as a trigger for formal follow-up (e.g., a home visit) by a Masangane staff member or volunteer. Based on knowledge about specific members of their congregation or community, liaisons passed along names of persons who they thought might be in need of ARV treatment. A volunteer from Masangane would then meet with the potential client to conduct a formal assessment of the social criteria. If at all possible this meeting was to take place in the client's home in order to give the Masangane volunteer a better sense of how the "home life" of the client might affect their participation in a treatment program.

Using a standardized form adapted from the Treatment Action Campaign (used also in the Lusikisiki program), volunteers conduct formal assessments of the social criteria. Questions move from general information about the household (e.g., "how many people eat and sleep regularly in the house?") to personal questions about family planning strategies. Questions also attempt to understand the potential client's current knowledge of ARV treatment (e.g., "do you know that ARVs need to be taken twice every day for many years?") While some potential clients are referred prior to HIV testing, others are already aware of their sero-status. Thus the questionnaire includes specific questions about who else is aware of the potential client's sero-status.

The assessment is intended to give Masangane's central committee a sense of the support systems clients might draw upon during treatment. At the same time, the assessment provides information about the degree of an individual's need relative to other

applicants for treatment support. For example, a section on financial support elicits information about both the sources of household income and number of dependents. Such information, as well as the stage of illness, is used by the selection committee to direct resources to those—all other criteria being equal—who are most in need. In practice, an early memorandum on selection criteria suggests, a mother of five would be given preference over a single male in the treatment selection process.<sup>417</sup>

The initial home visit serves a second function in addition to the formal assessment. Masangane volunteers provide “counseling.” In the HIV response, counseling can entail different things depending on the stage in which it is carried out. In the pre-clinical stage (i.e., the client has not yet been tested by a Masangane-affiliated doctor), counseling entails a candid discussion about the commitments clients will need to make in order to be enrolled, the potential side effects of treatment, the risks of defaulting, and the possible outcomes of clinical tests with a doctor.<sup>418</sup> During the assessment and counseling, potential clients are strongly encouraged to choose—if they have not already done so—someone close to them to serve as a treatment assistant.

If the individual meets the social criteria, the Masangane volunteer helps arrange an appointment with a doctor. The doctor evaluates the client according to clinical and biological criteria. Clinical criteria for inclusion in the treatment program are based on best practices established by the World Health Organization. To meet the clinical criteria

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<sup>417</sup> Ibid.

<sup>418</sup> It is important at this stage for potential clients to understand that testing positive for HIV does not automatically qualify them for treatment. An HIV-positive individual may have a CD4 count that exceeds the recommendations for when to start treatment. In 2003, the WHO guidelines set the CD4 count for starting treatment at 200. More recently studies have demonstrated that starting treatment earlier can have significant impacts. The guidelines now suggest starting treatment for persons who have CD4 counts below 350. Of course, one consequence of this is that more persons become immediately eligible for treatment in health systems already struggling to meet goals for enrolling persons based on the more restrictive guidelines. See World Health Organization, *Antiretroviral Therapy for HIV Infection in Adults and Adolescents: Recommendations for a Public Health Approach: 2010 Revision* (Geneva: WHO, 2010).

in 2003, an individual had to present to the doctor as a WHO stage III or IV—for example, present with past or current symptoms of HIV, including tuberculosis or a CD4 count less than 50.<sup>419</sup> Additionally, persons were deemed clinically eligible if they scored above 40% on the Karofsky Performance test, an evaluation of a patient's functional impairment.<sup>420</sup> Biological criteria referred specifically to the results of blood tests. The criteria included a CD4 count between 0 – 200 and two separate tests confirming an HIV-positive sero-status.<sup>421</sup>

Only doctors who have signed an agreement with Masangane can perform the clinical and biological assessment. The results of the CD4 tests are discussed in a follow-up appointment with the doctor. If the patient meets the criteria, Masangane staff again provide counseling, emphasizing especially the conditions for participating in the treatment program. At this point, it is of particular importance to inform the patient that her sero-status and other confidential health information will be shared with the larger web of Masangane staff and affiliates (e.g., members of the selection committee). The willingness of potential clients to disclose their status to an increasingly wider public is a witness to the influence of the Treatment Action Campaign and the commitments of Dr. Reuter in the Lusikisiki program. As a health pandemic and a social crisis, the argument goes, fighting social stigma with greater disclosure rates is as important as (if not more so) fighting the virus itself.

In effect, the various criteria assessed facilitate what might be called socio-medical triage. The finite amount of donor funds available for the treatment program

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<sup>419</sup> Jellouschek, "Untitled [Evaluation of Masangane Program]." For a discussion of these criteria, see Charles F. Gilks et al., "The WHO Public-Health Approach to Antiretroviral Treatment against HIV in Resource-Limited Settings," doi: 10.1016/S0140-6736(06)69158-7, *The Lancet* 368, no. 9534.

<sup>420</sup> Jellouschek, "Untitled [Evaluation of Masangane Program]."

<sup>421</sup> The CD4 count of a healthy person ranges between 500-1500.

supports a limited number of clients. The cap on the number of persons Masangane can enroll with full treatment support (set at 30 – 40 in year one) forces the central treatment preparedness committee to make difficult distributive decisions.<sup>422</sup>

Unlike medical triage, socio-medical triage includes attention to non-medical factors, as exemplified above in the hypothetical example above of priority for treatment being given to a woman with five children versus a single man with no dependents. Taken together, the social, clinical, and biological criteria guide the treatment committee in its decisions about who is most in need. The upshot of such distributive practices is that meeting the biological and clinical criteria does not guarantee the potential client a “slot” in the treatment program.

If the committee decides to fund the applicant, one more criteria must be satisfied: potential to adhere to lifelong treatment, or reliability. After another round of treatment counseling, the Masangane volunteer and client meet with the doctor to initiate ARV treatment. As indicators of reliability, the doctor and volunteer draw on the client’s ability thus far to keep appointments and take regular doses of vitamins. But reliability also refers to the willingness of the client to have their behavior monitored regularly by a designated treatment supporter. Behavior monitoring might include treatment-specific behaviors (e.g., inspecting pill containers), but it might also include monitoring behaviors suspected of leading clients to default on treatment, including alcohol or drug dependency.

If the client satisfies all of the criteria, she begins treatment and becomes the center of a web of care that includes, minimally, the treatment supporter (identified by the

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<sup>422</sup> Recall that in 2003, the South African public health system had not yet adopted a policy to distribute ARVs widely and for free. For most persons living in the Masangane catchment area there was no alternative source for ARVs.

client), a Masangane volunteer, and a Masangane-affiliated doctor. Ideally, the client also attends a support group facilitated by a Masangane staff specifically for those on ARVs. Whether or not an individual's application is successful, she receives on-going support from the Masangane staff and volunteers. For example, Masangane may provide non-treatment support in the form of securing medicines for opportunistic diseases, arranging transportation for a tuberculosis test, or assistance navigating the social welfare grant system. In addition, all individuals are encouraged to attend weekly support group meetings for persons who are HIV-positive but not currently on ARVs.

Many of these services could be provided by nonmedical or minimally trained medical volunteers and staff. Yet, doctors remained an essential part of starting a treatment program, despite Dr. Reuter's expressed hope for a doctor-less primary health care approach. Only doctors could procure the ARVs. And given the fast pace at which medical knowledge of ARVs was expanding, including knowledge about the interactions of ARVs with traditional medicines and legitimate concerns about the development of ARV-resistant strains of HIV, the specialized training and professional responsibilities of doctors provided an important check against a treatment program that uncritically applied the "key learnings" from the rapidly proliferating community health worker training workshops. Necessarily streamlined to get out information quickly to persons with varying degrees of education, the workshops assume that community health workers are working in consultation with professional doctors and nurses in order to provide the best possible care and treatment for PLWHA.<sup>423</sup>

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<sup>423</sup> For examples of such training materials see the Lutheran Communion in South Africa (LUCSA) website. In South Africa, the Moravian Church is included in the Lutheran Communion. Masangane staff and volunteers are familiar with these training materials.

The shortage of medical personnel in the Eastern Cape suggests that this assumption likely does not hold in most cases. And even if it did, Jellouschek is quick to point out, doctors should not be granted authority on the basis of their professional status, alone. With a chronic shortage of doctors in the Eastern Cape, those who are present often function as general practitioners, treating a range of illnesses from the common cold to those that fall under the anachronistic medical specialty “tropical medicine” (e.g., malaria, guinea worm) as well as a host of challenges that have less to do with pathology and more to do with poverty, including various expressions of malnutrition like stunting, wasting, and neurological delays caused by micronutrient deficiency. The general shortage of doctors is compounded, then, by an even greater dearth of doctors with specific knowledge of HIV and its treatment.<sup>424</sup>

To ensure that Masangane clients receive the best care possible at the lowest cost, Jellouschek recommended a contract between doctors and Masangane in which doctors “commit to certain therapy guidelines that will be discussed” and agree, in advance, to “consultation fees that will be charged.”<sup>425</sup> The doctors who affiliate with the Masangane program gain immediate access to evolving standards of care and treatment regimens developed by HIV specialists at MSF. Reflecting on the importance of this relationship between local doctors and consultants from MSF in the early stages of the treatment program, Masangane co-founder, Renate Cochrane, explained: “Many patients were saved by cell phone contact with Dr. Reuter as the local doctors in Matatiele were not

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<sup>424</sup> During my first visit to the Eastern Cape in August 2007—four years after the roll-out was announced by the government—the public health officers at one of the district hospitals informed me that the hospital had only one full-time doctor and no dedicated doctor for HIV, despite prevalence rates in the area that were some of the highest in the world. As a result, the full-time doctor allocated one-quarter of his time to treating PLWHA.

<sup>425</sup> Jellouschek, “Untitled [Evaluation of Masangane Program],” 4.

sufficiently aware of the new treatment.”<sup>426</sup> The clients of Masangane offer the most immediate confirmation of “lives saved.”

But, of course, many other lives were lost due to the overwhelming number of persons in need of treatment and the limited capacity of Masangane to provide it.<sup>427</sup> In determining selection criteria for the treatment program, Masangane stakeholders faced two significant constraints: funding and capacity to provide sufficient support. The most expensive part of the treatment program, by far, was the ARVs themselves. Despite the availability of generic ARVs and the steep discount in cost of treatment that resulted, lifelong treatment for an individual remained well beyond the means of the Moravian Church in South Africa, a church, like many others, that often did not have enough funds to pay its pastors. A self-sustaining treatment program required financial assistance from an external source.

External funding was already in place for the orphan care program.<sup>428</sup> And, as noted above, the Lutheran Church in Germany provided the initial subsidy for the pregnant mother Rev. Mgcoyi first accompanied to a private doctor near Queenstown.<sup>429</sup> But to underwrite a treatment program that required lifelong adherence for its participants, additional funding was required, especially given the expense of second- and third-line drug regimens for clients who inevitably develop drug tolerance to the initial

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<sup>426</sup> Renate Cochrane, e-mail message to author, June 1, 2009.

<sup>427</sup> According to the most recent statistics, 56% of persons needing ARVs in Eastern and Southern Africa have access to the drugs. The average includes two countries, Botswana and Namibia, that have achieved universal coverage. An estimated 7,600,000 PLWHA in Eastern and Southern Africa still need access to ARV drugs. UNAIDS, UNICEF, and WHO, "Global HIV/AIDS Response: Epidemic Update and Health Sector Progress Towards Universal Access: Progress Report 2011."

<sup>428</sup> Donors for the orphan care program include: EMS Stuttgart (Germany), DIFAEM (Germany), Kassel Partnership (Germany), Zeister Zendingsgenootschap (Netherlands) and private donors. See Thomas et al., "Let Us Embrace," 19.

<sup>429</sup> To understand why a Lutheran denomination was sponsoring a Moravian project in South Africa, it is important to note that the Moravian Church in South Africa is a part of the global Lutheran communion by way of its membership in the Lutheran World Federation.

combination therapy. To initiate treatment for PLWHA without the guarantee that the treatment would be available for the foreseeable future is not only an especially cruel abuse of medical power and a short-sighted application of the principle of beneficence, but it also plants the seeds for a public health apocalypse in which drug-resistant strains of HIV develop in persons who default on their treatment, in this case through no fault of their own.<sup>430</sup>

Funding was of paramount concern in the yearlong deliberations among the Masangane board members about starting a treatment program. Moreover, the experience of the MSF pilot study in Khayelitsha suggested that access to ARVs was a necessary but not sufficient condition for a successful treatment program.<sup>431</sup> The capacity to provide on-going education about HIV and ARVs, to monitor various aspects of the course of therapy, and to respond appropriately and expediently to complications that arise while on ARVs was of equal importance as securing funding for ARVs. For Jellouschek, a responsible treatment program included both long-term access to ARVs *and* the “capacity to give people on treatment sufficient support.”<sup>432</sup> With limited

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<sup>430</sup> This remains one of the most pressing concerns in global health as more and more persons begin ARV treatment. Though fear of defaulting patients is often expressed not in terms of drug shortages, but in terms of noncompliance on the part of patients. Noncompliance can be framed as both intentional, e.g., a patient chooses not to continue taking the drugs, or circumstantial / structural, e.g., a patient cannot continue using the drugs because they are too expensive, too difficult to obtain, ineffective because of nutritional instability, etc. Given the evidence of, among other factors, drug supply-chain disruptions, high rates of unemployment, and malnutrition, the latter framework offers a more sympathetic, and ultimately more compelling, account of the variety of reasons a person might default on treatment in South Africa. For a discussion of retention issues for clients on ARVs, see Rosen, Fox, and Gill, "Patient Retention in Antiretroviral Therapy Programs in Sub-Saharan Africa: A Systematic Review."

<sup>431</sup> For assessments of the Khayelitsha study, see Tassie et al., "Highly Active Antiretroviral Therapy in Resource-Poor Settings: The Experience of Medecins Sans Frontières."; Coetzee et al., "Outcomes after Two Years of Providing Antiretroviral Treatment in Khayelitsha, South Africa."

<sup>432</sup> Tassie et al., "Highly Active Antiretroviral Therapy in Resource-Poor Settings: The Experience of Medecins Sans Frontières."; Medicins sans Frontières, "Implementing HIV/AIDS Services Including ART in a Rural Resource-Poor Setting: *Siyaphila La* Programme-- Lusikisiki, Eastern Cape (Activity Report 2003-2004)."; Coetzee et al., "Outcomes after Two Years of Providing Antiretroviral Treatment in Khayelitsha, South Africa," 4.



financial resources, Masangane could only meet these two criteria—long-term access and sufficient treatment support—for a small number of persons living with HIV and AIDS.

Over time, Masangane sought to mitigate some of this difficulty in two ways: expanding the number of clients it was supporting at any given time (up to sixty by 2008) and focusing its energies on stabilizing clients quickly so that they could be transferred to a public health system that had been slowly scaling up its ARV program.<sup>433</sup>

Prior to 2005 in South Africa, efforts to address the gap between the treatment available and those in need of treatment focused primarily on expanding the donor base in order to support more clients on ARVs. Masangane was literally “standing in the gap” for PLWHA in the Eastern Cape who had no other means for accessing the life-saving drugs widely available in other parts of the world. Donor support from U.S. and European organizations enabled Masangane to expand incrementally the number of clients on first-line treatment at any one time.<sup>434</sup> By 2008 year, the treatment program had the capacity to provide full treatment support for over sixty persons living with AIDS. In addition, through counseling, home visits, transportation to clinics, and other services, Masangane supported persons who were not yet eligible for treatment.

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<sup>433</sup> Such careful attention to the multiple dimensions of a treatment program is consistent with James Gustafson’s insistence that “having the most accurate information and most careful analyses and arguments [is] more responsible than to assert moral and social policy positions on the basis of deep moral or ideological convictions alone.” While this can lead to moral paralysis, it need not. For Christian social ethicists like myself who work in the tradition of liberal Protestantism, determining the relationship between the careful analyses of social context and Christian-informed moral positions is often an elusive, but no less urgent task. It is a task, however, that in its best moments can be mutually generative for theological ethics and global health. The proposal for theo-ethical reflection as a religious health asset at the end of this dissertation is one attempt to understand not only what this task entails with regards to global health, but also how to get on with the work it requires. Gustafson, *Intersections: Science, Theology, and Ethics*, xv.

<sup>434</sup> The faith-based Vesper Society based in San Francisco, California is one of the primary funders of the Masangane ARV program. Information on the Vester Society, including reference to their support of the Masangane program can be found at <http://www.vesper.org>.

Masangane's commitment to an "integrated" treatment program meant, however, that simply securing drugs for clients was not enough. Increasing funding for ARVs, did not, in itself, build the capacity necessary to support more clients or to support existing clients over a lifetime. Increasing the number of clients served by the program required increasing the number of volunteers and staff who could form relationships with the clients through home visits, etc. And home visits, clinic visits, and support group attendance all required transportation. Most persons on ARVs did not live within walking distance of a clinic or hospital.

Thus, some of the initial donor funds were used to help offset the cost of bus fares for both clients and volunteers. In addition to the financial infeasibility of this arrangement, crowded buses in areas with increasingly high incidence rates for infectious diseases, notably tuberculosis, posed a health threat for PLWHA. Conversely, bus drivers were reluctant to transport obviously ill riders, some of whom had arrived at the bus stop in wheelbarrows, too weak to ambulate often steep, rutted paths from the tarmac to their homestead.

While transportation subsidies remain an important part of the program, the acquisition of a vehicle (a "bakkie," or small pick-up truck with covered back) and the hiring of a driver dramatically enhanced the ability of Masangane staff to check-in on clients. Without such "nonclinical" components of ARV treatment programs, the political rhetoric of universal access to treatment rings hollow, measured by numbers of ARVs distributed rather than persons receiving care, treatment, and support.

The establishment of a satellite office in areas surrounding Matatiele also helped Masangane serve its clients better. Satellite offices, initially a shipping container donated

by foreign organizations, provided semi-private space for support group meetings, counseling and testing, as well as an on-going presence in rural areas accustomed to the impermanence of district-level mobile health clinics. Yet such incremental expansions in the face of unprecedented prevalence rates only served to reinforce what Masangane founders had known from the beginning: a small faith-based, donor-dependent treatment program could not stand-in for a publicly supported, nationwide ARV roll-out.

As early as 2003, as the government was outlining its plan for making ARVs widely available, the South African government articulated, in general terms, a role for faith-based organizations in the response to HIV.<sup>435</sup> Prior to the nationwide roll-out of ARVs, these partnerships focused on prevention, care, and support. In 2005, programs like Masangane that had demonstrated success as treatment providers became potential partners in the nationwide roll-out of ARV treatment, as well.<sup>436</sup> But what this partnership entailed remained an open question.

For Masangane, efforts to save lives in rural areas through provision of ARVs arose organically from its existing orphan program. Preventing the death of a mother—recall Rev. McGoyi’s initial foray into the world of treatment provision was in response to a dying mother in his community—reduced the number of orphans. Yet as it grew, Masangane served as a witness to what was possible in terms of treating PLWHA in under-resourced rural areas. Masangane over time came to embody what Dr. Reuter had envisioned as the telos towards which HIV treatment should be moving: a primary health care approach to ARV provision, minimally dependent upon professional health workers.

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<sup>435</sup> See, for example, Ministry of Health Government of South Africa, "HIV and AIDS and Sti Strategic Plan, 2000-2005," (2000), <http://www.safAIDS.net/files/S.A%20Strategic%20Plan%202000-2005.pdf>.

<sup>436</sup> Thomas et al., "Let Us Embrace," 65.

Indeed, Masangane eventually bore out Reuter's prediction that a successful ARV treatment program could be run without the direct involvement of doctors or even nurses—a possibility that seemed to take the concept of community health care to its logical conclusion. By 2009, Masangane's treatment program operated with a remarkable degree of autonomy from the world of professional government health workers. Aside from a quarter-time retired nurse—hired in response to the government's mandate for a professional nurse to be present for HIV testing—and its use of private doctors for patient referrals, clinical consultations, and donated office space, the treatment supporters carried out the day-to-day activities of an integrated treatment program, weaving social, medical, psychological, vocational, and logistical support into a web of care.

So when South Africa decided to provide free, universal access to ARVs for its citizens in late 2003, it raised important questions about what the day-to-day activities of Masangane might consist of in the near future: Should Masangane seek to align its program more closely with the formal public health program? Could Masangane maintain its commitment to the faith-derived integrated treatment and care that had distinguished it from the government health services (as well as its peer church-affiliated programs), while at the same time working more closely with district health personnel at newly designated ARV sites?

Given the design of the roll-out—first to hospitals, and then, later to clinics—Masangane would remain in the short term one of the only treatment providers accessible to large segments of the rural population around Matatiele. Yet, the nationwide roll-out, even with its delays, served as a reminder to Masangane of the double-vision of care and justice animating early discussions of whether or not to initiate a treatment program.

From the outset, the treatment program was intended as a form of advocacy on behalf of those denied access to the healthcare necessary for living with HIV.

This extended description of the evolution of Masangane from a home-based and orphan care program to a comprehensive, integrated HIV treatment program shows the practical context in which processes of theo-ethical reflection were taking place. This practical context, including the scientific and social advances in HIV treatment as well as the scarcity of political and economic resources limiting the provision of this treatment, gave a particular shape to the theo-ethical reflection process among the various pastors, bishops, and other religious leaders and medical consultants who conceived of and were responsible for guiding the direction of Masangane. The following section explores how these processes of theo-ethical reflection were shaped by this context and how the commitments that emerged challenged the assumptions about HIV treatment for persons at the margins of the health system.

#### **IV. Embracing a Theology of Abundant Life for All**

Where the South African health system saw death, Rev. McGoyi and the other Masangane founders saw life. And not just life as biological survival but abundant life in which PLWHA “feel welcome and loved dearly.”<sup>437</sup> A theology of abundant life is a contextual theology as well. As one client attested, Masangane witnesses to the Christian imperative to reach out as Jesus did to those “who are despised (vulnerable and marginalized), sick, and those people who are outcasts.” It is part of the church mission to

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<sup>437</sup> Ibid., 46.

“come close to people, love each other, and not segregate from each other just because one of us has a certain condition.”<sup>438</sup> Yet, in the specific context of ARV treatments, a theology of abundant life runs up against the reality of resource scarcity—financial, human, or otherwise.

The decision at Masangane to initiate a treatment program was more than just an opportunity to test theories about public health service delivery, build an evidence-base, or challenge the efficacy of particular policies. It was an opportunity to embrace a more expansive vision of what one of its earliest constitutions described as a commitment to “render services to those infected and affected by HIV and AIDS *as a service of compassion*.”<sup>439</sup> The availability of treatment—a medical and political achievement—demanded a re-visioning of what it meant to have life and have it abundantly, a renewed theology of abundant life responsive to changing medical and political realities. The prophetic and pastoral traditions invoked implicitly by the MSF programs in Khayelitsha and Lusiksiki found explicit expression in Masangane’s theo-ethical commitments: 1) to live out a theology seeking justice in the form of expanded access to treatment for those marginalized by illness, poverty, and social stigma; and, 2) to promote a theology of abundant life by providing treatment and care for the whole person, not because it was a more effective strategy, but because it was the type of service compassion demanded.

Clients of Masangane, as well as the medical personnel affiliated with the program, agree that what distinguishes Masangane from the public health system is its commitment to spend significant time with the client outside of the clinical encounter.<sup>440</sup>

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<sup>438</sup> Ibid., 46.

<sup>439</sup> Masangane Moravian AIDS Programme, "Constitution [B]," 1. Emphasis added.

<sup>440</sup> For testimonials to this distinctive quality of Masangane, see “Episode 10: Caring for AIDS Orphans,” documentary television series, *Siyayingoba Beat It!* (2004), <http://www.beatit.co.za>.

Home visits, transportation to and from the clinics, support groups, etc., constitute the practices of accompaniment. These are the form accompaniment assumes in order to nurture experiences of abundant life even in the midst of death.

The web of care clients gain access to includes regular home visits, transportation to appointments and support groups, assistance with social welfare applications, provision of food in situations of food insecurity in the household, etc. The web of care attends to dimensions of human flourishing beyond the pharmaceutical, beyond the biological. And it suggests what a theology of abundant life—and the theo-ethical commitments to justice and care it generates—might entail in the context of an HIV and AIDS treatment program, including adequate food, meaningful contact with caring others, participation in community life (e.g., support groups), and recognition by society.<sup>441</sup>

The web of care that emerges from Masangane's theology of abundant life, at least as observed in the selection and treatment criteria, rubs up against the conventional biomedical principle of autonomy. This friction is familiar in public health ethics, given the precarious balance between individual rights and paternalism. HIV blurs the line between clinical and public health, between biomedical principles most appropriate in the doctor-patient encounter and conceptions of public health ethics informed by population-level concerns and accountable to the protection of society. But unlike many public health programs, the coercive effect of the behavior monitoring and other paternalistic practices is justified in language more akin to covenant than contract. That is, participants

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<sup>441</sup> This last one—recognition by society—can be seen in the efforts of Masangane staff to help clients—even those not on treatment—navigate the welfare system. Successful application for one of the welfare grants is a form of recognition, an acknowledgment by the government of the particular challenges in one's life. In this way, getting into the system can be an exercise of agency, a way of claiming a place in the larger society.

derogate their individual rights to privacy as part of their covenant with others receiving treatment and all those involved in the provision of treatment, care, and support.

What distinguishes this covenantal relationship from contractual relations between public health clients and providers? The threat of suspending treatment for a noncompliant Masangane patient either implied before the start of treatment as part of the selection criteria or invoked afterwards can certainly be seen as a form of coercion. But it is Masangane's only recourse to those who break the covenant, whereas public health officials have access to more extensive punitive measures, including the restriction of other freedoms (e.g., quarantine restricts freedom of movement). In and of itself this may not seem sufficient, but, in practice, the remarkable efforts to which Masangane staff and volunteers go to support clients in all areas of their lives and not just as treatment monitors suggest that the relationship is something more than a contractual exchange between service providers and clients. This intuition is buoyed by the fact that all of the Masangane treatment supporters are HIV-positive themselves and receive minimal compensation. These two facts work to mitigate the underlying "us and them" logics that undergird paternalism. It does not resolve the tension between a strong principled individual rights ethic and public health ethics in a pandemic, but Masangane witnesses to one way in which this tension is being negotiated on the ground. At minimum, the testimonies of Masangane clients and the broader community suggest that this negotiation has been successful in preserving, even enhancing, respect for the individual, while remaining attentive to the individual's location in community.<sup>442</sup>

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<sup>442</sup> See epitaphs at the beginning of this chapter for an example of a client testimonial that supports this claim. See also client quotes throughout Thomas et al., "Let Us Embrace".



The success of the pilot treatment program ushered in a new era for Masangane. A revised Constitution in 2004 proclaimed three main objectives for this new era: (1) To prevent new HIV infections; (2) To enable HIV positive persons to prolong their lives for many years; and, (3) To lessen the hardships of orphaned children and assist their caregiver families.<sup>443</sup> A commitment to prolong the lives of PLWHA was *de facto* a commitment to develop a treatment program. It was a commitment that provided focus for the general call in earlier constitutions “to render services to those infected and affected by HIV and AIDS as a service of compassion.”<sup>444</sup>

The earlier emphases on orphan care, home-based care, and counseling (psychological and spiritual) illustrate what services of compassion looked like before ARVs became available in South Africa. They were the primary means for mitigating suffering, pain, and poverty among persons affected by HIV and AIDS—the practices animating a theology of abundant life in the absence of treatment. The introduction of ARV treatment at Masangane did not diminish the need for these services of compassion, but it did redefine the abundant life that was possible—namely, through extending the quantity and quality of life years for PLWHA.

The provision of ARVs and the support it entailed had in the course of the pilot program become a practice vital to Masangane’s understanding of abundant life. And as with the other practices (e.g., home visits), the need in the community would always outstrip the human and financial capacity of this small, church-affiliated project in the rural Eastern Cape. Consequently, the focus on treatment generated a greater awareness of the gap between the theological vision of abundant life and the practices necessary for

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<sup>443</sup> Masangane, "Masangane Constitution," (Moravian Church in South Africa, 2004), 1.

<sup>444</sup> Masangane Moravian AIDS Programme, "Constitution [A]."

living into it. Though experienced by some, for most PLWHA in the Eastern Cape abundant life remained an eschatological hope, the realization of which was thwarted by the limited access to ARVs. And even for those who did have access to ARVs through Masangane, lifelong treatment entailed the need for expensive and scarce second- and third-line regimens. Provision of lifelong treatment would require financial stability elusive for a community organization dependent upon the vicissitudes of private donor funding.<sup>445</sup>

In its prophetic and practical witness to what was possible in rural under-resourced area, Masangane's treatment program revealed the interdependence of its commitments to care and justice. At Masangane, caring for PLWHA and orphans had, in itself, always been an act of justice, a public recognition of the many and diverse forms of injustice present in the suffering of persons affected by HIV and AIDS. Still, the constellation of events that opened Rev. McGoyi's eyes to the possibility of responding directly with treatment to the suffering of persons without access to ARVs animated Masangane's "theology seeking justice" in ways the orphan care and prevention programs had not.

The early success of the treatment program in enrolling and sustaining PLWHA with a quality of care lauded by clients and outside observers distinguished Masangane among both its immediate peers, i.e., the many other church-affiliated community organizations responding to the pandemic with home-based care services and orphan

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<sup>445</sup> It is important to recognize that even the theology of abundant life animating Masangane—one in which life is not defined simply by access to treatment but with access to all the trappings of an integrated program—cannot avoid the unintended consequences of limiting abundant life for those with other neglected illnesses. Thus a full-fledged theology of abundant life necessarily calls into question the presupposition of resource scarcity in public health; it must denounce such presuppositions as failures to imagine other possibilities for responding to suffering in society.

programs, as well as from government health services.<sup>446</sup> Earlier commitments to holistic services of compassionate care for persons affected by HIV and AIDS provided a heightened sensitivity to the particular forms of suffering among those marginalized and stigmatized in its community.

Yet the ability to respond appropriately to this suffering was as much a consequence of this close, embodied attention—of the commitment to a continuum of care and the on-going relationships with persons affected by HIV it entailed—as it was the willingness to pay attention to another kind of margin: the margins of global health programs in which MSF was piloting treatment programs for those dismissed as untreatable. As the ARHAP report on Masangane concludes:

To its credit, Masangane as a programme has been able to maintain a connection to the teaching, values, and structures of the religious tradition within which it is embedded while maintaining a scientific approach to the actual treatment it offers. To be able to call on the resources of its religious tradition, and yet remain open to new possibilities in responding to AIDS; to offer a Christian embrace to those with HIV—wherever they come from—and draw them into a well controlled biomedical treatment programme is no mean feat.”<sup>447</sup>

## **Conclusion**

From the perspective of global health leaders, Masangane appears to be an ideal partner—offering in its practices compelling reasons to turn to religious entities as an ally

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<sup>446</sup> Thomas et al., “Let Us Embrace”.

<sup>447</sup> Ibid, 61.

in the response to HIV. I have attempted in this chapter to show theo-ethical reflection as an integral part of the Masangane story. Yet, the tendency among global health leaders remains to separate the processes of theo-ethical reflection from the global health-specific work the religious entities can contribute to—even among global health leaders sympathetic to the greater involvement of religious entities.

For example, a draft WHO report on faith-based organizations and primary healthcare distinguishes between religious entities, like Masangane, that have embraced scientific approaches to HIV and the “harmful cultural traditions” that impede such approaches. As one of the key components of the evidence-base supporting the report, the Masangane program is lauded for its global health-friendly answer to the question: “How can we [religious leaders] expect to make a real difference in the health and well-being of our communities, if we do not draw on the wisdom and experience of those dedicated to and trained in these [medical and global health] fields?”<sup>448</sup> This is an intersection question. Religious leaders engaged in the response to HIV stand in an intersection where traffic from the biomedical sciences and global health are critical sources of information about the prospects for human flourishing in the midst of a pandemic. It is these religious leaders and the communities they lead that are candidates for global health funding and partnerships.

Interestingly, the first part of the quote, also included in the WHO report, suggests an imperative for public health practitioners to pay attention to religion as “the most important thing in their lives, even if it may not be so in our own.”<sup>449</sup> The value of religion, according to this line of thinking, is in what it tells public health folks about how

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<sup>448</sup> Bandy et al., "Building from Common Foundations.", 21.

<sup>449</sup> Ibid., 21.

sensitivity to religious practices and beliefs can lead to more efficient service delivery. The conclusion that immediately follows in the report suggests that religious entities can help public health officials solve a management problem: “If FBOs are harnessed creatively, public managers can ‘achieve greater results or reach broader communities.’” The combination of these factors and their reach into their respective communities presents an incompletely tapped resource that, if harnessed, could contribute to national healthcare outcomes and achievement of the MDGs.<sup>450</sup> Noble aspirations, to be sure, but couched in terms that afford little place for theologians to participate as theologians, or for the prophetic critique that can arise from theo-ethical praxis done in religious communities.

Theo-ethical reflection is valued, then, only insofar as it also generates practical resources that can be harnessed for the purposes of scaling-up treatment, legitimating paradigm shifts already underway (e.g., a return to primary healthcare), or supporting other global health priorities. Under the heading “Supportive and Substantive Roles of FBOs,” the report concludes: “Microlevel religious entities and health assets are usually interconnected with religious institutions, ecumenical networks or international faith-based development agencies. Participative healthcare system re-engineering could be strengthened by the support functions offered by these larger faith organizations. Additionally, channeling resources through these organizations to the grass-roots level could accelerate the scale-up of effective work.”<sup>451</sup> Masangane exemplifies each of these “supportive and substantive roles.” It is connected to the Moravian church in South Africa (religious institutions), the Lutheran church in Germany (ecumenical networks),

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<sup>450</sup> Ibid., 21.

<sup>451</sup> Ibid., 27.

and the Vesper Society (faith-based development agency). Its volunteers serve as a shadow social work force (support functions) that makes possible the move to primary healthcare and its more holistic approach to the constitutive elements of human flourishing. And, it has succeeded in retaining clients in an under-resourced, rural area with one of the highest HIV prevalence rates (accelerate the scale-up of effective work). On these merits alone, Masangane can be seen as a vital religious health asset, or, perhaps more accurately from the vantage point of global health, a vital health asset that is religiously affiliated.

In this dissertation, I contend that this is a potentially important distinction. The latter framing suggests Masangane is, effectively, a health asset like many other community-based organizations embedded in international webs of support. Client comments may offer a glimpse of the distinctive religious character, or at least the client's association of certain Masangane practices with the religious character of the organization (for example, in the holistic approach to service delivery, the linking of daily scripture readings to pill taking, and the inclusivity of the support groups).

The hermeneutic of the participant theologian developed in the previous chapter, I argue, can help raise the profile of theo-ethical reflection in the decision to initiate a treatment program. In this chapter I try to raise this profile of theo-ethical reflection within a religious entity engaged in health, but I do not have sufficient evidence of the actual processes of theo-ethical reflection—e.g., transcripts of conversations among the Masangane advisors or interviews with key leaders, etc.—to make a more robust claim about these processes in relation to the actual implementation of the program.<sup>452</sup>

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<sup>452</sup> I see this as a possibility for future work with the Masangane Program. Though I regret never having had the opportunity to meet Rev. McGoyi who passed away in 2005 while still leading Masangane.

In the end, though, even this may not be sufficient for illuminating Masangane as a distinctively religious health asset as opposed to a health asset that is religiously affiliated. That is, it is one thing for global health leaders to recognize theo-ethical reflection as an integral part of the framing and motivation for Masangane's work—framing and motivation are constitutive elements of theo-ethical reflection. But it is another thing to recognize these framings and motivations as a source of legitimate, constructive critique of the inadequacy of existing global health priorities, policies, and programs.

So, for example, while the decision to expand the program and provide treatment was catalyzed by the scientific and global health advances in ARV treatment—set, importantly, against the backdrop of the on-the-ground knowledge Masangane had accumulated from its extant involvement in the response to HIV—the motivations and framings for Masangane to respond to these advances came from the explicit extension of theological commitments (e.g., theology seeking justice and a theology of abundant life). But are these framings and motivations valuable insofar as they legitimate or otherwise give rise to a certain set of practices recognizable in global health circles? Or are they valuable as potential sources for gaining critical leverage on the inadequacy of existing global health policies, priorities, and practices? Are processes of theo-ethical reflection recognizable to global health leaders in any sense as a source of ontological claims, for what they say about how the world actually is? To say how something actually is, is to say something theological, if one takes seriously Gustafson's understanding of

participation in a theocentric world. In a qualified way, the converse is true as well: to say something theological is to say how the world actually is.<sup>453</sup>

To limit the value of theo-ethical framings and motivations instrumentally with regards to the practices they legitimate is to misunderstand not only this ontological aspect of theo-ethical reflection but also its dialogical character, as my use of Cahill to expand the concept of the participant theologian attempted to make clear. For example, the involvement of Rev. McGoyi in networks of social change and his direct engagement with those affected by HIV both gives rise to and qualifies the types of theo-ethical claims that Masangane seeks to live out of and into. Reflection and action can be seen in this case as co-determining. Consequently, the “truth and viability” of Masangane’s theo-ethical reflection on what constitutes an abundant life cannot be understood apart from its attempt to enact practices that lead to a more abundant life for those affected by HIV. Ultimately, then, theology as participatory discourse or the theo-ethical reflection of participant theologians implies that the dialogical character of theo-ethical reflection delimits the ontological dimension. That is, the theology of abundant life and the theology seeking justice are shaped by the particular medical and social resources available for promoting human flourishing. The availability of ARVs and innovative social emphasis in MSF informed the context of theo-ethical reflection in which the pastors and religious leaders guiding Masangane were engaged. Prior to the advances in ARV treatment, the theology of abundant life and the theology seeking justice necessarily

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<sup>453</sup> The qualification can be seen in Gustafson’s analysis of the different forms of moral discourse and his appreciation for the place of first-order religious language, e.g., in liturgies. In these discussions, to say something theological might involve saying something about things ought to be, for example. See, for example, his discussion of the liturgical potency of the theological claim that “God is an unmarried pregnant teen-age black girl on the west side of Chicago.” Gustafson, *An Examined Faith: The Grace of Self-Doubt*, 104; Gustafson et al., “Doubting Theology.”



took different forms. Saying something theological about the way things really are could not have included the information about life-prolonging treatments or the possibility of a primary health care approach to a complicated, medically elusive pandemic.

What does this mean with regards to my claim that global health tends to view the value of religious entities as partners in instrumentalist terms? How does this understanding of the ontological dimension and dialogical character of a participatory theo-ethical praxis inform my claim in this dissertation that theo-ethical reflection is a health asset? The answer to both questions has to do with the way institutions instantiate the outcomes of theo-ethical reflection, and thus render visible, albeit indirectly, the process of theo-ethical reflection.

It may not be a stretch among religion scholars who have made the turn to practices to argue that the practices of religious entities, themselves, are a theo-ethical argument. For example, the practices are an active witness to how the world actually is or what it should be. In the context of this chapter, the specific practices of caregiving in an integrated HIV treatment program appear as a theo-ethical argument for what constitutes an abundant life. But is this how such practices are viewed in global health circles? The argument in the dissertation thus far suggests the answer is no. Instead, the specific practices of caregiving visible in the work of Masangane volunteers are viewed as complementary to an evidence-based understanding of human flourishing articulated in global health policies and programs. The coincidence in Masangane of the theo-ethical argument for what constitutes an abundant life and the evidence base for human flourishing obscures the generative potential of theo-ethical reflection, the potential of theo-ethical reflection to provoke critical reflection on the priorities of global health.

This chapter stops short of articulating the precise nature of theo-ethical reflection as a religious health asset. The purpose was to illustrate first, theo-ethical reflection as a primary activity of religious entities involved in global health issues, and, second, how a participatory theo-ethical reflection integrates knowledge from other arenas of inquiry (e.g., medicine) into its ontological claims and practices. As a religious entity recognized by global health leaders both as a religious health asset, itself, and as a holder of specific health assets, the example of Masangane shows clearly how nontheological ways of knowing contribute to the theo-ethical reflection of religious entities, even as it raises questions about the adequacy of the current religious health assets framework to account for the contribution of theo-ethical praxis to nontheological ways of knowing.

It remains to be seen whether the theo-ethical framings and motivations enacted in the work of Masangane will be appreciated in global health circles as generative of new ways of doing global health, or whether they will be seen as religious ornamentation for existing ways of doing global health, limited in their value to framing and motivating the confessional communities conversant in and formed by particular theological worldviews. Even within this more limited view, the case of Masangane shows how partnerships with religious entities can have a significant impact on global health outcomes. But, as the case study in the next chapter makes clear, when global health leaders engage directly with the theo-ethical reflection of religious entities, the very nature of global health can be affected.

## CHAPTER SIX

### THE RECOVERY OF PARTICIPANT THEOLOGIANS IN GLOBAL HEALTH HISTORY:

#### A CASE STUDY OF THE CHRISTIAN MEDICAL COMMISSION

*It is a godly coincidence that nearby the World Council of Churches (WCC) is also celebrating its 60th year. Together WHO and WCC share a common mission to the world, protecting and restoring body, mind, and spirit. It is important that this is also the 40th anniversary of the Christian Medical Commission, whose values and experience in primary health care, informed and shaped the 1974 WHO Guidelines for Primary Health Care, which were reaffirmed at Alma Ata.*

Archbishop Desmond Tutu<sup>454</sup>

#### I. INTRODUCTION

In May 2008 a small conference took place in Buckeystown, Maryland. The theme of the conference, “Community Health and Wholeness,” serves as shorthand for a renewed interest in the intersection of practices of community-based public health and a particular set of health-related theological commitments among Christians. The fine print included on the conference flier suggests a prominent role for “People of Faith” in helping others to navigate this intersection:

Please join us as we celebrate the unique and important role that the faith community can play in providing quality health care at the community level. ...

We will review past and current community health efforts and we will end the

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<sup>454</sup> Tutu, "Address by Reverend Desmond Mpilo Tutu."

conference with a Call to Action to People of Faith to embrace their mantle of leadership in the global revival of community-based health care.<sup>455</sup>

Two aspects of this promotional blurb stand out for their implicit challenge to the conventional wisdom about the relationship of religion and health. One, “People of Faith” are identified not merely as partners, but *leaders* in the “global revival of community-based health care.” Two, this leadership is not predicated solely on the coherence of a particular theological anthropology nor the superiority of a specific form of ecclesial witness, but on the ability to provide “quality health care at the community level.” In issuing these challenges, Christian Connections for International Health (CCIH) revitalize a longer history of Christian theo-ethical reflection on and involvement in community-based health initiatives.

This chapter sets out to recover part of this history as a way of demonstrating how, in the past, theo-ethical reflection has played a critical role in shaping global health priorities and policies. In this way, the case study below extends the evidence from the previous chapter to show how a participatory theo-ethical praxis can contribute to nontheological ways of knowing and generate transformative and connective practices among scholars and practitioners working in the global health intersection. The historical evidence of this contribution and the institutional connections it helped to generate offer compelling justification for identifying theo-ethical reflection as a distinctive and vital religious health asset.

The chapter tills the fecund theological, public health, and institutional soil out of which the community-based primary health care movement of the 1970s grew. The first

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<sup>455</sup> Christian Connections for International Health, "Community Health and Wholeness," *Annual Conference*(2008), <http://www.ccih.org>.

section is historical. It begins with a description of a mid-twentieth-century paradigm shift in Christian theological and ethical reflection on health. Primary documents from ecumenical Christian consultations provide the foundation for this history. It is told largely from within the perspective of Christian theologians and leaders involved in medical missions. The chapter moves in the second section to tell an institutional story about the establishment of the Christian Medical Commission (CMC) in the late 1960s and the role it played in the primary health care movement during the 1970s. The chapter concludes with reflection on how the history of the CMC serves as an example of the persistence of the theological in global health. The waning influence of the CMC after the Declaration of Alma Ata highlights particular challenges to theological persistence—to recognizing the value of theo-ethical reflection—in a global health sector increasingly defined by the priorities and metrics of donors (philanthropists, NGOs, or nation-states). A possible response to these challenges, focused on global health as transdisciplinary space, will be explored in the concluding chapter.

The chapter draws on primary sources from the 1960s as well as a nascent secondary literature that has been spurred by two factors: (1) increased scholarly interest in and appreciation for global health history,<sup>456</sup> and (2) a debate, detailed throughout this dissertation, about the appropriate role of religious entities in the strengthening of health systems (e.g., scaling-up the provision of services).

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<sup>456</sup> For examples of this increased interest in global health history, see Brown, "The Value of History to Public Health."; Brown, Cueto, and Fee, "The World Health Organization and the Transition From "International" To "Global" Public Health."; Brown and Fee, "A Role for Public Health History."

## II. Christian Medical Commission: A Theological History

The story of Christianity and health care dates back to the early church as Jesus' disciples continued to preach and practice his distinctive healing ministry.<sup>457</sup> Today, debates about the relationship between modes of healing—medicine, magic, or miracle?—or the connection between salvation, eschatology, and healing narratives in the Bible continue to stimulate new work in New Testament, early church, rabbinic, and Hellenic studies. To tell the full history of Christianity and health care from its origins in the first century to its multiple expressions in the twenty-first century is well beyond the scope of this dissertation. More to the point, for the purposes of this dissertation, the extended history is less relevant than how the distinctiveness of Jesus' healing ministry was “rediscovered” by members of the Christian ecumenical consultation who gathered in Tübingen, Germany in 1964.<sup>458</sup> As will be made clear below, however, the theological “rediscovery” of healing is part of a larger effort among Christians to make sense of the global social, political, and economic changes of the mid-twentieth century.

### *Tübingen I: The Healing Church, or the Priesthood of All Healers*

In 1962, the Lutheran World Federation (LWF) and World Council of Churches' Division of World Mission and Evangelism initiated a joint study process on the

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<sup>457</sup> Hector Avalos, *Health Care and the Rise of Christianity* (Peabody, Mass.: Hendrickson, 1999); James C. McGilvray, *The Quest for Health and Wholeness* (Tübingen, Germany: German Institute for Medical Missions, 1981), especially 2-3.

<sup>458</sup> This consultation was not the first attempt to bring together theologians and medical personnel in the hope of clarifying a Christian conception of healing. The Anglican Archbishop's Commission on the Church Ministry of Healing and other dialogues sponsored by Mainline denominations took place throughout the 1950s and early 1960s. But these attempts failed to get off the ground. James McGilvray observes that theologians could never quite reconcile their doctrinal differences and the medical professionals were primarily interested in religion as an existential balm, a “resource which gave meaning to life in situations of inner emptiness,” for example, illnesses for which there was no medical cure. See McGilvray, *The Quest for Health and Wholeness*, 12.

“essential issues” of medical missions.<sup>459</sup> Intentionally modest in scope, the two world bodies sought the advice of a small group, constituted primarily by medical doctors, on the appropriate role of the LWF and WCC in responding to the perceived challenges facing medical missions. Preparatory papers focused on different conceptions of and contexts for healing: from the pre-scientific to modern medicine and from the congregation to the mission field.<sup>460</sup> By the end of the week together, the members of the consultation, much to their own surprise and that of the planners, had moved, or—to echo the tenor of the participants, *had been moved*—from reflection to proclamation.

The findings of the consultation found expression in the “statement on the Christian Concept of the Healing Ministry of the Church,” understood by participants and subsequent generations of Christian health workers as a fundamental challenge to the two-fold task of medical missions: meeting physical needs and preaching the Gospel.<sup>461</sup> The statement reconfirmed in language both theological and practical that the Christian Church has a *distinctive* role to play in healing. While acknowledging that Christians involved in health work express similar ethical commitments as non-Christians, e.g., compassion, a concern for the dignity of individuals, etc., the statement makes explicit the relationship between healing and the Christian drama of salvation history.

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<sup>459</sup> Lesslie Newbigin, ed. *The Healing Church: The Tübingen Consultation, 1964* (Geneva: World Council of Churches, 1965), 5.

<sup>460</sup> Though the full proceedings are not available from the consultation, key elements were preserved in *The Healing Church*. Preparatory papers reproduced in their entirety include: Lesslie Newbigin, “The Healing Ministry in the Mission of the Church”; Erling Kayser, “Medicine and Modern Philosophy: An Introduction”; Martin Scheel, “Some Comments on Pre-scientific Forms of Healing”; and, John Wilkinson, “Christian Healing and the Congregation.” See *Ibid.*

<sup>461</sup> *Ibid.*, 34. Reflecting on the impact of Tübingen I, Christoph Benn and Erlinda Senturias assert: “Even today, many churches in Africa and Asia feel that the conclusions of the Tübingen consultation deeply influence their work in health care.” Christoph Benn and Erlinda Senturias, “Health, Healing and Wholeness in the Ecumenical Discussion,” *International Review of Mission* 90, no. 356-357 (2001), 10.

Theologically, healing bears witness to the “breaking into human life of the powers of the Kingdom of God, and of the dethroning of the powers of evil.”<sup>462</sup> Such an incarnational view of healing is intended as an invitation for the “priesthood of all believers” to become a priesthood of all *healers*, actively responding to the spiritual as well as physical dimensions of suffering.<sup>463</sup> In the older, Enlightenment-inflected formulation, curative medical practices were a jumping off point for proselytizing, but not in a strict means-end relationship. Physical healing was neither the means to, nor evidence of, salvation; rather care for the body and care for the soul were seen—consistent with Cartesian ontology—as distinctive activities.

The incarnational theology articulated at Tübingen presented both epistemological and eschatological challenges to this distinction. Epistemologically, Tübingen I sided with nascent liberation theologies that legitimized knowledge generated outside of the professional medical establishment. Knowledge of the body, more specifically, one’s own body, was not the exclusive domain of medical doctors and researchers. In the medical missionary encounter, they noted, knowledge of the body was more accurately described as an amalgamation of Western science, traditional medicines, culturally specific anthropologies (theological or otherwise), and experience. This is not to say that the participants at Tübingen I had embraced cultural relativism, however.<sup>464</sup>

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<sup>462</sup> Newbiggin, ed. *The Healing Church: The Tübingen Consultation, 1964*, 35.

<sup>463</sup> The language in the statement is consistent with the mid-twentieth century preoccupation among theologians with existentialism, e.g., anxiety about death, meaning of life, etc. Such preoccupations may have been an important catalyst for broadening the definition of health as health professionals and theologians, alike, recognized the limits of physical healing for addressing the isolation and anxiety that continued to plague modern life, despite advances in economic well-being, medical technology, etc.

<sup>464</sup> As noted above, the salvation history in which they located healing was unapologetically Christian and could easily be perceived as triumphalist or predestinarian (e.g., healing is only possible for the elect). However, Christoph Benn and Erlinda Senturias point out that such triumphalism is mitigated at Tübingen by an approach to healing that is both holistic and eschatological.



Rather, Tübingen I articulated an eschatological etiology of disease in which disease is a “sign for a world awaiting salvation” and “healing represents the defeat of transpersonal evil that contradicts the original good intention of God for all human beings.”<sup>465</sup> The eschatological frame is more accurately described as a shift in emphasis from “broken” individuals in need of fixing to a broken world in need of healing—physically as well as spiritually.<sup>466</sup> Practically, this is embodied by a medical missionary who sees his role not as the primary vessel through which individuals are saved but as a witness to a Christian theological understanding of history in which the dialectic between sin and salvation finds this-worldly expression in the breaking and healing of relationships—with God, with others, and with one’s self.

Health, itself, is understood as an eschatological concept. It is never achieved, but as David Jenkins, one of the key interlocutors in the Christian Medical Commission’s early discussions, describes, health “is what God promises and offers in the end... [it is] what is available now both in foretastes and as the aim and ideal which judges our current activities and structures while at the same time provoking us to more healthy responses.”<sup>467</sup> The work of Jenkins and James McGilvray to develop an eschatological idea of health both brightens and toes the line between Western missionary medicine and Christian healing that had been drawn at Tübingen I. It toes the line in its insistence that medicine is a service profession and should be “more widely and directly available to all

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<sup>465</sup> Benn and Senturias, "Health, Healing and Wholeness in the Ecumenical Discussion," 12.

<sup>466</sup> The influence of process philosophy can be detected in this shift as the world is understood to be something that is in the process of becoming. More specifically, process theologians emphasize that these processes are part of the unfolding of God’s good creation. See, for example, Marjorie Suchocki, *The Fall to Violence : Original Sin in Relational Theology* (New York: Continuum, 1994).

<sup>467</sup> David Jenkins, “Foreword” in McGilvray, *The Quest for Health and Wholeness*, xiii.

suffering human beings.”<sup>468</sup> This is a call for a reorientation, not a rejection, of Western medicine. It brightens the line, though, in its invitation to think of health as a “vision of possibilities” that cannot be reduced to the “possibilities or failures of medicine.”<sup>469</sup>

The concern for a Christian understanding of healing at Tübingen I could, if taken in certain other-worldly directions, call into question the grounds on which hospitals and clinics were deemed necessary.<sup>470</sup> But the participants at Tübingen I, most of whom were medical professionals and not theologians, advocated a less radical reform of medical mission that sought to reintegrate (rather than ex-communicate) the professional medical worker into the wider healing church and to supplement medical skills with “practical acts of love and service... sanctified by the ministry of the word, prayer and the sacraments.”<sup>471</sup> In this commitment to reconnecting medical missionaries to the corporate life of Christian fellowship, Tübingen I offered a new ecclesiology.

The church as “healing community” was a correction to what was identified by participants as one of the critical issues in medical missions: the increasing power, specialization and professionalization of medicine. Specialized medical practice and the institutions in which it was practiced, even if nominally Christian, had become, they argued, disengaged from the life of the congregation. This had an effect not only on the practice of medicine, but also on how Christians understood their own capacity to be agents of healing.

In a health worldview described largely in the language of professional medicine, i.e., health is the absence of disease, the authority of the Great Physician to heal is

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<sup>468</sup> Jenkins, “Foreword” in *Ibid.*, xiii.

<sup>469</sup> Jenkins, “Foreword” in *Ibid.*, xiii.

<sup>470</sup> *Ibid.*, 16.

<sup>471</sup> *Ibid.*, 15-16.

masked by the proliferation of pretty good physicians who can diagnose, prescribe, and, in some cases, cure the physical ills that humans suffer. One of the fundamental claims of Tübingen I, however, was that “all healing is of God.”<sup>472</sup> As members of healing communities, then, Christians must recognize their theologically rooted moral obligations to accompany others at every stage of their health journey, especially those stages not recognized or adequately addressed by the hospital-based system.<sup>473</sup>

In effect, Tübingen participants intoned, Christians reclaim their capacity to heal by recognizing both the theological grounds of healing and the multi-dimensional reality of health. A multi-dimensional view of healing affords multiple entry points for persons with diverse talents to participate in healing processes, and thus, de-centers the medical professional without necessarily rejecting her contribution.

Tübingen I urged the Church not “to surrender its responsibility in the field of healing to other agencies,” since Christianity is understood as offering a distinctive approach to health and healing that is derivative of the Gospel’s emphasis on wholeness and the reconciliation of human relationships with one another and with God. For the participants at Tübingen, the healing church offered a vision of a transformed community that took seriously its unique responsibility to be a place of refuge from the existential anxiety as well as physical illnesses that plagued the modern world. Reflecting on the consultation nearly two decades later, James McGilvray offered this assessment of the epiphany at Tübingen I:

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<sup>472</sup> Newbigin, ed. *The Healing Church: The Tübingen Consultation, 1964*, 47.

<sup>473</sup> Though Lambourne was not a part of the initial Tübingen consultation, his insights about the relationship between churches and healing predate the consultation and became a centerpiece of the second Tübingen consultation in September 1967. See Robert A. Lambourne, *Community, Church and Healing: A Study of Some of the Corporate Aspects of the Church's Ministry to the Sick* (London: Darton, Longman & Todd, 1963).

Their original intention had been to address themselves to the problems of their service and to discover a cogent rationale for the churches' involvement in medical care. Yet, in every case, they found themselves concluding that the church had somehow lost its capacity to heal partly because it had chosen to define this role too narrowly in terms of medical practice, addressed especially to those in sore need, and, partly because it had lost its sense of corporateness and community through a pre-occupation with individual salvation. In this sense, the church suffered the same imbalance as medicine which was most frequently practiced on a one to one relationship between physician and the individual patient.<sup>474</sup>

The Enlightenment, according to this line of thinking, and the development of modern medicine in its wake effectively ruptured the intrinsic connection between the Gospel and health, first by separating out the constitutive parts of the human (mind, body, spirit), and second, by transferring the authority to heal into institutions and technologies driven by the logic of scientific positivism. The upshot, in Christian theological terms, is that modern medicine could not account for the paradoxical place of suffering in the Christian tradition. Healing, or salvation, in medical terms was preoccupied with the total removal of illness; health was negatively defined as the absence of disease. Modern medicine, in other words, did not offer a satisfactory soteriology to persons who experienced illness and suffering as more than physical.

The problems with medical missionary work had been identified and a general reorientation articulated at Tübingen, but what that actually meant going forward

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<sup>474</sup> McGilvray, *The Quest for Health and Wholeness*, 21.

remained undecided. Despite drawing such a stark contrast between the logic and practices of Western medicine and a theology of Christian healing—and, perhaps, as the quote from McGilvray suggests, humbled by the church’s own failure to walk the talk—the participants at Tübingen I left open the question of whether to fulfill this “responsibility in the field of healing” through the maintenance of separate Christian health facilities or through the participation of individual Christians in secular agencies.<sup>475</sup> Any answer to this question would, of course, need to be consistent with the theology of health and healing “rediscovered” at Tübingen I, but it would also have to account for the radical historical transformations in which this rediscovery was taking place.

As McGilvray observes, a description of the pioneering role of churches “in the establishment and maintenance of hospitals” is not the same as a prescriptive claim about the churches’ “unique responsibility” within a modern state.<sup>476</sup> The post-colonial context underscored just how different those two claims can be.

### *Medical Missions in a Postcolonial Context*

The new ecclesiology may have found theological justification in a recovery of earlier Christian conceptions of healing, but it was the profound political and social upheaval of the independence movements throughout the European colonies that served as the catalyst for rethinking the relationships between the institutional legacy of a medical mission model (e.g., hospital-based, curative care centers) and the emerging nation-states of Africa, Asia, and the Americas. As Christoph Benn and Erlinda

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<sup>475</sup> Newbigin, ed. *The Healing Church: The Tübingen Consultation, 1964*, 35. This open practical question would continue to permeate subsequent ecumenical discussions about health, including the second Tübingen consultation (Tübingen II). (See “Christian Medical Commission” section below for how this question finds, if not an answer, at least a forum in the establishment of the Christian Medical Commission.)

<sup>476</sup> McGilvray, *The Quest for Health and Wholeness*, 3.

Senturias observe in their historical review of the ecumenical discussion of health and healing: "The churches had to face the issue of whether or not there was a specific Christian ministry of healing and how to define this ministry. They also had to articulate the differences between a government and a church hospital."<sup>477</sup> With independence, nations were beginning to develop their own public health systems and in the process were calling into question the working relationship between church hospitals and colonial administrators.

Politically, church hospitals were associated with the recently overthrown colonial regimes, and thus, suspect, an impediment to complete liberation. Practically, however, church-supported health care made up a significant amount of total health care in newly independent countries.<sup>478</sup> Governments responded in various ways, including: building new government hospitals, nationalizing mission hospitals, and allowing the hospitals to continue operating under the auspices of emerging independent national churches (e.g., Evangelical Lutheran Church of Tanzania). Yet, all of these responses confronted the problem of financing.

The practical (and urgent) problem of financing a new health system can be seen as both one of revenue generation and escalating health care costs. The former is part of the larger array of challenges facing governments in transition, including the necessity of establishing a tax structure capable of providing revenue for the health budget. The latter problem, however, was not unique to new nations, though it had a disproportionate effect on them. The rise in health care costs was associated with expensive new technologies

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<sup>477</sup> Benn and Senturias, "Health, Healing and Wholeness in the Ecumenical Discussion," 9.

<sup>478</sup> Church-supported hospitals accounted for an estimated 2100 hospitals prior to World War II, a number that does not include primary or secondary clinics. See Ibid.; McGilvray, *The Quest for Health and Wholeness*.

and a continued emphasis on specialized curative services delivered by tertiary institutions.<sup>479</sup>

The Tübingen consultation had been convened around the essential issues facing medical missions and the Church's role in healing. But as the participants articulated an answer to the latter—an answer motivated by political and economic considerations as much as by theological reflection—the very model of medical missions was called into question. Political changes had begged questions of the legitimacy and purpose of the medical mission enterprise; financial considerations at the local and denominational level had forced questions about its viability and sustainability; and, theological questions had surfaced a Christ-informed holistic understanding of health and human being that challenged the positivism and individualism of the predominant medical mission model.

*Tübingen II: Here is the Healing Church, Here is Its Steeple, Open It Up and...?*

Something had happened at the first Tübingen conference. A healing church had been, if not born, at least conceived. Tübingen I identified a distinctive identity for Christian communities, yet in so doing it made explicit the gap between Christian understandings of health and healing, on the one hand, and Western biomedical explanations of illness and health, on the other. In attempting to “discover a cogent rationale for the churches' involvement in medical care,” participants at Tübingen I called into question the premises of medical care, itself, at least as practiced in the West and among medical missionaries.

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<sup>479</sup> Benn and Senturias estimate that only twenty percent of the population of newly independent countries had access to modern health care. Benn and Senturias, "Health, Healing and Wholeness in the Ecumenical Discussion," 9. See also McGilvray, *The Quest for Health and Wholeness*, 4.

The take home message from Tübingen I was that medical accounts of health are insufficient without insights from Christian theology, especially insights about salvation. But this message left open two important questions: “whether the theologian’s view of salvation would be complete and sufficient without the contribution of the scientist?”<sup>480</sup> And what would a healing church actually look like in practice?

These questions would form the basis for a second consultation at Tübingen in 1967, three years after the initial gathering. By this time, efforts were underway to look for examples of the healing church in the world. Surveys by the World Council of Churches’ Committee for Specialized Assistance to Social Projects (SASP) had been fielded in individual nations with the intention of eliciting the scope and role of “church-related medical programs” in the context of emerging independent states.<sup>481</sup>

The results of these surveys informed the discussions of Tübingen II, offering specific evidence of the ways the medical missionary model failed to meet the health needs of the vulnerable persons it was intended to serve. Echoing earlier concerns about the disproportionate emphasis on curative care, surveys found that 95% of church-related health programs focused on curative rather than promotive or preventive medicine. Moreover, as governments in newly independent states rushed to modernize, they, too, placed an emphasis on curative services. As a result of this narrower emphasis and the legacy of colonial disregard for a comprehensive health system, it was estimated that only 20% of populations had access to modern medical care—government or church-provided.

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<sup>480</sup> McGilvray, *The Quest for Health and Wholeness*, 23

<sup>481</sup> *Ibid.*, 15. The two objectives of these surveys: "(1) To discover the relevance of Christian medical work as a professional activity within the context of the existing health and medical needs and in relationship to other agencies, governmental and private, which were also seeking to meet those needs; and (2) to seek the relevance of Christian medical programmes to the life and mission of the church particularly on the national and local level." Survey objectives quoted in *The Quest for Health and Wholeness.*, 32.



Even with access to care, the curative care focus contributed to a rise in operational costs for hospitals, e.g., expense of upgrading diagnostic technologies. Higher fees for services were implemented to offset these additional costs, further restricting the potential clientele to those who could afford to pay the higher fees.

The post-colonial era underscored two additional findings of the surveys. One, locations of health services tended to follow identifiable patterns leftover from colonial rule. For example, the placement of hospitals and clinics was largely a function of strategic decisions on the part of colonial administrators and missionary churches rather than a response to the specific health needs of the colonized. As a result, the health system new leaders in sub-Saharan Africa inherited was a patchwork of various colonial and denominational interests incompatible with a planned, comprehensive national health system. The church-related hospitals and clinics dotting the sub-Saharan African landscape had emerged over time in the former colonies and did not reflect a coordinated effort to provide medical care across localities.

Thus, another finding of the surveys was that the actual and potential contribution of churches to healthcare services in post-colonial Africa was largely ignored by the leaders of newly independent states, in part because the lack of coordination within and across denominations undermined the coherence of a church voice in debates about how to address the health needs of all citizens.<sup>482</sup> Given all of this, examples of what the healing church might look like were hard to find, especially if the search for the healing church was conducted within the amalgam of existing church-related health programs.

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<sup>482</sup> McGilvray, *The Quest for Health and Wholeness.*, 40-41.

Still, the concept of the healing church served to disrupt the dominance of biomedical frameworks for health that had relegated religious leaders to “reactors,”<sup>483</sup> uncritically adopting the language and approach of Western biomedicine. Medical-speak had increasingly become the default language for articulating the fundamental questions of human suffering as well as the responses they evoke—questions Tübingen participants recognized as central to the Christian story. At the same time, participants at the first Tübingen consultation attempted to reclaim elements of the Christian healing tradition without retreating to pre-modern understandings of healing (e.g., healing as miracle), nor reverting to a narrow view of medical mission as primarily a means of proselytizing, or saving bodies to save souls.

The reassertion of the priority of healing in the Christian tradition was intended as a constructive critique, animated by an impulse to reform rather than reject the assumptions of Western medicine, a corrective to what James McGilvray lamented was the “idolatry of the problem-solving powers of science.”<sup>484</sup> McGilvray outlines the consequences of such idolatry as a form of hubris: “What is wrong is not the ‘medical model’ but the human tendency to invest too much in valuable human powers and discoveries so that, first, idols are produced and then there is nowhere to turn when both their tyranny and inadequacy (on their own) begin to be obvious.”<sup>485</sup>

Indeed for Robert Lambourne, whose book, *Community, Church, and Healing* (1963) was emerged as one of the core texts at Tübingen II, recognition of the tyranny and inadequacy of the medical model had become increasingly obvious even within the profession of medicine:

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<sup>483</sup> Ibid., 31.

<sup>484</sup> Ibid., 100.

<sup>485</sup> Ibid., 101.

Recent years have seen a revival of interest within Medicine and Church in the possibility of co-operation with each other. There is now amongst the majority of men and women working in the medical and social services, some sympathy with church and religion. This is something new, for before two world wars shook man's confidence in his ability to master the world and himself, a mood of atheism or condescending agnosticism was dominant in Medicine. One sign of this these new times is that universities and hospitals founded at the end of the last century without a chapel are now building chapels and appointing chaplains. Another is the growing emphasis amongst doctors upon a holistic approach to medicine. This holistic approach respects the fact of the psychosomatic unity of the person. As a consequence the clinician, whatever his personal position in matters of faith, now recognises ideally that no case history is complete which does not record some understanding of the patient's thoughts and feelings about his place and purpose in the universe. This understanding is not, of course, necessarily communicated in religious language.<sup>486</sup>

In the mid-20<sup>th</sup> century interest in holistic health, the psychosomatic unity of the person, or what might be described as the phenomenon of human being appeared widespread.<sup>487</sup>

For those at Tübingen II, this interest raised questions about the capacity of both science (i.e., medicine) and Christian theology, in and of themselves, to articulate a comprehensive understanding of the multiple and interlocking dimensions of healing.

Tübingen I had proposed the healing church as a corrective to the limits of the dominant

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<sup>486</sup> Lambourne, *Community, Church and Healing: A Study of Some of the Corporate Aspects of the Church's Ministry to the Sick*, vi.

<sup>487</sup> For a general overview of this interest and its historical relation to the religion and psychology conversation, see James M. Nelson, *Psychology, Religion and Spirituality* (New York: Springer, 2009).

medical view of health, but Tübingen II was forced to confront the limits of the healing church.

Of immediate concern was the practical implication of the healing church model for the ongoing provision of medical care in developing countries. Did the epiphany at Tübingen I imply that government or other nonreligious health care providers would always fall short of the vision of health made possible within a Christian framework of salvation history? If so, did that provide a mandate for Christian health care providers to resist the increasing intrusion of secular health care into what was understood to be the rightful domain of churches?

Reflecting on the criticisms of Tübingen I and the clarifying work undertaken at Tübingen II, Benn and Senturias suggest that the healing church was never intended as a substitute for other health care institutions. Drawing on notions of subsidiarity as well as the financial and professional impracticality of the church as health system, they underscore the “primary responsibility for the health care of people remains with the government of nations.” The churches should “try to complement government services when these cannot fulfill their commitments or when there are particularly disadvantaged people for whom nobody cares.” To task the church with the maintenance of a national health system “would be a misunderstanding of the church’s mission.”<sup>488</sup> The healing church as manifest in actual institutions on the ground, stands in society’s gaps and in so doing provides a witness to the specific ways national health systems fail to meet the health needs of its citizens (e.g., discriminating against certain populations).<sup>489</sup>

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<sup>488</sup> Benn and Senturias, “Health, Healing and Wholeness in the Ecumenical Discussion,” 12.

<sup>489</sup> See, for example, McGilvray’s rhetorical questions regarding the uniqueness of Christian health care: “Nobody seems to question the relevance of Christian medical service in leprosy institutions nor in remote areas which fail to attract other members of the professions. Did this suggest that the churches’ role in the

In addition to the practical concerns, the vision of the healing church raised theological concerns. If healing is linked to salvation, as a sign of the coming kingdom of God, to borrow from Tübingen I, what does that mean for those who do not experience healing, for example, those with chronic diseases? The theological vision that gave rise to the notion of the healing church risked trending towards Christian triumphalism (e.g., “healing as a sign of for the beginning of the kingdom of God and of the dethroning of the powers of evil”<sup>490</sup>) or fatalism associated with concepts of double pre-destination (e.g., whether one is healed or not provides direct knowledge of one’s state of grace or damnation).

Yet, the fundamental insight that “all healing is from God” was intended neither as an abdication of human responsibility to provide medical care to those in need, nor as a rationale for not seeking this-worldly healing. Rather, it was a call for all members of the church to participate as healers according to their particular gifts, and in the process transform congregations into healing communities. In this way, the theological vision of the healing church might be translated into an ecclesial and social reality with impact on the varied dimensions of suffering in this world.

The holistic understanding of health and the priesthood of all healers it created space for was not, in the end, a denial of the critical role of medical professionals in church-related health programs. Indeed, the “epiphany” of Tübingen II was that understanding the implications of the healing church required an intimate and ongoing conversation between the disciplines of theology and medicine, among others. The key

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provision of health services was that of a pioneer in meeting human need where no other provision was available but that when secular agencies were willing and able to accept responsibility then the church could withdraw?" McGilvray, *The Quest for Health and Wholeness*, 7.

<sup>490</sup> Benn and Senturias, "Health, Healing and Wholeness in the Ecumenical Discussion," 12.

question of whether theology and medicine could speak coherently to one another about the phenomena of health, or more broadly about what it was to be human, remained open. Tübingen II did not provide definitive answers to the questions of “whether the physician’s view of health is complete and sufficient without a contribution from Christian theology, and whether the theologian’s view of salvation would be complete and sufficient without the contribution of scientists.” Instead, the second consultation ended with a deeper awareness of the challenges that would need to be overcome in order to move the healing church from vision to reality. The bold call for a healing church announced in 1964 (Tübingen I) as a corrective to trends in Western medicine gave way by 1967 (Tübingen II) to a kind of epistemic humility that recognized the partiality of all disciplines—including theology—for comprehending fully the phenomena of healthy human being. It also ended with a greater resolve to address these challenges with the full resources of the larger ecumenical movement.

The following section tells the story of how the Christian Medical Commission brought together (and institutionalized) the theological vision of healing and wholeness and, eventually, gave rise to the community-oriented primary care movement in global health.

### **III. Christian Medical Commission: An Institutional History**

Established by a mandate of the World Council of Churches in 1968, the CMC was “charged with the responsibility to promote the coordination of national church-related medical programmes, and to engage in study and research into the most appropriate ways in which the churches might express their concern for total health

care.”<sup>491</sup> The mandate emphasized the practical tasks of the CMC even as it implied the theological dimensions of the new approach to medical missions articulated in the Tübingen consultations.

Practically, the CMC was to be “an enabling and supporting organization. Surveys conducted prior to 1968 revealed that member churches of the World Council of Churches were affiliated with 1200 hospitals worldwide, but the growing role of government in public health combined with an increase in costs as a result of both technological advances and aging institutions required a reevaluation of church-related health programs.<sup>492</sup> When the Commission identified an innovative programme, it would use the Commission’s contacts to get funding for its work, and put its organizers in touch with people doing similar work elsewhere.”<sup>493</sup> But as James McGilvray, the CMC’s first director, noted at the inaugural annual meeting, the mapping of these innovative programs had a “theological flavour.”

Documenting church-affiliated health care programs provided answers to the descriptive question: what are churches doing? But analysis of the actual programs, especially in relation to other non-church health services, offered a starting point for answering theological questions about the distinctive contribution of church-affiliated services, as well. Recalling the emphasis on salvation history and wholeness that

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<sup>491</sup> Gillian Patterson, "The CMC Story: 1968-1998," *Contact*, no. 161/162 (1998), 3. See Christian Medical Commission and World Council of Churches, "Annual Meeting" (Geneva, 1968), 2-3.

<sup>492</sup> Based on a sample of twenty-five hospitals in twenty different countries, costs had increased 100 - 150% between 1958 - 1968. James C. McGilvray, "The Historical Perspective: Our Inheritance," in *Christian Medical Commission Annual Meeting* (Geneva: World Council of Churches, 1968), 25. The average age of the church-affiliated hospitals was 40 years with an expected life expectancy of between 5-15 more years. Christian Medical Commission and World Council of Churches, "Annual Meeting", 1 Preliminary surveys in several countries indicated that although globally, church-affiliated medical services accounted for only one third of one percent of available beds and treatment, in select countries throughout Africa this percentage ranged from 27% to 43%. See McGilvray, "The Historical Perspective: Our Inheritance," 24.

<sup>493</sup> Patterson, "The CMC Story: 1968-1998," 8.

permeated the Tübingen discussions, McGilvray declared: “The Church is not simply another service agency or an ecclesiastical foreign aid programme.”<sup>494</sup> And after Tübingen, the Church was not simply the Church, anymore. It had become the healing church, leading some observers to suggest that “healing considered as the responsibility of the entire community may be precisely one of those gaps into which Christian congregations should do pioneering work.”<sup>495</sup>

The initial mandate from the WCC located the CMC within its Division on World Mission and Evangelism (DWME), and affiliated it with its Division of Inter-Church Aid, Refugee, and World Service (DICARWS). The Commission’s twenty-five members included the chairs of both DWME and DICARWS as well as the General Secretary of the WCC. Though a priority was placed on selecting health care and community development professionals, representatives with theological and mission interests were included as well.<sup>496</sup> The by-laws required that at least ten members come from non-Western countries, defined as *not* North American, Australasian, or European.

The mandate divided the Commission’s work into two stages. Stage One (1968-1971) was concerned with establishing the evidence base: “For a period of three years it shall be primarily engaged in surveys, the collection of data on existing institutions,

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<sup>494</sup> Christian Medical Commission and World Council of Churches, "Annual Meeting", 1 For a powerful restatement of this declaration within the HIV pandemic forty years later, see African Christian Health Associations' Technical Working Group on Human Resources for Health, "Letter to Mubashar Sheikh, Executive Director, Global Health Workforce Alliance," (August 26, 2008). The letter presents evidence of the distinctive role faith-based health organizations play in the HIV response and requests that the Global Health Workforce Alliance cease its practice of analyzing faith-based organizations as just another member of the private sector.

<sup>495</sup> See especially Dr. Jacques Rossel’s report “On the Threshold of New Development,” in Christian Medical Commission and World Council of Churches, "Annual Meeting", 10. Rossel was the former chair of the WCC’s Specialized Assistance to Social Projects, one of the divisions in the WCC to which the CMC reported.

<sup>496</sup> Of the twenty-four Commission members present at the first meeting, nine can be reasonably identified as representing theological, missionary, or church service interests. For example, persons identified as Rev., Archbishop, or representative of church agency. *Ibid.*



investigation of more adequate forms of administrative relationships and research into the most appropriate ways of delivering health services.”<sup>497</sup> It was also to be a period for promoting cooperation on global health issues among national, regional and international organizations.

Stage Two was conceived of as the application phase. Based on the evidence from Stage One (e.g., identification of specific programs, models for cooperation, etc.), the Commission would begin dispersing financial support to supplement existing or initiate new programs consistent with the CMC’s commitments to “comprehensive and promotive health.”<sup>498</sup> Moreover, programs funded by the Commission had to demonstrate “a reasonable amount of local support” such that its reliance on the Commission funding would not exceed five years.<sup>499</sup>

The small staff, explicitly limited to the Director plus no more than three additional staff, began its Stage One work with a modest budget of \$500,000 over three years.<sup>500</sup> With the addition of its role as fiscal agent in Stage Two, the budget was projected to increase to \$5,000,000 over five years. Given these budgetary limitations and the scope and scale of the problems plaguing global health, generally, and medical missions, specifically—many of which, as noted above, were related to problems in financing—the CMC’s role was primarily one of a consultant and best-practices repository.

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<sup>497</sup> Ibid., 4.

<sup>498</sup> Ibid., 2.

<sup>499</sup> Ibid., 4.

<sup>500</sup> Of the \$128,000 in expenditures projected for the first fiscal year, 90% were allocated for salaries, staff travel, and conferences. See 1969 Budget in Ibid., 71.

In both stages an emphasis was placed on the need for better coordination and joint planning to determine priorities. The justification for this emphasis was offered by McGilvray with reference to a 1964 government report in Tanzania:

‘At least 21 separate voluntary agencies operate medical services in Tanzania.

The number and variety of these agencies present many difficult problems of developing an integrated service. There is no central organization to which these agencies owe allegiance... . There is little co-ordination, even among the voluntary agencies themselves, or between the voluntary agencies and the public sector.’<sup>501</sup>

McGilvray describes this variety of agencies and lack of coordination as “typical for most countries,” though its impact is likely greater in countries like Tanzania where in the 1960s, 43% of all treatments were provided by church-related hospitals and clinics.<sup>502</sup>

#### *Theological and Public Health Critique of Hospital-based Medical Missions*

The CMC, echoing both the theological and institutional concerns of Tübingen, was interested in models of comprehensive primary health care, i.e., programs that balanced preventive, promotive, and curative health care. Hospital-based care should, the CMC contended, remain a vital component of medical missions, but the near-exclusive emphasis on hospitals in medical mission activities was problematic for two reasons, in addition to the financial and infrastructure challenges mentioned above.<sup>503</sup> First, hospitals

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<sup>501</sup> Unidentified official report to the Government of Tanzania, 1964, as quoted in McGilvray, "The Historical Perspective: Our Inheritance," 24.

<sup>502</sup> Ibid.

<sup>503</sup> The Commission reported that hospital-based care constituted over 90% of all medical mission activity. See Christian Medical Commission and World Council of Churches, "Annual Meeting", 64.

serve only those who come through their doors. Second, curative treatment is only one part of health and healing.

Both reasons suggest that hospital-based care is inherently exclusive (and by implication at odds with a Christian gospel that emphasizes inclusivity).<sup>504</sup> Hospitals in the first instance are exclusive in the same way as a church that does not engage in outreach. They operate on the logic that if you build it, they will come. Such a logic has an impact on how the health priorities of a given community are determined. Who is present and what symptoms they present with matters. But in epidemiological terms, it fails to account for the complete health ecology of a given community. In slightly more theo-ethical, though health-resonant, language, it fails to meet the needs of the most vulnerable, those who exist at the furthest margins of a community—whether in actual geographic proximity to the hospital or as a result of illness-related stigma—since these persons are less likely to come to access hospital services.<sup>505</sup>

The second challenge of a health system centered around hospital-based care can be seen as related to the question of meeting actual needs. In this case, however, the failure to meet actual needs is understood as the inadequacy of a curative model of

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<sup>504</sup> Such a commitment to an inclusive healing ministry was given explicit theological justification by the CMC in its explication of “The Christian Calling”—the first substantive section of “The Commission’s Current Understanding of Its Task”: “Christ’s command to love our neighbor commits us to the compassion He has shown for all who suffer, demands that we see in our neighbour the dignity of one who is created in the image of God, and leads us to serve our fellow man [sic] in the imitation of Christ.” *Ibid.*, 64.

<sup>505</sup> As described in the discussion of the Masangane program in the previous chapter, both forms of marginalization continue to impact who receives treatment in a given “catchment” area, even with the addition of primary and secondary health facilities. The epidemiological impact of poor roads, cost of transportation, availability of specialized medical staff, etc., is exacerbated in communities where HIV and drug-resistant forms of tuberculosis co-exist, as they do in startling numbers along the border of KwaZulu Natal and the Eastern Cape. For TB patients, long rides on public transportation risks exposing others to TB even as they, themselves are vulnerable to co-infection with other drug-resistant strains of TB. For HIV-infected persons with compromised immune systems, the presence of TB on a bus, in a waiting room, etc., is especially dangerous. And with both diseases, treatment regimens are not “one and done” but require on-going monitoring and testing, drug refills, etc.

medicine to address the wide range of causes that contribute to ill health. While a trip to the hospital may result in the diagnosis and initial treatment of HIV, the hospital is limited. Recalling, though admittedly anachronistically, the example of HIV in this dissertation, the hospital is limited in its ability to impact the nutritional stability of a household (essential for ARV effectiveness) or the on-going sexual negotiations among “sero-discordant” couples (i.e., couples in which one partner is HIV positive). The actual needs of an HIV-infected person in rural South Africa, for example, include, but are not limited to the availability of antiretroviral drugs.

Viewed through the language of Tübingen and the CMC, this second challenge is exclusive in its failure to see human beings (and their health) as multidimensional and its failure to recognize the role of non-medical professionals in healing.<sup>506</sup> This, too, can be phrased epidemiologically and theologically. Epidemiologically, this exclusion can make it difficult to discern salient factors in disease patterns.<sup>507</sup> Theologically, it risks substituting a medicalized understanding of illness for an existential understanding of suffering.

### *Specific Objectives of CMC*

Given the criticisms of hospital-based medical missions, the CMC identified nine specific objectives to guide their work, three of which are highlighted below. The

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<sup>506</sup> Again, the section on “The Christian Calling” (see fn. 14) makes explicit the theological justification for the multiple dimensions and levels of both illness and healing: “No man alone can heal the brokenness of the human condition. Rather through a variety of talents, gifts, and disciplines the whole man is healed with God’s grace.” Christian Medical Commission and World Council of Churches, “Annual Meeting”, 64.

<sup>507</sup> For an example, see Sydney Kark’s work on the spread of syphilis in South African mines. Kark, “The Social Pathology of Syphilis in Africans.”

backbone of the new approach to medical mission and health systems more generally was a vision of comprehensive care anchored by a community orientation.<sup>508</sup>

For the Commission, comprehensive care has three dimensions: 1) a “spectrum” of services including treatment and rehabilitation as well as preventive and promotional activities (e.g., health education); 2) a health system with clear linkages between all of its constitutive parts, from home-based care to primary care clinics and all the way up to tertiary institutions (e.g., specialized hospitals); and, 3) a diverse network of care providers—medical professionals, community health workers, and church members—large enough to address the health needs of a community.<sup>509</sup>

The conceptual and personnel demands of the first two objectives require significant coordination, both horizontally and vertically. Horizontal and vertical refer to levels of health care provision. So, for example, horizontal coordination may refer to the relationships between a local church-based health program and a primary care clinic or between two denomination-specific health strategies. Vertical coordination results in a consistent approach at the global, regional, national, and local levels.<sup>510</sup> The CMC identified vertical and horizontal coordination as a practical necessity for implementing a

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<sup>508</sup> The shift in emphasis from the individual to the community as patient builds on the insights of the Sydney and Emily Kark at the Pholela Health Centre in South Africa over a quarter century earlier. The Karks pioneered methods for understanding how the individual’s location in a web of relationships can impact health. Thus, the “whole man [sic]” must be cared for within the “community ecology,” a phrase intended to extend the concept of health beyond what can be diagnosed in the doctor-patient encounter. Christian Medical Commission and World Council of Churches, “Annual Meeting,” 67. For the Karks’s pioneering work on community health care, see Sidney L. Kark, “A Health Service among the Rural Bantu,” *South African Medical Journal* 16(1942); Sidney L. Kark and John Cassel, “The Pholela Health Centre: A Progress Report,” *South African Medical Journal* 26, no. 6 (1952).

<sup>509</sup> Christian Medical Commission and World Council of Churches, “Annual Meeting”, 66. For a complete list of the nine objectives see the section in the Annual Meeting report entitled, “The Commission’s Current Understanding of Its Task,” 64-68.

<sup>510</sup> The “Three Ones” framework—one agreed upon AIDS action framework, one national AIDS coordinating authority, and one agreed upon country-level monitoring and evaluation system, is an example of a current attempt to increase vertical coordination in the global response to HIV. See UNAIDS, “The ‘Three Ones’ in Action: Where We Are and Where We Go from Here,” report,(2005), [http://data.unAIDS.org/publications/irc-pub06/jc935-3onesinaction\\_en.pdf](http://data.unAIDS.org/publications/irc-pub06/jc935-3onesinaction_en.pdf).

model of comprehensive care. But it also saw this coordination, and more specifically the planning process that led to it, as an ethical necessity. That is, it was a commitment to participatory communicative processes in which all of the relevant voices were present. For nascent public health systems in the late 1960s, medical missionaries, community and parish nurses, traditional healers, etc., were integral not only to the provision of health services but also to developing deeper understandings of health and more transparency in planning health programs.<sup>511</sup>

One of the implications of such an inclusive planning process is that the question of what health is remains open. From a public health perspective, this definitional looseness can generate tension with the demands for measurability and comparability. The power of epidemiology is its ability to discern patterns and that requires stepping back to see the forest and not just the trees. There is real power in this and the CMC to a large extent acknowledged this in exhorting the Church to “fit its health activities into general [Government] plans.”<sup>512</sup> But as global health debates in the late 1970s about the viability of primary health care versus *selective* primary health care would make clear,

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<sup>511</sup> This may seem rather obvious: those who provide health services should be a part of the design of a health system as well as the conceptualization of health upon which that design is predicated. But, as the contemporary response to HIV in South Africa illustrates poignantly, a seat at the table often comes after one has been serving the table. The recent efforts by ARHAP to map the religious entities providing health services throughout southern Africa, and the enthusiasm with which the WHO and the Gates Foundation have embraced this mapping is indicative of this lag. The evidence suggests a significant role of religious entities in providing services for those affected by HIV, and the National Strategy documents make explicit their importance, yet their inclusion in the *planning* processes that led to the national HIV strategies was limited. It is possible to interpret this disconnect in many ways, but one way that seems consistent with the earlier CMC insistence on this inclusion, is that religious entities may present challenges to some of the basic assumptions of a national health system, including its reliance on utilitarian moral logic or the very understanding of health. Religion, to borrow from Christian Smith, may be *disruptive* of the present understanding of a health system. Christian Smith, *Disruptive Religion : The Force of Faith in Social-Movement Activism* (New York: Routledge, 1996).

<sup>512</sup> Christian Medical Commission and World Council of Churches, "Annual Meeting", 67.

quantifiable measures of health can dilute the vision of comprehensive health care expressed at Tübingen and embraced by the CMC.<sup>513</sup>

Why? Because the CMC was influenced not only by the pendulum swing of public health strategies, emerging methodologies, and increasingly sophisticated data sets, but also by a theological understanding of the world in which healing, itself, was a process through which God breaks into human lives. That the stories of this “in-breaking” presence could be narrated in diverse modes—e.g., as successful vaccination campaigns or as faith-healings—and by an infinite number of voices was, as noted above, an invitation to think of health as a “vision of possibilities” that cannot be reduced to the “possibilities or failures of medicine,” or public health, for that matter.<sup>514</sup> The task of the CMC during its initial years was, in part, to bear witness to this “vision of possibilities” as embodied in the variety of church-affiliated health programs throughout the world.

A significant test of the CMC’s capacity to hold together the eschatological vision of Tübingen and the new community-oriented primary health care focus in global health can be seen in the debates surrounding primary health and selective primary health care (SPHC). The next section provides a brief overview of these debates.

### *Health for All! For a Moment, Anyway*

Despite divergent interpretations of the approach, the basic commitments of primary health care found widespread agreement in the mid-1970s. At its core, PHC was about increasing equality throughout health systems and protecting the dignity of

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<sup>513</sup> See, for example, Kenneth Newell’s critique of selective primary health care in Kenneth W. Newell, “Selective Primary Health Care: The Counter Revolution,” *Social Science & Medicine* 26, no. 9 (1988).

<sup>514</sup> McGilvray, *The Quest for Health and Wholeness*.

patients.<sup>515</sup> Though the two are not mutually exclusive, an emphasis on equality placed the burden on health system administrators to justify resource allocations that resulted in disparities between urban and rural populations, rich and poor, racial or ethnic sub-populations, and types of disease burden. Protecting the dignity of patients, often referred to as patient-centered care, involved, among other things, increasing the participation of patients in defining health needs at the individual and systems level, transparency with regards to treatment options, and a general acknowledgment of the patient as an equal partner in the healing process.<sup>516</sup>

In 1975, the WHO gave formal expression and priority to these commitments in its seven principles of primary health care. These principles, in turn, set the stage for the ambitious campaign slogan “Health for All by 2000” at the World Health Assembly in 1977 and the subsequent consensus document, the Declaration on Primary Health Care drafted at Alma Ata a year later. The principles emphasized the health *ecology* (i) of a community, *integration* (ii) of PHC with the various components of the health system, *intersectoral* (iii) cooperation, *participatory* planning (iv), *practicability* (v) in terms of cost and existing community assets, *complementarity* (vi) among promotive, preventive, and curative health, and a form of *subsidiarity* (vii) for linking health interventions to the appropriate providers.

Since its earliest days, the CMC had made equality and patient dignity part of its core commitments. Moreover, as seen above in the discussion of the “Commission’s current understanding of its task,” the CMC articulated a similar vision for how to go

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<sup>515</sup> Alberta W. Parker, Jane M. Walsh, and Merl Coon, "A Normative Approach to the Definition of Primary Health Care," *The Milbank Memorial Fund Quarterly. Health and Society* 54, no. 4 (1976).

<sup>516</sup> Note that related trends included increased attention to research ethics. Examples of this increased attention can be seen in the adoption of the Nuremburg Code and the development of institutional review boards.



about fulfilling these commitments. For some at the CMC, however, the WHO's seven principles offered an opportunity to examine the connection between the strategies of primary health care and the broader CMC framework for understanding health (including its eschatological dimensions).

But the primary health care movement was more than just a growing consensus on its definitional attributes. Commitments to primary health care had found expression in communities throughout the world.<sup>517</sup> Charles Elliott, a development economist and Anglican priest, writing for the influential CMC magazine *Contact*, identified five trends that suggested a growing appreciation for the *effectiveness* of strategies consistent with the primary health care approach: 1) the increasing reliance on paraprofessionals (often referred to as community health workers) as frontline workers; 2) the addition of preventive medicine to curative approaches; 3) a noticeable shift from vertical, disease-specific global health initiatives (e.g., campaign to eradicate malaria) to integrated, intersectoral programs; 4) a willingness to challenge the dominant cost-effectiveness analysis, particularly as it was used to justify a disproportionate distribution of health care resources for urban areas; and, 5) a heightened sensitivity to the practices of traditional healing as complementary, rather than contradictory, to the dominant Western medical model.<sup>518</sup>

The work of the CMC as documentarian, disseminator, and definer of trends in PHC was well-respected by the leadership at the WHO in the 1970s. Much has been made about the close relationships between then WHO director Halfdan Mahler and CMC director James McGilvray. Moreover, the proximity of the two organizations in

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<sup>517</sup> For documentation of various communities committed to primary health care approaches, see Kenneth W. Newell, ed. *Health by the People* (Geneva: World Health Organization, 1975).

<sup>518</sup> Charles Elliott, "Is Primary Health Care the New Priority? Yes, But ..." *Contact* 28(1975), 3-4.

Geneva played a role in the frequency of contact between the two organizations, whether in formal consultations or simply as observers at various high-level meetings.

And though many factors led to the Declaration of Primary Health Care at Alma Ata in 1978, recent historical scholarship emphasizes the important role of the CMC in preparing global health actors for the policy-level paradigm shift to primary health care.<sup>519</sup> The degree to which the Declaration reflects the initial commitments of the Commission (see section above describing the Commission's "current understanding of its task") provides further confirmation of this cross-pollination—though it does not necessarily establish the direction of causal arrows—between the two organizations.<sup>520</sup>

In its first decade, the CMC played a significant role in framing the concept of primary health care that would eventually be adopted by the World Health Organization at the Alma Ata Conference in 1978. By the 1980s, however, *Selective Primary Health Care* (SPHC) had become the buzzword among donors and international institutions who sought to quantify progress in global health according to a standardized set of measurable health outcomes.

SPHC emphasized growth monitoring, oral rehydration, breastfeeding, and immunizations (or GOBI) as four measures of global health that could be readily

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<sup>519</sup> For the most explicit examination of the link between the CMC and the WHO's primary health care approach, including the personal relationships animating these links, see Socrates Litsios, "The Christian Medical Commission and the Development of the World Health Organization's Primary Health Care Approach," *American Journal of Public Health* 94, no. 13 (2004); "The Long and Difficult Road to Alma-Ata: A Personal Reflection," *International Journal of Health Services* 32, no. 4 (2002).

<sup>520</sup> Indeed, the difficulty in distinguishing whether the CMC influenced the WHO or was simply reflecting trends already underway at the WHO lend credibility to arguments that emphasize the close relationship between the two organizations, especially its leadership, as a and relatively short-lived historical anomaly. Though I do not develop this argument fully here, it is worth exploring these close relationships helped create space for a transformative encounter between Christianity and global health in the 1970s. One of the tragedies of the reframing of the role of religion in the 1980s and 1990s was a loss of these personal relationships. As a result, the return to religion in the twenty-first century has meant expending a lot of energy in re-establishing these relationships.

operationalized and reported out to various donors.<sup>521</sup> (Some versions, known as GOBI-FFF, included food supplementation, female literacy, and family planning.) The move towards SPHC received significant support from the Rockefeller Foundation who served as the key sponsor for a conference on “Health and Population in Development” in Bellagio, Italy in 1979. The agenda for the conference emanated from a paper entitled “Selective Primary Health Care, an Interim Strategy for Disease Control in Developing Countries.”<sup>522</sup>

SPHC advocates criticized the comprehensive primary health care call at Alma Ata as too idealistic and vague. SPHC was intended to bring order and clarity to the concept, though critics of SPHC contend that in its selectivity SPHC effectively rolled back the conceptual advances that had been made to link health and socio-economic development, or what is now referred to as the social determinants of health approach. While SPHC was donor-friendly—that is, donors could see the evidence of where their dollars went and measure the impact, for example, in number of persons immunized or number of oral rehydration kits distributed—critics argued that these measures did not address the structural problems that could have a bigger impact on sustaining global health improvements. For example, a focus on oral rehydration kits diverts attention away from the longer lasting impact of greater access to clean water supplies.<sup>523</sup>

Ken Newell, a strong advocate of comprehensive primary health care, declared in no uncertain terms the seductive “threat” of SPHC. SPHC is “a counter-revolution,” Newell argued because it prioritizes short-term goals at the expense of sustained change

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<sup>521</sup> Marcos Cueto, "The Origins of Primary Health Care and Selective Primary Health Care," *American Journal of Public Health* 94, no. 11 (2004), 1869.

<sup>522</sup> As cited in *Ibid.*, 1868.

<sup>523</sup> *Ibid.*, 1870.

over time.<sup>524</sup> The primary healthcare movement was lauded as a move away from the vertical disease approach that had defined international health in the mid-twentieth century, but SPHC appeared, to its critics, as a throwback to that era—an era in which international health was constituted by various disease-specific silos, with little intentional coordination of the work in these silos.<sup>525</sup>

As the SPHC became the program of choice in global health circles in the 1980s,<sup>526</sup> the leadership role of the CMC on the global health agenda became more limited. Other scholars have attributed the CMC's loss of influence, at least among the expert cultures dominating global health policy discussions,<sup>527</sup> to changing political relationships (e.g., the 1980s were less amenable to global health approaches influenced and supported by communist countries) and changing leadership (e.g., as directorships at the CMC and the WHO changed, the ties—both personal and programmatic—between the CMC and the WHO weakened.<sup>528</sup> Against the backdrop of these changes, the CMC found it increasingly difficult to find a sympathetic hearing for its comprehensive, theological vision of health and human flourishing—a vision grounded in both the practices of community health and the church as a healing community.

The work of the CMC continues though the organizational structure and programmatic priorities have continued to evolve. For example, in the 1980s the CMC, in

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<sup>524</sup> Newell, "Selective Primary Health Care: The Counter Revolution."

<sup>525</sup> Cueto, "The Origins of Primary Health Care and Selective Primary Health Care," 1870.

<sup>526</sup> Initially the WHO sought to retain the comprehensive primary health care approach, but with key players at the Bellagio Conference on board (e.g., UNICEF, USAID, the World Bank, the Ford Foundation, and the Rockefeller Foundation), SPHC became the new paradigm in global health. *Ibid.*, 1868.

<sup>527</sup> The CMC remained influential among those implementing policy on the ground in many countries, and was particularly active in the 1980s debates about access to medicine. See Stuart J. Kingma, "Beyond Mere Survival to the More Abundant Life : An Overview of the Concerns of the Christian Medical Commission," *Ecumenical Review* 33, no. 3 (1981); Patterson, "The CMC Story: 1968-1998."

<sup>528</sup> Litsios, "The Christian Medical Commission and the Development of the World Health Organization's Primary Health Care Approach."; "The Long and Difficult Road to Alma-Ata: A Personal Reflection."; Cueto, "The Origins of Primary Health Care and Selective Primary Health Care."

conjunction with other humanitarian organizations, articulated the first guidelines for drug donations, guidelines that would eventually be institutionalized in 1990 in the WHO Action Programme on Essential Drugs. During this period, the CMC continued to try to understand the practical implications of its vision of the healing church. The CMC coordinated regional meetings to elicit feedback on how the healing church is expressed organizationally, liturgically, and in financial priorities.<sup>529</sup> In the 1990s, the CMC (or, CMC-Churches' Action for Health, as it came to be called) became active in the response to HIV, coordinating consultative processes throughout the world and helping to spur the development of the International Christian AIDS Network.<sup>530</sup> Eventually, in 1998, the formal organization of the CMC dissolved, though its work has been taken up by various other parts of the World Council of Churches. For example, the highly respected *Contact* magazine continues to be published under the auspices of various regional bodies of the WCC. Recent issue themes show the extent to which the original intentions of the CMC continue to find expression in responses to contemporary global health concerns such as HIV<sup>531</sup> and health system strengthening.<sup>532</sup>

#### IV. CONCLUSION

Despite the international (and ecumenical) consensus on the concept of primary health care, it never really got off the ground, or, rather, it never got on the ground after

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<sup>529</sup> Christian Medical Commission, "Healing and Wholeness: The Churches' Role in Health," (Geneva: World Council of Churches, 1990).

<sup>530</sup> Patterson, "The CMC Story: 1968-1998," 34. Patterson notes that one of the primary ways the CMC has continued to impact global health is by helping to set-up other organizations such as ICAN. Other examples of organizations the CMC has helped to create include the International Breastfeeding Action Network (IBFAN) and the Pharmaceutical Action Group (PAG).

<sup>531</sup> See especially *Contact* magazine issues no. 177-178 and 185 for CMC and HIV.

<sup>532</sup> For a focus on health system strengthening, see *Contact* issue no. 189.

Alma Ata, at least not in formal global health policy, priorities, and programs. Yet, in 2008, a decade after the CMC dissolved and amid global health commemorations of the thirtieth anniversary of Alma Ata, the World Health Organization resurrected primary health care, touting it as an urgent priority with particular relevance for the scale-up of access to antiretroviral treatment for persons infected with HIV.<sup>533</sup> But, as WHO Director Margaret Chan intoned, a renewed interest in primary health care is not meant to invoke the revolutionary spirit (e.g., the popular but much maligned slogan “Health for All!”) that so captured the original formulation of the concept. Rather, the 2008 World Health Report in which primary health care is the theme is meant to clarify and provide practical, technical guidance on how to integrate primary health care into the WHO’s ongoing commitment to health systems thinking.<sup>534</sup>

In many respects, Chan’s approach to primary health care is understandable. Her institutional location—the specific role and responsibilities of a WHO Director—requires attention to efficiencies and the kind of systems thinking that has come to the fore recently among global health experts. Primary health care is an important part of the health system, but it must be integrated with other parts as well. The managerial and logistical complexity of such integration is daunting. At the same time, the WHO has formalized efforts to understand the relationship between social conditions and health, captured by its emphasis on the social determinants of health.<sup>535</sup>

Taken together, the emphasis on primary health care and the social determinants can be seen as representing the *letter*, but perhaps not the *spirit*, of the CMC’s work.

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<sup>533</sup> World Health Organization, "The World Health Report 2008 - Primary Health Care (Now More Than Ever)," (Geneva: World Health Organization, 2008).

<sup>534</sup> Ibid.

<sup>535</sup> CSDH, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health: Final Report of the Commission on Social Determinants of Health*.

Community-oriented primary health care as originally articulated in the CMC and reaffirmed at Alma Ata pays attention to the social and cultural determinants of health and emphasizes the potential of communities to support better, more widely accessible health care for their members. The WHO's focus on primary health care and social determinants operationalizes the CMC's original vision. But what of the *spirit* of the CMC's work?

Does the operationalization of the CMC's original vision reflect a process of value generalization in which once-theologically resonant ideas are absorbed into broader, non-explicitly theological contexts—contexts that have developed institutional and moral logics that for all intents and purposes are no longer dependent on theo-ethical framings and motivations? If so, this process raises questions familiar to human rights advocates concerned about the grounds, if not religion, of the human rights framework.<sup>536</sup> Neither this chapter nor the dissertation as a whole suggests that global health requires a theological grounding. Instead, my claim that theo-ethical reflection is a religious health asset is a relatively modest one, deriving from an understanding of Christian theology and ethics as participatory and pragmatic—a full explanation of this understanding will be worked out in the final chapter. The emphasis in this chapter on the theological backstory of the primary health care movement illustrates one way in which a participatory theo-ethical reflection contributes constructively to non-explicitly theological approaches to health and human flourishing. That such a contribution was recognized within official, expert-dominated global health discussions suggests the need for global health leaders to

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<sup>536</sup> For an example of these concerns with regards to the more general question of religion and human rights, see Michael Perry, "The Morality of Human Rights: A Nonreligious Ground?," *Emory Law Journal* 54, no. Special Edition (2005).

pay closer attention to substantive theo-ethical claims about human being and human flourishing offered by theologians participating in the intersections of global health.

That this recognition in the global health public square was in large part due to the CMC's connective practices, many of which were initiated prior to formal collaboration with the WHO in the 1970s, shores up Cahill's bold claim about the potential of participatory theological bioethics. For example, efforts to connect communities to the best community-oriented primary health care approaches and the resources required to implement these approaches as well as facilitating consultative sessions to generate new and strengthen existing ties among organizations committed to bringing about transformation in access to healthcare are ways in which theologians actively participate in the alleviation of human suffering and the conditions that give rise to it.

Set in the larger argument of this dissertation, the history of the CMC provides insight into two dimensions of what I have referred to as the turn to religious entities as allies in global health. On the one hand, the contemporary turn to religious entities has been accelerated by the explicit, if not entirely new, appreciation for the social determinants of health, especially as understood within the context of HIV. The widely recognized and arguably less controversial work of religious entities to address the social conditions that contribute to human suffering, more generally, make them visible and desirable in a global health paradigm attentive to the social determinants of health. The historical moment in which the CMC had a direct influence on organizations like the WHO reflects a similar dynamic. That is, as the World Health Organization turned in the 1970s to conceptually broader understandings of health and community development, the



value of religious entities sensitive to community dynamics was more readily recognizable.

Yet my attempt in this chapter to retain the link between the processes of theological reflection in the CMC and the paradigm shift to primary health care runs up against a global health discourse that has been largely unwilling and unable to acknowledge the value of religion in terms other than instrumental ones. For global health, the take-home message from the CMC story appears to be: religious entities, properly trained and with technical support from global health institutions, can serve as a para-health workforce, extending the reach and accelerating the scale-up of global health priorities.

For Christian theologians and ethicists, however, the CMC story can be read as both indictment and invitation. It is an indictment of the parochialism of Western theological bioethics and its lack of sustained attention to inequities in global health, even as attention and significant resources were directed in the past three decades towards clarifying principles for the practice of biomedicine in highly industrialized countries with already long life expectancies, low infant mortality rates, and comparatively low burdens of disease.<sup>537</sup> But the CMC story is also an invitation, as those gathered at the Christian Connections for International Health conference in Buckeystown, Maryland understood, to reclaim with a degree of historical legitimacy the “mantle of leadership in the global revival of community-based health care.”<sup>538</sup> To do so, the concluding chapter argues, requires Christian theologians and ethicists to make a compelling case for theological reflection as a distinctive and vital religious health asset. In this way, perhaps, the

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<sup>537</sup> Maura A. Ryan, "Beyond a Western Bioethics?," *Theological Studies* 65, no. 1 (2004).

<sup>538</sup> Christian Connections for International Health, "Community Health and Wholeness."

commitment to “protecting and restoring body, mind, and spirit” might truly be, as Archbishop Tutu exhorts, a “*shared* mission,” one that emerges from both our shared sense of finitude and our commitment, in spite of and because of this, to co-participate in the patterns and processes of interdependence that sustain human flourishing.<sup>539</sup>

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<sup>539</sup> Tutu, "Address by Reverend Desmond Mpilo Tutu."

## CHAPTER SEVEN

### THEO-ETHICAL REFLECTION AS A RELIGIOUS HEALTH ASSET: IMPLICATIONS FOR PARTICIPANT THEOLOGIANS AND GLOBAL HEALTH LEADERS IN TRANSDISCIPLINARY SPACE

#### I. Introduction

In November 2009, Dr. Eugene Gangarosa, respected cholera expert, veteran public health researcher, and recipient of the Centers for Disease Control's highest honor for distinguished scientific contribution, rose from his seat at the end of a sparsely attended lecture and offered the following remarks: "I will continue the applause. I've heard many lectures... [and been] with the CDC for over fifty years, and I don't think I've heard anything as inspirational as this. I congratulate you."<sup>540</sup> Dr. Gangarosa's congratulatory remarks were directed towards the Reverend Dr. Steven de Gruchy, South African theologian and founding member of ARHAP. De Gruchy had just concluded a lecture entitled, "Water and Spirit: Theology in a Time of Cholera," in which he offered a theological meditation on the tragic, but preventable deaths of 4000 persons during a cholera outbreak in Zimbabwe in 2008-2009. In reflecting on the theological meaning and ethical implications of "water, cholera, life and death," de Gruchy placed himself in an intersection that includes traffic from politics, ecology, global health, and economic development. But it also includes the stories of those whose lives were lost, stories that

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<sup>540</sup> The lecture was later revised and published as Steve De Gruchy, "Water and Spirit: Theology in the Time of Cholera," *Ecumenical Review* 62, no. 2 (2010).

speak to the shared vulnerability of persons on and often beyond the margins of our societies.<sup>541</sup>

De Gruchy closed his reflection with an invitation to remember what connects us to one another and to our environment: “Water, life, death, and cholera. Folks, we need to vision a new way of being on this planet. And reminding ourselves that we are born of both water and spirit is a good place to begin.”<sup>542</sup> Gangarosa does not give any more indication of what, specifically, about de Gruchy’s meditation so moved him, except to note that he is grateful to have lived long enough to witness the coming back together of religion and public health in collaborative efforts. And he expresses lament that many of his global health students were not present in the audience to hear de Gruchy’s eloquent and compelling articulation of what cholera means, theologically. Though I can’t be sure, I would like to believe that Gangarosa was responding to de Gruchy’s expression of the “religious imagination.”

James Cochrane and Gary Gunderson, de Gruchy’s ARHAP colleagues and friends, describe the religious imagination as a deep sensitivity to “the lure of new possibilities and their embodiment,” and one source contributing to the transformation of existing paradigms in global health.<sup>543</sup> This religious imagination, and the theological forms in which it is expressed, is ignited by more than sacred texts or doctrinal statements. For de Gruchy, theology involves “understanding the world and ourselves.” In a time of cholera, this understanding requires theologians to participate in “respectful dialogue and engagement” with global health experts, development economists, politicians, ecologists, internally displaced persons, families who have lost loved ones to

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<sup>541</sup> Ibid., 188.

<sup>542</sup> Ibid., 201.

<sup>543</sup> Gunderson and Cochrane, *Religion and the Health of the Public*, 21.

water-borne diseases... . In this way, his attempt to interpret the meaning of cholera theologically requires first “knowing what cholera *is*” and how it is experienced. But it also requires coming to terms with the “cognitive shock that something we understand to be given by God—namely water—works not for life but for death.”<sup>544</sup> Knowing what cholera is begins with, but takes the theologian beyond, scientific theories and evidence of cholera as a water-borne disease. It also takes the theologian beyond “just contemplation of the mysteries and sacredness of water.” For de Gruchy, Christian theological reflection on water, cholera, life and death must “be rooted in the struggles of people in the midst of water shortages, denied access, and cholera.”<sup>545</sup>

De Gruchy is, for me, an exemplar participant theologian in the expansive sense laid out in chapter four. Tragically, a few months after his lecture at Emory, de Gruchy was lost in South Africa’s Mooi river while tubing with his family. The outpouring of grief and words at his passing constitute a testimonial to how Steve lived his vocation—his life—as a participant theologian. The Reverend Canon Ted Karpf, the Partnerships Officer in the Office of the Secretary General of the World Health Organization, offered these words in response to the news of Steve’s death:

On behalf of friends and collaborators in Geneva at the World Health Organization, I can only say that the pioneering efforts of the ARHAP team, of which Steve was a crucial part, have moved the global health systems debate to a higher and more accountable level which can be shared with more people worldwide. The evidence [of religious health assets] presented by the WHO-

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<sup>544</sup> De Gruchy, "Water and Spirit: Theology in the Time of Cholera," 197.

<sup>545</sup> *Ibid.*, 200.

ARHAP study has changed the way global health is viewed and understood by many, including health ministries around the world.<sup>546</sup>

Dr. Elias Bongmba, professor of religion and author of *Facing the Pandemic*, reflecting on the impact of Steve's death, named aloud the integrative spirit with which Steve lived out his vocation as a participant theologian: "The South African academy, the faith community, and Africa as a whole have lost one of the most articulate and erudite voices on justice."<sup>547</sup>

The academy, the church, the wider community. These are the contexts participant theologians hold together in doing theo-ethical reflection. For de Gruchy, theo-ethical reflection on global health issues from AIDS to cholera necessitated literacy in the science of global health and demanded sustained attention to the lives that bear a disproportionate burden of these diseases. This literacy and sustained attention was not only in the pursuit of keeping Christian ethics relevant in global health circles, that is, an expression of a Christian ethics that reflects in its recommendations an understanding of the scientific and institutional complexities global health policymakers must negotiate. This literacy and sustained attention was constitutive of the theological claims he could make as well. "We cannot speak glibly of God and of life, unless we understand the relationship between water and death for so many people in the world," de Gruchy asserts.<sup>548</sup> Such understanding requires participating simultaneously in the intersections of academic disciplines, collaborative social action, and, as his life's work attests, ecumenical networks.

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<sup>546</sup> As quoted in James R. Cochrane, "Steve De Gruchy- in Memoriam," *Practical Matters*, no. 4 (2011), <http://www.practicalmattersjournal.org>.

<sup>547</sup> Ibid.

<sup>548</sup> De Gruchy, "Water and Spirit: Theology in the Time of Cholera," 197.

## II. Appreciating Theo-ethical Reflection as a Religious Health Asset

In this dissertation, I have attempted to show how the turn of global health toward religion is predicated largely on an instrumental and necessary revaluing of religious entities as health assets in the scaled-up response to the HIV pandemic. This turn readily recognizes the work of de Gruchy and his ARHAP colleagues in identifying and mapping the health assets of religious entities, especially assets that can be operationalized and leveraged to help those at or beyond the margins of global health resources. But what, then, are we to make of the distinctive activity of theo-ethical reflection and the participation of theologians highlighted throughout this dissertation? The persistence of theo-ethical reflection in the pioneering work of the CMC and Masangane, as well as the positive reception of de Gruchy's lecture by a veteran global health expert, point to something distinctive to religious entities and something of value, but what is it exactly?

Can global health leaders appreciate processes of theo-ethical reflection as a health asset in the same way that they have come to appreciate the reach of denominational networks into areas not covered by formal health systems, or the trust advantage religious entities hold over public health workers in many communities? The answer to this question takes me back to the two-fold meaning of appreciate that comes from the initial ARHAP-WHO research project in Zambia and Lesotho.<sup>549</sup>

Appreciation, for ARHAP, entails both *recognizing* and *increasing* the value of religion as a health asset. The case study chapters attend to the first sense—recognizing—

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<sup>549</sup> See chapter three for my initial discussion of this distinction as used to understand the meaning of appreciating assets. See also African Religious Health Assets Programme, "Appreciating Assets."

and show the specific forms theo-ethical reflection has taken in global health debates about priorities, policies, and programs. More generally, I understand Masangane and the CMC as revealing the role of religious entities in creating and sustaining space for ongoing theo-ethical reflection on the patterns and processes of human flourishing in which we all participate.

Yet, the direct value of creating and sustaining this kind of space may be difficult to operationalize from a global health perspective. However, something of this value, I contend, is recognizable in the participant theologians who emerge out of this space. That is, by creating and sustaining space for thinking together theo-ethically, religious entities cultivate participant theologians like Rev. Fikile McGoyi and those affiliated with the CMC who, in both word and deed, live into Cahill's bold call for a mode of participatory theological ethics capable of "alleviating the social conditions" that negatively impact all aspects of human flourishing. And the activities in which these participant theologians engage—from securing funding for ARVs in communities without access to raising the profile of successful community health practices around the world to articulating criteria for community-oriented primary health care—are recognizable to global health leaders as valuable, even if the processes of theo-ethical reflection that frame, motivate, and sustain these activities are less visible, if they are visible at all. Minimally, I believe the evidence in this dissertation supports the argument that in the recent turn to religion as an ally, the *outcomes* of theo-ethical reflection are recognizable and valued, though perhaps not named explicitly, as religious health assets. In this sense, perhaps the best argument to global health about the value of *processes* of theo-ethical reflection is an indirect one, one that focuses on what these processes give rise to, whether that is in the theo-ethical claims



that support specific global health priorities and policies or in the participant theologians who facilitate the interaction between religious entities and global health programs.

I have focused on stories of constructive theo-ethical engagement in global health to clarify the dynamics involved in the clear discursive shift toward religious entities as allies in the response to HIV and the increased attention to the empirical evidence of religious entities as health assets (chapter three). But I remain cognizant of other forms of theo-ethical engagement that have presented obstacles to the goals pursued by global health (chapter two)—forms that are not erased simply because global health has begun to emphasize the value of particular religious entities. My claim that processes of theo-ethical reflection can be valued as religious health assets is not the same as claiming that processes of theo-ethical reflection are always religious health assets. Examples throughout this dissertation, from the opening vignette about the guest speaker in the public health AIDS course to the Bukoba statement of the Lutheran bishops in Tanzania, witness to how religious entities can create and sustain space for processes of theo-ethical reflection that are liabilities to global health.

Given this ambivalence among religious entities and the type of space they create for theo-ethical reflection, it is imperative that global health leaders turning to religious entities as allies are sufficiently literate in theo-ethical discourse to parse the framings and motivations animating the religious landscape more carefully. Not all religious entities make good allies in global health. This imperative for a more nuanced turn to religion emerges most clearly when global health leaders begin to engage and assume the value of theo-ethical reflection as a religious health asset. Health assets held by religious entities are considered “at rest” until acted upon by an agent. The assets themselves may

be recognizable as potentialities, but they only become valuable when they are actualized through an agentic process. Thus, the evidence that one of the distinctive activities of religious entities is to create and sustain space for theo-ethical reflection may be recognizable for its potential as a health asset. But processes of theo-ethical reflection can only be valued as health assets once they are actualized through some agentic process. In other words, it matters *who* is thinking together theo-ethically and to *what* they are paying attention.

This is no less true for the other assets identified by ARHAP. The imperative for greater nuance is built into the larger ARHAP assets framework as well. For example, one of the most obvious, tangible health assets recognized by global health are the buildings religious entities own in communities without a stationary health clinic. These can become health assets if they are used as sites for such activities as voluntary counseling and testing or space for HIV training workshops. They can just as easily become liabilities if the buildings are used to conceal practices that are detrimental to health. Similarly, the intangible asset of emplotment, or the way in which religious entities encourage adherents to see themselves as part of a larger narrative, can easily become a liability, from a global health perspective, if that larger narrative reinforces stigma or soteriologies hostile to antiretroviral treatment. That is, if religious health assets are at rest and need to be activated, they can be activated in more than one direction—a direction that supports the priorities of global health or a direction that impedes the priorities.

This, then, is where I would locate the normative force of the expanded concept of the participant theologian and theocentric understanding of participation developed in

chapter four. Because the participant theologian takes seriously the disciplinary traffic coming from academic conversations relevant to global health and participates in collaborative social action focused on global health inequities, she is well-positioned to activate processes of theo-ethical reflection in ways that lead to *mutually generative* conversations between global health leaders and religious entities. That these conversations can be mutually generative, as evidenced in particular in the CMC chapter, should give pause to global health leaders who have recently turned to religious entities for the way in which the specific assets they hold support existing global health policies and paradigms. The value of religious entities is also derivable from the contributions they make to understanding health and human flourishing. In this sense, processes of theo-ethical reflection activated by participant theologians can lead to constructive critiques of existing global health paradigms—critiques, importantly, that can be heard by global health leaders as saying something about how things really are with regards to health, as the CMC’s role in the primary health care movement suggests. The participant theologian, thus, facilitates the recognition on the part of global health leaders of theo-ethical reflection as a religious health asset.

But what about the second sense of appreciate signaled by ARHAP’s use of the term assets? How do global health leaders leverage or increase the value of processes of theo-ethical reflection in order to improve health outcomes for all persons? I have suggested above one strategy for recognizing the impact of these processes, focusing on the activity of participant theologians and the particular commitments of the religious entities that sustain them. So, does it follow that in order to leverage processes of theo-

ethical reflection global health leaders simply need to include more participant theologians in their conversations?

Recalling the example of buildings as tangible assets, it is easier to say with some confidence that efforts to encourage more churches to provide space for volunteer counseling and testing, educational workshops, and health clinics is a way of appreciating (i.e., increasing the value of) religiously affiliated buildings as health assets. Certainly, Dr. Hermann Reuter of Doctors without Borders would recognize the exponential impact of this strategy of appreciation, since Reuter believes that one of the biggest barriers to stemming the HIV pandemic is the lack of a clinic or testing site within easy walking distance of everyone in the community.<sup>550</sup> It is at least plausible that something similar could be argued about putting a participant theologian in every pulpit, and in every conversation about health—local or global.

This, of course, remains at the end of this dissertation an unsubstantiated claim, but a claim that I believe is worth exploring going forward, especially if global health leaders continue to see and engage religious entities as vital partners in responding to the persistent, yet dynamic challenges threatening human health. By way of beginning this exploration, I conclude the dissertation by articulating what I understand to be the practical implications of this dissertation for preparing Christian theologians and ethicists as well as global health professionals for the possibility of mutually generative conversations about health. It is in these conversations, I submit, that the limits and possibilities of scaling up participant theologians and processes of theo-ethical reflection can best be evaluated. It is also in these mutually generative conversations that I believe

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<sup>550</sup> Steinberg, *Sizwe's Test: A Young Man's Journey through Africa's AIDS Epidemic.*, especially 104-7.

the full potential of the turn to religious entities as both relevant and desirable will find expression.

### **III. Getting a Sense of Transdisciplinary Praxis**

In the end, Gustafson's image of health or human flourishing as an interdisciplinary intersection does not capture adequately what is necessary for mutually generative conversations among participant theologians and global health leaders. Or rather, it does not accurately represent the logical conclusion toward which his understanding of participation, and Cahill's extension of it, ultimately lead: the need for transdisciplinary praxis.

In both Gustafson and Cahill, participation entails an openness to disruption—epistemically, ontologically, theologically, and ethically. What a Christian ethicist actually says about God and the world is continually disrupted by the accounts of human being offered by others, whether those accounts emerge from the systematic and scientific study of what humans require to flourish or from persons whose experience of suffering cannot be expressed without revealing the structural inequalities that limit their access to health care. Such radical openness to disruption suggests that the arc of interdisciplinary inquiry into the phenomena of human being bends towards transdisciplinary praxis. That is, the fullest account of human being does not emerge from the aggregation of different disciplinary perspectives but from the integration of these perspectives into something new that can no longer be explained with reference to particular disciplines.

This is not a call for the end of disciplines so much as a call for a candid assessment of the limits of their analytical power and, simultaneously, a commitment to co-participation in, and not merely translation between, one another's disciplinary or epistemic communities. Gary Gunderson, one of the ARHAP co-founders, expresses both the vulnerability and vitality of this type of commitment:

Working in the relationships between disciplines, fields of practice, institutional capacities and competencies...is not primarily an intellectual space, but a physical, existential space that is in between all those things we know. The space in which we are trying to do scholarship is filled with haunting ambiguities and confusions in which hope and horror are intermingled.<sup>551</sup>

ARHAP members describe their work as “working in a bounded field of unknowing,” by which they intend a field that despite having fairly well-developed component literatures (e.g., health, religion) remains largely unexplored as an integrated field. The bounded field of unknowing, like the religious imagination described by Gunderson and Cochrane, proceeds with a sensitivity to new ways of interpreting complex phenomena, in large part because of the epistemic humility these phenomena invite, even demand, from researchers—or, at least, I would argue, *should* invite from researchers, especially researchers and scholars committed to articulating ways of human being that lead to greater human flourishing for all persons. That is, when we recognize our located-ness and reflect on our participation in the patterns and processes of interdependence that animate the complex social phenomena we are trying to describe, interpret, and transform, it becomes increasingly difficult to ignore the limits of our own disciplinary

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<sup>551</sup> Olivier et al., " ARHAP Literature Review: Working in a Bounded Field of Unknowing," 71.

perspectives and experiences of the world around us, and we become increasingly aware of the “haunting ambiguities and confusions” we must attend to.

The evidence in this dissertation, and the ongoing work of ARHAP, suggests that one viable response to these limits is to participate in spaces of transdisciplinary praxis. Participant theologians and global health actors, I submit, create and inhabit spaces of transdisciplinary praxis when they commit to mutual generativity and seek to nurture together in both discourse and practices a modest hope for “alleviating the social conditions” that negatively impact health.

It is tempting to default to first-order religious language to describe the impact of these spaces. The participants at Tübingen reflected on being moved by something unexpected; Gunderson and Cochrane’s articulation of religious imagination echoes incarnational theologies and the in-breaking of hope and possibility; Rev. McGoyi was, metaphorically, on the road to Damascus, the scales that had prevented Masangane from imagining the possibility of treatment in the rural Eastern Cape falling off on his return from Cape Town after witnessing the success of an ARV treatment program in the Khayelitsha slums. Gustafson’s senses of piety, which I paraphrase as awe, gratitude, remorse, finitude, and dependence, might also be appropriate first-order descriptors of the dispositions cultivated in spaces of transdisciplinary praxis.<sup>552</sup>

For Gustafson, these senses are how we experience the divine, but it is not difficult to imagine these senses as a necessary part of any commitment to global health—theistic or not: a sense of awe at the complexity of global pandemics and what they reveal about the patterns and processes of interdependence at work in the world; a

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<sup>552</sup> Gustafson has articulated various lists of these senses in different works. For one such list, see Gustafson, “Say Something Theological!,” 88-89. Here he identifies six senses: dependence, gratitude, obligation, remorse, a sense of possibilities, and a sense of direction.

sense of gratitude for the work of many others who have pioneered approaches that have led to better health outcomes for significant portions of the global population as well as debts of gratitude to all those who sacrificed—oftentimes unknowingly and unwillingly—their own health and lives as part of the scientific advances leading to improved health for future generations; a sense of remorse for the unintended consequences of well-intentioned work to improve the health of communities (e.g., vaccination campaigns gone awry) as well as for the intended consequences of mal-intentioned work to disrupt the healthworlds of communities; a sense of dependence recognizable from the cellular level (e.g., parasites, good bacteria, etc.) to the global level (e.g., the necessary coordination of diverse nation-states to carry out global health initiatives); and, finally, a sense of human finitude deepened in the daily work of global health as community healthworkers and policymakers absorb in ways equally unimaginable impersonal statistics of morbidity and mortality and personal stories of suffering and death. Understanding better how these senses actually play out among global health actors could strengthen the argument in this dissertation by clarifying the task of participant theologians in global health conversations and testing the limits of the conceptual bridge linking theocentric understandings of participation to theo-ethical reflection as a religious health asset.

Specifically, this better understanding could be achieved through additional research, including interviews with global health leaders and participant theologians about the framings and motivations for their work, the broader worldview into which these framings and motivations are set, etc., and a more fully developed engagement with Gustafson's senses of piety. The limits of this dissertation, however, do not permit any



further claims about the nature of any shared senses among participant theologians and global health leaders or derivative arguments about the relationship of these shared senses to creating and sustaining spaces of transdisciplinary praxis.

Even without this additional research, though, it is possible to describe institutional priorities and arrangements that are likely to evoke something of these shared senses among global health actors and participant theologians. In the next section I describe three such arrangements that could be conducive to transdisciplinary praxis.

#### **IV. Toward Mutually Generative Conversations**

##### *Training*

The first arrangement involves the preparation of Christian ethicists and global health professionals. My year spent in the Rollins School of Public Health as a Center for Health, Culture, and Society Fellow was an immersion experience in how what I understood to be senses of piety manifest themselves in the framings of a global health curriculum and the motivations of aspiring global health professionals. The fellowship, in which graduate students from letters and sciences cross the bridge to take classes at the public health school and public health master's students cross in the opposite direction, afforded me an opportunity not only to observe these framings and motivations but also to actively engage with them in small group discussions, collaborative policy papers, and over lunches hosted at the Center. This engagement forced me to confront the limits of my own academic training in Christian ethics, specifically the ways in which critical, theoretical studies can often, over time, work to restrain the impulse for doing something

to effect real-world change. But this engagement also made me sensitive to the eschatological framings of global health—another world is possible! And we, as future global health professionals are helping to usher it in! The zeal with which this is embraced among students borders on the missionary. And it can lead to the same dogmatism and certitude, an uncritical endorsement of the right approach to saving the world.

These depictions of the limits of academic training in Christian ethics and professional training in global health are caricatures, but accurate enough to highlight a basic tension between academic and professional education. In the public health classroom, with few exceptions, information was packaged and transmitted to the students, with little opportunity for discussion or critical engagement with what was presented. Projects were problem-based and directed toward implementable policies. My default mode, reinforced through years of study in the humanities, was to step back, to question the assumptions of the approach being presented, investigate the worldviews being described, or engage the theoretical debates behind the policies. This mode felt out of place in this context. At the same time, the fellows who crossed the bridge to take courses in letters and sciences described similar experiences of cognitive dissonance in which their urge to problem solve or to get to the implications of an argument were stymied by the priority of close, critical reading of texts.

Spaces of transdisciplinary praxis in religion and global health draw on both ways of thinking through problems. In these spaces, Christian ethicists and global health professionals must negotiate the tension between academic and professional education and the myriad ways in which this tension manifests. One way for Christian ethicists to

learn what this negotiation entails is an immersion experience in the professional training of public health professionals. At minimum, it fosters awareness in Christian ethicists of the practical constraints within which global health professionals operate. Though one year is not sufficient time to become fluent in the discourse of global health, an immersion experience, like the traditional language requirements in Ph.D. programs, can surface enough of the basic elements of the discourse to help Christian ethicists discern what is most important to pay attention to (e.g., recurring barriers to improving health outcomes, factors that affect the relationship between priorities, policies, and programs, options available for health systems financing) and which resources are most appropriate for understanding a specific global health issue.

For Christian ethicists who direct their attention to global health, an immersion experience in the training of public health professionals should be encouraged, if not required. Certificate programs, fellowship programs, and joint degrees are all intentional, institutional arrangements that could both encourage Christian ethicists, and prepare them better, to become participant theologians.

A related institutional arrangement involves direct and indirect support for collaborative research projects.

### *Research*

Collaborative research projects are nothing new. But for such projects to truly embody the spirit of transdisciplinary praxis, the projects need to go beyond a collection of articles from different disciplines on the same phenomena. Emory University hosted a conference in 2007 that was a step toward transdisciplinary praxis, strategically pairing presentations from different disciplinary perspectives so as to generate a conversation

about the distinct insights each perspective brought out in the other. But, in the end, the conference stopped short of showcasing the potential of a research process that, from the start, was conceptualized dialogically as transdisciplinary.<sup>553</sup> This type of project could be especially generative because of the demand it places on all those involved to find or create ways of expressing their shared sense of purpose and to name and work through, rather than avoid, the methodological, theoretical, and practical tensions as they emerge. I see in ARHAP's recent efforts to create a working lexicon adequate to the concepts emerging as the result of collaborations between public health scholars and practitioners and religious scholars and practitioners as one place in which these tensions are being negotiated.<sup>554</sup>

The generativity also emerges from the levels of trust such transdisciplinary thinking together requires. There is a shared intellectual vulnerability to “working in bounded fields of unknowing” where everyone is, in some sense, at the margins of their knowledge. In my experience at ARHAP colloquia, this shared vulnerability manifests itself as epistemic humility and a willingness to modify one's claims, which are always subject to correction from one's differently located academic interlocutors as well as the experience and concerns of the communities affected by and affecting the research. That these claims are recognized as provisional does not mean they are less important to pay attention to.

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<sup>553</sup> See Religion and Public Health Collaborative, “Maps and Mazes: Critical Inquiry at the Intersection of Religion and Health,” Emory University (November 26-29, 2007), <http://www.rhcemory.org>. The conference, titled “Maps and Mazes,” was co-sponsored by the Religion and Public Health Collaborative at Emory University and ARHAP.

<sup>554</sup> The “Better Words” project is an attempt by ARHAP to create a shared lexicon for religion and public health scholars and practitioners. The current lexicon is accessible on the ARHAP website: [http://www.arhap.uct.ac.za/words\\_words.php](http://www.arhap.uct.ac.za/words_words.php).

Rather, I understand these collaborative research projects as creating and sustaining spaces of transdisciplinary praxis that resemble simultaneously a laboratory and a community. These spaces are communities in the most robust sense of the term. They assume diverse perspectives and individual commitments are held in creative tension with the good of the community. Respectful disagreement is expected and encouraged, a sign of a vibrant community. These spaces are also a laboratory in a loose sense. Participants in these spaces work together to make it a safe place to push the limits of one another's own assumptions, explore the variety of interpretations any one idea yields, and test, using one's particular disciplinary lens and experiences, the claims of others. Individual failure, as in any experiment, is expected as part of the process of coming to a more reliable truth. The truth claims or interpretations of reality that emerge are necessarily and intentionally provisional, but all the more powerful because of the participatory character of the processes that give rise to them and the shared purposes to which they are directed.

This last clause suggests a resonance with a concept that has been developed to understand how processes of theo-ethical discernment might strengthen organizational leadership, especially in the business world. The concept is a "circle of temporary trustees," and it serves as the jumping off point for the final institutional arrangement that I believe can facilitate the creation of transdisciplinary praxis spaces.

### *Leadership*

According to David Specht and Richard Broholm, a circle of temporary trustees is a group of organizational leaders who are called together "to hold a member organization in trust around a difficult challenge it is facing." The role of the temporary trustees is not

consultative in the conventional sense of offering advice to solve the particular problem. Instead, the temporary trustees “draw upon their own lived experience and the sacred ideals and lore of their faith traditions for wisdom and perspective and inspiration which may be a source of encouragement and guidance to the leadership team as they wrestle with the challenge.” To hold a leader and her organization in trust requires “listening deeply with ears and hearts” and a commitment to confidentiality. The organizational leaders understand that the circle of temporary trustees is “sacred time and sacred space,” in that it is time set apart for thinking together on behalf of another.<sup>555</sup>

The circle of temporary trustees model emerges from a working group committed to “seeing things whole.” This working group of theologians, other academics, and business leaders latched onto a “theology of institutions,” an idea first expressed in Robert Greenleaf’s 1979 essay titled, “The Need for a Theology of Institutions.” In that essay, Greenleaf expresses the telos of a theology of institutions: “The movement I hope to see is when all institutions will become more serving of all persons they touch, to the end that those being served will grow as persons: while being served they will become healthier, wiser, freer, more autonomous, and more likely themselves to become servants.”<sup>556</sup> Greenleaf understood institutions to be the primary modes through which caring for and serving the needs of others was done in modern societies. He believed that “if a better society is to be built, one that is more just and more loving, one that provides greater creative opportunity for its people, then the most open course is to raise both the capacity to serve and the very performance as servant of existing major institutions by

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<sup>555</sup> David Sprecht and Richard Broholm, "A Process for Holding Institutions in Trust" (paper presented at Toward a Theology of Institutions, Minneapolis, MN, June 10-11 2009), 100.

<sup>556</sup> Robert K. Greenleaf, "The Need for a Theology of Institutions," in *Seeker and Servant : Reflections on Religious Leadership*, ed. Anne T. Fraker and Larry C. Spears (San Francisco: Jossey-Bass, 1996), 98

new major regenerative forces operating within them.”<sup>557</sup> Global health and religion are two of the major institutions committed to caring for and serving the needs of others. And I hope to pursue in future work, how Greenleaf’s call for a theology of institutions and its development by groups like Seeing Things Whole might add another dimension to the argument in this dissertation about theo-ethical reflection as a health asset. For the moment, though, I am suggesting the circle of temporary trustees as a dialogical practice that could support spaces of transdisciplinary praxis and lead to mutually generative conversations among global health leaders and participant theologians.

What would it look like for global health leaders and religious leaders, including participant theologians, to come together in a circle of temporary trustees, as opposed to high profile summits or academic conferences? I imagine it would look something like the initial gathering at Tübingen in which the theo-ethical seeds of the CMC were first articulated. Today, it might take shape as a response to Bishop Tutu’s World Health Assembly address with which this dissertation began. In these circles, leaders are more likely to engage the religious imagination and the “lure of new possibilities” since the dialogue process encourages participants to draw deeply on the wisdom of theological and philosophical traditions as they think together through responses to complex phenomena.<sup>558</sup>

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<sup>557</sup> "The Institution as Servant," in *Servant Leadership : A Journey into the Nature of Legitimate Power and Greatness*, ed. Larry C. Spears (New York: Paulist Press, 2002), 62.

<sup>558</sup> ARHAP has worked with another model that offers some of the same advantages of the circle of temporary trustees, most importantly “a safe, controlled space for encounter and dialogue on critical but potentially controversial themes.” The model is an adaptation of the “executive sessions” approach pioneered at the Hauser Center, Kennedy School of Government, Harvard University. James R. Cochrane and Barbara Schmid, "The Executive Session Approach to Leadership Engagement," in *ARHAP International Colloquium: Working Papers*, ed. Barbara Schmid (Cape Town, South Africa: ARHAP, 2007), 87.

Tutu expresses what I understand to be held in trust in these circles: health for all. A commitment to responding to the suffering of others is part of the “sacred and solemn covenant”<sup>559</sup> undertaken by global health professionals and religious leaders, a commitment that seems to suggest some basic awareness of the shared senses animating global health and religious responses to the “conditions of possibility for newness and renewal.”<sup>560</sup>

## **V. Conclusion: Christian Ethics after Pentecost**

The current turn to religion as a global health ally presents an opportunity to re-imagine the spaces in which complex social phenomena are described, interpreted, and responded to. These reimagined spaces are characterized by transdisciplinary praxis. Christian ethicists live into the role of co-participants in these spaces when they seek to cultivate both a greater attentiveness to the ways in which those outside of the academy are co-participants in processes of theo-ethical reflection and develop a greater competence for engaging the complex arena of global health policy and programming. At the same time, global health leaders live into the role of co-participants when they recognize, engage, and value theo-ethical reflection as a vital health asset and as a distinctive part of what makes religious entities desirable as allies in global health. What emerges in these spaces is a more fully participatory global health that better reflects in its priorities, policies, and programs the actual ways persons experience and make sense of health and human suffering.

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<sup>559</sup> Tutu, "Address by Reverend Desmond Mpilo Tutu."

<sup>560</sup> Gustafson, *Ethics from a Theocentric Perspective. Vol.2, Ethics and Theology*, 322



In a sense, it is to move from the presumption of doing Christian ethics after Babel to the hope of a doing Christian ethics after Pentecost. Practicing Christian ethics after Pentecost begins with the presumption that we are all trying to communicate to one another about our sense of the various forces affecting our ability to flourish as human beings and that, in the end, we can understand one another because we are all in some way responding to and co-constituting the patterns and processes of interdependence that give a particular shape to our world in this moment.

In the introduction, I pegged the success or failure of my argument to (1) whether or not I could present compelling evidence to global health policymakers for paying attention to those saying something theological about the human experience of illness and health and (2) whether or not Christian ethicists can recognize in the argument a responsibility to enter more fully into the global health fray, conscious of their role as *participant* theologians. I believe I have presented the evidence for the first criteria, but am less confident that it will be compelling enough to global health readers to make any significant changes in their hospitality or hostility to processes of theo-ethical reflection in global health settings. With regards to the second criteria, I believe I have also offered a plausible argument for how Christian ethicists can take seriously our responsibility to participate *as theo-ethicists* in global health conversations. In the short term, to borrow from Gustafson one last time, I hope that the merits of the argument will be evaluated on whether or not I have “encourag[ed] critical self-awareness in my readers,”<sup>561</sup> including Christian ethicists and global health professionals. In the long run, however, I know that the strengths and limitations of this argument will depend in large part on my own

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<sup>561</sup> Gustafson et al., "Doubting Theology," 36.

capacity as a participant theologian to cultivate and sustain spaces of transdisciplinary praxis guided by the goal of “health for all”—my ability to do Christian ethics after Pentecost. Tutu’s concluding words to the global health leaders gathered at the World Health Assembly seem to me just as fitting for those of us who identify as Christian ethicists: “God is watching. The people are waiting. You are commissioned to go to wipe the tears away from all faces and bring forth lives filled with strength and purpose which will make for peace.”<sup>562</sup>

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<sup>562</sup> Tutu, "Address by Reverend Desmond Mpilo Tutu."

## BIBLIOGRAPHY

- Ackermann, Denise M. "Deep in the Flesh' Women, Bodies and HIV/AIDS: A Feminist Ethical Perspective." In *Women, Religion and HIV/AIDS in Africa: Responding to Ethical and Theological Challenges*, edited by Teresia M. Hinga, Anne Nkirote Kubai, Philomena Mwaura and Hazel Ayanga, 105-25. Pietermaritzburg: Cluster, 2008.
- — —. "From Mere Existence to Tenacious Endurance." In *African Women, Religion, and Health: Essays in Honour of Mercy Amba Ewudziwa Oduyoye*, edited by Isabel Apawo Phiri and Sarojini Nadar, 221-42. Maryknoll: Orbis, 2006.
- Actuarial Society of South Africa. *Summary of Biennial Report on the State of the South African HIV/AIDS Epidemic*. 2006. <http://www.doh.gov.za/docs/reports/2006/summary.html>.
- African Christian Health Associations' Technical Working Group on Human Resources for Health. "Letter to Mubashar Sheikh, Executive Director, Global Health Workforce Alliance." August 26, 2008.
- African Religious Health Assets Programme. "Appreciating Assets: The Contribution of Religion to Universal Access in Africa." Research Report for the World Health Organization, 2006.
- — —. "Appreciating Assets: The Contribution of Religion to Universal Access in Africa." *Report for the World Health Organization* (October 2006).
- Agadjanian, Victor, and Soma Sen. "Promises and Challenges of Faith-Based AIDS Care and Support in Mozambique." *American Journal of Public Health* 97, no. 2 (2007): 362-66.
- Allen, Peter Lewis. *Wages of Sin: Sex and Disease, Past and Present*. Chicago: University of Chicago Press, 2000.
- ARHAP. "Appreciating Assets: Mapping, Understanding, Translating, and Engaging Religious Health Assets in Zambia and Lesotho." Report to the World Health Organization, 2006.
- Avalos, Hector. *Health Care and the Rise of Christianity*. Peabody, Mass.: Hendrickson, 1999.
- Aviles, J. M. M. "Intercessory Prayer and Cardiovascular Disease Progression in a Coronary Care Unit Population: A Randomized Controlled Trial." *Mayo Clinic Proceedings* 76, no. 12 (2001): 1192-98.

- Awoyemi, Stephen M. "The Role of Religion in the HIV/AIDS Intervention in Africa: A Possible Model for Conservation Biology. Editorial." *Conservation Biology* 22, no. 4 (2008): 811-3.
- Ayres, Jennifer Ryan. "'With an Urgency Born of This Hope...': A Constructive Practical Theology of Reformed Christian Social Witness Practice." PhD dissertation, Emory University, 2007.
- Bandy, Gary, Alan Crouch, Haenni Claudine, Paul Holley, Carole Jane Larsen, Sian Penlington, Nicholas Price, and Carolyn Wilkins. "Building from Common Foundations: The World Health Organization and Faith-Based Organizations in Primary Healthcare." Geneva: Geneva Global and Department of HIV/AIDS of the WHO, 2007.
- Banta, James E. "From International Health to Global Health." *Journal of Community Health* 26 (2001): 73-76.
- Bazant, Eva S., and Marc Boulay. "Factors Associated with Religious Congregation Members' Support to People Living with HIV/AIDS in Kumasi, Ghana." *AIDS and Behaviour* 11, no. 6 (2007): 936-45.
- Bedelu, Martha, Nathan Ford, Katherine Hilderbrand, and Hermann Reuter. "Implementing Antiretroviral Therapy in Rural Communities: The Lusikisiki Model of Decentralized HIV/AIDS Care." *The Journal of Infectious Diseases* 196, no. s3 (2007): S464-S68.
- Benn, Christoph. "The Influence of Cultural and Religious Frameworks on the Future Course of the HIV/AIDS Pandemic." *Journal of Theology for Southern Africa* 113 (July 2002): 3-18.
- Benn, Christoph, and Erlinda Senturias. "Health, Healing and Wholeness in the Ecumenical Discussion." *International Review of Mission* 90, no. 356-357 (2001): 7-25.
- Bennett, John C. *Christian Ethics and Social Policy*. New York: Scribner and Sons, 1956.
- Bersagel Braley, Matthew. "Checking Vitals: The Theological (Im)Pulse of Christian Leadership in Global Health," *Practical Matters* no. 4 (2011), <http://www.practicalmatters.org>.
- . "Towards the Sources in Our Midst: Exploring the Use of Ethical Sources in the Commitment to Global Justice." master's thesis, United Theological Seminary of the Twin Cities, 2003.

- Bishops of the ELCT. "The Bukoba Statement." Bukoba, TZ: Evangelical Lutheran Church in Tanzania, 2004.
- Bongmba, Elias K. *Facing a Pandemic: The African Church and the Crisis of AIDS*. Waco, Texas: Baylor University Press, 2007.
- Boulay, Marc, Ian Tweedie, and Emmanuel Fiagbey. "The Effectiveness of a National Communication Campaign Using Religious Leaders to Reduce HIV-Related Stigma in Ghana." *African Journal of AIDS Research* 7, no. 1 (2008): 133-41.
- Bouwer, Johan. "Human Dignity and HIV/AIDS." *Scriptura* 95, no. 2 (2007): 262-68.
- Brody, Jane E. "Women Struggle for Parity of the Heart." *New York Times*, April 12, 2005.
- Brown, Theodore M. "The Value of History to Public Health." *American Journal of Public Health* 96, no. 2 (2006): 208.
- Brown, Theodore M., Marcos Cueto, and Elizabeth Fee. "The World Health Organization and the Transition From "International" To "Global" Public Health." *American Journal of Public Health* 96, no. 1 (January 2006): 62-72.
- . "The World Health Organization and the Transition From "International" To "Global" Public Health." *American Journal of Public Health* 96, no. 1 (January 2006): 62-72.
- Brown, Theodore M., and Elizabeth Fee. "A Role for Public Health History." *American Journal of Public Health* 94, no. 11 (2004): 1851-53.
- Burawoy, Michael, Joseph A. Blum, Sheba George, Zsuzsa Gille, Teresa Gowan, Lynne Haney, Maren Klawiter, *et al.*, eds. *Global Ethnography: Forces, Connections, and Imaginations in a Postmodern World*. Berkeley and Los Angeles: University of California, 2000.
- Butler, Anthea, Michelle Gonzales Maldonado, Sarah Posner, Becky Garrison, and Matt Recla. "'Biblical' Disaster in Haiti: Pat Robertson and the Curse of Unyielding Ignorance." *Religion Dispatches* (January 15, 2010).
- Cahill, Lisa Sowle. "James M. Gustafson and Catholic Theological Ethics." *Journal of Moral Theology* 1, no. 1 (January 2012): 92-115.
- . *Theological Bioethics: Participation, Justice, Change*. Moral Traditions Series. edited by James F. Keenan Washington, D.C.: Georgetown University Press, 2005.

- Calhoun, Craig, Mark Juergensmeyer, and Jonathan VanAntwerpen, eds. *Rethinking Secularism*. New York: Oxford University Press, 2011.
- Campbell, Catherine. "Migrancy, Masculine Identities and AIDS: The Psychosocial Context of HIV Transmission on the South African Gold Mines." *Social Science & Medicine* 45, no. 2 (1997): 273-81.
- Carpenter, Stephen T. "What Perceived Benefits Do HIV Positive Patients on Anti-Retroviral Therapy Derive from Participation in a Local Church?: The Experience of Patients at Valley Trust ARV Centre, Kwazulu-Natal." master's thesis, St Augustine College of South Africa, 2007.
- Casanova, José . *Public Religions in the Modern World*. Chicago: University of Chicago Press, 1994.
- Chigwedere, Pride, George R. III Seage, Sofia Gruskin, Tun-Hou Lee, and M. Essex. "Estimating the Lost Benefits of Antiretroviral Drug Use in South Africa." *Journal of Acquired Immune Deficiency Syndrome* 49, no. 4 (December 1 2008): 410-15.
- Childress, James F. "Religion, Theology, and Bioethics." In *The Nature and Prospects of Bioethics: Interdisciplinary Perspectives*, edited by Frank G. Miller, John C. Fletcher and James M. Humber, 43-68. Totowa, New Jersey: Humana Press, 2003.
- Christian Connections for International Health. "Community Health and Wholeness." *Annual Conference* (2008). <http://www.ccih.org>.
- Christian Medical Commission. "Healing and Wholeness: The Churches' Role in Health." Geneva: World Council of Churches, 1990.
- Christian Medical Commission, and World Council of Churches. "Annual Meeting." Geneva, 1968.
- Cimperman, Maria. *When God's People Have HIV/AIDS: An Approach to Ethics*. Maryknoll, NY: Orbis Books, 2005.
- Clarke, Gerard. "Faith Matters: Faith-Based Organisations, Civil Society and International Development." *Journal of International Development* 18, no. 6 (2006): 835-48.
- Cochrane, James R. *Circles of Dignity: Community Wisdom and Theological Reflection*. Minneapolis: Augsburg Fortress, 1999.
- . "Damned If You Do, Damned If You Don't: Rereading the Public Theology of the Christian Institute for the Contemporary Practitioner." In *Christian in Public:*

*Aims, Methodologies and Issues in Public Theology*, edited by Len Hansen. Beyers Naude Centre Series on Public Theology, Stellenbosch University, 165-76. Stellenbosch: SUN Press, 2007.

- — —. "Fire from above, Fire from Below': Health, Justice and the Persistence of the Sacred." *Theoria*, no. 116 (August 2008): 67-96.
- — —. "The Language That Difference Makes: Translating Religion and Health." *Practical Matters* no. 4 (2011). <http://www.practicalmattersjournal.org>.
- — —. "A Model of Integral Development: Assessing and Working with Religious Health Assets." Chap. 10 In *Religion and Development: Ways of Transforming the World*, edited by Gerrie ter Haar, 231-52. New York: Columbia University Press, 2011.
- — —. "Religion in the Health of Migrant Communities: Asset or Deficit?". *Journal of Ethnic & Migration Studies* 32, no. 4 (2006): 715-36.
- — —. "Seeing Healthworlds Differently." *Religion and Theology* 14, no. 1 (2007): 6-27.
- — —. "Steve De Gruchy- in Memoriam." *Practical Matters* no. 4 (2011). <http://www.practicalmattersjournal.org>.
- Cochrane, James R., and Bastienne Klein, eds. *Sameness and Difference: Problems and Potentials in South African Civil Society*. Washington, D.C.: Philosophy and Values, 2000.
- Cochrane, James R., and Barbara Schmid. "The Executive Session Approach to Leadership Engagement." In *Arhap International Colloquium: Working Papers*, edited by Barbara Schmid, 86-90. Cape Town, South Africa: ARHAP, 2007.
- Cochrane, James R., Barbara Schmid, and Teresa F. Cutts, eds. *When Religion and Health Align: Mobilizing Religious Health Assets for Transformation*. Pietermaritzburg: Cluster Publications, 2011.
- Coetzee, David, Katherine Hilderbrand, Andrew Bouelle, Gary Maartens, Françoise Louis, Veliswa Labatala, Hermann Reuter, Nonhutuzelo Ntwana, and Eric Goemaere. "Outcomes after Two Years of Providing Antiretroviral Treatment in Khayelitsha, South Africa." *AIDS* 18, no. 6 (April 9 2004): 887-95.
- CSDH. *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health: Final Report of the Commission on Social Determinants of Health*. Geneva: World Health Organization, 2008.

- Cueto, Marcos. "The Origins of Primary Health Care and Selective Primary Health Care." *American Journal of Public Health* 94, no. 11 (November 2004): 1864-74.
- De Gruchy, Steve. "Editorial: Doing Theology in a Time of AIDS." *Journal of Theology for Southern Africa* 125 (2006): 2-6.
- . "Re-Learning Our Mother Tongue? Theology in Dialogue with Public Health." *Religion & Theology* 14, no. 1/2 (2007): 47-67.
- . "The Value of Religion in Religious Health Assets." Paper presented at the ARHAP International Colloquium, Cape Town, South Africa, March 13-16, 2007.
- . "Water and Spirit: Theology in the Time of Cholera." *Ecumenical Review* 62, no. 2 (2010): 188-201.
- De Walque, Damien. "Sero-Discordant Couples in Five African Countries: Implications for Prevention Strategies." *Population and Development Review* 33, no. 3 (2007): 501-23.
- De-Graft Aikins, Ama, Nigel Unwin, Charles Agyemang, Pascale Allotey, Catherine Campbell, and Daniel Arhinful. "Tackling Africa's Chronic Disease Burden: From the Local to the Global." *Globalization and Health* 6, no. 5 (2010).  
<http://www.globalizationandhealth.com/content/6/1/5>.
- Deane, Nawaal. "The Political History of AIDS Treatment." In *HIV/AIDS in South Africa*, edited by S.S. Abdool Karim and Q. Abdool Karim, 538-50. Cambridge: Cambridge University Press, 2005.
- Denis, Philippe. "The Church's Impact on HIV Prevention and Mitigation in South Africa: Reflections of a Historian." *Journal of Theology for Southern Africa* 134, no. Journal Article (2009): 66-81.
- Dorrien, Gary J. "Truth Claims: The Future of Postliberal Theology." *Christian Century*, July 18, 2001, 22-29.
- . *The Making of American Liberal Theology 2: Idealism, Realism, and Modernity, 1900 - 1950*. Louisville, Ky: Westminster John Knox Press, 2003.
- . *The Making of American Liberal Theology: Imagining Progressive Religion, 1805-1900*. Louisville, Ky: Westminster John Knox Press, 2001.
- . *Soul in Society: The Making and Renewal of Social Christianity*. Minneapolis, MN: Fortress Press, 1995.
- Doupe, Andrew. "Partnerships between Churches and People Living with HIV/AIDS Organizations." 96. Geneva: World Council of Churches, 2005.



- Dube, Musa W., ed. *HIV/AIDS and the Curriculum: Methods of Integrating HIV/AIDS in Theological Programmes*. Geneva: WCC Publications, 2003.
- Ecumenical Pharmaceutical Network, and World Council of Churches. "HIV and AIDS Treatment- FBOs Getting Involved." *Contact*, October - December 2007 2007.
- "ELCA Presiding Bishop Washes Feet of HIV-Positive Women." *ELCA News Service*, August 4, 2008.
- Elliott, Charles. "Is Primary Health Care the New Priority? Yes, But ...". *Contact* 28 (August 1975): 3-8.
- Epstein, Helen. *The Invisible Cure: Africa, the West, and the Fight against AIDS*. New York: Farrar, Straus and Giroux, 2007.
- Eriksson, Elisabeth, Gunilla Lindmark, Pia Axemo, Beverley Haddad, and Beth M. Ahlberg. "Ambivalence, Silence and Gender Differences in Church Leaders' HIV-Prevention Messages to Young People in Kwazulu-Natal, South Africa." *Culture, Health & Sexuality* 12, no. 1 (2010): 103-14.
- Farley, Margaret. "Prophetic Discourse in a Time of AIDS." In *HIV Prevention: A Global Theological Conversation*, edited by Gillian Paterson, 57-68. Geneva: Ecumenical Advocacy Alliance, 2009.
- Farmer, Paul. *Infections and Inequalities: The Modern Plagues*. 2nd ed. Berkeley, CA: University of California Press, 2001. 1999.
- — —. *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. Berkeley: University of California Press, 2005.
- Ferguson, Todd, Ted Karpf, Cathleen E. Crain, Robin Swift, and Nathaniel Tashima. "Report on the Global Consultation on Decent Care." Geneva: World Health Organization, 2006.
- Foege, William H., Robert W. Amler, and Craig C. White. "Closing the Gap." *JAMA: The Journal of the American Medical Association* 254, no. 10 (September 13, 1985 1985): 1355-58.
- Frederiks, Martha T. "HIV and AIDS: Mapping Theological Responses." *Exchange: Journal of Missiological and Ecumenical Research* 37, no. 1 (2008): 4-22.
- Garner, Robert C. "Religion in the AIDS Crisis: Irrelevance, Adversary, or Ally?". *AIDS Analysis Africa* 10, no. 6-7 (1999).

- . "Safe Sects? Dynamic Religion and AIDS in South Africa." *The Journal of Modern African Studies* 38, no. 1 (2000): 41-69.
- Germond, Paul, and Sepetia Molapo. "In Search of Bophelo in a Time of AIDS: Seeking a Coherence of Economies of Health and Economies of Salvation." *Journal of Theology for Southern Africa* 126 (November 2006).
- Germond, Paul, Sepetla Molapo, and Tandi Reilly. "The (Singular) Health System and the Plurality of Healthworlds." Paper presented at the ARHAP International Colloquium, Cape Town, South Africa, March 13-16, 2007.
- Gilks, Charles F., Siobhan Crowley, René Ekpini, Sandy Gove, Jos Perriens, Yves Souteyrand, Don Sutherland, *et al.* "The WHO Public-Health Approach to Antiretroviral Treatment against HIV in Resource-Limited Settings." doi: 10.1016/S0140-6736(06)69158-7, *The Lancet* 368, no. 9534: 505-10.
- Gilson, Lucy, Natasha Palmer, and Helen Schneider. "Trust and Health Worker Performance: Exploring a Conceptual Framework Using South African Evidence." *Social Science & Medicine* 61, no. 7 (2005): 1418-29.
- Government of South Africa, Ministry of Health. "HIV and AIDS and Sti Strategic Plan, 2000-2005." (2000). <http://www.safAIDS.net/files/S.A%20Strategic%20Plan%202000-2005.pdf>.
- Grady, Denise. "In Heart Disease, the Focus Shifts to Women." *New York Times*, April 18, 2006.
- Green, Edward C., and Allison Herling. "The ABC Approach to Preventing the Sexual Transmission of HIV: Common Questions and Answers." Christian Connections for International Health, 2007.
- Green, Edward C., and Allison Herling Ruark. "AIDS and the Churches: Getting the Story Right." *First Things*, no. 182 (2008): 22-26.
- Green, Edward C. "Faith Based Organizations Contributions to HIV Prevention." Washington DC: US Agency for International Development (USAID) and The Synergy Project TvT Associates, Harvard Centre for Population and Development Studies., 2003.
- . "The Impact of Religious Health Organisations in Promoting HIV/AIDS Prevention." In *The AIDS Crisis in Developing Countries*, edited by E. C. Green. Westport: Praeger Publishers, 2003.
- Green, Edward C., Daniel T. Halperin, Vinand Nantulya, and Janice A. Hogle. "Uganda's HIV Prevention Success: The Role of Sexual Behaviour Change and the National Response." *AIDS and Behaviour* 10, no. 4 (2006): 335-46.

- Greenleaf, Robert K. "The Institution as Servant." In *Servant Leadership : A Journey into the Nature of Legitimate Power and Greatness*, edited by Larry C. Spears. New York: Paulist Press, 2002.
- — — . "The Need for a Theology of Institutions." In *Seeker and Servant : Reflections on Religious Leadership*, edited by Anne T. Fraker and Larry C. Spears. San Francisco: Jossey-Bass, 1996.
- Grundmann, Christoffer H. "Health Assets of Religious Practices and Convictions: The Impact of the Immaterial." Paper presented at the ARHAP International Colloquium, Cape Town, South Africa, March 13-16, 2007.
- Gunderson, Gary R, and Teresa F. Cutts. "Decent Care for Life." In *Restoring Hope: Decent Care in the Midst of HIV/AIDS*, edited by Ted Karpf, Todd Ferguson, Robin Swift and Jeffrey V. Lazarus. New York: Palgrave Macmillan, 2008.
- Gunderson, Gary R., and James R. Cochrane. *Religion and the Health of the Public*. New York: Palgrave Macmillan, 2012.
- Gunnemann, Jon P. "Thinking Theologically About the Economic." In *Christian Ethics: Problems and Prospects*, edited by Lisa Sowle Cahill and James Childress. Cleveland, OH: Pilgrim Press, 1996.
- Gustafson, James M. "Context Versus Principles: A Misplaced Debate in Christian Ethics." *The Harvard Theological Review* 58, no. 2 (April 1965): 171-202.
- — — . *Ethics from a Theocentric Perspective Vol. 1, Theology and Ethics*. Chicago: University of Chicago Press, 1981.
- — — . *Ethics from a Theocentric Perspective. Vol.2, Ethics and Theology*. Chicago; London: University of Chicago Press, 1984.
- — — . *An Examined Faith: The Grace of Self-Doubt*. Minneapolis, MN: Fortress Press, 2004.
- — — . *Intersections: Science, Theology, and Ethics*. Cleveland, OH: Pilgrim Press, 1996.
- — — . "Moral Discernment in Christian Life." Chap. 2 In *Moral Discernment in the Christian Life: Essays in Theological Ethics*, edited by Theo A. Boer and Paul E. Capetz. Library of Theological Ethics, 25-40. Louisville: Westminster John Knox Press, 2007.
- — — . "Moral Discourse About Medicine: A Variety of Forms." *The Journal of Medicine and Philosophy* 15 (1990): 125-42.

- — —. "A Retrospective Interpretation of American Religious Ethics, 1948-1998." *Journal of Religious Ethics* 25 (1997): 3-22.
- — —. "Say Something Theological!". Chap. 6 In *Moral Discernment in the Christian Life: Essays in Theological Ethics*, edited by Theo A. Boer and Paul E. Capetz, 85-97. Louisville: Westminster John Knox Press, 2007.
- — —. "The Sectarian Temptation." In *Moral Discernment in the Christian Life: Essays in Theological Reflection*, edited by Theo A. Boer and Paul E. Capetz, 142-54. Louisville: Westminster John Knox Press, 2007.
- — —. "The Theologian as Prophet, Preserver, or Participant." In *Theology and Christian Ethics*, 73-96. Philadelphia: United Church Press, 1974.
- — —. *Theology and Christian Ethics*. Philadelphia: United Church Press, 1974.
- — —. *Varieties of Moral Discourse: Prophetic, Narrative, Ethical, and Policy*. Calvin College and Seminary, 1988.
- Gustafson, James M., William C. Placher, S. Mark Heim, and P. Travis Kroeker. "Doubting Theology." *Christian Century*, June 29 2004, 25-36.
- Gyimah, S. O., E. Y. Tenkorang, B. K. Takyi, J. Adjei, and G. Fosu. "Religion, HIV/AIDS and Sexual Risk-Taking among Men in Ghana." *Journal of Biosocial Science* 42, no. 4 (2010): 531-47.
- Habermas, Jürgen. "Religion in the Public Sphere." *European Journal of Philosophy* 14, no. 1 (2006): 1-25.
- Haddad, Beverly., Jill. Olivier, and Steve De Gruchy. "The Potential and Perils of Partnership: Christian Religious Entities and Collaborative Stakeholders Responding to HIV and AIDS in Kenya, Malawi and the DRC." African Religious Health Assets Programme (ARHAP), 2008.
- Haddad, Beverley. "Surviving the HIV and AIDS Epidemic in South Africa: Women Living and Dying, Theologising and Being Theologised." *Journal of Theology for Southern Africa*, no. 131 (2008): 47-57.
- Halperin, Daniel. "Putting a Plague in Perspective." *New York Times*, January 1, 2008.
- Hartwig, Kari. "Confronting Religion, AIDS and Gender in Tanzania: Church Leaders at the Crossroads." *Journal of Constructive Theology* 12, no. 2 (2006): 25-43.
- Hauerwas, Stanley. *The Hauerwas Reader*. edited by John Berkman and Michael G. Cartwright Durham, NC: Duke University Press, 2001.

- — —. "Time and History in Theological Ethics: The Work of James Gustafson." *Journal of Religious Ethics* 13, no. 1 (Spring 85 1985): 3-21.
- Hauerwas, Stanley, and John Berkman. "The Chief End of All Flesh." *Theology Today* 49, no. 2 (July 1, 1992 1992): 196-208.
- Hefner, Philip. *The Human Factor: Evolution, Culture, and Religion*. Minneapolis: Fortress Press, 1993.
- Hinga, Teresia M., Anne Nkirote Kubai, Philomena Njeri Mwaura, and Hazel Ayanga. *Women, Religion and HIV/AIDS in Africa: Responding to Ethical and Theological Challenges*. Pietermaritzburg: Cluster, 2008.
- Ikedo, F. "The Effects of Prayer, Relaxation Technique During General Anesthesia on Recovery Outcomes Following Cardiac Surgery." *Complementary Therapies in Clinical Practice* 13, no. 2 (2007): 85-94.
- Iozzio, Mary Jo, Mary M. Doyle Roche, Elsie M. Miranda, and James F. Keenan. *Calling for Justice Throughout the World: Catholic Women Theologians on the HIV/AIDS Pandemic*. New York: Continuum International Publishing Group, 2009.
- Jellouschek, Stefanie. "Untitled [Evaluation of Masangane Program]." 5. University of Cape Town: IRHAP archIVes, 2003.
- Karim, S.S. Abdool, and Q. Abdool Karim, eds. *HIV/AIDS in South Africa*. Cambridge: Cambridge University Press, 2005.
- Kark, Sidney L. "A Health Service among the Rural Bantu." *South African Medical Journal* 16 (1942): 197-98.
- — —. "The Social Pathology of Syphilis in Africans." *International Journal of Epidemiology* 32, (2003): 181-86. doi:10.1093/ije/dyg025.
- Kark, Sidney L., and John Cassel. "The Pholela Health Centre: A Progress Report." *South African Medical Journal* 26, no. 6 (February 16 1952): 101-04, 31-36.
- Karpf, Ted, J. Todd Ferguson, Robin Swift, and Jeffrey V. Lazarus, eds. *Restoring Hope: Decent Care in the Midst of HIV/AIDS*. New York: Palgrave Macmillan, 2008.
- Keenan, James. "Four of the Tasks for Theological Ethics in a Time of HIV/AIDS." *Concilium: International Journal for Theology*, no. 3 "AIDS" (2007): 64-76.
- Kinast, Robert. *What Are They Saying About Theological Reflection?* Mahwah, NJ: Paulist Press, 2000.

- Kingma, Stuart J. "Beyond Mere Survival to the More Abundant Life : An Overview of the Concerns of the Christian Medical Commission." *Ecumenical Review* 33, no. 3 (1981): 257-71.
- Koenig, Harold G., and Harvey Jay Cohen. *The Link between Religion and Health: Psychoneuroimmunology and the Faith Factor*. Oxford: Oxford University Press, 2002.
- Kopelman, Loretta M. "If HIV/AIDS Is Punishment, Who Is Bad?" In *Ethics & AIDS in Africa: The Challenge to Our Thinking*, edited by Anton A. van Niekerk and Loretta M. Kopelman, 208-18. Claremont, South Africa: David Philip, 2005.
- . "If HIV/AIDS Is Punishment, Who Is Bad?" *Journal of Medicine and Philosophy* 27, no. 2 (January 1, 2002 2002): 231-43.
- Krakauer, Mark, and Jodie Newbery. "Churches' Responses to HIV/AIDS in Two South African Communities." *Journal of the International Association of Physicians in AIDS Care* 6, no. 1 (2007): 27-35.
- Kretzmann, John, and John McKnight. *Asset-Based Strategies for Community Development*. Chicago: Asset-Based Development Institute of Northwestern University, 2002.
- . *Building Communities from the Inside Out: A Path toward Finding and Mobilizing a Community's Assets*. Chicago: ACTA Publications, 1993.
- Lambourne, Robert A. *Community, Church and Healing: A Study of Some of the Corporate Aspects of the Church's Ministry to the Sick*. London: Darton, Longman & Todd, 1963.
- Landman, Christina. "A Theology for the Older, Female HIV-Infected Body." *Exchange: Journal of Missiological and Ecumenical Research* 37, no. 1 (2008): 52-67.
- Larke, Natasha. "Male Circumcision, HIV, and Sexually Transmitted Infections: A Review." *British Journal of Nursing* 19, no. 10 (2010): 629-34.
- Larson, James S. "The World Health Organization's Definition of Health: Social Versus Spiritual Health." *Social Indicators Research* 38, no. 2 (1996): 181-92.
- Lawn, Joy E., Jon Rohde, Susan Rifkin, Miriam Were, Vinod K. Paul, and Mickey Chopra. "Alma-Ata: Rebirth and Revision 1: Alma-Ata 30 Years On: Revolutionary, Relevant, and Time to Revitalise." *The Lancet* 372, no. 9642 (2008): 917.
- Lebouché, Bertrand, Jean-François Malherbe, Christian Trepo, and Raymond Lemieux. "Religion in the AIDS Crisis: Irrelevance, Adversary, or Ally? The Case of the

Catholic Church." Translated by Brian McNeil. In *Applied Ethics in a World Church: The Padua Conference*, edited by Linda Hogan, 170-79. Maryknoll: Orbis Books, 2008.

Levy, Nomi C., Rebecca A. Miksad, and Oliver T. Fein. "From Treatment to Prevention: The Interplay between HIV/AIDS Treatment Availability and HIV/AIDS Prevention Programming in Khayelitsha, South Africa." *Journal of Urban Health* 82, no. 3 (September 2005): 498-509.

Litsios, Socrates. "The Christian Medical Commission and the Development of the World Health Organization's Primary Health Care Approach." *American Journal of Public Health* 94, no. 13 (2004): 1884-93.

———. "The Long and Difficult Road to Alma-Ata: A Personal Reflection." *International Journal of Health Services* 32, no. 4 (2002): 709-32.

Lux, Steven, and Kristine Greenaway. "Scaling up Effective Partnerships: A Guide to Working with Faith-Based Organizations in the Response to HIV and AIDS." 132. Geneva: Ecumenical Advocacy Alliance, 2006.

LWF. "Lutheran World Federation Action Plan for Responding to HIV/AIDS Pandemic: Compassion, Conversion, Care." 2002.

Mageto, Peter. *Victim Theology: A Critical Look at the Church's Response to AIDS*. Bloomington, IN: AuthorHouse, 2006.

Maman, Suzanne, Rebecca Cathcart, Gillian Burkhardt, Serge Omba, and Frieda Behets. "The Role of Religion in HIV-Positive Women's Disclosure Experiences and Coping Strategies in Kinshasa, Democratic Republic of Congo." *Social Science & Medicine* 68, no. 5 (2009): 965-70.

Marshall, Ellen Ott. *Christians in the Public Square: Faith That Transforms Politics*. Nashville: Abington Press, 2008.

Marshall, Katherine, and Lucy Keough. "Faith Communities Engage the HIV/AIDS Crisis: Lessons Learned and Paths Forward." In *Berkley Center Religious Literacy Series*. Washington, D.C.: Berkley Center for Religion, Peace, and World Affairs, Georgetown University, 2007.

Masangane. "Masangane Constitution." Moravian Church in South Africa, 2004.

Masangane Moravian AIDS Programme. "Constitution [A]." 2: Masangane Moravian AIDS Programme, Undated.

———. "Constitution [B]." 5: Masangane Moravian AIDS Programme, Undated.

- Mashau, Thinandavha Derrick. "Where and When It Hurts Most: The Theology of Hope and Accompaniment in the Context of HIV and AIDS in Marriage and Family Life." *Exchange: Journal of Missiological and Ecumenical Research* 37, no. 1 (2008): 23-34.
- Matinisi, Ntombentsha. "Breaking the Silence in the Churches." *Informationsbrief* (April 2001): 4.
- McCutcheon, Russell T., ed. *The Insider/Outsider Problem in the Study of Religion: A Reader*. New York: Cassell, 1999.
- McGilvray, James C. "The Historical Perspective: Our Inheritance." In *Christian Medical Commission Annual Meeting, 22-28*. Geneva: World Council of Churches, 1968.
- — —. *The Quest for Health and Wholeness*. Tübingen, Germany: German Institute for Medical Missions, 1981.
- Medical Research Council. *The Demographic Impact of HIV/AIDS in South Africa: National and Provincial Indicators for 2006*. 2003. <http://www.mrc.ac.za>.
- Medicins sans Frontières. "Achieving and Sustaining Universal Access to Antiretrovirals in Rural Areas: The Primary Health Care Approach to HIV Services in Lusikisiki, Eastern Cape." Cape Town, 2006.
- — —. "Implementing HIV/AIDS Services Including ART in a Rural Resource-Poor Setting: *Siyaphila La* Programme-- Lusikisiki, Eastern Cape (Activity Report 2003-2004)." 15: Medecins sans Frontières; Nelson Mandela Foundation, 2005.
- Messer, Donald. *Breaking the Conspiracy of Silence: Christian Churches and the Global AIDS Crisis*. Minneapolis, MN: Fortress Press, 2004.
- Messer, Donald E. *Breaking the Conspiracy of Silence: Christian Churches and the Global AIDS Crisis*. Minneapolis: Augsburg Fortress, 2004.
- Miller, Neville, and D. L. Rubin. "Factors Leading to Self-Disclosure of a Positive HIV Diagnosis in Nairobi, Kenya: People Living with HIV/AIDS in the Sub-Sahara." *Qualitative health research* 17, no. 5 (2007): 586-98.
- Miller, R. L. "A Rock in a Weary Land: AIDS, South Africa, and the Church." *Social Work in Public Health* 24, no. 1/2 (2009): 22-38.
- Moltmann, Jürgen. *God in Creation : An Ecological Doctrine of Creation: The Gifford Lectures 1984-1985*. London: SCM, 1985.



- Moyo, Fulata L. "Sex, Gender, Power and HIV/AIDS in Malawi: Threats and Challenges to Women Being Church." In *On Being Church: African Women's Voices and Visions*, edited by Isabel Apawo Phiri and Sarojini Nadar, 127-45. Geneva: World Council of Churches, 2005.
- Musopole, Augustine C. *Spirituality, Sexuality and HIV/AIDS in Malawi: Theological Strategies for Behaviour Change*. Zomba: Kachere Series, 2007.
- — —. "Christic Realism and AIDS: Theological Strategy for Behavior Change." *Theologies and Cultures* 4, no. 2 (2007): 52-85.
- Myer, Landon, Chelsea Morroni, and Ezra S. Susser. "Commentary: The Social Pathology of the HIV/AIDS Pandemic." *International Journal of Epidemiology* 32 (2003): 189-92.
- National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. "HIV in the United States." Atlanta: Centers for Disease Control and Prevention, 2011.
- Nelson, James M. *Psychology, Religion and Spirituality*. New York: Springer, 2009.
- Newbiggin, Lesslie, ed. *The Healing Church: The Tübingen Consultation, 1964*. Geneva: World Council of Churches, 1965.
- Newell, Kenneth W., ed. *Health by the People*. Geneva: World Health Organization, 1975.
- — —. "Selective Primary Health Care: The Counter Revolution." *Social Science & Medicine* 26, no. 9 (1988): 903-06.
- Niebuhr, H. Richard. *Christ and Culture*. New York: Harper and Row, 1951.
- — —. *The Meaning of Revelation*. New York: Macmillan Publishing Company, 1941. 1967. 1941.
- Noble, Rob. "South Africa: HIV & AIDS Statistics." <http://www.avert.org/safricastats.htm>.
- Nweneka, Chidi V. "Sexual Practices of Church Youths in the Era of HIV/AIDS: Playing the Ostrich." *AIDS Care* 19, no. 8 (2007): 966-69.
- O'Brien, Kevin. "An Ethics of Biodiversity: Moral Theology, Ecology, and Environmentalism." PhD dissertation, Emory University, 2006.
- Ojikutu, Bisola. "The Realities of Antiretroviral Therapy Rollout: Overcoming Challenges to Successful Programmatic Implementation." *Journal of Infectious Diseases* 196, no. 3 (2007): 445-48.

- Ojikutu, Bisola, Chris Jack, and Gita Ramjee. "Provision of Antiretroviral Therapy in South Africa: Unique Challenges and Remaining Obstacles." *The Journal of Infectious Diseases* 196, no. s3 (2007): S523-S27.
- Olivier, Jill. "Where Does the Christian Stand? Considering a Public Discourse of Hope in the Context of HIV/AIDS in South Africa." *Journal of Theology for Southern Africa* 126 (November 2006).
- Olivier, Jill, James R. Cochrane, and Barbara Schmid. "Arhap Bibliography: Working in a Bounded Field of Unknowing." Cape Town: ARHAP, 2006.
- Olivier, Jill, James R. Cochrane, Barbara Schmid, and Lauren Graham. "Arhap Literature Review: Working in a Bounded Field of Unknowing." (2006).
- Otolok-Tanga, Erasmus, Lynn Atuyambe, Colleen K. Murphy, Karin E. Ringheim, and Sara Woldehanna. "Examining the Actions of Faith-Based Organisations and Their Influence on HIV/AIDS-Related Stigma: A Case Study of Uganda." *African Health Sciences* 7, no. 1 (2007): 55-60.
- Ottati, Douglas F. "Christian Theology and Other Disciplines." *The Journal of Religion* 64, no. 2 (1984): 173-87.
- — —. "How Can Theological Ethics Be Christian?" *Journal of the Society of Christian Ethics* 31, no. 2 (2011): 3-21.
- Parker, Alberta W., Jane M. Walsh, and Merl Coon. "A Normative Approach to the Definition of Primary Health Care." *The Milbank Memorial Fund Quarterly. Health and Society* 54, no. 4 (Autumn 1976): 415-38.
- Parker, Warren, and Karen Birdsall. "HIV/AIDS, Stigma and Faith-Based Organizations: A Review." 33: Centre for AIDS Development, Research and Evaluation (CADRE), 2005.
- Parry, Sue. *Beacons of Hope: HIV Competent Churches: A Framework for Action*. Geneva: WCC Publications, 2008.
- Paterson, Gillian Margaret. "Escaping the Gender Trap: Unravelling Patriarchy in a Time of AIDS." *Concilium: International Journal for Theology*, no. 3 "AIDS" (2007): 102-11.
- — —. "The CMC Story: 1968-1998." *Contact*, no. 161/162 (June-July and August-September 1998): 3-52.
- Perry, Michael. "The Morality of Human Rights: A Nonreligious Ground?" *Emory Law Journal* 54, no. Special Edition (2005): 97-150.

- Perry, Tonya E., Denise Davis-Maye, and Durrenda N. Onolemhemen. "Faith, Spirituality, Fatalism and Hope: Ghanaian Women Coping in the Face of HIV/AIDS." *Journal of HIV/AIDS & Social Services* 6, no. 4 (2007): 37-58.
- Phiri, Isabel Apawo. "Life-Affirming African Theological Reflection on HIV and AIDS." *Concilium: International Journal for Theology*, no. 3 "AIDS" (2007): 41-47.
- Phiri, Isabel Apawo, Beverley Haddad, and Madipoane Masenya. *African Women, HIV/AIDS and Faith Communities*. Pietermaritzburg: Cluster, 2003.
- Piot, Peter. "Closing Address." In *XVI International AIDS Conference*. Toronto, Canada, 2006.
- Porter, Roy. *The Greatest Benefit to Mankind: A Medical History of Humanity*. First American ed. New York: W.W. Norton & Co., 1998. 1997.
- Potter, Ralph. "The Logic of Moral Argument." Chap. 4 In *Toward a Discipline of Social Ethics: Essays in Honor of Walter George Muelder*, edited by Paul Deats, Jr., 93-116. Boston: Boston University Press, 1972.
- Risse, Guenter B. *Mending Bodies, Saving Souls : A History of Hospitals*. New York: Oxford University Press, 1999.
- Root, Robin. "Religious Participation and HIV-Disclosure Rationales among People Living with HIV/AIDS in Rural Swaziland." *African Journal of AIDS Research* 8, no. 3 (2009): 295-309.
- Rose, Matthew. "An Examined Faith: The Grace of Self-Doubt." *First Things: A Monthly Journal of Religion & Public Life*, no. 151 (2005): 54-55.
- Rosen, Sydney, Matthew P. Fox, and Christopher J. Gill. "Patient Retention in Antiretroviral Therapy Programs in Sub-Saharan Africa: A Systematic Review." *PLoS Medicine* 4, no. 10 (2007): e298. doi:doi:10.1371/journal.pmed.0040298, www.plosmedicine.org.
- Russell, Letty M. *The Church with AIDS: Renewal in the Midst of Crisis*. Louisville: Westminster/John Knox Press, 1990.
- Ryan, Maura A. "Beyond a Western Bioethics?." *Theological Studies* 65, no. 1 (2004): 158-77.
- "SA Life Expectancy Decreases." *Mail & Guardian*, November 19 2009.

- Sachs, William L. *Empowered by Faith: Collaborating with Faith-Based Organisations to Confront HIV/AIDS*. Arlington, VA.: Family Health International (FHI)/USAID Bureau for Global Health Office of HIV/AIDS, 2007.
- Sadgrove, Jo. "Keeping up Appearances': Sex and Religion Amongst University Students in Uganda." *Journal of Religion in Africa - Religion en Afrique* 37, no. 1 (2007): 116-44.
- Schmid, Barbara. "AIDS Discourses in the Church: What We Say and What We Do." *Journal of Theology for Southern Africa* 125 (July 2006): 91-103.
- — —. "The Faith-Based Factor: What Value Does Religion Add to Health Services." 1-12: African Religious Health Assets Program, 2006.
- Schmid, Barbara, Liz Thomas, Jill Olivier, and James R. Cochrane. "The Contribution of Religious Entities to Health in Sub-Saharan Africa (Study Commissioned by Bill and Melinda Gates Foundation)." Cape Town: African Religious Health Assets Programme, 2008.
- Schneider, Helen, and Didier Fassin. "Denial and Defiance: A Socio-Political Analysis of AIDS in South Africa." *AIDS* 16 (2002): S45-S51.
- Schweiker, William. "On the Future of Religious Ethics: Keeping Religious Ethics Religious and Ethical." *Journal of the American Academy of Religion* 74, no. 1 (2006): 135-51.
- Seidel, Gill. "The Competing Discourses of HIV/AIDS in Sub-Saharan Africa: Discourses of Rights and Empowerment Vs. Discourses of Control and Exclusion." *Social Science and Medicine* 36, no. 3 (1993): 175-94.
- Simone, Renata, William Cran, Greg Barker, Will Lyman, Wgbh, Ltd Paladin InVision, Productions Silverbridge, et al. *The Age of AIDS*. Alexandria, Va.: PBS Home Video, 2006.
- Siwila, Lilian. "Care-Giving in Times of HIV and AIDS, When Hospitality Is a Threat to African Women's Lives: A Gendered Theological Examination of the Theology of Hospitality." *Journal of Constructive Theology* 13, no. 1 (2007): 69-82.
- Smith, Christian. *Disruptive Religion : The Force of Faith in Social-Movement Activism*. New York: Routledge, 1996.
- Smith, Daniel Jordan. "Youth, Sin and Sex in Nigeria: Christianity and HIV/AIDS-Related Beliefs and Behaviour among Rural-Urban Migrants." *Culture, Health & Sexuality* 6, no. 5 (September-October 2004): 425-37.

- "South Africa HIV & AIDS Statistics." Avert, <http://www.avert.org/south-africa-HIV-AIDS-statistics.htm>.
- South African Press Agency. "SA State Hospitals in Crisis." *Mail&Guardian*, May 24, 2009.
- Speicher, Sara. "Final Report." Paper presented at the Global Assessment and Strategy Session on Faith Communities Accessing Resources to Respond to HIV/AIDS, Geneva, Switzerland, January 18-20 2005.
- Sprecht, David, and Richard Broholm. "A Process for Holding Institutions in Trust." Paper presented at Toward a Theology of Institutions, Minneapolis, MN, June 10-11, 2009.
- Steinberg, Jonny. *Sizwe's Test: A Young Man's Journey through Africa's AIDS Epidemic*. New York: Simon & Schuster, 2008.
- Stout, Jeffrey. *Democracy and Tradition*. Princeton: Princeton University Press, 2003.
- . *Ethics after Babel: The Languages of Morals and Their Discontents*. Boston: Beacon Press, 1988.
- Suchocki, Marjorie. *The Fall to Violence : Original Sin in Relational Theology*. New York: Continuum, 1994.
- Tassie, Jean-Michel, Elisabeth Szumilin, Alexandra Calmy, and Eric Goemaere. "Highly Active Antiretroviral Therapy in Resource-Poor Settings: The Experience of Medecins Sans Frontières." *AIDS* 17, no. 13 (September 5 2003): 1995-97.
- Taylor, N. "Working Together? Challenges and Opportunities for International Development Agencies and the Church in the Response to AIDS in Africa." In *HIV and AIDS Briefing Paper 7*. Teddington, UK: Tearfund, 2006.
- Tearfund. *Faith Untapped: Why Churches Can Play a Crucial Role in Tackling HIV and AIDS in Africa*. Teddington, UK: Tearfund, 2006.
- ter Haar, Gerrie, ed. *Religion and Development: Ways of Transforming the World*. New York: Columbia University Press, 2011.
- The Catholic Bishops of Uganda. "Message on the AIDS Epidemic: To the Clergy, the Religious and All People of God, to Men and Women of Good Will: Peace and God's Blessing." *African Ecclesial Review* 31, no. 5 (1989).
- Thomas, Liz, Barbara Schmid, Malibongwe Gwele, Rosemond Ngubo, and James R. Cochrane. "'Let Us Embrace': The Role and Significance of an Integrated Faith-

Based Initiative for HIV and AIDS." 76. Eastern Cape, South Africa: African Religious Health Assets Programme, 2006.

Tipton, Steve. "Social Differentiation and Moral Pluralism." In *Meaning and Modernity: Religion, Polity, and Self*, edited by Richard Madsen, William Sullivan, Ann Swidler and Steven Tipton. Berkeley: University of California Press, 2002.

Townes, Emilie M. *Breaking the Fine Rain of Death: African American Health Issues and a Womanist Ethic of Care*. New York: Continuum, 1998.

Turner, D. D. "Just Another Drug? A Philosophical Assessment of Randomised Controlled Studies on Intercessory Prayer." *Journal of Medical Ethics* 32, no. 8 (2006): 487-90.

Tutu, Desmond Mpilo. "Address by Reverend Desmond Mpilo Tutu." In *Sixty-first World Health Assembly*. Geneva: World Health Organization, 2008.

Ucheaga, D. N., and K. A. Hartwig. "Religious Leaders' Response to AIDS in Nigeria." *Global Public Health* 5, no. 6 (2010): 611-25.

UNAIDS. "2008 Report on the Global AIDS Epidemic." 357. Geneva: UNAIDS, 2008.

———. "AIDS Epidemic Update." 100. Geneva: Joint United Nations Programme on HIV/AIDS and the World Health Organization, 2009.

———. "AIDS Epidemic Update." [http://www.unAIDS.org/en/HIV\\_data/epi2006/default.asp](http://www.unAIDS.org/en/HIV_data/epi2006/default.asp).

———. "Getting to Zero: 2011-2015 Strategy." Geneva, 2010.

———. "Global Report: UnAIDS Report on the Global AIDS Epidemic (2010)." Geneva: UNAIDS, 2010.

UNAIDS. "Partnership with Faith-Based Organizations: UnAIDS Strategic Framework." 32. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS), 2009.

———. "Terminology Guidelines." (2011). <http://www.unAIDS.org>.

———. "The 'Three Ones' in Action: Where We Are and Where We Go from Here." report, (2005). [http://data.unAIDS.org/publications/irc-pub06/jc935-3onesinaction\\_en.pdf](http://data.unAIDS.org/publications/irc-pub06/jc935-3onesinaction_en.pdf).

———. "Universal Access to HIV Prevention, Treatment, Care and Support: From Countries to Regions to the High Level Meeting on AIDS and Beyond." Geneva: UNAIDS, 2011.

- UNAIDS, UNICEF, and WHO. "Global HIV/AIDS Response: Epidemic Update and Health Sector Progress Towards Universal Access: Progress Report 2011." Geneva: UNAIDS, 2011.
- UNDP. "Human Development Report: International Cooperation at a Crossroads (Summary)." New York: United Nations Development Programme, 2005.
- United Nations. "The Millennium Development Goals Report, 2005." New York: United Nations, 2005.
- van Klinken, Adriaan S. "When the Body of Christ Has AIDS: A Theological Metaphor for Global Solidarity in Light of HIV and AIDS." *International Journal of Public Theology* 4, no. 4 (2010): 446-65.
- Villa-Vicencio, Charles. *A Theology of Reconstruction: Nation-Building and Human Rights*. Cambridge: Cambridge University Press, 1992.
- Vitillo, R. J. "Faith-Based Responses to the Global HIV Pandemic: Exceptional Engagement in a Major Public Health Emergency. Special Report." *Journal of Medicine and the Person* 7, no. Journal Article (2009): 77-84.
- Wagner, G. J., I. Holloway, B. Ghosh-Dastidar, G. Ryan, C. Kityo, and P. Mugenyi. "Factors Associated with Condom Use among HIV Clients in Stable Relationships with Partners at Varying Risk for HIV in Uganda." *AIDS and Behavior* 14, no. 5 (2010): 1055-65.
- Wakhusama, Evelyn. "Abused and Infected with HIV: A Call for a Communal Response." In *Women, Religion and HIV/AIDS in Africa: Responding to Ethical and Theological Challenges*, edited by Teresia M. Hinga, Anne Nkirote Kubai, Philomena Mwaura and Hazel Ayanga, 168-78. Pietermaritzburg: Cluster, 2008.
- Watt, Melissa H., Suzanne Maman, Mark Jacobson, John Laiser, and John Muze. "Missed Opportunities for Religious Organizations to Support People Living with HIV/AIDS: Findings from Tanzania." *AIDS Patient Care and STDs* 23, no. 5 (2009): 389-94.
- Weber, Max. "Politics as Vocation." Translated by H.H. Gerth and C. Wright Mills. In *From Max Weber: Essays in Sociology*, edited by H.H. Gerth and C. Wright Mills, 77-128. New York: Oxford University Press, 1946.
- Whitmore, Todd David. "Crossing the Road: The Case for Ethnographic Fieldwork in Christian Ethics." *Journal of the Society of Christian Ethics* 27, no. 2 (2007): 273-94.
- Wilson, Edward O. *Consilience: The Unity of Knowledge*. New York: Alfred A. Knopf, Inc., 1998.

- Winskell, Kate, Laura K. Beres, Elizabeth Hill, Benjamin Chigozie Mbakwem, and Oby Obyerodhyambo. "Making Sense of Abstinence: Social Representations in Young Africans' HIV-Related Narratives from Six Countries." *Culture, Health & Sexuality* 13, no. 8 (2011/09/01 2011): 945-59.
- Woldehanna, Sara, Karin Ringheim, Colleen Murphy, Jenna Gibson, Bernadette Odyniec, Calixte Clerisme, Bella Patel Uttekar, *et al.* "Faith in Action: Examining the Role of FBOs in Addressing HIV-AIDS." Washinton, D.C.: Global Health Council, 2005.
- World Bank. "Concept Note." In *HIV and AIDS Workshop for Faith-Based Organisations and National AIDS Councils*. Accra, Ghana: World Bank, 2004.
- World Health Organization. *Antiretroviral Therapy for HIV Infection in Adults and Adolescents: Recommendations for a Public Health Approach: 2010 Revision*. Geneva: WHO, 2010.
- — —. "Constitution." In *Basic Documents*. Geneva: World Health Organization, 1986.
- — —. "Faith-Based Groups: Vital Partners in the Battle against AIDS." In *The '3 x 5' Target Newsletter*. Geneva: World Health Organization, 2004.
- — —. *Preamble to the Constitution of the World Health Organization*. New York: World Health Organization, 1946.
- — —. "Taking Stock: Health Worker Shortages and the Response to AIDS." WHO/HIV/2006.05, (2006). <http://www.who.int/HIV/pub/advocacy/ttr/en/index.html>.
- — —. "The World Health Report 2000 - Health Systems: Improving Performance." Geneva: World Health Organization, 2000.
- — —. "The World Health Report 2002: Reducing Risks, Promoting Health Life." Geneva: World Health Organization, 2002.
- — —. "The World Health Report 2008 - Primary Health Care (Now More Than Ever)." Geneva: World Health Organization, 2008.
- Wuthnow, Robert. *The Restructuring of American Religion: Society and Faith since World War II*. Princeton, NJ: Princeton University Press, 1988.
- Zou, James, Yvonne Yamanaka, Muze John, Melissa H. Watt, Jan Ostermann, and Thielman Nathan. "Religion and HIV in Tanzania: Influence of Religious Beliefs on HIV Stigma, Disclosure, and Treatment Attitudes." *BMC Public Health* 9, no. 75 (March 4 2009).