

Checking Vitals: The Theological (Im)Pulse of
Christian Leadership in Global Health

Matthew Bersagel Braley

Viterbo University

ABSTRACT

In the past decade, global health leaders have begun to speak about Christian religious entities as “vital partners” in the response to global health crises like the AIDS pandemic. These partnerships, however, are predicated on a particular understanding of the value-added contribution of religious entities to global health programs. The assessment of religion’s value often ignores one of the most vital and vitalizing dimensions of Christianity: constructive theological reflection. Christian religious entities are welcomed in a supporting role *as long as* their beliefs and practices support, or can be translated into, existing paradigms in global health. This article recovers part of the history of Christian leadership in global health to show how intentional processes of theological reflection enabled Christians to play a leading role in the paradigm-shifting primary health care movement. James Gustafson’s “participant theologian” is introduced as an analytical frame for understanding the active participation of Christian leaders in this particular history.

Introduction

In May 2008 a small conference took place in Buckeystown, Maryland. The fine print on the conference flier highlights 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. . . . [W]e will review past and current community health efforts, and we will end the 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.¹

Two aspects of this promotional flier suggest something important about current understandings of the relationship between religion and public health. First, “People of Faith” are identified not merely as participants but as *leaders* in the “global revival of community-based health care.” Second, this leadership is predicated, in part, on the ability to provide “quality health care at the community level.” That is, faith communities are recognized for the value they contribute to the actual practices of healthcare at the community level.

The leadership of faith communities in health and the quality of health care they provide is, of course, not new. The conference theme, “Community Health and Wholeness,” taps into the longer history of theological and ethical participation in community-based health initiatives. This article recovers a unique part of that history as a way of gaining critical leverage on the limits of existing forms of Christian participation and leadership in contemporary global health crises.

The first section identifies the practical reasons global health leaders have turned to religious entities as partners in the face of persistent and pervasive global health crises. The middle sections focus on how theological reflection on a crisis in Christian medical missions proved catalytic for new ways of thinking about health and human flourishing and the specific practices of global health that support them. The final section develops James Gustafson’s concept of the participant theologian in order first to clarify the role of theology in the story of the CMC and, second, to highlight the possibility of an expanded understanding of Christian leadership in the response to contemporary global health issues.

Religious Entities as Vital Partners in Global Health

Global health institutions are actively pursuing partnerships with religious entities that exist at all levels, including the community (e.g., traditional healers), the national (e.g., Christian Health Associations), and the global (e.g., Lutheran World Federation).² Identification of religion as a “vital partner” in global health raises important questions about what the participation of religious entities looks like in global health policy debates and programs.³ What, if anything, do religious entities contribute as partners in global health?

Partnerships with religion may simply be pragmatic. According to this line of thinking, interest in religious entities as vital partners is predicated on two related observations by global health leaders: 1) health-seeking behaviors informed by religion or notions of the sacred persist in many communities facing some of the most entrenched health issues, and 2) religious entities have (and are) resources that can be used to promote health in a community.⁴ The example of the global response to the HIV pandemic illustrates how these two observations inform global health leaders' understanding of how religious entities contribute to more effective prevention, promotion, and treatment campaigns.

Public health professionals have long-recognized that the effectiveness of their prevention campaigns requires sensitivity to cultural dimensions of the target population. It follows, then, that as part of culture, religious beliefs and practices need to be taken into account when devising HIV prevention strategies. For example, ongoing efforts to promote safe forms of male circumcision as a strategy for reducing the transmission of HIV confront resistance from community members who see the traditional methods of male circumcision as a religiously resonant rite of passage vital to maintaining the identity of the community.⁵

With regards to the second observation about religious entities as a resource, a network of scholars affiliated with the African Religious Health Assets Program (ARHAP) has documented in many communities throughout sub-Saharan Africa the presence of “tangible religious health assets.” The tangible assets that can be leveraged by global health actors include buildings for HIV testing and counseling, personnel for visiting persons living with HIV and AIDS (PLWHA), as well as other forms of material support.⁶ Religious entities also possess what ARHAP calls “intangible assets,” defined as “volitional, motivational, and mobilizing capacities that are rooted in vital affective, symbolic, and relational dimensions of religious faith, belief, behavior, and ties.”⁷ These, too, are being leveraged in global health programs.⁸

Minimally, partnerships with religious entities require acknowledgment that religion matters to global health.⁹ A growing body of literature offers evidence of how, specifically, religious entities matter to global health programs.¹⁰ In the example of male circumcision, above, sensitivity to religion becomes a particular instance of an overall commitment to global health's professed sensitivity to cultural particularity in designing interventions and responses. In the ARHAP example, research describing and mapping the religious health assets of a community is used as “data” for making global health policies related to HIV and AIDS more effective.

According to this literature, the work ahead consists primarily of 1) aligning the assets of religious entities with existing and emerging programs and strategies in the response to HIV and AIDS;¹¹ 2) developing a working lexicon and mediating structures for persons working at the intersection of religion and health;¹² 3) understanding more fully the plural worldviews that influence the health-seeking behaviors of diverse populations;¹³ and 4) finding new ways to operationalize the value of religion, including intangible assets like hope (e.g., metrics for the impact of hope on health outcomes).¹⁴ Ultimately, the success of this work will be determined by the potential of

partnerships to generate improved health outcomes in a given population.

But much of this work and the forms of partnerships with religious entities it has encouraged obscure a constitutive dimension of religious activity: critical theological reflection.¹⁵ To state the problem succinctly, global health leaders recognize partnerships with religious entities as necessary, but the valuation of those partnerships threatens to render critical theological reflection unnecessary. Theology is a cheerleader but never a constructive critic. Partnerships are formed on the basis of selective engagement with dimensions of religion that are 1) supportive of existing practices in global health and 2) easily transposable into the dominant institutional logics of global health. As such, the value of religion in the response to global health is limited to the activities of informing and conforming. From the perspective of Christian ethics, these limits crowd out one of Christianity's most distinctive activities: *transforming* the world—an activity shot through with ongoing, critical theological reflection.

Religious beliefs and practices can *inform* global health programming, providing, for example, a better understanding of the cultural obstacles that global health programs may encounter on the ground. At the same time, the various health assets of religious entities can be *conformed* to, or aligned with, existing health programs. For example, global health leaders view church buildings as a potential religious health asset since the building can be set up as a site for an HIV testing clinic, an especially important asset in areas where public health clinics are few and far between. Note that while the commitment to provide church space for testing may have resulted from a process of theological reflection within the church, this is different from critical theological reflection as part of a wider conversation about the purposes and prospects of global health policies. As long as the internal processes of theological reflection result in religious activities that support, or conform to, existing global health policies, religious entities are welcomed as vital partners. But this is to miss a significant dimension of what makes many religious entities vital: a commitment to and space for ongoing theological reflection about what constitutes human flourishing.

The following history of the theological impulses that gave rise to Christian Medical Commission and the primary health care movement provides evidence of religious entities transforming fundamental commitments within global health. In so doing, the history suggests a reason for why global health leaders today should pay attention to processes of theological reflection as part of what makes partnerships with religious entities vital.

Ecumenical Epiphanies, or the Joy of Saying Something Theological

The story of Christianity and health care dates back to the early church as Jesus's disciples continued to preach and practice his distinctive healing ministry. The following case study of the origins of the Christian Medical Commission illustrates how this distinctive healing ministry was "rediscovered" and given new institutional form at two mid-twentieth century gatherings of theologians and medical missionaries in Tübingen, Germany.¹⁶

TÜBINGEN I: ORDAINING 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 "essential issues" of medical missions.¹⁷ 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.¹⁸

The study participants gathered in 1964 in Tübingen, Germany. By the end of the week, 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.¹⁹ 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.²⁰ 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.

Theologically, healing bears witness to the "breaking into human life of the powers of the Kingdom of God, and [to] the dethroning of the powers of evil."²¹ 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.²²

The participants at what would eventually be referred to as "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."²³ 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. Practically, this is embodied by a medical missionary who sees his role not as an evangelist 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, others, and one's self.

In this framing, health 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.”²⁴ The work of Jenkins and James McGilvray to develop an eschatological idea of health both highlights and toes the line between the Western missionary medicine and Christian healing that had been drawn at Tübingen I. It highlights the line in its invitation to think of health as a “vision of possibilities” that cannot be reduced to the “possibilities or failures of medicine.”²⁵ It toes the line in its insistence that medicine is a service profession and should be “more widely and directly available to all suffering human beings.”²⁶ This, ultimately, is a call for a *reorientation*, not a rejection, of Western medicine.

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.²⁷ But Tübingen I participants, most of whom were medical professionals rather than 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.”²⁸ In this commitment to reconnecting medical missionaries to the corporate life of Christian fellowship, Tübingen I offered a new ecclesiology: the healing church.

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 attendant institutions in which it was practiced, even if nominally Christian, had become disengaged from the life of the congregation.²⁹ This affected not only the practice of medicine but also how Christians understood their own capacity to be agents of healing.

If health is 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 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.”³⁰ As members of healing communities, then, Christians 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.³¹ In effect, 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 derivative of the Gospel’s emphasis on wholeness and reconciliation. For the participants at Tübingen, the healing church offered a vision of a transformed community that takes seriously its unique responsibility to be a place of refuge from the existential anxieties as well as physical ill-

nesses plaguing the modern world.

Reflecting on the consultation nearly two decades later, McGilvray offered this assessment of the epiphany at Tübingen I:

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.³²

According to this line of thinking, the Enlightenment 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.³³ Healing, the medical equivalent of salvation, is preoccupied with the total removal of illness; health is negatively defined as the absence of disease. Modern medicine, in other words, does not offer a satisfactory soteriology to persons who experience illness and suffering as more than a physical phenomenon.

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.³⁴ Any answer to this question had 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.³⁵

TÜBINGEN II: HERE IS THE HEALING CHURCH, WHERE IS THE STEEPLE?

Something had happened at the first Tübingen conference. A healing church had been conceived, if not born. 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. 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: 1) “whether the theologian’s view of salvation would be complete and sufficient without the contribution of the scientist”³⁶ and 2) what a healing church would actually look like in practice.

These questions formed the basis for a second consultation at Tübingen, three years after the initial gathering. By 1967, 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.³⁷ The results of these surveys informed the discussions of Tübingen II, offering evidence of the ways the medical missionary model failed to meet the health needs of the vulnerable persons it was designed 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. 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.

Two additional findings of the surveys reflected specific concerns of the post-colonial era. First, locations of health services tended to follow colonial patterns. 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. This institutional patchwork of health providers presented a challenge to new leaders interested in developing planned, comprehensive national health systems. The church-related hospitals and clinics dotting the sub-Saharan African landscape emerged over time in response to the specific needs of the former colonies and did not reflect a coordinated effort to provide medical care across localities.

A second 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.³⁸ 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.³⁹

The theologically rich concept of the healing church served to disrupt the dominance of biomedical frameworks for health that had relegated religious leaders to “reactors,”⁴⁰ 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. Reasserting 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 identified as an “idolatry of the problem-solving powers of science.”⁴¹

Indeed, for Robert Lambourne, whose book *Community, Church, and Healing* (1963) was 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:

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. . . . 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.⁴²

In the mid-twentieth century, interest in holistic health, the psychosomatic unity of the person, or what might be described as the phenomenon of human being appeared widespread.⁴³ 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 medical view of health, but Tübingen II was forced to confront the limits of the healing church.

Reflecting on the criticisms of Tübingen I and the clarifying work undertaken at Tübingen II, Christoph Benn and Erlinda Senturias suggest that the healing church was never intended as a substitute for other health care institutions, arguing that 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.”⁴⁴ The healing church as manifest in actual institutions on the ground, according to this assessment, 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).⁴⁵

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. With healing no longer circumscribed by the field of medicine, members of the healing church could see themselves in the role of healers through a range of activities such as accompanying ill persons home from the hospital or advocating for improved sanitation and potable water in a village. In this way, the theological vision of the healing church might be translated into an ecclesial and social reality with impact on the varied causes of suffering in this world.

The holistic understanding of health and the priesthood of all healers for which it created space 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 to understand the implications of the healing church required an intimate and ongoing conversation between the disciplines of theology and medicine, among others. The key 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 difficulty in transitioning from a *vision* of the healing church to its realization. It also ended with a greater resolve to address these challenges with the full resources of the larger ecumenical movement, a resolve that would eventually take institutional form in the Christian Medical Commission, or CMC.

From Consultations to Consultant: The Early Years of the Christian Medical Commission

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.”⁴⁶ 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.⁴⁷ When the Commission identified an innovative program, it used the Commission's contacts to help secure funding for its work and put its organizers in touch with people "doing similar work elsewhere."⁴⁸ But as McGilvray, the CMC's first director and a veteran hospital administrator, noted at the inaugural annual meeting, the mapping of these innovative programs had a "theological flavour."⁴⁹

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, too. Recalling the emphasis on salvation history and wholeness that permeated the Tübingen discussions, McGilvray declared, "The Church is not simply another service agency or an ecclesiastical foreign aid programme."⁵⁰ And after Tübingen, the Church was not simply the Church anymore. It had become the healing church, leading some observers to suggest that "[h]ealing considered as the responsibility of the entire community may be precisely one of those gaps into which Christian congregations should do pioneering work."⁵¹ The examples of accompaniment and advocacy above suggest what some of this work might look like. Christian congregations could also serve in an educative capacity, providing information about health risks specific to the diverse communities in which they were located.

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 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 it posed.⁵² First, hospitals 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.⁵³ Hospitals in the first instance are exclusive in the same way as a church that does not engage in outreach. They operate on a *Field of Dreams* logic: 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. In epidemiological terms, such an approach fails to give an accurate picture of the health ecology of a given community. In slightly more theo-ethical, though still 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.

The second challenge of a health system centered on 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 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 an illness, the hospital is limited in its ability to attend to the broader context in which the

illness is experienced.⁵⁴

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.⁵⁵ These two challenges presented the CMC with a real-world opportunity to live into and out of its theological understanding of the healing church.

The Great Commission: The CMC and Primary Health Care

In its first decade, the CMC played a significant role in framing the concept of primary health care (PHC) that would eventually be adopted by the World Health Organization at the Alma Ata Conference in 1978. 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 patients.⁵⁶ 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.⁵⁷

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 1) the health *ecology* of a community, 2) *integration* of PHC with the various components of the health system, 3) *intersectoral* cooperation, 4) *participatory* planning, 5) *practicability* in terms of cost and existing community assets, 6) *complementarity* among promotive, preventive, and curative health, and 7) a form of *subsidiarity* 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. 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. The proximity of the two organizations in Geneva played a role in the frequency of contact between them, whether in formal consultations or simply as observers at various high-level meetings. While 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.⁵⁸ The degree to which the Declaration reflects the initial commitments of the Commission provides further confirmation of this cross-pollination—though it does not necessarily establish the direction of causal arrows—between the two organizations.⁵⁹

The theological backstory to the CMC and the primary health care movement offers one example of how persons and institutions committed to ongoing theological reflection can help facilitate transformations in the fundamental commitments of global health institutions.⁶⁰ Partnerships between religious entities and global health leaders can, this history suggests, be catalysts for new ways of thinking about health and human flourishing and the specific practices of global health that support them.

Christian Leaders as Participant Theologians

In 1970, just as the Christian Medical Commission was getting its institutional bearings, Christian ethicist James Gustafson introduced the “participant theologian” as an ideal type for Christian engagement in the world.⁶¹ Though I have not found evidence suggesting Gustafson was familiar with the Christian Medical Commission, its origin story recounted above leads me to suspect that Gustafson would recognize in the persons of early participants at Tübingen, as well as the later work of the CMC, kindred spirits to his elusive participant theologians.⁶²

The participant theologian, according to Gustafson, is a reformer, actively engaged in “the shaping of events and in the development of and reordering of institutions.” The participant theologian avoids two extremes, represented by the prophetic theologian and the preserver theologian, namely “the condemnation of the existing state of affairs” and “whole-hearted support of them,” respectively.⁶³ 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.

The character of participation, or the disposition of the participant theologian, is epistemic humility. 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.⁶⁴

Epistemic humility, however, is not the same as absolute epistemic deference to knowledge generated by non-theological domains of inquiry since 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.”⁶⁵ The participant theologian is willing to be corrected by insights from other forms of inquiry but also makes a claim that the theological perspective may prove corrective as well, especially with regards to questions about the primary purposes of human being.⁶⁶ The participant theologian is persistent but not overly insistent, retaining “the grace of self-doubt,” to borrow from the first-order religious language of a recent Gustafson monograph.⁶⁷

The participant theologian draws from the best of what the discipline of theological reflection has always offered, including “imagination, critical reflection, and historical awareness.”⁶⁸ In this way, the participant theologian discerns in the dialogue with scientists and policymakers, among others, the appropriate moment to “say something theological” about what she sees as the menu of

options made possible by developments in other areas of inquiry.⁶⁹

Applied to the relationship between Christianity and global health, Gustafson's participant theologian brings to the global health table what Charles Swezey identifies as "theological convictions [that] will affect the analysis in a significant although not unique way."⁷⁰ While it may be possible to describe and analyze the phenomena of human health without reference to theological concepts, Gustafson's participant theologian claims a seat at the global health table based, in part, on her specialized knowledge and discipline of thought about the ends of human being.

In the abstract, this may not seem like a robust argument for contemporary global health leaders to pay attention to the theological insights generated by Christian religious entities. When backlit by the particular history of the primary health care movement detailed above, however, the work of participant theologians becomes more compelling. In the story of the CMC the impulse of the participant theologian finds institutional expression. The impulse to "bring to bear the insight and wisdom of the Christian community's long historical reflection about the chief ends" of human being gives rise to a specific commitment to seek out community health programs in which that insight and wisdom manifest. This impulse and commitment proved catalytic for a twentieth century transformation in global health that continues to inspire and challenge twenty-first century global health leaders.

Conclusion

The flier from the Christian Connections for International Health conference with which this article began emphasized the quality of health care provided by Christian religious entities at the community level. In this emphasis, the conference organizers acknowledged the dominant logic of global health's twenty-first century recommitment to primary health care: primary health care is a priority because the scientific evidence base shows that it is more effective in improving population-level health outcomes.⁷¹ But the "Call to Action" that ended the conference suggests that something besides an evidence base compels people of faith to "embrace their mantle of leadership" in the face of global health crises like the AIDS pandemic.

The vital and vitalizing presence of participant theologians in the original primary health care movement sheds light on what that "something" might be. Though one among many partners working to address human suffering, the distinctive contribution of Christian religious entities to global health lies at once within and beyond the identifiable health assets that can be leveraged by institutions like the World Health Organization. Partnerships with religious entities offer an opportunity for ongoing discernment within global health circles about "what the primary purposes of human existence in community and history are, about what the qualities of life ought to be" and, perhaps, even, "about what values are in accord with God's activity and intention" for creation.⁷²

Endnotes

1 Christian Connections for International Health, "Community Health and Wholeness," 2008 Annual Conference (May 26-28, 2008), <http://ccih.org> [accessed May 8, 2008].

2 I use the definition of religious entities employed by the African Religious Health Assets Program (ARHAP) as a way of distinguishing it from the narrower, and often misused, term "faith-based organization." Religious entities include religious organizations, organizations tied to religious groups (e.g., hospitals), community networks, and personal initiatives (e.g., the work of specific religious leaders, including traditional healers). For a more complete definition and the debates surrounding its use, see Jill Olivier, James R. Cochrane, Barbara Schmid, and Lauren Graham, "Arhap Literature Review: Working in a Bounded Field of Unknowing," (2006).

3 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).

4 For examples of these three observations, especially as they affect the global health response to the AIDS pandemic, see "HIV and AIDS and STI Strategic Plan for South Africa: 2007-2011," (Office of the Deputy President, 2007); Christoph Benn, "Why Religious Health Assets Matter," in *ARHAP: Assets and Agency Colloquium* (Pietermaritzburg, South Africa: African Religious Health Assets Programme, 2003); Andrew Doupe, "Partnerships between Churches and People Living with Hiv/Aids Organizations," (Geneva: World Council of Churches, 2005); Todd Ferguson et al., "Report on the Global Consultation on Decent Care," (Geneva: World Health Organization, 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); Olivier et al., "Arhap Literature Review: Working in a Bounded Field of Unknowing."; Tearfund, *Faith Untapped: Why Churches Can Play a Crucial Role in Tackling Hiv and Aids in Africa* (Teddington, UK: Tearfund, 2006); 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, "Faith-Based Groups: Vital Partners in the Battle against AIDS."

5 Thembele Kepe, "'Secrets' That Kill: Crisis, Custodianship, and Responsibility in Ritual Male Circumcision in the Eastern Cape Province, South Africa," *Social Science and Medicine* 70, no. 5 (2010); K. Peltzer and X. Kanta, "Medical Circumcision and Manhood Initiation Rituals in the Eastern Cape, South Africa: A Post Intervention Evaluation," *Culture, Health, & Sexuality* 11, no. 1 (2009).

6 ARHAP, "Appreciating Assets: Mapping, Understanding, Translating, and Engaging Religious Health Assets in Zambia and Lesotho," (Report to the World Health Organization, 2006), 40.

7 Ibid.

8 Faith-informed commitments to justice and practices of care, such as ARHAP's case study of the Masangane Integrated HIV Treatment Program, are recognized in the community as well as by the WHO not only for the ways in which they distinguish the program's mission from other programs but also for the direct correlation clients and observers draw between these commitments and the improved health outcomes of the population Masangane serves. See 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); World Health Organization, “Faith-Based Groups: Vital Partners in the Battle against AIDS.”; Ted Karpf et al., eds., *Restoring Hope: Decent Care in the Midst of HIV/AIDS* (New York: Palgrave Macmillan, 2008).

9 The shift towards an emphasis on assets does not ignore the negative impact of religion in the HIV response. Rather, as members of ARHAP argue, the claiming that religion *matters* should encourage global health leaders to pay attention to both religious health assets *and* liabilities, enabling “a more socially intelligent, humanly adequate response to the real complexities of health and ill-health.” See Olivier et al., “Arhap Literature Review: Working in a Bounded Field of Unknowing,” 13. In this article the focus on religious entities as an asset rather than a liability for global health is necessary in order to set-up a more nuanced argument about *how* religious entities are valued. Many scholars, including Christian theologians, have addressed the negative impact of Christian theological reflection on global health issues, notably the HIV pandemic. See, for example, Warren Parker and Karen Birdsall, “HIV/AIDS, Stigma and Faith-Based Organizations: A Review,” (Centre for AIDS Development, Research, and Evaluation (CADRE), 2005); S.H. Rankin et al., “The Condom Divide: Disenfranchisement of Malawi Women by Church and State,” *Journal of Obstetrics, Gynecology, and Neonatal Nursing* 37, no. 5 (2008); 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); 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); Anton A. van Niekerk and Loretta M. Kopelman, eds., *Ethics and AIDS in Africa: The Challenge to Our Thinking* (Claremont, South Africa: David Philip, 2005).

10 See note 4 for specific examples.

11 Thomas et al., “Let Us Embrace”; Barbara Schmid et al., “The Contribution of Religious Entities to Health in Sub-Saharan Africa,” (African Religious Health Assets Program, 2008).

12 See the section “Defining the ARHAP Lexicon” in ARHAP, “Appreciating Assets: Mapping, Understanding, Translating, and Engaging Religious Health Assets in Zambia and Lesotho,” 37ff.

13 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). See also the work of the World Health Organization to develop the concept of *decent care* as a mediating structure or middle axiom to guide the engagement of religious entities in HIV treatment, including Karpf et al., eds., *Restoring Hope: Decent Care in the Midst of HIV/AIDS*.

14 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); James R. Cochrane, “Of Bodies, Barriers, Boundaries, and Bridges: Ecclesial Practice in the Face of HIV and AIDS,” *Journal of Theology for Southern Africa* 126 (2006).

15 I am using the phrase “critical theological reflection” to indicate intentional activity on the part of Christians first to respond constructively to their experience of the world using theo-ethical insights discernable in the dynamic traditions that constitute Christianity. This use is consistent with the general form and purpose of theological reflection described in Patricia O’Connell Killen and John de Beer, *The*

Art of Theological Reflection (New York: The Crossroad Publishing Company, 1994). For an overview of different styles of theological reflection see Robert Kinast, *What Are They Saying About Theological Reflection?* (Mahwah, NJ: Paulist Press, 2000).

16 This consultation was not the first attempt to bring together theologians and medical personnel in the hope of clarifying a Christian conception of healing. Various dialogues sponsored by mainline denominations took place throughout the 1950s and early 1960s, for example. But these attempts failed to get off the ground. James McGilvray observes that theologians could never quite reconcile their doctrinal differences and that the medical professionals were mostly interested in religion as an existential balm, a “resource which gave meaning to life in situations of inner emptiness,” such as illnesses for which there was no medical cure. See James C. McGilvray, *The Quest for Health and Wholeness* (Tübingen: German Institute for Medical Missions, 1981), 12.

17 Lesslie Newbigin, ed., *The Healing Church: The Tübingen Consultation, 1964* (Geneva: World Council of Churches, 1965), 5.

18 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.*

19 Though a consensus document emerged, it was not without critique, including the vague use of the term “health” and the danger of connecting physical healing with Christian understandings of eternal salvation. For an overview of these critiques, see Christoph Benn and Erlinda Senturias, “Health, Healing, and Wholeness in the Ecumenical Discussion,” *International Review of Mission* 90, no. 356-357 (2001).

20 Newbigin, ed., *The Healing Church: The Tübingen Consultation, 1964*, 34. Reflecting on the impact of Tübingen I, Christoph Benn and Erlinda Senturias, longtime observers of ecumenical discussions, assert, “Even today, many churches in Africa and Asia feel that the conclusions of the Tübingen consultation deeply influence their work in health care.” Benn and Senturias, “Health, Healing, and Wholeness in the Ecumenical Discussion,” 10.

21 Newbigin, ed., *The Healing Church: The Tübingen Consultation, 1964*, 35.

22 The language in the statement is consistent with the preoccupation among some mid-twentieth century 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. 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.

23 Benn and Senturias, “Health, Healing, and Wholeness in the Ecumenical Discussion,” 12.

24 David Jenkins, “Foreword” in McGilvray, *The Quest for Health and Wholeness*, xiii.

25 *Ibid.*, xiii.

26 *Ibid.*, xiii.

27 Ibid., 16.

28 While the consultation included many medical professionals, it is important to acknowledge that during this period medical missionaries often had theological training as well. Ibid, 15-16.

29 Benn and Senturias, "Health, Healing, and Wholeness in the Ecumenical Discussion."

30 Newbigin, ed., *The Healing Church: The Tübingen Consultation, 1964*, 47.

31 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 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).

32 McGilvray, *The Quest for Health and Wholeness*, 21.

33 Lambourne, *Community, Church, and Healing: A Study of Some of the Corporate Aspects of the Church's Ministry to the Sick*.

34 Newbigin, ed., *The Healing Church: The Tubingen Consultation, 1964*, 35. This open practical question would continue to permeate subsequent ecumenical discussions about health, including the second Tübingen consultation (Tübingen II).

35 McGilvray, *The Quest for Health and Wholeness*, 3. Discerning the unique responsibility of churches in modern health care systems was complicated by the transition from colonial rule to independence in many countries at this time. The transition raised questions about the institutional and political viability of the colonial-era medical mission model in a post-colonial context. For a discussion of specific factors affecting medical missions in the post-colonial context see Christoffer H. Grundmann, "Mission and Healing in Historical Perspective," *International Bulletin of Missionary Research* 32, no. 4 (2008).

36 McGilvray, 23

37 McGilvray, 15. The two objectives of these surveys read as follows: "(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." Qtd. in McGilvray, 32.

38 McGilvray, 40-41.

39 The Christian Health Associations of various countries in Africa arose in part as a response to concerns about the relative invisibility of church health programs to leaders of newly independent states. The Christian Health Association of Malawi, notably, traces its origins to a chance meeting between a Roman Catholic Bishop, a General Secretary of the Malawian National Council of Churches (i.e., a Protestant ecumenical organization), and a surveyor commissioned by the WCC as part of the effort to document church-related health programs on the ground. For a fuller accounting of this chance meeting see McGilvray, *The Quest for Health and Wholeness*, 32-41. Despite the Mainline Protestant influence in the World Council of Churches, the task set by the Tübingen conversations was not limited to Protestant health care entities.

40 McGilvray, 31.

41 McGilvray, 100. 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.” See McGilvray, 101.

42 Lambourne, vi.

43 McGilvray, *The Quest for Health and Wholeness*, especially chapter three.

44 Benn and Senturias, 12.

45 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 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, 7.

46 Gillian Patterson, “The CMC Story: 1968-1998,” *Contact*, no. 161/162 (1998), 3. See also, Christian Medical Commission and World Council of Churches, “Annual Meeting” (Geneva, 1968), 2-3.

47 Based on a sample of twenty-five hospitals in twenty different countries, costs had increased 100-150%, between 1958 and 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 forty with an expected life expectancy of between five and fifteen more years. See 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. Several sources note, though without attributing a source, that these percentages remain the same today. See, for example, Thomas et al., “Let Us Embrace.”

48 Patterson, “The CMC Story: 1968-1998,” 8.

49 Christian Medical Commission and World Council of Churches, “Annual Meeting,” 1.

50 Ibid., 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.

51 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 divisions in the WCC to which the CMC reported.

52 The Commission reported that hospital-based care constituted over 90% of all medical mission activity.

See *ibid.*, 64.

53 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.

54 To take the case of HIV, for example: Hospitals have limited impact on the nutritional stability of a household (essential for ARV effectiveness) and 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 include, but are not limited to, the availability of antiretroviral drugs at the nearest hospital.

55 The section on “The Christian Calling” 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.

56 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).

57 Note that related trends included increased attention to clinical research ethics as evidenced in the Nuremberg Code (1947), the Declaration of Helsinki (1964), and the subsequent development of institutional review boards, officially beginning in 1974 with the passage of the National Research Act. For a brief history, see Robin Levin Penslar, “Institutional Review Board Guidebook” (United States Department of Health and Human Services), http://www.hhs.gov/ohrp/irb/irb_guidebook.htm.

58 For an examination of the link between the CMC and the WHO’s primary health care approach, 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).

59 The closeness of the relationship appears to be one of the features that created space for a transformative encounter between Christianity and global health in the 1970s. James Cochrane and Gary Gunderson suggest that the presence of two WHO staff members, transferred temporarily to the CMC, as well as the membership of several other prominent global health experts in the CMC, provided the WHO with up-to-date reports of what the CMC was finding on the ground with regard to innovative community-based health programming. Whether or not similar relationships—formal or informal—are possible in the twenty-first century remains to be seen, though the conclusion below suggests some possibilities. Personal communication with Cochrane, March 1, 2011.

60 The wording of this claim is chosen carefully to avoid reducing the account of the primary health care movement to the processes of theological reflection at Tübingen. Many additional factors came together to make possible the Declaration at Alma Ata. For details of these additional factors, see Banerji Debabar, “Reflections on the Twenty-Fifth Anniversary of the Alma-Ata Declaration,” *International Journal of Health Services* 33, no. 4 (2003); Socrates Litsios, “The Long and Difficult Road to Alma-Ata: A Personal Reflection,” *International Journal of Health Services* 32, no. 4 (2002).

61 James M. Gustafson, “The Theologian as Prophet, Preserver, or Participant,” in *Theology and Christian Ethics* (Philadelphia: United Church Press, 1973), 84.

62 Gustafson does not clarify who might be qualified to be a participant theologian, though his emphasis throughout his career on professional, academic theology suggests one answer. For the purposes of this article, I understand participant theologians to be persons willing and able to bring insights from theological reflection into a constructive and coherent conversation with findings and commitments expressed in non-theological lines of inquiry.

63 Gustafson, “The Theologian as Prophet, Preserver, or Participant,” 84.

64 *Ibid.*, 84-85.

65 *Ibid.*, 84.

66 Gustafson emphasizes that the specialized knowledge of the theologian is especially relevant to “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. . . . [The participant theologian] brings to bear the insight and wisdom of the Christian community’s long historical reflection about the chief ends of man.” *Ibid.*, 84

67 James M. Gustafson, *An Examined Faith: The Grace of Self-Doubt* (Minneapolis: Fortress, 2004).

68 Gustafson, “The Theologian as Prophet, Preserver, or Participant,” 84.

69 *Ibid.*, 84-85.

70 Charles Swezey’s “Introduction” to Gustafson, *Theology and Christian Ethics*, 15.

71 For details on the WHO’s recent recommitment to primary health care as well as the evidence-based justification, see World Health Organization, “The World Health Report 2008—Primary Health Care (Now More Than Ever),” (Geneva: World Health Organization, 2008); Margaret Chan, “Return to Alma-Ata,” *The Lancet* 372, no. 9642 (2008).

72 Gustafson, *Theology and Christian Ethics*, 84.