Global Health after Pentecost: Toward Theological Reflection as a Religious Health Asset

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Abstract

This article examines the recent turn on the part of global health leaders to Christian communities 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 faith-based organizations, including Christian churches. In this way, religious health assets — tangible and intangible — become valuable if they can be rendered intelligible and 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. But a closer examination of this revaluation reveals how it obscures a distinctive dimension of Christian participation, namely, critical theological reflection.

The current turn to religion as a global health ally presents an opportunity to reimagine the spaces in which complex social phenomena are described, interpreted, and responded to. Christians live into the role of co-participants in these spaces when they seek to develop a greater competence for engaging the complex arena of global health policy and programming. This competence emerges from demonstrating understanding of the empirical context in which global health is carried out as well as showing in an imaginative and compelling manner how the theological resources from their own tradition illumine the patterns and processes of human suffering.

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[1]

Introduction[2]

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. As Hanson explained to those gathered for the conference, "I am absolutely convinced that we as religious leaders and we in the religious community that so shunned and shamed people with HIV and struggling with AIDS . . . must begin by first engaging in public acts of repentance. Absent public acts of repentance, I fear our words will not be trusted."[3]

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. 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.

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 as well. 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.

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 persons living with HIV and AIDS (PLWHA) was well under way, as evidenced by denomination-specific publications and church-wide 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.[4]

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 fifteenth 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 leader 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.[5] 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.[6]

This does not imply that religion is an unmitigated good for global health; Byamugisha recognizes the friction points: "Some of us are still preaching condemnatory and stigmatizing sermons and approaches to HIV/AIDS."[7] However, it does

suggest the practical reasons why partnerships between Christian entities and global health organizations have increased in the past decade.[8] These practical reasons open up the possibility of a discursive shift, rendered metaphorically below as a move from global health after Babel to global health after Pentecost. That is, tensions between claims from theological and nontheological descriptions or interpretations of human suffering become catalysts for clearer thinking about the causes of the tension, rather than an indictment of the incommensurability of the different modes of knowing.

To move towards doing global health *after Pentecost* is to begin with the premise that theological and nontheological discourse describes the same phenomenon, in this case, human suffering related to HIV and AIDS. Even though we continue to recognize varying degrees of compatibility between accounts from virologists, theologians, counselors, epidemiologists, etc., the meaning of the phenomenon emerges out of the mutually generative interaction among all those who participate in the discourse and seek to "maximize coherence and minimize incoherence."[9]

Religious Entities as Relevant: The Turn to Religion

In the time between Byamugisha's bold claims from the plenary dais to Hanson's footwashing, a growing body of empirical research emerged documenting the activities of religious entities in the global response to HIV.[10] The first part of this article provides a snapshot of this research in order to show what Christian entities are actually doing and, equally important, how the terms for revaluing Christian participation in global health have been largely determined by scientific and policy discourses selectively attentive to religious activity.[11]

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.[12] 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.

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 the following. Is there a correlation between religious affiliation and engagement in risk behaviors associated with HIV transmission?[13] How does religious participation affect dynamics related to disclosing one's positive status?[14] Do persons on antiretroviral treatment benefit from church participation?[15]

Representative research questions focused on religious organizations include correlational studies. For example, what is the relationship between faith-based organizations and HIV-related stigma?[16] There are also what might be described as primarily descriptive studies. The latter seek to describe what specific religious entities are doing in response to HIV.[17]

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,[18] other studies suggest that socioeconomic factors account for much of this correlation, rendering religious participation largely insignificant,[19] while still others note it is both/and.[20] Similarly, at the organizational level, studies provide evidence both

of religious entities' active involvement in providing direct assistance to PLWHA[21] and religious entities largely absent from the provision of direct assistance.[22] These differences in findings simply underscore what for many scholars in religious studies is 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.[23]

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 gender at play in religious entities can illumine the challenges religious leaders face in generating consistent messages about gender equality and HIV-prevention messages.[24]

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.[25] 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. analyzed survey data from a stigma reduction program in Ghana involving national and local religious leaders and concluded that "attitudes related to a punitive response to PLHA both improved over time and were positively associated with exposure to the program's campaign."[26] With regard to increasing adherence, Watt et al. showed that despite the persistence of stigma and the lack of church support for PLWHA, prayer practices supported adherence.[27] In less direct ways, Perry et al. identified 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."[28] Religious leaders, practices, and meaning-making processes were, according to these studies, worth paying attention to.

Due to space limits, I have confined my literature review to empirical studies. This same time period witnessed a burgeoning of formal theological and Christian ethical reflection on the HIV pandemic and the global response to it. Much of the theological work took sub-Saharan Africa as the context for reflection. Taken together, the recent empirical and theological work on HIV suggest a qualitatively different starting point for engaging questions about the positive role of religion in global health than was possible a decade ago. Recognizing that diverse religious entities have been involved in a range of responses to HIV for the past three decades, the phrase "turn to religion" is intended to capture something of this qualitatively different starting point as reflected in the increasingly public discourse about, and intentional programming in response to, the HIV pandemic.[29]

Out of this surge in both the scientific 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 reli-

gious entities are being revalued as both *relevant* to global health and *desirable* as allies.[30] 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."[31] The concept of religious health assets 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.

Religious Entities as Desirable: Religion as a Health Asset

The International Religious Health Assets Program (IRHAP) is an international, interdisciplinary group of scholars and practitioners interested in the intersection of religion and public health.[32] IRHAP has sought "to address the general paucity of studies on faith-based organizations working in health."[33] The initial founders 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."[34] 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.[35]

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."[36] In an attempt to clarify different kinds of RHAs observed throughout sub-Saharan Africa, IRHAP distinguishes between *tangible* and *intangible* assets (see Table 1).[37] IRHAP defines tangible assets as: "The more visible and most studied religious health assets, including facilities, personnel, and activities, sometimes resembling those of secular entities."[38] Tangible assets include such things as church buildings, denominational networks, lay care workers, *etc*. In sub-Saharan Africa, the tangible 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, concept of an intangible religious health asset is less well understood. That is, to ask whether religion makes 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.

IRHAP 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."[39] This intangible dimension has proven much more difficult to operationalize in IRHAP 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. When these intangible dimensions of religious participation have been recognized in the response to HIV, they tend to be framed as a health liability, rather than an asset, for example, in the theologically resonant framing of disease as punishment.

Table 1. Religious Health Assets and Health Outcomes

Religious Health Assets		Health Outcomes: Direct	Health Outcomes: Indirect
	Intangible	• Prayer • Resilience • Health-seeking behavior • Motivation • Responsibility • Relationship: caregiver and patient • Advocacy/prophetic • Resistance – physical and/or structural/political	• Individual (sense of meaning) • Belonging (human/divine) • Access to power/energy • Trust/distrust • Faith-hope-love • Sacred space in a polluting world (AIC) • Time • Emplotment (story)
	Tangible	• Infrastructure • Hospitals – beds, etc. • Clinics • Dispensaries • Training – para-medical • Hospices • Funding/development agencies • Holistic support • Hospital chaplains • Faith healers • Traditional healers • Care groups • NGO/FBO – "projects"	• Manyano and other fellowships • Choir • Education • Sacraments/rituals • Rites of passage (accompanying) • Funerals • Network/connections • Leadership skills • Presences in the "Bundu" (on the margins) • Boundaries (normative)

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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 IRHAP 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*.[40] In part, it is a problem of 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?

Religious Health Assets: A Critical Appreciation

Discourse and practical actions on the part of global health actors have made explicit the relevance and desirability of religious entities as vital partners in response to HIV. 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 intersectional cooperation, recalling themes from the 1960s and 1970s that had been more muted in the intervening years.[41] 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. 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.

The HIV pandemic continues 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, 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 related to the broader field of global health.

To state the problematic provocatively: in the current turn to religion as a global health ally, Christian communities participate primarily by *in*forming and *con*forming. Religious leaders become *informants* in global health circles, sharing what they know about the beliefs and practices of a particular religious community and strategies for working 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 and legitimated by global health professionals.[42]

To be sure, these forms of participation are important and, in and of themselves, represent a revaluation among global health professionals of why and how religion matters to the policies and practices of global health. However, an emphasis on these two forms of participation fails to account for what is at the heart of Christian religious activity in the world: *trans*forming existing structures, institutions, and practices that act as limits to the full expression of the kingdom of God. Translated into the terms of global health, Christian participation should lead to policies and practices more responsive to 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."[43]

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, I am arguing here 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 IRHAP, 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 becomes "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.[44]

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. 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 socially engaged theological work.

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 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 inclusivi-

ty.[45] Stigmatization 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."[46]

Minimally, the absence of theologically informed participants in global health conversations should provoke questions — among religious 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 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.

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, but something of the power religions claim is lost when religious leaders mistake *conforming* to existing global health practices for the more 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."[47]

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 offered above 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 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 critical theological reflection they encourage, but for any *outcomes* of their theological reflection that can be readily appropriated in the service of existing global health paradigms.

Health For All Is History?

For readers familiar with the history of Christian participation in global health, the argument for valuing theological reflection as a transformative activity within global health should not be completely new. The history of the Christian Medical Commission's (CMC) catalytic role in the WHO's primary health care framework in the 1970s has been well documented in recent years. And, more recently, it has been argued that the new ecclesiological vision of the "healing church" that emerged from theological reflection on the crisis in medical missions throughout the 1960s forms an important, though less often noted backstory for making sense of the prophetic idealism

and eschatological hope that animated Christian participation within the early primary health care movement.[48]

Yet, in spite of 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 the Alma Ata Declaration, at least not in formal global health policy, priorities, and programs. 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.[49] 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.[50]

By invoking the history of the CMC and the primary health care movement at this late stage in the argument, I am not hoping to re-ground global health in theology. Rather, I am attempting to locate the current limited turn to religion in the longer, more robust history of Christian participation in global health. The CMC story is suggestive of a particular historical moment in which the value of Christian participation in global health can be seen in the capacity of Christians to articulate in theologically resonant language an expansive and compelling vision of health and human flourishing, and this vision proved sufficient enough to reorient priorities and mobilize resources. That such a vision was recognized within official, expert-dominated global health discussions suggests that global health leaders today may do well to pay closer attention not only to shared practices of health care but also to the creative and courageous health practices out of which Christians generate substantive theological claims about human being and human flourishing.

Global Health after Pentecost

The current turn to religion as a global health ally presents an opportunity to reimagine the spaces in which complex social phenomena are described, interpreted, and responded to. Christians live into the role of co-participants in these spaces when they seek to develop a greater competence for engaging the complex arena of global health policy and programming. This competence emerges from demonstrating understanding of the empirical context in which global health is carried out as well as showing in an imaginative and compelling manner how the theological resources from their own tradition illumine the patterns and processes of human suffering. At the same time, global health leaders live into the role of co-participants when they recognize, engage, and value the prophetic religious imagination 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.

For Christians, it is to move from the presumption of Christian medical mission after Babel to the hope of a Christian participation in global health after Pentecost. Christians participating in global health after Pentecost begin 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 this way, we are all responsible for carrying out the commission Archbishop Desmond Tutu set forth at the World Health Assembly in 2008: "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."[51]

The recent (re)turn to religion in global health circles documented throughout this article serves as an invitation to Christian leaders to recover within their own traditions a prophetic religious imagination, the deep sensitivity to "the lure of new possibilities and their embodiment," capable of transforming existing structures, institutions, and practices that constrain human flourishing.[52] In the end, it may be in this practical theological work that Christians find the imagination and courage to practice global health after Pentecost and in so doing bring into being the most valuable religious health asset: the healing church.

References and Endnotes

1. World Health Organization. Faith-based groups: vital partners in the battle against AIDS. Geneva: World Health Organization; 2004. p. 3.

2. See Acknowledgements below.

3. For a description of the foot washing and the pre-conference event, see ELCA Presiding bishop washes feet of HIV-positive women [Internet]. Chicago: ELCA News Service; [press release August 4, 2008; cited 2012 March). Available from http://www.elca.org/News-and-Events/6285

4. The turn to religion as an ally in global health can be seen as part of a larger conversation about the role of religious entities in supporting human flourishing more generally, or what has traditionally fallen under the auspices of development studies. For a good representation of the current role of religion in development, see Ter Har G, editor. Religion and development: ways of transforming the world. New York: Columbia University Press; 2011.

5. World Health Organization. Faith-based groups: vital partners in the battle against AIDS. Geneva: World Health Organization; 2004. p. 4.

6. 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. [Internet]. Geneva: UNAIDS; 2006 [cited 2007 October 29]; Available from: http://data.unaids.org/pub/epireport/2006/2006_epiupdate_en.pdf

7. World Health Organization. Faith-based Groups: Vital partners in the battle against AIDS. Geneva: World Health Organization; 2004. p. 3.

8. Much of the literature reviewed below emerges from research on Christian religious entities that fall under the broad umbrella of Protestant. While recognizing this as a possible limitation, I believe that there is sufficient evidence in Catholic circles to support my general claim regarding the "turn to religion." See, for example, Lebouché B, Malherbe J-F, Trepo C, Lemieux R. 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, Maryknoll: Orbis Books; 2008. p. 170-9.

9. Gustafson JM. An examined faith: the grace of self-doubt. Minneapolis: Fortress Press; 2004; 83.

10. 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. Collaborative for HIV and AIDS, religion and theology. Pietermaritzburg, South Africa; c2013. Available from: http://chart.ukzn.ac.za/

11. I have chosen to limit the literature review to 2006-2010 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 J, Cochrane JR, Schmid B. ARHAP Bibliography: working in a bounded field of unknowing. Cape Town: African Religious Health Assets Programme; 2006; Olivier J, Cochrane JR, Schmid B, Graham L. ARHAP Literature review: working in a bounded field of unknowing. African Religious Health Assets Programme; 2006.

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17. Krakauer M, Newbery J. Churches' responses to HIV/AIDS in two South African communities. J Int Assoc of Physicians AIDS Care. 2007;6(1): 27-35. Keough L, Marshall K. Faith communities engage the HIV/AIDS crisis: lessons learned and paths forward. Kessler M, editor. Washington DC: Georgetown University, Berkley Centre for Religion, Peace and World Affairs; 2007. Vitillo RJ. Faith-based responses to the global HIV pandemic: exceptional engagement in a major public health emergency. Special report. J Med Person. 2009;7:77-84. Bazant ES, Boulay M. Factors associated with religious congregation members' support to people living with HIV/AIDS in Kumasi, Ghana. AIDS Behav. 2007;11(6):936-45. Agadjanian V, Sen S. Promises and challenges of faith-based AIDS care and support in Mozambique. Am J Pub Health. 2007;97(2):362-6.

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21. Denis P. The church's impact on HIV prevention and mitigation in South Africa: reflections of a historian. J Theol South Afr. 2009;134:66-81. Denis notes three main areas in which the churches in South Africa have contributed: home-based care, orphan care, and ARV treatment.

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29. For a fuller account of the theological literature, see Bersagel Braley M. More than Just Health: Theoethical Reflection as a Religious Health Asset [Dissertation]. Atlanta, GA: Emory University; 2012.

30. 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 Garner RC. Religion in the AIDS Crisis: Irrelevance, Adversary, or Ally? AIDS Anal Afr. 1999;10(6-7). Garner RC. Safe sects? Dynamic religion and AIDS in South Africa. Journal Mod Afr St. 2000;38(1):41-69.

31. ARHAP. Appreciating Assets: mapping, understanding, translating, and engaging religious health assets in Zambia and Lesotho. Report to the World Health Organization. 2006; p. 39.

32. IRHAP, formerly the African Religious Health Assets Program (ARHAP), was renamed in 2011 to reflection of the expanding geographic scope of its work.

33. ARHAP. Appreciating assets: mapping, understanding, translating, and engaging religious health assets in Zambia and Lesotho. Report to the World Health Organization. 2006; p. 23.

34. Olivier J, Cochrane JR, Schmid B, Graham L. ARHAP Literature review: working in a bounded field of unknowing. African Religious Health Assets Programme; 2006; p. 8.

35. IRHAP 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 IRHAP 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, Foege WH, Amler RW, White CC. Closing the Gap. JAMA. 1985;254(10):1355-8. Gunderson GR, Cutts TF. Decent care for life. In: Karpf T, Ferguson T, Swift R, Lazarus JV, editors. Restoring hope: decent care in the midst of HIV/AIDS. New York: Palgrave Macmillan; 2008.

36. ARHAP. Appreciating assets: mapping, understanding, translating, and engaging religious health assets in Zambia and Lesotho. Report to the World Health Organization; 2006.

37. The distinction between tangible and intangible health assets is a source of considerable debate within IRHAP. The discussion presented here takes its cue from one of the initial matrices presented by IRHAP to explore the utility of the distinction.

38. See "tangible assets" in the glossary of ARHAP. Appreciating assets: mapping, understanding, translating, and engaging religious health assets in Zam-

bia and Lesotho. Report to the World Health Organization; 2006.

39. ARHAP. Appreciating assets: mapping, understanding, translating, and engaging religious health assets in Zambia and Lesotho. Report to the World Health Organization; 2006; p. 40.

40. ARHAP. Appreciating assets: mapping, understanding, translating, and engaging religious health assets in Zambia and Lesotho. Report to the World Health Organization. 2006; p.25.

41. World Health Organization. The World Health Report 2000 - health systems: improving performance. Geneva: World Health Organization; 2000.

42. See, for example, Parry S. Beacons of hope: HIV competent churches: a framework for action. Geneva: WCC Publications; 2008.

43. 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.

44. For discussions about how global health institutions can assist religious entities in accessing global donor resources, see Speicher S, editor. Final report. Global assessment and strategy session on faith communities accessing resources to respond to HIV/AIDS; 2005 January 18-20; Geneva, Switzerland: Ecumenical Institute of Bossey.

45. For the use of immanent critique as a strategy for engaging in conversations involving competing comprehensive visions of the good, see Stout J. Democracy and tradition. Princeton: Princeton University Press; 2003. For a representative theological proposal, see Messer DE. Breaking the conspiracy of silence: Christian churches and the global AIDS crisis. Minneapolis: Augsburg Fortress; 2004.

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47. Gustafson J. Moral discourse about medicine: a variety of forms. J Med Phil. 1990;15:125-42. [p. 141]

48. For a fuller account of the institutional and theological histories of the Christian Medical Commission, see Patterson G. The CMC story: 1968-1998. Contact. 1998 June-July and August-September(161/162):3-52. Bersagel Braley M. The Christian Medical Commission and the World Health Organization. In: Idler E, editor. Religion as a social determinant of health. New York: Oxford University Press; 2014. p. 298-318.

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52. Gunderson GR, Cochrane JR. Religion and the health of the public. New York: Palgrave Macmillan; 2012; p. 21.

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