Anabaptist Witness

A Global Anabaptist and Mennonite Dialogue on Key Issues Facing the Church in Mission

VOLUME 9 / ISSUE 2 / OCTOBER 2022

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Anabaptist Witness is published twice a year (April and October) and is indexed in the ATLA Religion Database® (ATLA RDB®), http://www.atla.com. It is a publication of Anabaptist Mennonite Biblical Seminary, Mennonite Church Canada, and Mennonite Mission Network. The views expressed in *Anabaptist Witness* are those of the contributing writers and do not necessarily reflect the opinions of the partnering organizations.

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The editor makes a public call for submissions for each issue of the journal, soliciting contributions that facilitate meaningful exchange among peoples from around the world, across professions, and from a variety of genres (sermons, photo-essays, interviews, biographies, poems, academic papers, etc.). All submissions to *Anabaptist Witness* undergo a double-blind peer review process. For full details of the current call for submissions, visit www.anabaptistwitness.org. Questions or comments about the journal's print or online content may be directed to the editor:

Jamie Pitts
JPitts@AMBS.edu

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ISSN 2374-2534 (print)
ISSN 2374-2542 (online)

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Anabaptist Witness
Anabaptist Mennonite Biblical Seminary
3003 Benham Avenue
Elkhart, IN 46517 USA

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Mission & Health

Editorial

The gospels portray physical healing as a central component of Jesus's ministry, and the Acts of the Apostles and the epistles suggest that healing was important in the early church. Caring for and restoring the integrity of the body is, in these New Testament examples, a sign of creation's renewal and the arrival of God's reign. Even when Christians have lost sight of this precedent, emphasizing instead an otherworldly salvation of the disembodied soul, the ministry of healing has rarely been completely discarded.

As signs, healings point to a longed-for reality that John of Patmos describes as the abolition of death, the cancellation of "mourning and crying and pain" (Rev 21:4, NRSV). For John, this glorious event is the result of God's making a "home . . . among mortals" (21:3). It is divine presence that heals and renews. If that is the case, then healing as present sign participates in the reality toward which it gestures. Healing, and above all the healed body, is sacramental proclamation, announcing good news by embodying it, mediating grace in the flesh. Healed bodies, we might say, are icons of the Resurrected One, displaying to the world its future.

Of course, even the Resurrected One bears the wounds of his crucifixion (John 20:24–29).[1] In the present, we know that longing for healing is not the same as obtaining it. The Christian life is a mix of joy over promises partially fulfilled, hope for more complete fulfillment, and disappointment over the difference. Disappointment is often accompanied by anxiety, by doubts—sometimes nagging, sometimes dominating—that the partial is the best we can do, the best we will do. Yet the space between the partial and the complete can also be a graced space, a space not only of enjoyment but also of experimentation and reorientation. Theorists and theologians of disability, among others, teach that we can learn in this space new ways to think about and act toward that which has been regarded as "unhealthy." Healing itself is transformed as we await the revelation of a new heaven and a new earth—and so, also new bodies (see 1 Cor 15:35–58).

This issue of *Anabaptist Witness* explores the place of healing in the church's conception of its purpose and task. Melissa Berkey-Gerard's essay on Community Peacemaker Teams (CPT) shows how that organization has come to see healing and care as foundational for the work of liberation. Mental and physical anguish related to COVID-19, in particular, convinced CPT leadership that the well-being of team members and partners was a primary, not secondary,

1 For a profound reflection on this point, see Shelly Rambo, *Spirit and Trauma: A Theology of Remaining* (Louisville, KY: Westminster John Knox, 2010), chapter 3.

concern. A written reflection and artwork by Monica Friesen expand our picture of the challenges related to COVID-19—Friesen is a nurse who worked for much of the pandemic at a hospital in Canada. Amid her grueling work, she frequently took comfort and inspiration from the memory and legacy of her grandparents, who served with Mennonite Central Committee (MCC) at a hospital in Taiwan.

Paul Shetler Fast, MCC's Health Coordinator, provides an historical overview of that agency's medical ministry. Shetler Fast narrates the agency's shifts from a focus of providing direct medical care to developing healthcare systems to a community-led model of public health. While this narrative could give the impression that MCC has progressed in linear fashion to perfect its health ministry, Shetler Fast emphasizes the overlapping, messy, and even "restless" character of the changes, as MCC and its partners have searched for the best way to provide care in a variety of contexts.

While COVID-19 has understandably become a focus of many recent conversations around health and mission, Beth Good reminds us that there are many pressing global public health issues that require our attention. Good, a nursing professor at Eastern Mennonite University (Harrisonburg, Virginia) and one of Shetler Fast's predecessors at MCC, is particularly concerned that we not forget the HIV/AIDS crisis. By telling stories from the church's work with HIV/AIDS patients in Kenya, South East Asia, and the United States, Good hopes that Christians will help break down the stigmas that keep such patients from experiencing "life in all its fullness."

Finally, Daniel Rempel's essay on "The Witness of Disability in a Medicalized World" challenges us to resist approaches to health that pathologize people with disabilities based on a conception of bodies as efficient machines to be repaired with medical technologies. According to Rempel, attending to the witness of people with disabilities can help Anabaptists develop understandings of disability and health that are at once more faithful and just. Ultimately, he argues, all of our health depends on receiving this witness.

Several book reviews conclude the issue, starting with an essay-length review by Anicka Fast of a book on Mennonite contributions to post-colonial African Studies. Other reviews concern Latino civil rights activism, Mennonite mission in Quebec, the Apostle Paul and prison, and a peaceable reading of the Book of Revelation. As Loren Johns, the author of the latter review, writes, "The power of the [slaughtered] Lamb consists of his faithful witness to God and to love."

While "mourning and crying and pain" still characterize the lives of mortals, may this witness shape our own.

—Jamie Pitts, Editor

Community Peacemaker Teams

Centering Care to Sustain Peace Workers

Melissa Berkey-Gerard

Our movements [organizations] themselves have to be healing, or there's no point to them.

—Cara Page

Community Peacemaker Teams (CPT, originally Christian Peacemaker Teams) works in areas of conflict around the world, in solidarity with those who are targeted by violence and oppression. CPT was founded thirty-five years ago by Anabaptist and other peace churches who heard the call of Jesus to actively work for peace as rigorously as the military has championed war. CPT is committed to building partnerships to transform violence and oppression in places such as Iraqi Kurdistan, Colombia, Palestine, the US/Mexico border, First Nations land in Canada/Turtle Island, and Greece.

As COVID-19 pandemic measures closed borders and halted international travel, CPT, as an international organization, paused to discern how best to continue or reimagine the work of accompanying communities that were under threat of violence. Many parts of the world went into a series of lockdowns, and violent and oppressive forces capitalized on pandemic measures as a cover to increase their violent acts against the people we partner with. By summer of 2020, despite some of our staff being unable to travel to rejoin their teams, we were able to resume CPT's work on the ground. In Palestine, for example, our team re-started physical accompaniment and presence with an all-Palestinian

Melissa Berkey-Gerard is the Care Coordinator for Community Peacemaker Teams (CPT, www.cpt.org). Melissa uses the framework of Healing Justice to accompany her colleagues in their vital work in conflict zones. Prior to joining CPT, she worked in Philadelphia and New York City non-profit organizations for twenty years, seeking out the intersection of spirituality and justice. Together with a group of incarcerated women and women living on the outside, she co-founded an Associates Degree program at a prison in New York City, and taught undergraduate students as a professor at the Oregon Extension of Eastern University. In addition to her work at CPT, Melissa nurtures space for people to heal and thrive through spiritual companionship/direction and facilitates retreats where she lives with her family on Lenni Lenape Land, known as Philadelphia, Pennsylvania.

team for the first time in the twenty-five years CPT has worked in Al-Khalil/Hebron in the West Bank.

Even in pre-pandemic times, those of us working with CPT regularly encountered systemic oppression as we listened to the stories of those targeted by violence and supported their nonviolent resistance. Recognizing the impact of these experiences upon staff, CPT's Undoing Racism Coordinator Sylvia Morrison, along with others at CPT, began the work of helping us become a trauma-responsive organization. This meant understanding that our work may be traumatizing and trying to prevent that trauma from becoming stuck, building up, and having a negative impact on us.

Over time we have built structures to support the well-being of CPT members, using the framework of Healing Justice to sustain ourselves as a community and individuals for the long haul. The Healing Justice practice grew out of the Southern United States social movements for racial justice and is defined by Cara Page and the Kindred Southern Healing Justice Collective as follows:

> Healing justice is the practice of reimagining wholeness at the intersection of intergenerational trauma, current structures of oppression, and a generative and co-created future. We hold that joy and pleasure create possibility to be in right relationship with ourselves, each other, and the land. We strive to demystify medicine and healing, and to make them accessible to everyone. We believe that each person is an expert of their own experience, body and needs, and that it is necessary to address the roots of trauma and injustice for individual and collective transformation.[1]

Healing justice is the liberating path we seek to follow and invite others into, that centers indigenous communities, people of color, and the LGBTQ community in healing from intergenerational trauma and current trauma. It is the practice of looking at wholeness and wellness imaginatively. It is more than just thinking about self-care or taking care of oneself at the expense of the group; instead, it recognizes that our movement for liberation MUST put healing and care at the center so that we can all stay motivated in our work and avoid burnout, quitting, or hurting each other. The COVID-19 pandemic can and has exacerbated trauma, so it has been important for CPT to give closer attention to strengthening structures and practices that mitigate trauma, build resilience, offer healing, and connect us with one another.

In times of crisis, this is one of our strongest assets—connection to one another. While the pandemic kept CPT members physically separated from one another and from many of our partners on the ground, we worked to promote and attend to the well-being of all of our staff. Relationships offer joy, break us out of isolation, and invite others to compassionately witness what we are going

1 Allied Media Conference 2018, Healing Justice practice space and Healing Justice track coordinators, Detroit, MI.


CPT
PALESTINE

through. Although we were only able to gather as an international community virtually, we began meeting weekly to ground and center ourselves spiritually and to check in on one another and offer support. We made space to collectively grieve the losses experienced during the pandemic. We held virtual "coffee hour" and shared life stories.

As the pandemic wore on, some of our workers began to experience symptoms of anxiety, depression, pandemic fatigue, and vicarious trauma. We identified the need for pyschoeducation and offered workshops on these symptoms for CPT members.

Even in non-pandemic times, we recognize the need to continuously offer space to process our experiences, both as teams and individuals. So when tensions run high because of stress, we invite space to name what is hard, to speak about the impact of oppression, and to heal as individuals. "I went through ups and downs from what I observed in the H2 area (controlled by Israeli military occupation), and one of the things that helped me to continue working was the system of care that we have," reflected a Palestine team member. "We do check-in sessions monthly with coordinators, which reminds me of the care plan I should do for myself, not to mention other team care practices. Without this system of care, I couldn't be able to work and have a normal life in a stress-and-dangers place we work in."

We need space to ask for support from our teammates, to draw out the strength and courage that we see in each other. We need to remind each other of what keeps us hopeful, why we do this work, and what matters at the deepest part of our beings. We need to stop together and listen for the quiet signs of liberation that break through even during tremendous suffering. One of our frequent rituals is a practice of naming what connects us spiritually to our work and why we continue to do the hard work of collective liberation.

Through the concept of healing justice, we know that resisting and breaking apart systems of oppression is itself the most important factor in our resilience and care for our community. Our collective liberation comes through creating a world where all people are free. Every time we train people in Iraqi Kurdistan in the tactics of nonviolence or provide unarmed civilian protection to a social leader in Colombia, we strengthen the worldwide resistance to military and armed forces of oppression.

With the majority of our field team members coming from the places where they serve, our CPT work has a new depth to it.[2] This also brings an increased risk of team members experiencing effects of trauma, as they are targeted by the same systemic oppression they are witnessing and documenting. For example, our Palestinian teammates are subject to the same checkpoints in Al-Khalil/

2 For several years, CPT has intentionally moved toward hiring local peacemakers for all teams.

Hebron that they monitor for human rights violations. Recently, I spent a few weeks with the team repeatedly witnessing Israeli soldiers with machine guns pointed at us requesting our ID cards and asking, "Do you have any weapons, guns, or knives, or anything sharp?" Every time, I was afraid the soldiers would mistake a cell phone for a gun or knife and that my teammates could lose their lives for this mistake. Similarly, in Colombia many Colombian social leaders are assassinated for standing up against armed actors. Our Colombian staff are not immune to these threats.

In recognition of this reality, CPT members who want to meet with mental health providers are matched with providers from their same background so they can receive culturally competent care in their native language. This is part of a larger effort to create even stronger structures that recognize the impact of systemic, continual oppression on our workers.

While CPT has always experienced the challenges of actively standing in solidarity against violence and oppression, the COVID-19 pandemic affected us deeply and inspired us to develop a more robust wellness approach. Though many of our connections are still virtual as a result of pandemic measures, we are finding each other. We are reminding each other of why we are here, sharing what keeps us hopeful, sharing songs of freedom and resistance. We join across time zones and light candles together, whisper our griefs, witness one another's pain, and hold each other in the love that liberates. We remind one another about the world we are working for—the one in which everyone is free.

Reflections on Mennonite Medical Missions in Taiwan from a COVID-19 Pandemic Nurse

Monica Friesen

In this reflective article I will introduce you to the Taiwanese Mennonite medical missions era of the 1950s–70s, focusing on my grandparents' deep involvement in that era and detailing some of its expressions in our family. I will then share how memories of my grandparents and their ongoing legacy in my own journey as a nurse gave me courage to continue nursing during the COVID-19 pandemic. I will tell you something of those difficult pandemic memories and share a piece of art I made in response to that time, explaining its significance to me and my journey as a pandemic nurse. In closing, I will reflect on the implications of medicine, mission, and faith as a nurse who follows Christ.

What I have to offer in missiology or theology for medical crisis is more practical than theoretical, coming through my family heritage and direct experience of the COVID-19 pandemic as a frontline registered nurse. During that time, I was caught up in a great storm and did my best to move through it with what courage and grace I could muster. For me, Mennonite medical missions had a unique role in that mustering. I hope you find some meaning in these stories[1] along with some considerations of what medical mission might mean in all its multifaceted, beautiful confusion.

Monica Friesen is grateful to be hosted in Treaty 7 lands and resides in Mohkinstis (Calgary), Canada. She currently works as a registered nurse in palliative care and Indigenous health research, and is pursuing masters studies in nursing. She is a twin sister, wife, and daughter and is in the early stages of cultivating her auntie energy. She is of Indigenous Austronesian, Mennonite, and Chinese descent.

1 I will embed a sense of storytelling in the style of this paper because I believe in the power of stories to impact the mind and heart of an engaged listener. For more information about storytelling and the interface of oral traditions in literature, see the discussion of "Indigenous Voice" in chapter 2 of Gregory Younging, *Elements of Indigenous Style: A Guide for Writing by and about Indigenous Peoples* (Edmonton, Canada: Brush Education, 2018).

Taiwan Mennonite Medical Missions: 1950s–1970s

The Birth of Mennonite Christian Hospital (MCH)

One of the first missionaries in post-war Taiwan was a Presbyterian American named Lillian Dickson. She published a book titled *These My People*[2] about missions among the Indigenous Austronesian peoples of the Taiwanese mountains. While some of her vocabulary and language feel socially and politically dated in our current times, her account of Christian witness is nevertheless adventure-filled and moving. Dickson writes, "In 1946 . . . they needed everything after the war. They needed food, they needed medicine, they needed clothing. They only asked for one thing, 'Are there any Bibles in America?'"[3]

As the workload in Taiwanese missions mounted, Dickson and her husband asked Mennonite Central Committee (MCC) to join alongside the projects Presbyterians had started; our family copy of Dickson's book has a typewritten financial support request letter still tucked inside the front cover, possibly from Dickson herself. In the 1950s, MCC began to send contingents of missionaries, doctors, nurses, and administrators to these underserved Indigenous populations in the remotest areas of Taiwan.[4] In 1954, Dr. Roland Brown founded a hospital that became central to the story of my family—Mennonite Christian Hospital (MCH) in the city of Hualien.[5] There MCC staff trained Indigenous locals to be nurses, dentists, and public health specialists.[6] Grandma Ruby Friesen (then Ruby Wang), the daughter of a local chief, was one of those trained at the nursing school. After graduation, she began her nursing career in mobile clinics and the MCH neonatal ward.

Grandpa and Grandma Friesen Join the Taiwan Medical Missions Work

Around 1957 or 1958, Grandpa Alvin Friesen moved from Canada to Taiwan to serve as a physician in the MCC mobile clinics and obstetrical/gynecological care at MCH,[7] where he became the primary obstetrician. Grandma must

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2 Lillian Dickson, *These My People: Serving Christ among the Mountain People of Formosa* (Toronto, Canada: Evangelical, 1958).

3 Dickson, 21.

4 Roland P. Brown, *Healing Hands: Four Decades of Medical Relief and Mission in Taiwan* (Newton, KS: Mennonite Press, 2017).

5 Brown, *Healing Hands*. Dr. Brown's influence and legacy thread throughout almost every account of Taiwanese Mennonite medical missions.

6 Mennonite Christian Hospital, "Introduction to MCH: MCH's Accomplishments & MCH's Special Accomplishments," Mch.org, 2010, https://www.mch.org.tw/english/introduction_accomplishments.shtm.

7 Brown, *Healing Hands*.

have caught the eye and attention of this young Mennonite doctor, as she describes him coming to spend time on the neonatal ward with her even after his duties were done for the day. Mennonite archival records show Grandpa and Grandma spending time together outside of the hospital as well; photographs depict Alvin and Ruby as young adults posing for various projects—in particular, the mobile clinics.[8]

The mobile clinics must have added quite the adventure to my grandparents' relationship. Grandma describes packing medical supplies into repurposed army vans (the medical missions version of Anabaptists turning swords into ploughshares, as it were), driving them out as far as there were roads, and then carrying the heavy supplies on their backs the rest of the way to remote mountain villages. In a similar vein, Dickson writes, "Whenever our Medical Mobile Unit starts out for the mountains, we know that adventure lies ahead, adventure with a capital 'A.'"[9] The photos of these mobile clinic vehicles—being driven rather intrepidly through the jungle on what can barely constitute roads, and crossing swollen rivers—seems to bear this out.[10] Upon arrival at each village, Grandpa and Grandma sometimes saw more than one hundred patients a day.

In 1961, Grandpa and Grandma were married. Their choice of each other for lifelong partnership defied many social conventions at the time, since interracial marriages were extremely uncommon and not usually approved by the couples' families. Of significance was the relationship my grandparents formed with Dr. Brown[11] and his wife, Sophie, who became close family friends and colleagues. Over the years, the children of the two couples grew up together. On my side of the family, that included my father, Han Friesen (named after Han Vandenberg, another Taiwan Mennonite missionary[12]) and his siblings—my Auntie Heidi and my late Uncle Peter.

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8 Mennonite Archival Information Database, "Item 2010-14-366," archives.mhsc.ca, February 23, 2015, https://archives.mhsc.ca/index.php/used-in-cm-7-21-4-information-on-back-of-photo.

9 Dickson, *These My People*, 55.

10 Brown, *Healing Hands*, 68; Mennonite Christian Hospital, *Serving the Lord—The 60th Anniversary*, Vol. 2 (Haulien, Taiwan: Mennonite Christian Hospital, 2008).

11 Roland Brown's influence and legacy thread throughout almost every account of Taiwanese Mennonite medical missions.

12 Susan Kehler, Paul Wang, and Peter Huang, "Taiwan Group Celebrates 60 years of Medical Ministry," Mennonite Mission Network, October 1, 2008, https://www.mennonitemission.net/news/Taiwan%20group%20celebrates%2060%20years%20of%20medical%20ministry. Han Vandenberg's name lives on today, as many people know my father as "Dr. Han Friesen."

For Dad and his family, medical missions life was just ordinary life.[13] Much of what I know about MCH comes from family stories from those years. Additional significant information comes from a three-volume bilingual Chinese-English historical account published to commemorate the hospital's sixtieth anniversary. This work is something of a family treasure for us. In 2008 Grandma and Auntie Heidi traveled to Hualien for its presentation and other sixtieth anniversary celebrations; Grandpa had passed away in 1995, and MCH wanted some of his family members present since part of the sixtieth anniversary involved dedicating a new obstetrical ward to his name.[14]

Pioneering Public Health and Social Equity

MCC was committed to serving people with the poorest and lowest social status, and in post-war Taiwan this was undoubtedly the mountain Indigenous peoples.[15] As an outgrowth of that commitment, Mennonite medical missions in Taiwan in the 1950s through the 1970s were pioneering concepts of public health and social equity, likely before the words were invented academically.[16]

In those days, infrastructure was limited and expensive between the east of Taiwan, with its Indigenous population, and the more affluent west of Taiwan, with its burgeoning immigrant Chinese population. Indigenous peoples had been forced into structural poverty due to multiple mechanisms of politics and colonialism.[17] They could not afford to travel to city hospitals on the west side for their healthcare or to pay the medical bills charged by those hospitals.[18]

A story involving Grandpa illustrates this challenge. According to Dad, a close nurse colleague of Grandma needed emergency surgery but was unable to make a trip to the large city hospital in Taipei. And Dr. Brown, a surgeon of

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13 I have a frail copy of an MCH 1970 calendar depicting the Friesens standing in a mission compound group photo, with their names listed on the back.

14 MCH, *Serving the Lord*, 20.

15 Brown, *Healing Hands*, 74.

16 Brown, *Healing Hands*.

17 Rosalyn Fei, "Settler Colonialism by Settlers of Color: Understanding Han Taiwanese Settler Colonialism in Taiwan through Japanese American Settler Colonialism in Hawai'i," *Asian American Research Journal* 2 (2022), accessed August 16, 2022, https://escholarship.org/uc/item/2mk3z9qk. Fei outlines the experiences of Indigenous peoples of Taiwan enduring several regimes of colonialism, one of which was the Japanese occupation after the Sino-Japanese War. The Japanese forcibly colonized Taiwan from 1895 until their withdrawal in 1948 after WWII. After this, the Chinese Kuomingtang Party enforced a Chinese regime in the country, many vestiges of which remain today. Each colonial regime viewed Indigenous peoples as incapable of being sovereign over our own traditional lands and actively oppressed us and our efforts to resist colonial rule.

18 Brown, *Healing Hands*.

some skill, was not available. So Grandpa read from a textbook on the needed surgery, then literally brought the textbook into the operating theater with him and performed the operation. When my family visited Taiwan in 2016, this nurse was still healthy and delighted to meet us.

MCH was also innovative for its time in providing training for local Indigenous populations to serve their own people.[19] The training helped people reconnect with one another. Grandma was a living example of this. Because she grew up during the Japanese occupation,[20] she was forbidden to speak her own traditional language in school and had never learned it properly. She told me it was not until she started serving fellow Indigenous patients as a nurse with MCH that she really began learning her own language.

Through unique partnerships between Mennonites, Indigenous locals, and Chinese-Taiwanese locals, these missions helped Indigenous peoples move toward health equity, or what could perhaps be termed health justice. Not only were immediate health needs served but Indigenous peoples and other locals were empowered to take charge of their own healthcare. To return power to the patient so that people have agency over their own health is now one of my own personal goals as a nurse, in part inspired by the work of my grandparents and Dr. Brown.

Reflections While Becoming a Nurse

As a teen in 2010 I remember my family visiting the MCH obstetrical ward, which was dedicated to Grandpa.[21] We were treated as honored guests and given a tour of the entire hospital. It was very disorienting to have a picture taken with much pomp and circumstance in front of a gigantic, larger-than-life image of my grandfather. I felt both proud of his achievements and undeserving of the honor bestowed upon us by subsequent generations of MCH staff—unearned, in our case, but offered for Grandpa's sake.

Grandpa was a very self-effacing person, and, from what people have said about him, my guess is he would be embarrassed if he knew such an honor had been given him posthumously. But people recognized and wished to commemorate Grandpa's undeniable love and passion for his Indigenous patients. Dr.

19 MCH, "Special Accomplishments," https://www.mch.org.tw/english/introduction_accomplishments.shtm.

20 Fei, *Settlers of Color*.

21 Perhaps I should add a caveat that Mennonite medical missions were not immune to the White-centric and male-centric pressures of North American evangelical efforts. One symptom of this was the recognition, at times, of Mennonite staff more than the Indigenous and Chinese-Taiwanese staff, with some notable exceptions. Colonial legacies in Christian mission are still being untangled today. As a descendant of Mennonite, Indigenous, and Chinese ancestors, I wrestle with these colonial contradictions.

Brown, for instance, describes the day that "Typhoon Winnie hit. It blew off part of the hospital roof. . . . Dr. Friesen, who lived two blocks away and was concerned for the patients, crawled on hands and knees to get to the hospital because of the strong wind."[22]

Grandpa left an enduring legacy after his death, and both my grandparents seem to have started a new vocational trend in our family. Previously, generations of Friesens and Wangs had simply continued farming like their grandfathers before them. After Grandpa and Grandma, however, Dad became a doctor, Auntie Heidi became an occupational therapist, and I became a registered nurse.

In my young adult life in nursing school, I used to tell my classmates about Grandpa and joke that the rest of us never measured up to him. It was not really a joke, however; the feeling of not measuring up did not dissipate after I started my registered nurse career in a busy hospital on the Canadian prairies. How could I feel like I was a meaningful healthcare professional as a little floor nurse in some random hospital when my grandfather had been such a visionary, with obstetrical wards named after him and special recognition from Taiwanese dignitaries?[23] I worked hard to begin my career but felt distinctly like an average, rather than exemplary, nurse. I could perhaps write more about how proud I am of Grandpa's legacy and how it inspires me in my own healthcare career to continue with his same passion and dedication. However, "not measuring up" is the more honest description of how I experience carrying his legacy. For me, commemoration of Grandpa's medical work is a complex mixture of pride in his accomplishments and worry about personal inadequacy on my part—that I may not be capable of the heights he achieved.

The 'Rona

Fast forward to March of 2020. When the 'Rona hit, as we nicknamed coronavirus SARS-CoV-2 in the small rural ICU I was working in at the time, nursing practice became unrecognizable almost overnight. In the "first wave," everything was an unknown—how contagious the virus was, exactly how it spread, and how to care for people who caught it.

Our healthcare team was slowly crushed under the weight of additional equipment and interventions needed to care for patients on the heightened isolation precautions required for COVID-19. We began running out of everything we needed: hand sanitizer, protective gowns, medical masks, gloves, eye goggles, and sanitizing wipes. We were mandated to ration, and sometimes reuse, our

22 Brown, *Healing Hands*, 110.

23 MCH, "Special Accomplishments," https://www.mch.org.tw/english/introduction_accomplishments.shtm.

personal protective equipment (PPE). Some days we did not know where our next shipment of gowns or gloves was going to come from. Our ICU only had one negative pressure room and needed several more for the "aerosol-generating procedures" much covered but poorly described by the media. So our maintenance department cut holes in the window glass of the ICU rooms and installed makeshift negative pressure machines.

Hospitals everywhere struggled to keep up with the scant and constantly changing available evidence about how to manage this virus. Each morning I would read our hospital policy updates, and by each afternoon they were already obsolete. This made providing care a guessing game, a shot in the dark about what was safe and effective.

I had been a registered nurse for only two years when the pandemic hit. I felt woefully unprepared for such a crisis and yet was thrust into a frontline role without preamble, amid concerns for my own safety. I thanked God I had no children in my house and felt for my colleagues who worried about carrying the virus to their children.

The shortage of PPE was alarming and stressful, but by far the worst nursing experience of the pandemic was caring for patients who were suffering and dying alone. With visitor restrictions and bans in effect, hospital staff were instructed to make only strictly necessary entries into each patient room, which resulted in minimal opportunity for conversation or emotional and spiritual support for these patients. We nurses were often their only human contact, and yet, heavily garbed and muffled in our PPE, we were still separated from them by sweaty layers of plastic.

It was probably the saddest and most dehumanizing season of my life. I did everything I could as a nurse for these patients but saw that their deaths were lonely and bereft of peace and dignity. I could not count the number of times I had to turn away visitors at the door or refuse them on the phone as they begged me to let them see their dying loved one. I felt I had failed to provide good care to these patients and families. I would hold back my tears during shifts, then cry on my commute home when tears would not bother anyone or interfere with my work. Once home, I would refuse to touch or hug my husband until I had showered. Then I laundered my scrubs separately from all of our other clothes.

It was hard to summon the courage to reenter the fray each shift. Occasionally I phoned Dad and Grandma. Dad was in the midst of COVID-19 in his own hospital. He was calmer than I was, since he had doctored through H1N1 and other pandemics. Dad also reminded me to think of our forefathers and foremothers in Mennonite medical missions. Despite dangerous circumstances and limited resources, they had ventured into the unknown to deliver healthcare to people who needed it desperately. I understand their stories more keenly now after facing the challenges of being one small team member in a rural ICU

without the benefit of proximity or access to the specialized supplies and equipment of my city colleagues.

Doing what was possible in rural areas while constrained by limited resources is precisely what Grandpa and Grandma did for years. I thought about them struggling through the Taiwanese jungle in the medical mobile clinic vans and backpacking their supplies over literal mountains. When I phoned Grandma during the various lockdowns and told her about my work, she never coddled me or felt sorry for me. She did not say, "Oh, I could never do what you do," which I heard frequently from others. Grandma had a sort of calm acceptance that a hard nursing job to do is still a nursing job to do. Her approach was influenced, I believe, by the backbreaking work she undertook during her years at MCH. Her attitude helped me stiffen my own backbone, re-summon my courage, and keep showing up for shifts and serving however I could.

Pandemic Nurse Art

In the summer of 2020, I started a piece of beadwork art to cope with everything that was happening. The piece is shaped like a circle, outlined by heartbeats. The heartbeats represent both the quotidian heart rhythm strips I analyzed every shift and also the common heartbeat we all share. On the left is a representation of the young jingle dress dancer Skye Yannabah Poola. The jingle dress dance is a healing dance created among North American Indigenous peoples during the 1918 flu pandemic.[24] Skye and others like her posted themselves dancing on social media during COVID-19. Alongside the memory of my grandparents' work, these jingle dancers helped to bolster my courage. On the right of the artwork is an image of myself in some ordinary blue scrubs. On the bottom are incense prayers, and on the top is a stethoscope in a heart shape. The inside of the circle is filled with white. The micro-sized white beads are organized in a variety of orientations and patterns. This represents the ever-shifting nature of the sheer unknown that healthcare workers faced during the pandemic.

I found the art evolving and changing as I worked on it, much like the COVID-19 pandemic itself. I added the white MCC dove into the middle to honor the work of my grandparents in Mennonite medical missions that inspired me to keep going. I also put in a 1-mL Luer-Lok™ syringe, the kind of syringe the COVID-19 vaccines are delivered in. For me, the vaccines meant protection from harm and hope for the end of the pandemic one day. When I received my first COVID-19 vaccine, months after I had started pandemic nursing with limited protection from the virus, I almost cried with relief in

24 Harper Estey, "The History of the Jingle Dress Dance," Ncai.org, National Congress of American Indians, August 12, 2020, https://www.ncai.org/news/articles/2020/08/12/the-history-of-the-jingle-dress-dance.

front of the public health nurse. The vaccine felt like a weight off my shoulders. Ironically, soon after I put that syringe into the beadwork, my workplace was no longer allowed to order them for normal medical purposes; 1-mL Luer-Lok™ syringe supplies were, understandably, funneled instead toward the vaccine efforts. For non-COVID injections, we received cheaper "slip-tip" syringes. They did not fit our needles well, but we were expected to make do. It is a tiny detail but one that stays in my memory as an example of things we never anticipated would be pandemic problems.

I also decided to add "star" beads to the outside of the circle to honor the patients I had lost during COVID-19. Each of those stars represents a patient dying alone whose death wrenched at my heart and soul. I did not feel that we honored these patients' emotional needs or their dignity in their deaths, so I hope to honor them in this work. I like to think of them as looking down on us with love from the spiritual dimension beyond this life.

Finally, I added one special, unique bead to represent Grandpa. I put him close by me looking over my shoulder as I went about my pandemic work. I would think to him, "Grandpa, of all the people who might be able to see me now, you know more than anyone what this journey is like." I imagined him looking down from heaven, saying, "Yes. I know what this is like. Stay strong. You can do this."

My Father

Like me, Dad felt his medical practice as a physician hospitalist never measured up to the sheer scope and accomplishment of Grandpa's work. I believe he has downplayed his impact, however, in his own career. Over the course of more than thirty years of medical practice, Dad has mentored hundreds of residents, training the next generation of doctors. His humble, friendly, and approachable demeanor makes him highly respected and well-liked by doctors, nurses, and patients alike throughout his hospital. It is not uncommon for someone to recognize him somewhere in public, approach him, and thank him for the care they received from him at some time or another. As a child watching these encounters, I had the impression that Dad knew just about everyone in our city.

Continuing the work Grandpa started as a Mennonite doctor, Dad—as the second Dr. Friesen—exemplifies hard work, kindness, and Christ-like love. I believe Grandpa would be very proud of him. In addition, Dad's calm and reassuring presence through so many healthcare "storms" over the years has been invaluable to young healthcare professionals like me. Although his medical career has not been as outwardly dramatic as Grandpa's in Taiwan, I firmly believe it has been no less important. Dad does not consider the sheer number of people he has encouraged, uplifted, and cared for—both patients and professionals—throughout decades of quiet service. He should give more credit to his presence and legacy in medicine.

Faith during the Pandemic

Rather than articulating what Christian witness to healthcare systems should look like, I am simply sharing my experience as a Christian who witnessed healthcare systems in the midst of a pandemic. In those terrifying and unforgettable times, I resonated more with God as Sufferer than God as Healer. It did not seem like much physical or spiritual healing was happening, which weighed upon my soul. As I held the hands of the dying in my own gloved hands, I thought that Christ must be present in the horror, because he understands and enters suffering. A person who is "a man of sorrows and acquainted with grief"[25] is someone one can cling to during a pandemic, someone who will not run away from the suffering. This thought brought me a kind of grim comfort and helped me to not run away either, to continue despite my grief.

I have heard plenty of sermons about finding joy in hardship. None of them felt meaningful to me during pandemic nursing. Hardship was hardship, and there was no joy in it. What I did find myself receiving instead was grit. When joy was not possible, the Creator gave me grit to keep sticking to the tasks at hand. Some small ember within me never quite died, and I was determined to

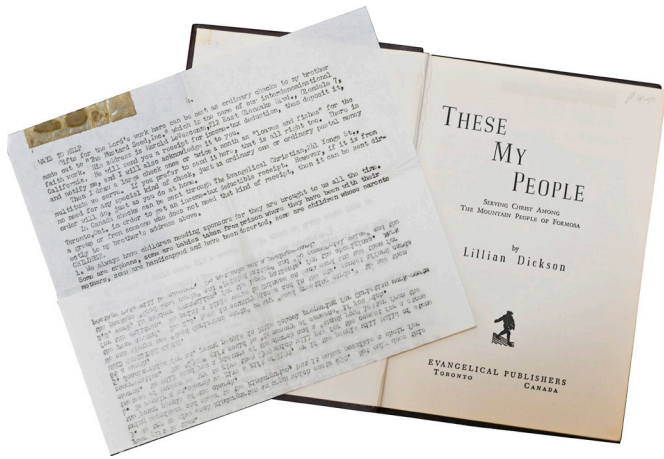
25 Isaiah 53:3 ESV.

see the pandemic through, no matter how deep and dark it became. I believe this speaks to grit as a spiritual gift. Though not as beautiful as something like joy, its presence in hard times is an unlikely but welcome spiritual nourishment. I thank God for grit.

The Nature of Mission

Though perhaps not as intrepid and exciting as my grandparents' Mennonite medical missions, pandemic nursing was the medical mission I landed in. Both required determination, creativity, hard work, physical and spiritual strength, and, above all, Christ-like love. The Mennonite medical missions of my grandparents' era had an explicit proselytizing purpose. Those mobile clinics brought, in approximately equal measure, the gospel, fortified milk for children, and deworming medications to remote Indigenous villages.[26] Chaplains circulated to each patient in MCH to deliver the gospel message and attempt to connect patients with churches after their discharge.[27]

I do not personally take this approach today. I will not proselytize at the bedside, nor do I feel that to do so is appropriately respectful of patient autonomy. This is likely the influence of my modern values and nursing training. To me, the actions of nursing and medicine are already mission in themselves because they embody the call of Christ to heal the sick, care for the lonely, and, in pursuing health justice, seek freedom for the oppressed. Thus, despite differences of opinion with my forebears in Mennonite medical missions, I still highly respect their hearts, love, and sheer medical excellence. Those doctors



26 Brown, *Healing Hands*.

27 Brown, *Healing Hands*.

and nurses, out of love for Christ, served thousands of people that no one else considered worth the effort. Dickson wrote:

> Let me tell you a secret. You have to look at each patient . . . (though their great need of help thunders at one)—as if it were Christ Himself waiting to be ministered to. It makes all of the work a sacrament, holy, happy, exalting.[28]

May all Christian healthcare providers look at each patient and see Christ himself; may that great need of help still thunder at us. That is our mission, and that is our sacred care. It was an immense sorrow but also an immense honor for me to minister to patients in a pandemic. I could not have done so without the grace and strength of Christ and without the courage my grandparents' legacy gave me.

I will leave the reader with a poem I wrote during the pandemic, and a final word of encouragement:

pandemic nursing is

pure uncertainty
pure fear
pure confusion
pure determination
pure change
pure adaptability
pure sorrow
pure teamwork
pure tragedy
pure grit
pure grief
pure courage
pure liminality
pure love.

In the words of Grandma's Indigenous language, *saicelen salikaka mapolong* (Never give up, keep going, all my relatives).

28 Dickson, *These My People*, 116.

More than a Mere Social Service Agency

Mennonite Central Committee's Health Ministry from 1920 to Today

Paul Shetler Fast

The COVID-19 pandemic revealed to many people the fragility of our health systems, shook the foundations of many institutions, and called into question countless assumptions about public health. Many relatively privileged people who believed infectious diseases had been banished to history, to the poor, and to the marginalized were reminded of our shared vulnerabilities to disease and death. Many who believed they could trust their government to protect them in a crisis were disappointed by their leaders. Many who thought they saw eye-to-eye with their family members, neighbors, and fellow believers were wounded by the deep and painful fissures that divided people over questions of risk, who and what to believe, and what values should take precedence in times of |crisis. Many organizations, including faith-based nonprofits and churches, were forced to rethink what activities were worth what level of risk; what health-related responsibilities they had to the people whose lives they touched; and how to balance the potential competing priorities of mission, staff and constituency well-being, and the health of the broader communities they serve. For many Christians, navigating the pandemic brought to the surface deeper faith-related questions about how we understand health, risk, solidarity, liberty, purpose, and community, as well as what we are willing to sacrifice and take risks for. For many Anabaptist agencies engaged in health work, COVID-19 forced a reexamination of our implicit theology of health and its role in our witness.

Mennonite Central Committee (MCC) has been one of global Anabaptism's largest expressions of collective faith through global service in the past century. While not explicitly evangelistic, MCC has seen itself from the beginning as more than "a mere social service agency" doing secular humanitarianism

Paul Shetler Fast is Health Coordinator for Mennonite Central Committee (MCC). Prior to this, he and his wife served as MCC Representatives in Haiti. Paul is an affiliate faculty of public health at Goshen (Indiana) College and is pursuing his doctorate in public health at Indiana University in Indianapolis. Paul and his family live in Goshen, Indiana.

and development work.[1] Instead, its founding members viewed the organization as a form of witness through action "in the name of Christ," whereby meeting basic needs (including health needs) became a way of embodying Christ's love for the world.[2] MCC describes itself as being "a ministry of Anabaptist churches" brought together to share "God's love and compassion for all in the name of Christ by responding to basic human needs."[3] While little has been written about an explicit theology of health in MCC, its Anabaptist faith perspective—which infuses all aspects of the organization's identity, purpose, vision, and way of working—has informed the ways that MCC staff and programs have conceptualized and approached questions of health and healing in their work.

As MCC's Health Coordinator through the COVID-19 pandemic, I've helped support and guide MCC's international health programming and internal response through these difficult and polarized times. This has forced me to think critically about the values and principles that underly our work at the intersection of faith, community, and health. By looking back at the past century of MCC's health programming, it is possible to articulate the foundational values that have informed MCC's health ministry as it has restlessly sought to respond to ever-evolving needs in the communities it serves. More clearly articulating these values and how they have manifested over time in MCC's work can serve to ground difficult health-related decisions, especially in times of polarization and crisis. Four faith values that have proven particularly important in guiding MCC's approach to global health programming are (1) a call to minister to those who are suffering, uprooted, and vulnerable; (2) a wholistic conception of humanity, where the spiritual, psychological, social, and physical elements of health are intertwined; (3) community as the center of lived faith; and (4) humility.

What these faith values mean in practice to MCC's health programming is best understood by observing how they have shaped and been shaped by the historical trajectory of this work over the past century. MCC's health work has spanned the globe and included distribution of medical supplies in Europe during wars and post-war reconstruction; staffing and then running North American mental health hospitals starting in World War II in the United States and Canada; direct construction, staffing, and management of clinics and hospitals around the world from the 1940s through the 1980s; community water

1 M. C. Lehman, *The History and Principles of Mennonite Relief Work: An Introduction* (Akron, PA: Mennonite Central Committee, 1945), 41.

2 John D. Unruh, *In the Name of Christ: A History of the Mennonite Central Committee and Its Service, 1920–1951* (Scottdale, PA: Herald, 1952), 363.

3 Mennonite Central Committee, "Priciples and Practices: Guiding the Mission of Mennonite Central Committee in the Name of Christ," (Akron, PA: Mennonite Central Committee, 2012).

and sanitation projects; HIV/AIDS responses in the 2000s and 2010s; and more recent work responding to trauma, sexual violence, and the neglected health legacies of violence.

While this programming history is complex, it can be simplified as falling into three broad and overlapping approaches to health work that have been dominant in MCC's health ministry in different eras: (1) medical relief, (2) the development and strengthening of health systems, and (3) community-led public health. Each of these approaches to health work has been informed and shaped by MCC's faith values, and the transition from one approach to the next was often driven by a desire to live into these same values more fully as MCC learned from its experiences and strove to adapt and respond to changing local contexts.

Medical Relief: Direct Ministry to Those Who Are Suffering

MCC was founded in 1920 to provide short-term humanitarian aid primarily to coreligionists in Europe.[4] During the World Wars and their aftermath, much of MCC's international programming continued to focus on a short-term relief model. For healthcare, the focus was on sending supplies and personnel to address the immediate medical needs of suffering, uprooted, and vulnerable people. This approach grew out of MCC supporting their constituency's desire for a direct and immediate response to suffering. It aligned with the faith value of ministering directly to people's basic needs.[5] This focus on short-term, highly targeted, direct medical relief was also the dominant form of global health, humanitarian action, and medical missions at the time.[6]

During MCC's opening trip to Ukraine in 1920, some of the first programmatic work organized by MCC staff Clayton Kratz and Orie O. Miller was medical relief. They purchased medical equipment and supplies for two Mennonite hospitals; selected a doctor as one of the first three field staff hired; and provided the most war- and famine-affected communities with emergency medical supplies, including medications, cloth for bandages, and soap for disinfection.[7]

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4 P. C. Hiebert and O. O. Miller, *Feeding the Hungry: Russia Famine 1919–1925: American Mennonite Relief Operations under the Auspices of Mennonite Central Committee* (Scottdale, PA: Mennonite Central Committee, 1929).

5 Mennonite Central Committee, "Twenty-Five Years: 1920–1945," in *Mennonite Central Committee Archive Collection IX-39-2*, ed. Mennonite Central Committee (Goshen, IN: Archives of the Mennonite Church, 1945).

6 Randall M. Packard, *A History of Global Health: Interventions into the Lives of Other Peoples* (Baltimore, MD: Johns Hopkins University Press, 2016), 13–15; Anne-Emanuelle Birn, "The Stages of International (Global) Health: Histories of Success or Successes of History?," *Global Public Health* 4, no. 1 (2009): 53–55.

7 Hiebert and Miller, *Feeding the Hungry*, 97.

As MCC's relief work expanded in Europe—and eventually, globally—medical relief was a key component of this programing. The work was generally defined by its focus on short-term emergency response and simple, technical, and materially based interventions (i.e., sending medical supplies and equipment) that relied on foreign technical staffing (doctors, nurses, lab technicians, etc.). The clinical focus was generally on acute medical needs directly tied to the humanitarian emergency: wound care, acute malnutrition, surgery, physical trauma rehabilitation, and so on. MCC constituency packed crates of medical supplies (including bandages, basic medications, needles, syringes, and surgical tools); sent doctors, nurses, and other medical professionals; and sponsored short-term relief missions to war- and disaster-affected communities. Medical professionals sent by MCC as volunteers to do this work tended to be on very short-term assignments—often shorter than six months—and did the clinical work directly. Local staff and volunteers often served in auxiliary and logistical support roles or shadowed foreign staff to train under them. Expatriate service workers often came with all the supplies and equipment they would need, generally raised their own support, and relied little on local resources, supply chains, or staffing.

MCC incurred relatively little expense for this work, as most supplies and equipment were donated, staff volunteered their time, and many clinical staff paid their own way or raised their own support. This approach to global health ministry was appealing both because it aligned with the faith value of direct aid to those suffering acute needs and because it involved low barriers to entry, few long-term commitments, and little need for extensive local infrastructure or staffing.

Geographically, MCC's medical relief work started in Ukraine in the 1920s, stretched across Europe during World War II, and followed Mennonite refugees to South America before spreading globally in the 1940s. Early examples of this medical relief work include the following:

- Regular material aid shipments of medical supplies, equipment, and medications to violence- and famine-affected areas of southern Russia/Ukraine and the areas Mennonites fled to starting in the 1920s. This medical material aid was part of more comprehensive emergency relief, which included food, agricultural supports, clothing, and blankets.[8]
- Financial, material, and staff support for emergency medical services in United Nations Relief and Rehabilitation Administration (UNRRA) camps serving refugees across Europe and Egypt during World War II and its aftermath.[9]

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8 Hiebert and Miller, *Feeding the Hungry*.

9 Mennonite Central Committee, "Annual Workbook: 1945," in *MCC Archives, MCC Executive Office and Annual Meeting Minutes, IX-05-02.1* (Akron, PA: Mennonite

- Short-term volunteer doctors, surgeons, nurses, and dentists sent with supplies to support urgent clinical work in the Mennonite colony in Primavera-Friesland, Paraguay, starting in 1942.[10]

Despite the appeal of this type of programming and its resonance with MCC's constituency to provide direct, tangible aid to ameliorate acute suffering, the limitations of relying too heavily on short-term medical relief work quickly became apparent to both MCC staff and partners. Short-term direct-aid projects can be effective at addressing immediate needs, but they too often do little to develop long-term sustainable systems of healthcare. Using mostly foreign staff on short-term assignments does little to develop local capacities or independence and creates challenges to ensuring culturally, contextually, and linguistically appropriate care.

This became particularly apparent as project participants became increasingly diverse with MCC's expansion beyond Europe and historic Anabaptist communities. Without shifting models to something more rooted in the communities they served, MCC ran the risk of being seen as "patronizing" or perceived as "motivated by racial, national or even ecclesiastical prejudice."[11] Additionally, MCC staff and partners began to worry that their hard-fought short-term health gains would quickly be undone if deeper issues driving poor health were not also addressed.

By the early 1940s, as MCC put down roots in more diverse contexts and sought to live more fully into its faith values, its approach to health work began to shift. As MCC worker Robert W. Geigley explained in a 1943 evaluation of the struggling health programs in Paraguay:

> Here you cannot assume that [short- term] material aid will bring any lasting result. You save a man from syphilis, and he dies of tuberculosis. You cure him of TB, and he goes back to the same home with the same poor food and diet, and in six months he has TB again. . . . The approach to problems here must be very different than in the case of European areas. . . . We therefore [propose] a long, slow developing [health] program, with the idea of starting at the bottom with broad projects . . . looking for results only over a period of ten to twenty years.[12]

Central Committee, 1945).

10 "Report to Mennonite Central Executive Committee Meeting, March 13, 1942," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #01/12, Meeting #89* (Akron, PA: Mennonite Central Committee, 1942).

11 Lehman, *Mennonite Relief Work*, 41.

12 Robert W. Geigley, "Report: Paraguayan 'Thank You' Project," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #01/15, Meeting #106* (Akron, PA: Mennonite Central Committee, 1943), 2.

This push toward longer, more durable impact that was more responsive to and owned by the communities being served can be seen across MCC programs in the 1940s to the 1960s. While support for developing durable healthcare systems and public health approaches became dominant models of health work for MCC after the 1940s, medical relief has remained a part of MCC's work around the world, particularly in emergency and disaster relief contexts. Medical relief work retains its appeal, despite its shortcomings, because of its resonance with MCC's faith value of working directly to alleviate acute suffering. Today, MCC continues to support medical-relief-style projects in several humanitarian crisis hotspots. However, unlike earlier medical relief work, these projects are primarily led by local partners, with local staff and local supply chains.

Development of Healthcare Systems: Wholistic, Durable, Community-Based Care

MCC's shift toward more sustained development of local healthcare systems, starting in the 1940s, grew out of several intertwined issues: (1) the recognition noted above that medical relief's impact, however well targeted at those most in need, was always going to be short-lived; (2) a renewed focus on a faith-based wholistic conception of humanity and health that is poorly served with short-term acute medical care alone; and (3) a faith-based desire to situate health and healing within community and the outreach activities of the church. The two dominant ways in which this new approach manifested in MCC health programming starting in the 1940s were (1) the placement of Civilian Public Service (CPS) staff at American hospitals and clinics (specifically mental health hospitals) during World War II and (2) hospital and clinic construction, staffing, and management as strategic entry points to new communities during MCC's global expansion. In both cases, these types of health programs often started as short-term medical-relief-style initiatives that quickly morphed into longer-term support for and development of local healthcare systems.

Starting in 1941, MCC became both a primary administrator for CPS placements of conscientious objectors to military participation and an overseer of medical care for CPS camps.[13] In 1942, 103 CPS volunteers were placed in mental health hospitals in Virginia, Delaware, New Jersey, Pennsylvania, and Ohio. This number grew to 748 volunteers across 21 hospitals in 11 states by 1943, with 130 CPS volunteers waitlisted for placement and an additional 200

13 Unruh, *In the Name of Christ*; Mennonite Central Committee, "Our Responsibility for Medical Care in Civilian Public Service Camps: Definition of Its Scope and Limitations," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #01/11, Meeting #86* (Akron, PA: Mennonite Central Committee, 1941).

wives of male CPS volunteers serving alongside them in mental health hospitals.[14]

In 1944, this engagement with US mental health hospitals expanded beyond CPS through the Hospital Summer Service program for women at mental health hospitals in Ypsilanti, Michigan, and Howard, Rhode Island.[15] This program quickly grew to include 58 volunteers by 1946.[16] The majority of MCC staff serving in mental hospitals through these programs were classified as ward attendants, who provided for the personal care of patients and served in administrative and logistics roles (rather than as medically trained staff providing clinical care). During World War II, over 1,400 men and 400 women served with MCC in mental health facilities across the United States.[17]

This exposure to the mental health system was transformative and connected deeply with MCC staff and constituency's belief—rooted in their faith—that health and healing was more wholistic than the narrow physical biomedical construct dominant in Western medicine at the time, including in the domain of mental health.[18] As MCC-CPS director Albert M. Gaeddert wrote, "This program has opened to us a whole new area of human need of which we had not been altogether sensitive."[19]

MCC staff were increasingly driven to be pioneers in improving the quality of mental health services and, because of their faith, advocating for the humanity and dignity of people with mental health conditions. Gaeddert described MCC's particular calling to transform the "callousness" of mental healthcare as a "service of love . . . for our fellowman . . . under the guidance of God . . . in

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14 J. N. Byler, "Annual Report of CPS Men Serving in Mental Hospitals," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #01/16, Meeting #110* (Akron, PA: Mennonite Central Committee, 1943).

15 Mennonite Central Committee, "Annual Workbook: 1944," in *MCC Archives, MCC Executive Office and Annual Meeting Minutes, IX-05-02.1* (Akron, PA: Mennonite Central Committee, 1944).

16 "Evaluation of Hospital Summer Service Program," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #01/26, Meeting #141* (Akron, PA: Mennonite Central Committee, 1946).

17 "Annual Workbook: 1945."

18 Michael Kennedy, *A Brief History of Disease, Science, and Medicine: From the Ice Age to the Genome Project* (Mission Viejo, CA: Asklepiad, 2004), 396–99; Allan V. Horwitz, *PTSD: A Short History* (Baltimore, MD: Johns Hopkin University Press, 2018), 51–79.

19 Albert M. Gaeddert, "Exhibit X: The Report of the Civilian Public Service Program to the Mennonite Central Committee," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #01/19, Meeting #123* (Akron, PA: Mennonite Central Committee, 1944), 6.

following the uniqueness of the Anabaptist vision."[20] MCC's faith values called the organization beyond simple short-term medical relief, to see the individuals they served as fully human, with spiritual, psychological, and social needs that could not be disentangled from their physical circumstances and health.

As early as 1944, MCC staff and constituency were pushing for deeper engagement in mental healthcare system transformation rather than the short-term staff placements the work had begun with.[21] This shift toward systemic change of the mental healthcare system was exemplified by the writing and publication in 1946 of "The Attendant," a practical training guide written by MCC CPS volunteers for new mental health staff to provide higher quality care.[22] This pamphlet later became the *Handbook for Psychiatric Aides: A Textbook of Patient Care*, the go-to reference guide for decades for frontline inpatient mental healthcare.[23] Additionally, by 1945 MCC's Mental Hygiene program was being recognized as a leader in the United States and Canada for its depth of frontline expertise and commitment to quality patient care and advocacy in mental health.[24]

In 1946 MCC began the process of establishing its own mental health facilities to model alternative approaches to mental health treatment that would live up to the "highest Christian standards of care" in a "home like atmosphere" that used only "scientific therapies of demonstrated value."[25] As Elmer Ediger, MCC's Director of Mental Health Services and Executive Secretary of Voluntary Services, wrote in 1946, "We recognize that the Christian has a responsibility to the mentally ill and the mentally deficient. . . . As followers of our Master, we are constrained to bring to our fellowmen the ministry of healing [and] our responsibility extends not only to those who suffer physical illness but to those

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20 Gaeddert, 6–7.

21 Mennonite Central Committee, "Evaluation of Hospital Summer Service Program."

22 Gaeddert, "Exhibit X: The Report of the Civilian Public Service Program to the Mennonite Central Committee."

23 National Mental Health Foundation, *Handbook for Psychiatric Aides: A Textbook of Patient Care* (Philadelphia, PA: National Mental Health Foundation, 1946). This reference guide remained in publication for three editions over twenty-five years. For broader historical perspective, see Alex Sareyan, *The Turning Point: How Men of Conscience Brought About Major Change in the Care of America's Mentally Ill* (Washington, DC: American Psychiatric, 1994), 159.

24 Mennonite Central Committee, "Annual Workbook: 1945," 2–3.

25 Elmer M. Ediger, "Exhibit III: Considerations and Recommendations on Possibility of Utilizing Leitersburg, Maryland Farm as Mental Rest Home," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #01/27, Meeting #142-143* (Akron, PA: Mennonite Central Committee, 1946), 5.

who are ill in mind and soul."[26] MCC's faith calling here was to effective clinical care that did not disregard the wholistic humanity of the patients or the need for them to remain embedded in community. By 1967, MCC had supported the development of seven mental health hospitals in the United States and one in Canada. Soon after, an additional three Mennonite mental health facilities became associated with the growing Mennonite Mental Health Services program in the United States and MCC Canada's Mental Health Program.[27] Eventually, all of MCC's US and Canadian direct service mental health programs were spun off to local ownership. Decades later, many continue to be leaders in mental health within their regions.

Paralleling this deeper engagement with mental health systems in the United States and Canada, MCC's work abroad became increasingly connected with healthcare systems, starting in the 1940s. As MCC expanded its global footprint and began programming in new communities, healthcare was often seen as a natural starting point at the intersection of locally identified community needs, MCC's historic competence and constituency interest in medical relief, and the faith calling to minister to the acute needs of suffering people. This work was often done in coordination with mission hospitals and missionary medicine, which was growing in prominence globally during this era alongside colonial health structures. In many colonized countries, government-run colonial medicine was tasked with protecting the health of colonial and local elites and organizing disease-control public health campaigns while health services for the poor majority were left to missionary and philanthropic groups or what locals could afford or provide on their own.[28]

In 1942, MCC began building and staffing a hospital in Primavera-Friesland, Paraguay. This new work included paying for the medical education of locals to eventually take over from expatriate volunteer doctors.[29] This was the first documented instance of MCC's health program intentionally shifting from a medical relief model—with imported staff and supplies—to a strategy of building health system capacity to provide local health services for the long run. In 1943, MCC began staffing and developing medical, dental, and nutrition clinics and hospitals around La Plata, Puerto Rico, with a mix of foreign and local

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26 Ediger, 1.

27 Mennonite Central Committee, "Executive Secretary's Report to the Mennonite Central Committee Canada Board," in *MCC Canada Archives, Executive Committee Minutes 1956–2012, Folder 1967 June MCCC Board Meeting Attachments, Meeting #020* (Winnipeg, Canada: Mennonite Central Committee Canada, 1967), 2.

28 Packard, *A History of Global Health*, 22.

29 Mennonite Central Committee, "Primavera Hospital Report to the Executive Committee," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #01/15, Meeting #106* (Akron, PA: Mennonite Central Committee, 1943).

staff.[30] In 1946, MCC was building on the "foundation of a medical program" in China that had begun as a missionary effort to create a mission hospital that would eventually serve as a base for building relationships and expanding a full spectrum of MCC programming.[31] This same year brought new hospital and clinic construction as well as volunteer staffing in the Philippines, Ethiopia, and Mexico, with India following close behind.[32]

In each of these cases, MCC's involvement started with shorter-term volunteers and medical supplies, in line with the established model of medical relief that MCC was accustomed to. These projects, however, quickly morphed into the development and support of durable healthcare systems as it became obvious that making long-term investments, building local capacities, and providing more wholistic care were needed to make durable impacts in line with the organization's driving values.

This shift toward directly owning and operating healthcare systems rather than supporting short-term placements with partners and mission agencies also allowed MCC more control over operations, values, and approach. This higher level of control allowed MCC programs to take on what one MCC leader described as "a consistently MCC pattern of service," where fewer compromises on values had to be made to accommodate partner agencies, whether secular, governmental, or church-affiliated.[33] For example, when MCC began its medical work in Cuauhtémoc, Mexico, in 1951 through short-term staff seconded to a governmental hospital, staff were quickly frustrated by the low standards of care and their inability to effect system changes. This prompted the launch of MCC-run clinics instead.[34]

In Haiti, MCC began its work in 1958 by seconding medical staff to the Hôpital Albert Schweitzer (HAS), which was run and funded privately by the

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30 Orie O. Miller, "Exhibit Ix: Report of Visit to Puerto Rico to the Executive Committee," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #01/23, Meeting #137* (Akron, PA: Mennonite Central Committee, 1946).

31 C. L. Graber, "Exhibit Xi: China Report to the Executive Committee," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #01/25, Meeting #140* (Akron, PA: Mennonite Central Committee, 1946), 2.

32 Mennonite Central Committee, "Annual Workbook: 1946," in *MCC Archives, MCC Executive Office and Annual Meeting Minutes, IX-05-02.1* (Akron, PA: Mennonite Central Committee, 1946).

33 "Memo of Understanding: Vietnam Unit 8/16/54," in *Mennonite Central Committee Archive Collection IX-5-1*, ed. Mennonite Central Committee (Archives of the Mennonite Church, Goshen, IN, 1954).

34 Harry Martens, "Exhibit 2: Commisioner Report to Mexico: Cuauhtémoc," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #03/06, Meeting #213* (Akron, PA: Mennonite Central Committee, 1953).

American philanthropists Larry and Gwen Mellon. While the clinical quality of work at HAS was excellent for its time, MCC staff were dissatisfied with a lack of autonomy to shape their approach to the work; the colonial-style and distance between HAS staff and the community it served; the lack of local ownership and staffing; and the inability to integrate faith and a wholistic faith-based vision of health into their work they felt called to.[35] As one MCC staff in 1959 reflected, "HAS was like an American colony in the heart of Haiti, and we as MCC did not always fit well within that."[36]

In response, MCC began work to start its own standalone clinic and hospital in partnership with the Haitian Ministry of Health in Grande Rivière du Nord, Haiti, in 1959. While MCC continued its support for HAS and the MCC-run clinic in Grande Rivière du Nord for several decades, by the early 1960s the health programming approach had clearly shifted from short-term relief-style staff placements to long-term development of durable health systems. This shift allowed MCC staff to fully live into their faith values of community ownership, wholistic health, and humility in walking alongside locals in less colonial patterns.[37]

This model of health programming through health system development and strengthening, with increasing shifting of responsibility to local control, became the dominant form of MCC health programming from the 1940s through the 1980s. While MCC no longer directly runs clinics and hospitals, modern versions of this approach can still be seen in MCC projects that support partner-run healthcare systems around the world.

Current projects that invest in the development of durable healthcare systems include Lebanon, where MCC has partnered for many years with the Middle Eastern Council of Churches in developing and sustaining Our Lady Dispensary clinic in Beirut; Nigeria, where MCC has partnered with Faith Alive Foundation to establish, develop, and expand clinics that provide wholistic maternal and child healthcare and HIV-specific care; and Democratic Republic of Congo, where MCC supports local primary and emergency care clinics for displaced people in Kikwit and Mubimbi.

Each of these health systems is administered and staffed by local health professionals, governed by local boards, staffed and resourced for long-term sustainability, and takes a wholistic view of health and healing. They embody

35 Elaine Stoltzfus, *Tending the Vision, Planting the Seed: A History of the Mennonite Central Committee in Haiti 1958 to 1984* (Akron, PA: Mennonite Central Committee, 1985), 17–30.

36 John M. Bender, Interview by Paul Shetler Fast, May 21, 2021.

37 Elaine Stoltzfus, *Tending the Vision, Planting the Seed*, 34–75; John M. Bender, *Mennonite Central Committee in Grande Rivière Du Nord, Haiti: The First Year 1959–1960* (Dolores, CO: Self-published, 1999).

the logical end point of the approach MCC staff began working toward in the 1940s as they pivoted away from a short-term, medical relief model with expatriate staffing and an urgent-care physical medicine approach to health and healing.

Community-Led Public Health: Humility in Giving Up Control

Despite the successes of MCC's healthcare system programming, staff and partners wondered—even in the early years of these projects—if a more localized, wholistic, preventative, and community-owned approach might be both more successful in the long run and a better fit with MCC's values. In Haiti, Dr. John Bender, who was tasked with starting the MCC-run clinic in Grande Rivière du Nord in 1959, very quickly realized that deeper change was required. "There were overwhelming healthcare needs," said Bender. "We did what we could, but it was never enough. Only treating problems after they developed medically was never going to be enough."[38]

Within a year of its launch as a medical clinic, MCC's work in Grand Rivière had begun to take on a more wholistic and public health approach. Agriculture programs were started in an attempt to prevent malnutrition before people needed to be treated clinically. Radio programming was developed to provide proactive public health education on disease prevention, water treatment, and sanitation. And preventive health outreach activities were launched to improve water quality, encourage latrine construction, prevent malaria transmission, and improve maternal and child health.

By the time MCC ended its support of clinical health work at Grande Rivière in 1980, and soon afterward at HAS, MCC's work in Haiti had almost completely transitioned toward supporting community-led preventive public health efforts.[39] The shift away from direct provision of medical care either as short-term relief medicine or longer-term healthcare system development was paralleled across the MCC system as community-led public health became the dominant approach to improving the health of the communities served. This work has been characterized by a focus on community-defined needs; seeking upstream preventive and durable solutions to health problems and using local staffing; adapting programming to the cultural context; and being community led.

MCC's earliest public-health-type work dates to water, sanitation, and hygiene (WASH) programming with CPS volunteers during World War II. In 1942, MCC CPS volunteers launched a hookworm eradication program—including basic latrine construction and WASH promotion—alongside local and

38 Bender, Interview.

39 Elaine Stoltzfus, *Tending the Vision*.

national government agencies in Crestview, Florida. While the program was initiated by governmental public health authorities, it only began seeing success when the community became involved in setting priorities and strategies.[40]

By 1944, similar basic WASH work with strong community participation was underway in Mississippi and Puerto Rico and soon became a central part of MCC's health work in the United States and abroad.[41] This specific public health focus on WASH and water systems, paired with community ownership of those systems, has remained a pillar of MCC's work and was a top funding priority under MCC's 2005–2015 strategic plans.[42] WASH remains a strategic priority for MCC health programming, accounting for more than one-third of all health funding in fiscal year 2022.

Community-led WASH programming supported by MCC is currently active in sixteen countries around the world. Recent examples of this type of community-led preventive public health WASH projects include

- Mozambique, where MCC has partnered with the Christian Counsel of Mozambique and the Anglican Church for two decades to provide wells, water storage tanks, school and home latrines, water treatment, and WASH education;
- Haiti, where MCC has partnered with Konbit Peyizan and local governments to help vulnerable families construct latrines and access water filters, install handwashing stations and water filters at primary schools and churches, and provide WASH education to tens of thousands of people, leading to the elimination of cholera from all participating communities;
- Chad, were MCC has partnered with Catholic-affiliated SECADEV to provide clean water, latrines, well construction, waste management systems, and WASH education to over a hundred thousand vulnerable and displaced people;
- Ethiopia, where MCC has partnered with a wide range of secular and church-based local partners to provide clean water access through borehole wells, water management systems, and latrines to schools and families across vulnerable regions of Ethiopia.

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40 MCC CPS BSC Camp #27, "Crestviews: Speical Conference Edition," in *MCC Archives, Civilian Public Service, IX-13-01, Box #24, Folder #17/43* (Crestview, FL: CPS Camp #26, 1942).

41 Mennonite Central Committee, "Exhibit X: The Report of Civilian Public Service Program to the Mennonite Central Committee," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #01/19, Meeting #123* (Akron, PA: Mennonite Central Committee, 1944).

42 "MCC Shared Strategic Plan, 2015–2020," (Akron, PA: Mennonite Central Committee, 2015), 2.

Another significant example of MCC's community-led public health approach since the 1990s has been the organization's work with HIV/AIDS. This work has focused on prevention education, destigmatization, wholistic supports, training of local frontline health workers, home-based care, acceptance in faith communities, and facilitating the integration of HIV/AIDS into existing primary care systems.

MCC's work with HIV began in 1985 with small projects in the United States and Canada. While these projects—like the clinic in Belle Glade, Florida—began small and not solely focused on HIV/AIDS, they quickly developed into comprehensive HIV/AIDS programs that included medical care, food supports, economic empowerment, destigmatization campaigns, and housing.[43] In 1987, MCC was shaken when two staff members were diagnosed with HIV. This led to the creation of an MCC "AIDS Policy" and more-focused HIV/AIDS programming.[44]

By 1990, MCC Canada had placed volunteers in HIV programs in Clearbrook, British Columbia, and Toronto, Ontario.[45] By 1991, MCC staff and partners in Africa were calling HIV "the scourge of the African continent" and asking MCC to direct more resources toward community-led education and prevention efforts.[46] By 1993, large wholistic community-led public-health HIV programs had been established in Zambia and Zimbabwe, followed by programs in South Africa, Tanzania, India, Brazil, and Ethiopia within the next five years.

In 2001, MCC officially launched its HIV/AIDS-focused "Generations at Risk" (later, just "Generations") program after conducting "listening sessions" with partners, community members, and staff in highly impacted communities. This campaign included targeted fundraising in the United States and Canada, and a more defined public-health approach to programming focused primarily on community-led prevention education, homecare, and support for HIV-impacted children.[47]

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43 "Exhibit 26: HIV/AIDS Program & Resources," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #10/28, Meeting #546* (Akron, PA: Mennonite Central Committee, 2002).

44 "September 1987 Executive Committee Meeting Minutes," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #08/24, Meeting #456* (Akron, PA: Mennonite Central Committee, 1987).

45 "Annual Workbook: 1990," in *MCC Archives, MCC Executive Office and Annual Meeting Minutes, IX-05-02.1* (Akron, PA: Mennonite Central Committee, 1990), 7.

46 "Annual Workbook: 1991," in *MCC Archives, MCC Executive Office and Annual Meeting Minutes, IX-05-02.1* (Akron, PA: Mennonite Central Committee, 1991).

47 "Spring 2001 Executive Committee Meeting Minutes," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #10/21, Meeting #538*

Under the original "medical relief" model, MCC would have directed the majority of its resources to sending North American clinical staff and supplies to care for the acute suffering of people with AIDS. Under the "healthcare systems" model, MCC would have invested the bulk of its resources in building out, staffing, and suppling HIV/AIDS treatment clinics and hospital wards. Under this new model of community-led public health, with the impacted communities and local partners setting priorities, less than 10 percent of all MCC HIV/AIDS funding in the Generations program went toward direct clinical services and medical supplies, and few medical specialists served in clinical roles outside their home communities in MCC projects.[48] By its peak, around 2010, MCC was supporting community-led HIV/AIDS public health programs with sixty-seven partners in twenty-nine countries, representing the single largest category of international program funding for the organization.[49]

Since then, HIV programming has slowly been winding down, after more than two decades as the primary focus of MCC's health work. This has primarily been because of other health issues becoming higher priorities for many communities served by MCC for two main reasons: (1) HIV became better funded globally compared to other health concerns (through mechanisms like the US government's PEPFAR program; UNAIDS; and the Global Fund to Fight AIDS, Tuberculosis, and Malaria), and (2) medical interventions and pharmaceutical prophylaxis increased in effectiveness. MCC's rapid ramp-up in HIV programing in the 1990s and 2000s, the type of programming it prioritized, and its wind-down of this priority area in the 2010s to fund other emerging health priorities were all driven by the same logic of community-led public health, rooted in MCC's faith values—prioritizing the needs of people who are suffering and underserved by existing institutions; wholistically responding to health needs; centering community-led interventions; and having the humility to shift course, learn from experience, and remain responsive to changing realities.

New public-health-style programming in this vein in MCC is increasingly focused on the areas of maternal and child health, sexual and gender-based violence (SGBV), and mental health. In all of these areas, MCC supports partners that work to empower individuals and communities to prevent harms from taking place, destigmatize care seeking, and develop community-led approaches

(Akron, PA: Mennonite Central Committee, 2001).

48 GAR Advisory Group, "Generations at Risk Fund Program Assessment Report," in *MCC Archives, US Departmental Files, IX-59-IP-01, Generations at Risk 2007–2012, Box #3* (Akron, PA: Mennonite Central Committee, 2007).

49 Mennonite Central Committee, "Annual Workbook: 2010," in *MCC Archives, MCC Executive Office and Annual Meeting Minutes, IX-05-02.1* (Akron, PA: Mennonite Central Committee, 2010).

that can mitigate harm and respond to people's health needs effectively, wholistically, and with dignity. Examples of these newer types of programs include the following:

- Kenya, Burkina Faso, Nigeria, Burundi, Somalia, and Uganda, where MCC works with local partners to provide community-based maternal and child health programming using the community-led Care Group model. This model empowers parents, grandparents, traditional birth attendants, community health workers, and local leaders to be agents of change in improving maternal and child health rather than waiting on external clinical interventions.
- Lebanon, where MCC partners with MECC, House of Light and Hope, and LOST to provide psychological first aid, psychosocial support, and effective triage and referral to survivors of trauma and sexual and gender-based violence, particularly to people displaced by violence.
- Haiti, where MCC partners with SOFA and Zanmi Lasante to provide wholistic psychological, medical, social, and legal support to people with unmet mental health needs and survivors of sexual and gender-based violence.

Living into the Faith Values Behind MCC's Health Work

Throughout more than a century of health programming, MCC has sought to be faithful to its calling, responsive to the communities and individuals it serves, and help bring healing to a suffering world. MCC staff and partners closest to the work have often been the primary agents of change as MCC's approach to health work has shifted in approach over time.

It was MCC staff in Paraguay who saw in the 1940s that short-term medical relief projects were not going to create lasting impact if they did not (1) address the deeper systemic and institutional problems leading to ill health and (2) empower communities to lead that change. It was clinical field staff, in places like Haiti in the 1950s, who realized that clinical medicine alone was never going to be enough to staunch the bleeding, and that more wholistic and preventive supports with local staffing would also be required. It was partners, participants, and staff in the field who signaled first that it was time for MCC to respond to the growing unmet suffering of HIV in the 1980s and 1990s, to prioritize community-led prevention efforts through local partners, and then to pivot once again away from HIV and toward other emerging priorities starting in the 2010s as community needs shifted.

MCC's health work has not remained static, and its history should not be interpreted as an evolution from good to bad, or vice versa. Each of the organization's three major approaches to health programming—medical relief, healthcare systems, and community-led public health—was dominant during

its period for reasons particular to that time and place as MCC struggled to live out its faith values:

1. **Medical relief work.** This approach served to engage a new MCC constituency and address urgent issues in places with little capacity at the time to sustain more complex work. It prioritized the faith value of responding to human suffering as quickly and directly as possible. As MCC staff member and Kenya Mennonite Church Bishop Maurice Anyanga said in a 2022 interview, "When the Church sees people dying it must respond; it must not be silent or wait for others to fix the problems. . . . The church has no option to look the other way."[50]
2. **Healthcare systems.** Building on MCC's experience of directly ministering to acute health needs, staff and partners began to call for the development of more durable community health services, to improve the quality and dignity of care in recognition of a shared wholistic humanity, and to develop local staff and capacities to sustain this work over the long term. This health-system-strengthening work leaned into MCC's faith values of a wholistic shared humanity as well as a centering of community as the locus of durable change.
3. **Community-led public health**. Despite the great successes of healthcare systems work, communities, staff, and partners realized that treatment-oriented medicine through institutions was neither sufficient to meet the overwhelming health needs nor responsive enough for rapidly evolving community priorities and the faith value of humility in giving up control. Out of these values, community-led public health, which had been a part of MCC programming since the 1940s, emerged as the predominant approach to health work globally and remained so through the COVID-19 pandemic.

Tellingly, all three major approaches remain a part of MCC's work today, as each is responsive to important faith values and each has the potential to be a good fit for particular contexts at particular times. Other parts of MCC's health work span these categories and defy easy categorization. Some projects include elements of all three approaches. Over the past century of health programming, the relative emphasis of MCC's health work has shifted over time, representing a slow, uneven, and largely decentralized evolution of approach to health that has attempted to be responsive to the diverse contexts where MCC works, the push and pull of various stakeholders, the steady accumulation of experience and wisdom, and the complicated discernment process of how faith values should guide this work. This history of health work is not best understood as an incremental refinement of a technical model of intervention but as a pragmatic,

50 Maurice Anyanga, Interview by Paul Shetler Fast, March 17, 2022, video call and notes.

earnest, and restless wrestling with a calling to minister to suffering, live out our faith values, and engage the messy collective process of discerning how best to do this in different contexts.

As Anyanga reflected on the history of MCC health work in his country of Kenya and the importance of responding to this call, he said:

> The Church has a Gospel mandate to help people in living abundant life. . . . Our responsibility to our brothers and sisters goes beyond spiritual boundaries to consider the person in their entirety. We cannot separate the spiritual from the physical, the individual from the community. . . . The body of Christ cannot turn away from suffering. People need healing, and we as the Church are called to be the hands that bring this healing. . . . Our healing of the physical body cannot be separated from healing the mind, the spirit, and even the community. When we as the Church have come together to respond to the health needs we see in front of us, whether it relates to HIV, clean water, or a sick child, we are ministering in the name of Christ, just as much as if we were preaching.[51]

MCC's health work, whether a century ago in Ukraine or present-day in the midst of COVID-19, has been shaped by this call to act—to minister to those who are suffering, without sacrificing their dignity or wholistic humanity; to remain rooted in community; and to serve with humility.

51 Anyanga, Interview.

The Church's Response to HIV/AIDS

Beth Good

In the early 1980s public health professionals were beginning to look more closely at specific and rare illnesses emerging within certain populations. For instance, pneumocystis carinii pneumonia (PCP) and Kaposi's sarcoma (KS), typically occurring in people who had weakened immune systems, were also associated with a host of other opportunistic infections among gay/bisexual men, infants and children of sex workers, and people using IV drugs. As the public health community searched for answers to these illnesses, the church faced an apparent dilemma: How should they respond to an emerging HIV/AIDS pandemic in light of perceived moral implications for assisting those most impacted by this disease? As Isabel Apawa Phiri put it, how was the church to both care for those who were suffering and, at the same time, discern if HIV/AIDS was a judgment from God?[1]

Beth Good is an assistant professor and program director for Eastern Mennonite University's Master of Science in Nursing program. She earned a PhD in nursing science and research and an MA in public health nursing from Widener University.

Beth has extensive international experience and has previously worked as the Global Health Coordinator for Mennonite Central Committee. She and her family have lived in Kinshasa, DRC (1984–1985), Kenya (1989–2001), Bukavu, DRC (2016–2018), and Kenya again (2018–2019). Beth has focused on the areas of public health in vulnerable settings, HIV/AIDS education, trauma healing, sexual gender-based violence, and intercultural awareness and humility.

Beth is ordained and leads the Administrative Leadership Cluster with Virginia Mennonite Conference Faith and Life Committee. She attends Waynesboro (Virginia) Mennonite Church, where her husband, Clair, is the pastor.

1 Isabel Apawo Phiri, "HIV/AIDS: An African Theological Response in Mission," *The Ecumenical Review* 56, no. 4 (October 2004): 422–31. See also National Research Council (US) Panel on Monitoring the Social Impact of the AIDS Epidemic, "Religion and Religious Groups," *The Social Impact of AIDS in the United States*, eds. A. R. Jonsen and J. Stryker (Washington, DC: National Academies Press, 1993), https://www.ncbi.nlm.nih.gov/books/NBK234566/.

These seemingly conflicting aspects of the question at hand led to a lack of response by many churches and faith-based organizations regarding the needs of those affected by HIV/AIDs. As the pandemic continued to spread, however, it was clear that any hope of stopping the spread and meeting the needs of those affected depended on using all resources from all possible avenues, including the church and its resources.

One of the ways faith-based organizations decided it was *safe* to address these exponentially growing needs was to respond to the growing crisis of widows, orphans, and vulnerable children. The success of these programs, as with many global health crises, was in supporting local organizations and congregations to work within their communities. Anabaptist churches in many countries embraced a call to care for those who were affected by the HIV pandemic; they focused on the needs of widows and orphans, planned educational events to inform their communities about risks of infection and methods of prevention, and partnered with local clinics and hospitals to provide visitation and care for the sick. Many of these churches and communities continue to offer relief to individuals and families today.

The Church in Action: A Sampling

The three following vignettes provide a very small illustration of the positive outcomes resulting from Anabaptist congregations responding to the needs of hurting people in their communities in spite of perceived theological complexities accompanying those responses.

Kenya

In 2006 during a trip to Kenya, I visited a widow and her children whom the local church had been helping to support since the death of her husband. When we saw Miriam's[2] home, it was obvious that no one had been able to provide upkeep in some time. The children shyly observed our group as Miriam slowly made her way from her bed to a stool to talk with us. Her smile was warm and welcoming, but her long limbs were thin and weak. Alarmed by Miriam's frail body, I wanted to make sure we did not tire her needlessly. First she spoke of her initial loneliness and despair. Then she described the day a church worker visited her home. With deep gratitude, she exclaimed, "Now, I have hope!"

Years later when I visited the same village, I saw a woman leading one of the HIV/AIDS support groups. Standing tall and strong, the woman clearly held the respect of the group as she shared her story and offered the hope she had found in her own journey. Then she smiled, and I stood there, amazed by a sudden memory of that same smile. Could this possibly be Miriam?

2 Miriam is not her real name.

When the class was over, we talked and hugged as I learned that this was indeed the same woman I had met years before. With the help of the church group, she had been able to connect with a clinic and get the treatment she needed. In addition, her children had completed school and were doing well. Miriam is now a leader in the church and very involved in HIV/AIDS ministry.

South East Asia

During a visit to a country in South East Asia, we traveled to a local hospital that had asked a congregation to partner with them. The hospital lacked the personnel to make home visits to the large number of patients living at home with HIV, so instead they provided training to volunteers from the church about good nutrition and how patients' medications should be taken. One day, on a home visit with one of the patient-care teams, we met a man lying under a blanket. Although weak, he sat up immediately and smiled when he recognized the volunteers. Then he expressed how grateful he was to welcome them and how much he looked forward to their visits. Clearly the volunteers were making a difference for the families they were visiting.

United States

In the United States, on more than one occasion after an HIV training in a church, individuals would discretely talk about someone in their family who was affected by HIV. Their hushed tones indicated that it was still difficult to deal with the stigma of HIV, but people were eager to learn and receive tools to provide support and comfort for their loved ones.

The Church's Message: Promote Life in All Its Fullness

The (justified) focus on COVID for the past two and a half years has led to the neglect of other global health concerns, and public health systems across the world are stretched beyond their limits. In the midst of this reality, it is even more critical for churches to participate in a global (and local) response to existing health crises. In this article, I've focused on just one such crises—HIV/AIDS, which is nowhere close to being eradicated. By the end of 2021, HIV/AIDS had claimed the lives of 40.1 million people and left another 38.4 million

people living with HIV.[3] In 2020, there were approximately 16.5 million children who had lost one or both parents to HIV/AIDS.[4]

UNAIDS Strategic Framework for Partnership with Faith-Based Organizations is calling for churches to be advocates for awareness and education to break down the stigma and silence around HIV/AIDS.[5] Such public health organizations have long understood that faith-based communities are uniquely positioned to take an active role in education, prevention, and support of people living with, or at risk of, HIV infection. The place of faith-based organizations in addressing HIV/AIDS in the global context is clear. "While HIV/AIDS brings fear and desperate actions, the message of the church should continue to promote life in all its fullness."[6]

3 World Health Organization, Global HIV Programme, *Key Facts and Latest Estimates on the Global HIV Epidemic*, 2021, accessed August 26, 2022, https://cdn.who.int/media/docs/default-source/hq-hiv-hepatitis-and-stis-library/key-facts-hiv-2021-26july2022.pdf?sfvrsn=8f4e7c93_5.

4 UNAIDS, *PEPFAR 2021 Annual Report to Congress*, accessed August 26, 2022, https://www.state.gov/wp-content/uploads/2021/02/PEPFAR2021AnnualReporttoCongress.pdf.

5 UNAIDS, *Partnership with Faith-based Organizations UNAIDS Strategic* Framework, December 2009, https://www.unaids.org/sites/default/files/media_asset/20100326_jc1786_partnership_fbo_en_0.pdf.

6 Phiri, "HIV/AIDS," 430.

The Witness of Disability in a Medicalized World

Daniel Rempel

Until recently, Mennonite theology has spent little time examining the place of people with intellectual disabilities in our ecclesial practices and confessions of faith. Kathy Dickson, in her essay "Disability and Mennonite Theologies: Resisting 'Normal' as Justice Anytime and in a Global Pandemic," outlines some of the ways that Mennonite theology and disability theology, when read together, offer complementary visions of human worth and resistance to Western cultural concepts of what it means to be a normal human being.[1] She also describes how communal efforts guide the work of justice, focusing particularly on the most vulnerable people within unjust societal systems.[2]

Dickson's essay moves in four parts:

1. She begins by describing the current landscape of unjust societal systems in her own American context, noting that, in light of policies centered upon caring for "normal" bodies, being diagnosed with conditions such as "mental retardation" or "dementia" could hinder one's ability to access care through being denied care on the basis of such conditions.[3]
2. Then she notes that the biases at play in Western medical diagnoses[4] are actually indicative of larger societal perceptions of disabled people, which scholars like Rosemarie Garland-Thomson have described as

Daniel Rempel is a PhD student studying theological ethics at the University of Aberdeen (Scotland). His research focuses on the Christian witness of people with intellectual disabilities. He currently serves on the board of directors at L'Arche Winnipeg and previously worked in disability services for six years.

1 Dickson here is herself speaking from a Western mindset, so this resistance must be understood as a resistance from within.

2 Kathy Dickson, "Disability and Mennonite Theologies: Resisting 'Normal' as Justice Anytime and in a Global Pandemic," *The Conrad Grebel Review* 38, no. 2 (Spring 2020): 107.

3 Dickson, 108.

4 Future references in this article to the medical model are referring to a Western, allopathic perspective and practice of medicine.

"normate biases."[5]

3. Next, Dickson argues that inherent to Mennonite theology is a tendency to push back against the "normal." This is evidenced most particularly by the way that Mennonite confessions of faith call us to ongoing resistance in a culture of violence, power, and wealth that pervades Western society, and to hold the value of living simply so that others may simply live.[6]
4. Finally, she describes the emphasis of both disability and Mennonite theologies on a communal interdependency as the appropriate way of being in the world—an interdependency that values the place of all members in the community.

Dickson suggests that reading Mennonite and disability theologies together can offer immediate responses to our medicalized world, especially in light of the recent COVID-19 pandemic. Trained by these two complementary disciplines herself, she contends that Christians—and Anabaptist theology in particular—can offer a better way forward for those trained in normate understandings of the world, while working toward a better and more just medical imagination for all.[7]

I draw on Dickson's essay from the outset here because of the exemplary way she weaves together not only Mennonite theology and disability theology but also personal experience; her theological integration follows from the way she frames her essay around the experience of her aunt's final days in the hospital and how her aunt's diagnosis with Down Syndrome affected the doctors' care and response. From Dickson's perspective, the doctors' medical gaze landed first on her aunt's Down Syndrome before seeing her aunt's person, which, in turn, affected how they proceeded with treatment. Where Dickson saw a loving

5 Dickson also notes that Amos Yong has adapted and expanded Thomson's definition, suggesting that for him, "'Normate biases' denote the 'unexamined prejudices that non-disabled people have toward disability and toward people who have them,' and that these assumptions function so normatively that the inferior status of people with disabilities is inscribed into the consciousness of society. He argues that 'non-disabled people take their experiences of the world as normal, thereby marginalizing and excluding the experiences of people with disabilities as not normal'" (111–)12. Cf. Amos Yong, *The Bible, Disability, and the Church* (Grand Rapids, MI: Eerdmans, 2011), 10–11.

6 Dickson, "Disability and Mennonite Theologies," 114.

7 To follow Dickson on this account is also to recognize the manner in which Christianity itself has contributed to the rise of what we will come to understand as the "medical model" of disability. It is not the case that Christian theology will only reform that which is "out there" in what Anabaptists have tended to understand as "the world"; our theologizing must also serve as a corrective to the ways in which Christian theology has erred and even led to the oppression of people groups within our own history.

family member, the doctors were trained to see a disabled woman. Dickson's personal encounter with a loved one's intellectual disability provided the foundational ground for her perspective; without the story of her aunt framing the essay, Dickson's argument would lose some of the force it carries in responding to Western medicine's normate biases.

In a similar vein, I argue that encountering the voices and experiences of people with intellectual disabilities is imperative for instructing Mennonites in particular, and Christians more broadly, in navigating medical systems. It is also how we come to understand what "good health" really is. In focusing on intellectual disability, the intent is not to discredit or disavow other non-intellectually disabled experiences but to focus on a particular group of people[8] who are commonly ostracized as a result of our perception of their inability to conceive rational thought. People with intellectual disabilities face unique challenges that those able to self-advocate do not, and their experiences also provide unique opportunities for reflection in light of both theology and our Western medical systems. It is thus my contention that by opening ourselves to being confronted by the lives of people with intellectual disabilities, we can learn to not only actively resist common-yet-harmful cultural conceptions of good health but also glimpse better understandings of health in the twenty-first century that have merit for all people in all bodies, mirroring life in the kingdom of God along the way.

Medicalizing Disability: The Birth of the Baconian Method

Disability has not always been pathologized. As Henri-Jacques Stiker argues, "There is no dis-ability, no disabled, outside precise social and cultural constructions; there is no attitude toward disability outside a series of societal references and constructs. Disability has not always been *seen in the same way.*"[9] In other words, according to Stiker, the category of disability has been created. It is not objective. It has not always existed. It shifts and evolves with the times, and people did not always understand the category of disability as they do now. Stiker's work is an attempt—and he is clear that it is *an* attempt, not *the* attempt—to trace these shifting cultural conceptions toward what we now

8 Yet, to make even such a distinction between physical and intellectual disability is not to raise awareness of the polyphony of experiences that are grouped under the label "intellectual disability." That is to say, there is not a unique positive characteristic that unites all people labeled as "intellectually disabled," for as the old colloquial saying goes, "If you've met one person with Autism, you've met one person with Autism." Such a remark highlights that there may be more that distinguishes individuals labeled as "intellectually disabled" than what unites them under the same label.

9 Henri-Jacques Stiker, *A History of Disability*, trans. William Sayers (Ann Arbor, MI: University of Michigan Press, 1999), 14.

understand to be disabled bodies, noting the ways in which societal conceptions have changed and evolved over time. We will return to Stiker's work below, but for now it is important to recognize that the way disability is understood today is not the way it has always been conceived.

To get a sense of how disability fits into our modern, medicalized world, it is imperative that we note how disability came to be pathologized.[10] To do that, it is helpful to begin with an examination of what has come to be known as the Baconian project.[11] According to Jason Reimer Greig, "The Baconian project remains the dominant mode of health care in Western, late modern society."[12] It represents the transition in moral discourse from the pre-Enlightenment vision of the "good life" to a commitment to eliminate suffering while expanding the capacity for human choice.[13] Exemplified in the work of Francis Bacon, the created order was seen as neutral raw material that can be molded in order to alleviate suffering in human beings. For Greig, "Although humanity's relationship with nature previously concerned discerning and contemplating God within life, Bacon now saw the vocation of humanity as one of God-given dominion over the Earth. Whereas the contingency of life had previously resigned people to a passive fate, humans could now seize the means of nature for the ends of a utopian future."[14] The Baconian project represents the movement from receiving life as a gift to an attempt to control and shape our life toward our own ends—ends that attempt to transcend our own finitude and vulnerability by mastering the world through newly conceived technological methods.

Such a claim is not to presume that people before the Baconian project never sought to control and shape their lives toward their own ends, or that those living in a post-Baconian world never seek to receive life as a gift. The historical situation may not be quite as distinct as we could be reading Greig to suggest. What Greig clearly gets right in addressing the Baconian project is that the at-

10 To say that disability is "pathologized" is simply to recognize that the medical gaze has sought to understand disability as a condition that can be cured rather than as a variation of human embodiment or expression.

11 Like Stiker's claim above, it is important to recognize that the Baconian project is but one way of narrating the story of how disability came to be pathologized. This article is not an attempt to craft a comprehensive narrative account but to serve as merely one telling of the story by highlighting a particular facet that is imperative for understanding the plight of people with disabilities today.

12 Jason Reimer Greig, *Reconsidering Intellectual Disability: L'Arche, Medical Ethics, and Christian Friendship* (Washington: Georgetown University Press, 2015), 52.

13 Here, Greig's is drawing heavily on Gerald P. McKenny's *To Relieve the Human Condition: Bioethics, Technology, and the Body* (Albany: State University of New York Press, 1997).

14 Greig, 53.

tempt to control and shape our life toward our own ends via the use of technology came to operate as the predominant mode of functioning in the world and is the dominant mode of perception for those captivated by the medical gaze. The problem of the Baconian project is not simply the attempt to orient life toward our own ends but also the way it encourages us to transcend our own finitude and vulnerability—the very facets of our being that make us human.[15]

Alongside the rise of humanity's perceived ethical responsibility to eliminate suffering through dominating nature, Greig notes the manner in which the rise of the Romantic ideal of "authenticity" was permeating Western culture and contributed to the ends of the Baconian project. In this context, "self-determination and self-definition increasingly became highlighted as imperatives for human flourishing. One increasingly could (and should) choose one's life, as opposed to simply accepting it from someone or something else."[16] Insofar as this emphasis on self-determination and self-definition related to the body, one began to see their body as their possession that can be manipulated to fulfill one's desires. This control over the body then becomes imperative to controlling one's existence.

Ultimately, in the Baconian project the body "becomes a 'project' that can be made and remade to fit the norms both of individual authenticity and social acceptance."[17] And as this happens, deviations from the norm become not only devalued but also a potential threat to personhood. "Persons began to fear less the illness itself than the loss of control that the illness engenders. When control of the body means mastery over any unchosen limitation, the constraints of illness look increasingly like dangers to the self."[18] Thus, as modern biomedicine began to emerge, it developed as a means by which human beings could eliminate individual suffering and increase autonomy and choice.

There is no question that the Baconian understanding has resulted in significant positive developments for humanity, both individually and collectively. However, a dark underside of the project eventually emerged—one that disability rights activists have come to know as the "medical model of disability," which began to appear in the mid-nineteenth century alongside the newfound

15 We can see how such tendencies would be damaging to disabled bodies when they are primarily understood through a pathologized gaze. Bodies that often display finitude and vulnerability so publicly are sought to be transcended in any way possible, and such possibilities do not prohibit the use of matters such as eugenics in medicine's attempts at mastery.

16 Greig, 55.

17 Greig, 55.

18 Greig, 55.

eugenics movement.[19] This medical model of disability is an understanding of disability that focuses primarily on a person's impairment. One's disability is rooted in their inability to perform or participate in certain tasks because of skills or abilities they lack, particularly regarding motor, sensory, or intellectual functioning. According to Greig, in the medical model "disability is an inherently *biological* reality that relates less to the surrounding environment than to individual, pathological bodies. The medical model locates the 'problem' of disability solely with the impaired body, whose dysfunction characterizes its lack of 'normality' and 'health.'"[20] In the medical model, disabled bodies are defective bodies, unable to accomplish the skills that "normal" bodies are able to.

In the Baconian project, biomedicine's response to disabled bodies is attempting to craft interventions that cure, repair, or rehabilitate individual impairments in an attempt to bring people "back" to "normal functioning." Such a mindset draws upon our conceptions of what a "normal functioning body" is and the presupposition that disabled bodies are deviations of this norm that must be returned to their normal functioning state. One may (rightly) interject that because of conditions that are "incurable" or possessed since birth, not all people are able to "return" to their "normal functioning state," and thus the medical model of disability is rendered inadequate on such grounds.

Such interjections remain inconceivable to the bastions of biomedicine, however, as evidenced by the account of disability activist Vic Finkelstein. Recounting his own medical encounter with paraplegia, Finkelstein notes, "If, as happened to me following my spinal injury, the disability cannot be cured, normative assumptions are *not* abandoned. On the contrary, they are reformulated as that they not only dominate the treatment phase searching for a cure but also colour the helper's perception of the rest of the person's life. The rehabilitation aim now becomes to assist the individual to be as 'normal as possible.'"[21] Under the fundamental Baconian presuppositions, realities such as Finkelstein's do not fuel alternate imaginations about the purpose and goal of biomedicine. Rather, these situations are seen as nothing more than challenges in the biomedical project—ones that must be assuaged to meet Baconian ends.

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19 Lennard Davis has helpfully tied the means of pathologizing disability to the discovery of the concept of an average or "norm." Yet, in doing this he also posits the bold claim that those who sought to further the concept of a norm in relation to the human body were all eugenicists in that they sought to improve humans so that deviations from the norm would diminish. See Lennard Davis, *Enforcing Normalcy: Disability, Deafness, and the Body* (London: Verso, 1995), 30.

20 Greig, 59.

21 Greig, 60. Cf. Michael Oliver, *The Politics of Disablement* (London: Macmillan Education, 1990), 54. Italics added.

Ultimately, in this medical paradigm abnormality becomes pathologized, evaluated through the lens of illness and disease. "When a fully functioning body and a complete lack of sickness come to be defined as the standard for human flourishing, impairments can only stand as deviations and flaws of normality."[22] If normal functioning bodies have become the means to further the Baconian project's ends, bodies that do not function normally are seen as threatening to normalized ends and must be remedied as quickly and efficiently as possible. Those whose bodies cannot be remedied to a certain level of functioning have faced segregation or extermination, for society cannot bear to gaze upon such "disordered" bodies. The implication of the Baconian project is for bodies to become normalized, and its powerful grasp may result in shaping attitudes toward people with impairments in all facets of life. Disability has not always been pathologized, but under the influence of the Baconian project it has become difficult to see disability in any other way.

Returning now to Stiker's claim in light of the medical model of disability, we are given the freedom to challenge this model as being the best way of perceiving people with disabilities.[23] If disability has not always been seen in the same way and there really is no disability outside precise social and cultural constructions, then we have the opportunity to create new and more just visions of not only the category of disability but also health in general. Just because the medical model of disability has become the predominant conception of understanding disability in the twenty-first century does not mean we are without alternatives.

The Social Model of Disability

The most common proposal for reconceptualizing disability emerged in the latter half of the twentieth century and has come to be known as the social model of disability.[24] In the social model, disability advocates suggest that it is not one's impairments that render one disabled but society that disables people because of the way it is constructed. Fueled by the colloquial phrase "nothing about us without us," the social model of disability attempts to move away from defining disability as a pathology and move instead toward something bound by social conceptions of the built environment. In doing this, advocates for the social model of disability suggest that social transformation is the "cure" that disabled

22 Greig, 60.

23 To be sure, there are certainly times when people with disabilities do benefit from the medical system, and such a telling of the medical model is not to suggest that people with disabilities ought to never seek medical care. However, this telling is an attempt to parse out our deep-seated assumptions about human lives and the differences that we encounter within other bodies.

24 Tom Shakespeare, *Disability: The Basics* (London: Routledge, 2018), 14–15.

people really need. Rather than therapies and treatments, disabled people need barriers to be removed and access to be increased. In the social model, society needs to change, not disabled people. Disabled people do not need a cure; they need access and the ability to determine their lives for themselves.

The social model has been a valuable resource for the disability rights movement in reforming and reframing conversations around disability, but it is not without its limits.[25] While the social model gives us proper cues about how we should conceive solutions to the problems that plague disabled people—most notably via the emphasis to listen to disabled people, or, "nothing about us without us"—it does not adequately address what those solutions are.[26] Partially, this is because what we conceive broadly as the social model is intentionally vague in an effort to be "big tent" regarding whom it seeks to include. It also was not intended to address *all* problems disabled people face. So, with the insights of the social model on our side, we now move to imagining alternatives to the Baconian project in relation to the medicalization of disability—alternatives that provide a more holistic vision of how our understanding of health can be conceived through the lens of disability.

Health in a Fallen World[27]

In his book *Wondrously Wounded: Theology, Disability, and the Body of Christ*, Brian Brock offers an alternative vision for understanding health by making the provocative claim that his son Adam is "the healthiest person I know."[28] He makes this claim not because of Adam's ability to avoid illness or injury but because "he reflects and disseminates the claim of the One truly healthy one, the One who lives at the heart of wonder."[29] This claim is startling, not only because

25 For more on the limits of the social model of disability, see Tom Shakespeare, *Disability Rights and Wrongs Revisited* (New York: Routledge, 2014), 11–46.

26 It should be noted that while the social model *qua s*ocial model does not give us constructive solutions, those who follow the social model do offer solutions. This is simply a disclaimer that the social model is not a distinctive approach. Rather, it's a broad categorization of approaches to disability that reject the medical model and attempt to source solutions to the "problem" of disability by reevaluating society and its systems through a disability lens.

27 This section draws from an argument I develop in Daniel Rempel, "The Healthiest Person I Know? Disability and Health," *Vision: A Journal for Church and Theology* 22, no. 1 (Spring 2021): 45–51; https://press.palni.org/ojs/index.php/vision/article/view/729/634. Thanks to the publishers of *Vision* for permission to repurpose that material here.

28 Brian Brock, *Wondrously Wounded: Theology, Disability, and the Body of Christ* (Waco, TX: Baylor University Press, 2019), 145.

29 Brock, 45.

in it we see Brock attempting to redefine the boundaries of what constitutes a healthy person but also because Adam has Down Syndrome and Autism, along with a host of other medical ailments.

Brock's claim that Adam is the healthiest person he knows comes in a chapter entitled "Health in a Fallen World." Here, we find Brock attempting to redefine conceptions of what health may mean to those claimed as citizens of the kingdom of heaven, disabled and able-bodied alike. Brock's account is starkly different from the account of the medical model of disability via the Baconian project surveyed above. The most noticeable difference comes from where one begins in assessing health and what makes a person healthy. For the Baconian project, health is a product of the norm, a regulated yet ultimately culturally contingent assessment of what commonly holds collective bodies together (contrary to the views of advocates of the medical model). For Brock, a proper understanding of health does not begin with a collective norm but is established by one's particular situatedness as a finite and sinful creature under God.

Guided by the work of the Jewish theologian Franz Rosenzweig, Brock argues that "God's merciful address *only* comes to people caught up in lies about themselves."[30] He notes a similarity in the work of Dietrich Bonhoeffer, who argued that the love of God drives deep into Christians," "particularly figured fallen personas."[31] Drawing on the work of Rosenzweig and Bonhoeffer, Brock makes the staunch claim that our particular situatedness in the world is inherently compromised by sin, and thus our fallen state as sinful human beings compromises our speech about health. If we are to assess our own conceptions of what makes someone healthy, we must recognize the way that sin has co-opted our ability to conceive these understandings. As a result, any appropriate Christian conception of health must first begin by wrestling not with our physical ailments but with our spiritual condition.

Because Brock begins his chapter on health by directing his reader to the topic of sin, one may anticipate him following a line of thought that argues illness is the result of the fall as one of the curses God places upon humanity in Genesis 3. Such a line of thought would be remarkably similar to the Baconian project, which determines illness as deviation from the norm.[32] However, this is not the case. For Brock, the primary result of the fall was not physical cursedness manifesting as illness or disease but rather separation from God and a distorted view of the self.[33] While the topic of sin does not figure overtly in

30 Brock, 143.

31 Brock, 143.

32 In this instance, the "norm" would be the original created status of human beings, and the deviation would be the sin that altered this original state.

33 In saying this, Brock is not attempting to answer questions about how and when biological illness and/or disease entered the human sphere. Rather, he is directing our

the rest of the chapter, it is important for Brock to locate its influence from the outset, understanding that sin, not illness, is the primary challenge that those who want to be healthy need to wrestle with. Sin is the reality that affects our health, a suggestion that runs starkly against the Baconian project.

Returning to Rosenzweig, Brock notes that in the midst of living with the muscular degenerative disease commonly known as Lou Gehrig's disease or ALS, Rosenzweig "believed most physically healthy modern people are suffering from a mortal illness. That illness is an incapacity to appreciate and receive their creaturely lives with all their individual peculiarities—including their physical illnesses and incapacities."[34] Rosenzweig is clear: what is most damaging to a person is not any physical illnesses or incapacities that may come their way but rather an inability to live "in the heart of wonder." Wonder draws human beings into deeper engagement with their everyday lives. It orients the Christian's gaze—that is, the way they perceive the world—seeing all of creation as God's gift to the world. Wonder may thus be the foremost way for Christians to combat out own sinful state and enter life in the kingdom of heaven.

Wonder is a task manifested properly in everyday life rather than primarily in extravagant circumstances. In an attempt to overcome such impulses for the extravagant, Brock argues that humans have a tendency to attempt to escape our current realities, even when those realities are ones we have been liberated to enjoy. He cites the Israelites complaining in the wilderness only months after being freed from Egypt as being a paradigmatic example of "captivity to the idea that satisfaction will be had in being somewhere else."[35] Ignoring their situatedness as creatures under God, Israel lost their sense of awe toward God's wondrous work of liberative mercy as they complained about their current situation. As Brock points out, it is exactly there—in the everydayness of life—where God wondrously breaks into our lives. "God breaks in on this situation of inner estrangement by revealing them to be *alongside* human beings, *in* the world, and *with* God."[36] Those who are attuned to the closeness of God in the everydayness of life are those who live by the sustenance given by relation to God. It is these people who, Brock argues, recognize health as life with God.

This example of the Israelites suggests that wonder and liberation are inherently interconnected. If creatures currently find themselves in a state limited by sin and the first step of moving oneself from sin into the kingdom of heaven is the practice of wonder, then to experience freedom is inherently connected to the practice of wonder. To further this claim, Brock shifts his focus from

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attention away from illness and disease as being the primary markers of our fallenness and toward separation from God being the primary marker of our distorted state of being.

34 Brock, 146.

35 Brock, 152.

36 Brock, 152.

Rosenzweig to Bonhoeffer to suggest that while creatures were created to be free, freedom "is a relation and nothing else."[37] This relation is manifested in our turn toward others, toward creaturely reality (our situatedness on earth), and ultimately in relation to God. Freedom is "being-free-for-the-other," recognizing that the fullness of our being is found in mutual cooperation and dependence. "To be a creature is to be dependent on and to depend on other creatures." However, such dependence is not arbitrary allyship; it comes about by "concretely depending on God's enlivening Spirit." Ultimately for Brock, our creatureliness—a true vision of the human person—is constituted in our dependence upon God and all that God has given as good gifts to those created by God.

Brock's final move in his chapter, after clearing the necessary ground through the work of Rosenzweig and Bonhoeffer, is to put forth his provocative constructive claim that his son Adam is the healthiest person he knows. He transitions by positing the following: "Taken together, Rosenzweig and Bonhoeffer offer a compelling conceptual explication of what is being said when Christians confess that to be saved is to be liberated to be free creatures. Being made free means continually being confronted with sin, and precisely so, invited into the kingdom of heaven. Here disability appears in a remarkably different light."[38] This difference, for Brock, is found not in the way he is to welcome his son into life in the kingdom of heaven. Rather, he strikingly states that it is Adam who welcomes *him* into the kingdom of heaven.

Brock notes four ways in which Adam's witness welcomes others into the kingdom of heaven:

1. Adam has an ability to live without worry of the future. Brock views this as a manifestation of Jesus's command to his disciples in Matthew 6:24–26 to not worry about their life or how they will survive, for their heavenly Father will provide all their needs. Adam's distinct ability to live solely in the present tense witnesses to people molded by a society obsessed with future goals, retirement funds, and hoarding possessions. He is a staunch manifestation of life devoted to the everydayness in which wonder takes place.

2. From Brock's perspective, there is no gap between what Adam says and what he does. Again, Brock draws on Jesus's words in Matthew, where he commands his disciples to let their yes be yes and their no be no (Matt 5:36–37). Adam "liberates everyone around him from suspiciously watching for signs of hidden motives, for other selves peeking out from

37 Brock, 156. Cf. Dietrich Bonhoeffer, *Creation and Fall in Dietrich Bonhoeffer Works* vol. 3, ed. John W. de Gruchy (Minneapolis: Fortress, 2004), 63.

38 Brock, 163.

behind masks."[39] Adam is who he is, and thus lives truthfully in a world that has become far too comfortable with distorting the truth. Thus, Adam may have a particular capacity to confront false narratives that sin thrusts into our lives.

3. Adam has a heightened level of emotional sensitivity. He is attuned to both the highs and the lows of those around him, yet at the same time has a remarkable tendency to position himself regarding ongoing social converse. Here Brock notes the way in which Adam embodies the Apostle Paul's teaching that members ought to have the same care for one another, where if one member suffers, all suffer together with it, yet if one is honored, all rejoice together (cf. 1 Cor 12:24–26). "Neither a loner nor an attention seeker, with absolute innocence he gravitates to the force fields of human converse. . . . I can only wonder at his attention to fields of interpersonal communion of which I never even dreamed."[40] Again, here we see a commitment to the everydayness in which wonder takes place. Adam's attentiveness to human emotion offers a picture of the way that members of the kingdom of heaven ought to be attuned to one another's needs.

4. Adam enjoys many people. Brock emphasizes this final point: "If the kingdom of heaven is a new social order whose characteristic is joy, I have most powerfully glimpsed what this might mean because I have lived with Adam."[41] Joy is imperative to life in the kingdom, for, as the Apostle Paul notes in Romans 4:16, "the kingdom of God is not food and drink but righteousness and peace and joy in the Holy Spirit." Wonder is not possible without joy, for joy often can be the outcome of a life lived at the heart of wonder. It is with this joy that Adam welcomes others into the kingdom.

In this chapter, Brock is attempting to claim that "a theological definition of health goes beyond this catalogue of bodily vulnerabilities in asking how people enact their creaturehood."[42] What is at stake is not how many doctor appointments one has to attend or how many prescriptions or treatments one is prescribed but how creatures operate in the world. It is in this way, in light of the examples listed above, that Brock can claim Adam is the healthiest person he knows. Adam's health is not represented by the absence of illnesses or diagnoses; on top of his Down Syndrome and Autism, Adam's life has been subject to sepsis, significant brain injury, inability to speak, and aversions to textures of certain kinds of food. The Brocks are unsure of how well he hears,

39 Brock, 163.

40 Brock, 164.

41 Brock, 165.

42 Brock, 168.

and at six months of age it was discovered that he had a pair of holes in his heart. Adam contracted leukemia at the age of eight, which resulted in over two years of chemotherapy. For years he has had problems with gastric reflux, which often keeps him up at night, and, most recently, he has contracted keratoconus, which results in loss of vision in addition to eye pain. Yet, not only despite this but exactly in light of all of this, Brock continues to claim that Adam is the healthiest person he knows.[43]

Ultimately, what is significant about Adam's health is the way he witnesses to an alternative social order, manifested in the everydayness of life, contrary to the Baconian model of health and normativity. Brock testifies that "it often interrupts me through the acts that Adam performs in which an alternative social comportment appears that is both extremely beautiful and a strikingly deep challenge to the social order of this fallen world. In this way his life *evokes* the almost unthinkable social dynamics to which Jesus pointed, and as he does so, he constantly *provokes* our world."[44]

Adam is both an exemplar and a witness, yet not of the ways we may traditionally think. He is an exemplar of life lived in an alternative order, and he witnesses to a reality that is possible beyond the snares and traps of our fallen world. This is not to claim that Adam is without sin or "wholly innocent"—a sort of divine creature who is distinct from all other human beings—but rather that perhaps the Apostle Paul was correct when he claimed that God has chosen those who the world views as foolish to shame the wise (1 Cor 1:27). It may just be that Adam (and people like him) have been chosen to witness to the alternative reality Jesus spoke about as the kingdom of heaven, drawing those around them into the heart of wonder.

To accept Brock's claim of Adam's health is to be confronted by Adam's invitation to life in the kingdom of heaven. It is to accept that Adam, alongside a host of others living with what we understand to be intellectual disabilities, may be a herald of the kingdom, calling others to faithfulness under God. The challenge presented to able-bodied individuals—and here I include myself and likely many readers—by this welcome is to evaluate our being in the world and how we conceive ourselves in light of our own sin, our capacity to wonder, and our pursuit of freedom. It is a challenge presented not in life's extravagant moments but in the everydayness of our existence—in the mundane, repetitive

43 To be clear, we must note that it is not *because* Adam is understood as disabled that he represents the healthiest person that Brian knows. Such logic could be read as reinstating a logic of subordination by simply reversing the bifurcation of disabled and non-disabled humans. Rather, Adam's disability is incidental to being understood as healthy. Nothing in the four points Brock notes above is predicated on Adam's disability, yet despite his disability, he remains the healthiest person Brock knows.

44 Brock, 165.

nature of our daily existence. The alternative social order to which Adam witnesses may not be one without sin (Adam as a human being is a sinner just like anyone else), but it is one that lives life presently, full of truthfulness, emotional sensitivity, and joy. Such a life may offer us glimpses of the kingdom of heaven in the places we least expect to find them.

It is worth noting the conditional statement in Brock's concluding chapter "Health in a Fallen World":

> *If the kingdom of heaven is anything like Jesus teaches,*
>
> *and* Adam displays in significant ways the tenor of this kingdom in his form of life,
>
> *and* it is the state of our hearts out of which the social order of our world flows,
>
> *then*, to recognize the true health of those we call disabled, we will have to have our hearts assayed to see how deeply they welcome this kingdom. To genuinely receive the presence of another person means not to pity them, be repelled or frustrated by them, but to welcome them without regret.[45]

Adam's witness is one of welcoming others into the kingdom of heaven. His is a life lived with God, the true sign of health. As Christians, we are called to join Adam and those like him in the kingdom of heaven, journeying alongside the God who liberates us from our false pretenses into a life full of wonder and freedom. For Brock, this is what it means to be healthy.

Receiving the Witness of Disability in a Medicalized World

Between the Western medical model of disability as a product of the Baconian project and Brock's conception of health exemplified by his son Adam, we find two starkly different conceptions of health. While both may have merit in certain contexts, it is clear that the medical model, as the dominant model of our day, has often resulted in the oppression and marginalization of people with disabilities. This oppression occurs not only when people with disabilities are set to receive medical care (although surely then as well)[46] but also as medicalized conceptions of disability have emerged as the dominant gaze by which ableist societies come to understand disabled persons. Thus, while recognizing the inherent

45 Brock, 167.

46 The case of Michael Hickson gained international attention when he was denied treatment for COVID-19 as a result of his disability. See Joseph Shapiro, NPR Morning Edition, Special Series: The Coronavirus Crisis, "One Man's Death Raises the Worst Fears of Many People with Disabilities," July 31, 2020, https://www.npr.org/2020/07/31/896882268/one-mans-covid-19-death-raises-the-worst-fears-of-many-people-with-disabilities.

benefits of the medical system, this final section seeks not to portray a synthesis between the Baconian model and Brock's reconception of health but to (1) note the ways in which Brock's understanding of health can witness to the Baconian system, (2) offer a call to reform the harmful ways that the medical system has treated people with disabilities, and (3) seek a better way of conceiving health in the twenty-first century that accounts for the experiences of all people.

The claim I want to advance is heavily related to the social model of disability noted above, in the sense that disability is a cultural construct and that what is most important in disability identity is not one's physical or intellectual impairments (defined in the broadest sense of the term) but rather how one's body is perceived by those embedded in particular cultural narratives (the stories we tell ourselves to make sense of the world). Recognizing the imperfections of the social model, and taking up the claim above posited by Stiker, we must recognize that there are better accounts of disability and health than the medical model, such as those posited by Brock. But how can we come to understand, like Brock, that those who carry the label "disabled" are worthy of being identified by such alternative conceptions of health?

Disability theorist Rosemarie Garland-Thomson has argued in her work on cultural narratives that shape structures story.[47] What Garland-Thomson means by this is that the shape our bodies take—in other words, our experiences as particular bodies in the world—form the narratives that our identities are bound up in. Such an argument, she posits, runs counter to the cultural impulse to standardize the body through medical technology. For Garland-Thomson, "Normal is the central concept governing the status and value of people in late modernity. It is the abstract principle toward which we are all herded by a myriad of institutional and ideological forces."[48] In this way, the predominant cultural narrative has become that the concept of normalcy structures our shapes—for instance, the way we understand our bodies. Bodies must submit to the structure imposed by normalcy—the center from which deviation departs—lest they be cast out from the prevailing cultural fantasy of bodily stability.[49]

To insist that shape structures story rather than story structuring our shapes means that particular accounts of human lives form and reform the way we come to see the world. For Garland-Thomson, the stories of disabled bodies offer an immediate counternarrative to the dominant cultural norms. They liberate us from the tyrannical imagination of the norm to a new way of perceiving the world. "Narratives do cultural work," she argues. "They frame our understandings of raw, unorganized experience, giving it coherent meaning and

47 Rosemarie Garland-Thomson, "Shape Structures Story: Fresh and Feisty Stories about Disability," *Narrative* 15, no. 1 (2007): 113.

48 Garland-Thomson, 114.

49 Such as we saw in reference to Davis's account of eugenics above.

making it accessible to us through story."[50] In insisting that shape structures story, Garland-Thomson argues that these stories always begin with particular bodies. To be faithful to narratives pertaining to disability, we then must begin our perception with bodies we have come to understand as disabled.

Similarly, Brock argues that if we want to recognize the true health of those we call disabled, we will have to have our hearts assayed in order to be able to perceive the world in the way they do. He notes elsewhere that the so-called challenge that disability presents is not so much the impairment that our normate gazes perceive but the structure of the normate gaze itself, which renders us unable to fully receive the life of the person we have come to understand as disabled. In this way, those in need of Jesus's liberation are not so much the people with disabilities but those possessed by the ableist gaze of Western society. Indeed, Brock suggests that "perhaps it is *Adam* who is the provocateur revealing the resistance of the church and world to lives like his, and drawing *us* in."[51] For Brock, the lives of his son Adam and those like him can witness to a new way of perceiving a world that looks different from the one that society trains us to see. Ultimately for Brock and Garland-Thomson, the problem lies not in disability itself but in society's inability to perceive people with disabilities for who they truly are.

For Christians, then, if we are to take the charge of Brock and Garland-Thomson seriously, we must recognize that if shape structures story, and particular bodies and particular lives confront our false perceptions of the human, we are in need of encounters with lives different from our own to shake us out of our false perceptions and into a renewed vision of life lived in the kingdom of God. And we know that there is one Living Body who continues to confront us and shake us out of our false (and even sinful) perceptions by offering us glimpses of the kingdom of heaven. If Brock is right that what makes a person healthy is communion with God and participation in the "heart of wonder," then, placing that understanding alongside Garland-Thomson's, we are charged with the claim that Christians need Christ's invading power to come in the form of his own scarred and wounded resurrection body to help us realize the fullness of the vision of the kingdom of heaven that he has to offer. It is only this wounded body that has the capacity to draw us out of our separation from God and place us in communion with the One capable of setting us free. And, as Matthew 25 tells us, sometimes Christ's appearance comes to us in the forms of bodies that we would least expect.

In saying this, we are drawn back to the account of Kathy Dickson that we began with in the introduction. As noted, Dickson deals with a wide array of themes present in both Anabaptist and disability theologies to craft an account

50 Garland-Thomson, *Shape Structures Story*, 122.

51 Brock, *Wondrously Wounded*, 240.

of how we can resist the problems of normalcy that plague the lives of people with disabilities. However, it is my contention that if Dickson had not been confronted by the witness of the life of her aunt with Down Syndrome, her essay would lose the force of its argument and Dickson herself might not have been trained to see the world as she now does. Here is how Dickson recounts the story of her aunt:

> Words spoken in the critical moments that led to my aunt's death haunt me to this day. I can still see the doctors in blue surgical coverings standing in the cove outside the ICU, facing us, her family. "Look, we have a woman with Down Syndrome here," were the first words out of the lead doctor's mouth. I heard everything else that was said, but those words punctuated every sentence for me. She was suffering; they needed to decide on a path and act quickly. Based on the doctors' picture of what was happening, we agreed that we had to say goodbye, then held her and sang to her. One solitary tear lay on her cheek as she took her last breath. I recount those moments in my head like all of us standing there that day, convinced in the moment that it was the right choice. But the framing the doctor's words gave to her death is the beginning of the haunt: "We have a woman with Down Syndrome here."

Here, we see the reality that many disabled people face—the desire of the medical gaze to pathologize people with disabilities rather than see the particularity of each person. It is my contention that what enabled Dickson to perceive the life of her aunt differently from the medical professionals was that they were looking primarily at Down Syndrome while Dickson was looking at her aunt, the person she had come to know and love. In this relationship, Dickson was trained not only to see her aunt as a person with intrinsic value but to also understand the entire medical apparatus as called to value the lives of all people, especially those with Down Syndrome. It may even be the case that it was Jesus revealing these things to Dickson through the very body of her aunt.

Dickson is thus right to suggest that Anabaptist theologies are well equipped to resist the dominant cultural gazes that lead us to pathologize disability under the medical model. And to take her claim seriously, we must be willing to grapple with Anabaptist theology in a manner that allows it to resist these dominant cultural gazes in the first place. In doing so, however, we must emphatically suggest that this resistance will only come to fruition if we let people like Dickson's aunt assay our hearts by welcoming their lives and witnesses into our own, the way they themselves demonstrate such a welcome of us. If we want to work for the liberation and justice of people with disabilities, especially as this liberation and justice pertains to the medical enterprise, we must only do so as we allow the lives of disabled people to come into our own and shape our stories. Such a welcome is not a conforming one where those welcomed in must assume a certain type of being in line with our cultural ideals. Rather, it is one in which the dominant group allows outsiders to enter and, in turn, is confronted and

shaped by those entering for the transformation of the dominant group. Personal vulnerability is essential in the task of welcoming.

An alternative vision of health is available that prioritizes welcome into the kingdom of God over conforming to a predetermined norm. However, it may just be the case that recognizing this alternate understanding of health is only possible if we allow ourselves to be confronted by the witness of people with disabilities and, in these confrontations, recognize where we have conformed our vision of health to ableist biases that reject the lives of those different from us. For, if Brock is right, then the one who is unhealthy is not the one with impairments but the one who is unable to recognize the way that God is at work around us. And it just may be the case that God is choosing to speak through the lives of people like Adam Brock and Kathy Dickson's aunt in order to drag us out of our old ways of being and conform us to a life that is more in line with Christ.

Responding as Anabaptist Communities

This essay argues for a new understanding of health that runs counter to the predominant mode of perceiving people with intellectual disabilities under the gaze of the Western medical apparatus. And if we want to modify our conceptions of health and the medical system, we cannot do so by privileging abstract accounts of theoretical possibilities; rather, we must be confronted by those whose lives are different from our own. In this case, the lives we identified as being different belong to people whom society has chosen to understand as "intellectually disabled." To conclude, I offer brief remarks about the way Anabaptist communities may respond to these confrontations and how we can work to create more faithful accounts of both health and disability.

As Karl Koop has argued, "All Christian communities hold to doctrines even if certain communities claim to be creedless or primarily praxis oriented."[52] Within Mennonite traditions, however, the abundance of confessions of faith suggests that Mennonites have at least been willing to change their views on matters of doctrine and faith throughout our history. In response to questions about the nature and place of doctrine in such an ever-evolving tradition, Koop suggests the modified statement of *lex orandi, lex vivendi*—the law of what is prayed is the law of what is lived. This, he suggests, "places what the church believes, teaches, and confesses in the context of Christian experience that is embedded in prayer, liturgy, and discipleship. . . . This ancient ordering also assumes a Christian imagination shaped by an encounter with the living God."[53]

52 Karl Koop, "Putting Doctrine in Its Place: Confessions of Faith, Modernism, and the Lex Vivendi," *Direction: A Mennonite Brethren Forum* 48, no. 2 (Fall 2019): 138.

53 Koop, 139.

In this view, doctrine is important, but it is secondary to encounters with the living God. Doctrine is shaped and understood through these encounters as we attempt to live and believe in a manner more faithful to the living and active God. These are not unhinged encounters; they are discerned in and through worshipping communities collectively striving to seek greater faithfulness and adherence to the revelation of God among us.[54]

Following Koop, I suggest that if God is indeed choosing to speak through the lives of people with disabilities we ought to be willing to change our beliefs and practices for greater adherence to the revelation of God through them. To live in this way is to continue taking belief and practice seriously while recognizing there may be places where we have erred in our doctrine and practice.[55] Humility is needed to recognize these errors and strive for a new way forward. Reconceiving our perceptions about health and disability may not require a wholesale overhaul of our confessions of faith, but we do need to be honest with ourselves about the way that our beliefs and practices may have negatively affected the lives of people with disabilities—and thus the larger community—not only in the past but also today as well.

If we take seriously Koop's charge, Mennonite communities are presented with a unique opportunity to respond to the faithful witness of people with intellectual disabilities, especially in the medical arena. It is likely the case that we have misdiagnosed the "problem" of disability and that what needs to change is neither the behavior nor abilities of people with intellectual disabilities but rather our ableist perceptions of them. We can never truly know who people with intellectual disabilities are if we keep them at a distance, refusing to be encountered by them and their witness. Our churches ought to be open to encounters with people who have intellectual disabilities, taking time to listen to them. Our health may depend on it.

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54 Such a framing is aligned with Brock's conception of health above, where he suggests that to be a creature is to concretely depend on God's enlivening Spirit.

55 For example, in a recent volume on Anabaptism and disability, both Jason Reimer Greig and Melissa Florer-Bixler raised concerns about the implications of believers baptism for people with intellectual disabilities, although each propose different accounts of how Mennonite communities can approach baptism in a theologically responsible way that takes into account the lived experiences of people with intellectual disabilities. See Jason Reimer Greig, "Re-Imagining Narratives: Anabaptist Baptismal Theology and Profound Cognitive Impairment," *Conrad Grebel Review* 38, no. 2 (Spring 2020): 120–34; Melissa Florer-Bixler, "Believers Baptism as Supported Decision," *Conrad Grebel Review* 38, no. 2 (Spring 2020): 135–46.

Book Reviews

Review Essay

John M. Janzen, Harold F. Miller, and John C. Yoder, eds., *Mennonites and Post-Colonial African Studies*, Routledge, New York, 2021. 298 pp. $160 hardcover; $44.05 e-book. ISBN: 9780367474324.

In *Mennonites and Post-Colonial African Studies*, editors John M. Janzen, Harold F. Miller, and John C. Yoder present the life stories of twenty-one mostly North American, mostly male Africanists who claim some connection to the Anabaptist-Mennonite movement. The editors frame the book as an exploration of how the scholarship and professional activities of these featured individuals interacted with, shaped, and were shaped by the vibrant and rapidly growing field of African Studies in the early post-colonial period (1960s and 1970s). In particular, the editors attempt to pinpoint how the Anabaptist background and values of these "pioneers," "professors," and "practitioners" shaped their contributions to African Studies.

Readers—who likely include non-Anabaptist Africanists as well as "insider" families and friends—are invited to appreciate the contributions of North American Mennonites to African Studies in a wide variety of areas, such as African religion, literature, music, development theory, history, anthropology, health, and theological extension education. All these contributions, the editors claim, "represent a distinctive Anabaptist perspective and approach to African studies," which is shaped by (1) contributors' "Anabaptist heritage"—notably, by the Anabaptist emphasis on "peace" as well as its "suspicion of state authority"; (2) the featured individuals' own experiences of "ethnic markers" and their sympathetic awareness of religion; and (3) the institutional support of Mennonite mission and service institutions (16).

The stories are arranged into three sections: pioneers, professors, and practitioners. The three missionary "pioneers" first interacted with Africa through Mennonite mission agencies in the 1940s and 1950s, prior to Independence and to the development of Mennonite Central Committee (MCC) programming in Africa, although their active careers continued into the 1970s and 1980s. The eleven scholars in the "professors" section and the seven "practitioners" (whose careers took a more applied direction) most strongly exemplify what contributor Curtis Keim calls "the remarkable MCC Africanist phenomenon" (76) in the immediate wake of Independence. MCC served as the channel to African studies for ten of the professors/practitioners: eight first served through MCC's Teachers Abroad Program (TAP) (Donald Holsinger, Curtis Keim,

Karen Keim, John D. Metzler, John C. Yoder, Lauren Yoder, Ronald J.R. Mathies, and P. Stanley Yoder); one served in MCC's Pax program (John M. Janzen); and one served a regular MCC service worker term (Franklin Baer). It is noteworthy, however, that just over half of the featured scholars developed an interest in African studies primarily through a non-MCC connection. Five of them (Donald Jacobs, Melvin Loewen, David Shenk, David Shank, and Fremont/Sara Regier) served primarily through a Mennonite mission agency such as Eastern Mennonite Missions (EMM), Congo Inland Mission (CIM), or Mennonite Board of Missions (MBM). One (Merrill Ewert) did Christian Service—a two-year Mennonite Brethren (MB) service opportunity similar to TAP/Pax. Five more developed a focus on African studies through familial or marital connections with Mennonite mission agencies (Saïd Sheikh Samatar, David Denlinger), African Mennonite churches (Musuto Chirangi), or North American Mennonite colleges (Mary Oyer, E. Wayne Nafziger).

In the introduction, the editors situate the contributors within the "formative early decades" of the emerging field of African studies, at a time when this field of study was in full flower but prior to its more recent focus on "intellectual decolonization." They also offer a historical overview that positions the contributors with respect to the Anabaptist-Mennonite movement and to MCC in particular. This historical sketch focuses on the voluntarism of the sixteenth-century European Anabaptists, the resulting persecutions and migrations, and the twentieth-century attempts to preserve Anabaptist "distinctiveness" through the reiteration of believers church principles in a new context. MCC is presented as the "most important institutional expression" of this twentieth-century reinterpretation of Anabaptism (8). Indeed, the editors devote six of the eight pages of their "brief Anabaptist-Mennonite history" to this organization, covering its inspiring beginnings in Russia, its large-scale feeding and refugee resettlement programs before and after World War II, and the development of programs for conscientious objectors—such as Pax and TAP—that led to significant encounters with the people and challenges of the Global South (10).

Oddly, the narrative gives only cursory attention to the missionary movement that began to put North American Mennonites in touch with Global South brothers and sisters in the first place, several decades before the creation of MCC, despite the clearly central role that this movement has played both in the lives of most of the contributors and in the foundation of MCC itself, especially in Africa.[1] The editors narrate a shift within MCC from relief efforts

1 MCC's work in Africa is a direct outgrowth of early North American Mennonite missionary efforts on this continent. MCC's first interventions in Africa were all "developed and discussed" with Mennonite mission boards, if not directly initiated by them. See Tim Lind, "MCC Africa Program: Historical Background," MCC Occasional Papers, no. 10 (Mennonite Central Committee, August 1989): 5–7, 13–15.

aimed at "blood relatives" to a primary focus on Global South contexts and on those "outside the Mennonite ethnic family" (11). However, although African members outnumber North Americans within the global Mennonite church today, the editors do not make this reality central to the "narrative arc" of their story; "Mennonites" are still implicitly assumed to be North Americans.[2]

Three closing chapters and a foreword by Aliko Songolo offer responses by voices "from outside" (255). These are perspectives from scholars, Mennonite or not, who are "close to the main story" but not part of it (17). These respondents tend to give the lie to the editors' assertion that the contributions of the Anabaptist Africanists highlighted in this book can be explained by the "defining role" played by their "Anabaptist heritage" (16). Stephen Feierman, for example, kindly points out that Mennonite scholars, as "good and moral" as their scholarship may be, have no monopoly on virtue, and he invites them to become more aware of their own temptations to nationalism (258–60). Paul Gifford sees no particular common thread among the contributors and concludes that being Anabaptist-Mennonite does not give them a "unique perspective" (261). Emily Welty laments the shocking lack of preparation of these well-intentioned volunteers, who often saw service in Africa as an "adventure" and an escape from closed Mennonite communities in America, and decries the fact that "vulnerable people" in Africa suffered from the ignorance of the volunteers, who later, bolstered by male and white privilege, went on to develop careers that drew on this knowledge about Africa (270).

Despite the rather self-congratulatory editorial framing and the puzzled responses by "outside" voices to this activity of chronicling and celebrating "Mennonite" contributions to Africa, I found the twenty-one stories themselves to be vibrant and inspiring accounts of transformation. They illuminate the phenomenon of young (mostly) North American (mostly) Mennonite (mostly) men having their lives changed through an encounter with Africa through the channel of MCC or other Mennonite service agencies in the 1950s, 1960s, and 1970s. They very clearly show the recurring factors that led these individuals to Africa, highlight how Africa changed them, and point out that their subsequent academic and professional contributions tended to focus on helping others better understand, appreciate, and develop kinship with Africans. The following examples of a "pioneer," four "professors," and a "practitioner" illustrate this transformation that was evident in all the stories and which differed in significant ways from the narrative proposed by the volume editors.

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2 John D. Roth, "What Hath Zurich to do with Addis Ababa? Ecclesial Identity in the Global Anabaptist Church," *The Conrad Grebel Review* 31, no. 1 (Winter 2013): 24–43, 32–33. Of the 2.13 million baptized Mennonites around the world, North American Mennonites make up 30 percent and Africans 36 percent. See Mennonite World Conference, "World Directory," 2015, https://www.mwc-cmm.org/article/world-directory.

Donald Jacobs (1928–2020) was of Lutheran background, and while he and his family joined a Lancaster Mennonite congregation during his adolescence, they did not embrace "conventional conservative" Mennonite culture (21). For example, during World War II, some of his six older brothers were conscientious objectors while others joined the army or the marines—all with their parents' support (21). As a young man working alongside Mennonite missionaries in Appalachia, Jacobs learned that a Germanic Mennonite "subculture" was an "obstacle" for missionary outreach (22)—a conviction that was later strengthened when he observed Lancaster Mennonite attempts at church planting in New York (25). While serving with his wife, Ruth, in Tanzania with Eastern Mennonite Missions in the 1950s, Jacobs' life was transformed by the East African Revival. Although his initial admiration of the revival was tempered with skepticism, his resistance "collapsed" as he experienced the "kindness, love, and encouragement" of an African fellow teacher (23). He became a full participant in the practices of confession, worship, and fellowship that characterized this remarkable transnational and transcultural religious phenomenon.

In Jacobs' subsequent doctoral studies, then throughout his years as a teacher in a Tanzanian Mennonite theological college, and as a mission administrator, he wrestled with the question of how newer churches would express their Mennonite or Anabaptist identity without copying Germanic Anabaptist cultural "trappings" (28). At the same time, he shared the message of revival with fellow Americans by leading a revival fellowship in New York (44). According to Jacobs' younger EMM colleague, David Shenk (also featured in this volume), the revival message that American missionaries such as Jacobs brought back to the Lancaster Mennonites helped to profoundly revive and renew the Lancaster Mennonite Conference; it injected "a vibrant and personal spiritual life into an ethnic Mennonite community which regarded obedience to powerful bishops and adherence to outward cultural markers such as traditional attire as far more important than an inner experience of faith" (49).

Jacobs' story includes little or no detail about how he may have influenced African Studies as a field of study, but it clearly shows how his spirituality and later career path were profoundly influenced by his interaction with and participation in the church in East Africa. Much of Jacobs' contribution to mission theology took the form of promoting the need for African churches to "formulate and answer their own questions" within their own cultural framework while working out what it meant to be part of a global "Mennonite" body. The impetus for this lifelong focus mostly came not from American Mennonite culture but in spite of it.

John M. Janzen (1937–) is an example of the Pax/TAP phenomenon. His story showcases the remarkable confluence of factors that contributed to enlarging the worldviews of privileged young North American Mennonite men during the early post-colonial period. Janzen notes that his General-Conference-ori-

ented, liberal Mennonite upbringing was shaped by the influence of teachers and pastors with MCC service experience and/or University of Chicago PhDs, offering role models that combined overseas service with academic careers (68). At the same time, his experiences of living, working, and developing friendships with African men during his Pax term were transformative, leading to tension with established missionary modes of interaction and to a deeper understanding of the political and cultural context of Congo and of the "reality of decolonization" (66–67).

Pax participants, as young single men, had the freedom to sit around fires and chat, the time to learn local languages, and the space to try local foods that the "more senior missionaries" did not always have. For Janzen, this contributed to friendships that led to a deep appreciation for the richness of Chokwe culture and music (66). In his graduate studies and subsequent academic career, he drew on all these formative experiences. His academic work and service focused on prophet movements such as that of Simon Kimbangu, Central African concepts of health and healing, and responses to collective trauma in Africa's Great Lakes region.

As Janzen reviews his life and career, he sees his trajectory as having been shaped in multiple ways by an "Anabaptist-Mennonite perspective," which, in his view, includes the values of empathy instilled during Pax service; an inclination toward the historical method; a focus on peacemaking; and a penchant for the study of "religious continuity, renewal, and change" (75). As is the case for most of the individuals featured in this volume, Janzen's chapter includes a degree of reflection about his own privilege and power—in his case, a developing awareness of his own power to represent or obscure the voices of others (74). However, it is the combined force of a dozen similar Pax/TAP stories that most strongly impresses upon the reader the extent of the privilege that allowed people like John—and not the "gifted Congolese individuals" who shaped his worldview—to pursue graduate studies and an academic career (66). And it is perplexing to see no analysis of this reality in the editors' introduction, which frames these stories primarily as distinctively Anabaptist contributions to African Studies.

Mary Oyer, Curtis Keim, and Karen Keim

Other professors' chapters illustrate some additional themes of the Pax/TAP phenomenon. First, while many of the professors point out the influence of Mennonite values, upbringing, or institutions in shaping their trajectory, most emphasize that it was the encounter with Africa that transformed them, helping to overcome the inertia, resistance, and conservatism (or liberalism!) of their narrow North American Mennonite worldviews. For example, for Goshen College professor and "dean" of Mennonite hymnody Mary Oyer—who was steeped in "highly Eurocentric" artistic paradigms—it was a US State-Depart-

ment-funded research trip to East Africa in 1969 that "transformed [her] into [a] cross-cultural broker with unremitting commitment to communicate with others the immense gift that Africa had brought" to her life (128) and to introduce African music into the "Mennonite canon" (132).

Second, almost all the professors refer to the generational tension between older Mennonite missionaries and younger MCC workers—a historical episode that is just beginning to receive scholarly attention.[3]

Third, the gendered nature of the phenomenon is illustrated by the stories of spouses Curtis Keim and Karen Keim (both contribute a chapter). It was Curtis's need to find an avenue for alternative service that brought the couple to Africa (88). Curtis did his PhD first, followed by Karen, who was "interrupted" by a child along the way (84). How many other Pax/TAP couples have a similar story? There were plenty of women TAP teachers. Did they not get invited to contribute? Were they less likely in the 1970s to follow up a TAP term with a PhD? As Welty aptly notes, the editors pay distressingly little attention to these questions (268). I share her disappointment about the strong skewing of the volume toward white men's stories.

For **Merrill Ewert**, listed as a "practitioner"—although he also had academic experience at Cornell University and Fresno Pacific University—personal and professional transformation was catalyzed by a confrontation with young high school students at the MB mission station of Kajiji in southern Congo. Ewert was reluctantly teaching math and religion in a local school at the request of church and mission leaders, even though his math skills were poor, his French nonexistent, and his Kituba based on only four weeks of study. In desperation, unable to tell students the right answers to math problems, and in the face of their criticism of his religion class, he resorted to teaching both classes primarily through questions, shifting from lectures to discussions in which students determined the answers themselves, sometimes through a vote (208–9).

Welty is right to point out how problematic it can be to celebrate such "missteps" that support the career development of an unprepared volunteer, while reducing "vulnerable people . . . to collateral damage of the Western volunteer's learning" (270). Nevertheless, Ewert's story provides a good example of how, at that historical juncture, a cadre of young and inexperienced, well-intentioned and unprepared North Americans teachers were transformed through an en-

3 Alain Epp Weaver, "'A Habit of Social Concern': Anxieties about the Relationship between Mennonite Central Committee's Relief and Service Programs and Mennonite Missions from the 1950s to the 1970s," *Journal of Mennonite Studies* 40 (2022, forthcoming); Jeremy Rich, "The Mennonite Central Committee in the Democratic Republic of the Congo, 1960–1985" (Global Anabaptist-Mennonite Young Scholars Symposium, sponsored by the Institute for the Study of Global Anabaptism, Goshen [Ind.] College, June 30, 2017).

counter with African students, church leaders, and colleagues, even when that transformation was not as mutual as it should have been.

Certainly "Anabaptist" factors played some role: Ewert was encouraged to consider international service by a Tabor College professor, and his extended family's "Anabaptist" values and MCC service experience instilled in him a "progressive" attitude toward development work that contrasted with the more "evangelical" approaches of his Mennonite Brethren context (204–6). However, although these experiences and orientations provided a doorway to service in Africa, it was a moment on the Kajiji basketball court, cringeworthy as it may have been, that transformed him and "redirected [his] life and career" (215).

As a collection of stories illustrating the TAP-Africanist pipeline, this book is fascinating. The various accounts describe a juxtaposition of factors pulling these young people to Africa that was nothing short of paradoxical. MCC alternative service options were born out of pacifist convictions, but these sat alongside the growing political sensibilities of a new generation of anti-colonial and civil-rights-minded young American Mennonites whose exposure to post-colonial theory led them to rebel against an earlier generation of missionary paternalism even as they had to learn, in Africa, to "act like elites" themselves (82).

Some drew deep motivation from the teaching of Goshen, Bethel, Messiah, and Tabor College professors, whether because of their Anabaptist peace theology (103), their expertise as historians (75), or their own experiences of overseas service (146, 205). For others, US federal funding for African Studies, at a high point in the 1960s and 1970s, played a non-negligible role in helping them translate their TAP experiences into a career as Africanists (79–80). Personal career considerations played a role alongside a genuine service mindset nurtured by the example of previous generations of Mennonite missionaries who the TAP/Pax workers now regarded as hopelessly colonialist (148, 235). English-speaking American Mennonites were attracted by the excitement of a year in Europe *en route* to Africa: French language training paid for by MCC was "appealing" (55) and even led some, such as David Shank, to doctoral studies in Europe (133). For Karen Keim, learning French in Belgium and Congo opened the door to a career in African literature. For John C. Yoder and his wife, Janet, the prospect of an all-expenses paid year in Europe was more of a draw than Africa itself; it served as a combination of "prolonged honeymoon" and *rumspringa* as young North American Mennonites could be freed from some of the constraints of the conservative Mennonite communities they had left (147). In the experience of Curtis Keim, TAP cohorts in Europe skipped out on church and enjoyed sampling alcohol despite having signed a no-drinking pledge with MCC (79).

In short, many North American Mennonites were drawn into African Studies because of some rather American, and not particularly "Anabaptist," factors. These are stories about how a non-nationalist pipeline to service (one

that nevertheless flirted with nationalism, hence the aptness of Feierman's warning) converged with a variety of contextual factors to produce some mostly male Africanist scholars who subsequently become ambassadors for a broader worldview among North American Mennonites. Being "Mennonite" was part of what drove this phenomenon; yet many of the participants reacted against Mennonitism, or saw their Pax/TAP terms as an escape from a narrow, ethnically defined identity.

As chronicles of the complex and fraught process of developing a more catholic and ecumenical self-conception, these are important stories, worth recording and even celebrating. But I would have loved to see the self-congratulations set aside long enough that readers could (1) more easily see and rejoice in how these young men and women were transformed by the global church; (2) critically reflect (as the "outsiders" in this book straightforwardly do) about the paradoxes of the nationalist structures that helped to push some Mennonites beyond themselves while simultaneously reifying ethnocentrism; (3) accurately recognize the role of Mennonite mission agencies in laying the groundwork for many of these transformations; and (4) begin to ask why such transformation has not been more long-lasting or profound.

Anicka Fast holds a PhD from Boston University (2020). She has been seconded by Mennonite Central Committee to serve with Mennonite Mission Network as a Specialist in church history and missiology for Francophone Africa. Anicka teaches courses focused on the history of the church and its mission in various Francophone theological institutions in West and Central Africa. She lives in Ouagadougou, Burkina Faso, with her husband and two daughters.

Felipe Hinojosa, *Apostles of Change: Latino Radical Politics, Church Occupations, and the Fight to Save the Barrio,* University of Texas Press, Austin, 2021. xiv + 219 pp. $45.00 (cloth). ISBN: 978-1-4773-2198-0.

Felipe Hinojosa follows his award-winning book *Latino Mennonites* with another accomplished search into the intersection between religion and ethnicity. In *Apostles of Change*, he invites us to look to the past so that we may dream for the future. Describing the story of four significant Latino radical movements that occurred in 1969—one year after the assassination of Reverend Dr. Martin Luther King, Jr.—Hinojosa seamlessly weaves in historical detail with captivating narrative. The book reads as an invitation to enter the year 1969 and acknowledge the Latina/o radicals who made significant contributions to the work of barrio (neighborhood) advocacy. *Apostles of Change* both inspires me and challenges the way I live into my faith and advocacy as a Latina religious studies scholar, minister, Anabaptist, and immigration advocate.

Hinojosa begins by making the case for writing about religion within the Latina/o freedom movement. Previous scholarship has largely ignored (or not had the opportunity to write about) the religious traditions of Latino/a political actors. Beyond the often referenced and nonetheless significant Liberation movement or the study of Pentecostal appeal among Latina/os, Hinojosa writes about the intricacies of negotiating Latina/o barrio concerns with religious institutions and peoples, conscientiously describing the complexity and challenges between Latina/o radicals and religious leadership. The relationships were tenuous, he notes, but they were significant for providing resources to "the people" whose geographies these churches occupied. "At least for a moment," he observes, "a robust relationship existed between young radicals and religious leaders." (5). For example, chapter one tells of the occupation by the Young Lords Organization (YLO) of McCormick Theological Seminary to protect the Lincoln Park neighborhood from being displaced by a construction company while the Presbyterian Latin American Caucus (PLAC) refused to support their cause. Both the Latina/o radicals and the religious leadership had desired and needed partnership and resources, but their voices had been largely unacknowledged before the occupation. Afterward, however, their impact was incredible.

Apostles of Change outlines three themes I highly resonate with and am challenged by: (1) collaboration, (2) the insider/outsider paradigm, and (3) sacred space:

Collaboration. In current discussions on equity and inclusion, much work is being done to continue contesting the Black/White binary of anti-racism work. Even so, institutions still bias or attend to certain voices over others. Hinojosa, on the other hand, envisions collaboration, disrupts the notion of the binary as being historic, and invites partnership across racial and ethnic lines for the barrio, our neighborhoods. In various instances, he mentions that Latina/o radicals were supported by seminary students, Black activists, neighborhood leaders, mothers, and the Poor People's coalition, to name a few. Reading *Apostles of Change* has provided me with encouraging examples showing that Black and "Brown" partnership has occurred in the past and will continue into the future.

Insider/Outsider Paradigm. The theme of insider/outsider arises in particular within a religious institutional view of activists. In other words, the insiders are the ordained clergy of the occupied spaces, and the outsiders are the Latina/o activists, regardless of their faith background. The insider/outsider paradigm does not discount the Latina/o activists' faith or lack thereof but rather acknowledges the way that church leaders prevented organizing efforts. The dichotomy that Hinojosa raises is provocative. Religious leaders, myself included, are encouraged to consider how our platforms and resources are advancing or *thwarting* voices from marginalized neighborhoods and their advocates. Hi-

nojosa's examples point to pastors who were struggling for their own visibility within their denominations. Do we likewise thwart voices through the excuse that we are fighting our own struggles, or do we share these struggles with the emerging activists and seek partnership not just across religious inclinations but also across age, socioeconomic status, and geographies? These are the questions I continuously ask myself, and this book assures me they are questions to keep asking.

Sacred Space. One of the most potent illustrations of sacred space from *Apostles of Change* is the occupation of St. Basil church in Los Angeles, California, by the Católicos Por La Raza (CPLR: Catholics for the People), who were challenging the sacredness of a three-million-dollar building sitting geographically close to impoverished Mexican American and other communities of color. The juxtaposition between the (assumed) sacred church and the (assumed) non-sacred group of young Latina/o radicals makes for an intense story. In this and another of Hinojosa's chapters, blood was shed over a people whom a religious authority had deemed as not sacred, raising the question: where is the sacred in physical violence against one's neighbor? Or racial violence? By examining these spaces under the sacred paradigm, Hinojosa insinuates the profane and complicates traditionally held sacred spaces that became locations of struggle for survival for Latina/o communities.

As I read through the Católicos activism I was reminded of Friendship West Baptist Church's advocacy for the removal of a mountain of shingles in Dallas's southern sector. Dumped on a predominantly African American neighborhood, the illegal mountain of shingles was slowly destroying the vegetation and land as toxic chemicals seeped out of the materials and infiltrated the soil. Churches are sacred not only within their walls but also outside of them (good news for all during the pandemic restrictions). There is a sacredness, an act of worship to God, when church members embody the love and justice and mercy of God's love.

The most significant part of the book is its contribution to the emerging field of Latina/o religious history through story. Much more of such storytelling is needed to help guide the future. At present, over-resourced churches attempt to collaborate with their under-resourced Latina/o church plants, but the partnerships are usually not equitable, or the advocates are discounted for various reasons (not faithful enough, not mature enough, not able to comprehend enough, etc.). Hinojosa opens the door for such stories of present-day Latina/o church struggles to be told and documented. Personally, Hinojosa challenges me to listen to the stories and partner with emerging local activists from my neighborhoods over their legitimate concerns for the barrio.

Apostles of Change is not just really good storytelling of inspired Latina/o activists from history but also a "dreaming and imagining something new and then working to make it happen" (148). It is a reminder that Latina/o activists are not a new phenomenon; we have been around, we will continue to be around, and we invite you to the table to collaborate.

Noemi Vega Quiñones lives in Dallas, TX, virtually attends Friendship West Baptist Church while pursuing her PhD in Religious Ethics at Southern Methodist University (Dallas), and serves as Associate Minister for InterVarsity's Latino/a Fellowship (LaFe).

Richard Lougheed, *Menno's Descendants in Quebec: The Mission Activity of Four Anabaptist Groups 1956–2021*, Pandora, Kitchener, Ontario, 2021. 255 pp. $28.00. ISBN: 978-1-926599-72-4.

Richard Lougheed, *Menno au Québec: Une histoire de la mission francophone de quatre groupes anaba1ptistes 1956–2021*, Société d'histoire du protestantisme franco-québécois, Montreal, Quebec, 2022. 253 pp. ISBN: 978-2-9819967-0-1.

Menno's Descendants in Quebec provides Anglophone readers in Canada and the United States with a solid outline of the complex history of Mennonite mission within the largest French enclave in North America. The simultaneous release of *Menno au Québec* presents this same story in the language of the mission enterprise itself.[4] Readers learn of the challenges, and the successes, of four Anabaptist groups: (1) the Mennonite Mission Board of Ontario, now Mennonite Church Canada (Église Mennonite du Canada), (2) the Canadian Conference of Mennonite Brethren Churches (Frères Mennonites), (3) the Church of God in Christ (Mennonite) (Holdeman) (Église de Dieu en Christ), and (4) the Brethren in Christ (In Canada, Be in Christ) (Frères en Christ), all of whom have established their presence in Quebec within the past sixty-five years.

Lougheed's personal faith history—that includes training at Anabaptist Mennonite Biblical Seminary (Elkhart, Indiana) and an academic background specializing in the history of French Protestants in Quebec—has prepared him to teach and to write, in both French and English. He comes with a lifetime of expressing his heart for mission in service to the church in Quebec in a variety of ways. These diverse experiences have provided a rich context for writing a comprehensive history of Anabaptist mission in Quebec.[5]

4 The publishers of both versions request that it be ordered from Amazon.

5 In a recent interview with the author, I explored with him some of his background and motivation for writing his book. See Lucille Marr, "Menno's descendants in Que-

With his expertise, Lougheed has situated this story skillfully in a broad framework that places the Anabaptist past within the history of evangelical mission in Quebec. Equally significant were the increased awareness of societal inequities created by the church's power and the English business monopoly over ordinary citizens. This understanding began a movement that came to replace theology with the social sciences. The so-called Quiet Revolution (La Révolution Tranquille) of the 1960s thus forever changed the religious, political, and social structures that had been in place in Quebec for two hundred years. This context Lougheed articulates well, with particular attention to how it affected Anabaptist mission, given that all four denominations had established their particular approach during these tumultuous times. Finally, Lougheed's discussion of parallel developments in France—the nation whose experience of the shift from the dominance of the Roman Catholic Church to becoming a secular society most closely parallels that of Quebec—provides a valuable point of reference.

Living and ministering in Quebec is complicated, and I have been wrestling with the rapid changes in Quebec from my vantage point of working largely on the English side of the "two solitudes" for the past twenty-one years.[6] I chose to read the French version of the book *Menno au Québec* in the hope that this immersion in Francophone Anabaptist mission would shed light on a world that my Anglo background makes it difficult to fully understand. As I read the stories of the first Mennonite missionaries immersing themselves in French, I am encouraged in my own ongoing, slow accessing of enough of the language to communicate.

Language is essential for mission activity, not just to communicate but also to begin to enter into the culture of the other. Lougheed's discussion of how Mennonite Brethren (MB) mission—with its evangelistic methods—benefited from the *Réveil* (the revival that merged in 1970 and lasted for the next dozen years) gives readers some insight into the rapid change occurring in the province. Our understandings of this era, where massive conversions led to dramatic

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bec: The Mission Activity of Four Anabaptist Groups, 1956-2021; A Conversation with Author Richard Lougheed," April 6, 2022, https://anabaptisthistorians.org/2022/04/06/mennos-descendants-in-quebec-the-mission-activity-of-four-anabaptist-groups-1956-2021-a-conversation-with-author-richard-lougheed/.

6 The phrase "two solitudes" has come to be used to describe the lack of communication between French and English Canadians.

growth in evangelical circles, benefits from Lougheed's years of study, much of it published elsewhere. He also addresses the ensuing stagnation and decline in the context of cultural changes.[7]

Lougheed identifies conflicts and struggles of Quebecois Mennonites as they attempted to adapt to a new faith, one that was wrapped up in a culture vastly different from their own. He credits, for example, the late Eric Wingender, an MB pastor and director of the MB theological school École de théologie évangélique du Québec (ETEQ), with "a prophetic understanding of the stagnation of French mission." Wingender spoke and wrote with passion, raising provocative questions about the Anabaptist practice of separation and the evangelical pietism of the mission workers. As Lougheed put it, "Eric Wingender croyait qu'un manque de contextualisation du message et de la pratique adaptés au Québec avait permis au piétisme européen du 19e siècle et à l›évangélism américain du 20e siècle de se conjuguer pour mener les Églises du Québec dans un cul-de-sac" (*Menno au Québec*, 136). To put it in English, Wingender critiqued the early mission movement for producing "Christian enclaves, separated from the context of the world, where converts could not mention lapses or doubts and lived a pessimistic pietism disconnected from those outside" (*Menno's Descendants*, 136).

Although Lougheed claims no direct answers to questions raised by Wingender and others, his thoughtful outline and comparative discussion (culminating in a helpful "Assessment" [*Menno's Descendants*, 199–209]), provides a basis for theological discussion and a launching place for the kind of conversation necessary if Anabaptist mission is to continue providing a voice in both the French and the English mission in Quebec.

Many Mennonites in English North America will relate to Lougheed's helpful discussion of "Offshoots of French mission" and "Anabaptists Outside the Church Walls" (*Menno's Descendants*, 155–98). In these last two chapters, he includes Mennonite Central Committee, the English churches, La Maison de l'amitié (House of Friendship), immigrant congregations, and multi-ethnic congregations and periodicals, rounding out the narrative to give a full picture of Anabaptist work and presence in Quebec.

I commend my friend and colleague for this careful and thorough study of Anabaptist mission and presence in Quebec. I have been privileged to have the opportunity to discuss his ideas with him and our colleague Zacharie Leclair in meetings of *La Société d'histoire mennonite du Québec*. Our discussions, and now reading the French version of the book, have grounded me more deeply in the broad scope of Anabaptist mission and presence here in the province.

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7 See, for instance, Richard Lougheed, "Clashes in World View: French Protestants and Catholics in the 19th Century," *French-Speaking Protestants in Canada: Historical Essays*, ed. Jason Zuidema (Leiden and Boston: Brill, 2011), 99–118.

Finally, I was pleased to see that Lougheed included a postscript identifying the significant role that women have played in this mission. My hope is that even as we embrace the "two solitudes" characteristic of mission in Quebec, our understandings will also grow to more fully integrate gender in our conceptualizing of the history of our Anabaptist forebears in this context.

Lucille Marr is a historian and an ordained Mennonite minister. She serves currently as Chaplain and Academic Dean at The Presbyterian College, Montreal, and is Adjunct Professor at McGill University's School of Religious Studies.

Ryan S. Schellenberg, *Abject Joy: Paul, Prison, and the Art of Making Do*, Oxford University Press, New York, 2021. 248 pp. $61.76. ISBN-10: 0190065516.

> *I thank my God for every remembrance of you, always in every one of my prayers for all of you, praying with joy for your partnership in the gospel from the first day until now.* (Phil 1:3–5, NRSVue)
>
> *But even if I am being poured out as a libation over the sacrifice and the service of your faith, I rejoice, and I rejoice together with all of you; in the same way also you should rejoice and rejoice together with me.* (Phil 2:17–18, NRSVue)
>
> *Therefore, my brothers and sisters, whom I love and long for, my joy and crown, stand firm in the Lord in this way, my beloved.* (Phil 4:1, NRSVue)

Traditional Western views of Paul often conceive of the apostle as a stoic figure, detached from his physical status and the ebb and flow of feelings, thanks to a strong sense of religious virtue. Yet, an attentive read of the above verses cannot be so neatly squared with this portrait of bodily and emotional indifference.

In an intriguing new analysis of the letter to the Philippians, Ryan S. Schellenberg argues for a view of Paul *as prisoner*—one whose bodily, emotional, and social self-conceptualization influenced the words put to the page. Schellenberg takes as his starting points two important interpretive factors: (1) that Philippians ought to be studied without reliance upon the heroic narrative Paul of Acts (4–13), and (2) that the apostle's historical imprisonments were the result of coercive force by local magistrates in response to public disturbances attached to his preaching (47–51). Such factors, per Schellenberg, guard against hagiographic readings of Paul's letters and create space for his self-conceptualization to emerge from behind the text.

Schellenberg invites his readers to view the imprisoned Paul from the perspective of the poor, for whom imprisonment was yet another source of bodily degradation imposed by a system built upon the idea of embodied dominance (58). Such an approach contrasts with a tendency in scholarship to primarily reference comments from the social elites of Paul's day. An analysis of Philippi-

ans from the vantage point of the non-elite is accomplished through the use of a variety of ancient and modern sources. From antiquity Schellenberg references letters of petition to regional magistrates, non-elite prisoner stock characters, and interpersonal correspondence. Weighed against such materials, Paul is seen as engaging in a process of self-identification as a divine messenger whose imprisonment played out on the cosmic stage (chapter 3). Such a battle found its locus in Paul's very embodiment, with social abjection reflected in his wounds and his hope placed in the expectation of a bodily transformation accompanying Christ's upending of earthly power dynamics at his return (87).

Also important for Schellenberg's arguments are modern prison diaries, which witness (from a historical distance) to affective components of prison life. Such materials illustrate two aspects of the letter's emotional functions: First, how Paul evidenced a "performative indifference" toward suffering and bodily degradation through rejecting traditional honor-shame categories (chapter 4). Second, that Paul, like many prisoners today, appears to have placed his hope and joy (at least in part) in moments of physical reunification with his beloved community outside of the prison's walls (chapter 5). His longing for physical proximity, whether with Christ following death or with the Philippian believers, is evident from the letter's opening chapter and remains an important concept throughout. And, although an imperfect substitute for physical presence, the sharing of letters served as an exercise in nurturing social and emotional bonds, further reinforced by visitations from the letter carriers to whom Paul alludes in the letter's second and fourth chapters. In other words, Philippians may have acted as "a sort of affective technology, wielded at once on the writer himself and on his addressees" (177).

Schellenberg's approach to the letter critiques traditional Western approaches to Philippians that downplay Paul's physicality, emotion, and self-interest in pursuit of a modern altruistic portrait. The Paul of Philippians, per Schellenberg, was not a disinterested philosopher waxing poetic about his stoic demeanor, but a fully embodied, emotive person whose hopes, fears, and joy bubbled over onto the page. This book invites us to see Paul afresh as one who suffered imprisonment not as a matter of indignity nor because of state hatred toward the church but as part of a larger cultural pattern of establishing control through the denigration of the poor (58). We are also invited to see how his ecstatic experiences of the risen Jesus, theologically influenced reflections on his present status, and emotional bonds with others enabled him to "make do" in an abject position.

In addition, this book challenges readers to reassess pious framings of earthly suffering and imprisonment. Whether in reference to the historical Paul, the modern martyr, or the imprisoned neighbor, Schellenberg helps readers reconceptualize their understanding of imprisonment. Such abjection is to be neither treated with revulsion nor romanticized but recognized as interplay between

body, emotion, and community on the parts of those in prison and those impacted by imprisonment.

This framework ought to assist Christian communities in interrogating our own views of the imprisoned. We must question whether culturally received ideas of bodily (in)violability cause us to withdraw in horror or shame from those imprisoned by our society. In addition, we must consider how both the "free" and the imprisoned in our communities can strengthen relational bonds to make "abject joy" attainable."

Matthew R. Peterson is a PhD candidate and Adjunct Instructor of Greek at Asbury Theological Seminary (Wilmore, KY, USA), a member of Plowshares Brethren in Christ (BIC) church, and a credentialed minister in the BIC U.S.

Ted Grimsrud, *To Follow the Lamb: A Peaceable Reading of the Book of Revelation*, Cascade, Eugene, Oregon, 2022. x, 278 pp. Paperback ISBN: 978-1-6667-3224-5 ($34); hardcover ISBN: 978-1-6667-2569-8 ($49); ebook ISBN: 978-1-6667-2570-4 ($34).

Ted Grimsrud's work on Revelation several decades ago changed my life. I edited his 1987 *Triumph of the Lamb: A Self-Study Guide to the Book of Revelation* for Herald Press. I had taken an undergraduate course on Revelation with Howard Charles at Goshen (Ind.) College, but Grimsrud's book alerted me that Revelation has a relevant ethical message tied to Revelation's Lamb Christology. I found it inspiring and exciting—a breath of fresh air and a hopeful new approach to the book.

A year later, I led a six-week study of Revelation using Grimsrud's book in a small group at my church. My interest in Revelation, sparked by Grimsrud, eventuated in my dissertation on the Lamb Christology of the Apocalypse of John at Princeton Theological Seminary and a career of teaching and writing on Revelation.

It was therefore with great anticipation that I read Grimsrud's newest book, *To Follow the Lamb*. As a theological ethicist, Grimsrud wrote a theological commentary, not an exegetical one. The subtitle is "A Peaceable Reading of the Book of Revelation." This book is unapologetically an attempt to read Revelation in support of peacemaking in the world today. Grimsrud locates himself in "the peaceable Revelation stream of interpretation" (4), which includes G. B. Caird, J. P. M. Sweet, Richard Bauckham, Vernard Eller, and others. He writes to make the peace theme "more central and obvious" (5).

In the introduction, Grimsrud defends the importance and value of Revelation for the world today. In discussing how to read Revelation, he knows he is interpreting "against the grain" of Revelation scholarship, and he is okay

with that. He works through Revelation section by section, elucidating how it consistently supports a peaceable theology.

Central to Grimsrud's argument is his conviction that there is little prediction in the book of Revelation. Even the beautiful New Jerusalem in Revelation 21–22 is not primarily a prediction about what *will happen*—a happy ending—but an invitation to see human history in a different way (249).

There are few true "futurists" among academic interpreters of Revelation today, in marked contrast to the many conservative evangelical interpreters. Nevertheless, most Revelation scholars see the central "disasters" in the book (seals, trumpets, plagues) as a prediction about how God will judge the guilty, the violent. These series form the center of Revelation 6–19. Amid these judgment scenes, which futurists see as chronological and nonfuturists see as parallel, scenes of worship and other mini narratives occasionally interrupt the flow of God's judgment.

Not so fast, says Grimsrud! The *worship scenes,* not the scenes of disaster, are the stepping stones that advance the plot. In Revelation, the author shows again and again *how* the Lamb conquers and *how* refusal to follow the Lamb results in suffering and disaster.

These are *in a way* scenes of judgment, expressions of God's wrath, but not in a direct way. Judgment is the result of sin and violence collapsing in on itself, of not following the Lamb. God's "wrath" is essentially impersonal. (Grimsrud could have cited 1 Macc 1:64.) God does not express wrath directly in a retributive justice-like punishment. "'Wrath' in Revelation generally has the sense of the processes of life" (159). "If God actually does think punishment will bring repentance and change, God is not very smart" (118). Although no rebellion of Satan or the powers can ultimately escape being at some level part of God's sovereign will, the Lamb's breaking of the seals is not primarily a revelation of God's *will*; it is a revelation of what is really going on in the world when people do not follow the way of the Lamb. The hermeneutical problem is that even readers of Revelation who are committed to peace theology often remain convinced that God's justice demands that evildoers will ultimately be killed or relegated to everlasting suffering, and that Revelation seeks to narrate that judgment in some imprecise or impressionistic way.

Grimsrud understands the shocking introduction of Jesus as a standing, slaughtered Lamb in Revelation 5 to be the key to understanding the rest of Revelation. I am convinced he is right about that. The power of the Lamb consists of his faithful witness to God and to the way of love. John uses the word "blood" *exclusively* with relation to followers of the Lamb. *At no point in Revelation* (not even in Rev 14 or Rev 19) does the word "blood" apply to the blood of those opposed to the Lamb.

Given the crucial centrality of Revelation 5, nothing that follows should be understood as contradicting that key revelation. "Only the evil powers are ex-

plicitly thrown into that lake. The 'destroyers of the earth' who are 'destroyed' are the powers, not the people" (18). There is a strong universal theme in Revelation: the victory celebrated in Revelation is for everyone!

The primary task of the follower of the Lamb is to emulate the Lamb in the Lamb's faithful witness through "*hypomonē*." Grimsrud likes Brian Blount's translation of *hypomonē* as "nonviolent resistance" (*contra* the typical "patient endurance"), which my own research on Revelation confirms as the best translation.[8]

One feature of the book that will be helpful to some and irritating to others is that at the end of each chapter, Grimsrud pauses to suggest how the message of Revelation connects with contemporary social and political issues. He addresses American militarism, consumerism, lack of environmental commitment, and empire-like world domination. In Revelation's historical context, Babylon pointed to Rome. In ours, Babylon points to the American empire. Throughout, Grimsrud regularly comments on contemporary political issues in the United States.

Although I disagree with some of Grimsrud's arguments, I highly recommend this book. It is one of the most sustained and most successful examples of reading Revelation with the book's redefinition of power front and central. Revelation continually reminds us of "our need to undergo a genuine revolution in how we conceive power, victory, and the character of God" (69)—so does Grimsrud. This book should inform all future discussions of Revelation's ethics and its contribution to peace theology.

Loren L. Johns, now retired in Florida and attending Jensen Beach Community Church (United Church of Christ), is New Testament Editor for the Believers Church Bible Commentary *and formerly Professor of New Testament at Anabaptist Mennonite Biblical Seminary in Elkhart, Indiana.*

8 Brian K. Blount, *Revelation: A Commentary*, New Testament Library (Louisville, KY: Westminster John Knox, 2009), 42. See also Elisabeth Schüssler Fiorenza, *Revelation: Vision of a Just World* (Minneapolis: Fortress, 1991), 51, and my *The Lamb Christology of the Apocalypse of John: An Investigation into Its Origins and Rhetorical Force* (Tübingen: Mohr Siebeck, 2003).