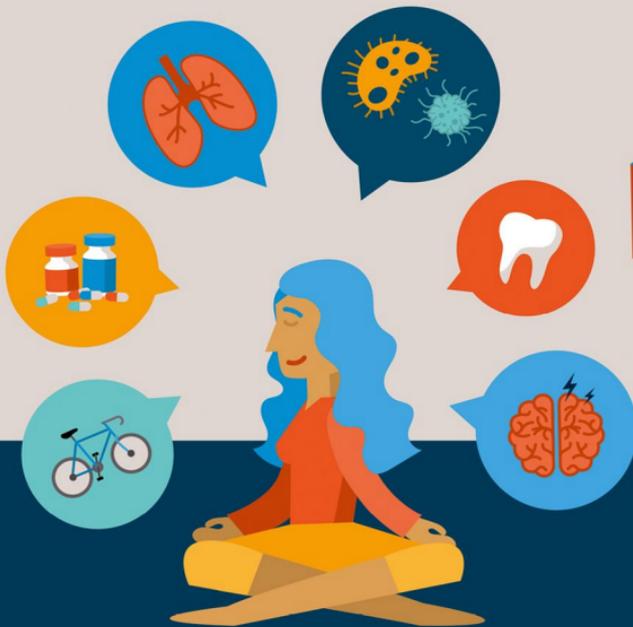


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The Spirit of Global Health

The World Health Organization
and the 'Spiritual Dimension'
of Health, 1946–2021



Simon Peng-Keller,
Fabian Winiger, and Raphael Rauch

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SIMON PENG-KELLER
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We hope this book will facilitate greater understanding and mutual respect between the realms of religion and health, and provide a modest—but undoubtedly much-needed—contribution to a historically grounded appreciation of spiritual care by national health systems.

Preface

At the hour of its birth, it was clear that the WHO was intended to carry out a mandate far broader than the often technical and bureaucratic minutiae evident in its daily operations today. As a specialized agency of the UN, the WHO was tasked in the aftermath of the Second World War with promoting the well-being of humanity in order to avert the spread of social malaise, feared to foment another world war. Adopted in the same year as the Universal Declaration of Human Rights, its constitution declared that health was a safeguard of peace and recognized 'unequal development' as a problem for all. It declared health a human right and gave governments the 'responsibility for the health of their peoples'. The WHO thus put forth a new social contract which saw in health the precondition for human beings to live fulfilling lives in peace and harmony.² The subject of this book is closely linked to this founding idea. While historians of medicine and political scientists have used archival sources to write the institutional history of the WHO, the present volume is the first to reconstruct how the WHO grappled with the legacy of its constitution, and how the 'spiritual dimension' of health emerged as the key term through which humanistic and moral considerations were raised, contested, and institutionalized.

Like any book, this one is the outcome of a process that in retrospect seems clearer than it was during its individual phases. It began with our curiosity about the fact that the historical origins of the emerging professional field of Spiritual Care had so far received so little attention. This applies in particular to the role of the WHO in this development. We found previous research to be highly fragmented and limited to individual aspects of a specific context or to individual actors. The standard narrative attributes the development somewhat simplistically to Cicely Saunders and the modern hospice movement, which allegedly brought the topic to the attention of the WHO. We wanted to review this narrative and, if necessary, correct or enrich it. Our inquiry was stimulated by the discovery of the 1984 resolution on the 'spiritual dimension' of health and its lack of reception both within and outside the WHO. This raised the question of how this resolution was created, who the actors were, and why it has been referred to so rarely.

By investigating this often-forgotten dimension of health, which so far has seldom been the subject of historical research and conceptualization, this study aims to make a contribution to the history of medicine and health-related

² Adam Gaffney, *To Heal Humankind: The Right to Health in History* (Abingdon: Routledge, 2018), 213.

spirituality in the twentieth and early twenty-first centuries. In this process, we have reconstructed and evaluated a development within the WHO which is far from concluded. In the final stage of our research project, with most of our work completed, the Covid-19 pandemic began. In this context, the WHO's engagement with the 'spiritual dimension' of health took another leap, which one day, with the benefit of historical hindsight, may well be recognized as a significant milestone. We will turn to this latest episode in the epilogue of this book.

It is a hermeneutic truism that knowledge always flows from a specific perspective. A 'view from nowhere' is not possible in historical research. This also applies to the present book, which was written at the Chair for Spiritual Care, created at the University of Zurich in 2015. This shapes our approach, for our study is a contribution to an interdisciplinary field that is still in its infancy. For this reason, the present work is a historical reconstruction of the emergence of a new concept within an international organization: the 'spiritual dimension'. Though we take a historical approach, we above all hope that this book will contribute to the development of Spiritual Care by clarifying the concept it explores.

Simon Peng-Keller, Fabian Winiger, Raphael Rauch

Zurich, 5 May 2022

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Abbreviations

ACT	Acceptance and Commitment Therapy
AFRO	African Regional Office
ARHAP	African Religious Health Assets
CAM	Complementary and Alternative Medicine
DALY	Disability-Adjusted Life Years
EB	Executive Board
EMRO	Eastern Mediterranean Regional Office
EPI-WIN	WHO Information Network for Epidemics
EURO	European Regional Office
FBO	Faith-based Organization
IDB	Islamic Development Bank
IHHA	International Holistic Health Association
IHP+	International Health Partnership
IOMS	Islamic Organization for Medical Sciences
LNHO	League of Nations Health Office
MRA	Moral Re-Armament
NAPRALERT	Natural Product Alert
NGO	Non-Governmental Organization
OIC	Organisation of Islamic Cooperation
PAHO	Pan American Health Association
PHC	Primary Health Care
PPP	Private–Public Partnership
PRC	People’s Republic of China
RHA	Religious Health Assets
SDGs	Sustainable Development Goals
SEARO	South-East Asia Regional Office
TBA	Traditional Birth Attendant
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDESA	United Nations Department for Economic and Social Affairs
UNESCO	United Nations Educational, Scientific, and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
USAID	U.S. Agency for International Development
WCC	World Council of Churches
WHA	World Health Assembly
WHO	World Health Organization
WHOQOL	World Health Organization Quality of Life (assessment instrument)
WHOQOL-SRPB	Spirituality, Religiousness and Personal Beliefs
WPRO	Western Pacific Regional Office

1

Introduction

Fabian Winiger and Simon Peng-Keller

Contrary to the widespread perception that the ‘spiritual dimension’ of health is primarily related to palliative care and has emerged relatively recently within the WHO, we show in this book that its history is considerably longer and more complex. The emergence of a ‘spiritual dimension’ in WHO discourse was connected to aspirations for universal primary healthcare, attempts to deliver a more holistic form of healthcare, and the search for a shared ethical framework to unify the disparate national interests represented in the organization. Since the WHO’s birth, these themes have enjoyed sustained attention from largely unconnected proponents ranging from individuals to Member States, regional offices, and directors-general, all of whom have grappled with the question of what a ‘spiritual dimension’ of health looks like, and how it might enrich the health policies advocated by the WHO. While ethical ideals silently motivated many key actors and policies—some of which, such as the provision of universal primary healthcare, embody the organization’s loftiest aspirations—the WHO’s official relationship with ‘spirituality’ advanced in fits, leaps, and setbacks. At times creative and interdisciplinary, at others deeply political, this process was marked by cycles of what we term ‘institutional forgetting’ and ‘remembering’. Rather than as a triumph of religious lobbyists, we argue, the ‘spiritual dimension’ of health may be better understood as a ‘ghost’ (or ‘spirit’) that has haunted—and continues to haunt—the WHO as it comes to terms with its constitutional mandate to advance health as a state of ‘complete well-being’ available to all.

We have chosen to focus on the WHO’s engagement with the ‘spiritual dimension’ of health because this organization is an important point of reference for the current discourse on spiritual care, particularly in the field of palliative care. The WHO’s influence on national ministries of health and their policies, including those relating to spiritual care, is especially apparent. Yet, references to WHO policy are almost always made without knowledge of how these guidelines were created, and which considerations have led to their acceptance and circulation as normative wisdom concerning the spiritual needs of a population. Our research may thus be understood as an attempt to place the development and provision of spiritual care on firmer ground.

We set out to write a book for experts in the emerging interdisciplinary field of spiritual care studies. Over the course of our work, however, we were surprised to

find that the underlying issues are also of interest to audiences working at the intersections of religion and health more generally. From the measured psychiatrist with a profound appreciation of the salutogenic role played by religion in his home country, to the evangelical Christian feeling marginalized for her faith, or the accomplished public health expert with an interest in leading-edge quantum physics, our interest in the ‘spiritual dimension’ opened minds, hearts—and doors—in unexpected places. We found an institution marbled by religious traditions, moral sentiments, and hopes to work for a higher good somehow ‘greater’, ‘deeper’, or ‘behind’ the bureaucratic façade of this institution.

These are not limited to the private sentiments of individuals, but in many ways may be understood as structural features of the institution. Following Whitmarsh and Roberts, we suggest that like other prestigious medical institutions, the WHO produces a peculiar kind of secular sphere which jealously guards its reputation for scientific sobriety, yet at the same time constitutes a ‘latent religious logic’.¹ Most obviously, perhaps, Halfdan Mahler (1923–2016), the charismatic director-general between 1973 and 1988 who helped launch the ‘Health for All’ initiative—an ambitious attempt to roll out primary healthcare globally—had an uncanny ability to appeal to this logic. In his eloquent speeches, the pivotal 1978 Alma-Ata conference became a ‘sacred moment’ of ‘spiritual and intellectual awakening’ leading to a global consensus to carry out the ‘gospel of health for all’.² As Max Weber once put it, ‘claims to pure rationality mask the gods and demons that we serve in its name.’³

The ‘spiritual dimension’ of health is rarely discussed in textbooks for students of global health, despite the fact, as one critic has argued, that many are ‘motivated by both religious and humanitarian concerns’.⁴ Our findings in this sense echo the words of the Harvard psychiatrist and medical anthropologist Arthur Kleinman, who points out that there is a tendency in global health discourses to ‘cloak’ religious values in ‘secular language’.⁵ The secular moral imaginary of human rights has served as a relatively neutral language providing global health with moral impetus relevant to believers of all creeds, while avoiding the historical baggage of colonialism and institutionalized religion. As Kleinman argues, ‘global health and human rights languages need to be both firm and flexible on the ground, drawing on and reverberating with local values and particularist religious beliefs, yet simultaneously representing, everywhere, the ideals of human equality, social justice, and a universal ethical aspiration.’ As he continues, ‘it is unclear,

¹ Whitmarsh and Roberts, ‘Nonsecular Medical Anthropology’, 204.

² WHO, ‘Primary Health Care Comes Full Circle: An Interview with Dr Halfdan Mahler’, 747, 748.

³ Weber, in Whitmarsh and Roberts, ‘Nonsecular Medical Anthropology’, 204.

⁴ Brown, ‘Religion and Global Health’, 290. For a prominent example, see Farmer, ‘Personal Efficacy and Moral Engagement in Global Health’.

⁵ Kleinman and Hanna, ‘Religious Values and Global Health’, 76.

however, why this demands that the rich and dynamic frameworks of religion must be excluded from the conversation.⁶

Against this background, it is no coincidence that the terminology of the ‘spiritual’ has surfaced within the WHO. Like the human rights discourse, it draws strength from its secular and universal connotations. As Ann Taves and Courtney Bender have pointed out, it is a term that goes beyond the binary *religious/secular*. It is a positively connotated term used to ‘describe experiences and denote positions and aspirations that are “more than” or “move beyond” either secularity or religion’.⁷ The ‘spiritual dimension’ of healthcare is inevitably imbued with value. For stakeholders in healthcare and health-related research, it is considered to be important insofar as it fosters well-being and dignity, and helps people cope with severe illness, disability, and death.⁸ It is precisely the vagueness of this term which facilitates its integration into secular healthcare and legitimizes spiritual care as relevant also to patients without a professed religion.⁹

Once anchored in a local moral world, the ‘spiritual dimension’ of health serves to retain and to a certain degree integrate the dynamism of religious traditions excluded from the explicitly secular and non-particularist discourse of human rights. This vagueness is achieved through the deliberate semantic abstraction of the ‘spiritual’ into a ‘thin’ but politically usable concept and its subsequent ‘enrichment’ into a ‘thick’ notion that expresses the interests of particular religions.¹⁰ This process may be understood in the sense of Habermas’ theory of institutional translation, through which religious norms are converted into secular liberal values.¹¹ But it would be an oversimplification to reduce the eventful history of the term within the WHO to such a secular transformation process. Rather, we can speak of a process of enrichment and differentiation in which the positive understanding of health formulated in the WHO preamble has been fleshed out in a way acceptable to a broad range of stakeholders, including representatives of the Global South.¹² As will be considered in more detail in the last chapter, the events discussed in this book can thus be interpreted as an explication process in which an aspect or a determinant of health has been variously abstracted, renegotiated, and addressed in more explicit terms. The discussion described here may in this sense be described not least as a creative process of ‘value generalization’ (Hans Joas).¹³

⁶ Kleinman and Hanna, ‘Religious Values and Global Health’, 82.

⁷ Bender and Taves, ‘Introduction: Things of Value’, 6.

⁸ Peng-Keller, ‘Genealogies of “Spirituality”’, 10.

⁹ Cadge, *Paging God*, 10, 11, 18–50; Lee, ‘In a Secular Spirit’.

¹⁰ Hanrieder, ‘The Public Valuation of Religion in Global Health Governance’. Cf. Sullivan, *A Ministry of Presence*.

¹¹ Hanrieder, ‘The Public Valuation of Religion in Global Health Governance’, 85.

¹² Chorev, *The World Health Organization*.

¹³ On the process of ‘value generalization’, see also Joas, *The Sacredness of the Person*.

The present study is not limited to a historical reconstruction, but aims to contribute to a conceptual clarification of the ‘spiritual dimension’ of health. To keep these two objectives as distinct as possible, we first examine the *de facto* historical use of this terminology by the WHO. In the last chapter, we then clarify this term conceptually, with particular attention to the WHO Quality of Life instrument, which represents the organization’s most systematic attempt so far to delineate a notion of ‘spirituality’ which can be operationalized across the vastly different cultural and religious worlds inhabited by its nearly two hundred Member States.

The semantic ambiguity of the term ‘spiritual’ in WHO documents makes it difficult to draw out a coherent narrative—for instance, towards greater secularization—in the institution’s discourse. Rather than getting entangled in the unsettled question of how—if at all—‘spirituality’ can be analytically distinguished from ‘religion’,¹⁴ our study builds on Bender and McRoberts’ genealogical method to show how this term may ‘align with different types of political, cultural, and social action’, and ‘how they are articulated within public settings’.¹⁵ Combining their critical-genealogical approach with a historical analysis of the WHO as a political institution, we analyse the strategic uses, contestations, and conceptual and political failures of the ‘spiritual dimension’ of health as they have occurred in the course of WHO’s institutional trajectory.¹⁶ How did references to the ‘spiritual dimension’ emerge? What were the political and ideological preconditions that made it possible for this issue to be discussed and debated within the World Health Assembly? How did this term intersect with local post-colonial and missionary legacies, traditional medical practices, the search for ‘social determinants’ of health, or the battle against infectious disease? The picture that emerges over the course of our investigations proves to be more complex, multi-layered, and heterogeneous than was initially expected. The chapters gathered here are thus connected less by an overarching narrative than by throwing into sharp relief fundamental (dis)agreements over the ethical and compassionate capacities of the policies advocated by the world’s leading medical institution.

¹⁴ Flanagan and Jupp, *A Sociology of Spirituality*; Hill et al., ‘Conceptualizing Religion and Spirituality’.

¹⁵ Bender and McRoberts, ‘Mapping a Field: Why and How to Study Spirituality’, 1, 2; Peng-Keller, ‘Genealogies of “Spirituality”’.

¹⁶ Peng-Keller, ‘Genealogies of “Spirituality”’. For an exploration of ‘spirituality’ as an analytical concept, see e.g. Flanagan and Jupp, *A Sociology of Spirituality*.

Previous Research

The present book builds on a small and widely dispersed secondary literature on the role of religion, morality, and the ‘spiritual dimension’ in global health and the WHO more specifically. Historians like Marcos Cueto, Theodore M. Brown, and Elizabeth Fee, Thomas Zimmer, and Javed Siddiqi have reconstructed the history of the institution in considerable detail, providing the backdrop for the developments discussed here.¹⁷ More granular studies like those of Farley and MacFadyen have, moreover, shed light on individual actors such as Brock Chisholm (1896–1971), or Melville Mackenzie (1889–1972), who exerted a significant formative influence on the organization.¹⁸ We also draw on sociologist and political scientist Nikita Chorev,¹⁹ whose analytical insight into the institutional logic of the WHO reverberates in many passages of this book.

At the time of writing, Tine Hanrieder’s work on values in global health, specifically on the translation of religion into ‘Factor X’ in the WHO,²⁰ and James Larson’s work on the ‘spiritual dimension’ as a possible extension to the WHO’s definition of health²¹ are two cornerstones of our specific concern. Hanrieder’s discussion of Habermas’ theory of institutional translation and the ‘thickening’ and ‘thinning’ of the ‘spiritual dimension’ in WHO discourse, introduced above, represents an important point of departure for the present study.

As Larson reminds us, such a dimension is firmly anchored in a Western worldview, and ought to be understood not merely as a factor influencing health but as intrinsic to the conceptualization of health itself. Larson thus returns to the preamble of the WHO’s constitution which, penned in 1946, extended the organization’s responsibilities far beyond the ‘mere’ absence of disease discussed in Chapter 2 of this book.²² The most detailed accounts to date of the fate of spirituality in the WHO come from Masako Nagase and Rodrigo Toniol. Nagase studied the meeting minutes taken by the Japanese ministry of health in preparation for the 52nd World Health Assembly held in 1999, when the integration of a ‘spiritual dimension’ into the definition of health was discussed (see Chapter 8). As Nagase shows, the majority of the committee—staffed mostly by physicians and biomedical researchers—rejected a broadening of the definition

¹⁷ Cueto et al., *The World Health Organization*; Zimmer, *Welt ohne Krankheit*; Siddiqi, *World Health and World Politics*.

¹⁸ Farley, *Brock Chisholm*; Macfadyen, ‘The Genealogy of WHO and UNICEF’.

¹⁹ Chorev, *The World Health Organization*.

²⁰ Hanrieder, ‘Orders of Worth and the Moral Conceptions of Health in Global Politics’; Hanrieder and Kamradt-Scott, ‘Same, Same But Different: Reforming the World Health Organization in an Age of Public Scrutiny and Global Complexity’; Hanrieder, ‘The Public Valuation of Religion in Global Health Governance’.

²¹ Larson, ‘The World Health Organization’s Definition of Health’.

²² On the genesis of the WHO’s definition of health, see Larsen, ‘Legitimizing Positive Health for All’.

of health on grounds that echoed critiques made throughout the WHO's history: it was too ambiguous, it threatened the separation of religion and state, and would create more problems than it might solve.

Writing as an anthropologist, Toniol shows how WHO archival documents have constructed a 'spirituality of Others' and, in more recent years, a 'spirituality of All', circumscribing a generalized category of the 'spiritual' understood as a universal right with measurable therapeutic value. Drawing on Peter Van der Veer's study of the 'spiritual' and secular statecraft in China and India²³ and Winnifred F. Sullivan's work on spirituality in North American jurisprudence,²⁴ he questions the 'dominant analytical perspective in the social sciences', which speaks of 'spirituality' 'merely to deal with individual, subjective and de-institutionalized forms of relationship with the sacred'.²⁵ Indeed, and quite in contrast with the anti-establishment connotations of the term 'spirituality' inherited from the countercultural movement,²⁶ this book shows how this term has been adopted by large, secular institutions.

As evident throughout this book, the 'spiritual dimension' may be understood, among other things, to imply a phenomenology of religious experience relatable to many religious traditions, while avoiding common associations of 'religion' with violence, the oppression of women, or right-wing populism. The apparent universality and innocence of 'spirituality' facilitates the convergence on shared values in multilateral organizations where the need for cooperation is great, but potential conflict over sectarian differences remains latent. To give but one example, which will be discussed in Chapter 3, it seems highly unlikely that during the WHA discussions on the moral underpinnings of the 'Health for All' initiative in the early 1980s, with a large communist voting bloc and regular accusations over the Israel-Palestine conflict, a 'religious dimension' of health would have gained the support of a majority of Member States. Though the 'spiritual dimension' avoids much of the historical baggage associated with the term 'religion', it certainly has its own, and we will return to Toniol and the (post-)colonial entanglements of the 'spirituality of All' in our chapter on the WHO's discourse on 'traditional medicine'.

Scope and Method

The actors whose interaction we examine in this book can be assigned to several fields. At the headquarter level, the WHO is constituted by 194 Member States who gather annually in the World Health Assembly (WHA), a legislative body

²³ Van der Veer, *The Modern Spirit of Asia*.

²⁴ Sullivan, *A Ministry of Presence*.

²⁵ Toniol, 'Minutes of the Spirit', 5450.

²⁶ Hanegraaff, *New Age Religion and Western Culture*; Heelas, *The New Age Movement*.

which appoints the Director-General for a term of five years and decides policy and budgetary matters on a ‘one country, one vote’ basis. These are carried out by the Director-General’s Secretariat. An Executive Board (EB), which is constituted by 34 elected members acting in a non-political capacity, oversees the implementation of activities decided on by the Assembly. Member States are in turn organized into six regional offices in Africa (AFRO), the Americas (PAHO), South-East Asia (SEARO), Europe (EURO), the Eastern Mediterranean (EMRO), and the Western Pacific (WPRO).²⁷ At the time of writing, the organization also operates about 150 country offices.

We examine not only the interactions of delegates from different Member States within the WHA but also those between the members of the EB, as well as the pronouncements and speeches of directors-general, documents and statements produced by the regional offices, and staff working across the numerous WHO divisions, departments, and programmes, such as the former Division of Health Manpower Development, the Division of Strengthening of Health Services, the Department of Mental Health and Substance Abuse, or the Traditional Medicine Programme. Due to the decentralized structure of the WHO and the considerable autonomy of the regional and country offices, we focus primarily on English language documents and discussions that were deemed to be of relevance to all WHO regions by the actors involved. While Chapters 4 and 5 present several cases illustrating how the ‘spiritual dimension’ was taken up in national contexts, further research on specific regional and country offices is needed for a more complete appreciation of the complexities of WHO policies as they are interpreted by national ministries of health and local communities.

In our research, we have drawn on documents held at the headquarters in Geneva and the regional offices, the National Library of Medicine, the catalogue of the Rockefeller Archive Center, the World Council of Churches, the Swiss and the German Federal archives, the Political Archive of the German Foreign Office, the cantonal Etter archive in Zug and the Ringier photographic archive in Aargau, Switzerland, the archives of the Church of Nazarene held in Kansas City, and the private collections of former WHO functionaries. In addition to official policy guidelines, training manuals, work reports, and internal publications such as the ‘WHO Chronicle’ or the ‘World Health Forum’ produced by official WHO offices, we consulted the minutes of meetings and verbatim records of WHA and EB deliberations. Heterogeneous as these sources are in formal terms (resolutions, minutes of meetings, guidelines, etc.), they constitute a normative discourse in which a highly elite organization struggles for institutional self-representation and self-assurance.

²⁷ Regional offices in turn consist of a committee, staffed by the ministers of health of Member States in the region, and an elected director.

Most of the primary sources we rely on were created at the WHO headquarters and speak the language of international health diplomacy. Conscious of the relatively insular and at times solipsistic professional milieu of physicians, public health experts, and career diplomats in Geneva,²⁸ we have attempted to include the voices of nurses, traditional healers, theologians, and philosophers who at different times have engaged with the WHO, but are often invisible and rarely involved in the production of official documents. In order to reduce reliance on the printed word, and to better understand the background and the political and personal considerations which informed the production of the documents studied, semi-structured interviews were conducted with current and former WHO staff, consultants, and programme partners.

Informants were selected through purposive sampling and snowballed to individuals who had worked as external consultants to the WHO or as programme partners at major faith-based organizations (FBOs) in the period since the early 1990s, along with WHO staff, consultants, and partners presently and directly involved in issues relating to religion and health. Interviews were coded using themes drawn from archival sources and analysed with a view to reconstructing the genesis of archival material, and contextualizing and prioritizing individual documents. Beginning in mid-2020, one author (FW) participated in a regular three-weekly WHO-internal consultation with religious actors on the coronavirus response, and advised a WHO-internal effort to organize a conference on spiritual care during the coronavirus pandemic.

We have attempted to do justice to the fact that some of the most far-reaching WHO initiatives—like the ‘Health for All’ initiative—have originated in the Global South among poor countries who have long struggled to reform and broaden WHO priorities to reflect on-the-ground needs. It would be mistaken to view WHO policies, including those related to the ‘spiritual dimension’ of health, as primarily the achievement of a small group of highly educated (and largely white and male) experts and diplomats in Geneva. On the contrary: one finding of our research, perhaps counter-intuitive to some readers, is that the ‘spiritual dimension’ was of interest not just to individual religious or political groups active in the WHO, but surfaced in often radically different contexts, ranging from ‘sub-Saharan’ missionary outposts to expert consultations on Quality of Life measurement or discussion meetings in Manila on topics like gender and health or peace and security.

In order to give voice to these—usually silent—actors in the WHO’s institutional trajectory, we organized an interdisciplinary roundtable in January 2020, hosted by the World Council of Churches (WCC). With its decade-long and well-documented work in global health, its physical (and at times institutional)

²⁸ In the minutes of the WHA meetings, most of the speakers are identified as medical doctors.

proximity to the WHO, and its role as a hub of faith-based non-governmental organizations (NGOs), the WCC proved to be an ideal partner for this event. The roundtable presented us with a valuable opportunity to consider how the WHO's interest or lack thereof in matters relating to the 'spiritual dimension' impacts those at the receiving end of national health policies. We greatly benefited from the collegial atmosphere and the goodwill of medical anthropologists, epidemiologists, nurses, and community health leaders with personal and organizational roots in countries across Europe, 'sub-Saharan' Africa, and the Indian sub-continent.

To be sure, the story of the 'spiritual dimension' in WHO health policy cannot be told without looking at the organization's myriad formal and informal partnerships with external actors such as the WCC. In the past two decades, and more recently in view of target 17 of the UN Sustainable Development Goals (SDGs),²⁹ a model of multi-stakeholder 'Private–Public Partnerships' (PPPs) has been adopted by UN agencies to increase cooperation between multilateral organizations like the UN and private enterprise, as well as NGOs, academic institutions, philanthropic foundations, and other civil society actors. In response, in 2016 the WHO adopted the 'Framework of engagement with non-State actors',³⁰ further formalizing cooperation with NGOs. At the time of writing, many FBOs are active in the United Nations system, where in recent years they have become increasingly important, not least due to the formidable task of financing programmes to achieve the SDGs.³¹ With the Covid-19 pandemic, discussed in the Epilogue, the potential role played by FBOs and other religious actors has become even more evident.

Due to the complex, indirect, and often personal networks through which most FBOs have in the past engaged with the WHO and other UN agencies, however, we have focused in this book on organizations which have been directly and officially involved in the creation and implementation of WHO initiatives relating to the 'spiritual dimension' of health, such as the Christian Medical Commission (CMC) of the WCC, the Fetzer Institute, the Islamic Organization for Medical Sciences, and academic collaborating centres on traditional medicine, among others. We hope that future scholarship will map in more detail the byzantine institutional ecology of UN agencies, FBOs, and other religious actors active in the field of global health. In particular, a critical ethnographic perspective, as it has been developed by medical anthropologists since the 1990s, is needed to complement our approach with a 'bottom-up' understanding of the intersections of the

²⁹ 'Strengthen the means of implementation and revitalize the global partnership for sustainable development', UN General Assembly, 'Seventieth Session, Agenda Items 15 and 116', 26.

³⁰ World Health Organization, 'Sixty-Ninth World Health Assembly, Provisional Agenda Item 11.3'.

³¹ Boehle, 'Religious NGOs at the UN and the Millennium Development Goals'; Baumgart-Ochse and Wolf, *Religious NGOs at the United Nations*.

WHO's 'spiritual dimension' with health inequities and other forms of structural violence, with the circulation of techno-scientific 'assemblages' of medical things, techniques, and epistemologies produced by the Global North, and with the failures and successes of international health planning.³²

Finally, we have taken into account the considerable 'grey' literature of works penned by individuals who have a vested professional interest in the WHO but write as historians or external commentators. Typical of this type of literature is Mohammad H. Al-Khayat, former head of the WHO's Eastern Mediterranean Office, who in 1999 published a discussion of the attempt in 1983/1984 to integrate a 'spiritual dimension' into the 'Health for All' initiative. Al-Khayat's recollections provide an Islamic view of the genesis of the 'spiritual dimension' and counterbalances the emphasis on the CMC in the accounts of the aforementioned scholars. Al-Khayat highlighted that Islamic Member States were critical in bringing this topic to the attention of the WHO. As we show in Chapter 3, Islamic interests indeed strongly influenced the discussions in the WHA, but ought to be understood in terms of a broader historical development which owes just as much to Christian, Hindu, and indeed humanistic proponents.

As historians have argued, contrary to the narrative that presents the WHO as a non-political technical agency operating chiefly on the basis of the best available medical evidence, politics is inextricably tied up in the priorities of the organization and the manner in which it pursues them.³³ The history of this organization, therefore—not least due to its democratized and federalized governing structure—is a product of a protracted process of what Nitsan Chorev terms 'strategic adaptation' by institutional agency to exogenous pressures.³⁴ This occurs not only between WHO, state, and institutional actors but also *within* the organization. Regional and country offices, departments, and indeed individual staff adeptly use the highly coded language of international health diplomacy to respond to signals from civil society, the pharmaceutical industry, and philanthropic foundations, and to the personal inclinations of institutional gatekeepers such as the directors-general, formally complying to the WHO's agenda while infusing it with their own discursive articulations. This is also reflected in the 'spiritual dimension' of health which, as we show, has over the past 75 years been enacted very differently depending on the historical circumstances of the time. References to 'the WHO' throughout this book should thus be read not to refer to a homogeneous entity, but bearing in mind the diversity and ongoing negotiation of viewpoints in this institution across the breadth of their activities.

³² Janes and Corbett, 'Anthropology and Global Health', 167; Storeng and Mishra, 'Politics and Practices of Global Health' and other contributions to the special issue in *Global Public Health* 9, no. 8 (2014).

³³ Siddiqi, *World Health and World Politics*; Chorev, *The World Health Organization*.

³⁴ Chorev, *The World Health Organization*, 33–40; Chorev, 'Restructuring Neoliberalism at the World Health Organization'.

Finally, as the reader will notice, the authors responsible for the present work have differing views on the subject they are investigating. While we have tried to emphasize areas of agreement, we have chosen not to homogenize the differences in approach and style, but to cultivate them. We invite the reader to remain open to the different perspectives—historical, anthropological, hermeneutical—we have taken in each context, and to use this as an opportunity to explore their own position.

Chapter Overview

Chapter 2 sets out by outlining the intellectual and political milieu that provided the soil in which the WHO would be created. We begin with the early twentieth-century reaction to an increasingly narrow and laboratory-based medicine, with the call by many physicians and social reformers to broaden public health reforms to include social and political factors, and the recognition of the international nature of health. We then turn to Henry E. Sigerist (1891–1957), the Swiss physician and medical historian whose work echoed this context and who supplied the wording to the definition of health contained in the preamble of the WHO's constitution. In the third part of Chapter 2, we examine the emergence of the term 'spiritual' within the WHO and analyse the ambiguous semantics of the term. Finally, we take a broad look at the post-colonial upheavals that contributed to a profound change in the WHO in the 1970s with the introduction of the new paradigm of Primary Health Care (PHC) and the 'Health for All by the Year 2000'. These developments created a favourable framework in which the WHO first officially adopted the 'spiritual dimension' as an area of concern.

In Chapter 3, we turn to the 36th and 37th World Health Assemblies of 1983 and 1984, at which the question of whether and to what extent WHO health programmes should include a 'spiritual dimension' was explicitly discussed in the context of the 'Health for All' initiative. The hitherto rarely discussed WHA resolution 37.13 represents a breakthrough insofar as it made explicit, for the first time, the significance of a 'spiritual dimension' for the organization's understanding of health. After a brief look at some preliminary developments, three phases of this process are explored in detail. We conclude with a brief analysis of the usage of the term 'spiritual dimension', which in these discussions served the purpose of bridging the divide between opposing worldviews, both political and religious. Inspired by the humanitarian ethos of the 'Health for All' initiative, the debate constituted a creative process in which the notion of a universal right to healthcare was reinforced.

In Chapter 4, we show how these discussions were continued in the Eastern Mediterranean Office (EMRO). Drawing on records of the WHO's Executive Board and World Health Assembly meetings, internal policy discussions and

official documents produced in the following 25 years, we suggest that the ‘spiritual dimension’ was initially presented within the WHO as an aspirational ideal beyond the rampant spread of materialism and the geopolitical world order dominated by Washington and Moscow. In the 25 years following its appearance, EMRO Member States translated the ‘spiritual dimension’ into concrete public health policies. However, as we show, many of these seemed at odds with the egalitarian, emancipatory moral imaginary which appeared to have been on the minds of many of its initial supporters.

Chapter 5 turns to a further discursive strand in which the term ‘spirituality’ regularly surfaces within the WHO: the matter of ‘traditional medicine’. In this chapter, we draw on primary literature published on this topic since the early 1970s to reconstruct three distinctive discourses behind the WHO’s interest in ‘traditional medicine’: the hope that it would provide the ‘manpower’ needed for primary healthcare reform in developing countries; the political need of newly decolonized nations for cultural and economic independence; and the idea that indigenous herbal remedies provided a repository of ‘active ingredients’ that would reduce the cost of medical care. Each rationale produced a distinctive accommodation of the inexplicable, ‘spiritual’ aspects of ‘traditional medicine’. While the driving forces behind this development are diffuse, this chapter shows that the WHO’s interest in ‘traditional medicine’ traces a meandering but steady path towards a greater acceptance of non-biomedical healing modalities and alternative epistemologies of healing and caring.

In Chapter 6, we take a detailed look at an area within the WHO in which spiritual care has become widely accepted as an integral part of national health-care policy: palliative care. In discovering new forms of comprehensive end-of-life care, the WHO performed and strengthened processes that also took place elsewhere in late twentieth-century medicine. Despite the largely uncontested recognition of the importance of a ‘spiritual dimension’ for palliative care, most WHO documents mention it without further elaboration. However, the rather casual way in which the topic is often mentioned has also facilitated dissemination in national guidelines; and as a constitutive element of palliative care, spiritual care is now established as a field of interprofessional cooperation. The chapter first outlines the emergence of palliative care and its introduction within the WHO in the 1980s, and then analyses the most important WHO documents in this field with regard to spiritual care. Finally, the chapter turns to the relationship between palliative care and HIV/AIDS. By historical coincidence, the WHO began to deal with palliative care as part of its cancer programme just as HIV was accelerating its spread worldwide. This led to a mutual validation: to the extent that the new palliative approach was recognized as appropriate for HIV/AIDS programmes, the global epidemic of the autoimmune disorder made it plausible that the WHO also had to contain a palliative component—which included spiritual care.

In Chapter 7, we turn our attention to the mid-1990s, when the WHO's Division of Mental Health developed a scale for the assessment of Quality of Life (WHOQOL), which departed radically from most such instruments at the time: it applied to both well and unwell populations, it was developed through a broad, systematic consultation process across various cultural settings, and it measured subjective well-being rather than the functional normality of the person. Drawing on early publications by the WHOQOL Group and interviews with former WHO staff and scientific consultants, this chapter shows how throughout the 1990s the Division developed a module for the WHOQOL to assess a hitherto overlooked aspect of well-being, which it termed 'spirituality, religiousness and personal beliefs' (SRPB). In its development, the researchers applied the same rigorous cross-cultural consultation that marked the WHOQOL methodology; but rather than identifying conventional biopsychosocial facets of quality of life, they brought together a group of medical and religious experts who sought to find commonalities across complex theological questions. The development of the WHOQOL-SRPB captures a fascinating and, until now, unstudied moment in the history of the WHO and the institutional trajectory of the 'spiritual dimension' of health.

In Chapter 8, we take up a second episode which has received little attention thus far: the attempt in the late 1990s to change the preamble to the WHO's constitution—which contains the much-cited definition of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'—to include the phrases 'dynamic state' and 'spiritual dimension'. Even though the Executive Board agreed on this change, the World Health Assembly did not pass the amendment necessary to alter the preamble. This is sometimes interpreted as a rejection of a 'spiritual dimension' of health. As this chapter shows, however, this failure may be understood in a broader context of a major attempt to reform the WHO, including complex structural and budgetary issues, which were postponed—together with the addition of a 'spiritual dimension'.

In Chapter 9, we take a brief look at developments in the new millennium. Both internal and external processes continued to push the development of the WHO's approaches to the 'spiritual dimension' of health. The chapter examines this in three sections. The first section focuses on the WHO's efforts in the field of mental health. In the second section, we investigate the growing recognition of the contribution of FBOs to global health. We trace the process of cautious rapprochement that ultimately led to a controversy about the neutrality of the WHO. Finally, the third section concludes by summing up the main strands of historical discourse and emphasizing that the fate of the 'spiritual dimension' of health in the WHO was highly dependent on changing visions about the principal goals of global health.

In Chapter 10, the perspective changes from historical reconstruction to a conceptual analysis. Concentrating on the WHOQOL-SRPB, whose cross-cultural development is reconstructed in Chapter 7, we examine the most comprehensive

attempt to date by WHO-internal actors to conceptually distinguish a ‘spiritual dimension’ of health from ‘mental’, ‘social’, and ‘physical’ dimensions and discuss its potential as an evaluative concept relevant to healthcare professionals and researchers.

In the Epilogue, we turn to the role of religious actors in the WHO’s attempt to strengthen its partnerships with civil society during the Covid-19 pandemic. In many ways, the urgency of this global health crisis has solidified a trend, evident in the past two decades, to consider the importance of ‘spiritual’ concerns in a significant proportion of WHO’s Member States. We show how in early 2020, WHO created an internal taskforce, the Information Network for Epidemics (EPI-WIN), to communicate the organization’s advice. EPI-WIN soon introduced a model of ‘communities of practice’, through which WHO has engaged in a thus far unprecedented consultation with religious actors. While this remains a new development at the time of writing, groundwork has been laid to introduce a framework for engagement with ‘faith partners’, hoped to deepen and formalize the organization’s engagement with the ‘spiritual dimension’ of health.

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2

Holistic Ideals and the ‘Spirit’ of International Health

Simon Peng-Keller and Fabian Winiger

In this chapter, we outline the intellectual and political milieus that created the WHO and gave rise to the idea of a ‘spiritual dimension’ of health. We begin with the influence of early twentieth-century holism, in particular that of Jan Smuts, who was instrumental in the creation of the League of Nations and its successor, the United Nations. The influence of holism on the conceptualization of the international organizations of the time, we suggest, was paralleled by a widespread reaction to an increasingly narrow and laboratory-based medicine, as well as a strong undercurrent of American mainline Protestantism which influenced the post-war discourse on universal human rights, and through it, the United Nations system and its newly founded agencies such as the WHO. We then turn to Henry E. Sigerist, the Swiss physician and medical historian whose work appears to have supplied the wording to the ‘definition’ of health contained in the WHO’s preamble. In his own way, Sigerist also promoted a medical holism inspired as much by his historical work as by socialist ideas. In the third part, we examine the emergence of the term ‘spiritual’ in the vocabulary of the WHO and analyse the oscillating semantics of the term in this context. The semantic ambiguity analysed in this part will prove to be a recurring motif in subsequent chapters. Finally, we will take a broad look at the post-colonial upheavals that led to a profound change in the WHO in the 1970s. The new approach of primary healthcare which emerged at that time offered a favourable framework in which the ‘spiritual dimension’ would become more relevant within the organization.

‘Holistic’ Healthcare and Social Medicine

In the late nineteenth century, a search for a healthy lifestyle emerged among American and European elites as a response to the challenges of the industrial age. Healthy nutrition and gymnastics were combined with naturopathic approaches and the spread of various philosophical ideas, many of which might today be described

as forms of ‘holism’.¹ Medical historian Charles E. Rosenberg distinguishes four types of holism:² *historical holism*, which denotes a ‘world-we-have-lost’ and strives to regain past holistic healing approaches; *organismic holism*, which seeks to cultivate mind–body unity; *ecological holism* wherein patients are seen as embedded in their environment; and *ideological holism*, which sees health and healing as related to society at large.

One of the most far-reaching articulations of early twentieth-century holism was that of Jan Smuts (1870–1950), a once highly respected statesman, former prime minister of the Union of South Africa (1919–1924), military commander, and—paradoxically—advocate of apartheid and European imperialism. Smuts was instrumental in writing the preamble of the United Nations Charter, in early drafts of which he wrote eloquently of ‘faith’, ‘sanctity’, and the ‘ultimate value of human personality’. He was responsible for the inclusion of a holistic conception of the person and the mention of ‘human rights’ in the Charter. His racist politics in South Africa, however, could not be separated from his work for world peace, and in the post-war era, Smuts’ stature was much diminished.³

Smuts developed one of the more peculiar forms of what Rosenberg might describe as *ideological holism*. It is significant to the WHO because Smuts influenced the establishment of the League of Nations, as well as its successor, the United Nations, which in turn furnished the ethical framework of agencies such as the WHO. The questions that Smuts dealt with, then, were similar to those that arose later in the founding phase of the WHO. At its core was the tension between the desire for regional self-determination and the need to take responsibility for growing global interdependence. Smuts had a clear vision of how to reconcile liberal and universalist ideals and national interests: he praised the British Empire for ‘fostering’ the ‘autonomy’ of its colonies under a ‘universalising order’ and argued for a ‘liberal imperialism’.⁴ Smuts’ holism integrated the widely dispersed imperial subjects within the whole of European colonial rule.

A similar logic informed his thinking on the League of Nations and, later, the United Nations. According to Smuts, in order to carry out its duties, the League had to be equipped with sufficient coercive power: ‘It is not merely sufficient for a conference to meet from time to time like an Areopagus to discuss questions; but there must be a union which has force behind it and which is bound to use that force when the occasion arises.’⁵ At the same time, the League was unlikely to gain support if it sought to supersede the sovereignty of its members. Smuts’ book *Holism and Evolution* (1926) offered a philosophical resolution to this tension and elaborated his own version of the holistic formula that the whole is greater than

¹ Cf. James, *On Vital Reserves*; Schmidt, *Restless Souls*.

² Rosenberg, ‘Holism in Twentieth-Century Medicine’.

³ Dubow, ‘Smuts, the United Nations and the Rhetoric of Race and Rights’.

⁴ Kochanek, ‘Jan Smuts: Metaphysics and the League of Nations’, 282.

⁵ Smuts, *War-Time Speeches*, 57.

the sum of its parts. Accordingly, the tendency to build up new synthetic wholes from particular entities was a creative principle of evolution. The complex wholeness of the human person is the result of an evolutionary process in which ever more highly developed wholes have formed: 'Human personality takes up into itself all that has gone before in the cosmic evolution of Holism. It is not only mental or spiritual but also organic and material. It is a new whole of the prior wholes; the structures of matter, life and mind are inseparably blended in it, and it is more than any or all of them.'⁶ In the same way, according to Smuts, higher-level political units are formed from previous entities. It is in this light that Smuts interpreted the emerging internationalism that he himself helped to shape: 'Thus the League of Nations, the chief constructive outcome of the Great War, is but the expression of the deeply-felt aspiration towards a more stable holistic human society.'⁷ Drawing on Darwin, Whitehead, and Bergson, Smuts' holism was equally organismic, ecological, and ideological. By inverting the historical 'world-we-have-lost holism' into a teleological 'world-we-have-to-gain holism', it was in keeping with the progressive political ideals of the League of Nations.

Like the United Nations, the WHO—which replaced the League of Nations Health Office (LNHO) after the Second World War—was profoundly influenced by the attempt to unite into a single, coherent structure radically disparate political and cultural identities, and to elevate these to a higher order of integration and coordination. This utopian dimension of the United Nations system was reflected in the WHO's preamble, which drew on Smuts' holism, as expressed in the UN charter. It called for a 'complete' state of well-being including social and mental dimensions as a means to maintain world peace.

In addition to Smuts' influence on the UN charter, an important source of the 'ideological holism' of the WHO's preamble was the budding field of social medicine, which had spread rapidly during the interwar years among senior physicians, politicians, and intellectuals uneasy with an increasingly narrow medical paradigm. Social medicine drew on nineteenth-century positivist social science, which sought to explain social phenomena in order to engineer them to create a more harmonious society.⁸ By widening the scope of medicine to the person in his or her full social and political complexity, it responded to the widespread social malaise wrought by industrialization, in particular the problems caused by urbanization, the epidemiological transition towards chronic diseases, and the widespread unemployment and deprivation of the Great Depression.⁹ The League of Nations Health Office and several of the key figures in the founding of WHO supported a vision of the new organization based on the

⁶ Smuts, *Holism and Evolution*, 273.

⁷ Smuts, *Holism and Evolution*, 353.

⁸ Porter, 'Introduction'.

⁹ Rosen, 'What Is Social Medicine?', 730.

'ideological holism' of social medicine.¹⁰ Moreover, this positive understanding of health as a 'complete' state of being should be made available to as many as possible, echoing the Benthamite utilitarian principle of the 'greatest good' for the 'greatest number', which had inspired British public health reformers like Edwin Chadwick (1800–1890) and the leading medical historians and public health intellectuals of the time.¹¹

The broad understanding of health enshrined in the WHO's preamble also benefited from a milieu of physicians and intellectuals described by medical historians as reacting against an increasingly narrow, laboratory-based medicine.¹² This loosely connected movement was shaped by figures such as Richard C. Cabot (1868–1939), Maximilian O. Bircher-Benner (1867–1939), Carl G. Jung (1875–1961), Helen F. Dunbar (1902–1959), and Viktor Frankl (1905–1997), who favoured what Rosenberg might call an 'organismic holism', and included a 'spiritual dimension' in their medical or psychiatric practice and theories.¹³

Finally, the new awareness of global interdependence wrought by the Second World War and the first use of the atomic bomb also contributed to the influence of an explicitly 'spiritual' type of holism. The most articulate proponent of this was Dag Hammarskjöld (1905–1961), the Swedish diplomat who served as the second Director-General of the UN, whose deeply spiritual views were drawn in part from medieval mystics such as Meister Eckhart. Hammarskjöld saw his work as service to a global 'community of spirit', and one of his legacies is an interfaith meditation room at the UN headquarters in New York.¹⁴ This recognition of global interdependence also bore fruit in the founding of the WHO, for the new organization—as reflected in its name—saw the health of every human being as necessarily related to that of all the other inhabitants of the planet, and closely tied to the creation and maintenance of world peace.¹⁵ The discourse of universal human rights, which in the post-war era defined the United Nations system, was moreover significantly influenced by American Protestant churches, new Christian communities, and missionary societies.¹⁶ As argued by John Blevins, the secularization of the Social Gospel movement after the Second World War by American mainline Protestants 'informed a variety of institutions responsible for today's global health and development initiatives'.¹⁷ One result of this is

¹⁰ Borowy, *Coming to Terms with World Health*; Solomon et al., *Shifting Boundaries of Public Health*.

¹¹ Porter and Porter, 'What Was Social Medicine?'; Solomon et al., *Shifting Boundaries of Public Health*.

¹² Tracy, 'An Evolving Science of Man', 163.

¹³ Peng-Keller, 'Spiritual Care im Gesundheitswesen'.

¹⁴ Van Dusen, *Dag Hammarskjöld*, 47; Stahn and Melber, *Peace Diplomacy, Global Justice and International Agency*.

¹⁵ Zimmer, *Welt ohne Krankheit*, 10, 112–27.

¹⁶ Nurser, 'The "Ecumenical Movement" Churches'.

¹⁷ Blevins, *Christianity's Role in United States Global Health and Development Policy*, 108. On holism in the twentieth-century Protestant gospel of health, see Klassen, *Spirits of Protestantism*.

introduced below: the founding by the WCC of the Christian Medical Commission (CMC), which would profoundly shape the WHO's primary health-care paradigm, and in the course of which in the early 1980s the World Health Assembly first discussed a 'spiritual dimension' of health.

In this light, it is unsurprising that several of the most influential figures in early WHO history expressed the opinion that medicine ought to care for the human being in its entirety, and that global responsibility for healthcare would play a crucial role in a united and peaceful post-war world order. Well-known proponents of this view included Thomas Parran Jr, the sixth Surgeon-General of the United States who chaired the meetings at the 1946 International Health Conference at which the WHO's constitution was adopted, and the Canadian Brock Chisholm, a paediatric psychiatrist and the WHO's first Director-General (1948–1953). Chisholm in particular had been well-noted for his concern for the future of humanity and his personal mission to create an emotionally, mentally, and socially 'mature' population of 'world citizens' which could rise to the challenges of the atomic age. Chisholm, though he was well known for his strong anti-religious views, had ensured the new health organization was named the 'World' rather than the 'International' Health Organization, emphasizing the WHO's holistic mandate.¹⁸ He was also a strong supporter of a broad definition of health that included a 'social' and a 'mental' dimension and which, ironically, would be later taken up by advocates of an even broader definition of health that included a 'spiritual dimension'.¹⁹

'More Than': Henry Sigerist and the WHO Preamble

If the historical currents outlined above prepared the way of the new international health organization, the seed of the definition of health contained in the preamble to the WHO's constitution was planted in the early 1940s, when the outcome of the war was far from certain. The first version of the preamble was introduced in 1946 by Andrija Štampar (1888–1958), an influential proponent of social medicine, and had been written during the Second World War by Raymond Gautier (1885–1957), then Medical Director of the LNHO. In a sketch for a new international health institution dated 15 March 1943, Gautier outlined a health organization which 'should have higher aims, requiring greater power and involving heavier responsibilities. For health is more than the absence of illness; the word "health" implies something positive,

¹⁸ Farley, *Brock Chisholm*, 173–84; Zimmer, *Welt ohne Krankheit*, 123.

¹⁹ The WHO's Eastern Mediterranean Office (EMRO), described in Chapter 4, for instance, would later speculate that Chisholm would have supported a 'spiritual dimension'. World Health Organization, Regional Office for the Eastern Mediterranean, *EMRO Partner in Health*, 81.

namely physical, mental and moral fitness.²⁰ Much in tune with the holistic currents introduced earlier, Gautier suggested that health should not be reduced to physiological pathology and considered the encouragement of health-promoting behaviour as a political task.²¹ Echoing the social medical thinking that dominated the LNHO during the 1930s, he highlighted, among other things, the health policy implications of a more comprehensive understanding of health. A general health insurance scheme and medical care accessible to all should be promoted.

As suggested by Lars T. Larsen, Gautier's formulation closely resembled a sentence found in the work of Henry E. Sigerist (1891–1957) who was 'widely admired as the world's leading historian of medicine' for nearly three decades.²² Between the early 1930s and late 1940s, Sigerist acted as the director of the Johns Hopkins Institute of the History of Medicine. From his scholarship Sigerist derived a programme for the reform of current medical policies. 'History', as Sigerist put it, 'teaches us where we stand today and what tasks have been assigned to us.'²³ A charismatic public speaker and prodigious medical historian, Sigerist was remarkably well received among his American colleagues, and popularized the importance of historical analysis and political reforms towards equitable, publicly funded healthcare systems. Sigerist saw his socio-medical ideals realized in the work of Andrija Štampar, whom he had met in Moscow in 1936 and in Zagreb in September 1938.²⁴ Štampar focused on public health nurses, regional health centres, and educational programmes, anticipating many aspects of the approach that the WHO introduced in the 1970s under the title 'Primary Health Care' (see below).

In the same year, Sigerist was invited to give the Terry Lectures, entitled 'Religion in the Light of Science and Philosophy'. According to the foundation charter, the lecture series should contribute to the nourishment of the 'Christian spirit'.²⁵ It was envisaged that the lectures would present scientific findings that might promote human welfare, and scientific and philosophical findings that would benefit a 'broadened and purified religion'.²⁶ With this ambitious target in mind, Sigerist felt compelled to make a personal comment before his lectures. He had hesitated to accept the invitation, he said, since he was neither a theologian nor a philosopher, 'nor even a religious man, at least not in the conventional sense

²⁰ Macfadyen, 'The Genealogy of WHO and UNICEF', 205; Larsen, 'Legitimizing Positive Health for All', 10.

²¹ Cf. Porter and Porter, 'What Was Social Medicine?'

²² Fee and Brown, 'The Renaissance of a Reputation', 1.

²³ Sigerist, 'The Medical Student', 415.

²⁴ Sigerist documented his experiences in an enthusiastic travelogue, cf. Sigerist, 'Yugoslavia and the XIth International Congress of the History of Medicine'. Štampar, who spent the Second World War in a Gestapo prison, visited Sigerist in his Ticino retirement home in 1948. On this encounter, see Sigerist's diary entries: Sigerist, *Autobiographical Writings*, 220f.

²⁵ Sigerist, *Medicine and Human Welfare*, vi.

²⁶ Sigerist, *Medicine and Human Welfare*, v–vi.

of the word'.²⁷ He could, however, identify unreservedly with the philanthropic orientation of the foundation, as medicine is at the service of human welfare. Although health is not a goal in itself, illness is a fetter that has often prevented people from fulfilling their goals in life: 'the world has been deprived of endless spiritual values by the illness and premature death of creative individuals.'²⁸ Sigerist emphasized that there was a close historical connection between medicine and religion that persisted to the present day, wrapping his own view in a laboriously formulated rhetorical question: 'And even in our day, when medicine has become a matter of science, is not the attempt to promote human welfare, to help in building a better world not in heaven but on earth, an effort that is not so very far from religion, although it excludes the transcendental?'²⁹

Against this background, the lecture title chosen by Sigerist, *Medicine and Human Welfare*, presents a strong argument that medicine should serve a broader, social purpose. The historical reconstruction increasingly turns into a plea for a more holistic medicine. Sigerist calls for an art of healing that also recognizes and includes the social aspects of illness and health. First, he points out that Greek medicine was not limited to healing diseases, and that the strengthening of health and 'hygiene' were regarded as a medical task.³⁰ As much as Sigerist sympathizes with the 'salutogenetic' approach of ancient Greek dietetics, he also draws attention to its limitations: 'it was a regime for the wealthy few, for a small upper class leading a life of leisure, a class produced and supported by an economy in which all manual labour was performed by slaves. It was an aristocratic hygiene and one that was concerned with the body alone.'³¹ At this point, Sigerist brings a Christian universalism into play. In contrast to the aristocratic healthcare of the Greek world 'Christian hygiene was catholic, addressing itself to all.'³² The free Christian healing practice is portrayed as a forerunner of social medicine. According to Sigerist, it combined the medical holism of Greek provenance with a Christian-inspired commitment to social justice:

A healthy individual is a man who is well balanced bodily and mentally, and well-adjusted to his physical and social environment. He is in full control of his physical and mental faculties, can adapt to environmental changes, so long as they do not exceed normal limits; and contributes to the welfare of society

²⁷ Sigerist, *Medicine and Human Welfare*, vii. In his diaries Sigerist's beliefs become more tangible. On 12 April 1949 he wrote: 'Buddhism appeals to me much more than Christianity—always did. It is logical, just, and compassionate. I like its attitude toward animals and plants. And who knows, if matter and energy are never lost, there may be a spirit which is not lost either.' At the end of the year, on 29 December, he noted that he 'became ever more equanimous probably due to my study of Hindu philosophy, particularly Buddhism'. And on 7 May 1950: 'Now I feel torn between Marxist materialism and Indian spiritualism, between ideals of my youth of a life in beauty, and my career as a fighter for social progress.' Sigerist, *Autobiographical Writings*, 227, 230, 232.

²⁸ Sigerist, *Medicine and Human Welfare*, vii.

²⁹ Sigerist, *Medicine and Human Welfare*, ix.

³⁰ Sigerist, *Medicine and Human Welfare*, 59.

³¹ Sigerist, *Medicine and Human Welfare*, 62.

³² Sigerist, *Medicine and Human Welfare*, 76.

according to his ability. Health is, therefore, not simply the absence of disease: it is something positive, a joyful attitude toward life, and a cheerful acceptance of the responsibilities that life puts upon the individual.³³

Sigerist associates the idea that health is a physical and mental state of equilibrium with ancient ideas on hygiene as well as with the health reformers of his time. He linked this idea to the postulate that there is a fundamental right ‘to benefit from all known means for the protection and cultivation of health’.³⁴ This fundamental right, from which he derived the demand for general health insurance, corresponded to a duty to health, to a healthy lifestyle, which not least should also be promoted at school.³⁵

Sigerist’s plea met with fierce resistance in the United States—especially his conviction that there was a right to health (care)³⁶—and his demand for general health insurance made him unpopular. Nevertheless, the influence of Sigerist’s ideas was remarkable: ‘his words and ideas provided the inspiration for a loosely organized and often fractured movement that would nonetheless provide energetic leadership for many decades in the still uncompleted attempt to implement his vision.’³⁷ Even though the connection between Sigerist’s lectures, published in 1941, and Gautier’s plan for a future health organization in 1943 cannot be conclusively established,³⁸ there is no doubt that the WHO’s preamble breathes the ‘spirit’ of social medicine.

Sigerist saw the preamble as a victory for the progressive cause of social medicine, and ended a 1949 essay on health insurance in Germany and the United Kingdom simply by underscoring Russian achievements—widely admired among proponents of social medicine—which signified a ‘changed attitude in the relation between society and medicine’. As evidence of this changed attitude, he pointed to the preamble of the WHO constitution, copied verbatim as a conclusion to his argument—as though with it the history of health insurance had taken an obvious, and manifestly progressive, step towards its historical telos.³⁹

³³ Sigerist, *Medicine and Human Welfare*, 100.

³⁴ Sigerist, *Medicine and Human Welfare*, 101.

³⁵ Sigerist’s lectures soon found enthusiastic readers. Among them was the Indian physician Kamla Ghosh, who visited Sigerist in Baltimore in 1941. On her return home on an oil tanker, where her life came to a tragic end, she wrote to Sigerist: ‘I [. . .] have your little “Medicine and Human Welfare” with me to dip into for a tonic at low moments’. Amrith, *Decolonizing International Health*, 59.

³⁶ Sigerist, *Medicine and Human Welfare*, 100–4. See also Sigerist, ‘The Medical Student’, 413.

³⁷ Fee, ‘The Pleasures and Perils of Prophetic Advocacy’, 218.

³⁸ Since Gautier was the founder and editor of the *Bulletin of the Health Organization* and Sigerist’s writings were highly regarded in the circles of social medicine and international health policy, this seems very likely. In his diary, Sigerist reflected on his influence, cf. Sigerist, *Autobiographical Writings*, 89.

³⁹ Sigerist, ‘From Bismarck to Beveridge’, 51, 52. In the 1950s, Sigerist worked as a technical expert in WHO committees on several occasions, cf. for instance: World Health Organization, Executive Board, ‘Appointments to Expert Advisory Panels and Committees’. In his diary he wrote of his first

The WHO health definition contained a kind of institutional soteriology of health. National governments should not limit their concern to the physical dimension of health but must also pay attention to social and mental factors. In this context, it is striking that the 'moral' dimension was lost: neither Gautier's 'moral fitness' nor Sigerist's 'a joyful attitude toward life, and a cheerful acceptance of the responsibilities that life puts upon the individual' made it into the final definition.⁴⁰

Read as part of the constitution as a whole, it is clear that the preamble to the WHO's founding document was concerned with far more than the health of individual bodies. Adopted in the same year as the Universal Declaration of Human Rights, it put forth a new social contract which saw in health the precondition for all human beings to live a fulfilling life in peace and harmony. Though in the first decades of the WHO the 'spiritual dimension of health' was hardly mentioned, later attempts to include it into the health definition cut right to the *raison d'être* of the WHO, insofar as the 'spiritual dimension' brought the holistic health definition to its fullest expression. The often criticized definition of health includes, on closer examination, the basic concerns of social medicine—and the question of the orientation of the WHO: Who, ultimately, should the organization serve? Should it primarily serve rich countries, who contributed most of its funding; pharmaceutical companies, who seemed to win the argument for pragmatism and cost; and the medical profession, whose recognition and respect the WHO relied on for its claim to be the leading international organization in the medical world? Or rather the poor countries, who carried most of the world's burden of disease; governments, who—as the WHO's founding figures had recognized—could not be excused from financing large-scale public health infrastructure; and the 'people', who struggled to fit into the institutional priorities of foreign medical professionals and bureaucrats? On the former side of this spectrum, dominant during the first 30 years of the WHO's existence, lay an increasingly narrow understanding of health as primarily the absence of disease. On the latter side, more dominant between the early 1970s and the late 1990s, was an understanding of health which extended towards social medicine and beyond—an attempt to rehumanize medicine by returning to it a dimension supposedly lost during the rapid expansion of the medical profession.

visit to Geneva: 'I had not done this kind of work for a number of years and felt somewhat apprehensive when I entered the Palais des Nations, but soon I felt in my true element and greatly enjoyed the work.' Sigerist, *Autobiographical Writings*, 237.

⁴⁰ In the draft, which Gautier wrote together with his French colleague Yves Biraud in December 1945 and which Andrija Štampar submitted, it was still stated that: 'Health, however, is something more than absence of disease and although curative and preventive medicine have not said their last word, they cannot endow the individual with that physical perfection which ensures joy of living. For this, the action of positive factors is required.' In Larsen, 'Legitimizing Positive Health for All', 14.

The Oscillating Semantics of ‘Spiritual’

From the very beginning, the term ‘spiritual’ appeared sporadically in WHO discourse. However, until 1978 it was used only casually and without attracting special attention.⁴¹ The only field where a more specific meaning came into play was the ‘rights of children’ which were already discussed during the first WHA. The issue harked back to the Geneva Declaration of the Rights of the Child, adopted in 1924 by the League of Nations, which had declared that the ‘child must be given the means requisite for its normal development, both materially and spiritually’.

Echoing this declaration, a 1948 report by Brock Chisholm spoke of the right of children to develop ‘materially, morally and spiritually’—though he likely did not think of conventional, religious spirituality—he himself, as mentioned, was a hardened critic of religion and in a speech to school parents went as far as lamenting children’s belief in Santa Claus.⁴² At a later point in the same document a second chord appeared: ‘physical, mental and social development’.⁴³ What exactly is the relationship between mental, moral, and spiritual development?

The term ‘spiritual’ first appeared in Philipp Etter’s (1891–1977) inaugural speech at the first World Health Assembly, chaired by Štampar, in 1948 (Fig. 2.1). The Swiss Federal Councillor represented Switzerland in this historic moment and welcomed the delegates as the conference host. In his speech, Etter praised the WHO’s preamble for opening up ‘new paths towards a vaster and more universal conception’ and for ‘embracing the whole nature of man, physical and spiritual’.⁴⁴ This short description of the WHO’s future task may not have attracted much attention in Geneva’s Palais des Nations, and the speech had no influence on the further discussions that we will examine in this volume. Nevertheless, it is worth taking a closer look at this point in the course of our investigation. For, in connection with this speech, there arises a fundamental problem that will occupy us in later chapters. We use Etter’s seemingly conventional use of the term as a paradigm case for the challenges that arise when using the term ‘spiritual’ in a global health institution.

⁴¹ A keyword search in IRIS, the WHO search engine for its digitized documents, yielded the following hits: 1950–1959: 42 hits; 1960–1969: 39 hits; 1970–1979: 69 hits; 1980–1989: 240 hits; 1990–1999: 250 hits; 2000–2009: 606 hits; 2010–2019: 519 hits.

⁴² ‘Any man who tells his son that the sun goes to bed at night is contributing directly to the next war... Any child who believes in Santa Claus has had his ability to think permanently destroyed... Can you imagine a child of four being led to believe that a man of grown stature is able to climb down a chimney... that Santa Claus can cover the entire world in one night distributing presents to everyone! He will be a man who has ulcers at 40, develops a sore back when there is a tough job to do, and refuses to think realistically when war threatens.’ In Farley, *Brock Chisholm*, 43.

⁴³ World Health Organization, Executive Board, ‘Declaration of the Rights of the Child’, 2, 4.

⁴⁴ See p. 24 of the first plenary meeting in World Health Organization, ‘First World Health Assembly, Geneva 24 June to 24 July 1948’.



Fig. 2.1 First meeting of the World Health Assembly in Geneva, 24 June 1948 (Philipp Etter is seated third left in the back).

Source: Jean-Pierre Grisel © StAAG/RBA1-1-9922_1. In Ringier Photographic Archive, Aargau cantonal archives, Signature RBA1-1-9922. Reproduced with permission.

As evidenced by archival documents, Etter wrote his speech in German (with French interjections) and then had it translated into French and English.⁴⁵ The translation shortened the German–French template, which also mentioned the ‘moral’ and ‘social’ aspects of human nature, and alluded more directly to the WHO’s definition of health. A literal translation would read as follows (German terms in brackets): The WHO’s

⁴⁵ Etter, ‘Ansprache an der Versammlung der Weltgesundheitsorganisation (Organisation Mondiale de La Santé) in Genf’. We thank Dr Thomas Zaugg for his assistance.

work is not just about fighting the dangers to and enemies of health. It is much more concerned with the positive promotion of the complete physical, mental [*mental*] and social well-being, thus encompassing the whole human being in his physical, spiritual [*geistig*], moral and social power.

In Etter's draft (shown in Fig. 2.2), the threefold definition of health (physical, mental, and social) was paraphrased by a fourfold determination: *physical, spiritual, moral, and social*. Etter's translator may have been tripped up by the shifting meaning of 'geistig', which in German may refer to both the 'mental' (e.g., *geisteskrank*: 'mentally ill'⁴⁶) and to the 'spiritual' (e.g., *Geister*: 'spirits'). The translator's choice of words may have been motivated by rhetorical considerations: the cumbersome fourfold understanding of physical, social, moral, and spiritual was more easily conveyed through the dualism of the 'physical and spiritual' (in the French, *corporel et moral*).

The problems faced by Etter's translator(s) are important for the question of this book, tied as they are to ambiguities that reach far back into Western intellectual history.⁴⁷ These inherited ambiguities inform several of the discussions examined in this volume, in which many representatives of non-English-speaking countries participated. As exemplified by a close reading of Etter's inaugural speech, a number of conceptual difficulties are thrown up concerning the 'spiritual'. While the version presented during the first WHA recalls the familiar dualism of body and mind, the handwritten originals cited above offer a much more complex concept of the human being, broadening and differentiating the tripartite concept of the WHO health definition.

What was the background to this semantic oscillation? Why did Etter paraphrase 'mental' by 'spiritual and moral'? With regard to his Catholic background, it could be hypothesized that Etter's inaugural speech was coloured by his own religious beliefs. This interpretation seems to be supported by his political trajectory.⁴⁸ Etter served as minister of the interior at a time when religious institutions were making a significant contribution to Swiss public health. However, in the standard vocabulary in Switzerland at this time, the term *geistig* did not have a religious flavour (as the term *geistlich* did), but a political one. Indeed, Etter was one of the most prominent spokesmen for a widespread political movement which influenced the public discourse in Switzerland at the time: the 'spiritual national defence' (*Geistige Landesverteidigung*). It had originated in the 1930s and was directed against the threat of National Socialism and Fascism by providing a platform for representatives of very different political camps.⁴⁹

⁴⁶ In the official German translation of the WHO's preamble, 'mental well-being' is translated as 'geistiges Wohlergehen', cf. Kompetenzzentrum Amtliche Veröffentlichungen, 'SR 0.810.1 Verfassung Der Weltgesundheitsorganisation vom 22. Juli 1946'.

⁴⁷ Peng-Keller, 'Genealogies of "Spirituality"'.⁴⁸

⁴⁸ Zaugg, *Bundesrat Philipp Etter*.

⁴⁹ Tanner, *Geschichte der Schweiz im 20. Jahrhundert*, 234–8.

20 /
 oberlichten ihr hauptsächlichstes Anliegen in der Bekämpfung der
 Krankheiten und der Epidemien. Die Organisation Mondiale de la
 Santé stellt ihr Ziel viel weiter und auch viel positiver. Ihre Arbeit
 gilt nicht nur dem Kampf gegen Gefahren und Feinde der Gesundheit.
 Sie gibt vielmehr der positiven Förderung der complete Bien-être
 physique, mental et social, umfasst somit den ganzen Menschen
 in seinem physischen, geistigen, moralischen und sozialen Stoff, das
 ist ein Schritt zu einer neuen, ~~er~~ ~~müht~~ ~~er~~ umfassenderen und
 universellen Auffassung der öffentlichen Gesundheitspflege. Vom
 vorletz realiser im programme constructif sur le plan scientifique
 contre sur le plan social. Dieses Programm zu erfüllen und es
 mit der Zähigkeit des Willens und der Anstrengungen, aber auch
 mit dem Wohl des Herzens und der Seele ~~zu~~ in die Tat umzusetzen,
 das ist eine herrliche, menschen- und völkerverbindende Aufgabe
 im Dienste des Friedens und des Glückes. An der Spitze dieses
 Werkes sollen alle Staaten und alle Nationen teilhaben. Universell
 im Ziel, universell auch im Hinblick auf die Zusammenarbeit aller
 Völker. Aber da steht der andere grosse, lapidare Satz in der
 Charta Ihrer Organisation: „La qualité de membre de l'Organisation
 est accessible à tous les états.“ Nicht nur die Mitglieder der
 Staaten der Vereinigten Nationen, jeder Staat soll die Möglichkeit
 des Beitrittes und der Mitarbeit haben. // ^{China} ~~Wird~~ ~~Freund~~ ~~des~~ ~~unser~~ ~~Land~~

Fig. 2.2 Swiss Federal Councillor Philipp Etter's handwritten notes on the WHO's definition of health.

Source: Staatsarchiv des Kantons Zug, P70-157, Manuscript Nr. 0266. Reproduced with permission.

In a programmatic document published in 1938, the Swiss Federal Council outlined the meaning and purpose of ‘spiritual national defence’:

The Swiss idea of the state is not born of race, nor of flesh, it is born of spirit. It is something great, something monumental that around the Gotthard, the mountain of divorce and the passport of union, an enormously great idea was allowed to celebrate its incarnation, its becoming a state, a European, a universal idea: the idea of a spiritual community of peoples and occidental cultures!⁵⁰

The political movement for ‘spiritual national defence’ was personally and ideologically related to the ‘moral re-armament’ (MRA),⁵¹ an international movement founded by the American evangelical pastor Frank Buchman (1878–1961). The MRA shared with the ‘spiritual national defence’ the conviction that the perils of that time had to be defeated not only by diplomatic and military means but also by a moral and spiritual renewal. The movement had its greatest impact through two organizations that grew out of the parent movement: the Alcoholics Anonymous fellowship and the youth movement Up with People.⁵² In the 1930s, the MRA reached influential Swiss social, political, and military circles.⁵³ At the first World Conference of this movement, held in Interlaken in 1938, a group of doctors, including the Geneva internist Paul Tournier, wrote a manifesto. It outlined an idea fundamental to Tournier’s later work: that ‘moral, spiritual and physical health form an inseparable whole’.⁵⁴ Tournier made a plea for a new form of spiritual care to be practised by physicians because, as he argued—much like Sigerist—an expanded, humanistic approach to healthcare constituted a pragmatic necessity. ‘Everything that contributes to healing belongs to medicine’, he wrote. And, as he continued, ‘it cannot be denied that facts of a spiritual order [*des faits d’ordre spirituel*]⁵⁵ can contribute to healing. So they must not be ignored by the doctor. Just as the doctor can use X-rays in his treatments without being a physicist, or inject morphine without being a chemist, so he can exercise spiritual care in the same way without being a theologian.’⁵⁶

Against the background of the Swiss ‘spiritual national defence’ and the MRA, Etter’s characterization of man as ‘spiritual, moral and social’ is given a much clearer profile. The formulation is shaped by the idea of uplifting the citizens’ spirit through the promotion of noble principles and humanist ideals. Without this background the meaning of the term ‘spiritual’ would remain vague.

⁵⁰ Staatsarchiv des Kantons Zug, BBl 1938/II, S. 999 cited according to UEK, Schlussbericht, S. 87. We thank Dr Thomas Zaugg for his assistance.

⁵¹ Before 1938 the movement was called the ‘Oxford Group’. In 2001 the name was changed to ‘Initiatives of Change’.

⁵² Sack, *Moral Re-Armament*, 4.

⁵³ Cf. Mottu, *Von der ‘Belle Epoque’ zur Moralischen Aufrüstung*.

⁵⁴ Mottu, *Von der ‘Belle Epoque’ zur Moralischen Aufrüstung*.

⁵⁵ Tournier, *Médecine de la personne*, 135.

⁵⁶ Tournier, *Médecine de la personne*, 141.

What is exemplified by Etter's speech applies to all WHO documents examined in this book, in which the term 'spiritual' appears in a more or less central passage. WHO documents, including minutes of meetings, are highly formalized texts written in a specific jargon. In this discourse, marked by diplomacy and medicine, 'spiritual' is an elusive term. The case of Etter demonstrates that interpreters of these texts would do well to assume that the uncommented use of 'spiritual' stands before the background of unarticulated ideological assumptions and presents translation difficulties.

Etter's use of the term is also paradigmatic in terms of content. The ambiguous and morally charged semantics of 'spiritual' as found in his speech is characteristic for the WHO's later usage of the term. In the first three decades of the WHO, the adjective 'spiritual' occurred mainly in two ways, both of which are also found in Etter: firstly, in contrast to 'material'/'physical'/'bodily'; and secondly, as a complementary term to 'mental' (and 'moral'). In the first usage, 'spiritual' represented all that is immaterial (with the emphasis that this is a higher order): aspirational values, ideals, beliefs, motivational forces, etc. In the second usage, the meaning of 'spiritual' was more elusive, especially when it appeared in the threefold formulation of 'mental, moral, spiritual'. The most elaborate attempt to solve this terminological problem was made by the Indian deputy minister of health Desh Bandhu Bisht (1927–). Heavily inspired by Sri Aurobindo's syncretic brand of Hinduism, Bisht understood this dimension in terms of human evolution. In a background document presented to the Executive Board in 1978, he argued that what differentiates humans from animals is the 'spiritual dimension'—or at least 'something', which he dubbed the 'Factor X'. While the life of animals includes physical, mental, and social dimensions, the spiritual dimension is an exclusive possibility of human life. As we will see in the next chapter, Bisht would bring his point of view to the 36th WHA a few years later.

The terminological ambiguity would return. In January 1979, at the 63rd session of the Executive Board, Jona B. Senilagakali, a delegate from Fiji, referred to a meeting held by the Economic and Social Commission for Asia and the Pacific, which, according to the minutes, 'had expressed the view that insufficient emphasis was being placed on the spiritual growth of the child'. The delegate emphasized that he 'would like to see WHO make some positive commitment to spiritual and moral growth as well as to physical growth, since it was essential to the development of satisfactory family life'. The director of the Division of Family Health, Angèle Petros-Barvazian, answered by referring to the biopsychosocial approach. The minutes read: 'As for the spiritual as well as the physical growth of the child, she [Petros-Barvazian] explained that the term "psychosocial" was being used, and hoped that that met the point made.'⁵⁷

⁵⁷ World Health Organization, Executive Board, 'Provisional Summary Record of the Ninth Meeting', 10, 11.

The spiritual dimension would therefore be included in good biopsychosocial care and would not need to be considered separately.

This answer may not have satisfied Senilagakali, a lay preacher in the Methodist Church of Fiji and Rotuma. Some months later, he repeated his plea in the 32nd WHA (1979), by adding a rationale for such an inclusion: 'While recognizing that cultural and religious differences made it difficult to develop a strategy in that regard, he thought that WHO should study the spiritual growth and development of the child. In so doing, it would be in line with the thinking and wishes of many Member States, notably those in the South Pacific, where spiritual development was an important part of children's upbringing.' Although Senilagakali's plea received little response in the documents of the WHA, Article 17 of the UN Convention on the Rights of the Child passed in 1989 continued to urge the inclusion of a spiritual dimension in a formulation evidently based on the WHO's definition of health. As the convention stated, nations should promote 'his or her social, spiritual and moral well-being and physical and mental health'.⁵⁸

From 'Magic Bullets' to 'Health for All'

Like many ideals enshrined in the United Nations system, the broad conception of health set out in the preamble was seriously tested in the two decades after its foundation. In the late 1940s and early 1950s, influential proponents of social medicine who had played a critical role in the establishment of the WHO came under sustained pressure in the United States as suspected communist sympathizers, and the WHO came to be staffed by many tropical medicine doctors trained in the former colonial powers. Meanwhile, lobbying efforts by the Soviet Union and its allied states for fundamental healthcare reforms culminated in their temporary withdrawal from the WHO.⁵⁹ Recently discovered 'magic bullets' such as penicillin, the BCG tuberculosis vaccine, and the miraculous potency of the insecticide DDT were making a strong case for the idea that, applied with military-like discipline and organizational structures, these breakthroughs could stem the spread of malaria, demonstrate that the WHO was more than a mere 'debating society',⁶⁰ and establish the new health organization as the leading global authority in health.⁶¹

⁵⁸ United Nations Human Rights Office of the High Commissioner, 'Convention on the Rights of the Child'. In the same vein the UN Department of Economic and Social Affairs, Division for Sustainable Development, asserts the rights of individuals to develop their 'full potential (including healthy physical, mental and spiritual development'. United Nations Conference on Environment and Development, 'Chapter 6'.

⁵⁹ Cueto et al., *The World Health Organization*, 61–7; Brickman, 'Medical McCarthyism'; Zimmer, *Welt ohne Krankheit*, 200–1.

⁶⁰ Cueto et al., *The World Health Organization*, 51.

⁶¹ The present characterization of the WHO's changing priorities in face of the Cold War is necessarily kept brief. For an overview, see Farley, *Brock Chisholm*; Packard, *A History of Global Health*; Litsios, 'Malaria Control'; Litsios, 'Rural Hygiene'.

In the mid-1950s, the colonial preoccupation with tropical diseases⁶² was recast into a Cold War logic, which saw the eradication of infectious diseases as a weapon against the spread of communism.⁶³ Driven by economic arguments put forth by the WHO regional office for the Americas and supported by Marcolino G. Candau (1911–1983), the WHO's longest serving Director-General (1953–1973), the WHO directed much of its resources to the deployment of technocratic means, and the control of malaria became its flagship programme.⁶⁴

The focus on infectious diseases earned some successes in the control of yaws in Haiti and Indonesia and the much-celebrated elimination of smallpox. But malaria was recurring persistently. Resistance to chloroquine and DDT had emerged, and the impact of environmental degradation, contamination of human habitats, livestock, insects, and birds extracted a painful toll on the health and livelihood of rural populations. As faith in the coming of scientific modernity, which had peaked in the early post-war period, began to wane, the perception of malariologists as 'sorcerer's apprentices' who could not contain the spirits they had unleashed became a liability.⁶⁵ By the mid-1960s, a consensus had emerged that the control of infectious disease was premised to a significant extent on the existence of a minimum standard of 'basic health services'. It is in this context that the WHO returned to the broadly conceived notion of health set out in the preamble to its constitution.

A defining influence in promoting this (re)turn to the 'spirit' of social medicine was the Christian Medical Commission. Founded in 1968, the CMC represented the culmination of two conferences held in the preceding years by the World Council of Churches and the Lutheran World Federation. Later dubbed Tübingen I and II, they had produced a consensus regarding the role of the church's medical mission in the post-colonial area.⁶⁶ Reflecting the post-war influence of a secularized Protestant social gospel on American development work⁶⁷ and the growing acceptance in liberal Protestant Christianity of non-Western understandings of health and healing,⁶⁸ the CMC advocated that medical missionaries should no longer engage in a parochial and quasi-colonial medical triumphalism over the beliefs and health problems of local peoples. According to the consensus that had emerged in Tübingen I, Christians had a unique contribution to make to health-care, but the entire community should be involved in healing. Compassionate

⁶² Amrith, *Decolonizing International Health*.

⁶³ Cueto et al., *The World Health Organization*, 96–107.

⁶⁴ Zimmer, *Welt ohne Krankheit*, 219–75; Cueto et al., *The World Health Organization*, chap. 4.

⁶⁵ Cueto et al., *The World Health Organization*, 93, 96–112.

⁶⁶ For an overview, see Braley, 'The Christian Medical Commission'; Flessa, 'Why Do Christians Care?' An assessment of the later development of the WCC is given by Klassen in *Spirits of Protestantism*.

⁶⁷ Nursner, 'The "Ecumenical Movement" Churches'; Blevins, *Christianity's Role in United States Global Health and Development Policy*.

⁶⁸ Klassen, *Spirits of Protestantism*.

healthcare should be provided to all, in particular to the rural poor, who had long been alienated by centralized, professionalized, and urban missionary hospitals.⁶⁹ Inspired by the Chinese model of 'barefoot doctors', community health workers became an important component of this reorientation.⁷⁰ Premised on a soteriology of health which saw in healthcare an expression of God's love and compassion, the CMC 'embarked on a crusade for social justice in the promotion and distribution of health services'.⁷¹ It gave itself 'responsibility to promote the national co-ordination of church-related medical programmes and to engage in study and research into the most appropriate ways by which the churches might express their concern for total health care'.⁷²

The CMC's pioneering work in Africa and Asia provided a model for the provision of 'basic health services', later institutionalized in the WHO's 'Primary Health Care' (PHC) strategy. The nascent paradigm of PHC represented a shift towards using relatively unskilled professionals, churches, local healers, and other community stakeholders to provide comprehensive health services for the prevention and treatment of illness.⁷³ It represented a radical departure from the vertical, 'top-down' approach of disease eradication, which had characterized much of the WHO's work during its first 30 years of existence. The PHC programme pioneered a local, interprofessional, and community-based approach to healthcare delivery which addressed health needs over the whole life course, and included prevention, diagnosis, treatment, and rehabilitation. Unlike the vertical attempt to 'eradicate' individual diseases through technological interventions, PHC valorized the contribution of relatively unskilled professionals, partnership with civil society actors including churches, local healers, and other community stakeholders. Key figures in the development of this new strategy, such as John Bryant and Carl Taylor, were members of the CMC.⁷⁴

⁶⁹ Benn and Senturias, 'Health, Healing and Wholeness in the Ecumenical Discussion'.

⁷⁰ Medcalf and Nunes, 'Visualising Primary Health Care'; Packard, *A History of Global Health*. In the past decade, community health workers have seen a renaissance, see Hanrieder and Maray, 'Digitalizing Community Health Work'. They have also returned as a concern of WHO policy, cf. World Health Organization, *WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes*.

⁷¹ McGilvray, *The Quest for Health and Wholeness*, 93.

⁷² McGilvray, *The Quest for Health and Wholeness*, 61.

⁷³ Litsios, 'The Christian Medical Commission'; Litsios, 'The Long and Difficult Road to Alma-Ata'.

⁷⁴ Cueto et al., *The World Health Organization*, 170. Exchange between the WHO and CMC seems to have peaked in the early to mid-1970s. On 22 March 1974, then WHO Director-General Halfdan Mahler held a meeting with the senior CMC staff to explore cooperation, cf. McGilvray, *The Quest for Health and Wholeness*, 94. As recalled by Nita Barrow, then CMC deputy director, upon hearing of cooperation between the two, she exclaimed that 'this is like David and Goliath!' To this, Mahler is said to have replied: 'Yes, but I am a parson's son and I know what David did to Goliath.' World Health Organization, *From Alma-Ata to the Year 2000*, 715; Smith, 'Church and Health', 312. In September of the same year, a joint standing committee was formed. According to McGilvray, the CMC's first director, 'the most significant result of this cooperation between the two organizations was the formulation of the principles of Primary Health Care for which WHO must take most credit.'

As argued by Chorev,⁷⁵ the WHO's recognition of the inadequacy of the 'magic bullet' approach in the 1960s and 1970s coincided with the fragmentation of the former colonial empires into newly independent states, which gave hitherto unprecedented leverage to these countries: many UN agencies, though largely funded by rich countries of the Global North, had instituted a 'one country, one vote system', which began to threaten the geopolitical and economic hegemony of the post-war order. In 1974, the group of 77 countries (G-77), a multilateral political lobby group associated with the United Nations Conference on Trade and Development, succeeded in passing a UN General Assembly resolution calling for the development of a 'New International Economic Order' (NIEO). The NIEO supplied a coherent economic paradigm for the Non-Aligned Movement, a political alliance of impoverished nations of the Global South. It demanded the regulation of multinational corporations, the promotion of self-sufficiency in production, transfer of technology and industrial capacities, removal of unfair trade restrictions, aid and debt relief, and so on. Like other UN legislative bodies with a 'one country, one vote' system, the WHO's World Health Assembly gave the agenda of the Global South a procedural advantage. Conceived as a consensus-based, non-political organization staffed by medical doctors and public health experts, the WHO found itself at the intersection between American, Soviet, and non-aligned interests.

The NIEO provided considerable political support for the WHO's attempt to move away from the vertical approach of disease eradication and towards the provision of universal primary healthcare. Following years of discussion and concerns over the influence of the Soviet Union, which aggressively promoted the centralized provision of 'basic health services',⁷⁶ the WHO in 1977 launched the 'Global Strategy for Health for All by the Year 2000'. It represented an ambitious attempt to replace the vertical, top-down eradication of diseases at the hands of foreign experts and bureaucrats with the PHC, which not only emphasized holistic care over the course of the lifespan and the employment of local non-professional health workers but challenged the import of overpriced drugs and high-tech medical interventions and unethical marketing practices for questionable products such as infant formula milk. In 1978, the International Conference on Primary Health Care was held in Alma-Ata, Kazakhstan, and reached a rare moment of consensus during the Cold War (Fig. 2.3).

McGilvray, *The Quest for Health and Wholeness*, 95. Contacts continued throughout the 1970s and 1980s, facilitated by the physical proximity of the two organizations in Geneva, and the personal relationship between Mahler and McGilvray. Braley, in 'The Christian Medical Commission', 313, speaks of a 'cross-pollination' between the two organizations, while in 1983, Eric Ram, then WHA representative of the CMC, spoke of 15 years of 'partnership' with medical missionaries, in World Health Organization, 'Thirty-Sixth World Health Assembly, Geneva, Committee A', 10.

⁷⁵ Chorev, *The World Health Organization*.

⁷⁶ Litsios, 'The Long and Difficult Road to Alma-Ata'.



Fig. 2.3 Poster of the Alma-Ata conference illustrating the primary care approach.
 Source: World Health Organization, 'Photo Exhibit Part 2: 1960–1979'. Reproduced with permission.

The Health for All initiative was revolutionary in that it challenged vested economic interests which perpetuated the exploitative relations of the colonial era in a nominally post-colonial context. In many ways, it embodied a paradigm shift in international public health policy: healthcare ought not be the preserve of the affluent, urban classes and the rich countries of the Global North, while poor populations only had access to vertical disease eradication programmes and the exploitative products of multinational corporations. Rather, all social layers had a right to comprehensive healthcare.⁷⁷

The lobbying for a greater emphasis on the 'spiritual dimension' of health by non-aligned countries may appear to be a misplaced priority, considering many lacked even basic healthcare infrastructures. The 'spiritual dimension', however,

⁷⁷ In this sense, the Health for All initiative institutionalized a tendency of post-war international health efforts to compete with colonial powers. The establishment of the WHO's regional office for the African continent in Brazzaville is instructive. See Pearson, *The Colonial Politics of Global Health*, chap. 4.

was entirely congruent with the rejection of the geopolitical and economic status quo perceived to dominate the UN and WHO. It appealed to the human desire for betterment and social justice which stood opposed to the colonial vestiges of greed and materialism. This 'non-material resource' was interior and immediate; it would be found in local communities rather than the expensive solutions of multinational corporations. It was precisely such 'intangible factors' which were hoped to motivate a grassroots effort towards the widespread 'adoption by people of social and behavioural alternatives to technical measures'. This would be necessary to bring the Health for All initiative 'into the homes, the fields, the factories, the schools and other educational institutions, as well as the streets'.⁷⁸

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⁷⁸ World Health Organization, 'Seventy-Third Session of the Executive Board, Geneva, 11–20 January 1984: Resolutions and Decisions Annexes', 24.

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3

Ennobling Ideas

The World Health Assembly Debates the 'Spiritual Dimension' (1983–1984)

Simon Peng-Keller

While in the first three decades of its existence the 'spiritual dimension' was only mentioned casually within the WHO, in the 1980s it was explicitly discussed. In 1984, the 37th World Health Assembly adopted a resolution which emphasized the importance of the 'spiritual dimension' in healthcare policy and linked it to the 'Health for All by the Year 2000' initiative, a programme promoting more equitable health services worldwide. How was it possible that such a resolution could be discussed and passed—notably, in the middle of the Cold War? Who were the key players, and how was the 'spiritual dimension' understood in this discussion? The present chapter reconstructs the genesis of this resolution, whose significance has so far been largely ignored within and outside the WHO. After a brief look at the preliminary developments, three phases are explored in detail: the debate surrounding the first draft of the resolution during the 36th World Health Assembly in 1983; an interim phase in which the then Director-General of the WHO, Halfdan Mahler, produced a comprehensive position paper on the 'spiritual dimension' of health; and finally, the subsequent discussions held during the 37th World Health Assembly and the adoption of resolution 37.13. The chapter concludes with a brief analysis of the usage of the term 'spiritual dimension' in these discussions.

Putting the 'Spiritual Dimension' on the Agenda

At the 61st session of the WHO's Executive Board, held in 1978, a Libyan physician named A. M. Abdulhadi criticized a report on adolescents' health needs because it 'made no reference to spiritual values and their impact on adolescent development'.¹ At the same session of the Executive Board, only few days later, the Indian health official Desh Bandhu Bisht argued: 'If the ultimate aim of health was peace and happiness for mankind, then the spiritual parameter

¹ World Health Organization, 'Sixty-First Session of the Executive Board, Geneva, 11–26 January 1978: Part III: Summary Records', 15.

should be added to those already included, namely, physical, mental and social health.² Bisht's proposal, however, failed to convince the Executive Board. But according to his own account, his initiative generated 'an immense interest in several countries', such that he was entrusted by WHO's South-East Asia Regional Office in 1982 to continue investigating the subject.³

In the same year, at the International Conference on Primary Health in Alma-Ata (now Almaty, Kazakhstan), the Alma-Ata Declaration made the provision of primary healthcare the flagship strategy of the WHO. After years of preparation, and with important contributions by the Christian Medical Commission, the Primary Health Care strategy was adopted by representatives of 134 countries. It was a landmark decision, as it represented a departure from the WHO's former health policy of focusing on the eradication of certain diseases. Now the WHO was to work towards providing access to comprehensive prevention, treatment, rehabilitation, and palliative care, drawing on readily available resources within the community. As shown in the previous chapter, the concept of primary healthcare was premised on a culturally sensitive and participatory approach, open to the involvement of local churches and other religious groups.

One of the main architects of the Primary Health Care concept adopted with the Declaration of Alma-Ata the WHO was Halfdan Mahler, who served as Director-General of the WHO between 1973 and 1988. The son of a Danish Baptist preacher, Mahler 'developed the need to dedicate his life to a useful mission. His asceticism and presumably Protestant work ethic were to fuel his entire career.'⁴ During his tenure, Mahler became one of the driving forces behind the 'Health for All' initiative. To Mahler, the initiative represented a 'contemporary roadmap of the constitution'.⁵ His reading was coloured by the cosmopolitan ideals that marked the creation of many international organizations in the immediate post-war period, and reflected a sense of impending doom, the urgency to overcome national boundaries, and the willingness to use the WHO as an instrument of social change beyond health. Noted for his speaking abilities, he invoked colourful rhetorical images of WHO as a 'temple of health', tasked with an indispensable role to play on the future course of 'spaceship earth'.⁶

Mahler developed his own idiosyncratic understanding of the utilitarian dictum, implicit in the preamble, that the WHO's task is to achieve the 'maximum health benefits to the greatest number'.⁷ For Mahler, the definition of health was a

² World Health Organization, 'Sixty-First Session of the Executive Board, Geneva, 11–26 January 1978: Part III: Summary Records', 161.

³ Bisht et al., 'The Spiritual Dimension of Health', 2. We have been unable to corroborate this claim through the documents preserved in the SEARO archives.

⁴ Hanrieder, 'Mahler, Halfdan Theodor'. ⁵ Chorev, *The World Health Organization*, 72.

⁶ Litsios, 'The Long and Difficult Road to Alma-Ata', 717. See e.g. World Health Organization, *From Alma-Ata to the Year 2000*, 97–99, 101, 125.

⁷ Litsios, 'The Long and Difficult Road to Alma-Ata', 725.

statement of ‘transcendental beauty and significance’ which generated a ‘complete light’ that would guide the organization on its path towards primary healthcare reform.⁸ In his experience, the Alma-Ata conference was a ‘sacred moment’ which united the pantheon of nations behind the ‘gospel of health for all’.⁹ Under Mahler, the World Health Assembly in 1979 launched the Health for All initiative, a programme infused as much by the new primary healthcare paradigm as by a humanistic ethos. It formed a major reference point for subsequent discussions, which will be examined more closely in the following.

The impetus to include a spiritual dimension in the Health for All initiative, however, was not exclusively linked with the push for primary healthcare. As we will see, delegates from predominantly Islamic states first took this step. In a report published in 2000, Abdul Rahman Al-Awadi (1936–2019), Kuwaiti minister of health and a former member of the WHO’s Executive Board, pointed out that the Islamic countries’ initiative had been connected with a shift in awareness that led to the foundation of the Islamic Organization for Medical Sciences (IOMS). The IOMS was set up in Kuwait in 1981 with the aim of working out an Islamic response to new forms of medical practice. In sharp distinction to



Fig. 3.1 Abdul Rahman Al-Awadi and Halfdan Mahler, shown signing the declaration of the global eradication of smallpox on 8 May 1980.

Source: WHO/Jean Germain, in WHO Photo Library, Image ID 38148. Reproduced with permission.

⁸ Mahler, ‘Address to the 61st World Health Assembly’, paras 3, 38.

⁹ World Health Organization, ‘Primary Health Care Comes Full Circle: An Interview with Dr Halfdan Mahler’, 748.

Western medicine, it advocated a return to Islamic medical tradition, including the reinstatement of the ‘lost’ spiritual dimension (see Chapter 4). Alongside the obvious concern to bring the Islamic perspective to bear on the context of global health policy, Al-Awadi’s advocacy for a ‘spiritual dimension’ of health may also have had personal motivations (Fig. 3.1). His commitment to medicine and public health had been awakened not by a religious experience, but by the early loss of a friend after an accident and medical failure.¹⁰

Looking back on the threshold of the new millennium, Al-Awadi wrote: ‘[The] IOMS was successful in including the spiritual component in the definition of the human being at World Health Organization’.¹¹ Can this statement be corroborated by other available sources?

Debates at the 36th World Health Assembly (1983)

In the words just quoted, Al-Awadi did not elaborate on the decisive role he himself played in this process. Remarkably, the discussion was initiated by the representative of a small African country with a colonial past: Samuel Hynd (1924–2016), the health minister of Swaziland. Hynd was a committed member of the Church of the Nazarene¹² and his father had worked as a medical missionary to build Swaziland’s healthcare system on European models.¹³ In his address to the plenary meeting on 4 May 1983, Hynd made the following statement:

At the risk of being misunderstood, but in order to identify an area to give further impetus to our unquestionably noble efforts, I find the definition of health in our Constitution is wanting. [...] there is a dimension to a man or a woman that goes beyond and above his physical, mental and social wellbeing. There is something within a person – [...] what one could call attitude, motivation, driving force, or by whatever name you wish to call it or define it, but which I prefer to call spirit.¹⁴

With this, Hynd put the ‘spiritual dimension’ into the spotlight of the WHA. He continued by linking it directly to the organization’s efforts for more effective and equitable healthcare systems:

¹⁰ Qattan, ‘Dr Abdul’.

¹¹ Al-Awadi, ‘The Role of the Islamic Organization for Medical Sciences in Reviving Islamic Medicine’, 68.

¹² Ellis and Hynd, *Footprints on African Hearts and Lands*.

¹³ Cf. Ellis and Hynd, *Footprints on African Hearts and Lands*; Dlamini, ‘The Introduction of Western Medicine in Southern Africa’.

¹⁴ World Health Organization, ‘Thirty-Sixth World Health Assembly, Geneva, 2–16 May 1983: Verbatim Records of Plenary Meetings, Reports of Committees’, 106.

Our founding fathers may have been afraid of this word for various reasons, but let us face it, the programmes in health that are proving successful in our countries are those led by people whose healthy spirit makes it a success. A programme can have all the ingredients of being good and successful, but it comes out dry and lacking the spiritual quality it needs. I may be accused of introducing some religious concept into WHO, but let me say that whether you are a priest or a mullah or a commissar, you are a success or otherwise by virtue of the spirit in which you conduct your programme and of your inner spiritual being. What I am really saying is, that if we want a healthy WHO and a healthy health for all, I want to see health in our Constitution this way: "Health is a state of complete physical, mental, social and spiritual wellbeing."¹⁵

Various elements of the resolution text ultimately adopted can already be found in Hynd's speech: the link to the Health for All initiative; the reference to the WHO's definition of health; the identification of a 'spiritual dimension' as a motivating factor in the promotion of healthcare; and the interreligious understanding of this dimension. Hynd appealed to the delegates at the World Health Assembly to support his initiative:

[...] if there is sufficient support forthcoming from the corridors and the coffee rooms and even the cloakrooms, I am willing to rejoin with those of like mind and press for their consideration by this, or even future, Assemblies. [...] I see the way to do this is to have the Director-General communicate a suggested amendment at least six months in advance of the Health Assembly. In fact, those who wish to join me in promoting this concept, tell me, and let us give the health politicians 12 months to do their lobbying and their manoeuvring and have it ready for debate at the Thirty-seventh World Health Assembly in 1984, if we are still on this planet by then.¹⁶

Hynd's plan was supported by several African countries, but most enthusiastically by delegates from Arab nations. The most prominent among them was Al-Awadi. On 5 May 1983 Hynd wrote in his diary: 'Kuwait Minister gave a very strong speech on the need for spiritual dimension to be included in health. As a former President of the Assembly his word carries much more weight than mine.'¹⁷

Al-Awadi took up the cause while adding elements of his own, including criticism of the prevailing, US-dominated geopolitical and cultural world order.

¹⁵ World Health Organization, 'Thirty-Sixth World Health Assembly, Geneva, 2–16 May 1983: Verbatim Records of Plenary Meetings, Reports of Committees', 109.

¹⁶ World Health Organization, 'Thirty-Sixth World Health Assembly, Geneva, 2–16 May 1983: Verbatim Records of Plenary Meetings, Reports of Committees', 110.

¹⁷ We thank Thomas A. Noble for the diary excerpt and Hynd's daughter Elizabeth for her help in deciphering the manuscript.

The anxiety and insecurity characterizing our age, he said, was due to a spiritual ‘vacuum’:

I am quite certain that, regardless of what we do to provide health care for the body and the mind, man will remain lost and restless until we provide for the spiritual aspect of life [...]. The need is therefore great today, for us who are responsible for the health care of man, to provide for this spiritual aspect in our programmes lest they become void and soulless. I would invite the Director-General to take into account the need to emphasize this spiritual aspect as the Organization establishes various health care programmes for mankind. I suggest, therefore, that we add this spiritual dimension to our definition of health, and I believe that all my fellow delegates will agree with me as to the need to modify the definition of health to accommodate this significant aspect in view of its importance in directing our course of action, if we are serious about providing health for all by the year 2000.¹⁸

Contrary to later statements in this debate, Al-Awadi did not contrast the ‘spiritual’ and the ‘materialistic’ here, but presented a ‘spiritual aspect of life’ as complementary to ‘health care for the body and the mind’. Al-Awadi’s motion was not taken up by the 9th plenary meeting, which was marked by a heated exchange concerning the ongoing Israeli–Palestinian conflict. Only in Mahler’s closing speech, which emphasized the various religions’ shared ethos and the current ‘spiritual resource gap’, was this topic referred to again.¹⁹

A week later, on 13 May, the representative of the Christian Medical Commission, Eric R. Ram (1935–2006), also lent his full backing to Hynd’s proposal. Ram used the opportunity to make the members of their committee (the so-called ‘Committee A’, which played a crucial role in the further development of the discussion) aware of the interfaith consultations that the CMC had conducted since 1977 in various countries around the world: ‘One clear factor had emerged from the study: body, mind and spirit were inseparable and, consequently, all dimensions, including the spiritual, had to be taken into consideration in the provision of health care.’²⁰

However, there was also clear opposition voiced at the same meeting. The spokesman of the opposing side was M. N. Savel’ev, representative of the USSR. The records of his statements are indirect evidence of the fact that there was already a draft resolution at hand, even though Hynd had suggested that such

¹⁸ World Health Organization, ‘Thirty-Sixth World Health Assembly, Geneva, 2–16 May 1983: Verbatim Records of Plenary Meetings, Reports of Committees’, 224–5.

¹⁹ World Health Organization, ‘Thirty-Sixth World Health Assembly, Geneva, 2–16 May 1983: Verbatim Records of Plenary Meetings, Reports of Committees’, 245–6.

²⁰ World Health Organization, ‘Thirty-Sixth World Health Assembly, Geneva, Committee A: Provisional Summary Record of the Fourteenth Meeting’, 11.

a resolution be prepared for the coming year's 37th World Health Assembly. The discussion was gaining momentum more swiftly than its initiator had anticipated.

As regards the draft resolution on the spiritual dimension in health care programmes, his [Savel'ev's] delegation had every respect for delegates' religious views; religious aspects certainly played an important role in the organization of health services in some countries – although he would stress that that was not universally the case. A request of that nature to the Director-General could involve him in serious problems, since there were a wide variety of religious teachings in the world and it would be extremely difficult for him to take them all into account in the preparation of primary health care programmes. A better solution might be for the Member States concerned to take action themselves when they planned their national programmes for primary health care. He would be submitting a number of amendments which, without altering the substance of the draft resolution, would render it acceptable to his delegation and better reflect the position of various countries and regions on the question.²¹

The discussion on the draft resolution was arranged for the 16th meeting of Committee A, scheduled for the next day. According to Hynd's personal diary, it was drafted by Al-Awadi and submitted by the delegates of the following countries: Bahrain, Botswana, Chile, Egypt, Kenya, Kuwait, Malawi, Mauritania, Morocco, Oman, Qatar, Saudi Arabia, Somalia, Sudan, Swaziland, Syrian Arab Republic, Tunisia, United Arab Emirates, Venezuela, Democratic Yemen, North Yemen, and Zambia. The provisional text, which included all four aspects referred to by Hynd, was entitled 'The spiritual dimension in health care programmes':

The Thirty-sixth World Health Assembly,

Pursuant to the objective of WHO spelled out in its Constitution, namely the attainment by all peoples of the highest possible level of health;

Recalling the first principle in the WHO Constitution that health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity;

Considering that a spiritual dimension is implicit in such a concept of health;

Bearing in mind the policy adopted by the Organization of ensuring primary health care for all peoples of the world in order to attain the social objective of health for all by the year 2000;

Recognizing the major importance of the spiritual dimension in providing the best possible health care to peoples;

²¹ World Health Organization, 'Thirty-Sixth World Health Assembly, Geneva, Committee A: Provisional Summary Record of the Fourteenth Meeting', 12.

1. AFFIRMS the importance of the spiritual dimension in providing health care to peoples;
2. REQUESTS the Director-General to take the spiritual dimension into consideration in the preparation and development of primary health care programmes aimed at the attainment of the goal of health for all by the year 2000.²²

The discussion of this draft was opened by Ali Youssel Al-Saif, who represented Kuwait together with Al-Awadi. His line of argument was a continuation of Al-Awadi's cultural criticism, and drew a sharp distinction between a 'materialistic' and a supposedly more 'spiritual' life:

Material concerns dominated human life; people were lost and sought security and calm. Physicians must try to take account of man's spiritual nature. Materialism had dominated daily life to such an extent that spiritual values no longer counted and men were afraid of the future. That malaise could be ascribed, to a large extent, to a lack of respect for spiritual values, and to the denial of the spiritual dimension, which could help men to live with confidence in the future.²³

Based on this diagnosis, Al-Saif concluded that the inclusion of a 'spiritual dimension' by physicians was a particularly pressing need in the current age: 'Physicians were attempting to implement the policy of WHO in achieving health for all by the year 2000 for reasons which should also induce them to take account of the spiritual dimension in the work of caring for the health of mankind.' Al-Saif then drew the consequences of this approach for physicians themselves, demanding that medical practitioners also adopt a spiritually-informed attitude, one 'that presupposed that health care, including both prevention and treatment, should take into account the mental and spiritual components of man's nature, and that in turn presupposed that physicians should try to rise spiritually above their material possessions'.²⁴

A critical stance on the draft resolution was taken by Savel'ev and the representatives of other communist states, whereas the delegates from the United Arab Emirates and Togo came out in favour. The 'spiritual dimension', the latter two argued, was to be treated in the same way as traditional medicine, which had, after

²² World Health Organization, 'Thirty-Sixth World Health Assembly, Geneva, Committee A: Provisional Summary Record of the Fourteenth Meeting', 15.

²³ World Health Organization, 'Thirty-Sixth World Health Assembly, Geneva, 2-16 May 1983: Verbatim Records of Plenary Meetings, Reports of Committees', 222.

²⁴ World Health Organization, 'Thirty-Sixth World Health Assembly, Geneva, 2-16 May 1983: Verbatim Records of Plenary Meetings, Reports of Committees', 222.

initial resistance, gained recognition by the WHO in view of its significance for healthcare (see Chapter 5).²⁵

Several speakers highlighted uncertainty regarding the precise meaning of the ‘spiritual dimension’ in the draft resolution. The most forceful input in this respect came from the representative of West Germany, who admitted that his delegation was ‘in the awkward position of no longer knowing what was really being talked about. The text of the draft resolution mentioned a spiritual dimension, but other delegations had spoken of a religious dimension; perhaps it was even the mental dimension that was meant. For that reason, his delegation would greatly appreciate any clarification of what was understood by “spiritual dimension”.’²⁶

M. T. Houénassou-Houangbe of Togo expressed his surprise about the resistance to the proposed terminology and advocated a broad interpretation: ‘the spiritual dimension could be anything from the purest atheism to the purest fanaticism’.²⁷ Finally, Halfdan Mahler also joined in the discussion, citing two definitions from the Oxford English Dictionary (‘spirit’: the ‘intelligent or immaterial part of man, soul’; and ‘spiritual’: ‘of spirit, as opposed to matter’). Since no consensus was about to be reached regarding the term and its inclusion, Mahler suggested deferring the final vote to the next World Health Assembly. The minutes of the meeting read as follows:

He [Mahler] did think that the Health Assembly, when dealing with such an interpretation of health, must read the word in a spirit – and he stressed the word ‘spirit’ – of real understanding and unanimity. He believed there would be a possibility of arriving at such unanimity if there was sufficient time for dialogue as to what was implied. For himself personally, he thought most would agree that there was a spiritual dimension of man, in the sense expressed by the Oxford Dictionary; whether there could be a spiritual dimension in health care programmes, according to the English language, he was not so sure. [...] he had to say that the Director-General obviously could not become the ‘driver’ of that spiritual dimension of man as it related to man’s health; that devolved on man himself, individually, or his family, community or representatives.²⁸

In the subsequent vote, a majority came out against both the amendments proposed by Savel’ev and for the postponement suggested by Mahler. The vote was followed by a further discussion, in which the representatives of various

²⁵ World Health Organization, ‘Thirty-Sixth World Health Assembly, Geneva, 2–16 May 1983: Verbatim Records of Plenary Meetings, Reports of Committees’, 224–5.

²⁶ World Health Organization, ‘Thirty-Sixth World Health Assembly, Geneva, 2–16 May 1983: Verbatim Records of Plenary Meetings, Reports of Committees’, 224.

²⁷ World Health Organization, ‘Thirty-Sixth World Health Assembly, Geneva, 2–16 May 1983: Verbatim Records of Plenary Meetings, Reports of Committees’, 224.

²⁸ World Health Organization, ‘Thirty-Sixth World Health Assembly, Geneva, 2–16 May 1983: Verbatim Records of Plenary Meetings, Reports of Committees’, 224.

countries expounded their position. Rubén Rodríguez Gavaldá from Cuba explained his contrary position by saying that it was unclear whether the integration of a 'spiritual dimension' in the Health for All initiative was compatible with the sovereignty of Member States. He also emphasized the importance of making a clear semantic distinction between 'religious' and 'spiritual'. The word 'compassion', he said, had a clear spiritual, but not necessarily religious connotation. Even Al-Saif made the point that the inclusion of a 'spiritual dimension' did not need to be understood in religious categories. According to him, it simply meant that the mental dimension had to be taken into account in addition to the physical one. The Dutch representative backed this, saying that his delegation had agreed to the proposed draft under the assumption that 'spiritual' was not synonymous with 'religious'.²⁹

The discussion was resumed in the plenary meeting the following week. The first speakers pointed out that no solid consensus had been reached in Committee A, and that more thorough preparatory work was therefore required. Dr Cabral from Mozambique highlighted the fact that a 'spiritual dimension' could be brought in connection with a variety of aspects—with 'mental health; medical ethics; respect for each people's culture; health education; and so on'. This also posed a problem with regard to implementation. 'How is this spiritual dimension going to be monitored or evaluated?'³⁰ Al-Saif, for his part, again reiterated his stance:

Care of the body alone is insufficient, we ought to cater for the spiritual side of man as well. If we examine closely the definition of health, stated in the Constitution of WHO, as 'a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity', we find that this concept includes the spiritual dimension. What is meant by the spiritual dimension is neither religion nor doctrine. Anyone who thinks that the draft resolution has religious or dogmatic implications is mistaken. What is meant by it is nothing more or less than the spiritual side of man, not the religions or doctrines followed.³¹

The plenary meeting finally approved the proposal to instruct the Executive Board to further clarify matters. This is what Hynd had requested in his initial statement, which had triggered the discussion. It is worth noting that neither the USA nor

²⁹ World Health Organization, 'Thirty-Sixth World Health Assembly, Geneva, 2–16 May 1983: Verbatim Records of Plenary Meetings, Reports of Committees', 225–6.

³⁰ World Health Organization, 'Thirty-Sixth World Health Assembly, Geneva, 2–16 May 1983: Verbatim Records of Plenary Meetings, Reports of Committees', 270.

³¹ World Health Organization, 'Thirty-Sixth World Health Assembly, Geneva, 2–16 May 1983: Verbatim Records of Plenary Meetings, Reports of Committees', 271.

Western European countries (apart from the quoted exceptions) took part in the documented discussions, nor did they co-sign the draft resolution.

Mahler's Report

As a basis for further discussions, Halfdan Mahler drafted an extensive report, which was concluded on 21 October 1983. Three months later, on 16 January 1984, the Executive Board discussed the report and approved it without reservation. A number of Mahler's formulations were later integrated into the resolution text. To narrow down the range of possible interpretations, the report began with terminological considerations. The adjective 'spiritual', said the report, indicates 'a phenomenon that is not material in nature but belongs to the realm of ideas that have arisen in the minds of human beings, particularly ennobling ideas'.³² Thus the spiritual dimension was differentiated in two ways: by qualifying it ontologically (spiritual vs. material), and by linking it to a realm of higher values ('ennobling ideas').

The meaning of the latter is explained in a section that Mahler entitled 'Historical overview', comprising a kind of historical anthropology. The distinctive feature that made humans beings into what they were, Mahler claimed, was their ability to develop ideas and to be guided by them. Mahler distinguished between ideas aiming to improve people's material circumstances and those that relate to the meaning of life and so lead to religious, moral, and philosophical concepts. His account took the reader from earlier historical developments directly to modern-day movements for freedom and democracy. The examples he gave for 'ennobling ideas' included those expressing political ideals that were espoused by different addressees of the report: 'All people are born free'; 'Liberty, equality, fraternity'; 'Workers of the world, unite!'³³

Finally, the report also emphasized the practical, social, and policy implications of such concepts and ideals. The Health for All initiative was interpreted as a continuation of the aforementioned humanistic concepts: 'It was greatly influenced by such humane qualities as a sense of decency, empathy with the world's health underprivileged, compassion, and the desire for social justice regarding health.' Mahler's line of argument tended to identify the spiritual dimension with non-material values that brought significant benefits to human life. The establishment of more just and value-sensitive healthcare provision required the accommodation of the prevailing values of the culture or community in question:

³² World Health Organization, 'Seventy-Third Session of the Executive Board, Geneva, 11–20 January 1984: Resolutions and Decisions Annexes', 23.

³³ World Health Organization, 'Seventy-Third Session of the Executive Board, Geneva, 11–20 January 1984: Resolutions and Decisions Annexes', 23.

Their value systems can express themselves in widely different ways, such as religious beliefs and practices, whether theistic or otherwise; political ideologies; moral sentiments; national, tribal or other group solidarity; the desire to perpetuate local and family traditions and cultural heritage; or concern for the future of the world's environment. For individuals, value systems can find expression in such ways as the reading or writing of literature or poetry; meditation; prayer; active or passive enjoyment of such arts as painting, sculpture, music and dancing; and the practice of sports.³⁴

In this list, Mahler's consensus-seeking intentions became clearly discernible. He emphasized that the 'spiritual dimension' encompassed any kind of conviction or practice that generates value and self-transcendence. For diplomatic reasons, Mahler's position oscillated between conceptual 'thinning' and 'thickening'.³⁵ He avoided turning 'spirituality' into a non-committal residual category by linking it to a humanistic ethos that informed efforts to build more equitable healthcare systems. Therefore, the concept of 'ennobling ideas', in the form of universal ethical principles and attitudes, formed the criterion for what was to be understood by the 'spiritual dimension'. In a meeting with the WHO Regional Committee for South-East Asia in 1978, Mahler's position was anticipated as follows: The 'spiritual heritage of Asia' could 'be expressed in one word "humanism"'.³⁶ Hence, one could characterize Mahler's approach as a humanistic reinterpretation of religiously influenced ideas.

Adoption of the Resolution at the 37th World Health Assembly (1984)

Mahler's report paved the way for resolution WHA37.13. At the 37th World Health Assembly, representatives of Arab states drove the discussion and took up Mahler's arguments. On 14 May 1984, Abdul Rahman Al-Awadi opened the debate in the fifth Committee A meeting. He stressed the fact that the 'spiritual dimension' cannot be reduced to religious teachings, but referred to a humanistic ethos in the sense outlined by Mahler, which included a commitment to a just system of healthcare. In the afternoon of the same day, Al-Awadi submitted an amended draft resolution, which was supported by Bahrain, Iraq, Kuwait, Oman,

³⁴ World Health Organization, 'Seventy-Third Session of the Executive Board, Geneva, 11–20 January 1984: Resolutions and Decisions Annexes', 24.

³⁵ Hanrieder, 'The Public Valuation of Religion in Global Health Governance'.

³⁶ World Health Organization, South-East Asian Regional Office, 'Report of the Thirtieth Session of the WHO Regional Committee for South-East Asia in Bangkok, Thailand, 2–8 August 1977', 137.

and the United Arab Emirates.³⁷ Surprisingly, a large number of countries that had backed the first draft resolution were no longer represented on this list. How can this reduction in numbers be explained? Perhaps by the fact that Swaziland was no longer represented by Samuel Hynd and his network was no longer available for the pursuit of the matter. But other reasons are also conceivable: for example, that the support of the Arab countries may have caused states to align according to their position in the Palestinian–Israeli conflict which overshadowed the debates in the WHA, or that the Gulf states saw the resolution above all as their own project and had missed the opportunity to involve other states.³⁸

The new draft remained close to Mahler’s conceptual input. Apart from item 9, it closely resembled the resolution ultimately adopted:

The Thirty-seventh World Health Assembly,

Having considered the Director-General’s report on the spiritual dimension in the Global Strategy for Health for All by the Year 2000 and the recommendation of the Executive Board thereon contained in resolution EB73.R3;

Understanding the spiritual dimension to imply a phenomenon that is not material in nature but belongs to the realm of ideas, beliefs, values and ethics that have arisen in the minds and conscience of human beings, particularly ennobling ideas;

1. THANKS the Director-General for his report and the Executive Board for its recommendation;
2. CONCURS with the reflections contained in the report;
3. NOTES that ennobling ideas have given rise to health ideals which have led to a practical strategy for health for all that aims at attaining a goal that has both a material and non-material component;
4. RECOGNIZES that if the material component of the strategy can be provided to people, the non-material or spiritual one is something that has to arise within people and communities in keeping with their social and cultural patterns;
5. CONSIDERS that the realization of the health ideals that form the moral basis of the goal of health for all by the year 2000 will itself contribute to people’s feelings of wellbeing;
6. RECOGNIZES that the spiritual dimension plays a great role in motivating people’s achievement in all aspects of life;

³⁷ World Health Organization, ‘Thirty-Seventh World Health Assembly, Geneva, 7–17 May 1984: Summary Records of Committees’, 82.

³⁸ Since also some of the Arab states did not take part any more, this assumption is not completely convincing either.

7. AFFIRMS that ennobling ideas have not only stimulated worldwide action for health but have also given to health, as defined in WHO's Constitution, an added spiritual dimension;
8. INVITES Member States to consider including in their strategies for health for all a spiritual dimension as defined in this resolution in accordance with their social and cultural patterns;
9. REQUESTS the Director-General to study further the role of the spiritual dimension in promoting the attainment of the goal of health for all by the year 2000.³⁹

As a result of the preceding discussions, the text of the resolution remained non-committal. Member states were not obliged, merely 'invited', to include a 'spiritual dimension' in their healthcare policies.

Nevertheless, the proposal to expand the concept of health touched the very core of what the WHO stood for. This might explain the ensuing controversial discussions around the new draft. As in the previous year, the critics were led by M. N. Savel'ev, who repeated his previous arguments. In his statement, he began by expressing his respect for Mahler's report and emphasizing the importance of moral, ethical, and social aspects, as well as cultural traditions, for the implementation of a global health strategy. He then proposed cutting down the resolution text to the introductory remarks and item 1. This proposal was rejected by the committee. By contrast, the proposal—submitted by the Czechoslovakian representative—to merely delete item 9 was approved by the meeting.

In addition to Al-Awadi, who reaffirmed his understanding of a 'spiritual dimension', the representatives of India and Canada also argued in favour of the draft text. Desh Bandhu Bisht reminded his colleagues that the matter had already been discussed by the Executive Board back in 1978, and that he had then expressed his view that the 'spiritual dimension' was what distinguished humans from animals. The difficulty of pinning down what it actually meant was not, according to Bisht, a conceptual problem, but the result of its grandeur and sublimity:

[...] as Socrates had said, the first step toward knowledge was to know that one knew nothing. It might be that we knew nothing of the spiritual dimension, but it could not be said that the spiritual dimension did not exist, and it was a worthy aim to seek to find it. The key to health in all communities and throughout the world might well be the addition of the factor X – better expressed, perhaps, as

³⁹ World Health Organization, 'Thirty-Seventh World Health Assembly, Geneva, 7–17 May 1984: Summary Records of Committees', 82–3.

'heart for all', defining the heart not in the anatomical but in the literary sense, as the centre of being.⁴⁰

Jean Larivière, the representative of Canada, confirmed that his country shared many of the ideas expressed in the draft, and pointed out that UNICEF had already adopted the same stance. Larivière particularly emphasized the significance of the psychosocial aspect, which, according to him, was encompassed in the 'spiritual dimension', with the latter being contained in the term 'care':

Psychosocial considerations presupposed that human beings were spiritual and loving creatures. The spiritual dimension was an intrinsic part of the word 'care' for health care workers and health care services. However, the spiritual dimension in the Global Strategy should not become a new research programme for WHO; rather, it should be a concept that would be borne in mind in developing and implementing health programmes.⁴¹

In the end, 55 delegates of Committee A voted in favour of a draft resolution shorn of the original item 9, while 31 abstained.⁴² The high number of abstentions might be an indication that Mahler's efforts to reach a broad consensus by expanding the original concept and adding an ethical flavour were only partly successful. On the following day, the text was officially adopted by the plenary meeting as resolution A37/VR/12.

Discussion

The discussions reconstructed in the preceding sections were influenced by many factors: national and regional political interests, and, not least, the personal convictions of the main actors. Moreover, as in all discourses within the WHO and other UN organizations, it is often unclear to whom the votes are primarily addressed and who should be convinced. It should now be clear that this discourse was not only about national interests but also about 'visions of the common good' and 'moral narratives'⁴³ on healthy societies and about the identity of the WHO itself.

⁴⁰ World Health Organization, 'Thirty-Seventh World Health Assembly, Geneva, 7–17 May 1984: Summary Records of Committees', 83–4.

⁴¹ World Health Organization, 'Thirty-Seventh World Health Assembly, Geneva, 7–17 May 1984: Summary Records of Committees', 84.

⁴² World Health Organization, 'Thirty-Seventh World Health Assembly, Geneva, 7–17 May 1984: Summary Records of Committees', 84.

⁴³ Hanrieder distinguishes between four 'visions of the common good': survival, fairness, production, and spirit. In Hanrieder, 'Orders of Worth and the Moral Conceptions of Health in Global Politics'.

Irrespective of how resolution WHA37.13 might have been put into practice, it was innovative on a conceptual level. Several different aspects of the term 'spiritual dimension' were brought to the fore in the discussions, and were given a certain substance by the following three distinctions.

Firstly, the contrast between 'spiritual' and 'religious' seemed significant: it is noteworthy that even Al-Awadi, who often began his speeches by invoking Allah, was adamant about differentiating between the two. In practice, this differentiation likely also served as a diplomatic step in the consensus-building process, since it helped bridge the divide between 'religious' and 'secular' and thus also the gap between various worldviews.

Secondly, there was the cleavage between 'spiritual' and 'material' (or 'natural').⁴⁴ This second distinction, which also informed the representatives of the IOMS, came up as a well-known ontological differentiation between various spheres of reality ('material reality'/'mental reality'),⁴⁵ or as a differentiation between aspects of the human being ('body'/'soul'). One of the remarkable paradoxes of the discussion analysed here is that the 'spiritual dimension', a holistic notion aimed at redressing the dominance of the biomedical approach, closely traced the Cartesian dualism which underwrites biomedical epistemology.

Thirdly, the question of 'spiritual' vs. 'materialistic' (in a moral sense) was discussed: as described above, the discussions, carried out in the context of the Health for All initiative, were strongly inspired by a humanistic ethos and a cosmopolitan 'order of worth'.⁴⁶ In Mahler's narrative, the programme itself represented one of the 'ennobling ideas' that contribute to humanity's material and immaterial welfare and can thus justifiably be called 'spiritual'.⁴⁷ What applies to the WHO's definition of health also holds true for the 'spiritual dimension': It was not a descriptive concept, but an evaluative or normative one linked to the universal right to health. Contrary to the tendency in public health to keep anything 'spiritual' in the private realm, the 'spiritual dimension' in the documents analysed here becomes manifest in social and community-building practices. In this respect, the discussion and its outcome can be interpreted as a programmatic basis for a social model of spiritual care.⁴⁸

⁴⁴ Cf. Mahler's usage of the term in a later speech: 'People all over the world have definite ideas about health, about how to strengthen health, how to prevent illness, how to cope with sickness. These ideas are part of the larger fabric of beliefs, assumptions, and practices concerning the body and people's relationships with each other and to natural and spiritual forces.' World Health Organization, 'Conference of Experts on the Rational Use of Drugs: Report by the Director-General: Part IV', 10.

⁴⁵ Cf. Peng-Keller, 'Genealogies of "Spirituality"'.
⁴⁶ Appiah, *Cosmopolitanism*; Hanrieder, 'Orders of Worth and the Moral Conceptions of Health in Global Politics'.

⁴⁷ In a later interview, Mahler linked the first distinction with the third one by highlighting that the term 'spiritual' was not to be understood 'in the religious sense [...] but in the sense that people wanted to accomplish something great'. World Health Organization, 'Primary Health Care Comes Full Circle: An Interview with Dr Halfdan Mahler'.

⁴⁸ Rumbold, 'Models of Spiritual Care'.

Historically, the process that culminated in the adoption of resolution WHA 37.13 can be described in a threefold way: First, as a quest for a health policy compromise, in which the term ‘spiritual dimension’ with its wide range of possible meanings served the purpose of bridging the divide between opposing worldviews. From this point of view, the course of the discussion described represents a process of conceptual ‘thinning’, in which the primarily religiously connoted term ‘spiritual’ was translated into a secular and abstract language.⁴⁹ Second, from the perspective of the principal actors in the process, it might be more appropriate to speak of an unfolding process, during which an aspect that was already implicitly present in the WHO’s definition of health was made explicit and henceforth impossible to ignore. Finally, the discussion described can also be viewed as a creative process of ‘value generalization’⁵⁰ or ‘norm construction’,⁵¹ in which the commitment to a better and fairer global healthcare was reinforced by framing it with a spiritual and cosmopolitan ‘order of worth’.⁵²

Irrespective of how the process and its result are to be interpreted, the discussions around resolution WHA 37.13 represent a milestone for the WHO’s approach to the ‘spiritual dimension’. It was the first and so far the only time in the history of the WHO that the WHA discussed this topic explicitly and in some detail. The fate of this resolution remained closely linked to the Health for All initiative, which provided a favourable context for the discussion. Already during Mahler’s last years in office, this paradigm lost importance in the WHO, so that the aims of the resolution were only rudimentarily adopted. The significance Mahler himself attached to the resolution was demonstrated in a lecture he gave in Rome three years later at the invitation of the Holy See. He not only contrasted ‘spiritual’ with ‘materialistic’ values and acknowledged the church’s commitment to health promotion, which ‘inspired the very concept of primary health care’ – a nod towards the influence of the CMC on the WHO during the 1970s (see Chapter 2). But he also spoke of the WHO’s ‘courageous definition of health in the WHO’s constitution, which says that health is a state of complete physical, social and spiritual well-being and not merely the absence of disease or infirmity’.⁵³ Interestingly, Mahler here extended resolution 37.13 on the ‘spiritual dimension’ of the Health for All initiative to the health definition anchored in the preamble to the WHO’s constitution.

⁴⁹ This interpretation is in line with Habermas’ idea of discursive abstraction and institutional translation of particular values, cf. Habermas, ‘Religion in the Public Sphere’; Bettiza and Dionigi, ‘How Do Religious Norms Diffuse? Institutional Translation and International Change in a Post-Secular World Society’; Hanrieder, ‘Orders of Worth and the Moral Conceptions of Health in Global Politics’.

⁵⁰ For this concept cf. Joas, *The Genesis of Values*.

⁵¹ Hanrieder, ‘The Public Valuation of Religion in Global Health Governance’, 86.

⁵² Cf. Hanrieder, ‘Orders of Worth and the Moral Conceptions of Health in Global Politics’; Hanrieder, ‘The Public Valuation of Religion in Global Health Governance’.

⁵³ Mahler, ‘Medical Cooperation with Developing Countries’, 8.

Conclusion

Far-reaching decisions often result from constellations that, in retrospect, are highly contingent in nature. This certainly applies to the discussions outlined in the sections above. The debate was triggered by the representative of a small, post-colonial African nation. Among the contingencies that contributed to the initiative's ultimate success was the humanistic ethos behind the Health for All initiative, inspired by social medicine and strongly promoted by Halfdan Mahler and other influential members of the WHO. Another factor was the fact that, two years earlier, several Gulf state representatives had set up an organization with the aim of integrating a 'spiritual dimension' into healthcare in a new way through a revival of Islamic medical traditions. The documents reviewed show that Abdul Rahman Al-Awadi had recognized the similarity of this goal with that of the proposal submitted by Hynd. However, the support of Member States from the Eastern Mediterranean region, without which the proposal would probably have shared the fate of Bisht's several years before, also had its drawbacks: it was liable to be interpreted as an attempt to bring vested religious interests and a conservative morality to bear on health policies. In the following chapter, the potential problems involved in such an occurrence are examined in detail using the translation of the 'spiritual dimension' of health into health policies in the Regional Office for the Eastern Mediterranean.

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4

From Religious Revival to Health Policy

The WHO's Eastern Mediterranean Office
(1981–2006)

Fabian Winiger

The 'spiritual dimension' of health, we have shown in the preceding chapters, provided a shared, 'holistic' ethical framework to unite members of international organizations such as the WHO across ideological differences. But the success of this initiative was not merely a remarkable feat of multilateral partnership. In this chapter, we turn our attention to another aspect: the entanglement of the 'spiritual dimension' with the struggle for post-colonial cultural and national identity by some Member States in the WHO's Eastern Mediterranean Regional Office (EMRO), in particular Kuwait and Saudi Arabia—who, notably, had considerable influence in United Nations through their control over the price of oil. They were supported by the Non-Aligned Movement, a voting bloc which had emerged during the Cold War, and several formerly colonized states, who through the 'one member, one vote' rule of the World Health Assembly had gained significant sway over the organization.¹

The introduction of a 'spiritual dimension' of health into WHO discourse was an achievement which EMRO claimed as 'perhaps [...] the major contribution of Eastern Mediterranean countries to the global philosophy of health'.² Drawing on records of the WHO's Executive Board and World Health Assembly meetings, and policy discussions and official documents produced between 1981 and 2006—the first 25 years following the first conference of the Islamic Organization for Medical Sciences (IOMS)—this chapter illustrates how this term was operationalized by political, medical, and religious actors committed to the promotion of Islamic medicine, and its proponents in the EMRO, who translated 'spirituality' into public health policy. Influential figures from the region initially promoted the 'spiritual dimension' to the WHA and the Executive Board by appealing to a shared aspirational ideal beyond the rampant spread of materialism and the

¹ Chorev, *The World Health Organization*, 6, 48. For a discussion of 'procedural' and 'resource dependence' in the WHO, see Chorev, *The World Health Organization*, 24–6.

² World Health Organization, Regional Office for the Eastern Mediterranean, *EMRO Partner in Health*, 77.

global, American-led, capitalist world order, a tenor much in tune with the growing influence of former colonial states in the WHO at the time. As we show, however, within many EMRO countries, the term ‘spiritual’ figured as a flexible term which could be ‘strategically adapted’ into a moral framework that underwrote at times rather problematic public health policies.³

The ‘Tragedy of the West’: Spiritual Rhetoric in the Islamic Organization for Medical Sciences

Among all the axial religions, it may be argued, Islam is the only one which refers to ‘health’ in its name. ‘*Slm*’ or ‘*salam*’ is a state of complete well-being in body, soul, and spirit—a state of wholeness. As *islam* is the reflexive form of *salam*, giving oneself to Islam may be understood as giving oneself to wholeness. ‘Muslims’ in this sense are those who have committed themselves in this way to wholeness.⁴ It is because of the central role played by health in Islam, argues one scholar of Islamic spiritual care, that many Muslim communities have developed a ‘holistic’ understanding of health. Moreover, unlike Plato and Aristotle, Islam seeks health not only in the unity of mind and body but also in the social sphere. Community and social belonging are therefore indispensable to Islamic health-care, and moral behaviour (*Lebensführung*) is key in ensuring harmony within the family and community, and to health in its social aspect.⁵

One implication of this is that religion impinges on institutions such as the hospital, the university, and indeed multilateral organizations such as the WHO, which in the course of the twentieth century became bulwarks of European Enlightenment rationality, and as such are often thought to be subject to the separation of church and state. Insofar as ‘Islam’ is lived as an inextricable aspect of individual and collective existence, daily life becomes imbued with significance for health and medicine. Some supporters of the ‘spiritual dimension’ argued on this basis that the detailed advice in the Qur’an and the *hadith* (records of the deeds and words of Muhammad) prefigures the wisdom of public health pamphlets a thousand years later.⁶

³ Chorev, *The World Health Organization*.

⁴ Schipperges (2002) in Şahinöz, *Seelsorge im Islam*, 42.

⁵ Şahinöz, *Seelsorge im Islam*, 42. We follow the use of EMRO documents and the cited secondary literature when referring to ‘Islam’ as a singular, internally undifferentiated entity. We acknowledge that Islamic religious expression varies greatly, particularly in the contemporary period and between regional, tribal, denominational, and individual contexts. For an overview of the genealogical complexity of Muslim societies, see Bowen Savant and de Felipe, *Genealogy and Knowledge in Muslim Societies*. For a contemporary anthropology of lived reality in various Muslim contexts, see Dupret et al., *Ethnographies of Islam*.

⁶ In the consultation for the WHO Quality of Life questionnaire (see Chapter 7), for instance, the two representatives of Islam made a detailed argument for the fundamental relationship between health and religion. Islam, they argued, is a ‘total and a complete way of life’ which ‘encompasses all aspects of

Since the early 1980s, this notion of health has become institutionalized in many Muslim-majority nations in the EMRO. Among EMRO Member States, the 'spiritual dimension' of health was first articulated by Islamic reformers who had 'become disillusioned with modern medicine' and claimed that 'its tendency to treat the patient symptom by symptom rather than as a whole person is inherently dehumanizing and medically unsound.'⁷ With the IOMS, this view gained a prestigious, well-funded, and politically connected institutional platform. Founded in Kuwait in 1981, the IOMS was part of the Islamic revival (*tajdid*) which since the 1970s had begun spreading in the region, forcing political regimes to legitimate themselves as independent, just, and culturally 'authentic' nation-states un beholden to Western influence.⁸ Like other institutions founded during this period, such as banks and universities, the IOMS attempted to formulate a distinct, Islamic alternative to the hegemony of Western modernity by applying and developing religious law (*shari'ah*) in light of the rapid changes brought by modernization.⁹

The understanding of 'spirituality' that circulated within the IOMS in the early 1980s was only partially articulated in the World Health Assembly discussions on a 'spiritual dimension' of health: the holistic view of patients as comprising both body and soul was emphasized. However, the 'spiritual dimension' was characterized as unrelated to 'religious or atheistic teachings' and likened to Mahler's notion of a 'spirit of endeavour which should be transmitted to every individual', while the moral critique of Western modernity was transposed onto the commitment to social justice made by the 1978 Alma-Ata declaration for universal primary healthcare.¹⁰

This discourse is apparent in the discussions at the First International Conference of the IOMS, held in 1981. According to Abdul Rahman Al-Awadi, the first president of the IOMS and Kuwait's minister of public health for 15 years, the conference aimed to demonstrate to the world that Islam was 'not only a

life including physical, social and spiritual well-being'. Because Islam does not separate religion from politics, 'economic and social transactions, as well as educational and political systems,' they argued, 'are also part of the teachings of Islam.' World Health Organization, Social Change and Mental Health Cluster, 'WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)', 34–7. See also World Health Organization, Regional Office for the Eastern Mediterranean, *Health Promotion through Islamic Lifestyles*, 16–42.

⁷ Gallagher et al., 'Medicine: Contemporary Practice', 9.

⁸ Krämer, *Geschichte des Islam*, 296.

⁹ While the early IOMS conferences were concerned with traditional Islamic medical practices, such as herbal medicine, and the valorization of historical Islamic surgeons and doctors, the IOMS from its inception served to problematize 'Western' medical interventions, including recent innovations in reproductive medicine such as in-vitro fertilization, perceived by some Islamic scholars to threaten the sanctity of life, and for which no clear religious ruling existed. Brockopp and Eich, *Muslim Medical Ethics*, 62; Gallagher et al., 'Medicine: Contemporary Practice'. Cf. Al-Awadi, 'The Role of the Islamic Organization for Medical Sciences in Reviving Islamic Medicine'.

¹⁰ World Health Organization, 'Thirty-Seventh World Health Assembly, Geneva, 7–17 May 1984: Summary Records of Committees', 77.

religion, but a complete method of life'. The following year, it would publish Kuwait's Islamic Code of Medical Ethics and recommend the establishment of the World Islamic Medicine Organization.¹¹ According to Al-Awadi,

[Muslims'] great achievements [in science] served the role of a lighthouse to the whole world for many centuries. These achievements formed the foundation of the contemporary scientific awakening. It is to be regretted, however, that as soon as Moslems lost their grip of that scientific approach, they were completely left out. They stood as mere witnesses of a fast-progressing world; a world that progressed by reasons of its exploitation of the Islamic heritage and the Islamic scientific approaches.¹²

'Western civilization', strong because of what it had taken from 'Islamic civilization', had come to separate Muslims from their religion, and 'almost dominated our minds and our feelings'; indeed, 'we almost forgot God, in our attempts to imitate their modes of behaviour, be they good or evil.' With Kuwait at its helm, the first meeting of the IOMS would be the initial step to undo this historic injustice: to recreate 'Moslems [...] as a homogenous unique entity', throughout the conference referred to as the 'Islamic nation', and to 'restore its glory'. Reviving the Islamic medical heritage, Al-Awadi argued, was a 'struggle' (*jihad*),¹³ and the conference participants made frequent reference to the 'enemies of Islam'. The closing session, held in a mosque, asked participants to 'shoulder' the 'heavy task', 'to restore Islam [...] until our Muslim Ummah reaches its leadership position in the world and manifests that saying "That you have been the best nation brought up to mankind, to join justice and to kill evil in the Name of Allah"'.¹⁴ The second conference, held in 1982, made clear where the 'enemies of Islam' were to be found:

The problems bothering our generation are too many and multifarious to be listed. We may safely say, however, that they can be traced back to the same source, namely, Western concepts that try to dominate the lives everywhere.¹⁵

The rejection of all that is 'Western' resonated with the rejection of a fundamentally unjust economic world order which frequently surfaced in WHA discussions

¹¹ Gallagher et al., 'Medicine: Contemporary Practice', 9.

¹² Kuwait Ministry of Public Health and National Council for Culture, Arts and Letters, *Proceeding of the First International Conference on Islamic Medicine*, 1: 12, 13.

¹³ Kuwait Ministry of Public Health and National Council for Culture, Arts and Letters, *Proceeding of the First International Conference on Islamic Medicine*, 1: 14.

¹⁴ Kuwait Ministry of Public Health and National Council for Culture, Arts and Letters, *Proceeding of the First International Conference on Islamic Medicine*, 1: 760.

¹⁵ El-Gindy and Hasan, *Proceedings of the Second International Conference on Islamic Medicine*, 2: 14.

at the time, and also framed the organization's Health for All initiative: both may be understood as a post-colonial attempt to undo centuries of imperialism which had helped enrich some countries at the expense of the Global South. In the WHO's Health for All initiative, the 'spiritual dimension' seemed to offer a way to undo a pervasive cultural imperialism in the area of medicine. To many EMRO Member States, economic and cultural emancipation appeared as two sides of the same coin; whereas the Health for All initiative connected matters of public health to a more just world order, the 'spiritual dimension' connected public health to Islam. The health equity pursued by the Health for All initiative and the Islamic revival hoped for by Al-Awadi and other advocates of Islamic medicine were in this sense congruent in spirit.

Like Mahler, Islamic conservatives such as Al-Awadi, who enjoyed considerable influence in the EMRO, thus gave the language of global health equity an additional moral-political spin: at the beginning of the follow-up conference in 1982, Al-Awadi cited Roger Garaudy—a French resistance fighter, communist author, and well-known anti-Semite—who that year had converted to Islam and found in it the antidote to 'the tragedy of the West', which was the 'dependence on persistent progress without a human or moral objective in sight'.¹⁶ The battle against Western 'spiritual poverty', argued Al-Awadi, was what motivated the organizers to make a panel on 'The Therapeutic Importance of Religious and Spiritual Aspects' the cornerstone of the IOMS conference and give it a 'prominent part in the proceedings'.¹⁷ The following year, the EMRO would lead the attempt to introduce the 'spiritual dimension'—*sans jihad*—into the WHO's Health for All initiative.¹⁸

Contra 'Materialism': EMRO Advocacy at the 36th World Health Assembly

Brought to the WHO, the 'spiritual dimension' appeared in a more docile light. At its first introduction at the 36th World Health Assembly, EMRO Member States presented spirituality as a way to address the materialism rampant in contemporary society. As argued by Al-Salif, the representative of Kuwait, after the floor was opened:

¹⁶ El-Gindy and Hasan, *Proceedings of the Second International Conference on Islamic Medicine*, 2: 12.

¹⁷ El-Gindy and Hasan, *Proceedings of the Second International Conference on Islamic Medicine*, 2: 12.

¹⁸ Al-Awadi later credited the IOMS with introducing the 'spiritual dimension' with the following words: 'The revival of Islamic teachings in the field of medicine is to restore for the Muslim heart its spirit that was lost [...] The IOMS concentrated on the necessity of including the spiritual component in the definition of human being at the World Health Organization (WHO). In spite of the opposition of others, we succeeded in introducing this spiritual dimension.' Al-Awadi, 'The Role of the Islamic Organization for Medical Sciences in Reviving Islamic Medicine', 69, 70.

[a]ll men suffered from worry and anxiety caused by the times in which they lived. Material concerns dominated human life; people were lost and sought security and calm. Physicians must try to take account of man's spiritual nature. Materialism had dominated daily life to such an extent that spiritual values no longer counted and men were afraid of the future.¹⁹

In response to concerns by the Soviet and Czechoslovakian delegates that 'spirituality' would impose 'certain religious beliefs' on atheists and Member States with no dominant religion, Al-Salif reiterated that the 'spiritual dimension' was 'not based on any specific religious belief'. The delegates from Yemen backed this retort: spirituality would counter materialism and 'did not mean fanaticism', and the United Arab Emirates joined in, saying that the sponsoring countries 'never compelled anyone to take the spiritual dimension into account'. Indeed, Al-Saif said, the suggestion that the spiritual dimension was a 'religious dimension' was 'quite irrelevant'.

Al-Awadi, who had set the tone at the first and second IOMS conferences, took Al-Salif's argument a step further:

Material progress in the contemporary world has reached levels unprecedented in past history or civilization. Yet we find that what prevail in this world are anxiety and apprehension, so much so that the distinguishing feature of this age can be said to be a sense of loss and uncertainty. I believe that you would agree with me in attributing this loss and uncertainty to the absence of the spiritual aspect of life, which has made man live in a vacuum, sensing a grim future ahead. This is because we have stripped him, over the past few decades of our modern history, of his spiritual values; and materialism is now in such absolute control of all aspects of our life that man feels lost and restless, desperately seeking tranquillity, serenity and peace of mind.

The loss of 'Islamic history' discussed at the IOMS conferences was here connected with the loss of a general type of 'spiritual values', rather than a (presumably Sunni-led) pan-Islamic morality, which would guide humanity to redemption.

In the EMRO's articulation of the 'spiritual dimension' at the WHA, the emotional appeal derived from references to *jihad* and the revival of the 'Islamic Nation' was replaced with a nuclear eschatology familiar from Mahler and others. As Al-Awadi argued, spirituality was important 'particularly now that the means of total destruction are readily available to those who hold the destiny of the world in their hands'. To be sure, nuclear war between the two powers, not the theft and

¹⁹ World Health Organization, "Thirty-Sixth World Health Assembly, Geneva, 2-16 May 1983: Verbatim Records of Plenary Meetings, Reports of Committees", 222.

corrosion Western immorality had wrought unto the 'Islamic Nation', was the reason for bringing this issue to the attention of the Assembly:

I have raised this point because I am convinced of its especial significance particularly at the present time, when competition is at its keenest between countries capable of using their technology in the manufacture of weapons of destruction. The need is therefore great today, for us who are responsible for the health care of man, to provide for this spiritual aspect in our programmes lest they become void and soulless.²⁰

Al-Awadi's critique that 'material progress' had robbed man of his humanity may not have convinced everyone at the assembly, considering he spoke as the minister of public health of a country which fuelled industrialized countries reliant on cheap oil imports, funded its own relatively well-developed healthcare system with said oil revenues, and was engaged in a brewing conflict with Iraq over drilling rights which would culminate in the first Gulf War.

At the 73rd Executive Board meeting on the matter, held the following year, Hussein Abdel-Razzak Al Gezairy, then Regional Director of EMRO, reinforced the critique of materialism, but broadened it to 'civilization' *in toto*. The 'crisis of spiritual values affecting contemporary civilization,' he lamented, had 'become an essentially materialistic one as a result of the subjugation of man and society by technology and the exploitation of man by his fellows'. Gezairy, who had been born in the city of Mecca, served as Saudi Arabia's minister of health for seven years and would advocate a 'spiritual dimension' for the remainder of his career, then pivoted from Cold War fears to the specific conflicts brewing in the Middle East. According to the summary records of the meeting, Gezairy

[...] was all the more aware of the gravity of that crisis since the Region in whose name he spoke had not only witnessed the birth and growth of Islam, which held that material things should be devoted to the welfare of man, but had also suffered during recent decades from misfortune inflicted by the injustice of man, as testified by the millions of refugees in Pakistan, Somalia, Sudan and Lebanon, as well as by the majority of the Palestinian people, who had been reduced either to the condition of refugees or were forced to live under foreign occupation. In the past, under the foreign occupation which had falsely maintained that its objective was to extend the scope of modern civilization to those countries, poverty, ignorance and disease had spread; the result was an acute

²⁰ World Health Organization, 'Thirty-Sixth World Health Assembly, Geneva, 2-16 May 1983: Verbatim Records of Plenary Meetings, Reports of Committees', 224.

shortage of trained manpower and a consequent underdevelopment of health systems.²¹

For the director of EMRO, the struggle against the scourge of materialism required a 'call for unity'; a concerted effort to stem the 'modern, materialistic form of civilization', which 'through the most sophisticated technology' had 'extended its shadows over hospitals'. Through the dialogical opposition of 'material things', 'injustice', 'disease', and 'modern civilization' with the 'welfare of man', 'health systems', and 'Islam', it could be argued, Gezairy blamed national health problems on the geopolitical status quo, effectively turning the 'spiritual dimension' into a euphemism for political resistance. By linking spirituality to 'foreign occupation', EMRO could shore up support from other post-colonial and non-aligned nations, for, as the Indian representative noted at the 36th WHA with reference to Palestine, these had always supported the 'Arab struggle for self-determination'.²²

As the 'spiritual dimension' moved from the IOMS into the World Health Assembly, polemics against Western immorality were replaced with the appeal to social justice and with relatively uncontroversial advocacy for medical holism, which fit well with the Alma-Ata recognition of patients as complex beings ill-served by the reductive approach of earlier top-down disease eradication campaigns. Physicians should employ a more holistic treatment of 'man', which included both body and soul. Perhaps in an attempt to diffuse the ramifications of Gezairy's earlier argument, M. H. Abdulla, a representative from Abu Dhabi and vice-chairman of the 73rd Executive Board Meeting, closed the board's discussion of the matter with the comment that 'the original idea had been to discuss the spiritual dimension in relation to treatment, in other words not to treat mind and body separately.'²³ With the reference to holism, EMRO Member States appealed to advocates of universal primary healthcare.

The critique of Western immorality articulated at the IOMS continued, although hopes for the revival of the Islamic nation gave way to fear of the future *sensu* Mahler and Hynd; the talk became of 'material progress' in general, with the reference to the 'West' implied in its greater degree of economic development and thus its responsibility for the spread of 'materialism'. To the extent that 'materialism' was all but synonymous with the excesses of global capitalism, which mostly benefited rich countries, the 'spiritual dimension' of health echoed the Health for All initiative's concern with social justice, and gained support from countries in

²¹ World Health Organization, 'Seventy-Third Session of the Executive Board, Geneva, 11–20 January 1984: Resolutions and Decisions Annexes', 60.

²² World Health Organization, 'Thirty-Sixth World Health Assembly, Geneva, 2–16 May 1983: Summary Records of Committees', 343.

²³ World Health Organization, 'Seventy-Third Session of the Executive Board, Geneva, 11–20 January 1984: Resolutions and Decisions Annexes', 83.

South America (Chile, Venezuela) and ‘sub-Saharan’ Africa (such as Botswana or Zambia), where Muslim populations represent a small minority, but which had a stake in a radical reorganization of the existing relations of power between the Global South and North.

The ‘Spiritual Dimension’ as Public Health Policy

The first director of EMRO, Aly Tewfik Shousha of Egypt, and his successor Abdul Hussein Taba of Iran, had been Western-educated medical doctors. By 1982, the Islamic revival had transformed the region, and Saudi Arabia had emerged as a new centre of wealth and influence. With Hussein A. Gezairy of Saudi Arabia and his deputy, M. H. Khayat of Syria, EMRO leadership had been given to two outspoken supporters of Islamic morality.²⁴ In this context, the WHO’s eventual recommendation to integrate a ‘spiritual dimension’ into regional health policy provided the EMRO with a moral framework for the public health campaigns in its Member States.

By equating religious orthodoxy with ‘healthy lifestyles’, personal matters of daily conduct normally within the purview of ministries of health were drawn into the sphere of religion. The reasoning was partly theological. As an EMRO publication on the ‘Ethics of medicine and health’ would put it in 1995, ‘[t]he main social virtue on which a Muslim’s conduct is based is collective rather than interpersonal.’ Individual illness was therefore writ large into a collective problem—a social sickness.²⁵ ‘Although’, the publication continued, ‘Islam clearly distinguishes between man as a separate entity and man as a member of the community’, these two realities are nevertheless deeply interrelated, and ‘from this interrelationship stems the concept that all that is done for the community has a spiritual value for the individual, and vice versa.’²⁶ Individual, private bodies in this way became integrated into a larger, religiously organized body politic.²⁷

A second line of argument, which gained traction with the retirement of Mahler in 1988, was the appeal to pragmatism and efficiency. Already at a Regional Meeting on Community Control of Cardiovascular Diseases held in 1983 in Syria, religious education was discussed as a means to reduce the risk of lifestyle diseases. Here, Gezairy argued that,

²⁴ Personal conversation, former EMRO employee, March 2019. For a sample of Khayat’s ideas on the WHO definition of health, see Al-Khayat, ‘Spirituality in the Definition of Health’. For his application of IOMS guidelines to contemporary bioethics, see Al-Khayat, ‘Research Ethics’.

²⁵ Kleinman, *Illness Narratives*.

²⁶ World Health Organization, Regional Office for the Eastern Mediterranean, ‘Ethics of Medicine and Health’, 3.

²⁷ Cf. Scheper-Hughes and Lock, ‘The Mindful Body’.

among the present most efficient tools which may change the habits and customs of the community, whose members are exposed to risk factors, are religious teachings which may change the habits and customs of a community, [...] by prohibiting harming or jeopardizing oneself, and urging moderation in food, drink and similar needs [...].²⁸

Religion, with its existing infrastructure and respected authority figures, provided a ready-made logistical network and political backing. The ‘spiritual dimension’ was important because ‘human behaviour [...] greatly influences all aspects of health and disease.’ And behaviour, in turn, especially in this region of the world, was most efficiently influenced by religion.²⁹ Even the prophet Muhammad, when asked to define religion, had said: ‘of course, religion is behaviour.’³⁰ Thus, it was hoped that the ‘spiritual dimension’ and religious life would form a mutually beneficial, practical alliance. At the 25th anniversary of the Alma-Ata conference on primary healthcare, Gezairy recalled the Eastern Mediterranean’s role as the ‘cradle of the divine religions’ and affirmed that its ‘deep rooted spiritual beliefs’ were ‘great assets to build on for better quality of life and healthy living’. The ‘spiritual dimension’, he argued, offered an ‘appropriate entry point to mobilize the individual, family, community and the nation to what the religious teachings require’.³¹

Finally, *realpolitik* played a role. As stated rather bluntly in a review of the past 40 years of EMRO history,

Health, social, cultural and economic development in the Region are not recognized as exclusively secular processes with decision-making based on democratic consultations. [...] no solution to any existing problem, no matter how brilliant, innovative and promising it may appear to be in other parts of the world, stands a chance of being translated into action in the Region unless it is compatible with the teachings and spirit of the Holy Koran.³²

Between 1986 and 2004, the EMRO published a series of publications, entitled ‘The Right Path to Health: Health Education through Religion’. The series included volumes on issues of special interest to Islamic healthcare (smoking,

²⁸ World Health Organization, Regional Office for the Eastern Mediterranean, ‘Regional Meeting on Community Control of Cardiovascular Diseases’, 2, 3.

²⁹ World Health Organization, Regional Office for the Eastern Mediterranean, ‘Regional Meeting on Community Control of Cardiovascular Diseases’, 2, 9.

³⁰ World Health Organization, Regional Office for the Eastern Mediterranean, *EMRO Partner in Health*, 82, 83.

³¹ World Health Organization, Regional Office for the Eastern Mediterranean, ‘Primary Health Care: 25 Years after Alma-Ata’, 8.

³² World Health Organization, Regional Office for the Eastern Mediterranean, *EMRO Partner in Health*, 81.

sanitation, animal slaughter, circumcision, HIV/AIDS) and offered comments on themes prevalent in global health discourse (e.g., human rights, environmental health). Although the term ‘spirituality’ was not used in all volumes and was often substituted with ‘religion’ or ‘morality’, the series represents perhaps the most systematic articulation of how EMRO officials applied the ‘spiritual dimension’ as a framework for public health policy. The volume on the Amman declaration (Fig. 4.1), a pivotal conference on ‘Islamic lifestyles’ held in 1989, set the agenda of religious injunctions which came to inform the EMRO interpretation of the ‘spiritual dimension’. Sixty topics, covering hygiene, sexuality and marriage, nutrition, conflict, the environment, exercise, and the disabled were discussed. One hundred and fifty-eight *hadith* were cited to provide guidelines of behaviour.³³

The dichotomous understanding of a ‘spirituality’ opposed to ‘materialism’ continued to provide the backdrop against which ‘Islamic lifestyle’ was defined in the EMRO. The ‘Islamic heritage’ of EMRO Member States protected them against the diseases of (Western) civilization, as evidenced by the rise of such diseases in an unfortunate number of ‘developing countries [which] had begun to adopt the unhealthy lifestyles of the West, particularly with the increase in urbanization and industrialization’. A moderate interpretation of this thesis referred to the prohibition of alcohol. Smoking and nutrition, too, were subject to Islamic creed, but here the EMRO still found want of progress—smoking was on the rise, and poor eating habits were spreading in certain sectors of society; *ergo*, religious education should be expanded.³⁴

The example of tobacco consumption illustrates the conversion of religious life into a vehicle of public health campaigns. Based on a religious ruling (*fatwa*) from the early seventeenth century which banned tobacco, 19 subsequent edicts and the declarations of contemporary Islamic scholars,³⁵ the EMRO declared smoking as un-Islamic. The office published a *fatwa* by His Eminence the Mufti of Egypt condemning smoking and tobacco consumption, which was distributed ‘in the form of posters among tens of thousands of mosques’ and, according to an evaluation study, was ‘instrumental in convincing a large number of smokers to quit or plan to quit smoking’.³⁶ The WHO’s aggressive lobbying against tobacco companies seems to have furnished the attempt to reduce tobacco consumption through religiously motivated behaviour changes with at least some of its success.³⁷

³³ World Health Organization, Regional Office for the Eastern Mediterranean, *Health Promotion through Islamic Lifestyles*, 16–42.

³⁴ World Health Organization, Regional Office for the Eastern Mediterranean, ‘Regional Meeting on Community Control of Cardiovascular Diseases’, 9.

³⁵ El-Awa, ‘The Role of Religion in Tobacco Control Interventions’, 894.

³⁶ World Health Organization, Regional Office for the Eastern Mediterranean, ‘Primary Health Care: 25 Years after Alma-Ata’, 8.

³⁷ Chorev, *The World Health Organization*, 196–206.

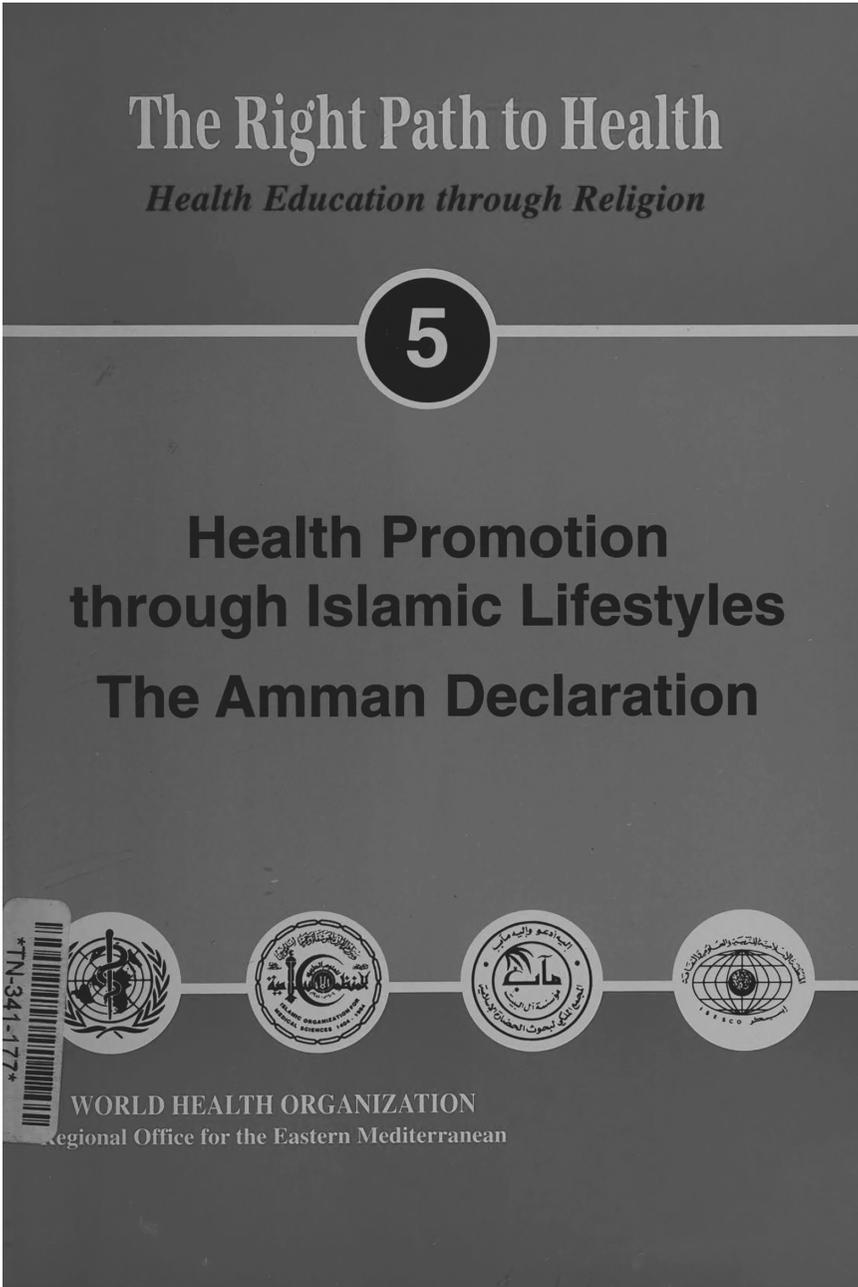


Fig. 4.1 The Amman Declaration on Health Promotion through Islamic Lifestyles, published by EMRO in 1996.

Source: World Health Organization, Regional Office for the Eastern Mediterranean. Reproduced with permission.

Public health problems, such as addictions of various kinds, and lifestyle choices not sanctioned by religious authorities were thus gathered into the category of ‘moral degeneration’, equating secular pleasures with mental illness and social subversion. As Al-Awadi argued in 1986:

[M]an had begun to seek purely material pleasure in everything. Thus moral degeneration and deviation from religious teachings had led to the appearance of diseases linked to social factors. These diseases do not threaten solely the individual, but the whole fabric of society. This has been substantiated by the increase in the number of persons addicted to, for example, alcohol, drugs and smoking, as well as by the appearance of the acquired immune-deficiency syndrome (AIDS) and other sexually transmitted diseases. Man has neglected God’s gift of health by indulging in excesses in daily life, and these have led to the emergence of individuals who are anxiety-stricken and psychologically unstable.³⁸

Two years later, the same line of argument was echoed in an EMRO discussion on the ‘Promotion and Protection of Mental Health’. This time, religion offered not a diagnosis, but a ‘total lifestyle’ as cure:

Modern man in search of a soul has come to recognize the importance of spiritual values, not only for mental but also for physical health. Religion, if properly understood and used, can be a powerful force for health promotion. Islam in particular, the dominant religion in the Region, offers a total lifestyle rather than an isolated belief system. Health services in countries of the Eastern Mediterranean Region could find particular support to their work on health care in the teachings of the religions dominant in the Region and in an alliance with religious leaders.³⁹

The characterization of ‘Western’ civilization as pathogenic and essentially at odds with Islamic teachings resembled concerns of late nineteenth- and early twentieth-century social hygienists who had advocated self-control, particularly in regard to pleasure and sexuality, as a solution to the social ills wrought by urbanization. In the EMRO context, this chiefly revolved around the reform of individual behaviour to express principles of Islamic morality, in particular the maintenance of prevalent social structures in family matters. As noted in a discussion at a conference on youth, health, and social development, the ‘weakening of the family

³⁸ World Health Organization, Regional Office for the Eastern Mediterranean, ‘Report of the Thirty-Third Session of the Regional Committee for the Eastern Mediterranean’, 2.

³⁹ World Health Organization, Regional Office for the Eastern Mediterranean, ‘Promotion and Protection of Mental Health’, 5.

and of spiritual influences were reported in the face of the new materialism'. Materialism, it was argued, weakens the family, which harms the development of the youth.⁴⁰

'Spirituality' was occasionally connected with the improvement of women's literacy, community outreach, and empowerment, and Gezairy did state that '[w]omen should enjoy the highest standard of health, physically, mentally, spiritually and socially, from early childhood', referring to the Qur'an (chapter 2, verse 187), which described 'husband and wife as being a source of comfort to each other, fitting each other like "a garment"' and providing each other with 'warmth, closeness, mutual care and benefit'.⁴¹ In many EMRO policy papers, however, this took on a more conservative tone. A guideline published in 2006 had lost the anti-Western polemic, but in a rare reference to a religious tradition other than Islam, argued for the primacy of the traditional family:

Marriage is the norm in Judaism and Christianity. In the Old Testament, marriage was considered the way for Adam: Then the Lord God said, "It is not good that the man [Adam] should be alone; I will make him a helper fit for him" [Genesis 2:18]. In Christianity, the church condones sexual relations only within marriage, the only acceptable alternative being abstinence. St Paul said in his first letter to the Corinthians: To the unmarried and the widows I say that it is well for them to remain single as I do. But if they cannot exercise self-control, they should marry. For it is better to marry them than to be aflame with passion [1 Corinthians 7:8–9].⁴²

Similarly, the guideline advocated:

Marriage should again be emphasized as the only way for sexual satisfaction. Adolescents should preserve their chastity until they get married. The virtues of virginity are too great to miss.⁴³

Abstinence represented a state of 'physical, spiritual and emotional wholeness', as well as 'self-respect and our bodily integrity and our freedom to make a choice'. This freedom and bodily integrity could be understood to emancipate women from patriarchal claims over the female body, as in the practice of female genital circumcision, or child-marriage, which is endemic in some EMRO Member States.

⁴⁰ World Health Organization, Regional Office for the Eastern Mediterranean, 'Health and Social Development', 5.

⁴¹ World Health Organization, Regional Office for the Eastern Mediterranean, 'Message from Dr Hussein A. Gezairy', 2.

⁴² World Health Organization, Regional Office for the Eastern Mediterranean, *Health Education of Adolescents*, 59.

⁴³ World Health Organization, Regional Office for the Eastern Mediterranean, *Health Education of Adolescents*, 125.

Indeed, the document warned against the health dangers of ‘premature marriage’, and the battle against gender violence has since become part of Health for All policy in the EMRO.⁴⁴ For girls over the ages of 18–19, however, marriage was ‘acceptable and even encouraged’, and the purpose of that union appeared as a given: ‘Contraception should be emphasised for married adolescent girls during the first couple of years of marriage in order to postpone the first pregnancy and space the subsequent ones.’

Evidently, ‘spirituality’ could denote both an egalitarian ideal where husband and wife complement each other on equal terms—fitting each other like a ‘garment’, in Gezairy’s words—or carry less emancipatory implications, where the woman exerted little agency over reproductive decisions. The aforementioned phrase ‘bodily integrity and our freedom to make a choice’ could therefore just as easily be interpreted to deny women’s wish to engage in sexual intercourse outside sanctioned social structures. It appears that the latter interpretation was on the minds of the EMRO officials who wrote this guideline, for the only morally justifiable choice seems to be ‘virginity’: ‘[w]hen we make choices about sex, choosing virginity is but an expression of self-respect; and thus we would be in a position to put ourselves into a situation of self-satisfaction and a cheerful mood.’ In a curious reversal, the exclusion of sexuality from healthy adolescent development was presented as one way in which young girls could be ‘empowered’ through ‘moral education’.⁴⁵ Lack of morality on the part of ordinary men and women, not the stalling implementation of primary healthcare infrastructure for the less privileged, as the Health for All initiative had demanded, was to blame for social and mental problems.⁴⁶

In the EMRO, the non-committal, egalitarian, and emancipatory understanding of the ‘spiritual dimension’ found in many WHA statements was often directly equated with Islamic religious education, at the expense of other religious groups in the region, or other ‘ennobling ideas’, which might offer more humane approaches to public health problems. The question of homosexuality and HIV/AIDS is instructive. According to the 2006 health education guideline:

homosexuals [...] no longer feel ashamed to admit it, and many mothers and fathers accept the sexual behaviour of their sons and daughters as a matter of fact.

⁴⁴ See e.g. World Health Organization, Regional Office for the Eastern Mediterranean, ‘Gender-Based Violence in Emergencies Highlighted on International Women’s Day 2018’.

⁴⁵ World Health Organization, Regional Office for the Eastern Mediterranean, *Health Education of Adolescents*, 125.

⁴⁶ It should be noted that *Health Promotion through Islamic Lifestyles* also contained many *hadith* which contradict popular preconceptions regarding Qur’anic morality and occasionally preceded contemporary cultural and medical consensus by several centuries. For instance, the prophet recommended that the ‘rights of wives (with regard to their husbands) are equal to the (husband’s) rights with regards to them’; to marry someone of similar age; that the husband should not ‘fall on her like a camel’; that he is to precede intercourse with ‘whispers and kisses’ and should attempt to help her attain climax (p. 27).

Homosexuals even call for their “right” to legally marry their partners [...], and some churches in some countries give their blessings to such marriages. [...] The disease AIDS first came to prominence among male homosexuals and then spread to the heterosexual population [...] Indeed, one cannot fail to wonder about the innocent victims of AIDS [...] What sin have they committed? [...] Islam categorically condemns homosexuality, and in the Quran Almighty God threatened Lot’s people by saying: You lust after men instead of women. Truly, you are a degenerate people [7:81].⁴⁷

Here, the ‘spiritual dimension’ of health seemed to act as the backdrop of state-sanctioned (and -funded) homophobic agitation. Considering the WHO’s position as the leading global scientific authority on public health issues, the EMRO’s language on this matter is surprising. Not only were pre-modern Islamic attitudes more akin to Greco-Roman culture and the notion of homosexuality may have been entirely absent, but in view of the origin of the virus, putting the blame of the HIV/AIDS epidemic on those populations most vulnerable to its transmission is both methodologically questionable and empirically mistaken.⁴⁸

Discussion

In the WHO’s Eastern Mediterranean region, the ‘spiritual dimension’ thus entailed two distinct moral imaginaries: the reform of global post-colonial relations of exploitation through an egalitarian and compassionate ideal, which was supported by advocates of the Health for All initiative; and a divisive polemic echoing a ‘clash of civilizations’, which turned medical into moral problems, negated non-monogamous relationships, and blamed homosexuals for the HIV/AIDS epidemic. This, it could be argued, effectively devolved responsibility for the attainment of ‘Health for All’ from institutional reform to the religious reform of individual life.

At least in its policy documents, the EMRO applied the ‘spiritual dimension’ as Mahler had wanted in his call for a ‘social revolution’: it attempted to mobilize people across all layers of society. Youth, for example, should be aided in questions of ‘suicide, psychosocial and mental-health problems, behavioural disturbances, and problems related to sexuality’, and ‘teachers, religious leaders and social workers, among others’, should be called to action.⁴⁹ However, the appeal to

⁴⁷ World Health Organization, Regional Office for the Eastern Mediterranean, *Health Education of Adolescents*, 60.

⁴⁸ Pepin, *The Origins of AIDS*; El-Rouayheb, *Before Homosexuality*. In defence of the aforementioned EMRO position it should be acknowledged that the WHO only declassified homosexuality as a mental disorder in 1990.

⁴⁹ World Health Organization, Regional Office for the Eastern Mediterranean, ‘Report of the Thirty-Third Session of the Regional Committee for the Eastern Mediterranean’, 31, 32.

spirituality manifested perhaps rather differently to what Mahler may have imagined. The ‘decency, empathy with the world’s health underprivileged, compassion, and the desire for social justice’ which had been on the agenda in 1983 also served to legitimize a battle against ‘moral degeneration’ vis-à-vis Western secular modernity. Rather than overthrowing a socio-political status quo in the name of an emancipatory ideal, in the 25 years of EMRO activities discussed here, the ‘spiritual dimension’ oftentimes seemed to reinforce the existing forms of hegemony, and at times ran counter to the foundational values written into the WHO’s constitution: that health is a human right, blind to race and creed, and should serve the peace and security of every human being.⁵⁰

Certainly, the cases discussed here are not representative of health-related religious beliefs in the region. Rather, they illustrate the influence of well-positioned individuals who subscribed to a fundamentalist interpretation of Islam. They ought not to detract from many cooperative successes the EMRO has shared with religious actors and national ministries of health.

Polio eradication efforts, for instance, greatly benefited from collaboration with religious groups. A cooperation between EMRO and UNICEF with the Organisation of Islamic Cooperation (OIC), the Islamic Development Bank (IDB), the International Islamic Fiqh Academy, the prestigious Al-Azhar Al Sharif Islamic university, and the Ministry of Health of Saudi Arabia illustrates this. In 2014, this partnership, entitled the ‘Islamic Advisory Group’, met to address vaccine hesitancy among some Islamic populations.⁵¹ In Nigeria and in Pakistan in particular, rumours such as that the vaccine was spreading HIV/AIDS or was a Western plot to sterilize Muslims had led to violence against health workers. An attempt by US intelligence to use Hepatitis B vaccination to identify the location of Osama Bin Laden seemed to confirm such suspicions.⁵² The group reassured Muslim communities that polio vaccination did not contain any forbidden (*haram*) substances, reaffirmed the solidarity of Muslim scholars with polio eradication efforts, and participated in community-level immunization initiatives, in some cases publicly taking the vaccine. Like similar efforts to control Ebola and Covid-19, discussed in Chapter 9 and the Epilogue respectively, this episode is perceived by many within the WHO as a case of successful partnership with religious actors.⁵³ If the EMRO’s current engagement with religious themes in the promotion of Covid-19 public health measures is indicative, most recently on the occasion of Ramadan celebrations (Fig. 4.2), faith leaders and WHO staff in

⁵⁰ International Health Conference, *Summary Report on Proceedings, Minutes and Final Acts of the International Health Conference Held in New York from 19 June to 22 July 1946*, 33.

⁵¹ World Health Organization, Eastern Mediterranean Regional Office, ‘Summary Report on the Consultation with Islamic Scholars on Polio Eradication’.

⁵² McNeil, ‘C.I.A. Vaccine Ruse May Have Harmed the War on Polio’.

⁵³ World Health Organization, Regional Office for the Eastern Mediterranean, ‘First Islamic Advisory Group (IAG) Meeting on Polio Eradication’.



Fig. 4.2 ‘Ramadan Messages from the Region’—image from a promotional video produced by EMRO to promote Covid-19 public health advice during the 2021 month of Ramadan.

Source: World Health Organization, Regional Office for the Eastern Mediterranean, ‘Ramadan Messages from the Region’. Reproduced with permission.

this region continue to cooperate to address religiously connoted narratives and practices perceived to put the population at risk.⁵⁴

The more extreme articulations of Islamic morality summarized in this chapter were largely confined to policy documents and were hardly reflected in the daily work of most EMRO staff—particularly as concerns over xenophobia, homophobia, and ethnic and religious schisms between staff from different regions resulted in increased recruitment of staff from outside the region.⁵⁵ The sometimes sobering life of the ‘spiritual dimension’ in the EMRO, we suggest, ought not to detract from the good faith of many of its advocates. Regardless how noble in intent, specific manifestations of attempts at human betterment pass through received vestiges of political ideology and are inevitably refracted across a wide gamut of conceivable outcomes. As a quote from the Qur’an cited in the Amman declaration would have it, God ‘will never change the Grace which He hath bestowed on a people until they change what is in their own souls (8:53)’.⁵⁶ Giving consideration to an aspect of health which promotes the intrinsic impetus of individuals to better themselves according to a salutogenic ethical or moral guideline of some kind would seem like an appropriate and far-sighted addition to many national public health policies. Particularly in a region as torn by conflict as

⁵⁴ World Health Organization, Regional Office for the Eastern Mediterranean, ‘Ramadan Campaign 2021 Key Messages’.

⁵⁵ Personal conversation, former EMRO employee, March 2019.

⁵⁶ World Health Organization, Regional Office for the Eastern Mediterranean, *Health Promotion through Islamic Lifestyles*, 7.

the Eastern Mediterranean, a common ethical framework for public health could exert a highly positive effect not only on health outcomes but also in the promotion of intercultural and interfaith dialogue, and concomitant processes, such as peace-building and maintenance.

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The Spirituality of Others and the WHO

Discourse on Traditional Medicine

Fabian Winiger

Over the past two decades, the WHO has rolled out a comprehensive strategy advising national health authorities on regulatory frameworks, guaranteeing access to safe, effective, and sustainable alternative medical care.¹ In October 2018, a global conference held on the 40th anniversary of the 1978 Alma-Ata declaration on primary healthcare reaffirmed the value of ‘traditional knowledge’ in primary healthcare reform. Knowledge, both traditional and scientific, it stated, is needed to ‘ensure access for all people to the right care at the right time and at the most appropriate level of care, respecting their rights, needs, dignity and autonomy’.²

These sympathies may be somewhat surprising considering the suspicious attitude of many biomedically trained physicians towards medical heterodoxy. Why did the WHO become interested in what it referred to as ‘traditional medicine’—and how, as a prestigious technical agency of the United Nations and a bulwark of scientific rationalism, did it encounter aspects of such healing traditions not currently explicable by prevalent biomedical wisdom? Drawing on a review of WHO strategy papers, discussions in the World Health Assembly, project reports and related documents and monographs published in Geneva and the regional offices, this chapter outlines three distinctive discourses found in the WHO’s encounter with ‘traditional medicine’. As this chapter illustrates, these discourses mediated the encounter of individuals such as Halfdan Mahler’s deputy, Adeoye Lambo, departments like the Division of Health Manpower Development, or academic partners such as the WHO Collaborating Centres for Traditional Medicine, with indigenous beliefs deemed incompatible with biomedicine.

Firstly, pragmatism: in this discourse, traditional healers provided ‘manpower’ that could be trained to distribute biomedical healthcare resources as part of the roll-out of PHC reforms put on the agenda in 1978 with the ‘Health for All by the Year 2000’ initiative. Here, the ‘spiritual’ aspect was either deemed irrelevant or a

¹ World Health Organization, ‘WHO Traditional Medicine Strategy: 2002–2005’, 20.

² World Health Organization and United Nations Children’s Fund, ‘Declaration of Astana: Global Conference on Primary Health Care: Astana, Kazakhstan, 25 and 26 October 2018’, 8.

pliable instrument for the propagation of biomedicine. Secondly, (post-)colonial: this discourse may be understood as a response to the perception by colonial regimes, missionaries, and public health planners of ‘local healers’ as superstitious cultural remnants obstructing the progress of scientific modernity. Newly independent nations, particularly in Africa, found in ‘traditional medicine’ a marker of cultural or ethnic identity. Here, ‘spiritual’ healing practices figured as an expression of an ineffable essence connecting an imagined community to its collective calling and offering a path towards an equal, if not superior, alternative to Western modernity. And thirdly, commercial: indigenous *materia medica* was viewed as a repository of ‘active ingredients’ that could be isolated and marketed as herbal remedies and food supplements, with spirituality providing a potent symbolism to differentiate them on the crowded transnational market for alternative health products.

Building on the work of Rodrigo Toniol, we suggest that in the WHO’s invention of ‘traditional medicine’, the ‘spirituality of Others’³—involving ‘thick’ notions of the ‘spiritual’ involving anthropomorphic spirits, witchcraft, and other modes of ethnomedical efficacy—was extrapolated and integrated into a decontextualized, universal, and inoffensive ‘spirituality of All’, open to empirical validation, amenable to regulation and standardization across different WHO regions, and a ready-made marketing ploy. As illustrated in the following two chapters, it was such a ‘thin’ conceptualization which, shorn of ethnomedical and ritual significance, was taken up and further abstracted and enriched in contexts such as palliative care or quality of life measurement.

Perhaps due to a perceived association with the medical regimes of the former colonial powers, or in recognition of the ethnocentrism and semantic conflation implicit in the term ‘traditional medicine’,⁴ the WHO’s encounter with non-biomedical healing practices has remained largely unstudied, and the specific trajectories and uses of this term are rarely distinguished. Fraught with instrumental imperatives and questionable assumptions as it may appear, the WHO’s interest is unlikely to disappear in the foreseeable future: in 2019, a report published by the WHO argued that traditional and complementary medicine is ‘undergoing a revival’ and ought to be valued as an ‘underestimated health resource’ uniquely suited for the systemic crises that mar public health provision today: the demographic and epidemiological transitions towards old age and chronic illness, soaring costs and ‘stagnant’ or reduced budgets.⁵ The present chapter may be read as a contribution towards a closer reading of the emergence,

³ Toniol, ‘Minutes of the Spirit’.

⁴ Van der Geest, ‘Is There a Role for Traditional Medicine’, 904. For a more recent discussion, see Kadetz, ‘Endangered Practices’.

⁵ World Health Organization, ‘Global Report’, 5.

construction, and trajectory of ‘traditional medicine’ and its inexplicable aspects within the WHO’s institutional history.

Recruiting ‘Manpower’: The WHO Turns to ‘Traditional Medicine’

The WHO’s interest in ‘traditional medicine’ must be read against the background of a growing recognition in the late 1960s that vertical disease-eradication programmes, particularly of malaria, were not succeeding. Widely received polemics weakening the authority of medicine,⁶ the oil shock of 1974, and growing anxieties over environmental degradation called for a change of strategy. In 1975, a joint study by the WHO and UNICEF entitled ‘Alternative Approaches to Meeting Basic Health Needs in Developing Countries’ admitted the limitations of vertical disease eradication in producing lasting health outcomes for most of the world’s population:

The enthusiastic application of new knowledge and technology has not always achieved the results expected, and some of the consequences have been untoward. In sum, history and experience show that conventional health services, organized along “Western” or other centralized lines, are unlikely to expand to meet the basic health needs of all people. The human, physical and financial resources required would be too great and the necessary sensitivity to the special problems of rural or neglected communities would rarely be attained. Clearly the time has come to take a fresh look at the world’s priority health problems and at alternative approaches to their solution.⁷

The spread of impoverished populations across widely dispersed rural and peri-urban settlements made accessibility the major challenge in the development of infrastructure capable of meeting these needs. As the study argued, in many countries, around 80 per cent of the population was ‘underprivileged’ and ill-served by the transplantation of a sophisticated and cost-intensive model of healthcare developed for affluent countries. Even where services were available, they were often scarcely used.⁸ The WHO’s attempt to move away from disease-eradication programmes and towards the provision of ‘basic health services’ was financially and logistically not feasible in poor countries, where these were needed the most.

⁶ See e.g., Illich, *Medical Nemesis*; Sontag, *Illness as Metaphor*.

⁷ Djukanovic and Mach, ‘Alternative Approaches’, 7.

⁸ Djukanovic and Mach, ‘Alternative Approaches’, 7–8; Samuelsen, ‘Therapeutic Itineraries’.

social and economic circumstances of a community.¹¹ The report presented case studies in Bangladesh, Tanzania, Venezuela, Cuba, and the People's Republic of China (PRC) as possible models.¹² Reports of visits to the PRC, largely uncritical and stripped of political context, suggested that its 'barefoot doctors'—village health workers trained in both Chinese and 'Western' medicine—seemed to prove the feasibility of this idea.¹³

Officially, the WHO's new strategy was chiefly a matter of pragmatism. Community health workers could not only help identify local health needs, facilitate preventive efforts such as vaccination and vector-control programmes, make referrals to physicians, and ensure treatment adherence¹⁴ but also had access to local remedies, which could potentially reduce the need for expensive imported pharmaceuticals. In a formulation circulated in the contemporaneous literature, the advantage of 'traditional medicine' could be summed up with 'Four A's': it was available, accessible, acceptable, and adaptable.¹⁵ In 1977, the 30th World Health Assembly adopted a resolution urging governments to prioritize 'traditional medicine' in PHC reforms, marking its formal 'incorporation' into the WHO.¹⁶ The importance of traditional practitioners was made a key point in the 'Global Strategy for Health for All by the Year 2000' and included in the 1978 Alma-Ata declaration. As Mahler argued:

With but 23 years to go [to the year 2000], and since it is unlikely that the least developed countries can even dream of having enough of the orthodox type of personnel, it is clear that unorthodox solutions must be sought. The training of health auxiliaries, traditional midwives and healers may seem very disagreeable to some policy makers, but if the solution is the right one to help people, we should have the courage to insist that this is the best policy in the long run, and is by no means an expedient acceptance of an inferior solution.¹⁷

The recruitment of local healers as 'manpower' attests to a surprising willingness to loosen the monopoly of biomedically trained physicians over the provision of basic health services. A progress report presented to the World Health Assembly in 1976, for instance, suggested that in Africa, 'herbalists, bone-setters, village midwives or traditional birth attendants, traditional psychiatrists and other

¹¹ Djukanovic and Mach, 'Alternative Approaches', 7, 8.

¹² Djukanovic and Mach, 'Alternative Approaches', 9.

¹³ See e.g., 'Study Tour in China'; World Health Organization, 'Primary Health Care – the Chinese Experience'. See also Cueto et al., *The World Health Organization*, 170–1; Lee, 'WHO and the Developing World', 38, 39; Navarro, 'A Critique of the Ideological and Political Positions of the Willy Brandt Report and the WHO Alma-Ata Declaration', 470.

¹⁴ Medcalf and Nunes, 'Visualising Primary Health Care'.

¹⁵ Anyinam, 'Availability, Accessibility, Acceptability, and Adaptability'.

¹⁶ Mahler, 'Foreword', 7. Cf. World Health Assembly resolution 30.49.

¹⁷ Mahler, 'The Staff of Aesculapius', 3.

specialists such as snake and scorpion bite experts', and even 'fetish-priests and priestesses, and witch doctors who are essentially spiritual healers and exorcists' could be trained as 'health auxiliaries' and deliver basic medical care.¹⁸ Notably, the report did not engage with 'fetish-priests' or 'witch doctors' on the basis of their supposed value for the well-being of local populations, but primarily as a means to promote biomedical notions of disease causation and treatment in a way which could be financed and was locally 'appropriate'.

Traditional birth attendants ("TBAs") seemed to illustrate the effects of simple and cost-effective training: the cutting of the umbilical cord with a sterilized blade, for example, could significantly reduce neonatal mortality rates.¹⁹ In the early 1980s, one observer estimated that 20 TBAs were available for every traditional healer involved in national healthcare projects.²⁰ Stacy Pigg's study of the training of Nepalese TBAs by Save the Children, a UK-based international humanitarian agency, suggests how 'utilisation' played out in practice. Accordingly, the training of *dhami-jhankris* (shamanic healers) to recognize the symptoms of common illnesses and provide first aid began

[...] by formulating an analogy between the spirits *dhami-jhankris* placate in order to heal and the germs the health post asserts causes illness: A case history is related to the group – "A man on his way home drinks water from a *kuwa* [water source] ... When he arrives home, he develops abdominal pain and gets diarrhoea and vomiting." The group are then asked for their diagnosis. The response is always the same – "*bhut lagyo*" or "caused by a bad spirit." Discussion then follows about the other activities that take place at the *kuwa* ... It is agreed that it is possible for dirt to enter the water that other people use for drinking. We next explain our theory of "*kira*" (germs) in water which can cause disease, and we say that although they are invisible to the naked eye, we can see them through our microscopes. The similarity of both spirits and germs both being invisible is again stressed.²¹

Equipped with a basic grasp of germ theory, *dhami-jhankris* would become ready advocates of 'conventional health knowledge' such as hand washing, sterilization, and hygienic handling of food and waste. Yet, as Pigg notes, though laudable in its attempt to build on rather than replace local practices, the attempt to co-opt *dhami-jhankris* as 'manpower' woefully distorted the beliefs of Nepali villagers:

¹⁸ World Health Organization, 'Provisional Agenda Item 2.5.7: Health Manpower Development', 47.

¹⁹ Mangay-Angara, 'New Status for the Hilot'; World Health Organization, 'The Promotion and Development of Traditional Medicine', 22–7; Cosminsky, 'Traditional Midwifery and Contraception'.

²⁰ Pillsbury, 'Policy and Evaluation Perspectives', 1827.

²¹ Pigg, 'Acronyms and Effacement', 57. Emphasis in original.

The distinctive ritual practices of a variety of spiritual intercessors who practice within diverse ritual complexes are collapsed into the generic label *dhami-jhankri*, a cultural lowest common denominator that blurs the differentiation of skills, kinds of power and relations to spirits that are of the utmost importance in healing practice. [...] As information from a particular place about the sorts of supernatural beings that afflict people becomes synthesized by training programs for more general application, the highly specific named entities known to people in a locale gradually become reformulated in the more generic categories of 'ghosts' and 'spirits', until eventually they disappear altogether into 'traditional beliefs'.²²

As suggested by Pigg's study, the use of spirit healers as 'manpower' thus ultimately risked reverting to a scantily veiled biomedical epistemology.²³

The 'spirituality of Others', to return to Toniol's phrase, was less pliant than imagined, and the integration of 'traditional medicine' into the WHO agenda, more difficult than anticipated. Community health workers, it turned out, were not a ready-made resource eagerly waiting to collaborate with local populations and improve their lives according to modern medical science, but often uninterested or entrenched in political relationships which undermined the democratizing, egalitarian aims of universal PHC.²⁴ A study published in 1981 by the WHO's Division of Health Manpower Development noted the dramatic decline of neonatal mortality rates in provinces of the Philippines where TBAs had received training. It reiterated both their 'vast potential', but also a number of serious questions with 'no immediate answers'. For instance, it remained unclear whether the trainer's knowledge of the local culture had any impact at all on the performance of TBAs; whether trained attendants could effect any change in their community if faced by resistance due to 'cultural reasons', or if training in biomedical methods would lead to an increase in referrals, overwhelming rural health stations and leading to a net loss of satisfaction in medical care.²⁵

In 1983, a major WHO survey of traditional medicine suggested that the 'old debate between advocates of scientific excellence and the champions of minimum effective coverage has been largely resolved by a general consensus that all citizens have a right to health', and that a wide range of primary healthcare services was required to honour that right. But the discussion, it continued, had 'taken place mainly between doctors and administrators' schooled in the 'technological and organizational assumptions of modern medicine and public health'. The notion of traditional medicine as a source of 'manpower' encountered 'grave doubts' by

²² Pigg, 'Acronyms and Effacement', 54.

²³ Pigg, 'Acronyms and Effacement', 57.

²⁴ Frankel and Doggett, *The Community Health Worker*; Medcalf and Nunes, 'Visualising Primary Health Care'.

²⁵ Mangay-Maglacas and Pizurki, *The Traditional Birth Attendant*, 205–11.

many local healers, who had experienced neglect or persecution in the past and feared being digested by official healthcare services.²⁶

In 1985, Olayiwola Akerele, the programme manager for Traditional Medicine at the Division for Diagnostic, Therapeutic and Rehabilitative Technology, gave a keynote address at the 'World Symposium on Traditional Medicine' held in New York. It painted a disappointing picture of past progress. In many countries, 'lip service' was being paid to programme staff; in others, programmes had been abandoned and policies on 'traditional medicine' had collapsed. Traditional practitioners and even physicians were being blamed for charlatany and opportunism, while 'technocrats' imposed their 'narrow "international medical standards" instead of trying to meet the overall health needs of the people'.²⁷

Colonialism and National Pride

The decade of the 1970s also saw the decolonization of large parts of Africa and the creation of several newly independent nation-states. They began to influence the agenda of several United Nations specialized agencies, where they sought to reform a global capitalist order perceived to serve the industrial countries of the Global North. Concerns began to be voiced over irresponsible marketing practices and reports that third-world countries were used as a dumping ground for untested, second-grade, or poorly labelled medicines.²⁸

When in 1977, at the 30th World Health Assembly, 'traditional medicine' was integrated into the PHC strategy, the discussions were shot through with a scathing critique of the ethics of 'Western' medical care. As Director-General Halfdan Mahler admitted, many of the 'methods, machines and medicines' deployed in poor countries had 'never undergone the critical evaluation of a controlled trial let alone a proper cost/effectiveness analysis'.²⁹ He continued:

In an era when such dramatic and productive efforts have been made to rid ourselves of political colonialism, it is unthinkable that we should continue to tolerate technological neo-colonialism in health. We must break the chains of dependence on unproved, oversophisticated and overcostly health technology by developing another kind of technology that is more appropriate because it is technically sound, culturally acceptable and financially feasible.³⁰

²⁶ As asked by one traditional practitioner: 'who phagocytoses whom?', in Bannerman et al., 'Introduction', 10. See also Unschuld, 'Western Medicine and Traditional Healing Systems', 10; Bibeau, 'New Legal Rules for an Old Art of Healing', 1849.

²⁷ Akerele, 'Towards the Utilization', 3.

²⁸ Chorev, *The World Health Organization*, chs. 3, 4.

²⁹ WHO, Thirtieth World Health Assembly, Geneva, 2–19 May 1977, 53.

³⁰ WHO, Thirtieth World Health Assembly, Geneva, 2–19 May 1977, 53. Cf. Mahler's address to the World Health Assembly 1978.

The first 30 years of the WHO's existence, when poor countries had asked for 'technical assistance' but largely accepted the authority of biomedical science, had done little for the health of most in 'underdeveloped' nations. Rather than serving the needs of the population, the WHO seemed to carry forth a legacy of the past, when medicine figured as a 'tool of empire' that primarily benefited administrators stationed in the colonial enclaves, increased the productivity of their labour forces, and kept infectious diseases from spreading to the old continent.³¹

Local health-related beliefs were typically deemed an obstacle to the triumph of medical modernity. An article published in a 1977 issue of *World Health*, for instance, described how in a remote area of Chile 'traditional ceremonies by witch-doctors called *machis* have given way to modern medical care'. The tone was celebratory: 'because of such beliefs and this way of life that I have described', it was said, 'the people of our communities led lives of poverty and backwardness [...] In 1974, a miracle happened. The National Health Service came to Casa de Piedra and began to solve our health problems.' The narrator then related how he had persuaded his father to no longer take part in 'ceremonies' and he himself was trained as a health auxiliary.³²

In many recently independent nations, the call to freedom from the 'yoke of oppression'³³ brought with it a revalorization of the culture and traditions neglected or oppressed during colonial rule. In this context, patronizing attitudes of Western-trained physicians towards local healing traditions appeared as a veiled attempt to seize cultural hegemony, complicit with the use by former oppressors of medicine to make a case for the humanitarian merits of imperialism. The WHO's search for 'manpower' thus revolved around a second rationale: local healers, the argument went, not only were far more available than biomedical care but offered an equivalent, if not superior body of knowledge that had sprung from the age-old wisdom of the people and, unlike the technology of the advanced industrial nations, was uniquely adapted to the needs of the population. If the 'utilisation' of traditional healers as 'manpower' was challenged by their magico-religious trappings, this rationale found in the ineffable air of local healing traditions a symbolic resource for the creation of a post-colonial collective identity expressive of a unique, non-Western modernity.

The 'spirituality' of traditional medicine in this sense may be understood in terms of what scholars have described as a 'politics of civilizational difference' in India, China, Japan, and Africa, where traditional culture furnished the symbolic resources to counter the imperialist project.³⁴ As Prasenjit Duara points out, 'Asian' spirituality served to 'authenticate' and 'authorise' national identities,

³¹ Cueto et al., *The World Health Organization*, ch. 6.

³² Huenumán, 'My Land, My People, My Mission', 16.

³³ WHO, Thirtieth World Health Assembly, Geneva, 2–19 May 1977, 113.

³⁴ Van der Veer, *The Modern Spirit of Asia*, 188, 189.

typically by presenting itself as encompassing the ‘West’ in its own culture or by positioning itself as its ethical negation.³⁵ ‘Traditional medicine’ thus signified an equivalent to biomedical science rooted in the culture of the nation (e.g., ‘Ayurvedic science’).³⁶ At the same time, it was superior to it, in that it expressed all the qualities lacked by the West—it was natural not technological, gentle not invasive, sustainable not exploitative, ancient not new-fangled, holistic not reductionist, local not transnational, and of course, ‘spiritual’ rather than materialistic. The changing configuration of power between the WHO and the Global South necessitated a rethinking of the relationship between spirituality and ‘traditional medicine’, prompting calls for some form of ‘structured coexistence’ of ‘traditional’ and ‘modern’ medicine.³⁷

The Christian Medical Commission of the World Council of Churches illustrates this process.³⁸ Founded in the 1968, the CMC worked on the frontlines of rural healthcare and its experience provided an important model in the development of the WHO’s primary healthcare strategy.³⁹ During the 1970s, *Contact*, a bulletin sent to missionary health workers, published several searching pieces on the relevance and applicability of their work. An issue published in 1973 on the topic ‘traditional beliefs, health and Christianity’ contained an essay written by Donald McGregor, a missionary stationed in Papua New Guinea. It began with the following ethnographic vignette:

In early 1972 Monda from Teloutei village became sick. [...] Very sorry for herself, she lay on her ‘pangal’ bed much quieter than usual. Concerned, husband Kauyu called for Wilaki, one of the medicine men in the village [...] Wilaki immediately concluded that ancestral spirits had afflicted her. Wilaki then informed Monda and everyone else that her sickness was the result of her bad behaviour. Maiweiyum, Kauyu’s mother, who died in 1961, had grown tired of hearing Monda insult Kauyu. Time and again Monda had also said nasty and untrue things about her husband to others in the village [...] Now Maiweiyum’s spirit was angry with Monda. Why should her daughter-in-law behave like this when she, Maiweiyum had worked so hard to care for and feed her son Kauyu when he was a baby?⁴⁰

Knowing that Monda’s sickness had come from bad spirits that had invaded her in retaliation, Wilaki asked her to resolve to be a ‘good woman’ in the future. With his mouth he ‘sucked and pulled out seven pieces of wood’ from her body shot

³⁵ Duara, ‘The Discourse of Civilization’, 108.

³⁶ Kurup, ‘The Science of Life’.

³⁷ Unschuld, ‘Western Medicine and Traditional Healing Systems’.

³⁸ For a discussion of the CMC and several additional examples, see Unschuld, ‘Western Medicine and Traditional Healing Systems’, 6–11.

³⁹ Litsios, ‘The Christian Medical Commission’; Braley, ‘The Christian Medical Commission’.

⁴⁰ *Contact*, 1973, 2.

into her by angered ancestors, and asked their god to send away the sickness and the bad spirits. As Monda's own spirits had also been taken away from her, he applied a heated leaf anointment, pleaded to his ancestral spirits and kin and lured Monda's spirits back into her body. The next day she was well again.

No longer, McGregor argued, could such practices be dismissed as 'isolated beliefs'. It was the responsibility of the missionary health worker to understand the 'logical picture of the world in which events make sense and have meaning'. As he continued:

We should not aim at undermining their world view (not that we can anyway), for on this foundation is built quite a reasonable set of values. Rather than destroy their world view and values (and, we may add, their social structure and culture), we should think more in terms of its changing, developing and being brought to fulfilment.⁴¹

Neither the physical sciences nor the Bible could disprove such beliefs; indeed, the biblical texts resembled many of the values in this worldview, and told of the existence of spirits and ancestral spirits.⁴² Addressing his fellow missionaries, McGregor wrote:

We virtually say that such things as the belief in their traditional spirits who make people sick is a lie of Satan who has darkened their minds; sickness has natural causes; ancestral spirits do not really exist, for when a person dies, the spirit goes immediately to either heaven or hell; the work of medicine men in pulling out arrows is trickery or satanic, as also is sorcery. Maybe we convey all this more implicitly than explicitly, but this is what we often teach.⁴³

Passing down a preconceived relationship between God and the supernatural had led to much misfortune. Instead, native Christians should formulate their own theology appropriate for the particular problems they faced in their lives.

McGregor's sobering reassessment of the privileged epistemology of medical missionaries is characteristic of the CMC's discourse on non-Christian spirituality and health during the 1970s, and the broader rejection of medical triumphalism and the embrace of non-Western healing modalities among many twentieth-century liberal Protestants.⁴⁴ It testifies both to the waning credibility of the colonial adventure and the nascent recognition that outright hostility or reluctant acquiescence to local healing practices had fostered an antagonistic climate at

⁴¹ *Contact*, 1973, 4, 5.

⁴² The author referred to the invocation of Samuel's spirit by Saul in Samuel 28.

⁴³ *Contact*, 1973, 9.

⁴⁴ Klassen, *Spirits of Protestantism*. For another example in *Contact*, see 1980, 13–18.

odds with bottom-up, community-based provision of basic healthcare services. The emerging paradigm of PHC had to engage with local people as independent and equal partners, not as passive witnesses to the triumph of Western medical modernity. 'When the medical missionaries brought their technology and their Bible into Africa, grievous wrongs were done. That's past history now', wrote the editors of *Contact* in 1980. 'Since then, in all these regions, independent nations have emerged, conscious of their own traditions. What does this have to say to the Christian churches?' *Contact* described twelve projects, conferences, courses, publications, and joint projects between Christian and medical institutions intended to orient medical missionaries in the new, post-colonial reality.⁴⁵ Just as Western medical science could serve as a 'divine instrument', it was suggested, so could local healers be integrated into the Christian healing ministry.⁴⁶ Insofar as senior WHO staff took cues from the CMC's community-based healthcare programmes, the openness towards 'traditional medicine' among former medical missionaries likely shaped the emerging PHC paradigm (Fig. 5.2).⁴⁷

Throughout the 1970s, the changing perception of indigenous healing also began to shape the tone in the World Health Assemblies, where India, Sri Lanka, and several African countries, led by the PRC, reworked the problematic connotations of 'traditional medicine' into a point of 'national pride'.⁴⁸ The following example illustrates this: between the late 1960s and early 1970s, the Democratic Republic of Congo (formerly Zaire) under the dictatorship of Mobutu Sese Seko instituted the policy of *retour à l'authenticité* to forge a new national identity thought to unite diverse ethnic and tribal groups in a single 'Zairean' culture. Dress styles and personal and place names were changed to purge the country of Christian and colonial influence. At the 27th World Health Assembly held in 1974, the representative of Zaire extended *authenticité* to medical care. Yet, the interest in 'traditional medicine' was caught between paradoxical desires to negate and to imitate Western medical science. As the representative argued:

Countries at an advanced stage of development have to some extent made their influence felt, condemning traditional medicine to remain in a very backward state. Thus discouraged, traditional medicine has been unable to develop [...] Thus, in order not to give away his secrets, his expertise and his knowledge, and to make a psychological impression on the patient, the traditional healer often makes use of the rituals of magic and witchcraft, accompanied by a series of meaningless gestures. Our political philosophy of a return to authenticity, as

⁴⁵ For instance, a symposium in Basel attended by 80 theologians and physicians entitled 'The African Medicine Man – What Can We Learn From Him?'

⁴⁶ *Contact*, 1980, 15, 16.

⁴⁷ On the relationship between WHO and CMC in the development of PHC, see Chapter 2.

⁴⁸ Lee, 'WHO and the Developing World', 38.

advocated by the guide of the Zairian nation, General of the Armed Forces Mobutu Sese Seko, now allows us to take a backward look, and we feel it is necessary to make a study of the medicinal plants used in traditional medicine in Zaire in order to discover their therapeutic properties and to make rational use of them.⁴⁹

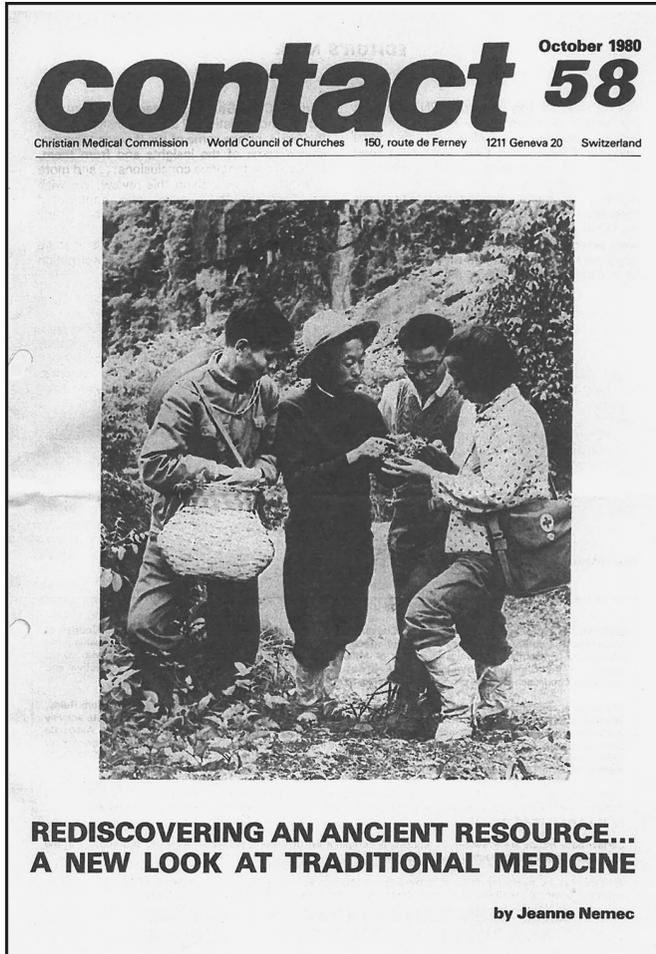


Fig. 5.2 Special issue of *Contact* on the 'rediscovery' of traditional medicine, October 1980.

Source: Nemeč, 'Rediscovering an Ancient Resource'. Reproduced with permission.

⁴⁹ Twenty-Seventh World Health Assembly, Verbatim Records of Plenary Meetings and Summary Records of Reports of Committees, 66.

Though *authenticité* rejected the colonial dismissal of African backwardness, indigenous healers authenticated ‘Zairean’ national identity once they had been purified through the gaze of Western medical science, making ‘magic and witchcraft’ a matter of ‘meaningless gestures’, and reducing local healing traditions to the study of medicinal plants.

The connection between political independence and ‘traditional medicine’ was well noted by key figures in the WHO. Take Mahler’s deputy, Adeoye Lambo, a Nigerian psychiatrist, who in the 1950s had pioneered the integration of Nigerian indigenous healers and Western-trained psychiatrists in ‘therapeutic villages’, thought of health as encompassing ‘a spiritual component’, and saw in ‘traditional medicine’ an opportunity to ‘re-humanise the medicine of the day’.⁵⁰ He was open about his expectation that politicians would support integration, due to the desire in developing countries for more self-reliance and to rediscover the culture they had discarded. Lambo considered the WHO’s first consultation on ‘traditional medicine’ in 1976 a ‘revolutionary’ step and expected resistance from the ‘medical mafia’, a reference to the American Medical Association and the American Psychiatric Association, who will ‘passionately defend [...] their own stand’.⁵¹

Unsurprisingly perhaps, Lambo’s strategy received a rather cool reception. A participant of the 1976 consultation thought it to be plainly obvious that Lambo was using ‘national pride and traditional cultural identity’ to gain support for his candidacy as Director-General. Another critic alleged that the WHO’s interest in ‘traditional medicine’ was a concession to the PRC, which had recently joined the WHO.⁵² More recently, one scholar wondered whether the WHO perpetuates an “‘international beauty pageant” of medical cultures’ that pretends to celebrate diversity but effectively legitimizes a hegemony of ‘common differences’ cleansed of ‘deeper underlying traditions or spiritual dimensions’.⁵³

The Search for ‘Active Ingredients’

As illustrated by Zairean *authenticité*, the WHO’s turn to ‘traditional medicine’ was accompanied by a third rationale, closely related to the matter of national pride: the search for the ‘active ingredient’ that made ‘traditional medicine’ efficacious. In 1978, the World Health Assembly called on Member States to study medicinal plants and ‘apply scientific criteria and methods for proof of

⁵⁰ Lambo, ‘A New Day Dawns’; Akerele, ‘Which Way for Traditional Medicine?’

⁵¹ Singer, ‘Interview with T. A. Lambo, M.D.’. The connection between ‘traditional medicine’ and political self-determination was also noted by Akerele and Bannerman, see comments in Bannerman, ‘Traditional Medicine in Modern Health Care Services’, 731, 747; Akerele, ‘Towards the Utilization of Traditional Medicine’, 6.

⁵² Singer (1988) and Velimirovic (1992) in Foran, ‘Medical Pluralism and Global Health Policy’, 89.

⁵³ Keane, ‘Globality and Constructions of World Health’, 229, 235.

safety and efficacy'.⁵⁴ Through better utilization of locally available medicines, it was hoped, poor countries could reduce their import of essential medicines, saving costs and increasing their political, cultural, and economic independence.

Like the top-down eradication campaigns of the past, this was caught up in the thorny issue of political disenfranchisement.⁵⁵ 'Let us not be in any doubt', wrote Mahler in the foreword of a *World Health* special issue in 1977, 'modern medicine has a great deal still to learn from the collector of herbs. And already a number of Ministries of Health, in the developing countries especially, are carefully analysing the potions and decoctions used by traditional healers to determine whether their active ingredients have healing powers that "science" has overlooked.'⁵⁶ Mahler's call for a sense of humility towards the 'collector of herbs' and his self-conscious use of quotation marks ('science') suggests that the self-privileging epistemology of medical science was recognized as an obstacle. It should not be forgotten, wrote one manager of the WHO's Traditional Medicine Programme in 1982, that 'Western style bio-medicine is itself a reflection of the prevailing culture and an expression of a particular world view.'⁵⁷ In practice, biomedicine remained largely unquestioned.

In 1975, a WHO collaborating centre at the University of Illinois in Chicago began to build an electronic database to catalogue ethnomedical pharmacopeia. Named NAPRALERT ('natural product alert'), this project systematically identified the 'active ingredients' thought to distinguish 'traditional medicine' with 'real' therapeutic value from those with 'ritual' and 'placebo' effects.⁵⁸ NAPRALERT became a central locus of activity within the Traditional Medicine Programme. Chemical agents could then be extracted, analysed, synthesized, and put in the service of the general public.⁵⁹ The emphasis on chemical agents may have reflected the PRC's ongoing influence over the WHO's Traditional Medicine Programme: In 1987, one-third of the 21 'collaborating centres' were located in the PRC, a highly politicized context marked by a decades-long state-controlled effort to cleanse Chinese medicine of its 'backwards' elements.⁶⁰ The Nobel prize-winning 'discovery' of the antimalarial artemisinin in *qinghao*, a Chinese herbal remedy for febrile diseases known for nearly two millennia, would become the most well-publicized success in the attempt to extract 'active ingredients' from 'traditional medicine'.⁶¹

⁵⁴ WHA 31.33, Twelfth plenary meeting, 23 May 1978 (Committee A, third report).

⁵⁵ See e.g., Mume, 'A Traditional Doctor Speaks'. ⁵⁶ Mahler, 'The Staff of Aesculapius', 3.

⁵⁷ Maclean and Bannerman, 'Utilization of Indigenous Healers', 1815.

⁵⁸ Farnsworth, 'The NAPRALERT Data Base', 184. ⁵⁹ Mahler, 'The Staff of Aesculapius'.

⁶⁰ Foran, 'Medical Pluralism', 88, 120, 121. See for instance the stance on 'illegal' superstitions by Cai Jingfeng of the Chinese Academy of Traditional Chinese Medicine in 1987 in Jingfeng, 'Toward a Comprehensive Evaluation', 661.

⁶¹ Manufacture of artemisinin began in 1986, and in the early 1990s the WHO began to investigate artemisinin and its derivatives, which have been widely promoted since 2004. Hsu, 'Reflections on the "Discovery"'.

Throughout the 1980s and 1990s, new laws in Africa, Asia, Europe, and North America increasingly sought to rationalize and professionalize local healers.⁶² Access to safe and effective plant extracts became a priority, and local healers had to be re-evaluated and brought 'up to date'.⁶³ This placed further pressure on practices inexplicable in biomedical terms. As a review of legislative frameworks commissioned by WHO warned in 1985: 'supernatural elements' were 'widespread', 'firmly rooted', and 'difficult to eliminate'. They harboured manifold opportunities for fraud and other 'serious dangers', many of which had been mitigated by colonial-era laws.⁶⁴ Gilles Bibeau, a Canadian anthropologist studying the institutionalization of Zairean 'traditional medicine' in the 1970s, summed up the problematic as follows:

WHO and many African governments seem ready to utilize traditional healers in the national health delivery system. I agree entirely with such a position. But I am convinced that such a utilization can be effective only if there is at the same time a recognition of the foundations on which this medical system is built. It is not a difficult task to organize healers and to give them licences. The real problem begins when you look at the way they work: healers are not only givers of herbal remedies but they also perform divinations; they perform rituals through which social relations are improved. But they also identify sorcerers and sometimes split the community. What part of this medicine is acceptable? Who has the right to say 'I reject this and maintain that'?'⁶⁵

The rationale behind the identification of problematic practices is most clearly exemplified by George Foster, a well-connected American anthropologist consulted by the WHO.⁶⁶ Foster distinguished between 'naturalistic' and 'personalistic' notions of disease aetiology. The former was broadly compatible with biomedicine: disease was caused by a loss of physiological equilibrium and unrelated to misfortune, religion, and magic, it was monocausal and could be prevented. Responsibility for illness and recovery stayed with the patient. Personalistic aetiologies were related to an external agent, typically deities, evil spirits, and sorcerers. Personalistic aetiologies were 'religious' or 'magical' in that they used prayer, exorcism, confrontation of the sorcerer, and so on.⁶⁷

⁶² Foran, 'Medical Pluralism', 216.

⁶³ Akerele, 'The Best of Both Worlds'; Yangni-Angate, 'Understanding Traditional Medicine'.

⁶⁴ Stepan, 'Traditional and Alternative Systems of Medicine', 331–3. For a detailed discussion published in 1986 see Last and Chavunduka, *The Professionalisation of African Medicine*, esp. Ngubane, 'The Predicament of the Sinister Healer'.

⁶⁵ Bibeau, 'New Legal Rules for an Old Art of Healing', 1846. See also Neumann and Lauro, 'Ethnomedicine and Biomedicine Linking' and the other contributions in the 1982 (16) special issue in *Social Science & Medicine*.

⁶⁶ Bruchhausen, 'Medicalized Healing in East Africa', 42. For a related dichotomy, see Young, 'Internalizing and Externalizing Medical Belief Systems'.

⁶⁷ Foster, 'Disease Etiologies'. For its use in WHO literature, see e.g., Bodeker, 'Traditional Knowledge and Health', 181, 182; Foster, 'An Introduction to Ethnomedicine', 18, 19.

The position that traditional knowledge principally revolved around 'naturalistic' causation effectively imposed an artificial distinction on complex spiritual and ritual ecologies that converged in the bodies of the ill, and played into the reduction of traditional healers to the biochemical efficacy of a pharmaceutical product.⁶⁸ Moreover, it posited a pluralism of discrete medical systems which privileged the scholarly traditions produced by literate elites in highly stratified societies (e.g., Chinese and Ayurvedic medicine) and ignored that often, naturalistic and personalistic aspects formed an inextricable whole which had only recently been separated.⁶⁹ As shown by Walter Bruchhausen in his study of the medicalization of East African healing practices, the interest of the WHO's African Regional Office and the Traditional Medicine Programme owed much to such a distinction. It had been imported into Tanzania by British rule, where the Witchcraft Ordinance tolerated herbal and 'psychological' medicine (*uganga*), while witchcraft (*uchawi*) was sanctioned with severe punishments. 'Traditional medicine', suggests Bruchhausen, was not destroyed by colonialism but *produced by it* and subsequent post-colonial regimes through the selective appropriation and suppression of practices judged 'medical' or 'religious'.⁷⁰

Questions also loomed over who were the ultimate beneficiaries of integration. In 1984, Akerele reported that the WHO's endorsement had prompted fears that the analysis of indigenous *materia medica* would continue a quasi-colonial relationship by exploiting local healers' knowledge to the benefit of multinational pharmaceutical companies. The WHO's endorsement, he wrote, had

encouraged a re-examination of the value of traditional medicine in most developing countries from which new cultural awareness of, and pride in, traditional values have emerged. This new-found national pride would be of little consequence unless it were translated into a meaningful form of action. [...] Having emerged from the colonial era, developing countries are anxious to prevent a second wave of exploitation. [WHO] is trusted to look after their interests so that whatever potentials exist in the area of traditional medicine, such as medicinal plant remedies, can be developed and used for the benefit of the local population, and not merely for commercial interests elsewhere.⁷¹

With the neoliberal restructuring of the 1990s, WHO policy began to respond to a booming herbal industry worth billions of dollars. In Tanzania, the growing

⁶⁸ For an introduction to this critique, see Adams, 'Randomized Controlled Crime'; Janes, 'The Health Transition, Global Modernity and the Crisis of Traditional Medicine'.

⁶⁹ Pool, 'On the Creation and Dissolution of Ethnomedical Systems'. More recently, see Kloos, 'Tibetan Medicine in Exile'; Littlewood, *On Knowing and Not Knowing*.

⁷⁰ Bruchhausen, 'Medicalized Healing in East Africa'. For a related critique of the term, see Geest, 'Is There a Role for Traditional Medicine', 904.

⁷¹ Akerele, 'Progress and Perspectives', 77.

demand for herbal supplements mobilized pharmaceutical multinationals, government-run laboratories, and traditional healers-turned-entrepreneurs.⁷² Though Tanzanian medicine bolstered national identity vis-à-vis the 'West', the production of pharmaceuticals derived from local medicinal plants all but purged them of any indigenous religious connotations. The spirit world, populated by immanent and morally ambivalent entities embroiled in ontological negotiations, transgressions, interference, and mythological narration, could not be encapsulated in pharmacological products. The 'spiritual' dimension of 'traditional medicine' thus mainly came to furnish decontextualized symbolic resources to market 'holistic' herbal remedies and food supplements abroad.⁷³ According to Stacey Langwick, 'stripped' of the social and spiritual context in which it had once been embedded, 'traditional medicine' lost its powers to heal. It became 'another commodity, its efficacy often measured in patents, packages sold, visibility outside Tanzania, publications, and global sales and rarely, [...] in terms of effects on suffering people's bodies and lives'.⁷⁴

Attempts to extend the training of birth attendants to primary healthcare continued.⁷⁵ But throughout the 1990s, the WHO increasingly reoriented itself according to the market logic promoted by the World Bank and the International Development Bank.⁷⁶ In this context, the regulation of pharmaceutical products became an overriding preoccupation, and the Traditional Medicine Programme was integrated into the WHO programme on drugs management. The five-year period between 1990 and 1995 shifted the focus to the industrial production of herbal remedies, again argued to be more cost-effective and 'appropriate' to countries facing economic crises and shortages of biomedical pharmaceuticals.⁷⁷ WHO advice shifted towards national legislation related to toxicological standards, research methodologies, quality control, evidence-based treatment evaluation, and environmentally sustainable production. Ensuring 'safety' came to dominate WHO literature.⁷⁸ In 2002, WHO published the first global strategy of traditional medicine, written by staff working on the WHO's 'essential drugs and medicines' strategy (Fig. 5.3). In this document, the idea of training traditional practitioners as 'manpower' for primary healthcare reform is absent, as are references to national 'dignity and self-confidence' and to the rich ritual contexts that embed and potentiate herbal remedies. Instead, 'traditional medicine' is equated with the Complementary and Alternative Medicine (CAM) prevalent

⁷² McMillen, 'The Adapting Healer'; Langwick, *Bodies, Politics, and African Healing*; Bruchhausen, 'Medicalized Healing in East Africa'.

⁷³ See e.g., Adams, 'Randomized Controlled Crime'; Langwick, 'Partial Publics'.

⁷⁴ Langwick, 'Partial Publics', 511; Langwick, *Bodies, Politics, and African Healing*, ch. 3.

⁷⁵ World Health Organization, Division of Strengthening of Health Services and the Traditional Medicine Programme, 'Traditional Practitioners as Primary Health Care Workers'.

⁷⁶ Chorev, *The World Health Organization*; Walker, 'Into the Machine'.

⁷⁷ Forty-Fourth World Health Assembly, Provisional Agenda Item 17.2, 1991, 3–5, 10.

⁷⁸ Kadetz, 'Safety Net'.

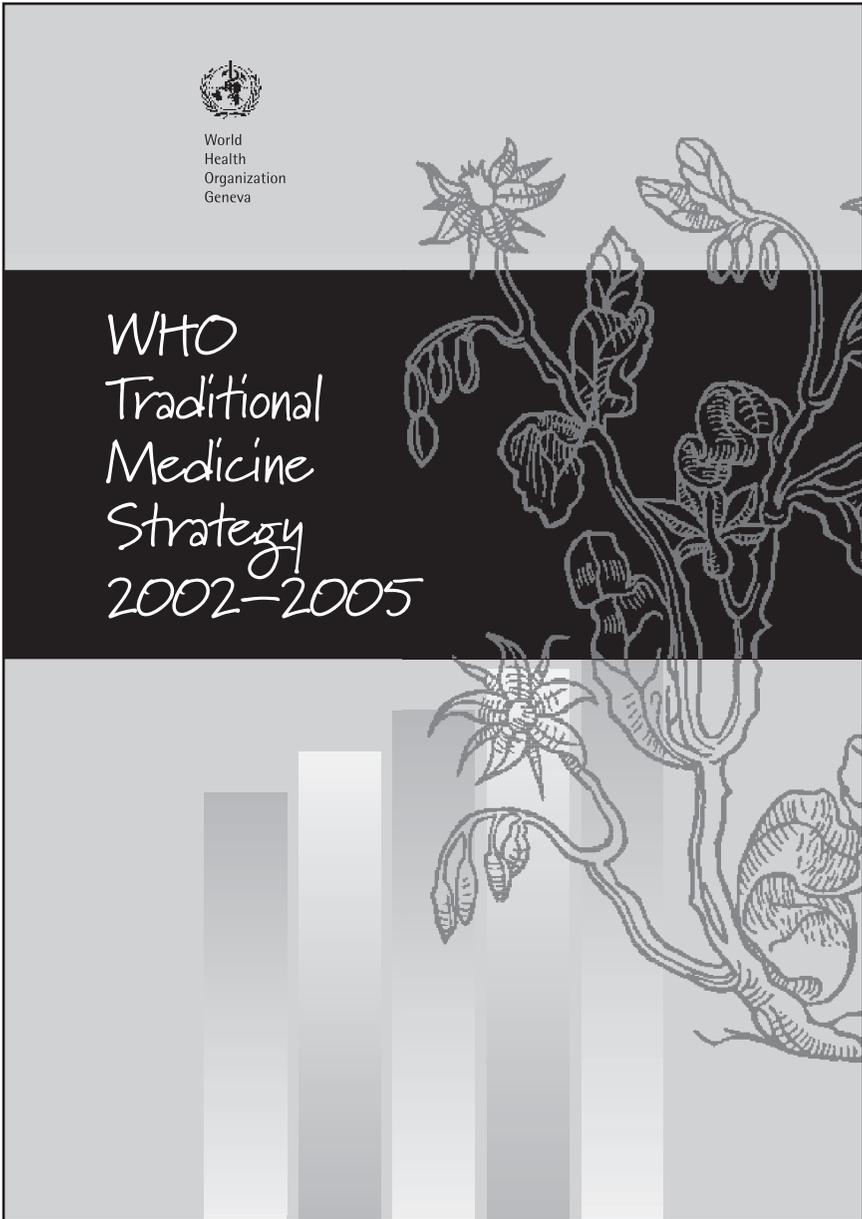


Fig. 5.3 The WHO Traditional Medicine Strategy 2002-2005.

Source: World Health Organization, 'WHO Traditional Medicine Strategy: 2002-2005'. Reproduced with permission.

in Europe, North America, and Australia, and said to share a ‘holistic approach to life, equilibrium between the mind, body and their environment, and an emphasis on health rather than on disease’.⁷⁹

Discussion

It is difficult to disentangle the three discourses—pragmatic, (post-)colonial, and commercial—outlined here. In practice, they were imbricated in a complex and often contradictory mosaic of diplomatic posturing, expert consultations, and policy recommendations and evaluations. The mass production of local herbal remedies, for instance, aligned with the PHC strategy of increasing national self-sufficiency by reducing imports of pharmaceuticals and other costly medical resources, but by the 1990s seems to have become a cash crop for commercial interests with little tangible benefit to most underprivileged populations. Similarly, the case of Zairean *authenticité* illustrates how the revalorization of traditional culture as a point of national pride was premised on the notion of underlying ‘active ingredients’, and in the same breath was accompanied by the reduction of indigenous healing practices to ‘meaningless gestures’.

The present argument concurs with the observation by Sung Lee that ‘it was in the shadow of retreating empires that WHO both identified its problems and offered solutions’.⁸⁰ It is unlikely that the WHO’s incorporation of ‘traditional medicine’ would have succeeded had it not been for the support of recently independent nations, and its connection to an ineffable, ‘spiritual’ essence thought to authenticate post-colonial political identities. The lobbying of the WHO’s Eastern Mediterranean Office to include a ‘spiritual dimension’ of health in the ‘Health for All’ initiative discussed in Chapter 4 is instructive. Its most tenacious proponent, Abdul Rahman Al-Awadi, had in the 1980s presided over two conferences of the IOMS, much of which pivoted on the attempt to scientifically study Islamic medicine as a contribution to a pan-Islamic revival. More subtly, Desh Bandhu Bisht, India’s former deputy minister of health and another key advocate of the ‘spiritual dimension’ in the WHO, was a devout follower of Sri Aurobindo, an Indian religious figure known for his strong nationalist views and his view that materialism was but a relatively low stage of a collective spiritual evolution.⁸¹

⁷⁹ World Health Organization, ‘WHO Traditional Medicine Strategy: 2002–2005’, 21. The most recent strategy paper has continued in a similar vein, but includes more comprehensive definitions of ‘traditional medicine’ and CAM. See World Health Organization, ‘WHO Traditional Medicine Strategy: 2014–2023’. On the production of residual categories in research on CAM, see Winiger, ‘Qigong in Three Social Worlds’.

⁸⁰ Lee, ‘WHO and the Developing World’, 26.

⁸¹ For an early discussion, see Singh, *Prophet of Indian Nationalism*.

The ‘pragmatic’ discourse outlined here may also be criticized as a belated sequela of a lack of adequate funding and binding regulatory mechanisms capable of achieving the goals of universal PHC. In this view, ‘appropriate technology’ such as ‘traditional medicine’ euphemizes a cruel utilitarian calculus.⁸² As Paul Farmer put it in his seminal work on structural violence in global health:

Why do we have an extensive literature on why it is not “cost-effective” or “feasible” (or “sustainable” or “appropriate technology”) to treat poor people who have complicated diseases? This opinion represents, in the view of some, another slick ruse to distract us from the fundamental ethical problem of our era: the persistence of readily treatable maladies and the growth of both science and economic inequality.⁸³

Père Lafontant, an Episcopal priest whom Farmer had met in his formative days in Haiti, put it more colourfully: ‘Do you know what appropriate technology means? It means good things for rich people and shit for the poor.’⁸⁴

This argument is reflected in a report published in 2011 by the Regional Office for South-East Asia. Looking back on the ‘Health for All’ initiative, it commented:

The incorporation of traditional medicine into the organized public health systems [...] has been very erratic and nonproductive, to say the least. This token acquiescence of Member States of the World Health Organization in galvanizing traditional medicine to achieve this collective goal has meant that the health status of the poor, especially the rural poor, has continued to be compromised.⁸⁵

Not only did integration appear as a political farce, but it may have been complicit in the failure to attain the goals of the ‘Health for All’ initiative. The substitution of ‘traditional medicine’, supposedly more in touch with the ‘spirituality’ of local communities, for state-of-the-art (i.e., ‘Western’) biomedical care, this suggests, hides a systemic ethical failure behind the guise of culturally sensitive public health policy.

Other than the unsettling instrumental rationalities outlined here, what remains of the WHO’s encounter with ‘traditional medicine’? While medical professionals have tended to explain the lack of greater acceptance of ‘traditional medicine’ by the medical establishment with the prevalence of supposedly

⁸² Suri et al., ‘Values and Global Health’.

⁸³ Farmer, *Pathologies of Power*, 209. Or, in a related formulation popularized in 1980s post-reform China: ‘when the material is not enough, the spiritual makes up for it’ (*wuzhi bu gou, jingshen lai zou*), cf. Palmer and Winiger, ‘Neo-Socialist Governmentality’.

⁸⁴ Kidder, *Mountains Beyond Mountains*, 90.

⁸⁵ Abeykoon and Akerele, ‘Development of Training Programmes for Traditional Medicine’, 183.

irrational beliefs about spiritual efficacy, some have looked instead for barriers in public health bureaucracies.⁸⁶ More sceptical voices have questioned whether traditional healers have any value at all,⁸⁷ or suggested that their benefit to the WHO was unproven and integration a bureaucratic mythos, perhaps neither possible nor desirable.⁸⁸ In Sri Lanka, for instance, the ministry of health since has since 2007 formally promoted the integration of Ayurveda, Unani, and Siddha practitioners into primary healthcare delivery—but a decade later, little has been put into practice.⁸⁹

For what it's worth, the organization has in recent years demonstrated a surprising willingness to accommodate epistemologies beyond the parochial worldview that marked much of its work until the 1970s. Unthinkable have become remarks such as those of the second Director-General Marcolino G. Candau, who in the First Report on the World Health Situation lamented that 'the struggle against disease, ignorance and poverty has been retarded by the persistence of superstitious beliefs and practices'.⁹⁰ Indeed, the dynamic seems to have reversed: in a UN report on 'traditional knowledge in policy and practice' published in 2010, a self-conscious reflection of 'modern science' suggested that 'the materialistic worldviews and mechanistic paradigms of modern science are *still* dominant in scientific communities across the globe.'⁹¹

The integration of a 'spiritual' dimension into WHO policy continues to matter to stakeholders marginalized by international public health discourse. An open letter of autochthonous peoples and medical anthropologists to the WHO published in 2017, for example, lamented the incompatibility of non-Western moral worlds with a notion of health applied globally as though it constituted a biological universal.⁹² A growing self-awareness of the limitations of biomedicine seems to be emerging, reflected in statements such as that found in a guideline on methodologies for the research and evaluation of traditional medicines, published in 2000. This cautioned researchers to take into account 'physical, emotional, mental, spiritual and environmental levels' of efficacy, and mentions a 'spiritual' aspect on several occasions.⁹³ Though this falls short of a watershed, clearly attitudes are slowly changing. A 2007 guide to increase the effectiveness of cancer control programmes, produced under the direction of the then Assistant Director-General for Noncommunicable Diseases and Mental Health and staff working

⁸⁶ Foster, 'Medical Anthropology and International Health Planning'.

⁸⁷ Velimirovic, 'Traditional Medicine Is Not Primary Health Care'; Velimirovic, 'Alternative Medicine, Dried Lizards and Holistic Fad'.

⁸⁸ Van der Geest, 'Integration or Fatal Embrace?' For a less polemical review of the first decade of the Traditional Medicine Programme in 'sub-Saharan' Africa, see Green, 'Collaborative Programs'. For a case study encapsulating some of these concerns, see Bellakhdar, 'A New Look'.

⁸⁹ Jones and Liyanage, 'Traditional Medicine and Primary Health Care in Sri Lanka'.

⁹⁰ World Health Organization, 'First Report on the World Health Situation 1954–1956', 11.

⁹¹ Haverkort and Reijntjes, 'Diversities of Knowledge Communities', 14, added emphasis.

⁹² Charlier et al., 'A New Definition of Health?'

⁹³ World Health Organization, *General Guidelines*, 5.

on Chronic Diseases Prevention and Management, suggested that there should be 'scope for an open discourse between health-care providers and traditional healers with a view to coordinate their efforts to address the needs of patients and their families, in a sensitive and respectful way, taking into account the diverse cultures of communities and individuals'.⁹⁴

The same year saw the first major global survey of alternative medical use. It suggested that, in addition to offering a cost-effective complement to biomedical treatment, the WHO's famously broad definition of health is in fact consistent with the growing emphasis in industrialized nations on a holistic conception of health that includes 'physical, mental, social and spiritual well-being'.⁹⁵ In the words of Gerard Bodeker, the principal author of this survey: 'There is an emerging awareness that any meaningful appraisal of a traditional health system and its contribution to health care must take into account the paradigm or cosmology that underlies diagnosis and treatment.'⁹⁶

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⁹⁴ World Health Organization, *WHO Guide for Effective Programmes—Palliative Care*, 29.

⁹⁵ Bodeker et al., *WHO Global Atlas*, vii; Bodeker and Burford, 'Introduction'.

⁹⁶ Bodeker, 'Traditional Knowledge and Health', 182. See also Bodeker et al., 'Policy and Public Health Perspectives', 11, 12; Posey, *Cultural and Spiritual Values of Biodiversity*, ch. 6.

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6

Spiritual Care in the Context of Palliative Care and HIV/AIDS

Raphael Rauch and Simon Peng-Keller

Although it is widely recognized that a ‘spiritual dimension’ is an essential element of palliative care, this was not always made explicit in the WHO documents in this field. For instance, palliative care was part of the ‘WHO Global Action Plan’ for the years 2013–2020, but there was no reference to spiritual aspects. This may be due to the very general language of the action plan, but it also suggests that the emphasis is more on access to opioids. Nevertheless, through the reception and worldwide promotion of palliative care, the WHO has contributed significantly to spiritual care becoming a public health issue in the last 30 years. National guidelines that call for consideration of a ‘spiritual dimension’ in palliative care often refer to WHO documents.¹ As this chapter will show, while these documents emphasize that palliative care must also take ‘spiritual problems’ into account, they rarely elaborate on how this should be done. However, the rather casual way in which the topic of spiritual care is mentioned in most WHO documents on palliative care has had a normalizing effect. The inclusion of a ‘spiritual dimension’ thus appears to be an undisputed and indisputable element of this new, comprehensive approach to treatment. Spiritual care is a central piece in the ‘normative story’ about palliative care.² The WHO’s role as a catalyst for spiritual care must therefore be put into perspective. For this, we first outline the emergence of palliative care as a distinct field and its introduction within the WHO in the 1980s. In the following sections, we analyse the most important WHO documents on palliative care with regard to the professionalization of spiritual care. Finally, we reconstruct the role of a ‘spiritual dimension’ in the WHO’s approach towards HIV/AIDS.

¹ See e.g., the Australian national standards in palliative care, Palliative Care Australia, *National Palliative Care Standards* or the Swiss federal guidelines, BAG and GDK, ‘Nationale Leitlinien Palliative Care’.

² Van Gorp et al., ‘Integrating Palliative Care by Virtue of Diplomacy’, 3.

Palliative Care as a Cultural Shift in Modern Medicine and Global Health

The idea of palliative care challenged the WHO's focus on prevention, the fight against infectious diseases, and drug control. The American neurologist Kathleen Foley, who chaired a WHO Expert Committee on Palliative Care in the 1980s, recalls early attitudes to palliative care as follows: 'How could we ever talk about palliative care when we needed to cure cancer, AIDS or Tuberculosis? So the dominant forces in the world at that time were the curative people who felt that anybody who talked about anything less than cure was an enemy.'³ In 1989, the European Association for Palliative Care defined palliative care as 'care of the terminally ill' when 'the disease is no longer responsive to curative treatment and when the control of pain, of the other physical symptoms and of social, psychological and spiritual problems is paramount'.⁴ This definition became part of the first official WHO definition of palliative care in 1990 and thus linked palliative care to a 'spiritual dimension' of health.

The emergence of palliative care is inextricably linked to the personal and professional career of Cicely Saunders. Her commitment to holistic support for the dying was inspired by the Christian hospices led by the Irish Sisters of Charity and closely linked to 'another journey of discovery for me, the search for my Christian vocation'.⁵ She interpreted her care for the dying as a spiritual practice and was not hesitant to address her patients' spiritual needs and to pray with them. Not least, her ideal of the hospice as a 'community of the unlike' also included staff and ward prayers. Saunders started as a ward nurse during the Second World War at St Thomas' Hospital in London. There she saw 'young patients dying of tuberculosis and septicaemia from war wounds' who 'begged us to save them somehow, but we had little to offer except devoted nursing'.⁶ The field of end-of-life care 'was virtually untouched by medical advance and support'.⁷ As a medical student in the 1950s, Saunders experienced 'a revolution in the drugs available for control of symptoms'. Hence, she was able 'to investigate terminal pain and its relief'. In these years, she learned how important it was for the doctor to have 'the time to sit and listen to a patient's story'.⁸ One of her defining insights was that death was a 'whole experience', and that the whole of a patient's life 'was reflected in a patient's dying'. These experiences informed her concept of 'total pain' which includes 'physical, emotional, social, and spiritual elements'.⁹ This

³ Interview with Kathleen Foley, 15.12.2019.

⁴ European Association for Palliative Care, 'Newsletter of the European Association for Palliative Care'.

⁵ Saunders, 'Hospice—a Meeting Place for Religion and Science', 225.

⁶ Saunders, 'A Personal Therapeutic Journey', 1599.

⁷ Saunders, 'Hospice—a Meeting Place for Religion and Science'.

⁸ Saunders, 'A Personal Therapeutic Journey'.

⁹ Saunders, 'A Personal Therapeutic Journey', 1600.

included not only an appreciation of the deeply distressing emotional states of the patient (anxiety, depression, fear) but also a concern for the relatives and their need to find meaning. Saunders' observation that spiritual distress frequently occurs and strongly affects quality of life at the end of life has now been widely empirically proven. Of particular relevance to global health is the fact that this is not a phenomenon limited to the Western hemisphere, but is equally prevalent in the Global South.¹⁰

Through the founding of St Christopher's Hospice in 1967, Saunders' name and her ideas became internationally well known. The term 'palliative care', however, was coined by the Canadian surgeon Balfour Mount.¹¹ It was Mount who suggested to Saunders that her approach 'could never meet the great level of need that existed in the wider healthcare system', and that the 'hospice approach' should 'be transplanted to the hospital context'.¹² 'Palliative care' is not only a change of name but also a change of perspective: palliative care means more than 'end-of-life care', and thus takes place not only in hospice work but also in the hospital or even on an outpatient basis or within the framework of primary or specialist care. However, this broad perspective on palliative care only developed later. Similarly, within the WHO, palliative care was initially conceived narrowly in the context of oncology and end-of-life care.

In 1982, the Swedish oncologist Jan Stjernswärd took over the WHO's Cancer Unit in Geneva. As he describes in an interview, he had lived for two years in India—an experience important in directing him towards a more comprehensive view on health.¹³ He became convinced that cancer care had a strong social and spiritual dimension. Besides his intercultural and interreligious experiences, Stjernswärd was influenced by Cicely Saunders and Robert Twycross, her former clinical research fellow. Under Stjernswärd, the WHO's Cancer Unit enlisted 'hospice-care leaders and cancer pain specialists, plus pharmaceutical manufacturers to develop a global Programme for Cancer Pain Relief'.¹⁴

One of the earliest mentions of palliative care in WHO documents dates to 1986, remarkably with reference to nursing—a profession whose contribution to the development of late modern spiritual care is often underestimated.¹⁵ According to a Danish representative at the World Health Assembly in 1986, nurses in Denmark 'agreed that their overall goals should be health promotion, disease prevention, curative and palliative care, and rehabilitation, and expected their relative importance to be assessed and weighted in each setting'.¹⁶

¹⁰ To cite just one of many studies, see Gielen et al., 'Prevalence and Nature of Spiritual Distress Among Palliative Care Patients'.

¹¹ Palliative Care McGill, 'Balfour Mount'. ¹² Clark, *Cicely Saunders*, 217.

¹³ Interview with Jan Stjernswärd, 9.12.2019. ¹⁴ Clark, *Cicely Saunders*, 240.

¹⁵ Cf. Peng-Keller, 'Genealogies of "Spirituality"', 92.

¹⁶ World Health Organization, 'Thirty-Ninth World Health Assembly, Geneva, 5–16 May 1986: Summary Records of Committees'.

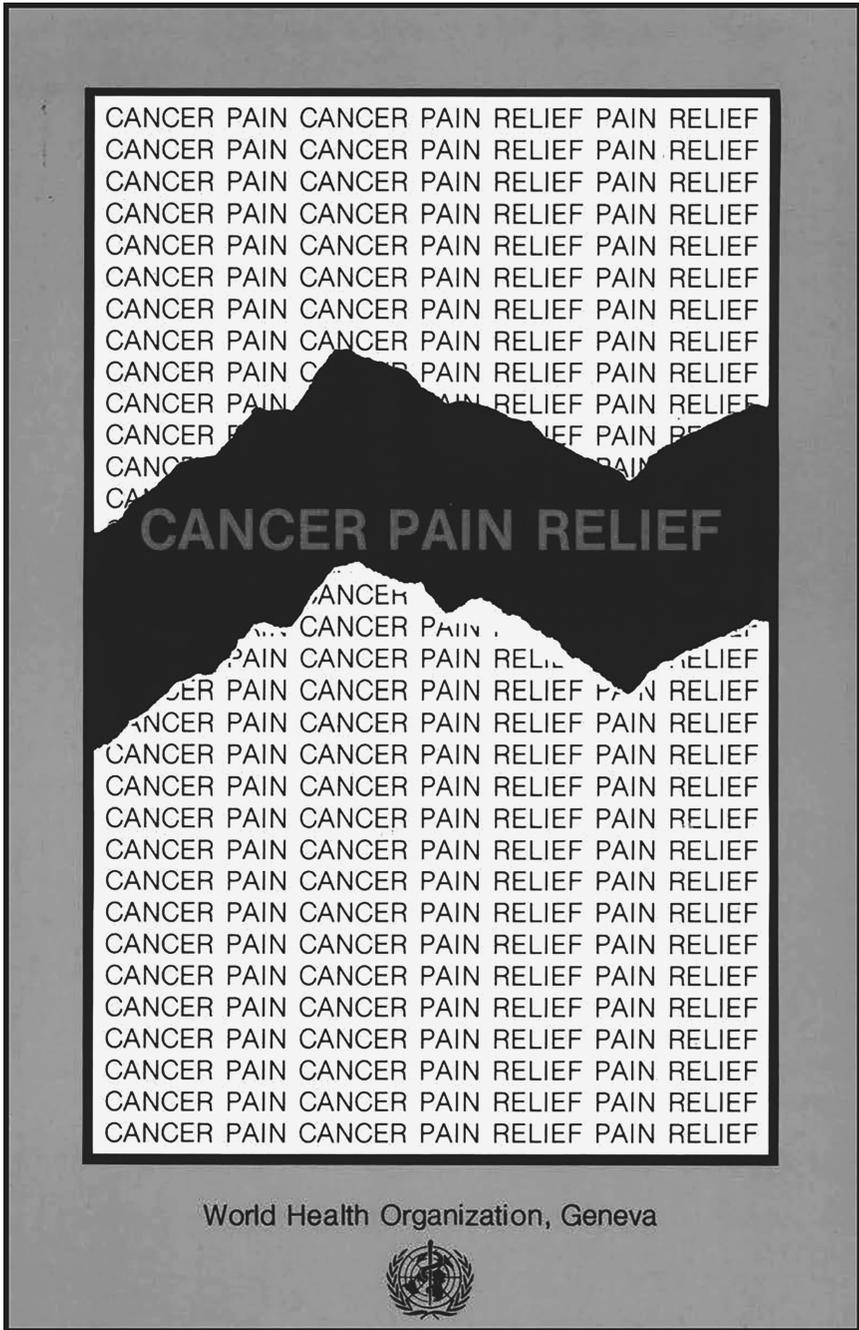


Fig. 6.1 Cover of the WHO's publication on *cancer pain relief* (1986).
Source: World Health Organization, *Cancer Pain Relief*. Reproduced with permission.

Also in 1986, the WHO Collaborating Centre for Cancer Pain Relief published a report in which ‘spiritual unrest’ is seen as a form of anxiety within the concept of ‘total pain’ (Fig. 6.1). Hence, pain assessment includes not only ‘the physical but also the psychological, spiritual, interpersonal, social, and financial components that make up the patient’s “total pain”’.¹⁷ Picking up on the term used by Saunders, pain is thus seen as something complex with multiple factors.

For the medical scientist Cecilia Sepúlveda, it is clear that ‘although at that time a major emphasis was given to cancer pain relief, the management of cancer pain was conceived as the spearhead for a comprehensive and integrated palliative care approach to be developed in the medium term.’¹⁸ According to Clark, the report from 1986 would ‘eventually lead to – and this was a huge landmark – its own definition of the emerging field of palliative care’.¹⁹

The Institutionalization of Interprofessional Spiritual Care

In terms of health policy, the WHO is often effective through technical reports written by expert committees. This also applies to palliative care. The first main basis for further discussion within the WHO was a report written by an expert committee and published in 1989. In this report, palliative care is defined as ‘the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount.’²⁰ This definition seems to deal with certain reservations about palliative care, since it implicitly addresses major concerns. Thus, palliative care is defined as active care: not passively letting people die, and as total care (as opposed to merely physical treatment) complementing such care.

In a separate section on ‘spiritual aspects’, the report emphasizes that ‘all programmes of palliative care should respect and incorporate the basic values of spiritual and religious diversity that are enshrined in the United Nations’ 1981 Declaration on the Elimination of All Forms of Intolerance and of Discrimination Based on Religion and Belief.’ According to that declaration, everyone shall have the right to ‘freedom of thought, conscience, religion and belief’.²¹ The report attempts to differentiate between ‘spiritual’ and ‘religious’: The notion ‘spiritual’ refers ‘to those aspects of human life relating to experiences that transcend sensory phenomena. This is not the same as “religious”, though for many people the

¹⁷ World Health Organization, ‘Thirty-Ninth World Health Assembly, Geneva, 5–16 May 1986: Summary Records of Committees’.

¹⁸ Sepúlveda et al., ‘Palliative Care’, 92.

¹⁹ Clark, *Cicely Saunders*, 241.

²⁰ World Health Organization, Expert Committee on Cancer Pain Relief and Active Supportive Care, *Cancer Pain Relief and Palliative Care*, 11.

²¹ World Health Organization, Expert Committee on Cancer Pain Relief and Active Supportive Care, *Cancer Pain Relief and Palliative Care*, 50.

spiritual dimension of their lives includes a religious component.’ Furthermore, ‘spiritual’ is characterized as ‘an integrating component, holding together the physical, psychological and social components’; as ‘being concerned with meaning and purpose’; as ‘associated with a need for forgiveness, reconciliation and affirmation of worth’ as well as with ‘inner healing’.²²

Compared with the WHO documents discussed in the following, the report provides an elaborated approach to the spiritual aspects of palliative care. This might be due to the need to make palliative care understandable for the first time in a new context. Consequently, the document is extensive, and also contains a relatively explicit understanding of the term ‘spiritual’.

The next milestone can be found in the guidelines *National Cancer Control Programmes*, published in 2002. These modified the perspective of the 1989 definition, which had focused on ‘patients whose disease is not responsive to curative treatment’.²³ As later acknowledged, this focus ‘might be interpreted as relegating palliative care to the last stages of care’.²⁴ In 2002, the perspective was broadened. The document emphasized that ‘the principles of palliative care should be applied as early as possible in the course of any chronic, ultimately fatal illness.’ One reason for ‘this change in thinking’ was ‘that problems at the end of life have their origins at an earlier time in the trajectory of disease’.²⁵

The document from 2002 coined a new, official definition of palliative care, which remains in force to the present day: ‘Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.’²⁶ The ‘spiritual dimension’ of health is relevant not only in end-of-life care but also in rehabilitation: ‘In general terms, physical and psychological rehabilitation should be provided as early as possible after treatment and within the community where the person lives. Rehabilitation should include support for mobility, self-care, emotional well-being, spirituality, vocational pursuits and social interaction.’²⁷

Concerning ‘care of the dying’, the report stressed that palliative care means more than ‘pain and symptom relief. It also supports the social, psychological and spiritual needs of the patients and their families. Therefore it is important to assess these needs and be able to respond with a holistic approach.’²⁸ This approach is

²² World Health Organization, Expert Committee on Cancer Pain Relief and Active Supportive Care, *Cancer Pain Relief and Palliative Care*, 50, 51.

²³ World Health Organization, Expert Committee on Cancer Pain Relief and Active Supportive Care, *Cancer Pain Relief and Palliative Care*, 11.

²⁴ World Health Organization, *National Cancer Control Programmes*, 83.

²⁵ World Health Organization, *National Cancer Control Programmes*, 83.

²⁶ World Health Organization, *National Cancer Control Programmes*, 84.

²⁷ World Health Organization, *National Cancer Control Programmes*, 80.

²⁸ World Health Organization, *National Cancer Control Programmes*, 87.

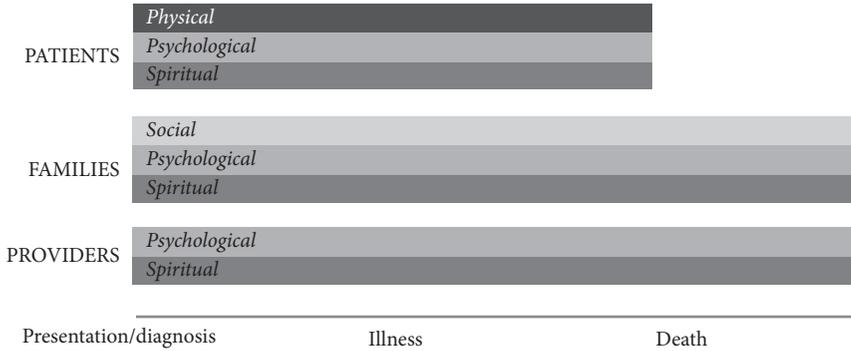


Fig. 6.2 Quality of life dimensions in palliative care.

Source: World Health Organization, *National Cancer Control Programmes*, 85. Reproduced with permission.

‘holistic’ in two respects: with regard to the patients and their relatives as well as with respect to the providers, whose ‘spiritual dimension’ is also relevant, as Figure 6.2 indicates.

In the early days of the modern hospice movement, professional and voluntary providers saw themselves as part of a caring community that also prayed together. It was ‘taken for granted that we would join in ward prayers morning and evening and carry out “last offices” with reverence and respect’.²⁹ The spiritual dimension was part of the pre- or trans-professional dimension of hospice work. The WHO documents examined do not comment on the participation of palliative care providers in explicit forms of spirituality, but rather show the professionalization of a basic attitude that is an essential part of the modern hospice movement by focusing on professional skills such as ‘spiritual counselling’.

The WHO Guide for Effective Programmes—Palliative Care, published in 2007, underlined the interprofessional aspect of palliative care: ‘Health-care providers involved in palliative care may include physicians, nurses, social workers, psychologists, spiritual counsellors, volunteers, pharmacists and traditional healers. Each can play a useful role.’³⁰ Remarkably, this list does not refer to ‘chaplains’, but to ‘spiritual counsellors’. Leaving open the question of their (non-) professional background and role, the task of spiritual counsellors is described as follows:

The spiritual counsellor should be a skilled and non-judgemental listener, able to handle questions related to the meaning of life. Such questions invariably arise for patients and their families. The role of the spiritual counsellor is often one of

²⁹ Saunders, ‘A Personal Therapeutic Journey’, 1600.

³⁰ World Health Organization, *WHO Guide for Effective Programmes*, 27.

listening, to facilitate recollection of the past and growing readiness for what lies ahead. The spiritual counsellor also often serves as a confidant and source of support for those with a religious tradition, organizing religious rituals and sacraments that are meaningful to them. Spiritual counsellors need to be trained in end of life care.³¹

The need for professionalization was stressed implicitly ('non-judgemental') and explicitly (training 'in end of life care'). The document left open what the training of spiritual counsellors involved and how their relationship with religious communities ought to be regulated.

In a pyramid-shaped diagram that outlines the composition of palliative care teams at the different levels of care in low- or middle-income countries, traditional healers appear at the community level, while the spiritual counsellors are missing (see Fig. 6.3). Apparently, only countries with high incomes may be considered capable of financing them. Given that only 14 per cent of the world population had access to the highest levels of palliative care provision in 2017, according to a global survey of palliative care in that year,³² it is questionable whether the promotion of palliative care has thus far led to new forms of spiritual care in low- and middle-income countries as well.



Fig. 6.3 Network of palliative care teams across the levels of healthcare according to the 2007 *WHO Guide for Effective Programmes—Palliative Care*.

Source: World Health Organization, *WHO Guide for Effective Programmes—Palliative Care*, 30. Reproduced with permission.

³¹ World Health Organization, *WHO Guide for Effective Programmes*, 28.

³² Clark et al., 'Mapping Levels of Palliative Care Development'.

The 'First-Ever Global Resolution on Palliative Care' (2014)

Through a wide range of activities and numerous publications, the WHO has, over the years, helped to move palliative care from the periphery to the centre of medicine. The process of strengthening palliative care in and through the WHO culminated in a 2014 resolution which affirms 'palliative care as a component of integrated treatment throughout the life course' and 'the inclusion of palliative care in the definition of universal health coverage'.³³ An important factor in the background to this development was the growing awareness in many countries that, in a rapidly ageing society, the institutionalization of palliative care is becoming increasingly urgent. In 2013, a palliative care advocacy group passed the Prague Charter, which urged 'governments to relieve suffering and ensure the right to palliative care'.³⁴ In this document, 'psychosocial or spiritual problems' are explicitly mentioned. One year later, the 'first-ever global resolution on palliative care'³⁵ passed the World Health Assembly. Resolution WHA 67.19 was the achievement of a complex process, in which several stakeholders were involved in addition to the Member States, including the Worldwide Palliative Care Alliance (WPCA), the International Association for Hospice and Palliative Care (IAHPC), the Union for International Cancer Control (UICC), and Human Rights Watch. Collaboration with non-state actors was crucial to the drafting and the approval of this resolution.³⁶

A basis for the resolution was a report by the WHO secretariat, published in December 2013.³⁷ In this report, the term 'spiritual' appears three times. The first mention recalls the palliative care definition of 2002, according to which palliative care also deals with 'other problems, whether physical, psychosocial or spiritual'. The second mention deals with 'palliative care services' which should 'be adapted to the increased physical, psychosocial and spiritual needs of patients'. The third mention appears in a call for 'access to all aspects of palliative care' which includes 'spiritual support to patients and families'.³⁸

Given that these statements are merely references to a wide-ranging consensus reflected in previous documents, one might think that the 'spiritual dimension'

³³ World Health Organization, 'Sixty-Seventh World Health Assembly, Geneva, 24 May 2014: Provisional Agenda Item 15.5 – Strengthening of Palliative Care as a Component of Comprehensive Care throughout the Life Course', 1.

³⁴ Involved were the European Association for Palliative Care (EAPC), the International Association for Hospice and Palliative Care, the Worldwide Palliative Care Alliance, and Human Rights Watch. Cf. Radbruch et al., 'The Prague Charter', 101.

³⁵ World Health Organization, *Planning and Implementing Palliative Care Services: A Guide for Programme Managers*, 1.

³⁶ Carrasco et al., 'Early Impact of the 2014 World Health Assembly Resolution on Palliative Care'.

³⁷ World Health Organization, Executive Board, *Strengthening of Palliative Care as a Component of Integrated Treatment throughout the Life Course: Report by the Secretariat*.

³⁸ World Health Organization, Executive Board, *Strengthening of Palliative Care as a Component of Integrated Treatment throughout the Life Course: Report by the Secretariat*, 3, 5, 8.

was not a major issue in the drafting of the resolution. However, there were critical moments, as a number of people involved in this process report.³⁹ According to Christina Puchalski, who was involved as an expert for the working group, there was hesitation about pushing the term ‘spiritual’ due to fears that ‘WHO will not use anything having to do with spirituality.’⁴⁰ According to Puchalski, ‘the main goal was to ensure access to opioids, and we don’t want to jeopardize that.’ However, the sceptics were convinced by the argument that ‘if people have spiritual distress, an opioid is not going to fix that necessarily.’⁴¹

Diederik Lohman, who at that time worked for the NGO Human Rights Watch, recalls that some WHO Member States asked if spiritual care was related to religion, and on one occasion wondered: ‘Well, is that actually a health issue?’⁴² Legal implications were also of some concern: ‘Is spiritual care part of medical services? If you need chaplains in a hospital, does the hospital pay for that? Does that come out of the ministry of health budget or does it come out of a different pot of money?’⁴³ As Lohman recalls, for some diplomats the exact meaning of ‘spiritual’ was unclear. A WHO expert described the challenge of finding a universal terminology as follows: ‘It’s difficult, because if you’re asking a Thai person, where spirituality is everywhere, in Africa, they have Voodoo, and then a European person goes to Shastra. There is no clear definition what spirituality actually is.’⁴⁴

Questions were also raised over the consequences that an official recognition of a ‘spiritual dimension’ would have for controversial topics such as abortion or euthanasia, where it was feared that the move might play into the hands of conservative religious groups.⁴⁵ As a consequence, some states wanted to remove the ‘spiritual dimension’ of health from the draft resolution; however, this was only in the preliminary discussions, not in the official meetings.⁴⁶ In the minutes of the Executive Board and the World Health Assembly in 2014, the ‘spiritual dimension’ is mentioned only briefly and in a positive way—by the delegates of Myanmar, Lebanon, the USA, and Indonesia.⁴⁷

On the five pages of the adopted resolution, the term ‘spiritual’ appears four times: three times in the preambulatory clauses and one time in the operative clauses. As with other areas of palliative care, the resolution does not contain any new aspects, but merely a reaffirmation of the status quo. The first mention of a

³⁹ This is confirmed by Diederik Lohman, Christina Puchalski, and Msgr. Robert J. Vitillo.

⁴⁰ Interview with Christina Puchalski, 20.11.2019.

⁴¹ Interview with Christina Puchalski, 20.11.2019.

⁴² Interview with Diederik Lohman, 26.8.2019.

⁴³ Interview with Diederik Lohman, 26.8.2019.

⁴⁴ Interview with a WHO representative, 14.5.2019.

⁴⁵ Interview with Diederik Lohman, 26.8.2019.

⁴⁶ Interview with an anonymous WHO expert, 14.5.2019.

⁴⁷ World Health Organization, Executive Board, ‘Executive Board 134th session, Geneva, 20–25 January 2014: Summary Records, List of Participants’.

‘spiritual dimension’ recalls the wording of the palliative care definition of 2002 (‘physical, psychosocial or spiritual’). The second mention of ‘spiritual’ assumes an ‘ethical responsibility of health systems’ and an ‘ethical duty of health care professionals to alleviate pain and suffering, whether physical, psychosocial or spiritual’. This duty is seen as ‘irrespective of whether the disease or condition can be cured, and that end of life care for individuals is among the critical components of palliative care’. The third mention appears in the discussion of the interprofessional and interdisciplinary approach of palliative care. The better teamwork functions, the better palliative care is, since it depends, among other things, on ‘strong networks [. . .] between professional palliative care providers, support care providers (including spiritual support and counselling, as needed), volunteers and affected families, as well as between the community and acute and aged care providers’.⁴⁸ Here it is implied that a spiritual care professional should be seen as a member of the team. Puchalski recalls that she wanted to go further and was arguing in favour of a clear statement that ‘every palliative care team, any hospice team should have a chaplain.’⁴⁹ But according to her, it was not possible to agree on what a hospital chaplain actually is.⁵⁰ At least the chosen formulation points to another group of professional caregivers whose domain is ‘spiritual support and counselling’. The fourth and last mention of ‘spiritual’ within the resolution appears in the operative clauses. The resolution urges that the spiritual needs of patients should be addressed more extensively ‘as part of in-service training of caregivers at the primary care level’.⁵¹ Remarkably, this underlines the idea that spiritual support is not limited to the field of specialized palliative care, but is already important in primary care.

Although these four references to spiritual care are formulated in a relatively open and non-committal way, they constitute a further step in a slow process of ‘implicit inclusion’: By ‘emphasizing the need to create or strengthen, as appropriate, health systems that include palliative care as an integral component of the treatment of people within the continuum of care’, the World Health Assembly also advocated the inclusion of spiritual support and counselling in the continuum of care.

Palliative Care and HIV/AIDS: An Intricate Relationship

The changing relationship between palliative care and HIV/AIDS is characterized by a double peculiarity. On the one hand, there is a temporal coincidence.

⁴⁸ World Health Organization, Executive Board, ‘Executive Board 134th session, Geneva, 20–25 January 2014: Summary Records, List of Participants’, 149, 150.

⁴⁹ Interview with Christina Puchalski, 11.10.2019.

⁵⁰ Interview with Christina Puchalski, 11.10.2019.

⁵¹ World Health Organization, Executive Board, ‘Executive Board 134th session, Geneva, 20–25 January 2014: Summary Records, List of Participants’, 151.

Palliative care began to spread worldwide in the 1980s. At the same time, HIV/AIDS emerged as a pressing issue within the WHO. On the other hand, there were pragmatic reasons for this special relationship. As oncologists have expertise in terminal illnesses, they were often the contact persons for AIDS patients. Since antiretroviral therapies would not be developed until many years later, HIV/AIDS increased the necessity for palliative care and hospices.

The 1989 WHO document on palliative care mentioned above dealt with HIV/AIDS as follows: 'In principle, there is no difference between the care of the patient with AIDS and the care of the patient with advanced cancer.'⁵² However, there were differences on many other levels: People suffering from HIV/AIDS were 'generally younger', 'experience stresses particular to their risk group (e.g., social ostracism)', and 'often suffer from organic mental disorders (confusion, dementia, organic mood syndromes) caused by HIV [...] or by complications'.⁵³

For these reasons, HIV/AIDS has remained an issue for palliative care. The question of spiritual support, however, has been a particularly challenging one, since the HIV/AIDS discourse is deeply linked to strong moral and also religious judgements. Conservative representatives of various religious groups interpreted HIV/AIDS as God's punishment for an excessive, promiscuous sexual life. 'It was clear from the beginning that the church could be either part of the solution to HIV or part of the problem – or, often, both simultaneously', states Manoj Kurian, the former Director of the Health and Healing programme at the World Council of Churches.⁵⁴ The WHO therefore not only had to develop programmes for a new group of patients but was also faced with the question of how to cooperate with faith communities that moralized HIV/AIDS and all too often also ostracized those who suffered from it.

In the early HIV/AIDS discourse, the WHO played an ambivalent role. Only in 1990 did the World Health Assembly remove homosexuality from the ICD.⁵⁵ At the same time, there was also a 'strong plea from everyone to fight bigotry and prejudice in dealing with persons infected by the AIDS virus'.⁵⁶ Already in 1983, the WHO had asked the WCC 'to raise awareness among the churches regarding the emerging disease called AIDS', and in 1984 the 'first conference of the WCC on AIDS' took place in Geneva.⁵⁷ However, the churches initially found it difficult to adapt their health programmes to the new challenge. In 1986, the WCC

⁵² World Health Organization, Expert Committee on Cancer Pain Relief and Active Supportive Care, *Cancer Pain Relief and Palliative Care*.

⁵³ World Health Organization, Expert Committee on Cancer Pain Relief and Active Supportive Care, *Cancer Pain Relief and Palliative Care*.

⁵⁴ Kurian, *Passion and Compassion*, vii.

⁵⁵ Cf. Cochran et al., 'Proposed Declassification of Disease Categories Related to Sexual Orientation in the International Statistical Classification of Diseases and Related Health Problems (ICD-11)'.

⁵⁶ Quote from the former EURO Director J. E. Ahsvall in Cueto et al., *The World Health Organization*, 210.

⁵⁷ Kurian, *Passion and Compassion*, 108.

acknowledged that ‘churches as institutions have been slow to speak and to act, that many Christians have been quick to judge and condemn many of the people who have fallen prey to the disease.’ Consequently, ‘many churches share responsibility for the fear that has swept our world more quickly than the virus itself.’⁵⁸

An example of how these tensions were encountered is a 1993 training manual of the WHO Regional Office for the Western Pacific. It emphasized ‘cultural and spiritual values’, stressing that ‘there may be communities in which AIDS is seen as evidence of antisocial or blasphemous behaviour and is thus associated with feelings of guilt and rejection.’ Spiritual concerns were also mentioned:

[...] impending death, loneliness, and loss of control may give rise to an interest in spiritual matters and a search for religious support. Expressions of sin, guilt, forgiveness, reconciliation, and acceptance may appear in the context of religious and spiritual discussions. Many of these and other concerns will appear or become more pronounced when a diagnosis of AIDS is made. The appearance of new infections, cancers, and periods of severe fatigue all have a significant emotional and psychological impact. The effect is likely to be even greater if the person with AIDS has been rejected by family or friends and has withdrawn from normal social relationships.⁵⁹

Eleven years later, the same regional office published another document in which the problem of ‘stigma and discrimination in the religious sector’ was highlighted. Since ‘religious groups have far-reaching influence on individuals, families, and communities’, the WHO called for ‘key responses to help reduce stigma and discrimination within religious sectors’. This included ‘identifying religious language and doctrines that are stigmatizing’, promoting ‘alternative language that is caring and non-judgmental’, and ‘promoting humanitarian, ethical and spiritual values of compassion for marginalized and stigmatized groups’.⁶⁰ The extent to which faith communities’ stance on HIV/AIDS has changed over the years cannot be traced here. It should be mentioned, however, that such a change was perceptible in some documents. In particular, *Building from Common Foundations*, published in 2008 and analysed in more detail in Chapter 9, suggested that the attitudes of faith-based organizations (FBOs) ‘have been changing as they work in the face of the reality and the extent of the AIDS pandemic’, and that ‘openness, acceptance and support for infected people are becoming the norm.’⁶¹

⁵⁸ Kurian, *Passion and Compassion*, 8.

⁵⁹ World Health Organization, Regional Office for the Western Pacific, *Teaching Modules for Basic Nursing and Midwifery Education in the Prevention and Control of AIDS*.

⁶⁰ World Health Organization, Regional Office for the Western Pacific, *HIV/AIDS Care and Treatment*, 85.

⁶¹ World Health Organization, *Building from Common Foundations*.

The WHO's response to HIV/AIDS was hampered by internal conflict. Disagreements between then Director-General Hiroshi Nakajima and Jonathan Mann, at the time head of the WHO's Global Programme on AIDS, led to Mann's resignation and a crisis in the WHO's HIV/AIDS response.⁶² Since 1996, the UN's efforts in the context of HIV/AIDS have been led by the Joint United Nations Programme on HIV and AIDS (UNAIDS), in which the WHO is one of several partners.⁶³ Parallel to the reorganization of UN engagement, the focus of the work has also changed. With the emergence of antiretroviral therapies, the link between HIV/AIDS and palliative care was loosened, depending on the national, economic, and socio-cultural background. As Cueto argues, during the 1990s, industrial nations 'had lost some interest in the international aspects of AIDS as the AIDS-related mortality rates in these countries began to decline'.⁶⁴ In developed countries, 'the perception of the disease shifted from a death sentence to a treatable illness'.⁶⁵ But on a global level, HIV/AIDS was and still is relevant for palliative care, since, unfortunately, the problem of ensuring access to drugs is still unsolved. According to UNAIDS, '37.6 million [30.2 million–45.0 million] people globally were living with HIV in 2020'.⁶⁶ The close relationship between HIV/AIDS and palliative care remains, although under different parameters.

In 2004, the WHO published one of its most comprehensive documents on HIV/AIDS and palliative care under the title *A Community Health Approach to Palliative Care for HIV/AIDS and Cancer Patients in Sub-Saharan Africa*. The document contains multiple references to 'spiritual needs', which are even quantified at one point. Data from Tanzania mentioned 'problems of the terminally ill', which were assessed as follows: 'financial: 63%; spiritual: 48%; physical: 30%; emotional: 18%; stigma: 90%'. Concerning spiritual support and counselling, health providers, churches, 'pastors and sheikhs', and communities are mentioned.⁶⁷

Discussion

No WHO documents are likely to have promoted the development of spiritual care as much as those on palliative care, even though the 'spiritual dimension' was discussed in greater depth in other contexts. As mentioned at the beginning

⁶² Cueto et al., *The World Health Organization*, 222.

⁶³ With regard to the inclusion of spiritual aspects, UNAIDS continued the approach developed by the WHO in the context of palliative care, but proactively strengthened collaboration with faith communities, cf. Knight, *UNAIDS*. UNAIDS' relationship with religious communities and FBOs is beyond the scope of this book. For further details on this topic, see Smith, 'Religion in the United Nations', written by a former UNAIDS employee tasked with FBO relations.

⁶⁴ Cueto et al., *The World Health Organization*, 221.

⁶⁵ Cueto et al., *The World Health Organization*, 224.

⁶⁶ UNAIDS, 'Fact Sheet 2021', 1.

⁶⁷ World Health Organization, *A Community Health Approach*, 25, 55, 56, 60, 61, 69, 72, 73.

of this chapter, the rather casual way in which the topic of spiritual care appears in most WHO documents on palliative care may have facilitated its dissemination in national guidelines. As a constitutive element of palliative care, spiritual care has been established as a field of interprofessional cooperation.

On closer analysis of the developments reconstructed in this chapter, a complex triangulation of three independent, but mutually reinforcing factors can be discerned: the integration of palliative care into medicine and global health, the HIV/AIDS crisis, and the development of spiritual care as an interprofessional field in both areas. By historical coincidence, the WHO began to deal with palliative care as part of its cancer programme at the very moment when HIV began to spread worldwide. This led to a mutual validation: to the extent that the new palliative approach was recognized as appropriate for HIV/AIDS programmes, the global epidemic of the autoimmune disorder made it plausible that the WHO's response also had to contain a palliative component—which included spiritual care. In discovering new forms of end-of-life care and in reassessing pain relief as a medical goal,⁶⁸ the WHO participated in a process that transformed healthcare in the late twentieth century.

Since Saunders' model of pain treatment (addressing physical, psychological, social, and spiritual aspects in equal measure) fits seamlessly with the enlarged WHO definition of health, their different origins might be easily overlooked. Saunders' holistic concept amounts to an interprofessional approach that is also reflected in the WHO documents on palliative care. With the integration of palliative care into the WHO's remit, spiritual counselling has become part of comprehensive care. But how does the conception of a 'spiritual dimension' in the WHO's documents on palliative care relate to that in the other texts studied in this volume? And why do earlier WHO documents on palliative care tend to explain what is meant by a 'spiritual dimension', while the later ones usually limit themselves to mentioning this dimension as part of the palliative approach? Is this a case of what Ann Bradshaw described, with regard to the hospice movement, as the 'secularization of an ideal'?⁶⁹ Or can this process be explained by the fact that the palliative approach and the inclusion of the spiritual dimension had to be made more plausible in a first phase?

Due to the complexity of the developments analysed here, only tentative answers are appropriate. To avoid speculation as far as possible, we adhere to the hermeneutic rule of interpreting the unclear through the understandable. Thus, the passages in which a 'spiritual dimension' is mentioned but not explained are to be understood in view of earlier and more explicit statements. According to this rule, the main reference document is to be found in the technical report *Cancer Pain Relief and Palliative Care*, published in 1989. As mentioned above,

⁶⁸ Cf. Callahan, 'Aging and the Goals of Medicine'.

⁶⁹ Bradshaw, 'The Spiritual Dimension of Hospice'.

the report characterizes ‘spiritual’ (1) as an integrative aspect of human life that holds ‘together the physical, psychological and social components’; (2) as related ‘to experiences that transcend sensory phenomena’; (3) as a life dimension, which may or may not contain a religious component; (4) as related to questions of meaning and purpose; (5) as ‘associated with a need for forgiveness, reconciliation and affirmation of worth’.⁷⁰

As in other WHO documents, the authors of the report use ‘spiritual’ to refer to a distinctive dimension of life, or to a particular cluster of problems which sometimes needs to be addressed separately. The tasks of spiritual support and counselling result directly from this description. By linking this concept with a prescriptive specification, the document set standards for how spiritual care should be provided and what it should encompass. It is in the context of the comprehensive goal of palliative care—improving the quality of life of people at the end of life, and that of their families—that spiritual care has its specific objectives: first, to actively ensure that people can freely exercise their religion and beliefs under restrictive conditions; second, improving quality of life through the reduction of ‘spiritual problems’; third, facilitating inner healing (e.g., through ‘forgiveness, reconciliation and affirmation of worth’).

With regard to interprofessional practice, *Cancer Pain Relief and Palliative Care* envisages two steps: first, ‘assessing spiritual needs’; second, ‘offering spiritual help and support’, and this ‘in ways that are non-sectarian, non-dogmatic and in keeping with patients’ own views of the world’. The document leaves no doubt that spiritual care is an interprofessional task to which volunteers and external ‘spiritual advisors’ can also make an important contribution.

In all of these respects, the WHO Expert Committee embraced what the modern hospice movement and clinical palliative care had developed and brought to maturity in earlier decades, including the emphasis on research and specialized training. By embedding palliative care in public health and requiring it for patients with HIV/AIDS, the Expert Committee induced a decisive change. Although focused on cancer care (as were most of the later documents), the report universalizes or globalizes palliative care. The historical coincidence with the AIDS pandemic has further contributed to the global spread of the approach—just as, conversely, the US opioid crisis is having a negative impact on WHO efforts to ensure good end-of-life pain management in low-income countries.

The 1989 document laid a foundation for spiritual care that would not be subject to further discussion or change within the WHO for the next three decades. Further elaboration and operationalization of this groundwork did not take place in the documents on palliative care studied in this chapter, but in another, related project for which the WHO’s Division of Mental Health was

⁷⁰ World Health Organization, Expert Committee on Cancer Pain Relief and Active Supportive Care, *Cancer Pain Relief and Palliative Care*, 50.

commissioned. The goal of understanding the determinants of quality of life for people living with HIV/AIDS led to the most sophisticated attempt made within the WHO to explicate what the 'spiritual dimension' encompasses: the WHOQOL-SRPB module, whose cross-cultural development will be explored in the next chapter.

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Spirituality, Religiousness, and Personal Beliefs in the WHO's Quality of Life Measurement Instrument (WHOQOL-SRPB)

Fabian Winiger

The WHOQOL-100 (pronounced 'whoquol') is a survey measure comprising 100 questions developed by the WHO during the 1990s for the assessment of the 'quality of life' of a population. It was intended to help clinicians understand how patients are affected by their illness, provide a more complete picture of the efficacy of a medical intervention, and so improve the relationship between physicians and patients. It was also hoped that the WHOQOL-100 would provide a more comprehensive view of treatment efficacy in the evaluation of clinical trials, especially for illnesses with poor prognoses, and in assessing the outcomes of health services and public health policies.¹

Drawing on reports of meetings held at the WHO's headquarters in Geneva, literature published by the scientific consultants involved, and interviews with five senior departmental staff and WHO administrators, this chapter reconstructs the development of a module on 'spirituality, religiousness and personal beliefs' (SRPB) for the WHOQOL. It begins with a brief summary of the rising interest in the relationship between 'spirituality' and health during the 1990s, and the concurrent development of the WHOQOL during that period, which represented an alternative to conventional 'functional' measures of health status prevalent at the time. It then sketches how the development of the WHOQOL brought to the attention of the researchers the importance of spiritual aspects of subjective quality of life. This subsequently led to the creation of a separate module, the WHOQOL-SRPB, which to-date remains the most systematic attempt to understand and evaluate what the WHO terms the 'spiritual dimension' of health as it relates to subjective quality of life across different cultural settings. The chapter ends with a brief account of the critiques levelled against this undertaking, and a

¹ WHOQOL Group, 'Study Protocol', 155; Orley and Kuyken, 'Preface', i.

discussion of the potential significance of the WHOQOL-SRPB for health systems reform at the time of writing.

‘Matters of Which We Cannot Speak’: Developing the WHOQOL Instrument

Once a relatively obscure topic, throughout the 1990s, the possible implications of ‘spirituality’ for health rose to the attention of many epidemiologists, behavioural economists, psychologists, and public health specialists. As a search on PubMed demonstrates (Fig. 7.1), in 1983 the National Institutes of Health indexed just one publication which mentioned ‘spirituality’ and ‘health’. By 1990, this had increased to 4 and thereafter to 45 by 1997, and 88 by 2000.²

In the early 1990s, this wave of interest reached the WHO. At that point, a group of researchers at the WHO had just begun work on a cross-cultural instrument intended to assess quality of life. Conventional measurements of morbidity and mortality had recently been expanded with more sophisticated assessments of the effect of illness, disability, and perceived health on daily life, but these typically inferred quality of life—for instance, in the assumption that impaired mobility entailed a lower sense of well-being. In the early 1990s, the phenomenology of illness remained a black box, largely untouched by such

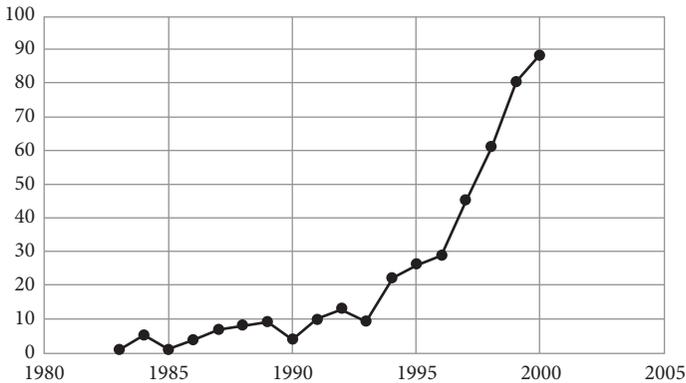


Fig. 7.1 Publications on ‘spirituality’ AND ‘health’ on PubMed (1983–2000).

² PubMed search on 20.4.2019, search mask: (‘spirituality’[MeSH Terms] OR ‘spirituality’[All Fields]) AND (‘health’[MeSH Terms] OR ‘health’[All Fields]) AND (‘1983/01/01’[PDAT]; ‘2000/12/31’[PDAT]).

assessments, and quality of life 'per se' was described as 'the missing measurement in health'.³

In many ways, the WHOQOL represented a paradigm shift. It employed a positive conceptualization of health (e.g., by referring to 'levels of independence' instead of 'dependence'), which took its inspiration from the WHO's famously 'positive' definition of health as a 'state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.⁴ The WHOQOL, it was hoped, would '[transcend] the problem-centred boundaries necessitated by the clinical consultation' and offer a 'holistic, more balanced view of QoL'.⁵ In the words of the WHOQOL Group, it sought to counter the 'increasingly mechanistic trend in medicine' with the introduction of a 'humanistic element into health care'.⁶ In this sense, the WHOQOL may be understood as a *cri du cœur* of humanistic medicine in a prevailing climate of biomedical reductionism.

It conceived of quality of life not merely as objectively measurable functional ability, but assessed subjective, self-reported experiences,⁷ that is, it was not so much interested in the ability to get out of bed, maintain personal hygiene, do one's own grocery shopping, and so on, but in the person's feelings ('self-reported subjective') about what they saw as their objective circumstances ('perceived objective').⁸ As the Group explained:

We suggest that health-related quality of life should broaden the focus of enquiry beyond symptomatology (e.g., location and nature of pain; presence and degree of fatigue) and effects of health/disease/illness on functional status (e.g., can you walk several blocks/half a mile/a kilometre?), to include the person's subjective evaluation (e.g., How afraid are you of experiencing pain? How satisfied are you with the energy that you have? How happy are you with your ability to move around?).⁹

³ Fallowfield, 1990, in WHOQOL Group, 'The Development of the World Health Organization Quality of Life Instrument', 42.

⁴ Skevington et al., 'The History of the WHOQOL Instruments', 7.

⁵ Skevington et al., 'The History of the WHOQOL Instruments', 7.

⁶ WHOQOL Group, 'Rationale and Current Status', 24; Sartorius, 'A WHO Method for the Assessment of Health-Related Quality of Life', 202.

⁷ Skevington et al., 'The History of the WHOQOL Instruments', 2; WHOQOL Group, 'The Development of the World Health Organization Quality of Life Instrument', 42.

⁸ Of course, 'self-reported subjective' well-being might correlate with 'perceived objective' measures, as in feelings of helplessness which accompany the experience of certain symptoms, but may also figure independently, e.g., in an increase of the person's sense of connectedness within a family or community of caretakers. Skevington et al., 'The History of the WHOQOL Instruments', 3; WHOQOL Group, 'Rationale and Current Status', 28, 29. Moreover, the narrative turn within medical anthropology has suggested that objective measures such as the loss of a limb may be experienced as profoundly transformative or empowering, cf. Mattingly, *Healing Dramas and Clinical Plots*; Mattingly and Garro, *Narrative and the Cultural Construction of Illness and Healing*.

⁹ WHOQOL Group, 'The Development of the World Health Organization Quality of Life Instrument', 43.

Unlike most earlier assessments which had been developed in a single culture, the WHOQOL was moreover intended for use across diverse cultural settings.¹⁰ The WHOQOL may have been the first such instrument to incorporate cultural conceptions of how people derive meaning from their lives rather than ‘acknowledging cultural influence as an extraneous variable’.¹¹ In order to generate a cross-culturally valid scale, the WHOQOL was developed in collaboration with 15 countries in a ‘participatory and non-patronising’ process, whereby questions were discussed in focus groups and written in the local vernacular, rather than the insular, generic, and proximal conceptualizations which in the past had been used by medical professionals.¹² The WHOQOL was unprecedented also in the scale of field-testing conducted for an international quality of life measure,¹³ and has since been translated into over 40 languages.¹⁴

Subjective measures of well-being represented an extraordinary methodological challenge and were under sustained critique by proponents of the measurement of objectively observable ranges of behaviour.¹⁵ Given the methodological complexity of quantifying the state of mind of a population, many limited their research to objective measures. As one proponent of functional measures suggested, paraphrasing Wittgenstein, one should remain silent ‘on those matters of which we cannot speak’.¹⁶ The valorization of subjective well-being, then, represented a somewhat marginal research priority—in the words of one proponent of subjective measures, ‘those of us interested in health-related quality of life assessment, are basically social activists’.¹⁷ Moreover, the WHOQOL was often viewed with suspicion as constituting an insufficiently ‘hard’ instrument, as it was developed within the Division of Mental Health, which enjoyed relatively little prestige within the institutional hierarchy and was perceived to exacerbate the credibility deficit of psychiatry within the WHO.¹⁸ Alas, despite strong arguments for a subjective instrument, the WHOQOL was a difficult undertaking.

During the development of the WHOQOL, the national field centres were surprised that in many focus groups, the topic of what would be summed up as ‘spirituality, religiousness and personal beliefs’ was repeatedly and spontaneously brought up by the participants. Although these were considered ‘vital’ by many

¹⁰ Kuyken et al., ‘Quality of Life Assessment across Cultures’, 5. For a discussion of the WHOQOL in view of contemporaneous attempts to devise a cross-cultural quality of life questionnaire, see Kuyken and Orley, ‘Introduction’ and the articles in vols. 22(2) and (3) of the *International Journal of Mental Health* (1994).

¹¹ Skevington, ‘Advancing Cross-Cultural Research on Quality of Life’, 135, 136.

¹² Skevington et al., ‘The History of the WHOQOL Instruments’, 2, 3.

¹³ Kuyken et al., ‘Quality of Life Assessment across Cultures’, 17.

¹⁴ Skevington, ‘Advancing Cross-Cultural Research on Quality of Life’, 139.

¹⁵ For an early discussion of the challenges encountered by the WHOQOL Group, see Orley and Kuyken, *Quality of Life Assessment*. For a critical overview of the literature as of the early 2000s, see Rapley, *Quality of Life Research*.

¹⁶ Rapley, *Quality of Life Research*, 225; Barofsky, ‘Quality of Life Research’, 1024.

¹⁷ Barofsky, ‘Quality of Life Research’, 1023.

¹⁸ Interview, senior departmental staff 2, 7.3.2019.

focus groups, this aspect of quality of life had not initially been considered by the WHOQOL group as very important to health, and a separate domain of questions related to SRPB was subsequently 'derived from the transcripts' by the researchers and formulated ad hoc into four questions on this subject.¹⁹ The domain of SRPB was thus added as an afterthought through the unusually 'participatory and non-patronising' methodology employed by the WHOQOL Group, and its inclusion amounted to a 'radical departure' from generic (i.e., not disease-specific) quality of life scales applied to health.²⁰

The importance of this topic became more evident with the subsequent development of an HIV/AIDS-specific version of the WHOQOL. As the WHOQOL-HIV Group wrote:

Many [people living with HIV/AIDS] reported experiencing a more intense spiritual life as a result of their HIV [...] Greater attention to the meaning of life, feeling worthy to live, and living more intensely were considered important components of QoL following HIV infection. Negative feelings such as guilt, blame, anger and forgiveness were also mentioned during discussions on spirituality, probably because these feelings are closely related to people's perceptions of cause and responsibility. Such perceptions may be influenced by religious and personal beliefs. Also, in certain settings the issue of divine love was raised during discussions on spirituality.²¹

Although antiretroviral therapy was becoming more widely available in the late 1990s, for many people living with HIV/AIDS, spirituality still arose in a context of palliative care: as a way of grappling with death and dying. The focus groups consulted in the development of the WHOQOL-HIV produced questions such as 'To what extent have you become more reflective about the meaning of life since your HIV infection?' (Brazil), 'How satisfied are you with the help you get from spiritual healers?' (Zimbabwe), or 'How preoccupied are you about suffering before dying?' (Brazil).²² The WHOQOL-HIV instrument was substantially expanded with three additional facets relating to these concerns.²³

¹⁹ Skevington et al., 'The History of the WHOQOL Instruments', 4; WHOQOL Group, 'Position Paper from the World Health Organization', 1406; WHOQOL Group, 'Development and General Psychometric Properties', 1570. These questions read: 'Do your personal beliefs give meaning to your life?', 'To what extent do you feel your life to be meaningful?', 'To what extent do your personal beliefs give you the strength to face difficulties?', and 'To what extent do your personal beliefs help you to understand difficulties in life?' WHOQOL Group, 'WHOQOL-100', 16.

²⁰ Skevington, 'Advancing Cross-Cultural Research on Quality of Life', 141, 142.

²¹ WHOQOL HIV Group, 'Initial Steps to Developing the World Health Organization's Quality of Life Instrument (WHOQOL) Module for International Assessment in HIV/AIDS'.

²² WHOQOL HIV Group, 'Initial Steps to Developing the World Health Organization's Quality of Life Instrument (WHOQOL) Module for International Assessment in HIV/AIDS', 354.

²³ WHOQOL HIV Group, 'WHOQOL-HIV Instrument', 21–3; WHOQOL HIV Group, 'Initial Steps to Developing the World Health Organization's Quality of Life Instrument (WHOQOL) Module for International Assessment in HIV/AIDS'. The additional questions relating to SRPB read: 'To what

It is in this context that Lynn Underwood, then director of research at the US-based Fetzer Institute and who for some years had developed her own scale for the assessment of spiritual experiences,²⁴ approached the WHO with funding to expand the WHOQOL's domain on SRPB. The Fetzer Institute had been created by John E. Fetzer (1901–1999), an American radio and television magnate who during the Second World War had overseen the US Office of Censorship, cultivated a strong interest in esotericism and was known as a lifelong fan of baseball and in 1961 bought the Detroit Tigers.²⁵ The sale of the Tigers and his media empire endowed the Fetzer Institute with upwards of \$500 million to advance research in mind-body health, which provided the financial backing for this project.

Rex Billington, in 1996 appointed Chief of Mental Health Promotion and Planning and later Acting Director of the WHO's Division of Mental Health, responsible for the entire WHOQOL programme, became convinced of the relevance of spirituality and religiousness to health-related quality of life while working in the WHO's regional office for the Eastern Mediterranean, and during his subsequent work for the Global Programme on AIDS. Following his transfer to the Division, he began to advocate for the development of the WHOQOL-HIV, and later the WHOQOL-SRPB.²⁶ Shekhar Saxena, who succeeded Billington, similarly had been acquainted with the importance of religion from his previous work on the WHOQOL in India.²⁷ While the WHOQOL had prepared the ground for such a project, and the importance of a 'spiritual dimension' of health was recognized by key figures in the Division, the initiative and funding for the WHOQOL-SRPB came from outside the WHO and was unrelated to the attempt in the early 1980s by many Member States in the Eastern Mediterranean to add a 'spiritual dimension' to the Health for All initiative (see Chapter 4).

extent are you bothered by people blaming you for your HIV status?'; 'How guilty do you feel about being HIV positive?'; 'To what extent do you feel guilty when you need the help and care of others?'; 'To what extent are you concerned about your HIV status breaking your family line and your future generations?'; 'To what extent are you concerned about how people will remember you when you are dead?'; 'To what extent do any feelings that you are suffering from fate or destiny bother you?'; 'How much do you fear the future?'; 'How much do you worry about death?'; 'How bothered are you by the thought of not being able to die the way you would want to?'; 'How concerned are you about how and where you will die?'; 'How preoccupied are you about suffering before dying?' and 'How much do you blame yourself for your HIV infection?'

²⁴ For an overview, see Underwood, 'The Daily Spiritual Experience Scale'.

²⁵ Wilson, *John E. Fetzer and the Quest for the New Age*.

²⁶ Personal communication, Rex Billington, 22.4.2019. Before Billington's tenure, the Division was led by John Orley, who led the WHOQOL project. Orley was himself supportive of a 'spiritual dimension' of health, see Orley, 'Spiritual Dimensions'.

²⁷ Saxena, 'Quality of Life Assessment in Cancer Patients in India', 102.

The Consultation on Spirituality, Religiousness, and Personal Beliefs

Spirituality, religiousness, and personal beliefs are the most intangible aspect of the WHOQOL instrument, and in some ways figured as a methodological spear-head: 'if you're prepared to accept the SRPB aspect,' one scientific consultant involved in the project argued, 'then you're prepared to accept the whole WHOQOL approach'.²⁸ The SRPB facets in this sense represented the most clearly articulated antithesis to functional measures of health status. As another consultant argued:

The functional world defines people in terms of how effectively they perform functions: in other words, as 'human doings' rather than human beings. The spiritual approach tends to view the functional aspect as just one part of life, with issues such as root motivations and attitudes such as appreciation, awe and compassion being ultimately more important.²⁹

How would a team of psychiatrists, psychologists, and public health experts at the WHO generate a cross-culturally valid questionnaire for a topic often so deeply ingrained in an individual's worldview as to make it invisible, without rupturing the countless arteries of political violence which permeate contemporary religious expression? The WHO's Division of Mental Health approached this task much like it had the WHOQOL: by bringing together a diverse group of international experts deemed authoritative on the subject, followed by a 'qualitative pilot' involving focus groups in national field centres.³⁰ On the basis of these data a pilot questionnaire was synthesized and tested in the field.³¹ But whereas the WHOQOL had brought together 'anthropologists, health psychologists, medical sociologists, psychometricians, policy makers, cross-cultural researchers' as well as 'clinicians with expertise in the major disease groups',³² the consultation for the SRPB module also included a very diverse group of religious experts. The outcome was a three-day meeting held in June 1998 in Geneva and joined by 30 people chosen to reflect a range of cultures and beliefs.³³ Several researchers involved

²⁸ Interview, scientific consultant 2, 12.3.2019.

²⁹ Underwood, 'A Working Model of Health', 60, in Lehtinen et al., 'The Intrinsic Value of Mental Health'.

³⁰ In 1994 the field centres involved in the development of the WHOQOL were Melbourne; Zagreb; Paris; Delhi; Madras; Beer-Sheeva; Tokyo; Tilburg; Panama City; St. Petersburg; Barcelona; Bangkok; Bath; Seattle; and Harare; WHOQOL Group, 'Rationale and Current Status', 27. By 1998/1999 over 30 centres were involved. Skevington et al., 'The History of the WHOQOL Instruments', 7.

³¹ For a detailed description of the stages in the development, see WHOQOL Group, 'Rationale and Current Status', 26, 40; O'Connell, 'Spirituality, Religion and Personal Beliefs', 8, 9.

³² Skevington et al., 'The History of the WHOQOL Instruments', 2.

³³ For a brief discussion of the rationale for this type of consultation, see O'Connell, 'Spirituality, Religion and Personal Beliefs', 132, 133.

describe this as the most memorable meeting of their career, and certainly within their time at the WHO.³⁴

The assembled scientists and religious experts noted that the ‘psychosocial dimension’ of quality of life was known to affect disease susceptibility, recovery, and survival time in cases of cancer, AIDS, and heart disease, and that for many patients, ‘spiritual or personal beliefs’ influenced their ‘coping’ by influencing their mood.³⁵ The report of the consultation then referred to discussions of the ‘spiritual dimension’ of health in the World Health Assembly in 1983 and the resolution at the 101st session of the Executive Board in 1998 which had requested the Director-General to extend the WHO definition of health with a ‘spiritual dimension’ (see Chapters 3 and 8). Noting the same entry in the Oxford English Dictionary which Mahler had cited at the 36th World Health Assembly, the group defined ‘the spirit’ as the ‘immaterial, intellectual or moral part of man’,³⁶ which was seen to include ‘beliefs of a non-material nature with the assumption that there is more to life than what can be perceived or fully understood’.³⁷ Spirituality was understood as relating to ‘questions such as meaning of life and purpose in life’ and was not limited to specific beliefs in supernatural beings, life after death of the body, and the specific practices of an individual, which were considered part of religion.³⁸ As in 1983, ‘spirituality’ was cast in extraordinarily broad terms, and ‘personal beliefs’ were added after concerns were raised that ‘spirituality and religiousness’ excluded patients with materialist or atheist convictions which exerted a comparable influence on quality of life.³⁹

Although most involved in the development of the SRPB did not understand their work to have emanated from that precedent,⁴⁰ the understanding of ‘spirituality’ in this context resembled that which had circulated in the WHO in the early 1980s, when the term had been left largely undetermined, and so enjoyed broad support from both religious and secular actors. A further reference point was provided by the salience of ‘spirituality, religiousness and personal beliefs’ in

³⁴ Interview, scientific consultant 1, 21.2.2019; Scientific consultant 2, 12.3.2019; Senior departmental staff 2, 7.3.2019.

³⁵ World Health Organization, Social Change and Mental Health Cluster, ‘WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)’, 4.

³⁶ World Health Organization, Social Change and Mental Health Cluster, ‘WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)’, 7. Note that Mahler cited the dictionary as referring to the ‘intelligent or immaterial part of man, soul’. At the time of writing the entry has changed to ‘relating to or affecting the human spirit or soul as opposed to material or physical things’ and ‘relating to religion or religious belief’.

³⁷ World Health Organization, Social Change and Mental Health Cluster, ‘WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)’, 7.

³⁸ World Health Organization, Social Change and Mental Health Cluster, ‘WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)’, 7.

³⁹ World Health Organization, Social Change and Mental Health Cluster, ‘WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)’, 8. Personal communication, former member of WHOQOL Group 1.

⁴⁰ Interview, scientific consultant 1, 21.2.2019; Scientific consultant 2, 12.3.2019; Senior departmental Staff 1, 27.2. 2019; Senior departmental staff 2, 7.3.2019.

the WHOQOL-HIV and the need, which became apparent in the course of its development, to consider the relevance of spirituality to quality of life outside 'preparation for death'; the apparent necessity to counteract the 'reductionism' and 'mechanistic view' of patients; and to consider the role of 'faith, hope and compassion in the healing process'. This 'non-material dimension' was also inspired by findings on the 'connectiveness of mind and body' in psychoneuro-immunology and the field of psychosomatic medicine, and the authors cited Herbert Benson, the Harvard physician whose work on the 'relaxation response' in the 1970s had brought the mind-body connection to the awareness of the medical establishment. The authors also oriented themselves in the field of nursing studies with regards to the role played by the will to live, fear and doubt, loneliness, and so on.⁴¹

Building on the facets which had emerged in the consultation for the WHOQOL-HIV in 1997, the group began to brainstorm suitable facets for the WHOQOL-SRPB.⁴² Representatives of the Judeo-Christian, Islamic, Hindu, and Buddhist traditions presented background papers on their religion in the context of medical research on spirituality and health. A written contribution of the Aymara, an indigenous people native to the Andes in Bolivia, Peru, Northern Argentina, and Chile, was also presented. Most representatives were psychiatrists, psychologists, public health specialists, academics and clinical experts on quality of life, and WHO staff in Geneva or at the regional level.⁴³

Martin Eisemann, from the Department of Psychiatry at Umeå in Sweden, presented a detailed discussion of Christianity ranging from Augustine to contemporary scholars such as Durkheim and Sartre, covering the meaning of suffering, the import of theodicy, eschatology and the afterlife, health-seeking behaviour, and the shift from religion to health as the penultimate arbiter of salutogenic behaviour.⁴⁴ Two representatives of the Eastern Mediterranean Regional Office discussed the importance of cleanliness, fasting, prayer, and sexuality; salutogenic behaviour in the *sunnah* (sayings and deeds of the Prophet), and concerns over dissection and organ transplantation.⁴⁵ Hassan Hathout (1924–2009), a well-known Egyptian-born physician and authority on Islamic medicine and medical ethics, and proponent of interfaith dialogue, contributed a theologically dense discussion of the *shari'ah*, the mind, and the

⁴¹ World Health Organization, Social Change and Mental Health Cluster, 'WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)', 7, 8.

⁴² World Health Organization, Social Change and Mental Health Cluster, 'WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)', 9–11.

⁴³ World Health Organization, Social Change and Mental Health Cluster, 'WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)', 12.

⁴⁴ World Health Organization, Social Change and Mental Health Cluster, 'WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)', Appendix 1.

⁴⁵ World Health Organization, Social Change and Mental Health Cluster, 'WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)', Appendix 2.

‘protection of life’.⁴⁶ Ahmad Mohit, an Iranian psychiatrist, presented a lengthy essay from the perspective of cross-cultural psychiatry and underlined the ‘more holistic thinking pattern’ which was reflected in Middle Eastern art, literature, architecture, poetry and philosophy, and the Sufi traditions, and which should be drawn upon to develop psychiatric services.⁴⁷

Narayana Reddy (1931–2017), former director of the prestigious Indian National Institute of Mental Health and Neurosciences, contributed an extensive discussion of the Hindu conception of body and mind, the values of life, the theory of karma, asceticism and ‘liberation’, with an extended appendix of empirical evidence and a detailed breakdown of how Hindu beliefs applied to each facet of the WHOQOL (e.g., Domain 5, Environment: ‘All pervasive nature of life and recognition of unity of self and universe’).⁴⁸ The most extensive individual contribution came from Desh Bandhu Bisht, who in 1978 had been the first to propose the extension of the WHO definition of health with a ‘spiritual dimension’ to the WHO’s Executive Board⁴⁹ and was involved in the discussion at the 37th World Health Assembly in 1984 to add a ‘spiritual dimension’ to the Health for All initiative (see Chapter 3). Bisht, who had once served as a Director-General at India’s ministry of health and was a passionate follower of Sri Aurobindo, presented a lengthy discourse on human evolution towards a ‘spiritual man’.⁵⁰

Masaya Yamaguti, the representative of Zen Buddhism, recalled Mahler’s definition of spirituality as ‘ennobling ideas’, which in the early 1980s had helped the World Health Assembly imagine a ‘spiritual dimension’ of the WHO’s definition of health.⁵¹ Drawing on Shin’ichi Hisamatsu, a Japanese academic, Zen Buddhist and friend of D. T. Suzuki, he understood Mahler’s definition in terms of the ‘ideas toward [a] transition from usual selfness to some other new state’, which he likened to the awakening of ‘our true self’. He ended his short text with a ‘vow of humankind’:

Calm and composed / Awakening to our true self; [. . .] / Recognizing the right direction / In which history should proceed / Joining hands as kin beyond the

⁴⁶ World Health Organization, Social Change and Mental Health Cluster, ‘WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)’, Appendix 3. For a detailed discussion of the discourse on the ‘spiritual dimension of health’ in the WHO’s Eastern Mediterranean Office, see Chapter 4.

⁴⁷ World Health Organization, Social Change and Mental Health Cluster, ‘WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)’, Appendix 4.

⁴⁸ World Health Organization, Social Change and Mental Health Cluster, ‘WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)’, Appendix 5.

⁴⁹ World Health Organization, ‘Sixty-First Session of the Executive Board, Geneva, 11–26 January 1978: Part III: Summary Records’, 161.

⁵⁰ World Health Organization, Social Change and Mental Health Cluster, ‘WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)’, Appendix 6.

⁵¹ The amended definition would have read: ‘Health is a state of complete physical, mental, social and spiritual well-being and not merely the absence of disease or infirmity.’

differences / Of race, nation, and class / With compassion, vowing to bring to realization / Humankind's deep desire for emancipation / Let us construct a world which is true and happy.⁵²

Additional views on Buddhism and research on quality of life were submitted by another participant.⁵³ The Aymara were represented with a description of their conception of health and a list of suggestions to improve the health and institutional self-determination of indigenous peoples.⁵⁴ Lynn Underwood, then the director of research at the Fetzer Institute, presented her 'Daily Spiritual Experiences Scale',⁵⁵ and James R. Zullo, a clinical psychologist, presented research on spirituality and health outcomes.⁵⁶

The final and perhaps most poignant contribution from a religious expert came in the form of five typewritten pages submitted by Bernard McGinn, the renowned Catholic theologian and historian of Christian mysticism. 'In discussing the meaning of spirituality,' he wrote, 'I often begin with Justice Potter Stewart's remark, "I don't know how to define obscenity, but I sure know it when I see it."⁵⁷ And like 'obscenity', argued McGinn, spirituality 'is very much in the eye of the beholder'. According to his short essay, spirituality had a long history in the Roman Catholic tradition but had recently become so ubiquitous as to constitute 'a necessary pseudoconcept we don't know how to replace'. McGinn did not 'want to bore' his readers 'with a scholarly review of the development of the term spirituality' and instead limited himself to a brief overview of the different conceptualizations of the term, which he likened to 'blindfolded sages examining the elephant'.⁵⁸

In a curious and probably unprecedented method of scientific collaboration, the sages gathered at the WHO were then asked to 'write between one to seven words, each on a slip of paper, to represent one idea or reason as to why spirituality, religiousness and personal beliefs are important to quality of life', which were 'posted on the wall and then arranged into clusters or groups of common ideas'.⁵⁹

⁵² World Health Organization, Social Change and Mental Health Cluster, 'WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)', Appendix 7.

⁵³ World Health Organization, Social Change and Mental Health Cluster, 'WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)', Appendix 8.

⁵⁴ World Health Organization, Social Change and Mental Health Cluster, 'WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)', Appendix 9.

⁵⁵ World Health Organization, Social Change and Mental Health Cluster, 'WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)', Appendix 10.

⁵⁶ World Health Organization, Social Change and Mental Health Cluster, 'WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)', Appendix 12.

⁵⁷ In the original wording, the 'obscenity' in question referred to 'hard-core' pornography, cf. *Jacobellis v. Ohio* (1964).

⁵⁸ World Health Organization, Social Change and Mental Health Cluster, 'WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)', Appendix 11.

⁵⁹ World Health Organization, Social Change and Mental Health Cluster, 'WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)', 12.

For example, 'kindness' and 'selflessness' were grouped together in one area, and 'death', 'mortality', and 'dying' in another.⁶⁰ A rule was set that every participant in each group had to agree that the concepts were related.⁶¹ In this way, preliminary facets of the elephant, such as 'awe' and 'divine love', were identified.⁶² The precise translation of these facets was left to be defined by the focus groups in 18 centres across the globe.⁶³ In the next step, the participants divided into three groups to discuss the themes which had emerged and construct preliminary facets and possible questions. These were then once more discussed in plenum.⁶⁴ Referring to the process with which the WHOQOL had been constructed previously, and anticipating translation into many languages, the participants were 'encouraged to feel as free and unrestricted as possible in this task'.⁶⁵

The ensuing discussions may represent the to-date most diverse and open-ended attempt at interfaith dialogue in an international panel of religious and public health experts, and certainly within the WHO.⁶⁶ As one senior WHO member of staff recalled thinking as he observed the representatives of these three traditions:

What a bizarre and wonderful thing this meeting was... the same commitment as in the UN, to include everyone on the planet, [but applied to] grappling with these concepts and, given that SRPB are quite intimate things, [to try and] develop a global language around this.⁶⁷

Even the voices of indigenous peoples, rarely represented in Euro-American biomedicine, were heard. In addition to the Aymara people, the spiritual efficacy of animist beliefs was considered in light of its potential theological import to the

⁶⁰ O'Connell, 'Spirituality, Religion and Personal Beliefs', 134.

⁶¹ O'Connell, 'Spirituality, Religion and Personal Beliefs', 134.

⁶² World Health Organization, Social Change and Mental Health Cluster, 'WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)', 12.

⁶³ Argentina; Lithuania; India (Pondicherry and New Delhi); Kenya; People's Republic of China; Turkey; Uruguay; Malaysia; Japan; Italy; Egypt; Israel; Spain; Brazil; Thailand; and England.

⁶⁴ O'Connell, 'Spirituality, Religion and Personal Beliefs', 134.

⁶⁵ World Health Organization, Social Change and Mental Health Cluster, 'WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)', 12, 13.

⁶⁶ A total of 18 facets of spirituality, religiousness, and personal beliefs were eventually identified: 'Connectedness to a spiritual being or force', 'meaning of life', 'awe', 'wholeness/integration', 'divine love', 'inner peace/serenity/harmony', 'inner strength', 'death and dying', 'detachment/attachment', 'hope/optimism', 'control over your life', 'kindness to others/selflessness', 'acceptance of others', 'forgiveness', a 'code to live by', 'freedom to practice beliefs and rituals', 'faith', and 'specific religious beliefs'. World Health Organization, Social Change and Mental Health Cluster, 'WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)', 13–20. They were distributed to two sets of national focus groups, one to discuss the facet definitions, and a second one to generate appropriate questions. A pilot instrument was then tested in a sample of agnostics, people with alternative beliefs, atheists, followers of minority religions, and both well and unwell people. World Health Organization, Social Change and Mental Health Cluster, 'WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)', 21.

⁶⁷ Interview, scientific consultant 2, 12.3.2019.

cross-cultural evaluation of quality of life. A strong consensus emerged that animist beliefs should be included.⁶⁸ A sense of mutual respect and global *comunitas* was felt by many participants and challenged previously held views of some attendees. One scientific consultant recalled that, despite having felt apprehensive towards Islam in the past, she suddenly found herself profoundly touched by the humanity of Muslim representatives and their shared understanding of God as ‘love’, and the centrality of loving God in their faith.⁶⁹

The questions which emerged in this process ranged across eight facets: ‘meaning of life’, ‘awe and wonder’, ‘wholeness and integration’, ‘spiritual strength’, ‘inner peace’, ‘hope and optimism’, ‘spiritual connection’, and ‘faith’, as well as several facets subsequently dropped or merged with others.⁷⁰ A set of 105 questions were then pilot-tested in 18 national collaborating centres, of which the 32 with the most robust psychometric properties were included in the final scale. Specific cultural and linguistic translations were also created by the national centres. The final product was a generic English scale which expanded the WHOQOL-100 with an additional 32 questions (Table 7.1).⁷¹

Criticisms of the WHOQOL-SRPB Instrument

An evaluation of the WHOQOL-SRPB against the background of current research on health-related measures of ‘spirituality’ lies outside the scope of this chapter. Here, I briefly sketch two lines of debate relevant to the WHOQOL-SRPB; the first theological, the second political.⁷²

What ought followers of a specific religion make of the instrument’s emphasis on the “experience” of having a belief’ rather than the ‘strength of religious

⁶⁸ Interview, scientific consultant 2, 12.3.2019. The SRPB consultation of animist beliefs would later inspire the incorporation of animal stories of the Wolof people of Senegal, Gambia, and coastal Mauritania in a Royal Dutch Shell project on HIV/AIDS in Africa.

⁶⁹ Interview, scientific consultant 1, 21.2.2019.

⁷⁰ ‘Connectedness to a spiritual being or force’, ‘divine love’, ‘inner strength’, ‘death and dying’, ‘detachment/attachment, control over your life’, ‘kindness to others/selflessness’, ‘acceptance of others’, ‘forgiveness’, ‘code to live by’, ‘freedom to practice beliefs and rituals’ and ‘specific religious beliefs’, World Health Organization, Social Change and Mental Health Cluster, ‘WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)’, 13–20.

⁷¹ Adapted from WHOQOL SRPB Group, ‘A Cross-Cultural Study of Spirituality, Religion, and Personal Beliefs’, 1489. The above adaptation does not represent the instrument in its entirety, which is available at World Health Organization, Department of Health and Substance Dependence and World Health Organization, ‘WHOQOL Spirituality, Religiousness and Personal Beliefs (SRPB) Field-Test Instrument’. Note that use of an official language version requires permission from the respective principal investigator listed in the aforementioned study.

⁷² For a more detailed discussion of critiques of the WHOQOL-SRPB and related instruments, see O’Connell and Skevington, ‘To Measure or Not to Measure?’, O’Connell and Skevington, ‘The Relevance of Spirituality, Religion and Personal Beliefs to Health-Related Quality of Life’; Jager Meezenbroek et al., ‘Measuring Spirituality as a Universal Human Experience’.

Table 7.1 SRPB facets and corresponding items

<p><i>Connectedness to a spiritual being or force</i></p> <p>To what extent does any connection to a spiritual being help you to get through hard times?</p> <p>To what extent does any connection to a spiritual being help you to tolerate stress?</p> <p>To what extent does any connection to a spiritual being help you to understand others?</p> <p>To what extent does any connection to a spiritual being provide you with comfort/reassurance?</p>	<p><i>Awe</i></p> <p>To what extent are you able to experience awe from your surroundings? (e.g. nature, art, music)</p> <p>To what extent do you feel spiritually touched by beauty?</p> <p>To what extent do you have feelings of inspiration/excitement in your life?</p> <p>To what extent are you grateful for the things in nature that you can enjoy?</p>
<p><i>Inner peace/serenity/harmony</i></p> <p>To what extent do you feel peaceful within yourself?</p> <p>To what extent do you have inner peace?</p> <p>How much are you able to feel peaceful when you need to?</p> <p>To what extent do you feel a sense of harmony in your life?</p>	<p><i>Faith</i></p> <p>To what extent does faith contribute to your well-being?</p> <p>To what extent does faith give you comfort in daily life?</p> <p>To what extent does faith give you strength in daily life?</p> <p>To what extent does faith help you to enjoy life?</p>
<p><i>Meaning of life</i></p> <p>To what extent do you find meaning in life?</p> <p>To what extent does taking care of other people provide meaning of life for you?</p> <p>To what extent do you feel your life has a purpose?</p> <p>To what extent do you feel you are here for a reason?</p>	<p><i>Wholeness & integration</i></p> <p>To what extent do you feel any connection between your mind, body and soul?</p> <p>How satisfied are you that you have a balance between mind, body and soul?</p> <p>To what extent do you feel the way you live is consistent with what you feel and think?</p> <p>How much do your beliefs help you to create coherence between what you do, think and feel?</p>
<p><i>Hope & optimism</i></p> <p>How hopeful do you feel?</p> <p>To what extent are you hopeful about your life?</p> <p>To what extent does being optimistic improve your quality of life?</p> <p>How able are you to remain optimistic in times of uncertainty?</p>	<p><i>Spiritual strength</i></p> <p>To what extent do you feel inner spiritual strength?</p> <p>To what extent can you find spiritual strength in difficult times?</p> <p>How much does spiritual strength help you to live better?</p> <p>To what extent does your spiritual strength help you to feel happy in life?</p>

affiliation⁷³ or, say, the reading of scripture or the receiving of divine grace? Would the evaluation of SRPB instrumentalize religion, reducing complex and profound cultural heritage to ‘coping’ with illness?⁷⁴ During the consultation, many doubted that SRPB could or indeed should be measured at all.⁷⁵ But scepticism did not only come from representatives of established religions interested in preserving the integrity of their faith. During the development of the WHOQOL-HIV in Australia, some people, particularly homosexual men who had been affected by the hostile attitudes of the Catholic church towards homosexuals at the time, were disturbed by the prospect of bringing their health into the purview of religious dogma.⁷⁶

One of the biggest challenges was the problem of cross-cultural commensurability, which quickly led to difficult normative questions: during the consultation, the gathered experts deliberated the use of the term ‘God’, since many people believed in a transcendent spiritual being which had created the world. But if the term was to be used, what was one to make of those who believed in several gods—as Hindus do—or in no God at all? And were abstract terms like ‘transcendent’ or ‘superior being’ alien to the daily experience of end-users in each country?⁷⁷ These questions were left to be decided by the national focus groups.⁷⁸ Contrary to the hopes of the initial consultation, however, they produced little consensus.⁷⁹ Furthermore, beliefs such as the Buddhist virtue of detachment were comforting in one context but meaningless or even offensive in another. The national version for Thailand, for example, asked ‘How well are you able to rid yourself of negative feelings through meditation?’⁸⁰ And when speaking of detachment, should the understanding in the Chinese (*mahayana*), Japanese (Zen), or Hindu tradition guide the question of the international questionnaire?⁸¹

Within individual countries, too, viewpoints at times diverged widely. In Brazil, a series of 15 focus groups were conducted with health professionals, Catholics, Afro-Brazilian evangelicals, spiritists, atheists, and recovered, acute, and terminal patients. It found that many chronic patients felt that ‘divine love’ was only relevant to Catholics, while atheists were confused by the facet on ‘wholeness/integration’, and a group of Afro-Brazilians did not deem ‘acceptance of others’

⁷³ O’Connell, ‘Spirituality, Religion and Personal Beliefs’, 134.

⁷⁴ For representatives of this argument, see Shuman and Meador, *Heal Thyself*; Bishop, ‘Of Idolatries and Ersatz Liturgies’.

⁷⁵ Senior departmental staff 1, 27.2.2019.

⁷⁶ Interview, scientific consultant 2, 12.3.2019. For a discussion of this problematic in the case of Islam, see Chapter 4.

⁷⁷ World Health Organization, Social Change and Mental Health Cluster, ‘WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)’, 12.

⁷⁸ World Health Organization, Social Change and Mental Health Cluster, ‘WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)’, 12.

⁷⁹ O’Connell, ‘Spirituality, Religion and Personal Beliefs’, 168.

⁸⁰ WHOQOL Group, ‘Rationale and Current Status’, 34.

⁸¹ Interview, scientific consultant 2, 12.3.2019.

important. According to a group of atheists and Afro-Brazilians, ‘forgiveness’ depended on what the person had done, whereas the group of Evangelicals felt it to be unconditional, and several health professionals suggested differentiating between forgiveness ‘of a higher being’ and ‘of a person’.⁸²

In the United Kingdom, national statistics had suggested that the three most important religious groups were Christians, those who report to be ‘spiritual’ rather than ‘religious’, and people moving into ‘alternative’ religions.⁸³

Corresponding focus groups were recruited through social networks, personal contacts, and an advertisement campaign (‘W.H.O. NEEDS YOU NOW!’) (Fig. 7.2).⁸⁴ The Christian sample included a group of Quakers, and ‘spiritual but not religious’ people were recruited from a ‘local environment movement’ thought to have strong non-religious beliefs.⁸⁵ For ‘alternative’ religions, ‘a decision was made to recruit Buddhists’ as a local group was available and willing to participate.⁸⁶

Agnostics and atheists shared widely divergent worldviews, ranging from eco-feminism (‘Life is precious, the earth is our mother’) to Star Wars (‘A bit like the force’) and music (‘Elvis Presley’s gospel music tells it all!’). Some seemed to view SRPB as an existential necessity (‘We are a cancer on a bio-system. It is only humans that MUST have a purpose’) while others referred to theosophy (‘divine wisdom – the lamp that shines behind all religions’), quantum mechanics (‘There is an “implicate order” that most humans have little contact with’), or rejected established authority altogether (‘In my opinion faith in doctors/authority is misplaced. You have to change yourself’). The question of theodicy loomed large, and several participants struggled with the ‘if there is a God, then...’ question: ‘if there isn’t something else, then what’s the point?’ asked one, and another: if there is a God, why did he ‘take my 41 year old husband with a brain tumour’? One man said nothing but mumbled ‘a load of nonsense’, while a 92-year-old male agnostic advised not to ponder the ‘puzzle’ of life until past the age of 90.⁸⁷ Very little commonality was found.⁸⁸

⁸² Fleck et al., ‘Development of WHOQOL Spirituality, Religiousness and Personal Beliefs Module’, 453, 454.

⁸³ O’Connell, ‘Spirituality, Religion and Personal Beliefs’, 139. It should be noted that the trend towards alternative religion and unchurched spirituality in the UK is debated. In light of this literature, the group’s attempt to include 20–25 per cent believers of ‘new age religions’ in the pilot phase (O’Connell, ‘Spirituality, Religion and Personal Beliefs’, 191) might be questioned. See Voas and Bruce, ‘Another False Dawn for the Sacred’; Heelas, ‘The Holistic Milieu and Spirituality’.

⁸⁴ O’Connell, ‘Spirituality, Religion and Personal Beliefs’, 140, 331.

⁸⁵ O’Connell, ‘Spirituality, Religion and Personal Beliefs’, 140.

⁸⁶ O’Connell, ‘Spirituality, Religion and Personal Beliefs’, 139, 145, 146. All groups included people who were well/unwell, male/female in different professions and age brackets; two groups were selected based on the nature of their illness.

⁸⁷ O’Connell, ‘Spirituality, Religion and Personal Beliefs’, 146, 267, 268.

⁸⁸ O’Connell, ‘Spirituality, Religion and Personal Beliefs’, 266.

May 1999

W.H.O. NEEDS YOU NOW!

The World Health Organisation, in conjunction with Bath University is researching the meaning and purpose of life in Britain today.

We need volunteers from the community of Bath to come to discussion groups during May/August 1999. We need you to give your views about what the "meaning and purpose of life" is to help us to develop a quality of life questionnaire.

If you could spare us a couple of hours we would like to hear from you as soon as possible. Please contact us by August 1999.

Please write to:

Dr S. Skevington
 Department of Psychology,
 University of Bath,
 Claverton Down,
 Bath BA2 7AY.
 Or phone Kathryn O'Connell
 Tel: (01225) 826826 ext. 5202

Fig. 7.2 Recruitment advert for the focus group in Bath, UK.

Source: O'Connell, 'Spirituality, Religion and Personal Beliefs', 331. Reproduced with permission.

When it came to discussing the facets, on the other hand, it was followers of specific religions who struggled to cohere. For example, on 'inner peace', a consensus emerged that the ability to 'remain calm in difficult times' depended on 'whether you are having a heart attack' (many participants suffered from heart conditions), whereas the group of Buddhists struggled with the statement that inner peace was a 'highly desirable state'.⁸⁹ The 'code to live by' reminded some of guilt and the Ten Commandments, while the Quakers felt that such a code should be periodically reviewed and re-evaluated. 'Acceptance of others' was widely felt to be important, but a litany of conditions emerged, ranging from severe crimes,

⁸⁹ O'Connell, 'Spirituality, Religion and Personal Beliefs', 337.

imposing one's beliefs, living geographically close, having extreme views, invading one's comfort zone, being dishonest, to affecting others or the wider community. The topic of 'divine love' was so divisive that it was hardly discussed.⁹⁰ When the field test was conducted, again among a rather motley sample of people,⁹¹ these critiques were reflected in the comments section: 'Hope your computer is clearer thinking', remarked one. Another had crossed out every page with a red pen and added, 'you are nothing but liars and fascists! What a waste of a trees [sic] life.'⁹² Evidently, the questions emanating from the profoundly inspiring meeting of minds in Geneva did not resonate with everyone equally.

In many cases, divergences between sample populations were resolved by country-specific questions added to the national versions of the WHOQOL-SRPB. The international version, however, demanded concepts which were sufficiently inclusive to allow the creation of a psychometrically robust instrument that allowed cross-cultural comparison. Here, a recurring complaint from the international focus groups was that facets such as 'connectedness to a spiritual force or being', 'faith', and 'divine love' were 'too "religious"' and 'too Christian'.⁹³ As a result, some of the more religion-specific items were rephrased for broader appeal. 'Divine love', for example, was changed to questions on 'love and compassion' and the 'giving and receiving' of love.⁹⁴ In order to avoid having to remove or rephrase all 'religious' questions, the field-test instrument simply asked the user to translate the question into their own worldview.⁹⁵ To this end, the survey included the following explanation:

The following questions ask about your spiritual, religious or personal beliefs and how these beliefs have affected your quality of life. These questions are designed to be applicable to people coming from many different cultures and holding a variety of spiritual, religious or personal beliefs. If you follow a particular religion, such as Judaism, Christianity, Islam or Buddhism, you will probably answer the following questions with your religious beliefs in mind. If you do not follow a particular religion, but still believe that something higher and more powerful exists beyond the physical and material world, you may answer the following questions from that perspective. For example, you might believe in a higher spiritual force or the healing power of Nature. Alternatively, you may have no

⁹⁰ O'Connell, 'Spirituality, Religion and Personal Beliefs', 346.

⁹¹ Participants in the pilot were recruited from the Guild of Pastoral Psychology; theologians and members of the Bath Royal Literary and Scientific Institution; a chronic pain self-help group, a 'half way house for people who had suffered from mental illness'; the neurology department of a hospital; Jehovah's Witnesses, shamans, pagans and Children of God contacted through the Information Network Focus on Religious Movements, and from the telephone directory. O'Connell, 'Spirituality, Religion and Personal Beliefs', 191–3.

⁹² O'Connell, 'Spirituality, Religion and Personal Beliefs', 234. Scientific consultant 5, 29.4.2019.

⁹³ O'Connell, 'Spirituality, Religion and Personal Beliefs', 167, 168.

⁹⁴ O'Connell, 'Spirituality, Religion and Personal Beliefs', 168.

⁹⁵ O'Connell, 'Spirituality, Religion and Personal Beliefs', 168, 169.

belief in a higher, spiritual entity, but you may have strong personal beliefs or followings, such as beliefs in a scientific theory, a personal way of life, a particular philosophy or a moral and ethical code. While some of these questions will use words such as spirituality please answer them in terms of your own personal belief system, whether it be religious, spiritual or personal.⁹⁶

The inclusion of any belief which might figure as an equivalent to religion in respect to its influence on quality of life was one of the most daring features of the instrument,⁹⁷ and several experts consulted in the development objected to it. The suggestion was made that, if personal beliefs were to be included, they should be made a facet separate from spirituality and religiousness and perhaps integrated into the psychological domain.⁹⁸ Notwithstanding these objections, personal beliefs were included due to concerns not to discriminate against people who may not be comfortable with 'spirituality' and 'religiousness'.⁹⁹ Particularly in Scandinavian cultures, where many people were atheist or agnostic, 'personal beliefs' catered to subgroups of the population which had been largely invisible to earlier quality of life assessments.¹⁰⁰ It also side-stepped the inclusion of a potentially endless list of particular beliefs, the appropriateness of which was questionable in many contexts and which required resource-intensive cross-translation and statistical validation.

At the same time, it opened the instrument to the critique that the inclusion of 'personal beliefs' made the instrument so broad as to become meaningless. Alexander Moreira-Almeida and Harold Koenig, two of the most productive and well-known researchers in the field of religion and health, argue that, among the eight facets of the WHOQOL-SRPB, 'five are not measuring religion or spirituality', namely Meaning of life, Awe, Wholeness and integration, Inner peace/serenity/harmony, and Hope/optimism. Accordingly, these 'can be outcomes of religiousness' but 'are not, themselves, religiousness or spirituality'.¹⁰¹ It follows that:

⁹⁶ World Health Organization, Department of Health and Substance Dependence and World Health Organization, 'WHOQOL Spirituality, Religiousness and Personal Beliefs (SRPB) Field-Test Instrument', 20.

⁹⁷ Scientific consultant 3, 22.4.2019.

⁹⁸ Interview, scientific consultant 1, 21.2.2019. Personal communication, 15.4.2019. This critique was also raised by researchers not directly involved in the project, e.g., Koenig et al., *Handbook of Religion and Health*. Note that global data gathered by the WHOQOL-SRPB Group suggested that SRPB were statistically relatively independent from psychological and social domains. Only 'hope/optimism' and 'inner peace' were strongly associated with the psychological domain; O'Connell, 'Spirituality, Religion and Personal Beliefs', 277-9.

⁹⁹ Senior departmental staff 1, 27.2.2019.

¹⁰⁰ Scientific consultant 3, 22.4.2019.

¹⁰¹ Moreira-Almeida and Koenig, 'Retaining the Meaning of the Words Religiousness and Spirituality', 844.

The acceptance of the Marxist historical materialism can give someone a strong sense of meaning in life and optimism (believing in the future development of society towards a communist society) so much so that many people have given their lives voluntarily to this ideology. However, they would probably take offense at being called spiritual or religious.¹⁰²

In a retort to this critique, Marcelo Fleck, who had conducted the Brazilian study, and Suzanne Skevington, the principal investigator of the instrument, argued that the WHOQOL-SRPB did not attempt to evaluate SRPB, but to assess the influence of what the focus groups claimed were SRPB relevant to their quality of life. This included conventional understandings of SRPB relating to a sacred, transcendent, and superior being as well as a wide array of philosophies and moral and ethical codes. Indeed, 'that is why WHOQOL-SRPB is called WHOQOL-SRPB, not WHOQOL-SR or WHOQOL-R.'¹⁰³

This leads into the second, political line of criticism. As demonstrated by the extraordinarily broad conception of 'spirituality' and the inclusion of 'personal beliefs', the approach of the WHOQOL-SRPB Group was decidedly pragmatic. Both the historical telos of Marxism—communist society—and the less self-consciously political expressions of collective salvation—nirvana, paradise, etc.—could be understood as analogous to religiousness or spirituality insofar as they produce similar negative or positive experiences (e.g., lack of inner peace, abundance of optimism), which in turn may exert comparable pathogenic or salutogenic influences on an individual's quality of life.¹⁰⁴ The addition of 'personal beliefs' in relation to their effect on quality of life thus extricated the instrument from the politically fraught question of what precisely ought to count as religion and spirituality.

To be sure, during the World Health Assemblies in the early 1980s the 'strategically vague' conceptualization of 'spirituality' had facilitated the necessary adaptation of divergent interests within the WHO. As an instrument for diplomatic consensus, it was understood as broadly as possible, enlisting the support of a pluralism of interests without becoming meaningless—a 'factor X', as the 'spiritual dimension' had been referred to by Bisht, which set apart humans from animals and united diverse constituencies around a common denominator. As demonstrated by the objections of Moreira-Almeida and Koenig, however, if personal beliefs are confused with spirituality, the term risks losing its theological

¹⁰² Moreira-Almeida and Koenig, 'Retaining the Meaning of the Words Religiousness and Spirituality', 844.

¹⁰³ Fleck and Skevington, 'Explaining the Meaning of the WHOQOL-SRPB', 68.

¹⁰⁴ The example of Marxism is of note, for at least the Chinese communist regime has engaged in an ongoing process of self-sacralization and has integrated the term 'spirituality' (*jingshen*) into its ideological vocabulary. See Palmer and Winiger, 'Neo-Socialist Governmentality'; Palmer and Winiger, 'Secularization, Sacralization and Subject Formation in Modern China'. Spirituality officially plays no role in public healthcare in the PRC. See Winiger, 'Who Cares?'

significance. Moreover, as an object of scientific study, the narrower the definition of a phenomenon, the more precise and reliable are the conclusions of its study. Regardless of the political merits of such strategic vagueness, the absence of a widely shared consensus on how to define religiousness, and particularly the even more subjective term 'spirituality', surely contributed to the apparently endless haemorrhaging of psychometric instruments on this topic.¹⁰⁵

In addition to facing the challenge of creating cross-culturally valid consensus on questions relating to the meaning of life, suffering, God and so on, the WHOQOL-SRPB was developed in an environment of mounting political and budgetary pressures on public health resources. During the late 1970s and early 1980s, the 'Health for All' initiative, which included a recommendation to integrate a 'spiritual dimension', had made primary healthcare an institutional priority. By the late 1990s, however, the initiative had been overshadowed as the WHO returned its focus to the relatively reductive, disease-specific control of infectious diseases. As the WHO 'could not do everything',¹⁰⁶ many felt the need to prioritize public health expenditures. This applied to health an instrumental rationality frequently at odds with the attempt to measure subjective quality of life. In an increasingly 'functional world' which administered human beings according to 'how effectively they perform functions', the WHOQOL-SRPB's valorization of ultimacy became more difficult to sustain.

In July 1998, one month after the first consultation of the WHOQOL-SRPB, the seat of Director-General at the WHO was given to Gro Harlem Brundtland, who began to recast the WHO's role in economic terms more amenable to donors and wealthy Member States. While the 1980s had been marked by the attempt to make healthcare a matter of human rights and social justice, Brundtland argued that the WHO remained relevant because 'investment' into health was indispensable to a nation's economic development.¹⁰⁷ In the same year, Christopher Murray, a Harvard physician and Oxford-trained economist instrumental in the development of the DALY (disability-adjusted life years), joined the WHO as executive director of the Evidence and Information for Policy Cluster. The DALY measured the burden of disease in terms of the number of years lost in a working life, and it was hoped that it would help national health systems identify those diseases which caused the largest economic burden and to allocate resources accordingly.

This fit well with the WHO's new strategy to frame morbidity and mortality through the lens of economic productivity. But by prioritizing healthcare according to an economic cost/benefit calculation, the DALY also brought a renewed sophistication to the biomedical reduction of human life: the value of life

¹⁰⁵ In 2008, Hall et al. counted over 100 psychometric tools measuring various aspects of religiosity. Hall et al., 'Measuring Religiousness', 135. For an overview of more recent literature, see Koenig et al., *Handbook of Religion and Health*.

¹⁰⁶ Personal communication, Senior departmental staff 2, 15.4.2019.

¹⁰⁷ Chorev, *The World Health Organization*, 6.

increased until the age of twenty-five, at which point it began to decrease, matching the course of economic productivity.¹⁰⁸ Although measurement of disability-adjusted life years showed that mental illness was one of the most significant causes of disability across the globe,¹⁰⁹ Murray was perceived by many WHO staff to harbour little sympathy for the Division of Mental Health and indeed for the entire WHOQOL approach. In 1998, he attempted to persuade the WHO to rename or change the WHOQOL to bring it in line with the conceptual approach taken by the DALY. The name change was unanimously rejected by the key figures in the WHOQOL Group.¹¹⁰ In 2000, a new director took over the Department of Mental Health who made no secret of his disdain for the WHO's research on spirituality.¹¹¹ With a lack of leadership at the department-level and the new strategic direction embodied by Brundtland and Murray, the institutional life of the instrument within the WHO came to an end.¹¹²

Summary

In many respects, the WHOQOL appears to be a heartening attempt to counteract the biological reductionism, ethnocentrism, and professional parochialism implicit in some quality of life scales. The WHOQOL-SRPB, we have suggested, took this attempt one step further: it sought not only to 'make speak' subjective matters of personal well-being normally outside the purview of biomedicine but to make them sing—sing songs of spiritual beings which provide 'comfort and reassurance', of 'finding meaning in life', of feeling 'touched by beauty', of 'hope', 'awe', and 'inner peace'.¹¹³ It is difficult to imagine a subject at once more anathema to the bench-tested scientific criteria that informs public health wisdom and yet

¹⁰⁸ For an overview of the critiques of the DALY instrument, see Chorev, 'Restructuring Neoliberalism at the World Health Organization'; Farmer et al., *Reimagining Global Health*, 225–44.

¹⁰⁹ Farmer et al., *Reimagining Global Health*, 225.

¹¹⁰ Personal communication, Senior departmental staff 2, 14.3.2019. Among other arguments, it was felt that health needs should not be 'appraised' and 'motivated' by cross-country comparison, which had no advantage for 'those at the bottom'. Accordingly, 'Yemen's DALY data' should not 'be compared to the USA or New Zealand or any other country before a decision is made to help it solve rickets and malaria'.

¹¹¹ Interview, scientific consultant 5, 29.4.2019.

¹¹² Note that several people involved in the development of the WHOQOL-SRPB continued its development at their own initiative, analysing different models for interpreting the relationship of spiritual to overall quality of life (O'Connell and Skevington, 'A Comparison of Theoretical Models'), finding evidence for a two-factor structure (Krägeloh et al., 'Evidence for a Two-Factor Structure'), and creating a short-form of the SRPB (Skevington et al., 'WHOQOL-SRPB BREF'). 'Spiritual' quality of life was also integrated into the new WHOQOL-Combi (Skevington et al., 'Introducing the WHOQOL-Combi'). The WHOQOL-SRPB has been used and in some cases validated in Brazilian, Chinese, Hong Kong, French, Norwegian, Canadian, Iraqi, Jordanian, Swedish, and Indian populations; stroke survivors and their caregivers, psychiatric patients, medical students and chronically ill, among others.

¹¹³ World Health Organization, Social Change and Mental Health Cluster, 'WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB)'.

more profoundly potent in restoring a sense of a life well lived in the face of illness or functional abnormality.

Blind to the lived phenomenology of illness, the biomedical attempt to cure risks trading subjective for functional 'health', producing iatrogenic sequelae which offset the outcome of the intervention,¹¹⁴ and imposing a normative ethic of what constitutes a desirable human life.¹¹⁵ A persuasive argument can be made that medical interventions which seek to 'cure disease' rather than 'heal illness',¹¹⁶ that is, restore functional normality without explicit regard to subjective well-being, constitute an unwise if not unethical overreach. At least, they would seem to fail the WHO's inaugural commitment to health defined as 'not merely' physical well-being.

From this perspective, the WHOQOL approach would appear like a long-overdue correction. But to followers of a specific creed, the partial and decontextualized representation of particular theological views may appear like a significant, if not prohibitive, defect of the instrument.¹¹⁷ Moreover, much like the biopolitics of the DALY, which valorizes economically productive lives over others, the practical and ethical implications of subjective and anthropologically informed assessments of the totality of well-being are not immediately obvious to policy-makers operating in an environment of ever tightening resource constraints.

Justified or not, it could be argued, these criticisms miss a larger significance of the WHOQOL-SRPB which lies beyond *realpolitik* and methodological rigour: its unprecedented breadth of consultation, openness, and mutual respect which transcended medical and religious solipsisms and produced a nuanced, verified, and widely shared consensus of what makes life worth living at all. The world, it could be argued, may not need more psychometric instruments, but it surely needs more consultations such as those that produced the WHOQOL-SRPB.

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¹¹⁴ Shapiro, "Violence" in Medicine'.

¹¹⁵ For a seminal work in the critique of 'medicalization', see Zola, 'Medicine as an Institution of Social Control'. For a recent and evocative sample of this literature, see Clare, *Brilliant Imperfection*.

¹¹⁶ Kleinman, *Illness Narratives*.

¹¹⁷ For a critique of the perceived appropriation of religion by medicine, see Shuman and Meador, *Heal Thyself*; Bishop, 'Biopsychosociospiritual Medicine and Other Political Schemes'; Shuman, *Reclaiming the Body*; Balboni and Balboni, *Hostility to Hospitality*, ch. 16.

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Attempts to Reform the WHO Definition of Health (1997–1999)

Raphael Rauch

The aim of this chapter is to analyse how the discussions within the WHO in the 1990s on the ‘spiritual dimension’ of health can be explained. Several contributing factors came together during this period: the geopolitical winds of change of 1989–1990, which suddenly made major reform projects more realistic; the recognition that the WHO health definition had deficits; and the realization that a holistic view of health was needed to handle the challenges of the twenty-first century. These factors culminated in a proposal to add the word ‘spiritual’ to the health definition in the preamble of the WHO constitution. The WHO Executive Board approved the constitutional amendment, but ultimately, the amendment did not pass the World Health Assembly. However, it would be a fallacy to interpret this as a rejection of a ‘spiritual dimension’ of health. It was not rejected; rather, a huge package of proposed constitutional amendments, including complex structural and budgetary issues, was postponed.

Barring some reservations, the discussions in the EB and in the WHA show an appreciation for a ‘spiritual dimension’ of health. As a result, these discussions serve as a case study for further understanding the strengths, weaknesses, opportunities, and risks of associating spirituality with health as seen by the parties involved. In this analysis, we first outline the situation of the WHO in the 1990s. We explain why the health definition was under pressure and how the idea to amend the preamble arose. We then describe the arguments discussed in the EB’s 101st session in January 1998. Afterwards, we show why the 52nd WHA in May 1999 was less receptive to the constitutional amendments. Finally, we discuss the results of this analysis.

The WHO in the 1990s: Geopolitical Winds of Change

With the end of the Cold War, the United Nations had hopes for a future where the United States and Russia—both UN veto powers—and their respective allies no longer blocked each other, thus marking the dawn of a new era of multilateralism to address the challenges of the twenty-first century. This included health. In the

early 1990s, it became apparent that Halfdan Mahler's vision of 'Health for all by the year 2000' was too ambitious and its aims would take much longer to achieve. Setting the course for the future and breaking down encrusted structures—including within the WHO—were therefore regarded as key tasks. At that time, the WHO 'was accused of inefficiency, lack of transparency, and irrelevance'.¹

For Western countries, the financial aspect was—as always—an important concern: After the fall of the Iron Curtain, the structure of the WHO Euro region had also changed, but without the necessary financial compensation. In addition to financial issues, the reform process included a number of initiatives, such as the request for a revision of the WHO constitution. According to an internal report of the Swiss Federal Office of Public Health, a working group was set up in 1992 'to deal with the new situation and to draw up proposals for reforms at all operational levels'.²

The Swiss administration identified three levels of reform: an administrative-organizational level, a constitutional level, and a strategic level. With regard to the administrative and organizational level, the report stated:

In 1994, a working group of the Executive Council formulated 47 recommendations for reforms within the framework of the existing constitution, which are intended to ensure that the organization can adapt to global change. These reforms have so far only been partially implemented by the WHO Secretariat.³

With regard to the constitutional level, the officials in Bern explained:

At Australia's suggestion, a comprehensive institutional reform has begun (completion not before 2000); due to the complicated ratification mechanism, only the most necessary changes have been made in the past 49 years. The suitability of the regional structures will also be examined (changes within the existing constitution are also possible in some cases).⁴

Other reform projects were also noted in the papers of the Swiss delegation. 'A number of other reform proposals will be presented to the World Health Assembly next May, in particular various amendments to the Constitution (including the extension of the definition of health to the spiritual level).'⁵ It is

¹ Cueto et al., *The World Health Organization*, 1.

² Bundesamt für Gesundheit. 51. Weltgesundheitsversammlung (WHA) Genf, 11.–16. Mai 1998. An die Mitglieder der Delegation. In: Swiss Federal Archive. All German sources were translated by the author.

³ 50. Weltgesundheitsversammlung, Genf, 5.–14. Mai 1997. Brief für Direktor Zeltner. In: Swiss Federal Archive.

⁴ Brief für Direktor Zeltner.

⁵ Brief für Direktor Zeltner.

noteworthy that the Swiss paper mentioned the spiritual dimension of health, among other points on how the WHA constitution might be changed. The reference suggests that the question of the spiritual dimension of health was well noted.

The Swiss perspective also reflected the frustration that has repeatedly become apparent in view of the WHO's inability to reform. This is also confirmed by a document by the German ministry of health arguing that 'the demands addressed to the Member States can hardly be contradicted; if they were actually fulfilled everywhere, or if they could be fulfilled everywhere [...] we would no longer need the WHO.'⁶ The demand for more money was and still is part of everyday WHO life. The German administration countered this by proposing that help should not only be provided by pouring 'money into the WHO pot, but [also] if necessary bilaterally or through experts'.⁷ In general, Germany was dissatisfied with the WHO reform project.⁸

There were different views on how the WHO should be reformed. The Swedish foreign ministry had commissioned a think tank to draw up a report on the WHO reform with the title *Tomorrow's Global Health Organization: Ideas and Options*. The Swiss diplomats regarded many of the suggestions as unusable, such as the establishment of a 'Global Health Organization', which should act, according to the proposal, more comprehensively than the WHO.⁹

Nevertheless, the report contained a few interesting passages with a view to a holistic understanding of health. A passage on the WHO's 'concept of health' emphasized the aspirational aspect of the WHO health definition and reiterated that health was a human right: 'An obvious criticism of the WHO health definition has been the impossibility of attaining a state of perfection, complete physical, social, and mental wellbeing for all the members of the human race.'¹⁰ The report elaborated on that point as follows:

A possible interpretation along this line of thought would be to consider the WHO definition and subsequent declarations as having the twofold purpose of setting a social goal and at the same time establishing a right to those services that will help to attain that goal. It has also been suggested that what is actually meant is rather a right to access to health services than to 'health' as such, 'health' not being a commodity that can be delivered on request.¹¹

These remarks reveal that, with respect to the WHO reform, those involved discussed not only concrete operational issues but also the big picture along

⁶ Brief für Direktor Zeltner.

⁷ Stellungnahme des Referates 317, Bonn, den 7. März 1997. In: German Federal Archives.

⁸ Stellungnahme des Referates 317.

⁹ WEOG-Sitzung vom 10. Februar.

¹⁰ Swedish Ministry for Foreign Affairs, *Tomorrow's Global Health Organization: Ideas and Options*, 17.

¹¹ Swedish Ministry for Foreign Affairs, *Tomorrow's Global Health Organization: Ideas and Options*.

with the basic principle, namely to what extent it made sense to assume a seemingly utopian definition of health. The report also dealt with 'health determinants'. It emphasized that 'health services cannot be judged only by their effect on prolongation of life. [...] There] are other effects of health care such as reduced suffering from disease and, in a more general sense, enhanced wellbeing or quality of life.'¹²

The report was critical, too, arguing that the bureaucratic red tape at the WHO produces great inefficiency and incentives standing at odds with each other, while the centralized hierarchical structure impedes creativity and professionalism within the organization.

Health Definition Under Pressure

After the discussion in 1983–1984 on resolution WHA 37.13, the spiritual dimension of health once again became a focus at the end of the 1990s. The question of whether the word 'spiritual' should be added to the definition of health in the preamble to the WHO's constitution arose in connection with an initiative by Australia at the World Health Assembly in 1995, when a resolution was adopted to evaluate whether the WHO constitution was still up to date less than five decades after its creation.¹³ In 1996, a 'special group' was established by the WHO Executive Board and began its work.¹⁴ The question of adding the word 'spiritual' to the preamble did not come from Australia, however, but rather from the Eastern Mediterranean Region. As in 1983–1984 (see Chapter 3), the representative of Kuwait was one of the advocates of this issue.¹⁵ As part of a revision of the Health for All initiative in 1997, he promoted the integration of a 'spiritual dimension' into the preamble. This position was supported by the representative of Yemen.¹⁶ The other health ministers of the region also liked the idea, such that, in 1997, the Regional Committee of the WHO's Eastern Mediterranean Region called on its Regional Director to pledge 'to incorporate the spiritual dimensions of health into the global document, as they are fundamental to health promotion, and also to incorporate

¹² Swedish Ministry for Foreign Affairs, *Tomorrow's Global Health Organization: Ideas and Options*, 18.

¹³ World Health Organization, 'WHO Response to Global Change'.

¹⁴ World Health Organization, 'Review of the Constitution of the World Health Organization'.

¹⁵ Al-Awadi was no longer the minister of health, however. The Kuwaiti delegation was represented in 1997 by Ali Youssef Al-Seif and Abdulatif Nasser At-Zaid Al Nasser, although the minutes do not state which one of the two made the proposal at the meeting. Cf. World Health Organization, Regional Office for the Eastern Mediterranean, 'Report of the Regional Committee for the Eastern Mediterranean, Forty-Fourth Session, Teheran, Islamic Republic of Iran, 4–7 October 1997'.

¹⁶ World Health Organization, Regional Office for the Eastern Mediterranean, 'Report of the Regional Committee for the Eastern Mediterranean, Forty-Fourth Session, Teheran, Islamic Republic of Iran, 4–7 October 1997'.

them into the WHO Constitution at the time of its revision'.¹⁷ This initiative finally resulted in the work of the 'special group', which proposed to the World Health Assembly the addition of the words 'dynamic' and 'spiritual' to the health definition in the preamble as follows: 'Health is a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity'.¹⁸ Besides addressing the question of spirituality, the proposed amendment also implied a shift towards a dynamic view of health. As the Japanese health scholar Masako Nagase argues, 'the concept of "health" was not identified as an individual's state of being healthy or ill but as a continuous and dynamic condition'.¹⁹ In the end, the question of the spiritual dimension of health became an issue in the WHO Executive Board's 101st session.

In any discussion of the official WHO definition of health, we would do well to recall that this definition has always been controversial. As medical scholar Johannes Bircher and WHO officer Shyama Kuruvilla argue, 'the WHO definition sets out aspirational and universal goals without much guidance on how these goals [might] be realized'.²⁰ In their view, it is not clear 'how governments should plan the "adequate health and social measures" to improve population health, and the requirements are likely to vary with each country's context'.²¹ They further note that health, as an objective, is subject to broad definition with great leeway for interpretation that may prevent informed, concerted action towards its realization.²²

The question of the WHO health definition's suitability remains controversial today, just as it was in the 1990s. A researcher from a medical school in Pakistan, for example, argued in a letter to the WHO that 'it is therefore recommended that we may substitute the word "complete" by another word: REASONABLE. The definition would then read as: "A reasonable state of physical, mental, and social wellbeing and not merely the absence of disease or infirmity."'²³ The WHO did not heed the arguments of the Pakistani researcher, however, answering his letter as follows:

WHO has emphasized over the years that the attainment of health as defined in the Constitution remains an aspirational goal for societies to work towards.

¹⁷ World Health Organization, Regional Office for the Eastern Mediterranean, 'Health for All for the Twenty-First Century'.

¹⁸ World Health Organization, 'Review of the Constitution of the World Health Organization'.

¹⁹ Nagase, 'Does a Multi-Dimensional Concept of Health Include Spirituality?'

²⁰ Bircher and Kuruvilla, 'Defining Health by Addressing Individual, Social, and Environmental Determinants'.

²¹ Bircher and Kuruvilla, 'Defining Health by Addressing Individual, Social, and Environmental Determinants'.

²² Bircher and Kuruvilla, 'Defining Health by Addressing Individual, Social, and Environmental Determinants'.

²³ Letter from Brig (ret.) Khalid Hassan Mahmood, Hamdard College of Medicine, Karachi/Pakistan, to Hiroshi Nakajima, 09/01/1997. In: WHO Archive, Geneva.

Recognition that one needs to be more operational, emerged during the Alma-Ata Conference which launched Primary Health Care as a strategy. There it was recognized that 'the attainment of the highest possible level of health is the most important worldwide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector'. By having a broad-based definition, WHO has moved to encourage Member States to implement policies and strategies that allow people to lead 'socially and economically productive lives'. [...] This involves recognizing that life expectancy gains are no longer a sufficient goal for public health. Rather, improving the quality of life throughout the life span and addressing inequalities in health are two additional vitally important goals that need to be met.²⁴

This reply shows that the WHO had already been aware of the weaknesses of its definition of health. Alma-Ata was cited as a key corrective that acknowledged the dependence of the WHO health definition on many other social and economic sectors, in addition to the health sector. Since social and economic issues were presented as being so important to achieving health goals, there was a strong concomitant commitment to primary healthcare. Alma-Ata also corrected a purely biomedical notion of health, since according to the WHO, health was not just about 'life expectancy gains', but also about improving the 'quality of life throughout the life span'. Another important goal was to eliminate health inequalities.

The criticism of the biomedical health model was also reflected in the activity of NGOs. In the 1990s, the professionalization of groups with a holistic understanding of health increased. The International Holistic Health Association (IHHA), founded in 1970, sought to establish official relations with the WHO and introduced itself as follows:

While we are proud of the achievements of modern medicine, it is absolutely imperative for us to be aware of the areas of ignorance and explore them with appropriate paradigms. There are a large number of modalities which are capable of helping our self-healing. The benefits based on empirical evidence, need to be made scientific, integrating the Psycho-Physio-Socio-Ecological and spiritual aspects of health and illness. A holistic approach of maintaining a balance of mind, body, spirit will bring health to our nation. This can be achieved by working with a humanistic approach to health.²⁵

²⁴ Letter from C. M. Chollat-Traquet, Division of Development of Policy, Programme and Evaluation, to Brig (retd.) Khalid Hassan Mahmood, Hamdard College of Medicine, Karachi/Pakistan, 07/02/1997. In: WHO Archive, Geneva.

²⁵ International Holistic Health Association (IHHA). Importance and Relevance of the Holistic Approach. In: WHO Archive.

It was clear from this statement that spiritual questions also belonged to a holistic understanding of health. Mind, body, and spirit were presented on equal footing, without one being ranked higher or lower than the others. According to the IHHA, while ‘modern medicine has made enormous advances using this method by concentrating on organs, cells and biochemical processes, this reductionist approach has given us only part of the story.’²⁶ One of the goals of the IHHA was to reach out ‘to the ideal of holistic health, bringing forth a transformation in the quality of the physical, mental, social and spiritual life of the individual and the community, through awareness and practice of health care strategies’.²⁷

A New Definition of Health?

How exactly did the dissatisfaction with the definition—caused by several factors—result in a discussion about change? In the WHO EB’s 100th session in May 1997, the ad hoc working group presented its report *Health Systems Development for the Future*.²⁸ In the ‘Values and Vision’ section, the working group stated that ‘the preamble of the Constitution of WHO outlines the values underlying health and health systems development.’²⁹ However, the definition of health had ‘been supplemented by the social target of health for all, namely, the attainment of “a level of health that will permit [people] to lead a socially and economically productive life.” Health for all is a call for social justice and is characterized by the values of human dignity, equity, solidarity and professional ethics.’³⁰ Hence, the right to health was central ‘to all human rights since health suffers when any human right is denied’.³¹ Solidarity implied distributing the burden in terms of both funding and care, where the rich shoulder responsibility for the poor.³²

In this early stage of the working group, the question of adding the word ‘spiritual’ to the preamble had not yet been discussed. During the EB’s discussions, Bhutan’s representative, Sangay Ngedup, emphasized ‘that sacred texts had profoundly changed the lives of mankind, shaping societies and civilizations and promoting spiritual well-being’. He also asked how one might bring promising

²⁶ International Holistic Health Association (IHHA). Importance and Relevance of the Holistic Approach. In: WHO Archive.

²⁷ International Holistic Health Association (IHHA). Objectives aims and goals of IHHA. In: WHO Archive.

²⁸ Members of that group were Boufford, Leppo, and Al-Muhailan (later replaced by A. Y. Al-Saif, V. Sangsingkeo, Y.-S. Shin, and T. J. Stamps). Cf. World Health Organization, ‘Executive Board, 100th Session, Geneva, 15–16 May 1997’.

²⁹ World Health Organization, ‘Executive Board, 100th Session, Geneva, 15–16 May 1997’.

³⁰ World Health Organization, ‘Executive Board, 100th Session, Geneva, 15–16 May 1997’.

³¹ World Health Organization, ‘Executive Board, 100th Session, Geneva, 15–16 May 1997’.

³² World Health Organization, ‘Executive Board, 100th Session, Geneva, 15–16 May 1997’.

ideas to life in the absence of funding and manpower or if there were no one to oversee the use of those resources, should they be available.³³

Eric Ram, the representative of World Vision International and former Director of WCC's Christian Medical Commission who had already argued in favour of the spiritual dimension during the 1983–1984 discussion (see Chapter 3), now said that 'health for all was an ethical imperative calling for a more profound definition of health which would include the spiritual dimension as an essential component.'³⁴

One year later, during the World Health Assembly in 1998, spirituality was mentioned during the plenary meetings, but in different contexts. WHO Director-General Hiroshi Nakajima noted that 'the founders of WHO recognized the interdependence of the peoples and countries of the world in their struggle for sustainable health, peace and prosperity.'³⁵ He cited Leonard A. Scheele, Surgeon-General of the United States Public Health Service and President of the Health Assembly in 1951, who said that 'the world cannot remain half healthy and half sick and still maintain its economic, moral and spiritual equilibrium.'³⁶

Besides Sri Lanka's delegate, Nimal Siripala de Silva, strengthening a 'spiritual dimension' of health was also the objective of the representative of the Islamic Republic of Iran, Mohammad Farhedi, who stressed that 'priority should be given to the most important, but neglected, components of health, in particular to its spiritual dimension, and religious values should be encouraged in order to promote social, mental as well as physical health.'³⁷

These issues culminated in the work of the 'special group' responsible for reforming the WHO's constitution, which ultimately suggested to the Executive Board that the word 'spiritual' should be added to the preamble. In the following section, we discuss how the Executive Board responded to this move.

Discussion in the WHO Executive Board

In 1998, during the 101st session of the WHO Executive Board, the Regional Director for the Eastern Mediterranean Office, Hussein A. Gezairy, said that the Regional Committee had requested him 'to ensure that contributions from

³³ World Health Organization, 'Executive Board, 100th Session, Geneva, 15–16 May 1997'.

³⁴ World Health Organization, 'One-Hundredth Session of the Executive Board: Provisional Summary Record of the Second Meeting, WHO Headquarters, Geneva, Thursday, 15 May 1997 at 14:30'.

³⁵ World Health Organization, 'Fifty-First World Health Assembly, Geneva, 11–16 May 1998: Verbatim Records of Plenary Meetings'.

³⁶ World Health Organization, 'Fifty-First World Health Assembly, Geneva, 11–16 May 1998: Verbatim Records of Plenary Meetings'.

³⁷ World Health Organization, 'Fifty-First World Health Assembly, Geneva, 11–16 May 1998: Verbatim Records of Plenary Meetings'.

Member States were reflected in the global document on health for all for the twenty-first century and to take measures to have the spiritual dimensions of health incorporated in that document as well as the revised WHO Constitution'.³⁸ The question of whether to add the word 'spiritual' to the WHO definition of health was the subject of extensive debate at the EB's session. The discussion prompted the representative of Egypt, Ahmed Badran, to say that 'the inclusion of a word on which there was almost unanimous agreement should not have provoked such a lengthy discussion.'

The main points of the discussion can be structured as follows: first, arguments of the proponents; second, criticism because the exact implications of the preamble amendment were not clear; third, criticism because the definition of 'spiritual' seemed too vague and imprecise; and fourth, pleas in favour of postponing the vote on the matter.

The delegate from Zimbabwe, Timothy Stamps, who was a member of the 'special group' assigned to review the constitution, interpreted the 'spiritual dimension' as part of an understanding of health that the founders of the WHO had already had in mind when they framed the original definition. He also stressed that spirituality should not be confused with religion, and certainly not with religious conflicts. He thus anticipated the objection that 'there was much evidence in recent times in many parts of the world that State interference in the spiritual freedoms of peoples created health problems.' However, 'the state of spiritual well-being should be the responsibility of every individual and every community as an essential ingredient of the complete state of health.' The 'spiritual dimension' of health 'was not a religious experience or particular form of religion or non-religion'. Rather, it was about 'spiritual well-being' which was 'necessary, especially in traditional medicine, for the effects of the medicine to be optimal'. Stamps claimed that Marxists had forced the removal of the concept from the original definition in 1948—an assertion we have been unable to corroborate. However, Stamps argued that the 'concept did not interfere with planning, except to the extent that no State, organization or community had any right to impose or impinge on personal spiritual beliefs and convictions; in fact, the State should facilitate personal spiritual ambitions and satisfaction.' For the 'special group' that had suggested the amendments, spirituality was as 'intrinsic to health as were social, physical and mental well-being'.

Other supporters of expanding the definition were the representatives from Egypt (Badran), Argentina (Pico), the Cook Islands (Williams), the United Kingdom (Calman), and Ireland (Hurley). A more detailed argumentation was not to be expected, given the existence of the 'special group', which had already held such discussions.

³⁸ Unless otherwise indicated, the following quotations refer to World Health Organization, 'Executive Board, 101st Session, Geneva, 19–27 January 1998'.

Unfortunately, there are no records of the considerations of the ‘special group,’ as far as we know. The arguments of the proponents on the EB made it clear that they distinguished between ‘religion’ and ‘spirituality’, that they emphasized the primacy of the individual in spiritual questions, and that ‘spirituality’ was of utmost importance when it came to ethical questions or quality of life. A strategy of anticipating objections from states that are rather critical of religious topics or from individuals who have had negative experiences with religion was to be expected.

There were questions as to what concrete and binding commitments would result from the preamble’s amendment. Behind these questions lurked the fear that a constitutional amendment adopted without full consideration of the implications could turn out to be a Trojan horse or a Pandora’s box.

With a view to clarification, the delegate from Peru, Augusto Meloni, wanted to know how exactly the inclusion of the word ‘spirituality’ would impact the organization’s work. His Polish counterpart, Jerzy Leowski, pointed out that ‘the introduction of “spiritual” in the definition of health was not reflected in subsequent articles on the functions of the Organization.’ In addition, the Dutch representative, Geert van Etten, argued that ‘the group had given no rationale for its proposal to include spiritual well-being in the definition of health given in the preamble.’ He therefore asked for more information regarding government actions in this regard and possible metrics for spiritual well-being.

The concept of ‘spirituality’ can achieve currency in the diplomatic arena as long as it remains vague, ambiguous, and open, as the discussions at the 36th and 37th WHA demonstrated (see Chapter 3). As the arguments in favour of the motion claimed, the term does not hurt anyone, and every state can interpret it to their liking at any given moment. On the other hand, this adaptability proved to be a drawback, because there was no clear definition of ‘spiritual (well-being)’ and thus no way of knowing what the implications would be for states were they to officially recognize a ‘spiritual dimension’ of health. Unsurprisingly, the ambiguity and unclear definition of the word ‘spiritual’ ultimately ignited controversy, as the following point reveals.

The objection that it was not exactly clear what ‘spiritual’ meant was a strong argument against the word’s inclusion during the EB’s discussion. As Chapter 3 has shown, different views about what could or should be understood by the notion of ‘spiritual’ were already prevalent during the discussion in 1983–1984, and the varying ideas and ambiguities had not been resolved even one and a half decades later.

The representative of Honduras, Luis Alonzo López Benítez, argued that ‘spirituality’ and ‘religion’ were two fundamentally different concepts, with the former not dependent on the latter. In his view, neither version of the definition would pose a problem to planners. The delegate from Burkina Faso, Arlette Sanou, stressed that ‘further discussion was necessary to ensure that the word had the

same meaning throughout the Organization.’ She also feared that ‘spiritual’ would hinder more than help.

In order to resolve the confusion, van Etten suggested ‘the insertion of an asterisk with a footnote providing a definition of the word “spiritual”’. However, his proposal only seemed to increase the confusion. By citing the futility of attempting to define the myriad terms in the constitution, de Silva argued that providing a definition for ‘spiritual’ would achieve nothing.

Calman disagreed with some definitions of the term, naming tribal medicine and homeopathy as elements that fell outside his understanding of ‘spiritual’. However, Stamps countered this by arguing that ‘spiritual healing [is] an intrinsic part of traditional medicine and central to health. The word “spiritual” [is] a very important one.’

For Ngedup, ‘spiritual’ ought to be understood in the broadest, most inclusive sense, and need not be defined more precisely. The representative of Botswana, Mulwa, argued that ‘[t]raditional healers [...] had an important role to play in the delivery of health services in some parts of the world.’

Stamps drew a comparison with other terms featured in the preamble, pointing out that ‘spiritual’ would not be the only word that was ambiguous and difficult to define. He noted that

[...] the functions of the Organization outlined in Article 2 did not specify what the Organization would do about spiritual well-being, pointed out that the same could be said of social well-being, but that the absence of the actual words did not mean that those aspects were not included in the list of functions. For example, a spiritual dimension was implicit in the proposed wording of Article 2, paragraph 2(h) on desirable and appropriate methods of teaching, and in paragraph 3(d) of the same Article, on promoting ethical standards. Moreover, spiritual well-being was a matter of personal choice, not something to be imposed by a community, and spiritual peace and comfort were a vital aspect of health.

It is remarkable that there was not even a consensus among the delegates from the EMRO on a definition of the word ‘spiritual’, even though the proposal to change the preamble had come from there. The Egyptian representative, Badran, stressed the recognition ‘that there was a strong link between spiritual and other aspects of health’. The representative from Bahrain, Faisal al-Mousawi, demanded a clear definition ‘because it referred to spiritual well-being rather than to such practices as homeopathy, herbal medicine and traditional healing’. Oman’s representative, A. J. M. Sulaiman, on the other hand, was in favour of a vague term that allowed for ambivalence. He viewed it as an umbrella term that could accommodate various forms of medicine across the world, not to mention individuals, from religious figures to frauds. Sulaiman argued that the spiritual dimension ‘had

not been adequately reflected in the Arabic text', after which Badran proposed 'an appropriate Arabic translation for "spiritual"'.

As the various voices in this section make clear, the question as to what exactly a 'spiritual dimension' of health should mean sparked a controversy not easily resolved. While some states accepted the term with all its vagueness, others wanted a precise definition and also a clear disassociation from misunderstandings or dangerous forms of religion and spirituality.

It was clear to the 'special group' that they could get the EB to accept the proposed amendment and forward it to the World Health Assembly. But not all members of the Executive Board agreed. Due in particular to the inconclusive deliberations regarding the exact definition of 'spiritual' and its implications, some countries believed it was too early to vote on proposed amendments. They argued in favour of a postponement instead. A pattern similar to what transpired during the 1983–1984 discussion repeats itself at this point: Following a proposal, a controversial debate over the concept of spirituality broke out, whereupon there was a motion for adjournment. In fact, the 1997–1999 discussion featured arguments that were nearly identical in some cases.

The representative of Japan, Y. Nakamura, argued that 'Member States would need more time to study the amendments to such a fundamental change.' Shin (South Korea) said 'that there was room for further reflection before the definition was discussed at the 103rd session of the Board in January 1999. The impact of the revised definition on WHO, health policy, the academic world and industry must be taken into account. It might be valuable to create a forum for wide-ranging discussion of the matter.' Elizabeth Ferdinand, the delegate from Barbados, agreed that 'further discussion might be needed before a decision was taken.' She emphasized that 'spiritual well-being was already included in the health promotion charter in [my] own subregion.' Sulaiman mentioned that 'there would be further opportunities to discuss the definition of health before the Health Assembly needed to make a final decision.' And Calman argued that the proposed amendment 'represented an important shift which required more discussion and acceptance by consensus. Voting during the present meeting would polarize views in ways that might be unhelpful.'

Other board members refused to postpone the vote, however. De Silva claimed 'that the matter had already been considered at length by the special group, and that, in the interests of projecting a dynamic image of the Organization, the Board should take a decision promptly'. Other board members also argued that more time would not result in better solutions, although they stressed that no final decision needed to be made—only a proposal to the WHA. In the end, the recommendation in favour of changing the preamble 'was approved by 22 votes to none, with 8 abstentions'.

During the debate, some representatives made the case that Member States that still required clarification should abstain. The relatively high number of eight

abstentions is therefore not surprising, although it is unusual. The UN and, by extension, the WHO thrive on diplomacy, whereby consensus is critical; an abstention, however, suggests dissent or—at the very least—discomfort. As former top WHO official Wilfried Kreisel remarked in retrospect, ‘eight abstentions on the Executive Board are already a lot, abstentions actually only occur on difficult topics.’ Kreisel was therefore not surprised that resistance arose later, because an abstention is sometimes to be understood as a gentle ‘no’.³⁹

Others were more optimistic. Eric Ram from World Vision was happy about the EB’s vote. He ‘noted with satisfaction the Executive Board’s recommendation in resolution EB 101.R2 that the Assembly should include a spiritual dimension in the WHO definition of health’.

Discussion during the World Health Assembly

After the agreement in the EB—albeit with many abstentions—the question of amending the preamble became a topic at the World Health Assembly. It was not the only topic, of course, but rather part of the larger issue of a general overhaul of the WHO constitution that the ‘special group’ had worked out. The plan was to reform the WHO not only by means of a new preamble but also by tackling many other questions, such as ‘regular budget allocations to regions’, ‘criteria for determining regions’, ‘representation of regions in the Executive Board and other bodies’, ‘term of office of Regional Director’, and ‘qualifications and method of selection’.⁴⁰

For this reason, the arguments for and against a ‘spiritual dimension’ of health were not discussed at the WHA in 1999; the question of the overall package was negotiated instead. Several Member States were not convinced that the constitutional questions would really have the desired effect of significantly improving the work of the WHO.

A statement by the delegate from Germany, which held the EU presidency at the time, suggested that a significant number of WHO Member States did not believe that a constitutional amendment would actually solve the WHO’s challenges. The problem for European countries was not so much the WHO constitution as it was the WHO management at that time. The discussion of the constitutional amendment coincided with the replacement of the Japanese WHO Director-General Hiroshi Nakajima by the Norwegian Gro Harlem Brundtland, who took office on 21 July 1998. As the German delegate Helmut Voigtländer put it on behalf of the European states, the first step was to await the

³⁹ Interview with Wilfried Kreisel, 5.5.2019.

⁴⁰ World Health Organization, ‘Executive Board Special Group for the Review of the Constitution of WHO’.

work of the new WHO leadership. The European position was supported by the representatives of Argentina and other Latin American countries, as well as China, Australia, and Russia.

Despite the backlash, two Arab countries tried to push through the preamble amendment at a minimum. Al-Mousawi 'referred in particular to the amendment to the preamble to the Constitution, since the Health Assembly had emphasized the spiritual dimension of health as long ago as 1984'. According to his Libyan colleague, Abudajaja, 'the definition of health was a very delicate matter and its spiritual dimension was extremely important.' The request by the Arab countries was supported by Sri Lanka. Colombo's delegate, Jeganathan, lobbied for a 'spiritual dimension':

Man was body, mind and soul, and the very important dimension of his spiritual well-being related to the manifestation of human values in daily life. A holistic approach was of great importance in trying to understand what health meant. However, the spiritual dimension should not be confused with religion; it was beyond mere religious practice.

Because of the strong oppositional front and the low chance of success, the matter was not voted on and instead dropped with the diplomatic phrase that 'the Director-General would keep the matter under review.'

Besides those already mentioned, Germany and the other European countries might have had other reasons for being against the revision of the WHO constitution. For example, they held the conviction that constitutional issues alone would not make an organization more efficient, especially since ratification would take a long time: 'I would like to remind you that the deposit of the German instrument of acceptance to amend Articles 24 and 25 of the WHO Constitution is still pending', as one internal German document argues.⁴¹

A letter from Helmut Voigtländer, a high-ranking civil servant at the German ministry of health, reveals doubts with regard to the new Article 2, which concerned 'nearly everything'.⁴² Bonn feared a loss of authority. The question arose as to whether the WHO really intended 'to pass regulations, e.g. in health education, vaccination or medical education. Moreover, there could be conflicts with EU regulations, for instance.'⁴³ Bonn was also not keen on Article 73, which would have made constitutional amendments easier. Voigtländer was concerned that 'if only 20 or 30 percent (for instance the industrialised countries) deposit a formal notification of rejection and if—for some reason or other—none of the

⁴¹ Betr. Änderung der Artikel 24 und 25 der WHO-Satzung. Auswärtiges Amt an Bundesministerium für Gesundheit, 7.2.2002. In: The Political Archive of the Federal Foreign Office, B 30 (ZA), Band 298494.

⁴² Schreiben des Ministerialdirigenten Helmut Voigtländer.

⁴³ Schreiben des Ministerialdirigenten Helmut Voigtländer.

Member States has ratified within the 18 months, the amendment would nevertheless enter into force.⁴⁴ Also, he criticized ‘the trend at WHO to set up more and more special pots outside the regular WHO budget’.⁴⁵

It must be noted that the motivation had nothing to do with a desire to reject a ‘spiritual dimension’ of health. In fact, the spiritual dimension was not an issue at all in the German documents. Rather, the rejection related to the whole package of constitutional amendments. From a German point of view, there were too many open questions left unresolved by the constitutional amendments. Also, the ratification process was and still is complex. It would have taken years to pass the amendments. The WHO should have focused on concrete internal reforms instead.

The medical doctor Manoj Kurian was responsible for health issues at the World Council of Churches in Geneva in 1999. Based on his recollections, a number of high-ranking WHO staff members from Western Europe spoke out vehemently against a ‘spiritual dimension’ of health. The decision not to put the constitutional amendment to a vote probably stemmed from the diplomatic convention to exclude controversial points as far as possible. Kurian suspects that ‘[i]t is possible that the resolution was not voted on, because it was deliberately, and strategically sidestepped, to avoid open divisions.’ Even today, Kurian believes that a preamble change would face a difficult road: ‘Even in those days, if the proposal would have further progressed, countries who are wary of mass spiritual movements would have opposed the measure.’⁴⁶

Why is it that the United States, one of the biggest WHO donor countries, stayed out of the discussion? Former top WHO official Derek Yach suspects that, for legal reasons, the United States had no interest in a constitutional amendment—nor in a preamble amendment. The government would have no interest in adopting amendments without knowing what legal implications they would have. ‘What would the practical implications be of adding the term “spiritual”? And could this conflict with a separation of church and state?’, asks Yach. In extreme cases, a change in the definition of health might mean that the Member States would have to change their health policies.⁴⁷

According to Wilfried Kreisel, however, different ideas about the proper relationship between health, state, and religion may also have been responsible for doubts about the spiritual dimension of health. For many Western countries, religion has no place in health issues, so ‘health and thus also the WHO are not religious. In the Arabic and Asian regions in particular, however, the view is different.’⁴⁸

⁴⁴ Schreiben des Ministerialdirigenten Helmut Voigtländer.

⁴⁵ Schreiben des Ministerialdirigenten Helmut Voigtländer.

⁴⁶ Email correspondence with Manoj Kurian, 30.1.2019.

⁴⁷ Telephone interview with Derek Yach, 12.4.2019. Cf. Yach, ‘Health and Illness: The Definition of the World Health Organization’.

⁴⁸ Interview with Wilfried Kreisel, 5.5.2019 in Geneva.

Discussion

Is this a classic case of ‘from bang to bust’? One might get this impression by analysing the discussions of adding the word ‘spiritual’ to the preamble of the WHO constitution. Representatives of the Arab states lobbied with enthusiasm and vigour on behalf of a ‘spiritual dimension’ of health. They managed to convince not only the ‘special group’ but also the Executive Board of the necessity of their concern, only to fall short during the World Health Assembly. However, it is important to stress again that the body did not specifically reject the spiritual dimension of health; rather, it postponed the entire process of revising the constitution. The WHA had no confidence that a constitutional amendment would significantly improve the output of the organization.

That said, our analysis suggests that many delegates applauded and embraced a ‘spiritual dimension’ of health, despite some scepticism that arose. It became clear over the course of the debate what the difficulties in the relationship between religion and health are—and where the lines of conflict are drawn.

Other scholars have examined this issue as well. Francesco Chirico, for example, traces these lines of conflict back to ‘Descartes’s and Newton’s discoveries’ which ‘led to an enduring split between religion and science with which we live to these days’.⁴⁹ Furthermore, he criticizes that people often forget that ‘religiousness, spirituality and personal beliefs are not synonymous.’⁵⁰

Masako Nagase has analysed the Japanese position during the amendment process from 1997 to 1999, drawing on the protocols of the Health Science Council of the Japanese ministry of health, which prepared the Japanese position for the World Health Assembly in 1999. The majority of the scientists concluded that a ‘spiritual dimension’ in the WHO health definition would create more problems than it would solve. The idea of a constitutional amendment concerning the addition of the word ‘spiritual’ to the preamble seemed too unclear to be included in healthcare in a useful way. The Japanese representatives also argued that the vote of Muslim countries was based on a link between state and religion that was too close. The Japanese doctors were implicitly critical not only of a ‘spiritual dimension’ but also of the WHO health definition as a whole. They favoured a biomedical health model instead.

Both Chirico’s and Nagase’s observations can be confirmed by the analysis of the 1997–1999 process. The first key point here is that the WHO reflects the different political cultures of its 194 Member States to date and their respective traditions concerning the relation of state and religion. Among WHO Member States, there are so-called theocracies like Iran or countries with a state religion. At the same time, there are many countries that have close links between state and

⁴⁹ Chirico, ‘Spiritual Well-Being in the 21st Century’, 13.

⁵⁰ Chirico, ‘Spiritual Well-Being in the 21st Century’, 13.

religion, such as countries in the Arab world. In some cases, states have adopted twinning arrangements, such as Germany or Switzerland. Other countries, however, have a strict separation of church and state—most prominently France with its *laïcité*. These different ideas about the ‘right’ relationship between state and religion clash in the WHO.

Secondly, the WHO also has very different ideas about how health should be defined. Western countries often assume a biomedical paradigm that can be seen as in line with a particular interpretation of René Descartes, based on his separation of the human soul and the body. African, Asian, and Arab countries, on the other hand, are more open to a holistic approach to health that emphasizes social determinants and a spiritual dimension of health as well. This can be seen, for example, by the delegate from Sri Lanka, de Silva, whose official title was not only ‘Minister of Health’ but also ‘Minister of Indigenous Medicine’.⁵¹

The third point is closely connected to the second point: The added value of a ‘spiritual dimension’ of health and the concrete consequences that a preamble amendment would have had for the Member States seemed unclear to some delegates. As Derek Yach, who was involved in developing the constitutional amendments, has pointed out, states such as the United States are reluctant to adopt amendments without knowing their legal implications. In extreme cases, for example, a change in the definition of health might mean that Member States would have to change their health policies.

Fourthly, this analysis reveals the role of *kairos* and coincidence. As described in Chapter 3, various countries used the *kairos* to pass a resolution in favour of a ‘spiritual dimension’ of health. They had an advocate for this concern in the person of then WHO Director-General Halfdan Mahler. More than a decade later, the climate had changed, and a pro-spiritual approach was no longer so welcome. Success in carrying out projects within the WHO therefore depends on good timing and appropriate support from the organization’s management.

Fifthly, an examination of the debates reveals that the ambiguity of the word ‘spiritual’ has advantages and disadvantages. Diplomacy thrives on vagueness. Semantic underdetermination allows for diverging interests to coalesce under one term, which can then be specified in different contexts.⁵² Between 1983 and 1984, resolution WHA 37.13 was adopted because different actors saw their different interests reflected in it. A vague term was thus successful in the diplomatic arena. But between 1997 and 1999, diplomats faced the other side of this coin, where vagueness turned out to be a risk. Some delegates felt that the ambiguous definition of spirituality was too vague for them, preventing them from voting

⁵¹ World Health Organization, ‘Fifty-First World Health Assembly, Geneva, 11–16 May 1998: Verbatim Records of Plenary Meetings’.

⁵² Cf. Rauch, ‘Von Alkohol-Prävention bis Zakat: Die Spirituelle Dimension von Gesundheit im EMRO 1984–2017’.

in favour of the constitutional amendment. As a result, supporters of a 'spiritual dimension' of health in the WHO face the challenge of being specific enough to appeal to as many nations as possible, but vague enough to remain capable of reaching a consensus and securing a majority.

Sixthly, the institutional memory of the WHO leaves much to be desired. The discussion from 1983 to 1984 seems all but forgotten. Technical discussions and reports by expert committees are ignored as well, for example the debate in the 1980s on palliative care (see Chapter 6) or in the 1990s on the WHOQOL-SRPB (see Chapter 7). It is apparent that the WHO delegates either were not familiar with these documents or did not refer to them. Doing so would at least have helped to handle the problem of underdetermination.

Lastly, this analysis makes it clear that the tension between religion and health is being used to productive ends, for even if there was a damper in 1999 regarding the stymied change to the preamble, the issue is regularly revived, thanks to efforts made by individual states and NGOs such as the World Council of Churches.

Although the 1999 constitutional amendment did not succeed, the lobbying by the EMRO testifies to the effort to attach special importance to a 'spiritual dimension' of health on a global level. Overall, appreciative, affirmative comments on the spiritual dimension of health dominated the discussion, while very critical rejections were few and far between. The critical comments focused on whether constitutional amendments were the right tool to improve the WHO's output.

The urgency of a constitutional amendment for Muslim states should also not be overestimated. A declaration by the health ministers of the Organisation of Islamic Cooperation in 1998 shows that the actual priorities were seen elsewhere, for example strategies in favour of 'poverty eradication, provision of primary healthcare facilities, adequate nutrition, safe drinking water, sanitation, clean environment and adequate shelter'.⁵³ Another focus was on access to affordable medicines, relating specifically to 'adverse effects that globalization and trade liberalization may have on the access to medicine, medical treatment and medical equipment at an affordable price for the population of developing countries'.⁵⁴

A successful constitutional amendment would have been more than just a symbolic victory. The failure of the constitutional amendment, however, did not harm the reception of the spiritual dimension of health within the EM region, since resolution WHA 37.13 is still valid.

As the episcopal priest and former WHO staff member Ted Karpf writes, the amendment to the preamble theoretically 'remains on the table of the Assembly to

⁵³ Statement of the Ministers of Health of the Member States of the Organization of the Islamic Conference, 13 May 1998. In: WHO Archive, W3-87-1(51), 51st World Health Assembly, General Arrangements, 1998.

⁵⁴ Statement of the Ministers of Health of the Member States.

be reconsidered at any time'.⁵⁵ Nevertheless, this seems unlikely at the moment. There are countries like China or France that, for their own reasons—totalitarian state control and *laïcité*, respectively—have no interest in upgrading religion or spirituality. Also, it is worth recalling that the ratification of constitutional amendments is still a protracted process that takes years.

Nevertheless, there remain some calls for a 'spiritual dimension' within the WHO definition of health. One striking example: In an EMRO publication from 2006, the preamble of the WHO constitution is quoted as follows: 'complete physical, mental, social [and spiritual] well-being and not merely the absence of disease or infirmity'.⁵⁶

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⁵⁵ Ted Karpf, 'Relationship between FBO and WHO' (unpublished typescript). Many thanks to Ted Karpf for providing the unpublished manuscript to us.

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Developments in the New Millennium

Simon Peng-Keller, Fabian Winiger, and Raphael Rauch

For the WHO, the new millennium brought a repositioning in the rapidly changing world of global health. After a crisis-ridden decade under Director-General Hiroshi Nakajima (1988–1998) and a failed reform process, the WHO was in need of new perspectives, initiatives, and most importantly new financial resources. Director-General Gro Harlem Brundtland, who led the organization between 1998 and 2003, promoted new public partnerships with philanthropic foundations, academic institutions and non-governmental organizations. In a speech given in 2000, she pleaded for a public health approach that goes ‘beyond the traditional health sector – working with people in their homes, their work places, their schools, their community halls and their places of worship’.¹ Although faith-based organizations (FBOs) did not feature in her speech and were not central in her policies, Brundtland paved the way for later cooperation with them.

The developments after the turn of the millennium are no less heterogeneous than those reconstructed in previous chapters. The inclusion of a ‘spiritual dimension’ into the 2005 Bangkok Charter for Health Promotion in a Globalized World can be seen as a success for advocates of spirituality in the new millennium. Committed to the spirit of social medicine and Alma-Ata, the charter reaffirmed the principles of the Ottawa Charter for Health Promotion published 20 years earlier.² It emphasized ‘that policies and partnerships to empower communities, and to improve health and health equality, should be at the centre of global and national development’. In allusion to the preamble to the WHO’s constitution it said: ‘The United Nations recognizes that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without discrimination.’ Health was understood in a positive and inclusive sense and inserted into the provision of human rights: ‘Health promotion is based on this critical human right and offers a positive and inclusive concept of health as a determinant of the quality of life and encompassing mental

¹ Gro Harlem Brundtland, Speech at Opening Dinner, Massive Effort Advocacy Meeting, 3 October 2000 in Wintertthur, Switzerland, cited in Cochrane, ‘Religion, Public Health and Church for the 21st Century’, 60.

² World Health Organization, ‘The Ottawa Charter for Health Promotion’.

and spiritual well-being.³ Thus, in 2005, the WHO reiterated the main concern of the resolution WHA 37.13 as well as the demand of those who advocated the revision of the preamble a few years earlier.

Some of the developments after the turn of the millennium have already been mentioned in previous chapters, such as the reassessment of traditional medicine (see Chapter 5) and the 2014 resolution on palliative care (see Chapter 6). In this chapter, the aim is not only to point out more recent developments but also to bring together the threads developed in this volume and to provide a balanced overall picture. The first section focuses on an area of WHO activity that has been somewhat neglected in this volume and where, in recent years, a significant trend can be identified: the field of mental health. In the second section, the new relationship of the WHO to FBOs is examined against the background of past conflicts. We trace a process of cautious rapprochement which was not without controversy. Finally, the third section concludes the reconstruction of the WHO's discourses on a 'spiritual dimension' of health and shows how the fate of this term has been highly dependent on the changing visions about the principal goals of global health.

Addressing Spiritual Needs in Mental Health

The WHO's most differentiated mental health approach to the spiritual dimension is to be found in the 2004 report *Promoting Mental Health*. No other WHO document describes in more detail how spiritual needs and resources are related to mental health. Two of the authors, Shekhar Saxena and Lynn Underwood, had already been involved in the development of WHOQOL-SRPB. The report stated that many 'would agree that to be fully human includes the spiritual dimension of life [...]. Spiritual well-being can be thought of as a component of mental health, but it also stretches beyond the comfort of the individual and his or her community to aspirations that transcend this.'⁴ It is remarkable that the spiritual dimension here is not simply assigned to the mental realm, but is said to transcend this realm.

Like the WHOQOL-SRPB, the report understood the 'spiritual dimension' in an inclusive manner. Nevertheless, the importance of 'religious spirituality' was underlined with regard to the world population: 'Spirituality can exist independently of religious practice or affiliation, but in most people their spirituality is nested in a religious context.' Contrary to the tendency to individualize spirituality and ignore its social aspects, the report emphasized precisely this embedding and its significance for good healthcare:

³ World Health Organization, 'The Bangkok Charter for Health Promotion', 1.

⁴ World Health Organization, 'Promoting Mental Health', 55.

Mental well-being for many people is linked to their relationship with their concept of God. Problems are considered to be caused by a breakdown in this relationship or an oversight in the respect that should have been shown. Consequently, problem-solving requires some action that repairs this relationship. Undertaking this spiritual action may not necessarily preclude other, more secular, problem-solving activities. In traditional African cultures the relationship breakdown may be concerned with ancestors and healing this relationship may require a concrete atonement of some kind, while in other belief systems the breakdown may be couched in other terms and require other actions.⁵

The report often used the term 'spirituality' and tended to identify it with 'spiritual well-being' and 'spiritual resources'. Thus 'spirituality' was seen as something that is in any case desirable. In contrast, 'religion' appears as something which may promote mental health, but may also impair it: 'Religion can also contribute negative features to a person's spirituality, however, such as guilt and inappropriate revenge-motivated behaviours. In general, though, the positive contribution of religion to spirituality is the dominant effect.'⁶

The relationship between mental health and a 'spiritual dimension' was seen as mutual. Not only does spirituality affect mental health, but the opposite is no less true: 'Maintaining mental health also has a positive effect on the development of a healthy spiritual life. It is more difficult to see the positive hopeful view, have faith or face the moral challenges and demands for ethical behaviours presented by the spiritual life if the mind is clouded by mental health problems.'⁷ As the WHO still struggles to provide a clear distinction between the mental and the spiritual dimension, it is remarkable that the present report drew such a clear line.⁸ Despite complex interactions between the mental and the spiritual, their difference comes to light in times of crisis. Far from merging into mental well-being, spiritual well-being can be experienced in its own way at moments of great distress: 'Spirituality can enable people to step outside or beyond the mental distress and experience comfort and calm. Especially in the midst of crisis, particular kinds of spirituality can prove to be a powerful resource which can be a real buffer against excessive mental distress and despair.'⁹ The report listed a number of studies that demonstrate the positive influence of religious-spiritual attitudes or spiritual practices such as meditation on health variables.¹⁰ But the view expressed in the report is not that spiritual factors are only significant to the

⁵ World Health Organization, 'Promoting Mental Health', 64.

⁶ World Health Organization, 'Promoting Mental Health', 64.

⁷ World Health Organization, 'Promoting Mental Health', 64.

⁸ This is also evident in some translations. The 1989 United Nations Convention on the Rights of the Child, contains the word 'spiritual'; the German version, however, refers to 'geistig', which stands both for 'mental' and 'spiritual'. UNICEF, 'Konvention über die Rechte des Kindes - Präambel'.

⁹ World Health Organization, 'Promoting Mental Health', 56.

¹⁰ World Health Organization, 'Promoting Mental Health', 192.

extent that they contribute instrumentally to better 'functional health', as is made clear in this passage: 'One of the most important ways spirituality contributes to human value is that it tends to define the human being in a way that is beyond merely the ability to function.'¹¹

This remarkable report signifies the beginning of a further development. In the years that followed, mental health remained one of the fields in which the significance of a 'spiritual dimension' has received greater attention within the WHO. This applies in particular to the question of appropriate mental healthcare in response to humanitarian crises. In this area, the WHO is cooperating with other humanitarian organizations, such as the United Nations High Commissioner for Refugees (UNHCR). Their jointly published documents reflect a broad international consensus. To give just one example: the IASC *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* published in 2007 contained a subchapter on how to 'facilitate conditions for appropriate communal cultural, spiritual and religious healing practices'.¹² The document pointed out the danger of underestimating spiritual needs in emergency situations:

In emergencies, people may experience collective cultural, spiritual and religious stresses that may require immediate attention. Providers of aid from outside a local culture commonly think in terms of individual symptoms and reactions, such as depression and traumatic stress, but many survivors, particularly in non-Western societies, experience suffering in spiritual, religious, family or community terms. Survivors might feel significant stress due to their inability to perform culturally appropriate burial rituals, in situations where the bodies of the deceased are not available for burial or where there is a lack of financial resources or private spaces needed to conduct such rituals. Similarly, people might experience intense stress if they are unable to engage in normal religious, spiritual or cultural practices.¹³

Another example from the same document describes the situation of non-local relief workers who requested permission to engage with local religious and spiritual leaders and practices. At the same time, they were warned: 'Because some local practices cause harm (for example, in contexts where spirituality and religion are politicised), humanitarian workers should think critically and support local practices and resources only if they fit with international standards of human rights.' They should learn about cultural, religious, and spiritual support and coping mechanisms in order to assess spiritual interpretations of crises and to

¹¹ World Health Organization, 'Promoting Mental Health', 56.

¹² Inter-Agency Standing Committee, *IASC Guidelines for Mental Health and Psychosocial Support in Emergency Settings*.

¹³ Inter-Agency Standing Committee, *IASC Guidelines for Mental Health and Psychosocial Support in Emergency Settings*, 106.

facilitate the establishment of conditions appropriate for burial and healing practices. The subchapter concluded with a short case report from Angola:

A former boy soldier said he felt stressed and fearful because the spirit of a man he had killed visited him at night. The problem was communal since his family and community viewed him as contaminated and feared retaliation by the spirit if he was not cleansed. Humanitarian workers consulted local healers, who said that they could expel the angry spirit by conducting a cleansing ritual, which the boy said he needed. An international NGO provided the necessary food and animals offered as a sacrifice, and the healer conducted a ritual believed to purify the boy and protect the community. Afterwards, the boy and people in the community reported increased well-being.¹⁴

Where the WHO has included the ‘spiritual dimension’ in its health programmes, it has often done so explicitly. But it would be a misconception to think that the ‘spiritual dimension’ is only taken into account where this term is used. A recent example of the implicit inclusion of a ‘spiritual dimension’ in the above sense may be seen in the WHO stress management course *Doing What Matters in Times of Stress*, published in 2020 and translated into 14 languages to date.¹⁵ This self-help programme, developed by the WHO’s Department of Mental Health and Substance Use, is well suited as a conclusion to this section, since value orientation is central to its approach.

The course, validated in a randomized trial involving almost 700 South Sudanese refugee women, builds on Acceptance and Commitment Therapy (ACT). Like all approaches belonging to the third wave of cognitive behavioural therapies, ACT has been profoundly influenced by the spiritual practice of mindfulness meditation, which focuses the attention on the present moment and facilitates a distancing from negative thoughts. Furthermore, ACT encompasses values clarification exercises ‘to maintain or change behaviour so that the person behaves in a way that is consistent with their subjectively identified values’.¹⁶ In encouraging language, the guide describes the importance of value orientation and acting on the basis of values as follows: ‘Your values describe what kind of person you want to be; how you want to treat yourself and others and the world around you. [...] And even if you are facing a very difficult situation and are separated from your family and friends, you can still live your values of being kind, caring, loving and supportive. You can find little ways to act on these values with the people around you.’¹⁷ Neither the guide itself nor the publication on the related

¹⁴ Inter-Agency Standing Committee, *IASC Guidelines for Mental Health and Psychosocial Support in Emergency Settings*, 109.

¹⁵ World Health Organization, *Doing What Matters in Times of Stress: An Illustrated Guide*.

¹⁶ Tol et al., ‘Guided Self-Help to Reduce Psychological Distress’, 257.

¹⁷ World Health Organization, *Doing What Matters in Times of Stress: An Illustrated Guide*, 80–2.

field study refer to a 'spiritual dimension' of health. But, it may be argued, this programme nevertheless incorporates what many documents examined in this book refer to by this term.

Building Bridges: The WHO and Faith-Based Organizations

The WHO's relationship with faith communities started with conflict. Brock Chisholm, the first Director-General, was a Mason, a Freethinker, and a former advocate of eugenics, euthanasia, and sterilization, as well as a fierce critic of traditional religion, especially of Catholicism.¹⁸ Chisholm was a vocal proponent of birth control by contraception, provoking a fierce backlash among some conservative Christian communities. From the outset, the issue of population control placed the WHO in a paradoxical situation: on the one hand, reducing infant mortality and improving healthcare worldwide was one of its core tasks; as an institution shaped by modern medicine, the WHO itself contributed to population growth. On the other hand, there were voices that pointed to the danger of overpopulation and called for measures that could certainly be justified on socio-medical grounds. This concern was particularly shared by the governments of South-East Asian countries (India, Ceylon, Thailand), while the European countries affected by the Second World War had to cope with high population losses.

At the request of India, Chisholm launched a WHO programme for population control in India in 1951. As a consequence, a fierce dispute broke out, in which delegates from mainly Catholic European countries attacked the planned programme and threatened to leave the organization. According to John Farley, the 'controversy nearly destroyed the WHO.'¹⁹ Finally the programme was stopped and the advocacy for birth control has been on hold for years. This did not yet resolve the conflict, which flared up again in the following decades, especially in the WHO's fight against HIV/AIDS (see Chapter 6). Despite this conflict-ridden history and dissent on questions like contraception, the WHO has normalized its relationship with the Catholic Church over the years. The Holy See participates actively as an Observer State at the meetings of the World Health Assembly and of the WHO's Executive Board.²⁰

After the turn of the millennium, the sometimes strained relationship between the WHO and FBOs took on new forms. In 2007, the WHO sponsored a meeting in the National Cathedral in Washington, DC. Chaired by WHO Executive Director Kevin De Cock, the conference members discussed 'what faith-based organizations [...] are actually doing in the fight against AIDS'.²¹ The discussions

¹⁸ Farley, *Brock Chisholm*, 173–84.

¹⁹ Farley, *Brock Chisholm*, 181.

²⁰ Cf. Tomasi et al., *The Vatican in the Family of Nations*, xviii, 851.

²¹ Cochrane et al., 'Mapping Religious Resources for Health', 344.

were based on the work of the African Religious Health Assets Programme (ARHAP).²² An even more important sign for the rapprochement of the WHO and FBOs was the invitation of the Nobel Prize laureate Desmond Mpilo Tutu to the 61st World Health Assembly in 2008. In his speech, the iconic figure of South Africa's anti-apartheid struggle stated that 'health not only encompasses the physical, mental and social well-being, but must be inclusive of spiritual well-being.' Tutu stressed that 'there is no situation that cannot be transformed. There is no person who is hopeless.' Therefore, everybody should enjoy the 'spiritual well-being of our creation in relationship to God and each other'. According to Tutu, 'it would be good for us to include the recognition that there is an intrinsic relationship between God and humankind, which can be acknowledged as "spiritual well-being".' He also expressed the hope that 'perhaps one day this notion of well-being can be included in the WHO definition of health.'²³

A year later, in 2008, the WHO published a 40-page booklet with a title that drew on the PHC approach developed in the 1970s. The title indicated a change of direction in the WHO policy toward FBOs: *Building from Common Foundations: The World Health Organization and Faith-Based Organizations in Primary Healthcare*. The photograph on the cover showed a picture from a church-based programme for Ethiopians affected by HIV: a laughing mother with a child wearing a necklace with an Ethiopian cross (Fig. 9.1). The booklet was sponsored by the philanthropic organization Geneva Global and co-edited by the episcopal priest Ted Karpf, who was employed by the WHO 'specifically because of his religious qualifications'.²⁴

The growing cooperation between the WHO and FBOs, demonstrated by this booklet and the aforementioned events, was all the more surprising as the then acting Director-General Margaret Chan had little interest in religious health institutions.²⁵ How was this possible? Seen from a wider perspective, this new cooperation embodies a trend of the first decade of the twenty-first century.²⁶ According to public health researcher Nathan Grills, there are two reasons that facilitate new partnerships between multilateral organizations and FBOs. On the one hand, 'AIDS has broken down some taboos regarding religion in the UN systems';²⁷ on the other hand, FBOs have grown in influence through the privatization of healthcare: 'Ironically, the liberal emphasis on individualism vis-à-vis

²² On the history of the ARHAP, see Holman, *Beholden*; Cochrane et al., 'Mapping Religious Resources for Health'.

²³ World Health Organization, 'Address by the Most Reverend Desmond Mpilo Tutu'.

²⁴ Grills, 'The Paradox of Multilateral Organizations Engaging with Faith-Based Organizations', 508.

²⁵ This assessment was expressed by several WHO staff members. This might also explain why Margaret Chan—unlike her predecessors and her successor—was not interested in meeting the Pope.

²⁶ Cf. Hanrieder, 'The Public Valuation of Religion in Global Health Governance'.

²⁷ Grills, 'The Paradox of Multilateral Organizations Engaging with Faith-Based Organizations', 511.

Building From Common Foundations

The World Health Organization and
Faith-Based Organizations in Primary Healthcare



 GENEVA GLOBAL
PERFORMANCE PHILANTHROPY



Fig. 9.1 Cover page of *Building from Common Foundations: The World Health Organization and Faith-Based Organizations in Primary Healthcare* (2008).

Source: Reproduced with permission.

the state has had the unexpected effect of promoting communal institutions such as FBOs.²⁸ Grills lists five reasons why cooperation with FBOs is attractive for

²⁸ Grills, 'The Paradox of Multilateral Organizations Engaging with Faith-Based Organizations', 509.

multilateral organizations such as the WHO: 'First, FBOs are an effective means of achieving social policy goals; second, they provide good entry points into hard-to-access communities; third, they have significant resources that can be utilized; fourth, they have commitment to, and experience in, particular localities; and finally, they tend to be cost-effective.'²⁹

FBOs contributed to building this bridge, among other things, by drawing on new research on spirituality/religion and health. The aforementioned ARHAP is an example of such an effort. Established in 2002 and assisted by the World Council of Churches, ARHAP drew on the spirit of Alma-Ata. However, ARHAP was not merely the reaffirmation of a programme developed in the 1970s. It enriched the PHC approach with new knowledge and ideas in order to overcome a particular bias in public health research: 'Research and policy in public health has largely been "religion blind", at best using criteria and categories that describe religion quantitatively or as derivative of another social dimension. Moreover, there has been a greater focus on the negative impact of religious messages and traditions.'³⁰ Due to this research bias, the impact of religion and faith communities is 'insufficiently understood, largely opaque to policy makers, and often not well aligned with public health systems'.³¹ The conceptual framework of ARHAP was inspired by the Interfaith Health Program, founded in 1991 under the auspices of the Carter Center in Atlanta, particularly by its first directors Gary Gunderson and William Foege. The latter, an epidemiologist famous for his work in the campaign to eradicate smallpox in the 1970s, pleaded for a 'reverse epidemiology', which is committed to a salutogenetic approach on a public health level: 'Where others look for early signs of pathology and the underlying pathogen, we look for effective community building and the underlying dynamic. Where most look for interventions that can stop the spread of disease, we are committed to interventions leading to an epidemic of good health.'³² This approach is well aligned with the WHO's positive concept of health and its programmes for health promotion: 'pay attention first not to the problems (pathologies or liabilities) but to what is life-giving (generativities or assets) and that may be strengthened.'³³

As its name indicates, it was the new concept of 'religious health assets' (RHA) that determined the programme: 'In Biblical terms assets are the "talents" of faith communities that can promote health.'³⁴ James Cochrane, one of the founders of the ARHAP, argued that this concept turns the point of view 'from the standard

²⁹ Grills, 'The Paradox of Multilateral Organizations Engaging with Faith-Based Organizations', 511; Bretherton, 'A New Establishment?', 377.

³⁰ Cochrane, 'Religion, Public Health and Church for the 21st Century', 62.

³¹ Cochrane, 'Religion, Public Health and Church for the 21st Century', 63.

³² Cited in Cochrane et al., 'Mapping Religious Resources for Health', 347.

³³ Cochrane et al., 'Mapping Religious Resources for Health', 347.

³⁴ Beate and Weyel, *Spirituality, Mental Health, and Social Support*.

discourse of “needs” or “deficits” to capabilities and agency in the local context of communities. “The language of assets, in the context of contemporary development theories about sustainable livelihoods and people-centred development practices, points to what people have available to them, no matter how disadvantaged they may be materially, politically and in other ways.”³⁵ To make visible the hidden potential of faith communities for public health, the focus has been extended from statistically recordable factors—the often underestimated ‘tangible’ assets such as facilities, equipment, and staff—to ‘intangible’ RHA, which are much harder to measure. According to Cochrane, RHA encompass ‘the volitional, motivational and mobilizing capacities that are rooted in vital affective, symbolic and relational dimensions of religious faith, belief, behaviour and ties. Local knowledge, access, reach, participation, trust and accompaniment are just some of these intangible religious health assets.’³⁶

The WHO tasked the ARHAP with research in Zambia and Lesotho and adopted its approach in *Building from Common Foundations*. The document underlined that ‘public institutions cannot harness only the secular elements of faith-based healthcare. Religious values have deeper and indivisible purposes.’³⁷ The executive summary lists the key insights of the publication, including the following:

FBOs are major health providers in developing countries, providing an average of about 40 percent of services in sub-Saharan Africa. Despite being closely aligned with community needs, FBOs often go unrecognized because they usually operate outside government planning processes.

FBOs’ core values lead them to offer compassionate care to people in need. [...]

Evidence from studies of FBO responses to HIV/AIDS demonstrates that they have delivered a range of treatment, care and prevention activities in accordance with WHO strategic priorities and primary healthcare principles. [...]

In partnership with FBOs, WHO can develop the concept of primary healthcare to provide guidance for the engagement of religious health assets.

WHO can engage in dialogue with faith institutions to consider the interplay between their respective values of compassion and decent care, and to ascertain the relative roles and contributions of FBOs in developing healthcare systems.

WHO can encourage national governments to consider public values created by FBOs and engage FBOs when developing national health plans.³⁸

³⁵ Cochrane, ‘Religion, Public Health and Church for the 21st Century’, 63.

³⁶ Cochrane, ‘Religion, Public Health and Church for the 21st Century’, 65.

³⁷ World Health Organization, *Building from Common Foundations*.

³⁸ World Health Organization, *Building from Common Foundations*, 5.

As well as mentioning the tensions in faith-based healthcare,³⁹ *Building from Common Foundations* validated a new partnership with FBOs by reaffirming the value of PHC. Although the focus was on African countries and the fight against HIV/AIDS, the document made it clear that the involvement of FBOs was of general importance. In this respect, it built on the foundations laid by resolution WHA 37.13. However, it used strikingly different language and did not even mention the resolution. While WHA 37.13 avoided religious terminology by opting for the term ‘spiritual dimension’, in *Building from Common Foundations*, Karpf drew on the conceptual repertoire of ARHAP: ‘religious’ appeared 87 times, ‘spiritual’ only 3 times. In two cases, ‘spiritual’ was connected with ‘holistic care’ ‘that address[es] the individual’s medical, physical, mental, social and spiritual well-being’;⁴⁰ in a third case it was linked to ‘spiritual healing’. This terminological shift may be explained by the fact that the document was focused on religious actors and their values, while WHA 37.13 sought to appeal to secular audiences. An aspect of the semantics of ‘spiritual’, which in 1983 had been equated with the non-material, appeared in 2008 under a new name: ‘intangible assets’.

This remarkable WHO publication illustrated further shifts in the institutional discourse of the ‘spiritual dimension’ of health. Much more than in earlier documents cited in this volume, biomedical reductionism was problematized and religious healing assessed positively. ‘Religious ideas also challenge materialist approaches to health and well-being and offer more holistic perspectives, bringing a qualitative contribution through religious faith for individuals and communities.’⁴¹ In sum: the ‘engagement of secular healthcare authorities with FBOs raises questions of power and influence on individuals and policies. But it also opens the biomedical environment to a more holistic perspective on the nature of people in communities.’⁴²

The authors did not neglect to place obligations on FBOs too and formulated clear requirements for cooperation. When it came to healthcare guidelines, the WHO asserted its leadership role: ‘Areas for improvement in FBO (and wider civil society) practices include greater emphasis on organizations using relevant WHO treatment guidelines instead of drafting their own, and more determined monitoring of effectiveness of activities across the spectrum of WHO strategic directions.’⁴³ At this point, the question arose as to whether the existing guidelines, to which reference was made, already contained a sufficient understanding of the RHA. Even if only to a very limited extent, *Building from Common*

³⁹ World Health Organization, *Building from Common Foundations*, 13; ‘the epidemiological concern for nonjudgmental protection has come into tension with religious values that discourage risky behavior. Moreover, the tension not only has impacted local strategies for distributing condoms but also has influenced policy debates and strategic actions in the global environment.’

⁴⁰ World Health Organization, *Building from Common Foundations*, 12.

⁴¹ World Health Organization, *Building from Common Foundations*, 12.

⁴² World Health Organization, *Building from Common Foundations*, 12.

⁴³ World Health Organization, *Building from Common Foundations*, 18.

Foundations also showed a trait characteristic of multinational organizations in their cooperation with FBOs: the tendency to ‘sanitize’ or standardize.⁴⁴ The booklet concluded with a look into the future: ‘Much can be achieved in renewed interaction and cooperation between WHO and FBOs. This requires a clear, long-term commitment to dialogue and mutual learning. The next step should involve forming a road map that interested parties can commit to so that they can embark on the next stage of the journey together.’⁴⁵ This final passage reads like an invitation to further stabilize and extend the bridge between the WHO and FBOs.

However, this initiative has remained a rough construction, at least until the outbreak of the West African Ebola epidemic and the Covid-19 pandemic. Its further development at the end of the first decade of the twenty-first century was overshadowed by a controversy involving the two editors of *Building from Common Foundations*.⁴⁶ The stumbling block was a Geneva conference on ‘Health and Lifestyle’ held in July 2009. The subtitle read: ‘An Exploration of Lifestyle in Primary and Spiritual Care’. The initiative for this conference, which included panels with distinguished UN and WHO representatives,⁴⁷ came from a particular faith community seeking closer cooperation with the WHO: the Seventh-Day Adventists. Belonging neither to the traditional nor to the largest Protestant churches, it may be surprising that the WHO was considering not only closer cooperation with the Adventists—it would be the first such venture with a particular church denomination—but was willing to host a joint conference at its Geneva headquarters. The Adventists’ well-known commitment to a healthy lifestyle, and the church’s engagement in healthcare and already existing joint projects on a regional level might have been the decisive reason for this step.⁴⁸ There were caveats about this alignment within the Adventist Church. Some members feared that ‘blending politics with faith’ would compromise ‘the church’s spiritual values’.⁴⁹ But for the church leaders, the conference marked the WHO’s welcome support for their commitment in healthcare worldwide. An Adventist rapporteur described it this way:

⁴⁴ Grills, ‘The Paradox of Multilateral Organizations Engaging with Faith-Based Organizations’, 515.

⁴⁵ World Health Organization, *Building from Common Foundations*, 29.

⁴⁶ Ted Karpf was announced with a presentation on ‘Decent Care – A Neglected Component in Health Care’ and Alex Ross with a session on ‘Pathways to Partnering’.

⁴⁷ Such as Dennis Aitkin, at that time Director-General’s Representative for Partnerships and UN Reform, Namita Pradhan, Assistant Director-General for Partnerships and United Nations Reforms, and Anarfi Asamoah-Baah, WHO’s Deputy Director-General. Christopher Drasbek, Regional Advisor of the Pan-American Health Organization, Carissa Etienne, Assistant Director-General for Health Systems Strengthening, Eugenio Vilar, Coordinator of Information, Evidence, and Research, and Hernan Montenegro, Senior Regional Advisor Health Systems and Services also joined the conference.

⁴⁸ Several studies confirm the Adventist’s healthy lifestyle, see e.g., Fraser et al., ‘Lower Rates of Cancer and All-Cause Mortality’.

⁴⁹ Ansel, ‘Potential Adventist Church-WHO Collaboration Looks Promising, Leaders Say’.

Last week's conference also revealed that many church institutions worldwide have already forged collaborative partnerships: Taiwan Adventist Hospital launched a WHO initiative of 40 hospitals dedicated to promoting healthy lifestyles among employees; in Zimbabwe, sexual health workshops for community parents and children have received national funding through USAID [U.S. Agency for International Development]; and the South Korean government is partnering with the Adventist Church's smoking cessation programs. The conference also gave an opportunity for Adventist Church officials to meet with WHO representatives at its Geneva Executive Meeting Room, the first such meeting between WHO and a church denomination.⁵⁰

The conference and the intended cooperation irritated some former WHO staff members. Jean-Jacques Guilbert, although he had already retired in 1988, became their spokesman.⁵¹ A former university professor of medicine, Guilbert represented a strong biomedical position. He noted with concern that in the conference's programme, 'the concept "Spiritual" is mentioned EIGHT times among many other references related to the same concept.'⁵² Guilbert lobbied against the congress in several areas.⁵³ His efforts ended in an intervention by the European representatives in Geneva. The Austrian representative in Geneva, Helmut Friza, alerted 'all European diplomatic staff about his impression that this Global Conference programme was "in conflict with the constitution of WHO"'. After this alert, a coordination meeting was convoked. There, the French representative pointed out 'that the announced presence of WHO's [deputy Director-General] as keynote speaker in the WHO Executive Board room – a sign of respectability – may lead people to believe that the prestigious WHO has officially recognized concepts which do not correspond to the definition of Health of 1948'. The conference took place, but the planned collaboration with the Adventists was called off.

A few months later, Karpf was involved in another conference, organized by the WHO Programme on Partnerships and UN Reform in collaboration with the

⁵⁰ Ansel, 'Potential Adventist Church-WHO Collaboration Looks Promising, Leaders Say'.

⁵¹ His main contribution to the WHO was a comprehensive educational handbook for health personnel first published in 1987. See Guilbert, *Educational Handbook for Health Personnel*. Guilbert was aware of the potential influence of religious factors on health and underlined that 'graduates of the M.D. programme should be able [...] to apply basic principles in health education in order to assist and lead the planning, implementation and evaluation of health programmes in promoting health, preventing disease, cure and rehabilitation, according to the needs of the community and local social, religious, customary and cultural values which can influence the state of health and disease.' Guilbert, *Educational Handbook for Health Personnel*, 1.24.

⁵² Email from Jean-Jacques Guilbert to the WHO, 23.6.2009. In: Private Archive, Jean-Jacques Guilbert.

⁵³ Guilbert complained to his former employer, the University of Geneva, and asked why the Adventists were allowed to host their conference there. The logistics centre explained that according to a decision of the *Conseil d'états* of 8 September 1976, the University aula is 'à disposition du public et notamment des partis politiques et des églises'. Cf. Location des salles de conférences de l'État. In: Private Archive, Jean-Jacques Guilbert.

Center for Interfaith Action on Global Poverty, which had been launched recently. The conference brought together representatives from 39 FBOs, along with academics, representatives from international organizations and governments, and key figures from ARHAP, as well as from UN agencies, including the World Bank, UNFPA, and UNAIDS. The conference gathered 39 FBOs, academics, international organizations and representatives from governments, key figures from ARHAP, as well as UN agencies including the World Bank, UNFPA, and UNAIDS. It was hoped that the conference would increase the visibility of the work done by FBOs in the provision of health-related services. As Karpf summarized the rationale of the conference:

The truth is, “If you are not on the map, then in the eyes of donors and Member States, you do not exist!” If you do not exist, you are not accountable or known, thus NOT invited to the health services table with donors, communities and Member States.⁵⁴

The conference acknowledged that ‘religious health assets’, though often invisible and taken for granted, made significant contributions in carrying the global burden of disease. It was hoped that increasing their visibility would make it easier for donor agencies and national governments to involve them in programmes, allowing them to contribute to planning—and receive funding—to a degree commensurate with their contributions to meeting global health challenges. One possibility discussed involved the extension of the WHO’s Service Availability Mapping software, a now-defunct database of global health infrastructure, with a module to ‘represent specific interests of FBOs’, such as the ‘provision of free or concessional care, capacity for spiritual care providers and volunteer staff, and provision of psychosocial services, including bereavement services’.⁵⁵

Another proposal was put forth by Kathy O’Neill, then the coordinator for Public Health Information and GIS (‘geographic information systems’) at the WHO. O’Neill reiterated that the lack of information on FBOs was seriously hindering their recognition in the labyrinthian network of practitioners in global health (Fig. 9.2), and noted growing demands for accurate data by funding bodies wanting track the progress and performance of health systems, evaluate results, and make funding decisions.

O’Neill suggested use of the International Health Partnership (IHP+) framework, which had been launched by a coalition of UN agencies, nation-states,

⁵⁴ World Health Organization and Center for Interfaith Action on Global Poverty, ‘Final Draft for Comments – WHO – CIFA Consultation’, 11.

⁵⁵ World Health Organization and Center for Interfaith Action on Global Poverty, ‘Final Draft for Comments – WHO – CIFA Consultation’, 5.

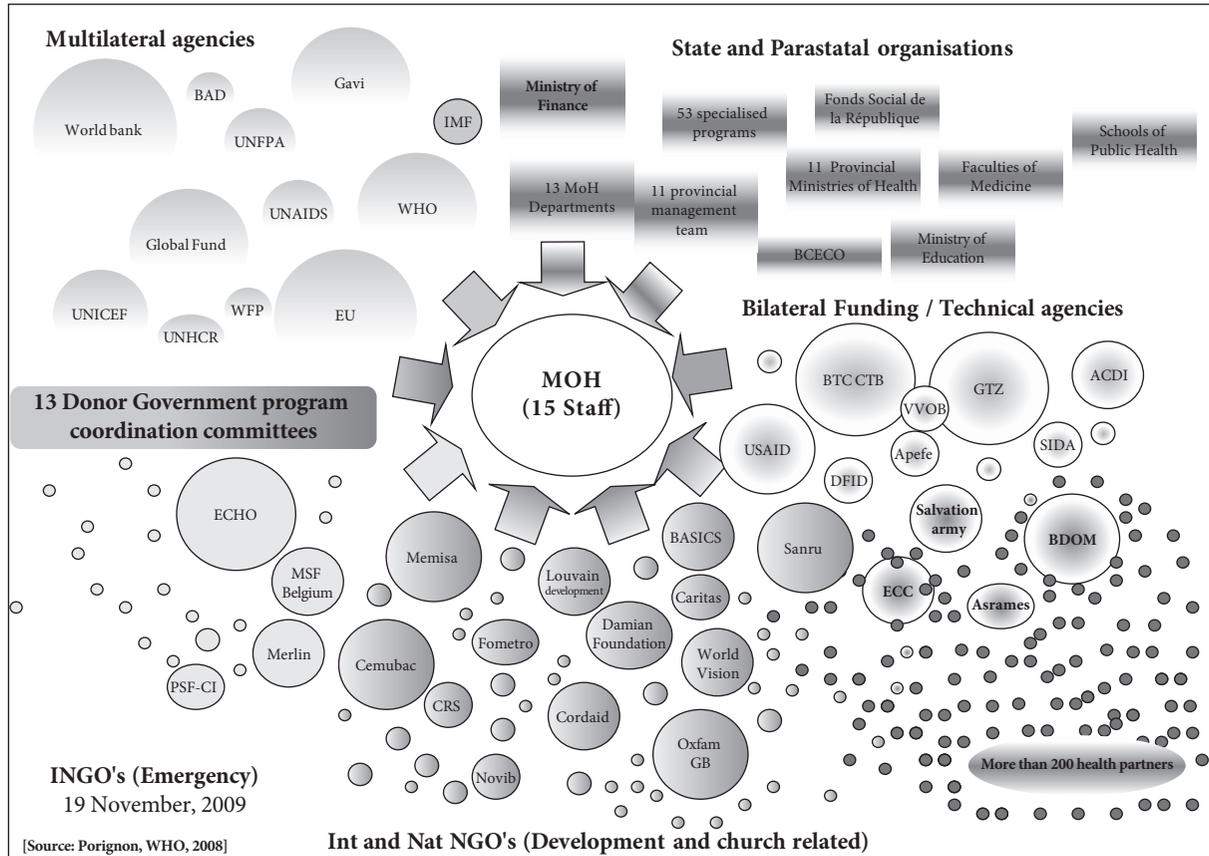


Fig. 9.2 'Schematic of multiplicity of players at the national level during crisis'.

Source: World Health Organization, 14. Reproduced with permission.

and donor agencies to 'harmonize' how health systems were monitored and evaluated. Based on the 2005 Paris Declaration on Aid Effectiveness, it aimed to increase transparency and accountability, particularly in low- and middle-income settings.⁵⁶ By evaluating and monitoring 'religious health assets' according to a shared framework, she argued, IHP+ could contribute to the mapping of FBOs, and therefore enhance their visibility.

The 2016 adoption of a 'Framework of engagement with non-State actors' at the 69th WHA was a further step in the formalization of relations between the WHO and external partners.⁵⁷ During the second decade of the twenty-first century, however, the relationship between the WHO and FBOs remained rather ad hoc and informal, and was activated chiefly during times of crisis with specific religious significance. The Ebola epidemic, which broke out in 2014, illustrates this.⁵⁸ From the perspective of the WHO, religious and spiritual practices or beliefs were both part of the problem and part of the solution. When the crisis broke out, some Christian ministers interpreted Ebola as divine punishment for homosexual practices.⁵⁹ Religious burial practices and traditional healers, who claimed to be able to cure the disease, were a major problem.⁶⁰ The WHO estimated that 60–80 per cent of the infections were linked to traditional burial practices:

In Liberia and Sierra Leone, where burial rites are reinforced by a number of secret societies, some mourners bathe in or anoint others with rinse water from the washing of corpses. Understudies of socially prominent members of these secret societies have been known to sleep near a highly infectious corpse for several nights, believing that doing so allows the transfer of powers. Ebola has preyed on another deep-seated cultural trait: compassion. In West Africa, the virus spread through the networks that bind societies together in a culture that stresses compassionate care for the ill and ceremonial care for their bodies if they die. Some doctors are thought to have become infected when they rushed, unprotected, to aid patients who collapsed in waiting rooms or on the grounds outside a hospital.⁶¹

While in some places there were violent clashes between emergency medical teams and the local population, FBOs elsewhere helped to build bridges between

⁵⁶ Evans and Kiemy, 'The International Health Partnership+.'

⁵⁷ World Health Organization, 'Sixty-Ninth World Health Assembly, Provisional Agenda Item 11.3'.

⁵⁸ Winiger, 'More Than an Intensive Care Phenomenon'.

⁵⁹ Crawford, *Ebola*; Hussain and Caspani, 'Gay Community under Attack in Liberia over Ebola Outbreak'.

⁶⁰ Manguvo and Mafuvadze, 'The Impact of Traditional and Religious Practices on the Spread of Ebola'.

⁶¹ World Health Organization, 'Factors That Contributed to Undetected Spread of the Ebola Virus'.

emergency medical aid and culturally deep-rooted practices and convictions: ‘Many faith-inspired initiatives started quickly and delivered wide ranging support (e.g., Caritas Internationalis and the Methodist Church); these initiatives included (besides healthcare) training of pastors and mobilization of volunteers, texting of health messages to congregations, and care for abandoned orphans.’⁶²

In this context, the WHO drew on resources from FBOs, which was also reflected in the guidelines. In order to conduct a ‘safe and dignified burial’, emergency workers were advised: ‘Always take into account cultural and religious concerns. [...] The burial process is very sensitive for the family and the community and can be the source of trouble or even open conflict. Before starting any procedure the family must be fully informed about the dignified burial process and their religious and personal rights to show respect for the deceased. Ensure that the formal agreement of the family has been given before starting the burial.’⁶³ After the burial the emergency team should engage the community for prayers (Figs. 9.3 and 9.4).



Fig. 9.3 Ebola health workers wearing protective equipment pray at the start of their shift. Monrovia, September 30, 2014.

Source: Reuters, ‘The Ebola Island Clinic’. Photo by Christopher Black/WHO. Reproduced with permission.

⁶² Marshall and Smith, ‘Religion and Ebola’. Regarding the commitment of Caritas Internationalis, cf. Robert Vitillo, ‘Response to Ebola Virus Disease (EVD): Guidelines for Planning and Provision of Pastoral and Social Support Services’, September 2014.

⁶³ World Health Organization, ‘How to Conduct Safe and Dignified Burial of a Patient Who Has Died from Suspected or Confirmed Ebola or Marburg Virus Disease’.

Step 11: Burial at the cemetery: engaging community for prayers

Engaging community for prayers as this dissipates tensions and provides a peaceful time

1. Respect the time required for prayers and funeral speeches
2. Family members and their assistants should be allowed to close the grave
3. Special attention should be given to the first shovel of earth, in general this is done carefully around the head area
4. Place an identification on the grave (name of the deceased and the date) and a religious symbol if requested
5. Recover all household gloves,
6. Place household gloves in an infectious waste bag for disinfection.
7. Burial team to attend funeral and offer condolences (sign book) or offer small gifts to support the funeral.
8. **Family to communally wash hands with disinfectant after the burial (using chlorine solution 0.05% or make an alcohol-based hand-rub solution available for hand hygiene performance) for all members involved in the funeral process.**
9. Thank the family members.

Fig. 9.4 Excerpt from WHO's guidelines for the 'safe and dignified' burial of victims of Ebola and Marburg virus disease (2014).

Source: World Health Organization, 'How to Conduct Safe and Dignified Burial of a Patient Who Has Died from Suspected or Confirmed Ebola or Marburg Virus Disease', 16. Reproduced with permission.

The positive contribution of FBOs to the management of the Ebola crisis was also appreciated in a speech by WHO Director-General Tedros Adhanom Ghebreyesus on the occasion of the 70th anniversary of the WCC. He emphasized not only the achievements of the Christian Medical Commission in the 1970s and 1980s but also the current developments. He concluded his address with a strong appeal for further cooperation, pointing also towards spiritual well-being:

As places of community and solidarity, churches and other faith-based institutions can play a vital role in promoting health. Faith leaders carry a voice of authority that sometimes speaks louder than that of governments and other leaders. Our shared vision should be for “Health Promoting Churches” all over the world that help to promote the physical and mental well-being of their people, as well as their spiritual well-being.⁶⁴

The Fate of the ‘Spiritual Dimension’ between Conflicting ‘Orders of Worth’

Does Tedros’ statement suggest that the WHO’s engagement with religion has been a ‘success story’? The conclusion we would draw is more ambivalent. What this study has brought to light is not least the precariousness of institutional memory. In the complicated institutional structure of the WHO, processes of reception and elaboration are paralleled by memory loss and setbacks. While an impressive range of WHO documents highlights the importance of a ‘spiritual dimension’ in healthcare, the status of this dimension has remained fragile and marked by tensions. This is not least due to the fact that the WHO discourses we examined are only loosely linked, which indicates a partial lack of intra-organizational coordination and reception. It is particularly striking that the most important document, the 1984 resolution, has almost completely disappeared from the institutional memory of the WHO.

In this respect, the breakthroughs documented in this volume appear more like seedlings that have not yet reached full bloom. This also applies to the WHOQOL-SRPB and to spiritual care in the WHO palliative care policy. It is true that the questionnaire was translated into many languages and that the palliative care guidelines were implemented in national programmes and legal frameworks. The resulting impact on the promotion of spiritual care should not be underestimated. However, the WHO itself has hardly ever used the questionnaire it developed, and the references to a ‘spiritual dimension’ in the more recent documents on palliative care are relatively sparse compared to earlier appearances.

⁶⁴ Ghebreyesus, ‘The 70th Anniversary of the World Council of Churches’.

The fate of a 'spiritual dimension' of health in the changing history of the WHO was highly dependent on the changing visions about the main goals of global health. As Tine Hanrieder has pointed out, these goals of global health owe themselves to conflicting 'orders of worth' which are embedded in moral narratives and visual representation. 'Orders of worth do precisely this: they imagine community on the basis of fundamental assumptions about human identity and the common good.'⁶⁵ Seen in this light, 'health' is a political concept which evokes and shapes different global communities: the biological community of human beings, the cosmopolitan community of free and generous citizens, the economic community of efficient producers, and the spiritual community of compassionate human beings. The competition and the fragile compromises of these four orders of worth can be observed in the changing history of the WHO. Alarmed by the Second World War, the Holocaust, and the atomic bomb, the goal of human survival dominated the first three decades of the WHO's existence. In the fight against infectious diseases, informed primarily by a biomedical, top-down approach, there was little room for spiritual aspects of healthcare. Things changed in the 1970s with the PHC approach, which Hanrieder assigns to a second 'order of value' in which solidarity and fairness are the guiding principles. In this context, the importance of a 'spiritual dimension' of global health was discovered and discussed. As early as the late 1980s, PHC was increasingly replaced by health policies oriented towards an economic rationality. Although this economic 'order of worth' was initially in pronounced tension with the inclusion of a 'spiritual dimension', after the turn of the millennium, economic considerations favoured a new valuation of (in)tangible 'religious health assets'. This latest development is significant in that it shows that the effort to embed a 'spiritual dimension' in global health policy can also succeed in an 'order of worth' that defines the common good independently from any spiritual framing. Depending on one's point of view, the history of the 'spiritual dimension' in WHO health policy can be seen as one of repeated marginalization, or rather, as one of successful resistance and creative reinvention.

Despite all humanistic ideals, the WHO has been marked by colonialism and by the hegemony of Western medicine.⁶⁶ The WHO's definition of health, which evolved during and after the Second World War in the spirit of social medicine, may be all-encompassing. Nevertheless, it originates in the particular tradition of Western, white, and male physicians. If the translation of this definition into German is already fraught with difficulties,⁶⁷ what happens when it is translated it into Mandarin or Arabic?⁶⁸ South African theologian James Cochrane, one of founders of ARHAP, put the problem in this way:

⁶⁵ Hanrieder, 'Orders of Worth and the Moral Conceptions of Health in Global Politics'.

⁶⁶ Amrith, *Decolonizing International Health*. ⁶⁷ See Chapter 2.

⁶⁸ For the case of Mandarin Chinese, cf. Winiger, 'Who Cares?' For the case of Arabic, see Chapter 4.

When we speak, in European languages for example, of the interface between religion and health, we express more than a worldview. We also express certain distinctions that are far from universal, and our ability to recognize this has an impact on our capacity to engage with local people in many contexts in ways that entrench and sustain appropriate public health activities. In Sesotho, for example [...] there are no direct equivalents for either 'religion' or 'health' [...]. The only appropriate Sesotho word is *bophelo* [...]. However, this word combines both our sense of what religion is and what *ubumi* [citizenship] health is, and also extends to include not just the individual body but also the social body from which the individual's health is inseparable.⁶⁹

What does it mean for global health that all available conceptions of 'health', 'healing', and 'good healthcare' are highly dependent on diverse cultural backgrounds and part of a specific order of worth built up by 'ennobling ideas' and moral narratives?⁷⁰ Which order, which narrative, and which understanding of health and healing should guide global health policy? And what does the pluralism of health concepts mean in relation to the right to health, which is enshrined in the preamble to the WHO's constitution and encompasses obligations to respect, to protect, and to fulfil?⁷¹ An extension of the social determinants of health by integrating cultural aspects, as proposed by the WHO's European Regional Office, may be a promising way to address the plurality of worldviews and the impact of personal beliefs on health and well-being.⁷² By articulating these determinants of health, the contexts of illness or recovery become visible as do the interpretational frameworks in which people understand their diseases and cures. As long as the 'spiritual dimension' is not excluded from the outset, spiritual aspects can be addressed as facets of these webs of interpretation and examined for their impact on physical and mental health. As detailed in this chapter, the 'religious health assets' programme led by James Cochrane and colleagues, has been instrumental in advancing this approach by making more visible the health work of FBOs.

Against this background, two things are indispensable to overcome the legacy of colonialism in the field of spirituality and healthcare: first, a reassessment

⁶⁹ Cochrane, 'Religion, Public Health and Church for the 21st Century', 68f.

⁷⁰ Cf. Chapter 3 and Hanrieder, 'Orders of Worth and the Moral Conceptions of Health in Global Politics'.

⁷¹ Cf. Office of the United Nations High Commissioner for Human Rights and World Health Organization, 'The Right to Health – Fact Sheet No. 31'.

⁷² For this, the EURO adopted the UNESCO concept of culture which includes a 'spiritual dimension': 'Culture should be regarded as the set of distinctive spiritual, material, intellectual and emotional features of society or a social group, and that it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs.' World Health Organization, Regional Office for Europe, 'Cultural Contexts of Health and Well-Being'.

of the values of secular public health, for the 'seemingly decontextualized sphere of global institutions is itself a cultural context among others'.⁷³ Second, the expansion of the epistemic community of health experts. A stronger integration of medical humanities and interdisciplinary spiritual care is a step in this direction. This book can also be read as evidence of the difficulties that such an epistemic expansion of global health policy entails. If it is essential to the WHO that it represent the world's inhabitants in health-related issues, then its legitimacy depends on it speaking for this global community and adequately safeguarding its interests.

Inevitably, the WHO stands in the conflict zone between different orders of worth and its ennobling ideas and narratives, formed by the 'hyper-goods'⁷⁴ of 'global survival' (through infectious disease control), 'justice in global health' (through primary healthcare and fair distribution of health assets), 'global productivity' (through economic development), and 'holistic health' (through compassion and spiritual care).⁷⁵ Since it is not foreseeable that one of these orders of value will definitely prevail in global health policy, the WHO has to face the question of the extent to which the views of the affected populations are included in the formation of orders of worth. As far as global health is characterized not only by structural violence⁷⁶ but also by epistemic injustice,⁷⁷ by the underrepresentation of affected groups in healthcare research and planning, the WHO falls short of the ambitious goals that it routinely invokes.

Broadening the epistemic community, as practised by the WHOQOL-SRPB researchers and other WHO working groups, undoubtedly has an impact on the main functions of the organization, as set out in Article 2 of the WHO's constitution: 'leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence based policy options, providing technical support to countries, and monitoring and assessing health trends'.⁷⁸ From a structural point of view, the WHO should be very well equipped against myopic planning. The Executive Board consists of 34 members, who are not supposed to represent the interests of their countries, but to contribute their expertise. As for the 'spiritual dimension' of healthcare, the EB acted in this way twice: in 1984 by adopting Halfdan Mahler's report, and in 1998 by affirming the enlarged version of the health definition (see Chapters 3 and 8). Even if the aspirations behind these discussions have not yet been fulfilled, an expansion of

⁷³ Hanrieder, 'The Public Valuation of Religion in Global Health Governance', 86.

⁷⁴ Cf. Taylor, *Sources of the Self*.

⁷⁵ Hanrieder, 'Orders of Worth and the Moral Conceptions of Health in Global Politics'.

⁷⁶ Farmer, *Pathologies of Power*.

⁷⁷ Carel and Kidd, 'Epistemic Injustice in Healthcare: A Philosophical Analysis'; Fricker, *Epistemic Injustice*; Bhakuni and Abimbola, 'Epistemic Injustice in Academic Global Health'.

⁷⁸ Office of the United Nations High Commissioner for Human Rights and World Health Organization, 'The Right to Health – Fact Sheet No. 31', 29.

the epistemic community has been initiated. Continuing this initiative would mean engaging in inter- and transcultural learning processes in which the WHO is in the position of a facilitator.

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Synthesis and Outlook

The Spiritual Dimension in Global Health

Simon Peng-Keller and Fabian Winiger

This chapter explores how the discussions of the preceding chapters might contribute to a better understanding of the ‘spiritual dimension’ of health as a useful concept for global health research and practice. The frequency with which the WHO refers to this term may be an indication that it has a significant function in the health context. It is clear from the previous chapters that it has often served as an umbrella term. Such terms are comprehensive at the cost of specificity. ‘Medicine’, ‘care’, and ‘science’ are examples of this trade-off. Umbrella terms are starting points, not operational concepts. They fulfil an integrative function. Thus, the term ‘spiritual dimension’ bridges the divide between the religious and the secular spheres.¹ A prominent example of this is the report *Cancer Pain Relief and Palliative Care*, according to which ‘spiritual’ ‘is not the same as “religious”, though for many people the spiritual dimension of their lives includes a religious component’.²

But the notion of a ‘spiritual dimension’ functions as more than a mere umbrella term. Even when it serves to bridge the gap between religious and secular approaches, the term is not merely a loose conceptual bracket. As philosopher John Cottingham writes, it points toward specific practices and attitudes that ‘command widespread appeal’:

The concept of spirituality is an interesting one, in so far as it does not seem to provoke, straight off, the kind of immediately polarised reaction one finds in the case of religion. This may be partly to do with the vagueness of the term [...]. Yet at the richer end of the spectrum, we find the term used in connection with activities and attitudes which command widespread appeal, irrespective of metaphysical commitment or doctrinal allegiance. [...] In general, the label ‘spiritual’ seems to be used to refer to activities which aim to fill the creative and meditative

¹ Bender and Taves, ‘Introduction: Things of Value’. For the historical background to this distinction, see Peng-Keller, ‘Genealogies of “Spirituality”’.

² World Health Organization, Expert Committee on Cancer Pain Relief and Active Supportive Care, *Cancer Pain Relief and Palliative Care*.

space left over when science and technology have satisfied our material needs. So construed, both supporters and opponents of religion might agree that the loss of the spiritual dimension would leave our human existence radically impoverished. [...] Spirituality has long been understood to be a concept that is concerned in the first instance with activities rather than theories, with ways of living rather than doctrines subscribed to, with praxis rather than belief.³

Cottingham's singling out of 'activities which aim to fill the creative and meditative space left over when science and technology have satisfied our material needs' indicates a line of thought that will be followed in this final chapter. As outlined in the previous chapters, the 'spiritual dimension' often refers to the aspirational and universalist ethos that has driven the WHO since its beginnings, to the ennobling idea of 'building a better world not in heaven but on earth, an effort that is not so very far from religion'.⁴ In this sense, the notion of the 'spiritual dimension' concerns not only a facet of health but also one of *healthcare*. The focus is not only on the populations and patients whose health the WHO is supposed to promote but also on all those who are responsible for health promotion and on their common goal: to secure the best possible care for all people. As we will highlight at the end of this chapter, the 'spiritual dimension', in the context of the WHO, turns out to be an evaluative concept closely linked with social justice.

In our attempt to synthesize a notion of the 'spiritual dimension' relevant across the many contexts in which the term occurs in WHO discourse, we will build on the most sophisticated attempt made within the WHO to outline in an evidence-based way what the 'spiritual dimension' encompasses: the WHOQOL-SRPB, whose cross-cultural development was reconstructed in Chapter 7. Focusing on this instrument clearly means a reduction in complexity. While it is not possible to bring together all the threads traced in the previous chapters in the WHOQOL-SRPB, this tool can serve as a magnifying glass through which the conceptual intricacies of this term emerge more clearly.

Spiritual Experiences and Attitudes across Cultures

The meaning of 'spiritual' in English research publications may differ from the everyday meaning of the term and its manifold translations.⁵ Of course, whether the state of mind of a patient can be labelled as 'spiritual well-being' or 'spiritual distress' by researchers or health professionals does not depend on whether the patient is familiar with this terminology. Nevertheless, the academic or

³ Cottingham, *The Spiritual Dimension*, 3.

⁴ Sigerist, *Medicine and Human Welfare*, vii.

⁵ For an example of the problems of translation, see Kwan, 'Negotiating the Meaning of Spirituality in Holistic Health Care from a Chinese Perspective'.

professional use of this term and its popular usage (which also varies in different contexts and social milieus⁶) are interrelated in complex ways. The plausibility of concepts like ‘spiritual well-being’ depends not least on whether people who consider themselves to be ‘spiritual’ are able to adopt them in their self-understanding. The WHOQOL-SRPB is particularly well-adapted to this requirement as a result of its cross-cultural development. In its identification of eight facets⁷ it concurs in many respects with Christopher Peterson and Martin E. P. Seligman’s seminal work on *Character Strengths and Virtues*⁸ as well as with more recent attempts to analyse the use of the term ‘spirituality’ in various everyday languages.⁹

The WHOQOL-SRPB differs in a central point from the other approaches outlined in this book: It doesn’t assume that spiritual well-being is an aspect of health, but conceives its eight facets as factors for health-related quality of life.¹⁰ Despite the reference to ‘personal beliefs’ in its name, the instrument does not focus primarily on beliefs, but rather on experiences (connectedness, awe, wholeness, spiritual strength, peace) and attitudes (hope/optimism, faith). Even if the relationship between experiences, attitudes, and beliefs remains unexplained, this approach has an obvious strength. By focusing on specific phenomena, the WHOQOL-SRPB avoids the myriad of different definitions and inconclusive discussions which often complicate analyses of abstract concepts (e.g., ‘justice’ or ‘love’).¹¹

Thus, in addition to being cross-culturally comprehensible, the instrument has the strength of mapping a cluster of distinguishable phenomena. It offers a heuristic matrix consisting of eight facets circumscribing and unfolding the ‘spiritual dimension’. To establish the conceptual consistency of the instrument, at least three objections must be discussed. The first concerns the distinction

⁶ Cf. Lüdeckens and Schimpf, ‘Observing the Entanglement of Medicine, Religion, and Spirituality’.

⁷ Connectedness to a spiritual being or force, meaning of life, awe, wholeness and integration, spiritual strength, inner peace/serenity/harmony, hope and optimism, and faith.

⁸ Peterson and Seligman, *Character Strengths and Virtues*.

⁹ Cf. Streib and Hood, *Semantics and Psychology of Spirituality*.

¹⁰ It should be noted that subjective quality of life as understood by WHO is a complex, value-oriented construct not reducible to hedonistic well-being, cf. World Health Organization, Division of Mental Health and Prevention of Substance Abuse, *WHOQOL: Measuring Quality of Life*, 1: ‘WHO defines Quality of Life as an individual’s perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person’s physical health, psychological state, level of independence, social relationships, personal beliefs and their relationship to salient features of their environment.’

¹¹ Cf. Bok, ‘Rethinking the WHO Definition of Health’, 419: ‘As with efforts to define many other abstract terms such as “happiness,” “suffering,” “love,” or “violence,” there are no agreed-upon rules for defining any of them; no established criteria for when they do and do not apply to particular circumstances [. . .]. The same is true of “health” and of “well-being.” Such abstract terms of universal scope provide ideal vessels into which people can place quite different, sometimes clashing, sorts of content.’

between the ‘mental’ and ‘spiritual’ dimensions. The second objection concerns the coherence of the instrument: Is there a feature common to the eight facets that justifies assigning them to a common domain? And finally, one may object to the evaluative conception of a ‘spiritual dimension’.

Distinguishing between the ‘Mental’ and the ‘Spiritual’

As already mentioned in Chapter 7, Alexander Moreira-Almeida and Harold Koenig have criticized the WHOQOL-SRPB for conflating mental health outcomes with ‘spirituality’. In their words: ‘Constructs such as well-being, meaning in life, and altruistic activities are usually, but not necessarily, related to spirituality—but should they be included in the definition itself?’¹² This objection points to a sensitive point of the discussion: the problem of the ‘healthification’ of spirituality.¹³ We shall concentrate here on the central issue to which Koenig and Moreira-Almeida draw attention: the question whether the eight facets can be adequately distinguished from phenomena usually assigned to the domain of mental health.

In their defence, the architects of the WHOQOL-SRPB emphasized the empirical result of the factor analysis, which confirmed the independence of the spiritual domain from the physical, psychological, social, and environmental domains.¹⁴ However, such an appeal to factor analysis may be unconvincing if it is not corroborated by further conceptual considerations. In the end, the decision to take account of a ‘spiritual dimension’ in healthcare is a political one, similar to the adoption of new human categories such as ‘disability’, ‘sexual orientation’, or ‘indigeneity’ by the UN.¹⁵ All categories used by political organizations like the WHO for assessing the needs of people from all ages, classes, and cultures must be continually examined. They need to be tested critically to ensure that they do not contribute to epistemic injustice by privileging certain interpretive patterns and devaluing others.¹⁶ As we have seen, the term ‘traditional medicine’, for example, tends to flatten and alienate the spiritual dimension of indigenous healing practices.¹⁷ Even the seemingly uncontroversial category ‘well-being’ is by no means unproblematic. A document on appropriate instruments for measuring quality of life, published by the WHO’s Regional Office for Europe in 2015, highlights that some questionnaires ‘have an in-built cultural bias. They define subjective wellbeing in terms of human flourishing in this world, a particularly

¹² Moreira-Almeida and Koenig, ‘Retaining the Meaning of the Words Religiousness and Spirituality’, 844. See also Edmondson et al., ‘Deconstructing Spiritual Well-being’.

¹³ Cf. Borup, ‘Pizza, Curry, Skyr and Whirlpool Effects’.

¹⁴ Cf. Fleck and Skevington, ‘Explaining the Meaning of the WHOQOL-SRPB’.

¹⁵ Cf. Bennani and Müller, ‘“Making Up People” Globally’.

¹⁶ Carel and Kidd, ‘Epistemic Injustice in Healthcare’.

¹⁷ See Chapter 5.

modern, secular, European definition of wellbeing. Many individuals and cultures throughout human history would see well-being not in terms of human flourishing but in terms of alignment with a spiritual dimension.¹⁸ The SRPB module corrects this cultural bias by focusing attention on such alignment.

Reframing quality of life by introducing a new dimension called 'spiritual' is justified if it draws attention to significant aspects of quality of life that have been omitted from previous classification systems. The introduction of the 'spiritual dimension' into its taxonomic vocabulary reflects the WHO's concern to envision and facilitate a more inclusive global health. With its eight facets, examined in more detail below, the module contributes to a differentiation of health-related perceptions and decisions. It counteracts exclusionary tendencies and epistemic injustice within global health and accommodates the self-conception of large populations.

With regard to the WHOQOL's biopsychosocial concept of 'quality of life', the contribution of the SRPB module can be interpreted in two different ways: It may either consist in a *linear extension* where the 'spiritual dimension' is attached to physical, mental, and social dimensions; or it may be conceived as orthogonal to these dimensions, as their *depth dimension*.¹⁹ In the first case, 'spiritual' refers to an extra-ordinary sphere; in the second case, to a dimension that can also be found in everyday reality. Since the SRPB questionnaire was designed as an additional module for the existing WHOQOL instrument, it is convenient to understand it in the first sense. But it can also be understood in the second sense.²⁰ In their response to their critics, the main authors of the instrument point in this second direction when they try to explain in what way 'inner peace, serenity and harmony' is more than 'mental wellbeing'. The working definition of this facet, Fleck and Skevington remind us, was defined as:

The extent to which people are at peace with themselves. The source of this peace comes from within the person and can be connected to a relationship the person will have with God, or it may be derived from their belief in a moral code or set of

¹⁸ World Health Organization, Regional Office for Europe, *Beyond Bias*.

¹⁹ An attempt to operationalize a transversal approach is to be found in Bélanger et al., 'The Quebec Model'. Along the same lines are formulations that emphasize the integrative character of a 'spiritual dimension', cf. World Health Organization, Expert Committee on Cancer Pain Relief and Active Supportive Care, *Cancer Pain Relief and Palliative Care*, 50f.: 'The spiritual aspect of human life may be viewed as an integrating component, holding together the physical, psychological and social components.'

²⁰ This is consistent with the 1989 document World Health Organization, Expert Committee on Cancer Pain Relief and Active Supportive Care, *Cancer Pain Relief and Palliative Care* (cf. Chapter 6), according to which 'spiritual' refers 'to those aspects of human life relating to experiences that transcend sensory phenomena. [...] The spiritual aspect of human life may be viewed as an integrating component, holding together the physical, psychological and social components.' A theological attempt to conceptualize spiritual experiences as a depth dimension of daily experiences is to be found in Rahner, 'Experience of the Holy Spirit'.

beliefs. The feeling is of serenity and calmness. Whenever things go wrong this inner peace helps you to cope. It is viewed as a highly desirable condition.²¹

The argument goes: Mental well-being and ‘inner peace/serenity/harmony’ should be kept apart analytically because the latter points to a special resource not reducible to others.²² One could try to make this plausible through cases where mental well-being and spiritual resources come apart. As the 2004 report *Promoting Mental Health* cited above highlights, ‘Spirituality can enable people to step outside or beyond the mental distress and experience comfort and calm. Especially in the midst of crisis, particular kinds of spirituality can prove to be a powerful resource which can be a real buffer against excessive mental distress and despair.’²³ Conversely, it may be argued that high psychological well-being is not necessarily associated with the phenomena indicated by the WHOQOL-SRPB facet ‘inner peace/serenity/harmony’.

A Coherent Matrix for Spiritual Resources?

In the previous section, two main strengths of the WHOQOL-SRPB were identified: its cross-cultural development and its mapping of a cluster of distinguishable phenomena. The latter will be further unfolded in this section, which discusses the objection that the instrument lumps together disparate phenomena by subsuming them into a common category. As already emphasized, it should not be disputed that the instrument lumps together phenomena which could also be categorized otherwise or left out of consideration. For all categories concerning human life are constructed by a discursive process of lumping and splitting.²⁴ We therefore focus here solely on the question of whether subsuming the aforementioned facets under a common category is justifiable. For this purpose, we shall analyse the facets in more detail. Two facets are explicitly described as ‘spiritual’ ones: *spiritual strength* and *connectedness to a spiritual being or force*. The term also appears in an item for the facet of awe: ‘To what extent do you feel spiritually touched by beauty?’ In all three cases the specification as ‘spiritual’ serves to identify specific experiences of connectedness, strength, and beauty. In this way they are distinguished from nearby phenomena, such as connectedness with human beings, physical strength, or being touched by beauty in a more ephemeral way.

A similar device is the metaphor of inwardness that is common in discourses about spirituality. We find it in the facet ‘*Inner peace/serenity/harmony*’ as well as

²¹ Fleck and Skevington, ‘Explaining the Meaning of the WHOQOL-SRPB’, 68.

²² Cf. Pargament and Mahoney, ‘Spirituality: The Search for the Sacred’.

²³ World Health Organization, ‘Promoting Mental Health’, 56.

²⁴ Zerubavel, ‘Lumping and Splitting’, 421.

in the related items: ‘To what extent do you feel peaceful *within yourself*?’, ‘To what extent do you have *inner peace*?’ The function is clear: It is not ‘peace’ and ‘harmony’ as intersubjective qualities that are of interest, but more subjective experiences linked with the attitude of serenity. Closely connected with this finding are two of the other facets of the cluster: *Wholeness and integration* and *Meaning of life*. *Wholeness* is covered by questions concerning both *connection* and *balance between mind, body, and soul*. Reminiscent of the classical triad of body, soul, and spirit, the sequential ordering of the terms is as striking as the distinction between mind and soul. This obviously refers to an experience of wholeness that is not limited to a harmonious relationship between *body and mind*, but points beyond it by adding the soul. A slightly different wholeness is associated with the term ‘integration’. The two connected items read: ‘To what extent do you feel the way you live is consistent with what you feel and think?’; and: ‘How much do your beliefs help you to create coherence between what you do, think and feel?’ The items touch the field of virtue ethics and the empirical study of character strength.²⁵ In the next section we will examine whether it is appropriate to understand spiritual attitudes as virtues (or vice versa).

That *Meaning of life* also appears among the eight facets is of little surprise. It is a widespread assumption that the search for the meaning of life is, or at least can be, a spiritual quest. For the sake of better differentiation, recent philosophical discussion and empirical research has distinguished between ‘meaning of life’ and ‘meaning in life’.²⁶ While the latter can be achieved through specific life contents, activities, and related experiences (family, job, hobbies, etc.), the former concerns a more fundamental question that may be called ‘existential’ or ‘spiritual’. Curiously, the first two items in the facet ‘meaning of life’ are focused on ‘meaning in life’: ‘To what extent do you find meaning in life?’; ‘To what extent does taking care of other people provide meaning of life for you?’ The third item asks the fundamental question ‘To what extent do you feel your life has a purpose?’, while the fourth item can be understood both on a fundamental and on a more pragmatic level: ‘To what extent do you feel you are here for a reason?’

The facet *Hope/Optimism* shows a similar ambivalence. While it is widely accepted that certain forms of hope qualify as spiritual, the four items are remarkably non-specific in this regard: ‘How hopeful do you feel?’; ‘To what extent are you hopeful about your life?’; ‘To what extent does being optimistic improve your quality of life?’; ‘How able are you to remain optimistic in times of uncertainty?’ Similar questions arise, finally, with regard to the items of the *Faith* facet as well.

²⁵ Niemiec et al., ‘The Decoding of the Human Spirit’.

²⁶ For a discussion of the relationship between ‘meaning of life’ and spirituality, cf. Cottingham, *On the Meaning of Life*.

To what extent do these eight facets form a coherent and useful matrix to identify factors which influence quality of life significantly *and* which are not yet covered by the other domains of the WHOQOL (i.e., physical, psychological, level of independence, social relationships, environment)? The second sub-question may be answered without further elaboration. Even if there were good reasons for ‘lumping’ some of the eight facets under the psychological domain, it should be clear that the items of the SRPB module *as a whole* cover an area that can only be inadequately categorized in the psychological domain and even less satisfactorily in the others. With regard to the empirical evidence that the facets refer to factors highly significant in the context of severe disease and the end of life, the extension of the original WHOQOL version with the SRPB module follows a rationale consistent with the goals of clinical practice and public health.

But what about the question of conceptual coherence? Do the eight facets form a cluster of phenomena that are related to each other and not just randomly lumped together? From our point of view, at least two answers are worth considering. The first recurs to causality. The coherence of the cluster is likely to result from a causal relationship of mutual reinforcement. For instance: experiences of connectedness (with a spiritual being), of meaningful life or of wholeness, as well as attitudes like hope or faith, tend to promote inner peace and spiritual strength. According to the second answer to be considered, the coherence of the eight facets owes itself to a common orientation. What makes their grouping plausible is their reference to what Thomas Luckmann called the ‘great transcendence’, in contrast to the ‘little’ and ‘intermediate’ transcendences of everyday life.²⁷ While the other domains of the WHOQOL explore the latter, the SRPB module turns to the former. It examines the depth dimension of ordinary phenomena and the encompassing whole. In this way, the instrument counteracts not only the tendency of modern medicine to split human life into fragmented components but also those reductionist approaches that deny or flatten the distinction between the ‘mental’ and the ‘spiritual’ dimensions.²⁸

The ‘Spiritual Dimension’ as an Evaluative Concept

Consistent with the majority of the WHO documents examined in this volume, the WHOQOL-SRPB assesses spiritual experiences and attitudes exclusively as beneficial to quality of life and health. One may ask where that leaves the ‘dark’ side of the spiritual dimension: troubling beliefs, spiritual distress, etc.²⁹

²⁷ Luckmann, ‘Shrinking Transcendence, Expanding Religion?’.

²⁸ Cf. Pargament and Mahoney, ‘Spirituality: The Search for the Sacred’.

²⁹ Cf. for instance Abu-Raiya et al., ‘Understanding and Addressing Religious and Spiritual Struggles in Health Care’.

It is striking that the WHOQOL-SRPB only asks about positive factors, although numerous studies have shown that quality of life is negatively affected by some forms of religious coping or spiritual beliefs. This exclusive attention to positive spiritual factors is in line with the ICD (International Classification of Diseases), the diagnostic manual of the WHO. While the US-American DSM (Diagnostic and Statistical Manual of Mental Disorders) introduced in 1994 the diagnosis 'Religious or Spiritual Problem' (V62.89),³⁰ nothing similar is to be found in the ICD to date. To put it positively, the WHO has avoided pathologizing the spiritual realm. The eight facets of the WHOQOL-SRPB indicate possible resources or 'intangible assets'³¹ which should be respected and taken into account by health-care providers.

This brings us to a crucial aspect of the WHO's approach to the 'spiritual dimension': In the WHOQOL-SRPB, as well as in most of the documents analysed in this book, the 'spiritual' functions not only as a descriptive term but also as an affirmative or evaluative one (similar to 'educated'). 'Spiritual' refers to a special kind of well-being (distinct from physical and mental well-being) as well as to virtuous attitudes and to altruistic action inspired by 'ennobling ideas'. Or, again, in the words of Cottingham, quoted at the beginning of this chapter: 'spiritual' points to 'activities which aim to fill the creative and meditative space left over when science and technology have satisfied our material needs'.³²

In Halfdan Mahler's report from 1983 (see Chapter 3), this evaluative quality is particularly clear. What initially appeared to be merely a diplomatic formula has turned out to be a key concept closely linked with social justice and the ethos of human rights. In this version, the 'spiritual dimension' is much more than a vague umbrella term. The evaluative quality facilitates a conceptual delimitation: Only what is compatible with altruistic goals and inspires selfless action is to be called 'spiritual'. This close intertwining of spiritual life and virtuous action corresponds well to the understanding of traditional faith traditions and current approaches in positive psychology³³ as well as to the self-understanding of all those who, whether religious or not, call themselves 'spiritual' today. Most of them share the idea 'that real spirituality is about living a virtuous life, one characterized by helping others, transcending one's own selfish interests to seek what is right'.³⁴

Inspiration for the Future Development of Global Health

What inspiration can be drawn from the WHO documents studied here for future developments in this field? At least four points can be identified.

³⁰ Lukoff et al., 'DSM-IV Religious and Spiritual Problems'; Chandler, 'Religious and Spiritual Issues in DSM-5'.

³¹ Cf. Chapter 9. ³² Cottingham, *The Spiritual Dimension*.

³³ Cf. Niemiec et al., 'The Decoding of the Human Spirit'.

³⁴ Ammerman, 'Spiritual but Not Religious?'

A first point concerns conceptual clarification. In particular, against the background of the WHO discussions just recapitulated, a case can be made for a clearer distinction between the 'mental' and the 'spiritual' dimensions. Following on from what has been said above, we suggest elaborating the latter as a *depth dimension* which emerges in physical, mental, and social phenomena—in practices, attitudes, and experiences—without being subsumed into them. But there is another, more pragmatic aspect to the distinction between the 'mental' and 'spiritual' dimensions hinted at in the documents studied. If one recognizes faith-based organizations as key partners in global health, then one must make accommodation for their self-understanding as spiritually motivated actors for whom the spiritual dimension extends far beyond the realm of mental health.³⁵ Thus, the term 'spiritual dimension' points also to communities embodying their 'spirituality' in practices that affect the physical and social dimensions of human life no less than the mental.

Secondly, inspiration may be drawn from the WHO's attempts to foster inter-professional collaboration in healthcare. These efforts respond to the functional differentiation of modern society, which becomes manifest in the health sector in the form of increasing professional specialization. More and more increasingly specialized professions are involved in ever more complex healthcare systems. This includes, not least, the further professionalization of healthcare chaplaincy as a profession specialized in spiritual care distinct from psychotherapy and psychological counselling.³⁶ Insofar as the 'spiritual dimension' refers to something which encompasses and permeates all other dimensions (and does not stand solely for a further particular aspect of human life), spiritual care-givers are, paradoxically, specialists for the whole. So far, the WHO has taken up this development only with regard to palliative care (see Chapter 6). However, its innovative strategy for interprofessional collaboration presented in 2010³⁷ has laid a solid foundation for involving specialized spiritual care-givers in other areas as well. Through their expertise they contribute to the interprofessional task of creating a 'shared understanding that none [of the collaboration professionals] had previously possessed or could have come to on their own'.³⁸

This leads us to a third point of inspiration, which concerns the need to cope with spiritual plurality in healthcare. Though not everything that is said within WHO documents on the 'spiritual dimension' is equally convincing, the communicative processes that brought them forth are instructive for future developments. We can identify at least four pathways for dealing creatively with the plurality of sometimes conflicting approaches to the spiritual dimension: conceptual

³⁵ On a communitarian approach to spiritual care, see Balboni and Balboni, *Hostility to Hospitality*.

³⁶ This development began as early as 1925 at Boston Massachusetts Hospital with the founding of Clinical Pastoral Education, cf. Myers-Shirk, *Helping the Good Shepherd*.

³⁷ World Health Organization, 'Framework for Action on Interprofessional Education and Collaborative Practice'.

³⁸ World Health Organization, 'Framework for Action on Interprofessional Education and Collaborative Practice', 36.

thinning,³⁹ multi-coding, interdisciplinary consensus-building, and cross-cultural empirical investigations. While the first two strategies were particularly tangible in the discussions within the 36th and 37th World Health Assemblies, the last two can be found, for example, in the development of the WHOQOL-SRPB and, to some extent, in the cooperation with the African Religious Health Assets Programme. All these approaches could and should be developed in pursuit of the goal of equitable and holistic healthcare. Why not try to further elaborate and integrate these four approaches?

A fourth and final point of inspiration arises from the previous discussion about the ‘spiritual dimension’ as an evaluative concept. While the health-related evaluation of spiritual factors has so far tended to raise the suspicion that an intrinsically valuable good is being used for medical purposes, the discussions traced in this book point in a different direction. The WHO has a singular role in discussions about health-related spirituality as it places it in the framework of global solidarity and human rights. This evaluative framing deserves further attention in future discussions. Bearing in mind the problem of epistemic injustice, all of the categories used in global healthcare for assessing health-related needs must be informed by the target groups and critically examined for biases of any kind. The introduction into the WHO’s vocabulary of the ‘spiritual dimension’ as an evaluative concept is a first step towards the self-conception of large populations whose understanding of health is still underrepresented in global health discourses.

Commitment to the common good of global health itself draws on spiritual sources. In the face of intensifying global threats, this broadening of the horizon is likely to become even more important. The inclusion of a ‘spiritual dimension’ is not a spillover of late-modern healthcare, but may be a part of the solution in a time of global crisis. The idea of being one and whole as an individual or as a community, on a local or a global level, is at its core a spiritual one, and it is at the heart of the health organization that this book takes as its subject. It is entirely appropriate that its name recalls the world that is the shared habitat of the global community.

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³⁹ Cf. Hanrieder, ‘The Public Valuation of Religion in Global Health Governance’.

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Epilogue

The WHO and Religious Actors during the Covid-19 Pandemic

Fabian Winiger

For much of its existence, the World Health Organization has done its work without attracting much scrutiny from the general public. With the Covid-19 pandemic, it has been thrust into the spotlight of global media attention. Accusations of pandering to political interests and calls for increased transparency and accountability have been followed by threats of defunding. Caught between a geopolitical struggle, a general loss of trust in public and multilateral institutions, and the virulence of abstruse conspiracy theories, the WHO has found itself in one of its most challenging moments since its founding in 1948. It may seem like an odd moment to turn our attention to what, admittedly, may seem like something of a sideshow.

In the 1970s and 1980s, the ‘spiritual dimension’ of health made its debut in the World Health Assembly in the context of the failure of a decades-long campaign to eradicate malaria, and the emergence of an alternative approach—what would be called ‘primary healthcare’. Spirituality has since typically been understood as a way of broadening medicine beyond the ‘curing’ of disease,¹ most relevant where complex and chronic lifestyle diseases call for the involvement of local communities and comprehensive, patient-centred healing. As the pandemic has shown, however, concern for spiritual needs is not only ‘nice to have’: early on, the rapid spread of the novel coronavirus in religious communities in South Korea and Iran powerfully demonstrated that the outbreak is a social as well as an ‘intensive care phenomenon’.² Religious actors have since regularly been implicated in superspreader events, such as a crowded funeral held for the senior bishop in Montenegro, attended by the patriarch of the Serbian Orthodox Church, who later passed away following a Covid-19 infection.³

¹ Kleinman, *Illness Narratives*. ² Winiger, ‘More Than an Intensive Care Phenomenon’.

³ Barry, ‘Serbia’s Orthodox Patriarch Tests Positive after Presiding over a Packed Funeral’. Despite ‘decimating’ the leadership of the Serbian and Montenegrin Orthodox Church, rituals reportedly continued without strictly enforced social distancing measures, including the taking of communion from a shared spoon and the kissing of bodies lying in state. Delauny, ‘Serbia Coronavirus’.

Much like during the 1970s, when the recurrence of malaria forced international health experts to sit at the same table as local communities and rethink the ‘top-down’ eradication of disease, the Covid-19 crisis has led to an unprecedented consultation with civil society stakeholders. While it is early days yet, it seems clear that the pandemic has generated sufficient institutional momentum to bring the ‘spiritual dimension’ of health to the attention of the organization’s senior leadership, where religious actors are recognized as potential partners in the global vaccine rollout. In March 2020, a ‘high-level dialogue’ was held between Director-General Tedros A. Ghebreyesus and leaders of Religions for Peace, a well-connected FBO which describes itself as a ‘movement changing the world and challenging the status quo through our mutual conviction that religions are more powerful, inspiring, and impactful when they work together’.⁴ The WHO’s Director-General affirmed the ‘wish to formalize WHO’s partnership with the faith community for both the COVID-19 response and the broader agenda of Health for All’, and expressed the view that ‘faith leaders and faith institutions play an important role in upholding health as a human right.’⁵ Though the pandemic was a catalyst, this suggests that the senior leadership hopes to partner with religious actors beyond the immediate and temporary necessities of global health emergencies. The ‘spiritual dimension’ of health, then, may become of greater interest to WHO staff working in fields such as mental health and palliative care, where religion plays an important but often poorly understood role. For the time being, the Director-General’s call for ‘partnership with the faith community’ has been taken up in the institutional response to the coronavirus pandemic.

Towards a ‘WHO Strategy for Faith Engagement’

In early 2020, the WHO created an internal taskforce with the curious acronym ‘EPI-WIN’ (‘Information Network for Epidemics’). It was asked to communicate the organization’s technical advice and address what WHO calls the ‘second disease’: the spread of dis- and misinformation.⁶ Shortly after, EPI-WIN reached out to well over 60 religious actors and communities, some of whom have for decades provided healthcare in the Global South. The ensuing exchange stands as one of the most extensive conversations the organization has had with religious groups to date, and resulted in the creation of detailed guidelines on topics such as

⁴ Religions for Peace, ‘Who We Are’, para. 4.

⁵ World Health Organization, ‘WHO Director-General and Global Faith Leaders High-Level Dialogue on COVID-19’, para. 7.

⁶ World Health Organization, ‘Infodemic Management – Infodemiology’.

gatherings, safe burial practices, and religious leaders' role in health education.⁷ The guidelines were hoped to build a bridge to populations in countries where the credibility of institutions is weak, and religious communities are key to communicating public health information. As argued by a former UNAIDS adviser engaged by EPI-WIN to consult on this engagement, religious actors are relied on by their communities as a trusted source of advice: 'few people have the opportunity to speak to their faithful personally on a weekly basis, politicians certainly don't.'⁸ Indeed, in some countries, they 'have been holding their governments to account' in the face of inadequate official responses to the pandemic.⁹

In the past, the WHO has often been late to engage with religious actors. This time, it took a more proactive approach. Shortly after the release of these guidelines, the 'Faith and Positive Change for Children, Families and Communities' initiative, a partnership between the United Nations Children's Fund (UNICEF), the Joint Learning Initiative on Faith and Local Communities and Religions for Peace—an international multifaith coalition advocating for humanitarian issues which works closely with WHO through the Inter-Agency Task Force—developed the WHO guidelines into more accessible and practical documents, including specific examples from scriptures which could be used to encourage the adoption of safe worship practices.¹⁰

Building on this initiative, EPI-WIN broadened its outreach to religious actors, with around 1,000 groups and individuals signing up to its mailing list.¹¹ In late 2020, it began to develop this initiative into a coherent 'strategy for faith engagement'. Based on a list of nine guiding principles,¹² it set out to facilitate the WHO's engagement with religious communities in future health emergencies. In addition to an event highlighting collaboration between the Sri Lankan ministry of health, the WHO, and FBOs during the pandemic and a technical briefing for FBOs on vaccine equity and access, EPI-WIN joined with UNICEF and Religions for Peace to organize several webinars on the 'role and impact' of religious actors in equitable vaccine access.¹³ In the most recent webinar, for instance, WHO staff addressed the question of how to build trust with religious communities by responding to fears such as that Covid-19 vaccines were not *halal*.¹⁴

⁷ World Health Organization, 'Practical Considerations and Recommendations for Religious Leaders and Faith-Based Communities in the Context of COVID-19 – Interim Guidance'.

⁸ Smith, 'Religious Engagement in the Covid Response'.

⁹ Smith, 'Religious Engagement in the Covid Response'.

¹⁰ Welsh, 'Faith Leaders Have Key Role in Stopping Spread of COVID-19, UNICEF Says'.

¹¹ Email exchange, EPI-WIN faith consultant, 5.8.2021.

¹² '1. Respect human rights, gender equality, and inclusion, 2. Be nationally led, 3. Promote shared values, 4. Be informed by data, 5. Respect religious differences, 6. Be fully representative, 7. Be community centred and accountable, 8. Nurture trust, 9. Be open and transparent'. World Health Organization, 'Collaboration in Health Emergencies: WHO, Faith Actors and National Governments', 8.

¹³ World Health Organization, 'COVID-19 Vaccine Communications Webinar Series'.

¹⁴ Frost and Dore, 'Trusted Voices'.

Concurrently, EPI-WIN established three ‘communities of practice’ involving WHO staff and religious actors. They collaborated with WHO staff in three areas of shared interest: one on vaccine communications, which includes the co-development of simplified messages for and by religious communities, the creation of a repository of trusted resources and advocacy on vaccination equity; one to co-develop a framework for engaging with ‘faith partners’; and one to identify shared research needs, training, and capacity-building, which focused on spiritual and palliative care and medical racism.¹⁵ By mid-2020, each community of practice numbered 40–50 members. Based on these consultations, the ‘EPI-WIN Faith Network’, as these groups are referred to internally, advised the WHO in the organization of a major virtual conference on topics of particular interest to religious communities during the Covid-19 pandemic. Three conference themes were planned corresponding to the work of these three communities of practice. The event was held over the course of several weeks in late 2021.¹⁶

The collaboration on this conference is significant in several ways. Firstly, these themes were decided not primarily on the basis of international health diplomacy or WHO-internal institutional priorities—as has so often been the case in the past—but represented the needs of a highly diverse community of religious leaders, faith-based health providers, advocacy groups, and other civil society actors working at the intersection of religion and global health. Secondly, the conference informed the creation of a framework on engaging with religious actors, comparable with those long established at other UN agencies such as UNAIDS.¹⁷ The strategy, the first of its kind in WHO history, was published shortly after.¹⁸ It was also the first time WHO engaged directly with spiritual care providers and healthcare chaplains. Finally, the intention appears to have been not merely the promotion WHO’s own efforts, but building trust and partnership. This was evident most clearly in plans for a third conference theme, organized in partnership with the WHO Collaborating Centre for Global Health Histories, which was hoped to acknowledge the painful history of medical racism, the legacy of which has played an important role in vaccine hesitancy, particularly in former colonial states.

The changing attitudes reflected in these events are also significant in that they may be understood as a departure from the WHO’s approach to religious actors in the past. While a critical reading might question whether religious actors are

¹⁵ Smith, ‘Religious Engagement in the Covid Response’.

¹⁶ World Health Organization, Information Network for Epidemics, ‘WHO and Religions for Peace Global Conference on Strengthening National Responses to Health Emergencies’.

¹⁷ UNAIDS, ‘Partnership with Faith-Based Organizations: UNAIDS Strategic Framework’.

¹⁸ World Health Organization, Information Network for Epidemics, ‘World Health Organization Strategy for Engaging Religious Leaders, Faith-Based Organizations and Faith Communities in Health Emergencies’.

indeed seen as ‘partners’—or whether this engagement primarily serves to co-opt religious communities to ‘amplify’ WHO messaging¹⁹—the developments described here suggest a new understanding that religious actors work most effectively in the interest of the organization if it listens to their needs in humility. An indicator of this change may be found in a comment of the Director-General at a civil society consultation held in 2020. Rather than taking questions from the audience, he implored participants to advise the WHO on what it should do: ‘the world is upside down. This happens only once, not even, in a hundred years. Just tell us what you think, and I will personally take it seriously and make it happen.’²⁰ For an organization whose legitimacy seems to be premised on knowing best, it might be argued, this represents something of a revelation. This is reflected in the approach taken by EPI-WIN. The strategy for engaging with ‘faith partners’, for instance, was not developed primarily by a panel of experts based in Geneva, but through a broad, multifaith and bottom-up process based on regular dialogue with members of the respective community of practice, which in turn consulted with their own organizations and religious communities, and fed their comments back into the drafting of the document.

The emerging approach to civil society engagement which has become evident during the Covid-19 pandemic built on the sediment of institutional memory throughout the historical episodes traced in this book. Several WHO staff and members of major FBOs involved in the creation of the guidelines for religious communities in early 2020, for example, had been involved in the response to the West African Ebola epidemic (2014–2017) and the production of the WHO guidelines on ‘safe and dignified’ burial for its victims,²¹ which in turn benefited from the experience with HIV/AIDS.

Another factor has been the democratizing possibilities of videoconferencing technology, which amidst global quarantine measures saw widespread adoption. The WHO headquarters in Geneva, too, moved staff to home offices wherever possible, and many of the developments outlined here transpired via videoconference calls. As in other international organizations, this changed both the pace of interactions and the ease with which conversations were held across vast distances. In the historical past traced in this book, the ‘world’ of the World Health Organization was divided by months of travel by steamship, or days by plane. During the pandemic, as dozens of religious actors across the globe convened with WHO staff, the world became a smaller place. It is difficult to imagine how the organization could otherwise have reached out to over 60

¹⁹ On the co-optation of local communities, see the ‘pragmatic’ discourse described in Chapter 5.

²⁰ Ghebreyesus, ‘WHO DG Webinar with Civil Society: Civil Society Engagement in COVID-19 Response at National and Local Levels’.

²¹ World Health Organization, ‘How to Conduct Safe and Dignified Burial of a Patient Who Has Died from Suspected or Confirmed Ebola or Marburg Virus Disease’.

participants in such a short time, as it did during the creation of the Covid-19 guidelines. Paradoxically, the social distancing measures advocated, no less, by the WHO itself, forced a new form of professional, interpersonal, and for some indeed spiritual connectedness untethered from geographic boundaries.

If the consultation across geographic divides was supported by the mass adoption of videoconferencing technology, cultural barriers were mitigated by WHO staff who were widely perceived as approachable and open-minded. Through a ‘community of practice’ model, gently moderated to facilitate an egalitarian atmosphere, these consultations were marked by a sense of mutual respect and genuine concern. A factor in the success of the WHO’s strategy for faith engagement thus far, then, has been a manner of dialogue which is both ‘high-level’ and ‘eye-level’.

Lastly, the suspension of bureaucratic hurdles in face of an unprecedented global health crisis has played a decisive role, and in early 2020 allowed the rapid production of guidelines for religious communities. But this is unlikely to survive the return to the normal course of business. The importance of multi-stakeholder ‘private–public partnerships’ in the UN system, affirmed in Goal 17 of the Sustainable Development Goals,²² however, will continue, and informs the strategic direction of the WHO, which in 2016 adopted the ‘Framework of Engagement with Non-State Actors’.²³ The participation of non-state actors in some aspects of the WHO’s activities seems to be welcomed by many Member States, reflected in a resolution passed in May 2021, backed by 74 countries, to extend the rights of the Holy See, currently a non-Member State Observer to the World Health Assembly, to include participation in debate and co-sponsoring of resolutions.²⁴

If the period of the 1970s and 1980s was a time of ‘cross-pollination’ and the institutionalization of the ‘spiritual dimension’ in the WHO, and the 1990s to early 2000s was a period of cooling-off and crisis, as we have argued elsewhere,²⁵ then the creation of a legal mechanism for FBOs to engage with the WHO as non-state actors might turn out to be the next milestone in what we have tentatively identified as a period of renewed interest in the evolving relationship between the WHO and religious actors.

²² UNDESA, ‘Goal 17 | Strengthen the Means of Implementation and Revitalize the Global Partnership for Sustainable Development’.

²³ World Health Organization, ‘Sixty-Ninth World Health Assembly, Agenda Item 16.1: Strengthening Integrated, People-Centred Health Services – 28 May 2016’.

²⁴ For the full list of privileges, which does not include the right to vote or propose candidates, see World Health Organization, ‘Seventy-Fourth World Health Assembly, Agenda Item 32’. Note that the special position of the Holy See at the United Nations remains contested, not least from liberal, pro-choice Catholics. See Beitinger-Lee, ‘Catholicism at the United Nations in New York’.

²⁵ Winiger and Peng-Keller, ‘Religion and the World Health Organization’.

Final Reflections

To paraphrase one fateful figure of the twentieth century, ‘there are decades when nothing happens, and there are weeks when decades happen.’²⁶ Since writing this book, decades happened in the relationship between religion and the WHO. In face of these rapid developments, it pays to pause and reflect. The primary healthcare paradigm, developed in the 1970s with the World Council of Churches as an answer to the failure of ‘top-down’ disease eradication, remains the fundament on which today’s health systems are built.²⁷ And, whether one sympathizes with religion or not, the religious make up a significant majority of the world’s population,²⁸ and faith-based organizations effectively carry a large share of the burden of disease—the Catholic Church alone, to name but one, manages over a quarter of the world’s healthcare facilities.²⁹ Though the WHO is a largely secular institution, secularism remains the exception rather than the rule in global health. The Covid-19 pandemic has served as a powerful reminder of the risks of ignoring religious communities, and of the extraordinary determination and commitment to a shared purpose required to meet the global health challenges of our era.

It is still too early to anticipate what positives might come of the Covid-19 pandemic. It may be the beginning of a worrisome trend towards the politicization of international public health institutions and what has been called an erosion of the WHO’s credibility as the leading global medical authority.³⁰ Or it might be seized as an opportunity to build on this fundament more resilient, adaptable, and sustainable health systems. In this effort, consultation with community stakeholders, which include religious communities, continues to be critically important.

Religious beliefs, of course, can also be highly problematic. The crises wrought by religious fundamentalism are a regular feature of global news coverage. And while a ‘spiritual fundamentalism’ may sound like a contradiction in terms, the adoption of a term which, almost per definition, figures as a purified notion of religion, does not solve the real challenges posed by extremism during global health crises. As shown in a recent study of Jewish, Muslim, Russian Orthodox, and Tibetan communities during the Covid-19 pandemic, the crisis has in some cases been instrumentalized, widening the division between orthodox and liberal

²⁶ This phrase has been attributed, perhaps erroneously, to Vladimir Lenin. The reader may prefer the second letter of Peter 3:8–9: ‘But do not forget this one thing, dear friends: With the Lord a day is like a thousand years, and a thousand years are like a day.’

²⁷ Braley, ‘The Christian Medical Commission’; Litsios, ‘The Christian Medical Commission and the Development of the World Health Organization’s Primary Health Care Approach’.

²⁸ Pew Research Center, ‘The Global Religious Landscape’.

²⁹ Catholic News Agency, ‘Catholic Hospitals Comprise One Quarter of World’s Healthcare, Council Reports’.

³⁰ Mandavilli, ‘In the W.H.O.’s Coronavirus Stumbles, Some Scientists See a Pattern’.

believers and increasing prejudice against others.³¹ But rather than justifying a lack of engagement with religion in the public health response, this underscores the relationship between ideological radicalization and the pervasive misinformation which the WHO has sought to address.

It should be kept in mind, moreover, that in most areas of the WHO's work, the challenge of religious conservatism typically revolves around sexual orientation, gender roles, and reproductive choices—and much like the WHO has evolved in its approach to healthcare provision, the positions of major religious groups in the UN system are increasingly diverse and often indistinguishable from non-governmental organizations with no religious orientation.³² Recognizing the role played by religion in this field, UNAIDS and the United Nations Population Fund (UNFPA) have for years proactively built partnerships with religious communities. Within the WHO, the consultation of groups such as the 'Global Interfaith Network for People of All Sexes, Sexual Orientations and Gender Identities and Expressions' in the development of the Covid-19 guidelines shows that cooperation between conservative, liberal, and secular groups is possible, and for some, long awaited.

The rapid spread of the novel coronavirus in some religious communities served as a wake-up call which brought the 'spiritual dimension' of health into the purview of the WHO's institutional response with a new urgency. Since then, the events described here have suggested a willingness to engage with religion, at least in principle, but increasingly so in specific collaborative projects. Over time this may well change how the WHO views, and is viewed by, religious communities: as an ally whose different values converge in a shared goal.

Meeting the challenges posed by the Covid-19 pandemic requires an 'all-of-society' response built on strong partnerships both within the UN system and between its agencies and civil society stakeholders.³³ The WHO's current efforts to reach out to religious actors may signal a change in what in the past has been a rather conservative institution in terms of such partnerships. Central to making this collaboration work, we suggest, is a recognition much like that of Eric Ram, the former director of the Christian Medical Commission and representative of World Vision International, who in the early 1980s had argued in favour of a 'spiritual dimension' in the World Health Assembly. Speaking of the 'special relationship between the doctor and the patient', he argued that 'both are, to some extent, sick and in need of healing, and that the idea that one is well and the other is sick is only illusory.' The stance that religious communities are 'sick' and

³¹ Käsehage, *Religious Fundamentalism in the Age of Pandemic*.

³² Beinlich, 'Religious NGOs'.

³³ UN Sustainable Development Goals Knowledge Platform, 'Partnerships against COVID-19 – Building Back Better, Together'.

the WHO is there to 'heal' is no longer tenable, as is the insistence that they hold the key to make the WHO 'whole'. What is needed, is 'empathy between them'.³⁴

The unifying ethos of the 'spiritual dimension' might provide a language through which to build such empathy—a language which facilitates the cooperation across borders needed to solve the global health emergencies of this time. In this sense, it may be understood to fulfil a similar function to secular humanist values such as the human rights discourse, which inspires many working in the UN milieu. Unlike the human rights discourse, long criticized by anthropologists, historians, and post-colonial theorists for its artificial universality,³⁵ the 'spiritual dimension' has emerged as a strategic co-production resonant both with the humanist ethics that underwrite the post-war diplomatic world order, and the age-old philosophical heritage of the major world religions. As such, it is not merely relevant to the beliefs and practices of those religious groups who during the pandemic engaged with the WHO, but speaks to a broadly human aspiration for collective betterment and transcendence.

It seems appropriate to conclude by returning to the WHO's well-known formulation of health as 'more than the mere absence of disease', enshrined in its constitution (see Chapter 2): The WHO can be more than a place where technical expertise is produced and circulated, careers are made and political contests played out. It can be a place which inspires peoples by demonstrating the possibility of working together across ethnic, cultural, and national boundaries: a 'temple of health', as former Director-General Halfdan Mahler once put it. This aspiration may not be written in the documents produced by the organization, and yet, as we have shown in this book, it has subtly informed much of what the WHO has tried to achieve.

The promise of a spirituality of health, we hope, lies in more than improving the effectiveness of public health interventions: in the possibility of dialogue and indeed friendship between secular institutions and peoples of all creeds. A world health organization built through dialogue across cultures and ideologies ceases to be perceived as a distant bureaucracy fighting a weary battle against 'dangers and enemies'—to borrow the words of the Swiss Federal Councillor Philippe Etter, who first used the term 'spiritual' in the WHO's inaugural assembly (see Chapter 2). Instead, it can serve as a bridge based on shared, universal human interests: health, happiness, a sense of well-being, growth, and contribution to our planet. It can partake, to echo Etter once more, in the global task, no less urgent now than in the post-war period when the WHO was founded: to promote the 'whole human being in his physical, spiritual, moral and social power'.³⁶

³⁴ Ram, 'Spiritual Leadership in Health', 6.

³⁵ Moyn, *The Last Utopia*; Spivak, 'Use and Abuse of Human Rights'; Goodale, 'Toward a Critical Anthropology of Human Rights'.

³⁶ Etter, 'Ansprache an der Versammlung der Weltgesundheitsorganisation (Organisation Mondiale de La Santé) in Genf'.

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APPENDIX 1

Chronicle of Events

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- 1924 Geneva Declaration of the Rights of the Child is adopted by the League of Nations.
- 1939 Henry Sigerist holds his Terry Lectures, providing the wording for the WHO's health definition.
- 1943 Raymond Gautier drafts his vision of the future health organization.
- 1946 The WHO constitution is drafted including the well-known positive definition of health as 'more than' the absence of disease.
- 1948 The term 'spiritual' first appears, during the inaugural World Health Assembly in a speech by Philipp Etter (1891–1977), then Swiss federal councillor. General-Director Brock Chisholm speaks of the right of children to develop 'materially, morally and spiritually'.
- 1968 The Christian Medical Commission is founded and begins to develop key principles of universal primary healthcare adopted by WHO in the 1970s.
- 1974 A UN General Assembly resolution calls for the development of a 'New International Economic Order', which in 1977 is echoed by WHO's 'Global Strategy for Health for All by the Year 2000', aimed at rolling out universal primary healthcare by the year 2000. A joint study between WHO and UNICEF entitled 'Alternative Approaches to Meeting Basic Health Needs in Developing Countries' admits the limitations of vertical disease eradication and calls for bottom-up approaches to primary healthcare provision, which would include providers of traditional medicine.
- 1976 The 30th World Health Assembly adopts a resolution urging governments to prioritize 'traditional medicine' in PHC reforms, marking its formal 'incorporation' into WHO. A report to the assembly argues that 'fetish-priests and priestesses, and witch doctors who are essentially spiritual healers and exorcists' could be trained as 'health auxiliaries' and deliver basic medical care.
- 1978 The pivotal Alma-Ata conference on primary healthcare is held in Alma-Ata (now Almaty), Kazakhstan, cementing the 'Health for All' initiative. The Libyan physician A. M. Abdulhadi criticizes a report on adolescents' health needs given to the 61st session of the WHO's Executive Board in 1978 because it 'made no reference to spiritual values and their impact on adolescent development'. A background document presented by Desh Bandhu Bisht to the same Executive Board meeting argues for the consideration of a 'spiritual dimension' of health.
- 1983 The 36th World Health Assembly is held: The inclusion of a 'spiritual dimension' of health initiated by Samuel Hynd is discussed and a draft resolution is submitted by delegates from Bahrain, Botswana, Chile, Egypt, Kenya, Kuwait, Malawi, Mauritania, Morocco, Oman, Qatar, Saudi Arabia, Somalia, Sudan, Swaziland, Syrian Arab Republic, Tunisia, United Arab Emirates, Venezuela, Democratic Yemen, North Yemen, and Zambia.

- General Secretary Halfdan Mahler is tasked to write a report on the proposal. WHO asks the World Council of Churches 'to raise awareness among the churches regarding the emerging disease called AIDS'.
- 1984 The 37th World Health Assembly is held:
Abdul Rahman Al-Awadi presents an amended draft resolution supported by Bahrain, Iraq, Kuwait, Oman, and the United Arab Emirates.
The draft text is adopted by the plenary meeting as resolution A37/VR/12.
The World Council of Churches holds its first conference on HIV/AIDS in Geneva.
- 1986 The WHO Collaborating Centre for Cancer Pain Relief publishes a report in which 'spiritual unrest' is seen as a form of anxiety within the concept of 'total pain'.
- 1986–2004 The WHO's EMRO publishes a series of publications entitled 'The Right Path to Health: Health Education Through Religion'.
- 1989 The 'Amman Declaration on Health Promotion through Islamic Lifestyles' is adopted by EMRO.
The WHO Expert Committee on Cancer Pain Relief and Active Supportive Care provides the WHO's most elaborate definition of 'spirituality', laying a foundation for spiritual care in palliative care for the next three decades.
- 1989 The UN General Assembly adopts the UN Convention on the Rights of the Child, Article 17 of which urges that a 'spiritual dimension' be included in terms evidently based on the WHO's definition of health.
- 1990s Academic research on 'spirituality' increases rapidly.
- 1997 A revision of the 'Health for All' initiative calls for the integration of a 'spiritual dimension'.
- 1998 The insertion of 'spiritual dimension' into the WHO's preamble is once more discussed, at 101st session of the Executive Board, and referred to the World Health Assembly.
- 1998–1999 The WHO's Department for Mental Health and Substance Abuse develops a module for 'spiritual, religious and personal beliefs' for its Quality of Life measurement tool (WHOQOL-SRPB) developed through a major transnational consultation with faith leaders.
- 1999 The revision of the preamble is postponed.
- 2003 UNAIDS holds a conference in Namibia where Christian representatives address 'the challenge of HIV and AIDS from their own religious perspective'.
- 2004 WHO publishes one of its most comprehensive documents on HIV/AIDS and palliative care with the title 'A Community Health Approach to Palliative Care for HIV/AIDS and Cancer Patients in Sub-Saharan Africa', in which it points out the considerable 'spiritual' problems suffered by HIV/AIDS patients.
- 2005 The 'Bangkok Charter for Health Promotion in a Globalized World' reaffirms a concept of health which includes 'spiritual well-being'.
- 2007 WHO and the United Nations High Commissioner for Refugees jointly publish the 'Guidelines on Mental Health and Psychosocial Support in Emergency Settings', which contains a section on facilitating 'cultural, spiritual and religious healing practices'.
- 2008 WHO publishes a 40-page booklet entitled 'Building from Common Foundations. The World Health Organization and Faith-Based Organizations in Primary Healthcare'.

- 2011 The WHO publication ‘Social Determinants – Approaches to Public Health’ acknowledges the importance of spirituality for First Nations youth.
- 2014 The first global resolution on palliative care is published; spiritual care is considered an essential aspect of palliative care.
WHO releases a guideline for the ‘safe and dignified’ burial of victims of the West African Ebola epidemic, developed in consultation with leading faith-based organizations.
- 2020 In response to the global Covid-19 pandemic, EPI-WIN for the first time in WHO history extensively consults with faith communities and releases detailed guidelines for religious leaders and faith-based communities.
- 2021 EPI-WIN produces a framework for engagement with ‘faith partners’ during health emergencies and, in partnership with Religions for Peace, holds a major conference on lessons learned in collaboration with religious actors.
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