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The World Health Organization's production and enactment of spirituality

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Introduction

In May 1984, academics, technicians, and politicians met at the headquarters of the World Health Organization (WHO), in Geneva, Switzerland, for the thirty-seventh General Assembly of the institution. Among other resolutions approved on that occasion, which I found through direct consultation of the agency’s archives, one of these in particular held my attention. It is related to the decision WHA37.13, enacted in the following terms:

Having considered the report from the board of directors [WHO] regarding the spiritual dimension for the program ‘Health for all by the year 2000’ and further accompanying the recommendations of the Executive Committee regarding resolution EB73.R3, the assembly [which]: . . . Recognizes that the spiritual dimension plays a significant role in motivating people’s achievement in all aspects of life; affirms that this dimension has not only stimulated worldwide action for health but has also given to health, as defined in WHO’s Constitution, an added spiritual dimension; Invites the 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.¹

Beyond my surprise at this resolution, the historical breadth of the debates underlying this adoption of spirituality within the WHO was also unexpected. Spirituality, as I was to realize through the reading the archives of the WHO, is a notion that has been present in the official documents of the organization since 1948, its founding year.

In this text, I analyze the use of the category of spirituality within the WHO. For that purpose, I turn to the minutes, memoranda, transcripts of speeches, official resolutions, and reports that show how the idea of spirituality developed over time within the institution. Mainly, this material makes it possible to think about how spirituality was articulated with other notions, such as culture, religion, rights, and wellbeing. Thus, although at times I took a chronological
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orientation to analyze how the term was established in the debates of the organization, I do not intend to describe the modalities of the relationship between spirituality and health using a continuous and progressive historical line. As I show, the different ways of instituting this category vary over time without this signifying in any way that different formulations cannot equally coexist. In other words, even within a determined interval of time, differing versions of spirituality may be observed in the documents of the WHO.

In the reflections that follow, I proceed from a dual viewpoint: on the one hand, I describe and analyze the instituted forms of spirituality within the WHO, anchoring my reflections in the final version of the documents, which have been publicly promulgated. On the other hand, I fix my attention on the processes of deliberation prior to the ‘spirituality resolutions’ being made official, giving priority, in this case, to the historical and political configurations that made them viable. This text has two parts. In the first and shorter of the two, I explain some of the issues surrounding the analysis of the theme of spirituality in the social sciences, and I justify the reasons why research such as this can contribute to such a debate.

In the second part of the chapter, I dwell on the WHO documents, presenting them from two axes of variation: the spirituality of Others and the spirituality of All. With the first concept, spirituality of Others, I refer to situations in which the notion of spirituality is used to deal with practices characteristic of traditional communities. In this case, spirituality is a trait of otherness, a particular characteristic of some groups described in the WHO documents. The second idea, the spirituality of All, refers to documents that universalize spirituality, treating it as a human, an a-cultural characteristic. My hypothesis, as I will demonstrate, is that WHO documents have gradually moved from the spirituality of others to the spirituality of all. Next, I explain how these two axes not only differ from one another but also articulate themselves in relation. I close the text by outlining a set of empirical consequences associated with formalizing spirituality as a component of health within the WHO, as well as elaborating specific theoretical and methodological lessons that we can derive from the analysis presented.

Institutionalized spirituality and the politics of spirituality

The objectives of this chapter are not directly aimed at any immediate aspect of medical practice, but rather to the ways of producing the pairing of spirituality and health in the context of a global health management agency. I do recognize, however, that there are both links and a significant resonance between the actions of the WHO and worldwide medical practice. After all, as Nitsan Chorev (2012) has demonstrated in his work, The World Health Organization between North and South, the discursive production of health and illness carried out within the WHO is by no means innocuous, often acquiring greater solidity locally.

The case for the legitimacy of spirituality as a dimension of health offers a timely counterpoint to how social scientists of religion have usually employed this category. Among many possible examples, the definition of spirituality suggested by Paul Heelas, Linda Woodhead, and colleagues is as follows: ‘Spirituality is a subjective form of existence of the sacred, which emphasizes internal sources of meaning and authority, as well as the cultivation or sacralization of subjective life’ (2005: 6). In that approach, spirituality indicates a kind of relationship with the sacred, which is established along deinstitutionalized and subjective lines.

This analytical key has indeed been instrumental in advancing the understanding of phenomena such as the New Age and also of the universe of the self-declared non-religious. However, it is equally pertinent to recognize that the aprioristic character of these definitions of spirituality inhibited the attention of researchers to other modes of existence and uses of that category. Among these other modes of the category of spirituality, I specifically highlight
its use as a potent device, activated within secular institutions, which inscribe it into public policies, government reports, legal debates, medical texts, and, as I show in this text, into resolutions, programs and instructions for health, promoted by the WHO.

The development of the following analysis is supported by a more general methodological principle, which is based on the recognition that spirituality is a historically situated concept. In a similar register to Talal Asad’s (1993: 29) analysis of the category of religion, I argue that to define spirituality is first and foremost an act in itself (see also Asad 2001: 220; see also Klassen 2005). This approach means that spirituality, while being a category, is continually being defined (or redefined) within social and historical contexts and that people have specific reasons for instituting it in one way or another. This is the starting point that allows for the development of analysis that is less interested in either defining or assuming a priori definitions about what spirituality is, and more concerned in following the ways in which this category is produced, both being mobilized by and mobilizing, in each of its ‘versions,’ different agents and institutions.

It is in this sense that the vague but pluralistic character of spirituality, which is often treated as a ‘complicating’ element in the analysis of social scientists of religion, is here converted into the very object of interest. After all, what the multiplicity of definitions of spirituality suggests is that, firstly, despite the variation in meanings, the recurrence with which it appears leaves no doubt whatsoever: its uses cannot be random. Second, what is more interesting than defining spirituality is ‘to observe how the term “spirituality” is used, and how distinctions within it make some practices and engagements more or less possible’ (Bender 2010: 5). It is thus a category that establishes itself upon a precarious equilibrium, balanced between the multiplication of what it can mean—the insistence on its relevance—and the efforts on the part of the different agents in defining it (van der Veer 2009, 2013).

This chapter is an attempt to advance the understanding of the statements of the World Health Organization regarding the category of spirituality and, at the same time, to reflect on the analytical force of providing visibility to the term in its capacity as a political device for population management—and, thus, not as a describer of any individual modality of sacred experience. I refer to population management because, in the end, what is at stake in these WHO resolutions is the establishment of norms regarding the links between spirituality and health, and, at the same time, setting out the principles so that the member states of WHO can put them into solid practice.

Thus, by dwelling on a context in which the category of spirituality is institutionalized, I establish a latent (but not discordant) contrast with analyses dedicated to subjective, deinstitutionalized, and unofficial spirituality, such as that implied in the definition from Heelas et al. (2005), mentioned previously. What I call institutionalized spirituality refers to official, bureaucratic, or properly institutional uses of this category. The contrast is latent because the institutional forms of establishing spirituality, even when the term is forged as a population policy variable, do not necessarily undo the link between the category and individual and subjective experience. It is, nevertheless, an act of formulation that recognizes the possibly individual character of spirituality, transforming it into an issue that transcends such individuality.

In light of the WHO documents, therefore, what matters is not the question ‘what is spirituality?’ but rather ‘who are the actors involved, which terms have been mobilized, and what are the effects involved each time this category is indeed instituted?’

Instituted documents, instituting documents

This chapter is based on an analysis of variations of the word spirituality—for example, spirit and spiritual—that I found in the physical and digital documents available in the archives of
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The WHO and the United Nations (UN). The initial result was the selection and analysis of a set of 1,497 documents, dating from between 1948 and 2017, comprising memoranda, minutes, reports, resolutions, and commemorative books. With such a volume of information, there is no lack of possible qualifications. It would be possible, for example, to build a classification based on materials that establish spirituality as a) a mental health dimension, b) a protective health factor, or c) an indicative vector of the quality of life. However, some of these ways of instituting spirituality reflect trends of specific periods of the debate on the theme, making it difficult for me to identify more general and long-term transformations. In the end, I decided to concentrate on two organizing and narrative axes for these documents, in order to contemplate the variations of the concept of spirituality within the WHO throughout an extended historical period, as well as to underline specific continuous characteristics of these formulations. Thus, I shall first describe the conditions of the formulation and the documents establishing the spirituality of Others after which, I dwell on the spirituality of All. As it becomes evident, it is not only relevant to identify the differences between these forms of instituting spirituality, but to further recognize that there is a dynamic connection between them, which shows how the elaboration of one was indispensable in the establishment of the other.

The spirituality of others

The WHO, created in 1948 as an agency of the UN, was invested with authority and responsibility for coordinating international action regarding health. Similar to other institutions created directly after the experience of two world wars, the mission of the WHO is to ‘instigate rules and standards of service, articulating health management policies, providing technical support and monitoring local action of its Member States.’ Its main goal, as set out in its inaugural constitution is as vague as it is ambitious: ‘Achieving the highest attainable standard of health for all peoples.’ In line with this, the WHO’s role concentrated on two basic fundamentals: on the one hand, ensuring universal access to quality health services for the most disadvantaged populations and on the other, creating the mechanisms of control and action towards global epidemics that, due to their characteristics, exceed the limits of frontiers and, therefore, whose combat depends on coordinated international action.

At the beginning of the 1970s, the global politico-economic conditions that had influenced the policies of the World Health Organization during its first decades of existence radically changed. With the end of the colonial period, newly independent states joined the block of the then so-called third-world countries and together they made up the majority group in the system of the UN and its specialized agencies, such as the WHO. This transformed the dynamic of international politics. The emergence of an agenda of cooperation between Latin American, Asian, and African countries further resulted in unified criticism directed at the developed countries that, according to this emerging block, acted to compromise the economic potential of these regions. In 1974, these accusations were formally voiced in the General Assembly of the United Nations, which ended by calling for the emergence of a New International Economic Order (NIEO). The NIEO was based on a set of fundamental principles that included fairness, justice, and the economic sovereignty of the countries (Chorev 2012: 42).

This new political and economic configuration also affected the actions of the WHO. The newly independent countries began to demand more autonomy in the management of their health policies and in the adaptation of the programs of the global agency to the local conditions. To comprehend the context is fundamental to understanding the reasons and justifications that enabled the consolidation of one of the most recurrent formulations of spirituality in WHO documents, that is, the notion of traditional medicine.
Similar to other healthcare contexts discussed in this handbook, the institutionalized spirituality of the WHO finds its roots in another agency, which had Christian grounding. Three years after the end of World War II, in the wake of the creation of a series of global institutions that aimed to strengthen and broaden the political visibility of hitherto unconnected church-based initiatives, the World Council of Churches (WCC) was created. Since its foundation, the WCC has been structured around priorities oriented by its particular objectives and autonomous agendas, but in line with the more general principles of the organization, such as ecumenism and the promotion of and participation in regional development projects.

Among the priority areas of the WCC was the so-called Christian Medical Commission (CMC), created in Geneva in 1968, and dedicated to the management of a network of hospitals and clinics built with the support of the WCC. This commission was also given the responsibility of coordinating the health actions that the council carried out in the countries where its medical missions were located, mainly in Africa, Asia, and Latin America.

As religion scholar Pamela E. Klassen has shown, the founding of the CMC in the 1960s was a pivotal point in the shift of previously evangelical medical missions. Until then, according to Klassen, mainstream medical missionaries worked in close connection with colonial governments, building hospitals and training centres. Post-independence, many newly decolonized governments sought to sever these relations, and the WCC increasingly adhered to the discourse of inter-religious dialogue, forming a framework that impelled the new ‘medical missions’ in a different direction. The CMC formally established an agenda, based on a post-colonial perspective and guided by a holistic ideal, designed to bring health agents closer to the reality of the sick (Klassen 2011). The CMC used the following keywords, describing the model as ‘primary health care’—a term that later had broad repercussions on health policies. Among other significant aspects of the displacement promoted by the CMC, and of particular interest to my discussion of institutionalized spirituality, is the status attributed to traditional healers. Previously disregarded (and even despised) by missionary doctors, the new model saw these agents integrated into the health structure and, above all, trained to work in a more capillary care network in the countryside.

It is at this point that the strategy of action adopted by the CMC to respond to the new political situation of former colonial countries finds a particular resonance with the very profile of missionary action guided by the WCC. As Klassen (2011) also observed, the professionals practising within the CMC forged the model of primary healthcare from language and forms progressively adopted in Christian medical missions. Following the rhetoric of ecumenical love and human universality, liberal Protestantism shifted its emphasis from evangelizing medical care focused on converting the ‘other’ to approaches that emphasized collaborative work with the local community, valuing their forms of knowledge, and conceptualizing ‘health’ as a holistic principle. The importance of this latter aspect should not be underestimated. Christoph Benn and Erlinda Senturias (2001), physicians who worked at that time in the commission, for example, recognized that openness to traditional healing techniques was possible only to the extent that ‘missionaries adopted a model of care that no longer favoured charity or had any proselytizing ideal but on the contrary placed their faith in the benefits of holistic care,’ to which local healers could also contribute. Local healers, according to Benn and Senturias, have become vital allies, since only they could carry out the specific care practices that are culturally compatible with local notions of the body and of the spirit (ibid.; see also Boddy and Williams in this volume).

The working model adopted by the CMC established an association between the practices of traditional medicine and, in its terms, attention to the spiritual dimension. Two aspects need to be retained at this point. Firstly, due to the transformation in the missionary mode of
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action, according to the guidelines of the WCC, contact with ‘native’ populations was guided by ecumenical and, therefore non-competitive, ideals, since it was not primarily aimed at religious conversion. This enabled the CMC to recognize the legitimacy of ‘practices of care and attention to the spirit’ carried out by the populations it served. The second dimension to be emphasized in this context is that the CMC also described these forms of care of the spirit as health practices. This process is by no means trivial since it refers to the transformation of subjects into ‘legitimate agents of healing’ who were only a short while before considered by the same institution as ‘priests of pagan religions.’

For my purposes, it is not the actions of the CMC that matter, but rather the recognition of how these actions have impacted the positioning of the WHO on the subject of spirituality. First, I must stress that the model established by the CMC, which articulates traditional medicine and care with what would be termed ‘spirituality,’ was the precursor of a process that would also be used in the WHO, thus inaugurating a series of formulations that associate this category with non-Western health practices. It is in this association that the spirituality of Others starts to gain form.

In November 1970, the CMC published the first volume of a journal created to chronicle and report on the work being carried out by Christian doctors. Significantly titled *Contact*, the publication describing CMC projects and actions attracted the attention of WHO delegates and staff who faced similar problems as the missionary doctors. WHO Director-General Tom Lambo referred directly to these shared problems in a letter to James McGilvray, then director of the CMC in November 1973, proposing ‘a meeting between the directors of the Christian Medical Commission and a group of delegates from the Organization, with the objective of exploring effective possibilities of working together’ (Klassen 2011: 54).

In fact, according to the records, the meeting took place only in March of 1979 and was attended by ten WHO senior delegates, as well as members of the CMC. Among the WHO delegates was Kenneth Newell, whose father had worked at the WCC between the late 1940s and early 1950s. According to reports (Litsios 2004), the primary outcome of the meeting was the creation of a small working group, coordinated by Newell and a director of CMC, to prepare a report indicating the viability of long-term partnerships between the two agencies and to develop more immediate proposals that could be presented at the General Assembly later that year.

Just three months after the meeting and the establishment of the working group, in July 1979, during the twenty-seventh World Health Assembly, the WHO adopted a resolution recommending that the Organization ‘should assist the governments of its Member States in conducting their health policies towards their own goals, with a priority on the rapid and effective development of their health systems.’ As suggested by Socrates Litsios (2004), a WHO delegate at the time, this text initiated the opening of the institution towards the model of primary healthcare, which was explicitly a result of the partnership with the CMC.

In 1978, the Primary Health Care Program of the WHO and CMC organized the International Conference on Primary Health Care in Alma Ata, then a territory of the Soviet Union, an event that became a consistent benchmark for the health policies elaborated afterward. Among other milestones, it was this event that established and instituted the notion of traditional medicine in the WHO. In the official text, the term is defined as: ‘the sum total of knowledge, skills, and practices based on theories, beliefs, and native experiences of different cultures whether empirical or not, used for maintaining health, as well as in prevention, diagnosis, and in the treatment of physical and mental illness.’ In a more recent WHO document, traditional medicine is explicitly related to specific regions of the planet:‘Throughout history, Asians, Africans, Arabs, Native American, Oceanian, Central American, South American, and
other cultures have developed a wide variety of traditional native systems.’ Traditional medical practices are always described as having a long history: ‘Traditional medicine can be codified, regulated, taught, and practiced both openly and systematically, while further benefiting from thousands of years of experience.’

Again, according to the definition established by the WHO, it becomes clear that the experiences and practices that ‘traditional medicine’ describes include the presumption of attachment to cultural systems, a non-Western origin, and distance from the biomedical language.

Put another way, the legitimation of traditional medicine in WHO documents is directly related to the increasing frequency of the use of the category of spirituality in WHO documents. In the understanding of the organization, traditional medicine, however varied it might be, operates via techniques that include ‘spiritual treatment’ and target populations that conceive of health as a totality that integrates body, mind, and spirit. In short, traditional medicine is the medicine of the Others who, by way of their specific cultural conditions, would conceive the spiritual dimension as the unavoidable face of their healing process.

A significant number of WHO documents that refer to the idea of spirituality linked this to the process of legitimizing so-called traditional medicine. In this model, I stress that the spirituality recognized by the WHO is one that corresponds to very particular forms of treatment and healing characteristic to only a portion of the globe: the Others of the West.

In the 1970s, associations of specific cultural forms of understanding processes of health and disease, traditional medical practices, and the notion of spirituality began to be described in WHO documents. We can see then by 2006, in a document of the Regional Committee of the Americas for Health, a description: ‘Indigenous peoples have a holistic view of the world. By incorporating native paradigms, one begins to conceive health through its dynamic relations and through the balance it presupposes between the physical, mental, emotional, and spiritual dimensions.’

So far, I have argued and demonstrated how the notion of spirituality in the WHO was instituted as part of the legitimization of traditional medicine, a formulation that determines its legitimacy as a health practice for specific cultural groups. On the one hand, however, WHO documents directed towards the African and American contexts have usually described traditional medical practices generically, emphasizing the need for differential attention to the native populations of these regions. On the other hand, resolutions addressed to Asia do not. For the most part, although these resolutions describe the cultural characteristics of the groups in question, they consider the therapeutic qualities of their practices. By emphasizing just the practice without its historical-cultural link to a specific group, these documents ‘deculturate’ the practice, by presenting its universal appeal. As I demonstrate later regarding the case of yoga, spirituality is formulated in terms of practice rather than as a cultural manifestation. It indicates one of the ways of changing the framework of spirituality, no longer confining it to the medicine of the Others, but rather allowing it to gain a foothold in culturally indiscriminate global policies and recommendations.

The case of yoga is emblematic of WHO documents that inscribe spirituality as a dimension of otherness and those who consider it pertinent to the health of all. The juxtaposition of two WHO documents is quite illustrative. In the first, entitled Traditional Medicine in Asia, published in 2002, yoga is described as a ‘spiritual journey. . . . Yoga is a developmental practice for spiritual evolution, but one that can easily be used for disease relief.’ The second paper uses ‘science’ to vouch for yoga’s power to increase both mental and spiritual wellbeing: ‘yoga may delay the progression of atherosclerotic cardiovascular disease or even help it regress. Yoga has no side effects and is low cost. Therefore, it is recommended to spread yoga [as], a healthy and holistic technique for promoting physical, spiritual, and mental wellbeing.
and useful for preventing heart disease and other lifestyle-related diseases.” It is in these terms that, in WHO documents, the previously limited need for attending to the spiritual dimension acquires prescriptive frameworks and thus transcends into a generalized recommendation. We are facing a metonymic game. Yoga, such as other traditional medicine, is a practice associated with spirituality. However, by recommending this practice globally, the WHO began to describe spirituality as universally appealing.

There are indeed differences in the treatment given by WHO to Asian, Latin, and African healing modalities. Asian practices were the first to go through this process of ‘deculturation’ and to be expressed as those with universal appeal. While this process is not restricted to Asian practices, one can see its occurrence firstly and more explicitly here.

In the next section, I investigate this second discourse of spirituality in the WHO documents, demonstrating how the spirituality of all proliferates in speeches regarding therapeutic practices, and becomes compatible with other notions such as the right to health and wellbeing.

### Spirituality of all—the right to spirituality

The first mention of the term spirituality in official WHO documents occurred in 1948, just six months after its foundation. At that time, the topic had not been addressed as a result of a request from any delegate of the agency, but instead from the UN, who sought the WHO’s position on the new version of the Declaration of Children’s Rights, a document that had initially been produced in 1924, under the auspices of the League of Nations. A UN revision in 1948 began with the following commitment: ‘Through this agreement, men and women of all nations recognize that humanity is committed to offering the best to children, beyond any consideration of race, nationality or creed.’ Following this, the first declaration of the text stated, ‘Children must have all their requirements for their normal development, both material and spiritual.’ This formulation was one of the first to describe spiritual development in terms of people’s inalienable rights. In later decades, especially in the 1970s and 1980s, the idea of spirituality as a right would also be established at WHO.

In 1948, the WHO representatives revised the preamble to the 1924 Declaration, eliminating the spiritual guarantee in favour of only the material: ‘Children must have all the requirements for their normal physical, mental and social development, through the provision of care and adequate housing conditions, nutrition and education.’ The proposal, however, was not endorsed by the UN, and, as far as the mention of spirituality is concerned, the Declaration of Children’s Rights, enacted in 1948, retained the original format. Eleven years later, in 1959, the UN enacted a new version of the document, this time removing the reference to ‘material aspects,’ and incorporating some suggestions forwarded by the WHO, but maintaining spirituality as an element. In 1989, the Declaration changed again, where the brevity of the previous ones gave rise to an extensive text, with fifty-four articles and as many subsections. In it, the use of the term spirituality was not only maintained, as in the original form but became even more recurrent, included in five new sections of the text.

Although the position of WHO delegates in 1948 had been to suppress the term spirituality, in the years that followed, not only updates to the Declaration of Children’s Rights include spirituality, but other WHO texts also use the term.

In 1984, one of the meetings of the World Assembly on Health recommended that spirituality be incorporated as one of the dimensions of human health, suggesting: ‘health [a]s a dynamic state full physical, mental, spiritual and social wellbeing, and not merely the absence of disease or illness.’ The proposal had enormous consequences, naming spirituality not only
a dimension of human health, but a right in WHO documents as well as in national health policies. To understand this, one needs to look back a few years.

Throughout the 1970s, the frequency with which the term spirituality appeared in official WHO documents increased compared to previous years. However, for the most part, these mentions were not propositional, but rather to denounce the little attention that the topic had been receiving from delegates. Then, from the end of the 1970s, the number of citations referencing spirituality in the analyzed documents jumps. Between 1978 and 1982, the occasions upon which delegates and directors of the WHO mentioned the relevance and the need to attend to spirituality also increased. At that time, the citations usually draw attention to the absence of debate. In 1978, for example, the Libyan delegate evaluated the organization’s resolution on adolescent health, pondering: ‘The report did not refer to spiritual values and their impact on development . . . and the maintenance of healthy habits.’ 11 On the same occasion, the delegate from India was even more explicit and pre-empted what was to happen some years later: ‘the spiritual dimension must be added to the already considered physical, mental and social aspects of health.’ 12 A similar position was indicated the following year by the delegate from Fiji: ‘It is regrettable that the emphasis on the spiritual aspect is not articulated with the development and balance of the physical and mental faculties. . . . [The] WHO should study the impact of the spiritual dimension on health.’ 13 The effects of these documents are not trivial; they contributed to inscribing spirituality as a legitimate topic in the healthcare debate.

In 1983, during the WHO’s thirty-sixth General Assembly, the debate on spirituality took on other forms, no longer being scattered in references indicating its absence in the organization, but instead became an official matter on the agenda. The transcripts of the meetings and the debates of the activities carried out in that period show that this new focus on spirituality triggered later events. The following is a comment of the delegate of Swaziland, Doctor Samuel Hynt:

The program [health for all by the year 2000] may have all the ingredients to be both pleasant and successful, but it lacks the contemplation of the spiritual dimension. I may be accused of introducing some religious concepts into the WHO. However, I would like to see health defined in our Constitution in the following way: ‘Health is a state of complete physical, mental and spiritual well-being.’ Before the legal experts discourage me, I see that the way to achieve this is to have the Director-General accept an amendment on the subject, which must be proposed by us, and at least six months before the General Health Assembly. Those who wish to join me in proposing this concept let me know. If we do this, we have 12 months to lobby, arrange, and prepare the debate on the topic before the 38th World Health Assembly in 1984. 14

Hynt’s proposal was by no means simple: to amend the WHO Constitution by changing the critical concept of the document, thus reinstituting the definition of health and inscribing the spiritual dimension as part of the responsibility of states in the care of their populations’ health. If what is described in the previous section points to a cultural autonomy to the notion of spirituality, increasingly aligned to therapeutic practices, Hynt’s proposal was even broader, conceiving spirituality as a universal need for human health. This proposition, which a decade earlier seemed unlikely let alone influential, found fertile ground.

A Scottish missionary doctor who was not only Swaziland’s delegate to the WHO, but also minister of health and doctor to the royal family, Samuel Hynt 15 articulated of a topic important for the WHO, medical missionaries, and emerging states of the southern hemisphere. With
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1960s political changes, new African, Asian, and Latin American countries—states with practices of traditional medicine—became WHO delegates with voting capacity that exceeded the bloc of Western Europe and the United States; as such, there was potentially more interest to engage in dialogue about spirituality. Additionally, although representing a small and newborn African country, Hynt was supported by the CMC, which remained active in its partnerships with the WHO.

Ten days after this call from Hynt, a motion for a resolution on the spiritual dimension of health was included for discussion on the Assembly’s agenda. Although extensive, I reproduce in what follows the text of the proposal and part of the discussions relating to it, recorded in a sequence of three plenary sessions.16 (The first intervention was made by a non-delegate, a representative of the CMC.)

DR. RAM (CHRISTIAN MEDICAL COMMISSION) I remind everyone that the CMC, which is linked to the World Council of Churches, has had a fruitful consultative relationship with the WHO over the last decade. . . . Since 1977, the Christian Medical Commission has participated in 10 regional [WHO] meetings held in different parts of the world. We often note citations about how all dimensions, including spiritual dimensions, should be considered in health care. Meeting other basic health needs is essential, but it is clear that the balance between these dimensions and the spiritual dimension is also an essential element for achieving the goal of health for all by the year 2000.

DR. SAVEL’EV (USSR) My delegation has every respect for the religious opinions of the delegates. Religious aspects certainly play an essential role in the organization of health services in some countries. However, there is a great diversity of religious perspectives in the world, and it would be challenging for him [the Director-General] to take all of them into account in the preparation of the text of the programs on primary health care. A better solution would be for each Member State concerned to take its action when planning their national primary care programs. Otherwise, I would have to table numerous amendments to this resolution.

DR. AL-SAIF (KUWAIT) We must take into account the role of the spiritual dimension in health care work. I am saying that health care, including prevention and treatment, must take into account the mental and spiritual components of human nature. Whatever technological progress is made, there can be no real progress while the bodies of men [sic] are dealt with alone, without regard to their soul[s].

DR. KLIVAROVÁ (CZECHOSLOVAKIA) My delegation is also in a tough position because it considers that the resolution cannot be accepted by all the Member States of the Organization since it is based on certain religious beliefs. There are different religious beliefs in different countries, as well as those countries with many atheists. In Czechoslovakia, for example, atheists and believers have the same rights. Therefore, my delegation cannot approve the proposed draft resolution.

SR WEITZEL (WEST GERMANY) My delegation is in an embarrassing position because we no longer know what is being discussed. The text of the draft resolution mentions the ‘spiritual dimension,’ but the delegations are talking about a ‘religious dimension.’ Perhaps what is being discussed is a ‘mental dimension.’ For this reason, we would greatly appreciate any clarification on what is being understood as a ‘spiritual dimension.’

DR. HOUÉNASSOU-HOUANGBÉ (TOGO) I am a bit surprised by all this discussion of a draft resolution that should have been voted on and approved. As a physician and health worker, I do not understand why the idea of [a] spiritual dimension offends certain people or why some seem to believe that this is intended to create a religion of primary health care. As
we have just suggested, the spiritual dimension can be anything from the purest atheism to the sheerest fanaticism.

DIRECTOR-GENERAL. I’m not sure what the best way to deliberate on this question is. I have examined the definition of ‘spirit’ in the Oxford English Dictionary, and the first definition is given the ‘intelligent or immaterial part of man, soul’; on ‘spiritual,’ it is defined as: ‘of spirit, as opposed to matter.’ At the same time, it is also true that there are many other definitions for these terms in the dictionary, which also creates many question marks for anyone. . . . For me, personally, I agree that there is a spiritual dimension in man [sic], in a sense expressed by the Oxford Dictionary. I am not so sure whether there could be a spiritual dimension in health care programs.

DR. HAMDAN (UNITED ARAB EMIRATES) Some years ago, folk medicine or traditional medicine were unacceptable in the health programs of this Organization. These practices were rejected and considered to be outside the scope of the development of health services in the world. These practices are now widely accepted, and we are now beginning to discuss a subject that may seem difficult to face, but we must look to the future. I know many countries where spiritual medicine plays an essential role in healthcare. Why should the WHO refuse to include this dimension in its Global Strategy? Why shouldn’t we try?

DR. AL-SAIF (KUWAIT) What is meant by spiritual dimension is not religion or doctrine. This dimension is nothing more than the spiritual side of man [sic]; this is not related to the religions or doctrines they follow.

At the end of the discussions, the motion for a resolution was adopted by eighty votes to thirty-three, with twelve abstentions.

Following this resolution, other proposals of a similar nature were presented to the WHO and eventually approved. Together, they establish that: 1) spirituality is an unequivocal and universal dimension of health—in some resolutions spirituality is not described as a universality of health, but instead of the person; 2) spirituality is a dimension of health (or the person) and spiritual attention is a fundamental aspect of care. Both formulations reinforce and consolidate the WHO’s central idea of spirituality as a characteristic of all.

The debate surrounding this formulation was a tense face-off between delegates in favour of the proposal who affirmed the universality of the idea of spirituality and those opposed, who rejected the resolution arguing that spirituality was an object of belief, equivalent to religion and, therefore, individual. Religion scholar Winnifred Sullivan has traced similar transformations of the chaplain service in the US military and civil hospitals. For Sullivan, the progressive legitimization of the spirituality/health pairing was one of the main justifications for the status of ‘chaplains’ in health settings to be changed from ‘specialists limited to religious assistance’ to ‘professionals trained to compose health teams’ or ‘experts in the treatment of the spiritual dimension of health’ (2014: 3). These professionals, Sullivan says, ‘stopped speaking in the name of some particular persuasion or religious identity and began to treat spirituality as a natural and universal aspect of all human beings’ (ibid.). Sullivan concludes that ‘at least in the United States, despite its secular law, all citizens are increasingly understood to be universal and naturally religious—in need of spiritual care’ (2014: 160).

Sullivan argues that the category of ‘spirituality consists of a new way of establishing a religion or, at least, a way of dissimulating religion in secular spaces.’ (2014: 200). While I recognize, in concert with Sullivan, that spirituality may be the new avatar of religion in public spaces or institutions such as the WHO, I do not concur that this category can be surmised as a ‘disguise for religion’ or that it cannot be instituted, indeed, in other terms. The analysis of WHO documents shows a double divergence via the strength with which this category can
be articulated with other notions, such as traditional medicine and culture, but also methodologically, since starting from the presumption that spirituality is religion makes other forms of existence and formulation of this category invisible.

In the situations presented in this section, for example, it is undeniable that the CMC had an important role in instituting the notion of spirituality in the WHO. It does not follow, however, that this process can be reduced to the work of missionary doctors nor that the developments are restricted to the interests of this group. This becomes clear when we identify another way of instituting the spirituality of All, this time, not by arguing that it is a right, but by promoting medical research on the positive relations between spirituality and health.

From the 1990s onwards, the WHO not only began to encourage clinical research on the topic (see Toniol 2018) but also incorporated spirituality as one of the central dimensions in its instruments for measuring the quality of life. It can be understood as a new step towards what I have called the universalization of spirituality. After all, transforming the spiritual dimension into a comprehensive item for measure, quality of life is a production of universalism, which is very different to spirituality as only a cultural dimension of traditional medicine practices. Even more than that, in suggesting a positive relationship between spirituality and wellbeing, the WHO may be pointing to a third movement, which would consolidate the passage from spirituality as a universal fact to a political attitude to promote the benefits of this dimension for health. In that case, we are witnessing a change from a spirituality of all to spirituality for all.

Final comments

I began this text by pointing out the need for attention to institutionalized spirituality, as well as attention to the ways of establishing this category as a political device with a substantial impact on life. I argued that it is necessary to make two analytical movements. First, to deny a priori definitions of the category of spirituality, choosing instead to follow the various ways in which it is instituted, mobilizing and being mobilized by diverse agents and protagonists. Second, to follow the processes institutionalizing spirituality, recognizing that these also imply stretching the dominant analytical perspective in the social sciences, which employs this category merely to deal with individual, subjective, and de-institutionalized forms of relationship with the sacred. Such movements are related to contemporary efforts to reframe the analytical perspectives on spirituality (See Bender and McRoberts 2012), emphasizing the processes through which contemporary uses of the category of spirituality have taken on its current values, how is it aligned with different types of political, cultural, and social action, and how it is articulated within public settings. To some extent, to assume this analytic is the very condition for answering Peter van der Veer’s call for ‘the politics of spirituality’ (2009, 2013), which considers the way this category produces realities, enacts players, and mobilizes institutions, as I hope to have explained in the previous pages.

Notes

1 A37/33, 15 May 1984, WHO archives.
2 This paper is based on our previous work (Toniol 2017).
3 SEA/RC27/11, July 1974, WHO archives.
6 CD47/13, 2006, WHO archives.
7 Traditional Medicine in Asia 2002: 94; 100, WHO archives.
8 Regional Workshop on Promotion of Mental Well-Being 2009: 13, WHO archives.
9 EB/2 1948, WHO archives.
10 A37/33, 15 May1984, WHO archives.
11 WHA/36-A36/VR/5, 4 May 1978, WHO archives.
12 Ibid.
13 Ibid.
14 A36/A/SR/14 13 May 1983.

15 Hynt’s parents, also doctors, brought him as an infant to Swaziland with the goal of expanding the medical missions of the Church of the Nazarene, which were founded in the United Kingdom by Hynt’s grandfather, George Sharpe, also a physician. Hynt’s parents succeeded in their purpose, founding the church in the country, setting up a mission hospital, a teaching network, and at least one university. Samuel Hynt took over the board of the Raleigh Fitkin Memorial Hospital in the mid-twentieth century when the model of ‘holistic healthcare,’ proposed by the Christian Medical Commission, was already in place.

Bibliography