

Religion and the World Health Organization: an evolving relationship

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ABSTRACT

Much has been written about WHO. Relatively little is known, however, about the organisation's evolving relationship with health-related personal beliefs, 'faith-based organisations' (FBOs), religious leaders and religious communities ('religious actors'). This article presents findings from a 4-year research project on the 'spiritual dimension' of health and WHO conducted at the University of Zürich. Drawing on archival research in Geneva and interviews with current and former WHO staff, consultants and programme partners, we identify three stages in this relationship. Although since its founding individuals within WHO occasionally engaged with religious actors, it was not until the 1970s, when the primary healthcare strategy was developed in consultation with the Christian Medical Commission, that their concerns began to influence WHO policies. By the early 1990s, the failure to roll out primary healthcare globally was accompanied by a loss of interest in religion within WHO. With the spread of HIV/AIDS however, health-related religious beliefs were increasingly recognised in the development of a major quality of life instrument by the Division of Mental Health, and the work of a WHO expert committee on cancer pain relief and the subsequent establishment of palliative care. While the 1990s saw a cooling off of activities, in the years since, the HIV/AIDS, Ebola and COVID-19 crises have periodically brought religious actors to the attention of the organisation. This study focusses on what we suggest may be understood as a trend towards a closer association between the activities of WHO and religious actors, which has occurred in fits and starts and is marked by attempts at institutional translation and periods of forgetting and remembering.

INTRODUCTION

A cursory look through the wealth of material produced by WHO and its six regional offices turns up remarkably few references to religion. Yet, the vast majority of the world's population is religiously affiliated, and WHO is an important player in the Global South, where state-run public health infrastructure is often weak, and health-related personal beliefs, 'faith-based organisations' (FBOs) and religious leaders and -communities ('religious actors') play a key role in the provision of healthcare. Given these circumstances, it may seem surprising that their concerns do

Key questions

What is already known?

- ▶ While the role of religion in development work and the UN system has been subject to several studies, relatively little is known about the specific role of religious actors in global health and particularly in WHO.
- ▶ The present data represent results of the first major academic study of religious actors and WHO which, despite their significant role played in low-income and middle-income countries, have thus far—with some notable exceptions—not been investigated.

What are the new findings?

- ▶ Data collected through archival research and interviews with current and former WHO staff, consultants and programme partners (n=18) suggest that the development of the WHO's relationship with religious actors has developed in three distinct but overlapping phases: an initial period of 'cross-pollination' and institutionalisation (1970s–1980s), a period of cooling-off and crisis (1990s–early 2000s), and renewed interest and rapprochement (early 2000s–present).

What do the new findings imply?

- ▶ The findings presented here have significant implications for the current and future engagement of WHO with religious actors, particularly as the organisation seeks to move towards a model of multistakeholder public-private partnerships already established in other UN agencies.
- ▶ Historical and interview data suggest that precedents of both functional and problematic cooperation exist and should be considered in attempts to develop the organisation's civil society engagement.
- ▶ The term 'spirituality' has historically provided a bridge between religious actors and secular institutions.

not feature more prominently in the organisation's agenda. Even more so as, since the 1990s and particularly the early 2000s, the importance of FBOs in the United Nations (UN) system has become more evident and several UN agencies and major donors have begun to build sustained partnerships with religious actors.



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In the early 2000s, academic research followed suit, when a recognised group of scholars produced the first in-depth investigation of the often hidden influence exerted by religious actors in the UN.¹ Several monographs and edited volumes have since been published on the intersection of religion and the UN system,^{2–4} with a major research project completed recently at the University of Kent.⁵ Meanwhile, intersectoral collaborations such as the Joint Learning Initiative on Faith and Local Communities (JLI) have gathered mounting evidence of the contribution by religious actors to development work.

Although in the past decade the importance of religion to global health has become increasingly acknowledged (see the special issue in *The Lancet*, 2015, and the *Review of Faith & International Affairs*, 2016),^{6–9} the relationship between WHO and religious actors has evolved slowly and remains poorly understood. To some extent, this may be related to the organisation's role as a specialised agency with the responsibility to direct and coordinate international health work as well as to set norms and standards on health. More than most UN agencies, the WHO's credibility rests on its reputation for political impartiality and scientific sobriety and is staffed primarily by highly educated medical professionals, a demographic long noted for its comparatively low degree of religious affinity.¹⁰ Yet, while a secular organisational culture may have contributed to the relative absence of religion in WHO, the relationship between religious actors and WHO, we suggest, is more complex.

In this study, we present findings from interviews and archival research in Geneva to briefly outline the circuitous but evolving relationship between religious actors and key individuals and initiatives within WHO. Our analysis focusses on two domains: first, on developments *internal* to the WHO's headquarters, in particular in the World Health Assembly (WHA), the Executive Board and various programmes initiated at the headquarters or the organisation's regional offices. Second, we focus on activities carried out by individuals or groups within WHO in cooperation with *external* stakeholders in global health, such as religious leaders and religious communities like the Seventh-day Adventists church, FBOs such as Islamic Relief or Caritas Internationalis, research and advocacy groups like Religions for Peace, the Interfaith Health Program at Emory University or the Center for Interfaith Action on Global Poverty (CIFA).

Rather than making a case for or against increased cooperation, we illustrate how this relationship, lacking an institutional framework for engagement—as established in other UN agencies—has been marked by a process of forgetting and remembering, producing successive periods of institutionalisation and norm production, cooling-off and renewal of interest. While reproductive and sexual rights in particular continue to pose protracted normative questions which complicate the encounter between religious actors and global health institutions, this article focuses on efforts to build partnerships with religious actors in the past five decades,

and attempts at what we term 'institutional translation' between religious actors and WHO initiatives.

METHODS

The findings presented here are the result of a 4-year research project on the 'spiritual dimension' of health in WHO funded by the Swiss National Science foundation and conducted at the University of Zürich (forthcoming). It combined historiographical and medical anthropological methods and drew both on extensive archival research and semi-structured interviews. Interviews (n=18) were conducted with current and former WHO staff, consultants and programme partners. Informants were selected through purposive sampling.¹¹ The sample was snowballed from individuals who since the early 1990s had worked as external consultants to WHO or as programme partners at major FBOs, to WHO staff, consultants and partners presently and directly involved in issues relating to religion and health. Between June and December 2020, one author (FW) participated in a three-weekly WHO-internal webinar held to consult with religious actors on the Coronavirus response. Archival research was conducted between 2016 and 2020 at the headquarters in Geneva, the World Council of Churches (WCC), the Swiss and the German Federal archives, the Political Archive of the German Foreign Office, the Etter Archive in Zug, the archives of the Church of Nazarene in Kansas City and the private collections of former WHO functionaries. Conceptual and historical analysis also included official policy guidelines, training manuals, work reports and internal concept notes, publications such as the 'WHO Chronicle' or the 'World Health Forum' produced by WHO offices, and meeting protocols and verbatim records of WHA and Executive Board deliberations. As the scope of archival research was primarily headquarter-level policy, some county/regional-level work may have been omitted.

Patient and public involvement

No patients were involved in this study. Discussions with interview partners and an interdisciplinary roundtable comprising community stakeholders and members of the project advisory council, held in Geneva in January 2020, informed this project in the formulation and prioritisation of research questions, and were regularly consulted throughout the duration of this study.

RESULTS

The historical and interview data analysed suggest three distinct but overlapping phases in the development of the WHO's relationship with religious actors: an initial period of 'cross-pollination' and institutionalisation (1970s–1980s), a period of cooling-off and crisis (1990s–early 2000s) and renewed interest and rapprochement (early 2000s–present).

'Cross-pollination' and institutionalisation

In the first 30 years following WHO's founding in 1948, religious actors only rarely gained the attention of its staff, partly because the language of human rights tended to frame humanitarian issues, partly owing to an open conflict over population control policy between the Catholic Church and the organisation's first director-general Brock Chisholm (1896–1971), an outspoken sceptic of organised religion.¹² Occupied with a campaign to eradicate infectious diseases such as malaria with recently discovered antibiotics, vaccines and insecticides, the WHO's work seemed eminently technical and well-placed in the hands of international health experts.

By the 1960s and early 1970s however, the persistent recurrence of malaria forced the organisation to find an 'alternative approach'.^{12 13 14} The vertical 'war' on individual diseases had proven costly and inadequate to significantly lessen the burden of disease in many countries, and the organisation began to explore a model of community-based, comprehensive care over the entire life course of a population built on civil society partnerships and drawing on local resources such as traditional midwives, healers and religious experts.¹⁵ One such model had already been developed by the Christian Medical Commission (CMC). Founded in 1968 by the WCC and the Lutheran World Federation, the CMC was premised on the notion that medical missionaries should no longer engage in a parochial and quasi-colonial medical triumphalism. It began to build a network of outpatient clinics in low-income countries to involve the entire community in healing and provide compassionate healthcare to all, in particular the rural poor in Africa and Asia.¹⁶

In the early to mid-1970s, WHO—whose headquarters is a short walk from the WCC—engaged in a series of exchanges with the CMC. Then-director-general Halfdan Mahler, himself the son of a pastor and a close acquaintance of the CMC's first director James McGilvray, was impressed by the work of the Commission—"Why are we not able to produce excellent things like this one done by that little outfit across the fields?", he exclaimed to his staff on one occasion¹⁷—and began to explore with CMC leaders the possibility of cooperation. A joint standing committee was formed, which resulted in the formulation of the key principles of what would become the primary healthcare paradigm.^{18 19} The Commission would later be granted non-voting observer status in the WHA. This period of 'cross-pollination'²⁰ between advocates of the Christian social gospel and senior WHO staff toiled the ground for the 'Global Strategy for Health for All by the Year 2000' (HFA): an attempt to roll out primary healthcare globally by the close of the millennium. It also greatly influenced the drafting of the 1978 Alma-Ata declaration, a watershed moment in international health which achieved a broad consensus on the centrality of primary healthcare.^{19 21}

The Alma-Ata declaration occurred in context of a shifting configuration of power in the wider UN system: with decolonisation, many small states of the Global

South began to influence the General Assembly, and in 1974 succeeded in passing a resolution calling for the development of a 'New International Economic Order' (NIEO). 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.²² The HFA initiative was both an attempt to rethink the quasi-colonial top-down imposition of medical science proven ineffective in the first decades of the WHO's work, and an answer to the NIEO, which forced UN agencies to leave behind the economic and political order of past years.

In the late 1970s and early 1980s, the relationship between WHO and religious actors took another turn, when Samuel Hynd (1924–2016), the son of a medical missionary and health minister of Swaziland, the CMC and several member states from the African and Eastern Mediterranean regions began to argue that the HFA initiative ought to be extended with a 'spiritual dimension' of health. The effort was led by Kuwait and Saudi Arabia and supported by other Gulf states, where since the 1970s, the Islamic 'revival' (*tajdid*) had begun to force political regimes to legitimate themselves as culturally 'authentic' nation-states un beholden to Western influence. This began to influence Islamic medical elites through the Islamic Organisation of Medical Sciences.²³ In 1978, the desire to include a 'spiritual dimension' in healthcare was expressed to the Executive Board by a member from Libya and Bandhu D. Bisht, the deputy director-general of India's ministry of health and a passionate follower of Sri Aurobindo, who submitted a detailed background paper arguing that a 'spiritual dimension' was the 'Factor X' missing in the roll out of universal healthcare.²⁴

The attempt was supported by members of the Non-Aligned Movement—an alliance of former colonial states in support of the NIEO—and in 1983 the 'spiritual dimension' was tabled for discussion at the 36th WHA.²⁵ Halfdan Mahler was tasked to write a report to clarify the matter, in which he presented the term 'spirituality' as an overarching ethical framework for global health, an 'ennobling idea' rooted in 'humane qualities as a sense of decency, empathy with the world's health underprivileged, compassion and the desire for social justice regarding health'.²⁶ Notwithstanding endorsement by the director-general, opposition by member states allied with the Soviet bloc and concerns over the politicisation of international health policy—assembly meetings regularly escalated into tirades against the Israeli occupation of Palestine—likely factored into a vote at the 37th assembly in 1984 to settle for an unbinding 'invitation' for member states to add a 'spiritual dimension' to their health programmes 'in accordance with their social and cultural patterns'.²⁷

Without a binding commitment, and in any case limited to the HFA initiative, few member states followed up on the WHO's call to add—in the words of the Executive Board representative to the 37th WHA—a 'touch of the

soul' (*supplément d'âme*) to their health programmes.²⁷ A notable exception was the WHO's Eastern Mediterranean Regional Office: here, 'spirituality' over the following decade began to figure both as a way to gain popular support for public health measures, in particular a campaign against tobacco use,²⁸ and as part of an at times rather conservative reading of Islamic morality in healthcare. In 1989, this culminated in the *Amman Declaration on Islamic Lifestyles*, which provided detailed guidelines for salutogenic behaviour based on the sayings of the Prophet Mohammed.²⁹ Although it fell short of the breakthrough hoped for by its advocates, the resolution of 1984 was in the coming decades repeatedly cited by both liberal and conservative proponents as a precedent for a closer relationship with religious actors.

In the mid-1980s to late 1980s, a further seed was planted which would come to fruition over two decades later. Before the 1980s, a strong belief in the curative paradigm had informed much of the WHO's work, and matters related to the care of patients beyond the curing of disease, such as palliative care, were generally viewed as outside the purview of medicine. In 1982, under the leadership of Swedish oncologist Jan Stjernswärd (1936–present), who—like several other key proponents of 'spirituality' in the WHO's recent history—had been inspired while working in India, the WHO's Cancer Unit began to appreciate the importance of health-related personal beliefs in oncology. In 1986, the WHO Collaborating Centre for Cancer Pain Relief published a report which took recourse to Cicely Saunders (1918–2005), a pioneer of the hospice movement who had coined the notion of 'total' (including 'spiritual') pain. Based on this, in 1989 an expert committee defined palliative care as 'the active total care of patients whose disease is not responsive to curative treatment', where 'control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount'.³⁰ This shaped the WHO's first definition of the field of palliative care, published in 1990, which would remain influential for the following decades.^{30 31}

Cooling-off and crisis

In 1988, the tenure of Halfdan Mahler, known as a charismatic leader and driving force behind universal healthcare, ended. The CMC, long disillusioned with the top-down and reductionistic turn the primary healthcare paradigm had taken, ceased close exchange with WHO. The following decade saw budgetary pressures, a lack of significant breakthroughs in innovation and the tenure of director-general Hiroshi Nakajima (1928–2013), widely perceived as an ineffective leader.³² The HIV/AIDS epidemic dominated the global health agenda, while tuberculosis coinfections and drug resistance to malaria treatment replaced the roll-out of primary healthcare with targeted campaigns to stem the spread of infectious disease in the Global South. Disagreements between Nakajima and Jonathan Mann (1947–1998), the head of the WHO's Global Programme on AIDS,

led to the resignation of the latter and the stalling of the WHO's HIV/AIDS response.³² Marked by halting efforts to combat this epidemic and the incumbent public health catastrophes in former Soviet states, the 1990s has been described by observers as a period of 'backsliding' in global health and pervasive institutional crisis within WHO.³³

In 1996, the Joint United Nations Programme on HIV/AIDS (UNAIDS) was founded. Housed in a building vis-à-vis the WHO headquarters in Geneva, UNAIDS was established to coordinate a multi-agency and multi-sectoral global response, including the WHO's Global Program on AIDS, capable of addressing the complex intersections of stigma, denial, structural and gender violence, and religious and cultural barriers to treatment and prevention. By pooling funding from major donors who—dissatisfied with the perceived bureaucracy of UN agencies—had increasingly begun to support bilateral aid programmes, it took over leadership in the defining public health crisis of the decade.^{34 35} From the outset, UNAIDS recognised the significance of religious actors in controlling the spread of HIV/AIDS: it employed a liaison coordinator for FBOs and included FBOs along with other NGOs and civil society representatives as non-voting members of the governing board.

The 'spiritual dimension' introduced in the late 1970s and early 1980s to the Executive Board and the WHA through the HFA initiative echoed the broad conception of health as 'more than' a mere matter of biological disease, which in the early post-War period had been famously written into the preamble to the WHO constitution. The 'spiritual dimension' in this sense signified a revalorisation of the social medical ideals on which the organisation had been founded. But the return to a relatively narrow approach taken by the eradication of singular disease epidemics, chiefly that of HIV/AIDS, stigmatisation of certain sexual behaviours and the reluctance of major religious actors to advocate condom use made clear that religion was part of the problem as much as it could be part of the solution.³⁶

While UNAIDS actively cooperated with religious actors to address these challenges, within WHO, health-related personal beliefs remained marginal and surfaced in but two contexts: passing acknowledgements within palliative care guidelines of the complexities incurred by the young age of victims and the initially high mortality rates associated with the epidemic, and general concerns over the existential suffering of patients infected with the virus. The latter was taken up by the Department of Mental Health and Substance Abuse and developed into a module for the WHO Quality of Life Instrument (WHOQOL), which assessed the impact of feelings of guilt, forgiveness, divine love, the meaning of life, among others, on subjective well-being of people living with HIV/AIDS.³⁷

The importance of such existential concerns was a surprise to key WHO staff working on the project and partly motivated the development of a second module

with an additional 32 questions dedicated entirely to what would be termed 'spirituality, religiousness and personal beliefs' (WHOQOL-SRPB). In a first in the organisation's history, the instrument was developed through extensive consultation with representatives of every major world religion, who were brought to one table with theologians, psychiatrists and health psychologists to identify the central themes of questions which would be tested by focus groups located in 18 centres across the globe. The development of this instrument was joined by Bandhu D. Bisht and took explicit recourse to the attempt to introduce a 'spiritual dimension' to the HFA initiative in the early 1980s.³⁸

At the 101st WHO Executive Board meeting held in 1998, a to-date final attempt was made to introduce a 'spiritual dimension' through a binding policy applicable to all regional offices—this time, by directly adding the term 'spiritual' to the 'mental' and 'social' aspects mentioned in the definition of health found in the preamble of the WHO's constitution.³⁹ The attempt was led by the Regional Director for the Eastern Mediterranean Office, Hussein A. Gezairy (1934–present), who had already lobbied for the matter in the early 1980s as part of the HFA initiative, and was backed by several Islamic-majority member states, as well as Argentina, the Cook Islands, the UK and Ireland. Despite winning the support of a special group tasked with reforming the constitution and a vote of recommendation by the board, objections over the precise meaning of the term, doubts over whether 'spirituality' is an appropriate interest for medical scientists, and concerns relating to the separation of church and state factored into the rejection of a constitutional revision at the 52nd WHA in 1999.⁴⁰ Notably, these objections may not have been the deciding factor in this decision, as the 'spiritual dimension' was rejected as part of a broad attempt to reform WHO and may have been viewed more favourably considered on its own merit.

Renewed interest and rapprochement

In the late 1990s and early 2000s, major philanthropic groups such as the Bill and Melinda Gates Foundation and programmes like the President's Emergency Plan For AIDS Relief created an influx of funding into global health programmes. In the same period, decreases in public health funding and the ambitious UN Millennium Development Goals increased reliance on a model of public-private partnerships between multilateral organisations, NGOs and private and multilateral funding bodies. Between 1998 and 2003, Gro Harlem Brundtland (1939–present) was elected director-general of WHO, cementing a neoliberal approach to public health which presented health programmes as an 'investment' into economic growth and political stability, and relied on the private sector for the implementation of programmes. This moved global health priorities towards individual, issue-based programmes—such as the battle against HIV/AIDS—where outcomes were more short-term and

quantifiable and implementation partners could be held accountable more easily.

The shift away from the rights-based, secular and state-funded and -operated development of public health gave new importance to the provision of healthcare services by FBOs, perceived to offer a comparative advantage due in part to their long-standing presence in impoverished regions, ability to raise funds and access to voluntary labour.^{41 42} In the following years, several events can be identified as putting religious actors on the agenda of the development sector: in 2000, the Millennium World Peace Summit was held, gathering over 1000 religious leaders in the UN headquarters in New York, and the World Faiths Development Dialogue was convened by former World Bank president James Wolfensohn and then-Archbishop of Canterbury George Carey. In 2001, the terrorist attacks on the World Trade Centre catalysed the recognition that religion had to be actively involved in the UN development agenda, and in the following years, the Center for Faith-Based and Community Initiatives was established at USAID, the major US development agency, and a major research programme was funded by the UK Department for International Development. UNAIDS, the United Nations Development Programme, the UN Population Fund (UNFPA), the World Bank and other agencies began to work more closely with religious actors. In 2007, this reached an important milestone with a UNAIDS conference of 40 religious leaders from various traditions, a UNFPA-report on lessons learned in cooperating with FBOs, and the founding of the UN Inter-Agency Task Force on Engaging with FBOs for Sustainable Development.⁴³

Within WHO, this was reflected in a nascent attempt to forge closer collaborations with civil society through consultation with important NGOs and FBOs. Already in 2003, the HIV/AIDS department had employed Ted Karpf, an Episcopal priest, as a 'partnerships officer' to build a closer relationship with religious actors.^{44 45} The promise of collaboration was exemplified by countries such as Lesotho, where an estimated 40% of national health services were reported to be delivered by Christian hospitals and health centres. In 2005, WHO contracted a major study to be conducted by the African Religious Health Assets Programme (ARHAP)—a collaboration between the Interfaith Health Programme at Emory University and three South African universities—to map the 'religious health assets' available in six African countries in the battle against HIV/AIDS.^{46 47}

A legacy of Rev. Karpf's work at WHO was a report on the role of FBOs in primary healthcare reform,⁴⁸ which contained a resounding endorsement of religious actors in global health well beyond the battle against the HIV/AIDS epidemic—including the questionable claim that 'FBOs are providing an average of 40% of healthcare'³⁸ (for a critique see Haakenstad et al.⁴⁹). In 2009, a major 6-day conference on 'health and lifestyle' organised by a group of Seventh Day Adventists was attended by over 600 members of the church

and representatives from WHO, with a reception in the meeting room of the Executive Board at the headquarters in Geneva—apparently the first time in the history of the organisation that this honour was extended to a church denomination.⁵⁰

The conference initially intended to include a roster of influential figures such as the WHO's deputy director-general and well-placed functionaries involved in reform of the UN system. It was hoped by church leaders to culminate in an official relation with WHO and forge a closer relationship between the organisation and religious actors more generally. Strong opposition from a former WHO staff member concerned over the involvement of religious actors in secular affairs however interrupted this plan and placed the intended collaboration on hold. Rev. Karpf's outspoken advocacy of such involvement eventually factored into his eventual departure from WHO.

In late 2009, a second major gathering was held, this time organised by the WHO Programme on Partnerships and UN Reform in collaboration with CIFA launched the previous year in Washington, DC. It brought together 39 FBOs, academics, international organisations and representatives from governments, key figures from ARHAP and UN agencies including the World Bank, UNFPA and UNAIDS, to discuss how to catalogue and monitor the health-related services provided by religious actors. 'Religious health assets', it recognised, carry a significant proportion of the global burden of disease, but are often invisible and 'taken for granted'. If they were 'put on the map', it was hoped, they would gain a 'seat at the table' of donor agencies and governments and could participate in planning and funding negotiations. Specifically, the report endorsed extending the WHO's Service Availability Mapping (SAM) software, a database used to monitor global health infrastructure, with data on health-care and 'valued-added' services such as spiritual care provided by FBOs. A joint WHO-CIFA report described the meeting as 'historic'.⁵¹

The discontinuation of SAM, the enormous complexity of identifying and cataloguing 'religious health assets' and the debacle at the previous 'health and lifestyle' conference erstwhile paused the rapprochement between WHO and FBOs. In the new millennium, a second issue however was gaining more sustained traction: that of health-related personal beliefs in palliative care. In 2002, WHO formulated a definition of paediatric palliative care.⁵² It departed from the recommendations from 1989, when palliative care was intended as a last measure when all curative options had failed and reflected a growing recognition that such care could figure as a form of complementary intervention introduced as soon as possible in order to prevent pain as well as social and 'spiritual distress'. In 2014, the WHA passed a resolution which cemented the importance of 'spiritual needs' of patients and their families.⁵³ Though the relevance of 'spirituality' is most widely recognised in the field of palliative care, concerns remained that the

provision of opioid-based interventions would be jeopardised by discussions on the importance of a 'spiritual' dimension.

In the same year, a high-level summit between the WHO, UNICEF and leading Islamic institutions and religious scholars was held to discuss polio eradication programmes particularly in parts of Pakistan, Somalia, Nigeria and Afghanistan, where suspicions of and attacks on health workers had been reported. The landmark meeting affirmed the compatibility of polio vaccination with Shariah law, expressed the "unequivocal" support of the participants for polio eradication programmes in the Islamic world, and called to deepen what the director of the WHO's Eastern Mediterranean Office referred to as a "close collaboration" with Muslim scholars on this issue.⁵⁴

Most recently, the West African Ebola crisis (2014–2017) returned religious actors to the centre of a major institutional priority. Efforts by infectious disease control teams to safely bury dead Ebola victims were seriously hampered by widespread distrust and beliefs in the importance of burial rituals according to local customs, often involving physical contact with the deceased. Regular attacks and even the murder of health workers, the hiding and stealing of bodies, refusal to cooperate with contact tracing and the distress of family members unable to farewell their relatives soon suggested that control measures had to be adapted in close dialogue with local religious actors, resulting in a consultation between WHO and the Red Cross, the Red Crescent, the WCC, Islamic Relief, Caritas Internationalis and World Vision to develop guidelines for the burial of Ebola victims felt by local communities to be both safe and 'dignified'.⁵⁵

The creation and adoption of the Ebola guidelines was perceived by many religious actors and WHO staff involved in the Ebola response as a success and became a precedent for a similar initiative: in early 2020, amid the rapid spread of Covid-19 in religious communities in South Korea and Iran, the WHO's newly created Information Network for Epidemics (EPI-WIN) began a far more extensive consultation with over 60 religious actors to develop guidelines for religious leaders and religious communities during the pandemic. In what appears to have been the most extensive dialogue between WHO and the religious actors thus far, detailed instructions for the adaptation of worship practices and gatherings were written, including special guidelines for the safe conduct of Ramadan and a flow chart and risk assessment tool to evaluate the risk of mass gatherings.^{56 57}

This time, the WHO's engagement with religious actors took a more proactive role. 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), JLI 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

religious scriptures which could be used to encourage the adoption of safe worship practices.⁵⁸ In late 2020, EPI-WIN engaged a former UNAIDS adviser on faith matters to consult WHO on developing this engagement beyond these guidelines. At the time of writing, it has established ‘communities of practice’ involving WHO staff and religious actors to consult in three areas of shared interest: vaccine communications, shared research and training and the development of a framework of engagement comparable to the UNAIDS strategic framework for partnering with FBOs.⁵⁹

DISCUSSION

During the 1970s and 1980s, ideological and geopolitical interests had advanced the ‘spiritual dimension’ in the WHO’s attempt to roll out primary healthcare. The 1990s had seen little development, but towards the end of the decade and the early 2000s, the spread of neoliberalism and increased reliance on partnerships with civil society once more rendered religious actors a valued resource. Rather than emerging from WHA discussions on an ethical framework in the sense of Mahler’s ‘ennobling ideas’, this relationship evolved from a pragmatic recognition that the achievement of the WHO’s institutional goals necessitated cooperation with civil society, including religious actors.

As Grills⁴⁴ has suggested, the relationship between multilateral organisations and religious actors remains fraught by apparent contradictions: even if a closer relationship is desired by both parties—as in the recent ‘pragmatic turn’—such engagement may be feared to enable groups working to undermine the secular mandate of multilaterals accorded by their member states. Western liberal values, which have dominated the UN system since its creation by allied post-War intellectual elites, are perceived as a foreign ideology by many member states and at times compete with core values of religious actors, such as community participation. The distinction between ‘rational’ multilateral and ‘value-based’ religious actors—problematic both because it implies that multilaterals are devoid of ethical values and that the values of religious actors contradict reason, the influence of the American religious right and more generally the suspected allegiance of multilaterals to the private sector, continue to create strong opposition to cooperation. This adds to practical concerns relating to the quality of care, transparency and accountability of health programmes operated or funded by religious actors, conflicting and incomplete data and exaggerated claims regarding the contribution of religion to global health.^{9 60}

The events outlined above illustrate a tendency to mitigate these contradictions through the translation of religious into secular values, preserving to some extent the intents and language used by religious actors while allowing integration into secular institutions. Building on Habermas, Hanrieder⁶¹ describes this strategy of conceptual euphemisation as a ‘dialogical process through which

the parties converge on a mutually accepted reinterpretation of a religious claim’, producing an intentionally ambiguous term encompassing general liberal values resonant with both secular and religious actors. This is evident in the ‘spiritual dimension’ of health, a phrase much less evocative of the politically vested and counter-secular institutions connoted by a ‘religious dimension’ of health. It is also evident in the introduction of the ‘spiritual dimension’ to the 1978 Executive Board meeting as the missing ‘Factor X’ of primary healthcare, the ‘ennobling ideas’ of Halfdan Mahler, and the instrumental rationality implied by the ‘African Religious Health Asset’. This translation may be either welcomed as a diplomatic feat or questioned as a potential threat to the principles of religious actors, as it occurred in the aftermath of the Adventists congress.⁵⁰

Finally, interviews have shown that, quite apart from these political contexts, even major breakthroughs such as the debates in the World Health Assemblies of 1983 and 1984 are simply forgotten. Although WHO documents often cite predecessors to signify a degree of institutional continuity, the size and regionalisation of the organisation—with over 7000 staff employed in nearly 150 countries—makes it challenging to retain an interpersonal (communicative) memory.⁶¹ Although WHO maintains an archive, the cultural memory recorded in official records, with the exception of the verbatim records of some WHA discussions, is typically limited to an achieved consensus that can guide policy decisions, and omits the messy process of institutional translation.

The ongoing crisis of multilateralism has underscored the importance of partnerships with civil society stakeholders. For better or for worse, WHO has sought to maintain the best current medical scientific evidence while sitting at a table joined by political ideologies, personal beliefs, scientific and pseudo-scientific counter-claims and contending expert opinions. This is illustrated by a comment of director-general Tedros A. Ghebreyesus at a recent consultation with civil society representatives, notably omitted in the official record. Rather than taking questions from the audience, in a curious reversal of roles he implored participants to advise 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”.⁶²

Taking seriously the risk and potential of cooperation with religious actors, we suggest, begins with the recognition that, while various forms of cooperation have historically been successful (e.g., on universal healthcare), some notions of what constitutes ‘good’ and desirable outcomes in global health (e.g., on sexual and reproductive rights) remain incommensurable. This normative dimension has potentially far-reaching effects on the type and availability of medical services, for religious actors can extend primary healthcare particularly in the Global South, but reliance on these resources may be argued to hasten the decay of publicly funded secular health infrastructure,

and thus compromise public health priorities, especially those related to the delivery of family planning services to underprivileged populations.

The incommensurability in some areas, however, ought not hinder cooperation in others, for instance, the provision of basic medical service to the poorest of the poor, where religious actors are known to play an important role.⁶³ Successful cooperation, we contend, thus remains a precarious balance between the degree to which religious actors are willing to carry out their work in a context of what may be criticised as a neoliberal instrumentalisation of religion, and the insistence on defining their own terms of engagement by remaking the nature and type of healthcare provided and influencing the agenda of multilateral organisations. As pointed out by Baumgart-Ochse and Wolf,⁵ much hinges on whether religious actors understand themselves as ‘mediators’ between religious communities and secular institutions, or ‘polarise’ global health discourse with political theologies which effectively hinder or reverse cooperation on shared goals in an institutional context founded on, and still overwhelmingly defined by, secular principles. Lastly, as WHO seeks to strengthen its partnerships with civil society, the prominence of religious actors in global health may give occasion to consider why in many liberal societies, community participation tends to be understood as a prerogative of religion—and what can be learnt from religious actors about non-religious forms of civil society engagement.

Consultative processes, long institutionalised in other parts of the UN system, have in the past played a relatively minor role. Still, as suggested by the recent cooperation with religious actors in addressing the Covid-19 pandemic, the organisation’s willingness to innovate may be changed, and changed quickly, if demanded by a time-critical challenge of global significance. While it is early days yet, this thus-far functional collaboration has demonstrated that at least in the present crisis, the need for partnership can override ideological purity. If the time has come to rethink WHO’s engagement with a broader coalition of stakeholders, the evolving relationship with religious actors may be a fitting place to begin.

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