SPIRITUALITY, HEALTHCARE AND HEALTH: A PRACTICAL GUIDE

A SUPPLEMENT TO THE 'COPC - A PRACTICAL GUIDE' HANDBOOK

THE DIFFICULTY OF EXPRESSING WORDS…

Many volumes of texts have been written about each of the words **spirituality**, **religion**, **faith** and **beliefs**. It would be impossible to do justice to the complexity of the many nuances, associations and interpretations in one small guide. We will therefore steer clear of any prescriptive use of these words, and ask also that you will accept these at face value within each of the different contexts and chapters.

Although the words are used interchangeably in the text, **spirituality** generally refers to the inner thoughts, emotions and actions that aims to meaningfully connect a person to something bigger than him or herself. Spirituality is also used as a way of gaining perspective, recognising that our role in life has a greater value than just what we do every day.

Religion and **beliefs** can be seen as outlets of our own spiritual reality with religion generally representing specific beliefs and practices, usually shared by a community or group.

Faith represents complete trust and confidence in the existence of something or someone, based on spiritual conviction without having seen proof. It is a strong component of religion and beliefs.

Oxford Dictionary

MOSES MAIMONIDES (1135-1204): RABBI, PHILOSOPHER, PHYSICIAN

"The eternal providence has appointed me to watch over the life and health of Thy creatures. May the love for my art actuate me at all times; may neither avarice nor miserliness, nor thirst for glory or for a great reputation engage my mind; for the enemies of truth and philanthropy could easily deceive me and make me forgetful of my lofty aim of doing good to Thy children.

May I never see in the patient anything but a fellow creature in pain.
Grant me the strength, time and opportunity always to correct what I have acquired, always to extend its domain, for knowledge is immense and the spirit of man can extend indefinitely to enrich itself daily with new requirements. Today he can discover his errors of yesterday and tomorrow he can obtain a new light on what he thinks himself sure of today.

Oh, God, Thou has appointed me to watch over the life and death of Thy creatures; here am I ready for my vocation and now I turn unto my calling."

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PREFACE

WIHAN ROSSOUW

There is a famous African expression, commonly known as Ubuntu that teaches us "a person is a person through other persons." [1] This booklet aims to bring the essence of this wisdom to life, by connecting you, the reader, with other persons, who are also struggling with questions of spirituality, health, and healthcare.

These persons are a unique set of individuals from a broad variety of disciplines and expertise, who will provide you with multiple perspectives on issues that are currently troubling healthcare workers, religious leaders, patients, and community members alike. Our aim is not to provide clear-cut answers to these questions, but to facilitate a conversation, where we can learn from each other and use different approaches to solve the problems that arise from the relationship between spirituality, health, and healthcare. Furthermore, this booklet hopes to provide context to religious beliefs and healthcare as it pertains to the South African landscape.

In order to capture the variety of perspectives across this landscape, the authors do not necessarily share the same worldview, research paradigm, or definitions. However, as the reader, you are the expert of your own context, which means that you are the best person to evaluate what advice will work best for your context and your problems.

The authors would welcome feedback! Whether you disagree, have an opinion about a topic, or have personal experiences or testimonies to share, we welcome your feedback and ask you to take part in this conversation. These are unchartered waters and the more insight we are able to gain, the more we can develop our collective understanding of the subject matter, its implications, and implementation. Ultimately, if needed, we are willing to go through as many editions as necessary to capture undocumented nuances, and we therefore urge you to provide any feedback that will benefit the communities and the health workers that serve them.

INTRODUCTION

MARTIN BAC

A booklet on spirituality, health, and healthcare is long overdue because some important aspects of human health have been neglected for many decades in medical and health education. In the past 100 years, medicine has increasingly been dominated by an evidence-based approach built on the natural sciences. Much attention was given to curing the patient, and to relieve symptoms when cure is not possible. As a result, the psychosocial-spiritual dimension has been neglected. Very little attention was given to this aspect during the training of healthcare workers and many researchers were not interested in this field. It is not surprising that many healthcare workers struggle in comforting their patients, although that should always be done. This has changed dramatically in the past 10-20 years and scientific evidence increasingly shows that spirituality plays a very important role in health promotion and disease prevention. How people cope with ill health, chronic diseases, and trauma are to a large degree determined by their worldview and spirituality. Doctors, social workers, and nurses know this of course from their clinical experience but were poorly trained to deal with spiritual issues. Are spirituality and spiritual distress part of your work and how do you address this? How do you deal with bitterness, shame, and guilt, or restore hope?

The patient's worldview determines their help-seeking behaviour. Does the person trust the Western-trained doctor, the sangoma, or the prophet? People's opinion on how you maintain a healthy balance in life and what is harmful also has spiritual dimensions. Lifestyle is directly influenced by peoples' spirituality, which gives guidelines about what the believers can eat or drink, how important moderation is and which sexual behaviour is acceptable.

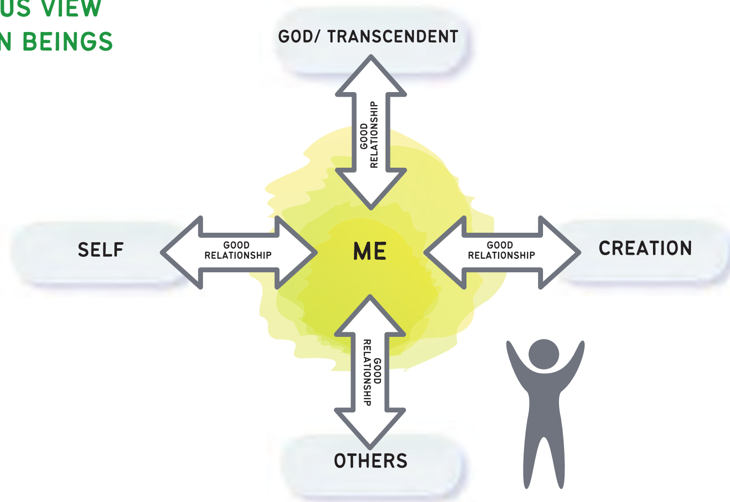
How do people give meaning to important changes in their lives such as the arrival of a new baby, the diagnosis of a serious life-threatening disease, or suffering at the end of life? This is largely determined by their spirituality and faith. Most religions have rituals to celebrate such occasions or to cope with losses.

If healthcare workers understand their own spirituality that of their patients and how important it is for a patient during a certain season, this can make all the difference in the quality of care the patient receives. It can build trust between the healthcare worker, the patient and the patient's family. This will not only influence patient satisfaction, but also the outcome of the patient's illness. This approach can make the difference between a lonely, agonizing death or a peaceful death surrounded by compassionate carers who respect and understand their patient's needs irrespective if those needs are physical, social, psychological, or spiritual.

Community members' lifestyles and behaviours are shaped by their worldviews. Similarly, our involvement in community health is built on our worldview assumptions. We would propose the use of a consensus model as a basis for a holistic approach to Community-Oriented Primary Care (COPC). Such a consensus model will make it possible for all people of goodwill, including healthcare professionals, to collaborate for the good of the community.

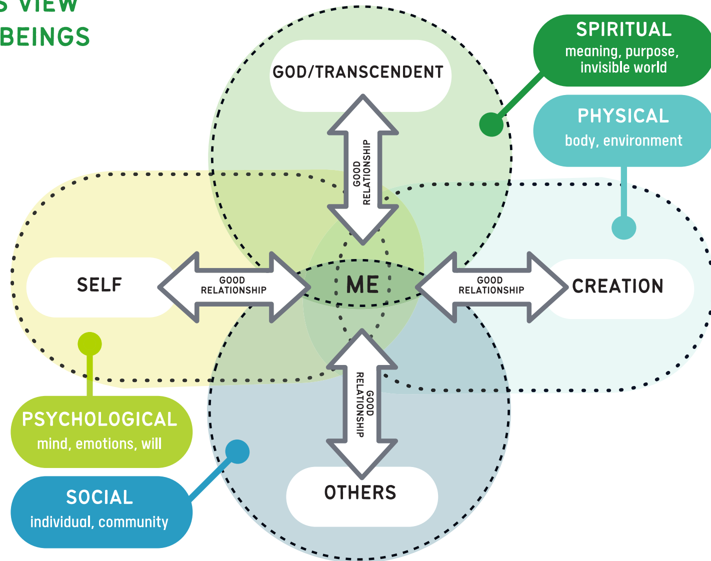
Therefore, we recommend using the four aspects of healthcare as put forward by the World Health Organization: spiritual, psychological, social, and physical. These four aspects can be readily applied to community-oriented primary care as well. Such an approach to community health could be based on the following view of human beings- a human is a being grounded in four basic relationships: with God / transcendent, with self, with other humans, and with the rest of creation/material world.

CONSENSUS VIEW OF HUMAN BEINGS



From this consensus view of human beings, one could then derive the following aspects of community-oriented primary care.

CONSENSUS VIEW OF HUMAN BEINGS



Throughout this booklet we will explore the key elements shown in these diagrams.
We trust that this booklet will equip you and assist you to understand how to detect the potential of holistic care for your patients and challenge you to integrate spirituality into your daily work and clinical practice. It will enrich you personally and increase your abilities to deal with the patient's and the community's needs and greatly improve your job satisfaction.

CHAPTER 1: WHAT IS SPIRITUALITY?

1

LUC KABONGO

WHAT ARE WE GOING TO DISCUSS?

In this chapter, I will discuss:
Firstly, the general meaning of spirituality.
Secondly, how spirituality contributes to making life meaningful and constructive.
Thirdly, how spirituality has an impact on someone's health and how it influences. Spirituality has benefits, irrespective of which way it is expressed in how we view healthcare.
Fourthly, how every culture is shaped by a spirituality or multiple spiritualities that need to be acknowledged and respected.
Finally, how spirituality is connected to faith which is sometimes expressed through religion.

1.1. BROAD EXPANSION

DID YOU KNOW?

Spirituality is a significant contributor to a patient's cure.
Discuss in your group how you understand spirituality, religion, beliefs and faith.

Spirituality can be defined in various ways. It originates from the Latin words *spiritus* or *spiritualis*. *Spiritus* means something that gives life to physical organisms. *Spiritualis* means breath [2]. Spirituality generally refers to a sense of connection or attachment to something bigger than oneself that brings meaning to life. It is "someone's relationship with the absolute" [3]. It encourages people to care for their "well-being and quality of life" [4]. It equips people to deal with "deep questions around the meaning of human life" [5].

DID YOU KNOW?

"The absolute" is an academic term that refers to the spiritual reality that undergirds and includes the whole universe [97]. This means that even though different religions/belief systems use different words to describe this spiritual reality or entity, we are able to use a neutral term to facilitate discussion.

Did you know? "The absolute" is an academic term that refers to the spiritual reality that undergirds and includes the whole universe [97]. This means that even though different religions/belief systems use different words to describe this spiritual reality or entity, we are able to use a neutral term to facilitate discussion. There is someone or something we can rely on in aspects of life when we can't understand or when we seek total goodness as the fundamental principle of the absolute. All human beings are born with the "characteristic of being spiritual" [6]. Some express and nurture their spirituality within the context of a church, temple, mosque, synagogue, altar or tent.

Others, like humanists, hedonists, and atheists, are comfortable expressing their spirituality as a private relationship with whoever or whatever they believe in. Spirituality has benefits, irrespective of which way it is expressed. These are:

1

1. Spirituality helps the nurturing of the relationship with our 'absolute'. It improves someone's sense of focus and attentiveness to what should matter the most in their lives.
   a. Our world has a way of diverting our attention through media, marketing and needs-based activities that take people's focus away from their inner self. Spirituality helps us to be aware of our identity and how it affects our context.

2. Spirituality helps provide a community for like-minded people. A community improves someone's quality of life because we are all social beings.
   a. Christians, for example, believe that God created human beings to be part of a community. They allude to the partnership of Adam and Eve in the book of Genesis, and Jesus who was raised in the family of Joseph and Mary.

3. Spirituality helps build resilience because it provides meaning to life at all times, especially during a challenging period such as illness.
   a. Christian spirituality, for example, equips people to find meaning in all circumstances they face in life because Jesus self-identified as the way, the truth and the life. Even when faced with an incurable illness, there is a belief in healing because they believe that nothing is impossible to God (Luke 1:37). Christians' hope is found in their belief in life after death.
   b. In African traditional spiritualities, there is also a belief in life after death. A deceased person is believed to be part of the family of the living and has more power than the living family [7]. There is also a belief in the power of healing in times of illness from the absolute or ancestors. This belief in life builds resilience, which could be critical in the healing from an illness or dying peacefully.
   c. In the impoverished community where I live and serve as a pastor, I have observed that spirituality is the driving force for resilience, faith and hope for healing. Such spirituality is not only Christian. In many cases, it is a combination of two or more worldviews.
   d. Villegas [8] confirms that spirituality enhances someone's sense of "resilience." In his research on the survivors of civil war in Colombia, the majority of his interviewees alluded to spirituality, learned primarily from their homes, as the pillar behind their coping mechanism.

4. Spiritual people tend to make sacrificial choices.
   a. Many faith based-organisations are involved in ministries of mercy to serve the poor, vulnerable and marginalised people in society.

5. Spirituality fosters hope. It equips people to be aware of their limitations and to project their ideal in the absolute they pursue. It builds hope in the sense that believers aspire to the ideal.
   a. The Jewish rabbi, Jonathan Sacks, refers to hope as an integral part of humanity. According to him, hope helps human beings "overcome the difficulties of any given here and now." [9]. It is through hope that we find meaning when we face the unknown or uncertainties.

Spirituality is also connected to healthcare because health has a spiritual component. It helps human beings process the fact that, especially when they are sick, they cannot control everything, that they are fragile and vulnerable. The situation of the COVID-19 pandemic reminded humanity that it cannot fully control everything. Things we have learned to find meaning in, such as going to work, gatherings, or school have been disrupted, because our physical health needed to be preserved. Many people find meaning in their plans and implementation of such plans. COVID-19 negatively affected this way of finding meaning.
This caused chaos in many lives and affected people's mental health.
As a result, many people are losing faith in their plans and are now trusting more in their absolute for guidance [10].

Oberholzer [11] reminds us that "from the earliest times, spirituality and healthcare have been dependent on and supported one another." In the traditional African culture, healthcare and spirituality are connected. The traditional African healer is both a spiritual and a physical healer.

Other societies have had a similar holistic approach to healing. The European Antiquity functioned that way when monks and nuns rendered holistic healthcare to the sick. Koenig, King, and Carson [12] confirm that in their 2800 studies on religion and spirituality, they concluded that there was a positive relationship between religion and spirituality as related to mental and physical health. In other words, one can conclude that spirituality and healthcare can have a good relationship.

1.2. WORLDVIEW

Every human being has a worldview, a set of assumptions through which they filter everything, whether it is important or not. Our spirituality has a significant influence on what we believe in and how we view healthcare.

Some people's belief system explains why they would not accept blood transfusion when healthcare professionals suggest them to do so, for instance. Some people would not eat certain types of food.
Others would first go to their spiritual leaders when they are sick. Some will stop drinking chronic medication when their spiritual leaders ask them to do so as an act of faith. Occasionally people will physically harm others with the blessing of their spiritual leaders. Our different worldviews and spiritualities explain why people understand the meaning of life differently.

Knoetze [13] says that spirituality, "does not withdraw us from the world, but…gives meaning to our lives." For example, I grew up in a context that sees illness as having spiritual and physical causes. The same context validates both Western and traditional (mostly the use of natural things such as plants, roots, etc.) medicines. Because of this worldview, my starting point of seeking healing is through prayer. It is only afterward that I use Western or traditional medicine. I have been healed by both Western and traditional medicines in many instances. Different people go about seeking a cure for an illness differently depending on their spirituality.

DID YOU KNOW?

Did you know that "incarnationally" comes from the Latin *incarnare*, which means into (*in*-) + flesh (*carn*-). Therefore, to incarnationally live the good news, means to embody the message that we are spreading.

1

I have witnessed many African healthcare professionals disregard African traditional medicines because their medicine dosage is different. Although they are entitled to their opinion, I often wonder if they do not have a colonial mindset. I would define the latter as "a mind that easily conforms to a dominant narrative" at the expense of his/her own cultural identity. [14]

A recent example is the herbal medication promoted by the president of Madagascar as a cure for COVID 19. The political analyst and traditional healer, Aubrey Mashiqi [15] argues along the same line when he remarks that: "In sub-Saharan Africa, the majority people are a minority culture in terms of dominance. The dominant narrative, logic, power is held by the minority people."

Every culture is shaped by a form of spirituality or spiritualities that needs to be acknowledged. Such a gesture is both honouring and dignifying to that culture. Colonialism promoted the hegemony of a certain spirituality. Such hegemony is still promoted nowadays, thereby undermining other spiritualities. The goal is not to stop talking to people about a different spirituality. The power of tangible persuasion through open conversations could be helpful here. John Hayes [16] stresses that our current "world needs more people to live the good news incarnationally, in a way that can be seen, heard and handled." A good spirituality should be assessed based on its tangible fruitfulness. Words alone are no longer enough to be classified as good news. Therefore, conversations supported by tangible actions could win someone into a certain spirituality. Christian spirituality, for example, is founded on altruistic love. This foundation encourages the fostering of three cultures:

George Mokoena

George Mokoena is 8 years old and is not doing well at school, he failed Gr. 1 twice and from time to time he has seizures and becomes unconscious. His parents have taken him to the traditional healers many times who diagnosed that he was bewitched.
They recommended several rituals to satisfy the ancestors but the boy has not improved. As a community health worker, you want to send the child to the clinic to see the visiting doctor but the mother is reluctant and does not trust the doctors from the local hospital.

How will you deal with this dilemma?

1. A CULTURE OF HONOUR

All human beings were created by God out of love and with equal worth. Therefore, everybody should be equally valued and is worthy of affection. Such a culture promotes “harmony within individuals and listening to others” [4].

2. A CULTURE OF ACCEPTANCE

DID YOU KNOW?

Did you know that “altruistic” comes from the Italian *altrui*, which means "other people" or "somebody else". This means that altruistic signifies love that is solely directed to other people i.e., someone else.

To love others is to accept people for who they are. Acceptance also welcomes diversity. The world is diverse, so are spiritualities. Christian spirituality teaches the building of a diverse and inclusive culture. An accepting heart gives the benefit of the doubt to people because it is optimistic. It also welcomes new ideas for the betterment of a certain structure, which fosters a culture of collaboration. It models respectful interactions among people.

3. A CULTURE OF SOLIDARITY

To love others implies empathizing with them. Christians believe that Jesus came to the world ‘to be in solidarity’ with all of us. Some people have dedicated their lives to serve the vulnerable and marginalized. Many of these people empathize so much with the vulnerable that they aim to identify with them holistically.

1.3. SPIRITUALITY AND FAITH

1

As mentioned above, all human beings are born with the characteristic of being spiritual. Their spirituality is connected to faith which is sometimes expressed through religion. Spirituality and faith are often defined interchangeably. Newman's interaction with these two terms is helpful in this reflection.

According to her, "spirituality is being in faith." [17] Religion is understood as an expression of faith through a set of beliefs. These beliefs can encourage hope and resilience in the improvement of someone's mental or physical health.

In the care for the vulnerable, it is critical to learn about the beliefs of an individual or a community in order to get an insight into their spirituality and care for them from that position. In the community where I live, I have learned that most people first learn the set of beliefs they live by from home, then the neighbourhood, then school, and finally the church if they are churchgoers. Their beliefs influence how they care for their personal health. They have an impact on how compliant they are in taking chronic medication, going for check-ups, deciding to (or not) infect others of a disease they may have, or what lifestyle they prefer. These beliefs may be the reason why they combine Western and African medicine to seek healing. A careful observation of acts of faith can help to understand someone's spirituality.

GROUP DISCUSSIONS

1. What stood out to you from this chapter?
2. What kinds of spiritualities do you encounter the most in your patients?
3. How knowledgeable are you of those spiritualities?
4. What have you learned from your patients about their spirituality?

CHAPTER 2: HOLISTIC CARE, COMPASSION AND WELLBEING

EDITH MADELA-MNTLA

WHAT ARE WE GOING TO DISCUSS?

In this chapter, we will discuss holistic care, compassion, and wellbeing. We will start by, firstly, discussing the origin of Logotherapy. Secondly, we will look at Holistic care. Thirdly, we will consider compassion and finally well-being.

2

INTRODUCTION

Holistic care, compassion, and wellbeing are rooted in the journey of Viktor Frankl, who provides a good example of compassionate holistic care through his Logotherapy, a useful conceptual framework for medicine as a spiritual ministry [18]. Victor Emil Frankl (1905 - 1997) was an Austrian neurologist, psychiatrist, and Holocaust survivor, who devoted his life to studying, understanding, and promoting "meaning." The basis for Logotherapy is the idea that we are strongly motivated to live purposefully and meaningfully, and that we find meaning in life as a result of responding authentically and humanely (i.e. meaningfully) to life's challenges [19]. This chapter briefly examines holistic care, compassion, and well-being in greater depth to fully unpack their respective places in modern-day healthcare.

2.1. HOLISTIC CARE

Holistic care is a comprehensive model of caring [20]. Holism has its origin in the Greek word *holos*, which means "whole." Holism is not about any cult or religion, rather, it is an approach that looks at things in a total perspective. It was first used in 1926 by Jan Smuts (1870-1950), a politician and Prime Minister of the Union of South Africa, who was a military leader and philosopher, in his book *Holism and Evolution*. Jan Smuts used evolution as an example to explain his concept of holism, however, this book actually became a trigger for systems thinking, and complex, interdisciplinary and integrative approaches in science [21]. The philosophy behind holistic care is based on the idea of holism, which emphasizes that for human beings the whole is greater than the sum of its parts and that mind and spirit affect the body [20]. Holistic care is described as a behaviour that recognizes a person as a whole and acknowledges the interdependence among one's biological, social, psychological, and spiritual aspects [22]; [23]; [24].

Different scientific disciplines, like physics, science, mathematics, philosophy, sociology, medicine, nursing, and many others, nowadays support the view that an entity's substance is a lot more complex and greater than the sum of its individual parts. In healthcare, a holistic model therefore requires an interpersonal and interactive relationship with a patient or a service user [25]; it is fundamentally person-centred. Some approaches to medicine that practitioners consider as person-centred are not holistic (e.g., many patient-centred approaches are highly specialized and not integrative). However, since health is a state of physical, mental, social, and spiritual well-being, complete health requires a holistic approach [23].

A comprehensive care approach to patient care is often confused by the belief that a multidisciplinary healthcare team will ensure that a patient's needs are covered. However, this approach is reductionist in practice and leads to fragmentation of care, and the problematic patients often slip through the cracks of the healthcare system [25]. All healthcare practitioners should aspire towards a holistic approach to patients and attempt to practice it, irrespective of their qualifications or speciality. Recognizing the 'whole' person in the prevention and treatment of a disease may hold the key to some diagnoses for doctors, whilst allowing valuable and important help and guidance to be given to the patient. However, in addition to a holistic approach, a team approach to a patient is also extremely important [22]. There are three types of teams: a multidisciplinary, interdisciplinary, and transdisciplinary team; which team gets used depends on the possibility, knowledge, and the patients' needs. In addition to forming a team, developing systems and providing resources that ensure the team can function effectively are also essential [22].

The holistic view of healthcare is centuries old. In the 4th century B.C., Socrates, a Greek philosopher, warned that treating only one part of the body would not have good results [24]. Hippocrates was even more specific, speaking about holistic medicine [26], with the holistic approach also advocated by Percival in his book - the first ever textbook of medical ethics, which was published in 1803. In it, Percival noted: "The feelings and emotions of the patients require to be known and to be attended to, no less than the symptoms of their diseases." [27]. John Macleod in his book "Clinical Examination", first published in 1964, also emphasised that "we should aim to be holistic in our care." [28] The nursing profession is also rooted in holism in its art. Florence Nightingale in 1969 [29], expressed the role of nurses as to "... put the patient in the best condition for nature to act upon him." She thought that touch, kindness, and other measures of comfort, provided within the context of environment treatment, are of crucial importance for nursing. These premises are still held in high regard today; they feature in the oaths that health professionals have to take before they start to practice.

Principles of a holistic approach include:

- all people have innate healing powers;
- the patient is a person, not just a disease;
- appropriate healing treatment needs a team approach;
- patient and physician are partners in the healing process; and
- treatment involves fixing the cause of the illness, not just relieving the symptoms.

2.2. COMPASSION

Compassion is a word derived from the Latin word meaning 'to suffer with'. It is described as a deep awareness of the suffering of another coupled with the wish to relieve it. The word "compassion" means more than caring for someone. Rather, it means to suffer with others and to be in solidarity with the sufferers [30]. It is a feeling evoked by witnessing others' pain that leads to taking measures to help them [31]. Compassion is the human and moral part of care, and according to a lot of nursing literature, compassion is the philosophical foundation and centrepiece of the nursing profession [32]. That makes compassionate care patient-centred rather than disease-centred, in that it focuses on the patient as a person in totality. Compassion is considered a vital component of quality healthcare, and healthcare providers are considered the primary conduit of compassion in healthcare [33].

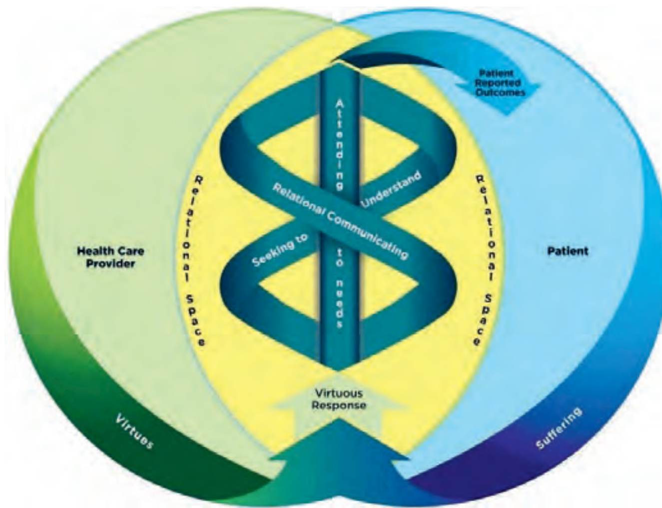
DID YOU KNOW?

Victor Frankl's book, Man's Search for Meaning, changed our perspective on the power of meaning in surviving seemingly impossible circumstances like Auschwitz or the Gulags.

Providing compassionate care can lead to higher satisfaction in patients, safer care, saving time and cost, a sense of satisfaction and effectiveness in the personnel, higher confidence, and coping skills in them [34]. Compassionate care from the patient's point of view is characterised by the healthcare provider being considerate and accurate in dealing with the patient's problems, being committed to realise and work to soothe the patient's pain while keeping a respectful relationship with the patient [35].

A research study in Canada (2016) generated the following patient-informed definition of compassion: 'a virtuous response that seeks to address the suffering and needs of a person through relational understanding and action' [33]. From this work, a model that best demonstrates key dimensions of compassionate care, the *Compassion model: compassion in clinical practice*, was developed, depicted in figure 1.

FIGURE 1: THE COMPASSION MODEL DEPICTING COMPASSION IN CLINICAL PRACTICE [33]



The model is built on the following elements of compassion care that emerged from the empirical data, in Table 1.

The core variable that emerges out of this Model is a "virtuous response to suffering," which is the enactment of a virtue toward a person in suffering.

TABLE 1: ELEMENTS OF COMPASSIONATE CARE [33]		
ELEMENT	ELEMENT	
VIRTUES	Genuineness Love Openness Honest Authenticity	Care Understanding Tolerance Kindness Acceptance
RELATIONAL SPACE	Patient awareness Engaged caregiving	
VIRTOUOS RESPONSE	Knowing the person Person as priority Beneficence	
SEEKING TO UNDERSTAND	Seeking to understand the person's need	
RELATIONAL COMMUNICATING	Demeanour Affect	Behaviours Engagement
ATTENDING TO NEEDS	Compassion-related needs Timely Action	
PATIENT REPORTED OUTCOMES	Alleviates Suffering Enhances Wellbeing Enhances Care	

2.3. WELL-BEING

The World Health Organisation defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity [36]. In addition, each aspect has to be interacting with the other, and each having differing levels of importance and impact according to each individual [36]. When all the parts of a human being are balanced and harmonious, there is a maximum of well-being [22]. According to the WHO, the primary determinants of health include the social, economic, and physical environments, as well as the person's individual characteristics and behaviours [37]. Health and wellness are terms that are often interchanged, but their origins and meanings are different. While health is a state of being, wellness is the state of living a healthy lifestyle. In short, wellness aims to enhance well-being [38].

There is an increasing body of epidemiological, social science, and experimental research that is beginning to suggest that initiatives which aim to promote physical well-being to the exclusion of mental and social well-being may be doomed to failure. In addition, a growing

number of epidemiological studies have shown that social and emotional support can protect against premature mortality, prevent illness, and aid recovery [39]. In the book The Science of Well-Being [40], a chapter on *A well-being manifesto for a flourishing society* cites findings on well-being research, which have identified the components of well-being as people's satisfaction with their lives, their personal development, and their social well-being. The author further cites factors of genetics, life circumstances, and intentional activities as having the greatest impact on well-being [41].

Evidence has shown that chronic stress and post-traumatic stress have serious health consequences because chronic stress can alter the immune system, resulting in immune suppression or excessive inflammatory reactions [42]. Unpacking what he called the practical failure of psychiatry to improve well-being, Cloninger, an author of a psychiatric book, noted that despite vast expenditures on psychotropic drugs and extensive efforts to enhance psychotherapy methods, there has so far been no substantive improvement in average levels of happiness and well-being in general populations. The most effective methods of intervention, he suggested, all focus on the development of positive emotions and the character traits that underlie well-being. They can be understood as working on the development of the three branches of mental self-government that can be measured as character traits, which include self-directedness (i.e., responsible, purposeful, and resourceful), cooperativeness (i.e., tolerant, helpful, compassionate), and self-transcendence (i.e., intuitive, judicious, spiritual) [43]. He formulated what he called “stages in the path to well-being.

TABLE 2: STAGES OF SELF-AWARENESS ON THE PATH TO WELL-BEING [44]

STAGE	DESCRIPTION	PSYCHOLOGICAL CHARACTERISTICS
0	UNAWARE	Immature, seeking immediate gratification (“child-like” ego-state)
1	AVERAGE ADULT	Purposeful but ego-centric; cognition able to delay gratification, but has frequent negative emotions (anxiety, anger, disgust) (“adult” ego-state)
2	META-COGNITION	Mature and allocentric; aware of own subconscious thinking; calm and patient, so able to supervise conflicts and relationships (“parental” ego-state, “mindfulness”)
3	CONTEMPLATION	Effortless calm, impartial awareness; wise, creative, and loving; able to access what was previously unconscious as needed without effort or distress (“state of well-being”, “soulfulness”)

Movement through these stages of development has been described and quantified in terms of steps in character development or psychosocial development, leading to well-being.

CONCLUSION

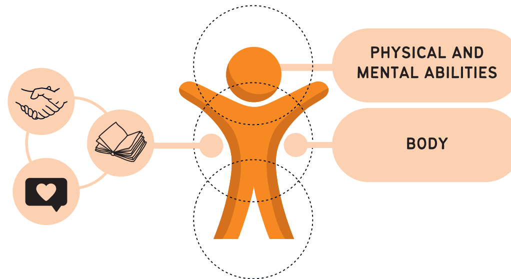
In holistic care, all aspects of patients and their effects on the treatment process are considered, and the patients' thoughts, emotions, cultures, opinions, and attitudes are factored in as contributing to recovery, happiness, and satisfaction. Compassion is particularly vital for well-being in the health-care in that it is associated with better adherence to medications, decreased malpractice cases, fewer mistakes, and increased patient satisfaction, and ultimately better health outcomes.

GROUP DISCUSSIONS

1. What stood out to you from this chapter?
2. Take turns to explain the concepts holistic care, compassion and well-being to the group.
3. Think about you own healthcare practices. Have you ever felt under such pressure that you didn't really care about a patient's immediate needs or their background?
   How would you respond to your own attitude?

CHAPTER 3: WHAT IS A PERSON?

SOPHIA TEMBO, ANGELINA SANDY AND CHRIS STEYN



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WHAT ARE WE GOING TO DISCUSS?

In this chapter, we will be discussing what a person is. Firstly, we will discuss why it is important to know what a person is. Secondly, we will discuss the two main answers to the question "What is a person?" Lastly, we will critically analyse the two options and propose the best answer to the question.

3.1. WHY IS IT IMPORTANT TO KNOW WHAT A PERSON IS?

Our worldviews include our view of human beings/persons. In turn, our view of human beings/persons influence how we see our patients and colleagues [45]. This will affect the practice and the ethics of community-oriented primary care and of healthcare in general. Human personhood is the central issue of ethics, for any theory that purports to explain how man should act towards his fellow man must begin with what man is [46]. Professor Stephan Holthaus affirms: "The ethical crisis is a crisis of anthropology. What is man all about? From where does our dignity come? Is the human soul free or determined? Are all people equal? All these ethical questions have to do with our view of man. If we have the right anthropology, we will have the right ethos for our life. But if we have a wrong anthropology, our behaviour towards other people will be in danger" [47]. "But in fact, disagreements about personhood lie at the heart of many current bioethical debates, including those involving stem cell manipulation, prenatal screening, medical infanticide, the persistent vegetative state, dementia and psychiatric illness" [48].

In the area of nursing sciences, Henderson states: "It is common in introductory nursing textbooks to refer to four concepts that are foundational for understanding professional nursing practice... - nursing, person, health and environment" [49]. In this chapter, we will explore one of these four concepts, namely the concept of "person" (and of "human being"). In the South African context, there are additional grounds for paying attention to this vital topic:

1. We need to consider the Constitution of the Republic of South Africa, especially Chapter 2: Bill of Rights [50].

In this Bill of Rights, extensive use is made of the concept "person," either as natural or as juristic person. According to section 39 of the South African Bill of Rights, it honours international law. One of the globally accepted expressions of international law is the "Universal Declaration of Human Rights" as adopted by the United Nations. Note that in the heading and throughout the Universal Declaration of Human Rights, reference is mostly made to "human" and not to "person". At the same time, reference is also made to "person" for example in the Preamble and in Article 3. A closer look reveals that the Universal Declaration of Human Rights uses both terms interchangeably as synonyms [51].

DID YOU KNOW?

The South African bill of human rights is considered one of the best in the world

3

2. "Persons" are referred to in the HPCSA Health Professions Code of Conduct: "They will exercise their profession to the best of their knowledge and ability for the safety and welfare of all **persons** entrusted to their care..." [52]. An example of how this is used is found in the Hippocratic Oath as it is used for Health Sciences graduates at Wits University [53].

3. "Persons" are referred to in the Code of Ethics for Nursing in South Africa. For example, it states: "the Code is premised on the principles of respect for life, human dignity and the rights of other **persons**...". And "This Code is based on the belief that nurses value: ... integrity of **persons** in their care..." [54]

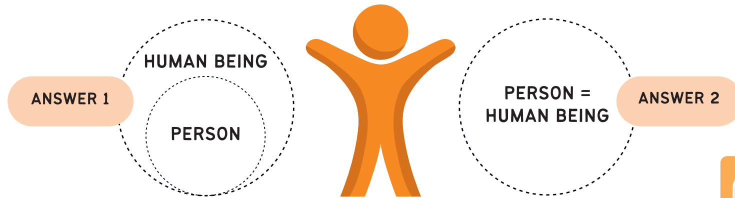
3.2. WHAT IS A PERSON?

There are two major schools of thought about the relationship between the concepts "human" and "person." The first school of thought maintains that these concepts are not the same. The second school of thought maintains that they are the same.
According to the Merriam-Webster online dictionary, a person is: "a human, individual; the personality of a human being" [55]. Note that the dictionary leaves room for both schools of thought in their definition.

3.3. THE KEY QUESTION: ARE PERSONS AND HUMAN BEINGS THE SAME?

Answer 1: Persons and human beings are not the same
If they are not the same, all persons are human beings but not all human beings are persons. That raises the very difficult next question: When is a human being a person and when not? This approach is found in some academic circles and among non-religious groups (e.g. secular humanism) [56] [57] [58] [59]. A variation on this theme is found in Buddhism [60] [61]. Many academics have sought to develop a universal list of criteria that could be used to determine whether a human being is a person or not. Those that meet the criteria of being a person are to be treated in an ethically responsible way.

Those that do not meet the criteria of being a person can be disposed of. [35] [59]
No consensus exists about the list of criteria that would authoritatively define what a person is. Neither is there agreement about when human beings do not qualify to be called persons.



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Answer 2: Persons and human beings are the same
If they are the same, all persons are human beings and all human beings are persons.

This approach is found in all three the major mono-theistic religions of the world: Judaism, Christianity, and Islam. The main reason for this reasoning is the Biblical statement that all human beings have been made in the image of God. Since God is a Person, all human beings are always persons. This is valid from conception to death and beyond.
Maliepaard and Steyn state that according to a Christian view: "the human being is an image of God, created for relationships. A human being cannot be divided into separate parts. One can distinguish separate aspects of the whole, but they form an interconnected whole. A human being is like a diamond with many facets - a complex unity with a heart at the core of his being." [62]
The traditional African view of human beings also sees a deep connection between human beings and God, without making a distinction between being human and being a person. Nkem Emeghara states: "the African realizes that God's imprint is within the human being, who imperatively acknowledges God's existence and worships accordingly". [63] One can rightfully say that the African soul is a spiritually sensitive soul.

All human beings are persons:

- Human beings / persons never lose the image of God, whether they can function or not, whether they are productive or not, or whether other people think their lives are valuable or not.
- Even before they are born, they are persons-in-development.
- Even when they are severely mentally disabled.
- Even when they are comatose, regardless of the amount of brain activity that can be seen on EEG.

Most of the citizens of South Africa self-identify as belonging to one of the above three religions or as a member of an African traditional religion. Therefore, all community-oriented primary care workers and initiatives should honour their beliefs in this regard. All human beings should be treated as persons and all persons should be treated as human beings - with respect, compassion and professionalism.

GROUP DISCUSSIONS

1. What stood out to you from this chapter?
2. Have you thought of the question "What is a person?" before reading this chapter?
3. What do you think is the best answer to the questions? Why?
4. How will this chapter influence your future health practices?

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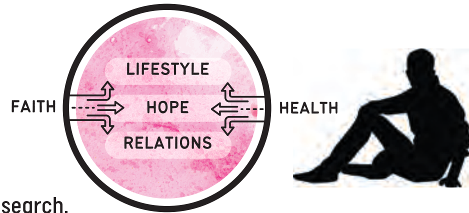
CHAPTER 4: THE RELATION BETWEEN FAITH AND HEALTH

KABONGO TSHILUMBA

WHAT ARE WE GOING TO DISCUSS?



This chapter will discuss what the current research tells us about the relationship between faith and health. We will start by, firstly, explaining what the research means with the concept of spiritual health. Secondly, we will discuss the history of the research. Thirdly, we will discuss the current empirical evidence. Lastly, we will discuss the recommendations and steps for integration suggested by this research.

4

INTRODUCTION

At this point, you are surely getting comfortable with the idea of conciliation or the coming together of faith and health. The fact is that spirituality and health are natural allies when it comes to a comprehensive outlook on healthcare. The constitution of the World Health Organisation (WHO), first adopted on the 22nd July 1946, defines health as: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" [37]. Although not amended to date, the above definition of health has been augmented by the resolution WHA37.13 of the 37th World Health Assembly (WHA) in 1984 [64] to include *spiritual health* [65] as one of the four pillars of health alongside physical, mental and social health. Yet, most healthcare workers in practice continue to treat "good health" mainly as the lack of illness and afflictions. Several reasons may exist for this. Amongst the most prominent reasons in the African context, we can name: 1. The constant lack of sufficient staff conditions, healthcare workers to rush through patients with a curative approach to caregiving rather than a comprehensive or compassionate one. 2. The compartmentalization approach in the management of the health sector and most public sectors in the administrations of our countries. 3. The lack of adequate healthcare worker training to equip the caregivers for care services that go beyond the basic scope of dealing with disease or infirmity.

In this chapter, you are invited to explore the connection between faith and health by subsequently looking at the history of their interaction, the empirical evidence of their connection, and recommendations for a way forward in the light of compelling evidence uncovered.

DID YOU KNOW?

Throughout history, most religious leaders also attended to the community's health.

4.1. HISTORY

The interaction of faith and health is a well-documented fact [12]. Koenig has rightly recognized that "religion, medicine, and healthcare have been related in one way or another in all population groups since the beginning of recorded history" [66]. Koenig also observed that "only in recent times have these systems of healing been separated, and this separation has occurred largely in highly developed nations; in many developing countries, there is little or no such separation" [66].

Koenig points out as well that faith-based organisations have been at the forefront of the health sector in its developmental stages in Western countries through the building of the first public hospitals and the supply of these hospitals' staff members. Karpf [67] affirms: "Since the Middle Ages, the establishment and maintenance of institutions to care for the sick has been the priority for the Western Christian church. In his book, Sent to Heal, Christopher Grundmann describes that in the 16th and 17th centuries the Jesuits and Franciscans sent missionaries to the New Worlds: Africa, Asia, and the Americas, where they practiced medicine, surgery, and pharmacy." [68]

DID YOU KNOW?

The enlightenment was an intellectual movement between 1600 and 1800, that valued reason above all else.

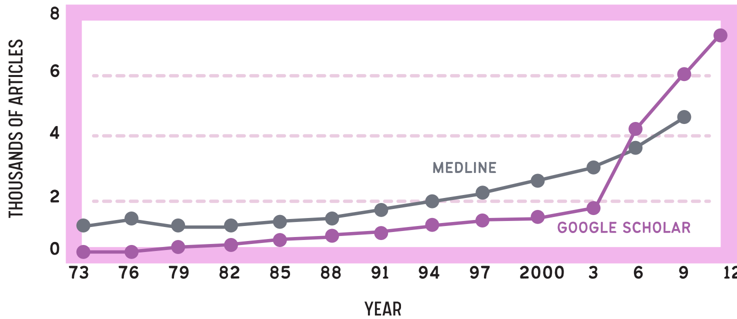
It is famously depicted by the words of René Descartes - *"I think, therefore I am"*

One may then ask the question to know where does the assumption of the separation of religion and health come from? The separation of these two healing systems was the logical outcome of advocacy for the separation of the state/public affairs and religion which peaked during the enlightenment period through the writings of John Locke [69] (1632-1704). Since today's health sector is an integral part of public affairs, the schism between spiritual health and health is simply observed evidence.

Myrick [70] explains: "The rise of a secular public sphere and the concomitant demand for tolerance of private religious beliefs has marked the development of modern thought. Fields once closely tied to religion, such as government, philosophy, and education, have sought non-sectarian grounding that opens them to members of any religious community or none at all. Medicine and medical ethics have likewise sought to separate themselves from confessional stances."

Yet, contemporary research trends have revealed a renewed consideration of the connection between faith and health and their complementary nature because both systems are fundamentally concerned with various aspects of the individual's well-being. Below is a useful chart from Koenig [66] pointing to the definite rise of research interest about the connections between faith and health.

FIGURE 2: GRAPH DEPICTING THE RISE IN INTEREST IN THE CONNECTIONS BETWEEN FAITH AND HEALTH [66].

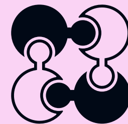


4.2. EMPIRICAL EVIDENCE

For an in-depth look at the evidence corroborating the correlation of faith (religion/ spirituality) and health we strongly advise you to consult Koenig et al [12] *Handbook of Religion and Health*. Below is a succinct summary of the influence of faith on health. Koenig [66] subsequently presents his findings on the evidence of the influence of faith on mental health, health behaviours, and physical health. He expresses the several benefits that Religion/ Spirituality (R/S) brings to mental and social health. He concluded that R/S is broadly identified with the betterment of one's health, the improvement in dealing with anxiety, and better mental health [66] which, together with healthy social support and a positive transformation of health behaviours, lead to a positive outcome on an array of physical diseases [66] and their treatment processes.

DID YOU KNOW?

Koenig conducted a meta-review. A Meta-review is when a researcher looks at all the available research and summarises it. It is then possible to make comprehensive inferences from all the literature on a specific topic.



Puchalski [71] already pointed out three major areas in which research was conducted to determine the influence of faith on health, namely: mortality, coping and recovery. Regarding mortality, Puchalski through research [72] [73] noted that faith practices have a positive impact on longevity, a negative impact on the increase of interleukin (IL)-6, an immune protein that acts as both a pro-inflammatory cytokine and an anti-inflammatory myokine. It also has a positive impact on stress management through the strengthening of coping mechanisms, by supplying stronger social support and building personal ethics as well as establishing a philosophy of life. Regarding coping, Puchalski [71] alluded to several studies that presented evidence that faith or religion helps the believing patient to cope with sickness, pain, death, and the stresses of life. She concluded that it is evident that people will often turn to faith to find the strength to manage and understand their sickness or loss. Regarding recovery, Puchalski [71] affirms that spirituality unlocks the power of hope and positive thinking.

She also alluded to the study of Dr Herbert Benson (a cardiologist and professor at the Harvard School of Medicine), namely "remembered wellness" [74] (the placebo effect) - which explores the processes of self-healing.

Koenig [66] supports Puchalski when he writes: "Religious/spiritual beliefs and practices are commonly used by both medical and psychiatric patients to cope with illness and other stressful life changes.
A large volume of research shows that people who are more R/S have better mental health and adapt more quickly to health problems compared to those who are less R/S."

Another compelling study worth noting here is the publication of Grim & Grim [75], which focuses on the crucial input of faith in both the prevention against and recovery from substance abuse addictions. Grim & Grim [75] write: "Hundreds [2] of evidence-based studies demonstrate the positive impact of faith on health and well-being, ... nowhere is this positive impact more evident than in the recovery of people who are suffering from substance abuse." Grim & Grim [75] further argued their position pointing at Dr Elinore F. McCance-Katz's observations [76] on the fight against substance abuse. Indeed, Dr Elinore named three necessary steps to successfully fight and remedy substance abuse (i.e: clinical care, social intervention, and social support). She further emphasised the relevance of faith-based communities and organizations in this fight, particularly in both the social intervention and social support steps for the long-term treatment of substance abuse addictions. Let us close this brief empirical overview with a couple of real-life stories of individuals who have relied on, or benefited from, both faith and science in their health recovery process. These stories are here recorded to further highlight the complementary nature of faith and science in the healing process.

A boy was brought in hospital as a male infant at two weeks of age. He was vomiting forcefully, so the doctors did a pyloromyotomy on him. He did not improve. The diagnosis of gastroparesis was concluded after a nuclear medicine gastric emptying study and intestinal manometry. The infant required a gastrostomy tube (g-tube) and a jejunostomy tube (j-tube) for feeding. At 11 months of age, the j-tube was converted into a feeding jejunostomy with Roux-en-Y limb. For 16 years he was completely dependent on j-tube feeding.

In November 2011, he experienced proximal-intercessory-prayer (PIP) at a church and felt an electric shock starting from his shoulder and going through his stomach.

After the prayer experience, he was unexpectedly able to tolerate oral feedings. The g- and j-tube were removed four months later and he did not require any further special treatments for his condition as all symptoms had resolved. Over seven years later, he has been free from symptoms.

2 e.g., Duke University n.d.; Koenig 2005, 2008, 2011, 2018; George et al. 2002; Johnson et al. 2002; Koenig et al. 2012; Rew and Wong 2006; Schoenthaler et al. 2018; VanderWeele 2017; Zemore 2008

First up is the recovery story of a 16-year old boy from gastroparesis after proximal intercessory prayer. Clarissa Romez et al [77] reported the following case in the 43rd volume of the Complementary Therapies in Medicine:

In a 2020 publication, Clarissa Romez et al [78] recorded another story of a female patient who relied on both conventional medicine and faith, ultimately, in her pursuit of full recovery from a juvenile macular degeneration condition.

An 18-year-old female lost the majority of her central vision over the course of three months in 1959. Medical records from 1960 indicate visual acuities (VA) of less than 20/400 for both eyes corresponding to legal blindness. On fundus examination of the eye, there were dense yellowish-white areas of atrophy in each fovea and the individual was diagnosed with juvenile macular degeneration (JMD). In 1971, another examination recorded her uncorrected VA as finger counting on the right and hand motion on the left.

4

She was diagnosed with macular degeneration (MD) and declared legally blind. In 1972, having been blind for over 12 years, the individual reportedly regained her vision instantaneously after receiving proximal intercessory prayer (PIP).[3] Subsequent medical records document repeated substantial improvement, including uncorrected VA of 20/100 in each eye in 1974 and corrected VAs of 20/30 to 20/40 from 2001 to 2017. To date, her eyesight has remained intact for forty-seven years.

The above two stories are some concrete analogies of the complementary nature of faith and healthcare. These stories depict how faith can sometimes come to the rescue when science reaches its limits. However, there are also countless stories where science, in the form of conventional medicine, has been welcomed as an answer to one's faith expressed through prayer for the recovery of personal health.

We argue that faith and medical science health are not incompatible. Therefore, where we can, we must take advantage of their evident complementary nature if we are to achieve wholeness. As the old saying goes: *"if it is not broken, don't try to fix it."* Humanity stands to win in the integration of faith and science, not to lose!

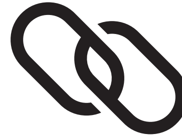
Have you ever heard similar stories from family members or friends of supernatural healing through prayer and faith?
Or do you have any personal experience of miraculous healing?

4.3 RECOMMENDATIONS

In light of the presented evidence, it is our firm conviction that faith (religion/spirituality) plays a positive role in the healing process of religious patients. Question: How then can we practically incorporate it into our daily medical or clinical practices?

3 Proximal intercessory prayer (PIP) is a term that refers to direct-contact prayer, frequently involving touch, by one or more persons on behalf of another.

As a healthcare worker, we must understand the relationship between religion and health, so that we can best attend to, or help the people around us. It is also important to create partnerships with religious leaders to help enhance this relationship.



Koenig [66] is very helpful in this regard as he suggests 8 reasons why spirituality needs to be considered as an enhancement to clinical practice and offers 7 steps to implement in the process of the inclusion of R/S in daily medical practices. Below is a succinct summary of his observations and recommendations.

Koenig [66] suggests that the addition of spirituality to clinical practice is useful because:

- many patients are religious and have spiritual needs related to medical or psychiatric illness;
- spirituality helps patients to cope with illness;
- beliefs affect patients' medical decisions and they may conflict with medical treatments;
- the physicians' own beliefs often influence medical decisions they make and affect the type of care they offer to patients;
- religion/spirituality is associated with both mental and physical health and likely affects medical outcomes;
- religion influences the kind of support and care that patients receive once they return home;
- research shows that failure to address patients' spiritual needs increases healthcare costs, especially toward the end of life; and finally,
- standards set by the Joint Commission for the Accreditation of Hospital Organizations (JCAHO) and by Medicare (in the US) require that providers of healthcare show respect for patients' cultural and personal values, beliefs, and preferences (including religious or spiritual beliefs).

Simon Mahlangu

Simon Mahlangu is a 35-year-old man who is a truckdriver and is back from a long trip to the DRC to transport copper from the mines. He developed a cough and feels weak. When you ask him, he tells you that he has lost about 10 kg and is sweating during the night and has right-sided chest pain. He suspects that he was poisoned during his last trip and has consulted the prophet of his charismatic church. They prayed for him and put some oil on his head but he has not improved so far.

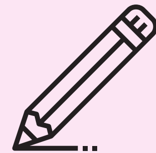
Discuss how you will manage this patient and how you answer his question about why God did not heal him.

Koenig [66] subsequently proposed 7 steps for the integration of spirituality in clinical care.

1. The health professionals should take a brief spiritual history [71] of the patients.
2. R/S beliefs of patients uncovered during the spiritual history should always be respected.
3. The health professionals without clinical pastoral education should partner with the Chaplains who have extensive training on how to do this.
4. Conducting a spiritual history or contemplating a spiritual intervention should always be patient-centred and patient-desired.
5. The beliefs of health professionals (or lack of belief) should not influence the decision to take a spiritual history, respect and support the R/S beliefs of patients, or make a referral to pastoral services.

6. The health professionals should learn about the R/S beliefs and practices of different religious traditions that relate to healthcare.
7. Finally, if spiritual needs are identified and a chaplain referral is initiated, then the health professional making the referral is responsible for following up to ensure that the spiritual needs were adequately addressed by the chaplain.

In closing, it is evident that this booklet is not advocating something new or incongruent to health practice. Rather, it is offering you the opportunity to courageously consider broadening the scope of your healthcare services by adopting a genuinely holistic approach to healthcare by incorporating spiritual care in your clinical practices. Consider taking up some clinical pastoral education or partnering with existing international organisations that can equip you in this regard and ground you on the spiritual aspects of medicine (i.e: The Healthcare Christian Fellowship, the Christian Medical Commission, International Christian Medical & Dental Association, Christian Medical Fellowship).



GROUP DISCUSSIONS

1. What stood out to you from this chapter?
2. What facts in this chapter surprised you the most?
3. Have you ever been taught how to integrate spiritual health into your healthcare practices?
4. How will this research influence the way that you view faith in your health practice?

CHAPTER 5: SPIRITUALITY AND VALUES

THEMBI MNGOMEZULU AND PETER FARRANT

WHAT ARE WE GOING TO DISCUSS?

The following chapter will discuss the relationship between spirituality and values. We firstly start by discussing what values are. Secondly, we discuss the relationship between value and give meaning to our daily experiences. This is demonstrated using the example of what it means to lead a successful life. Thirdly, we illustrate how values help us to prepare and cope with suffering, pain, and death. Lastly, we discuss how values and spirituality influence the practices of healthcare workers.

INTRODUCTION

5

Definition - values are the things that you believe are important in the way you live and work. An example of values are integrity, accountability, diligence, perseverance and discipline. Core values guide our behaviour, decisions and actions, they can help people understand the difference between right and wrong.

Examples of questions arising from core values and believes are:

- Is there a God?
- If there is one, how do I relate to God?
- What is the truth and how do I really know what the truth is?
- What is the meaning of life?
- Does it matter, in the end what type of life I live?
- Is there life after death?

5.1. MEANING AND VALUE ATTACHED TO LIFE

How one views or attaches meaning to life or value it depends on the worldview that one holds in life. There are many worldviews as discussed in Chapter 1 of this booklet. Worldviews play a central and defining role in our lives. Our belief system and how we interpret or give meaning to our daily experiences, and our responses to these experiences, and eventually how we relate to other people is shaped by our worldviews. If I hold a worldview that says ill health and suffering is caused by someone casting a spell on me, and I need a cleansing ceremony to get rid of the misfortune or curse, I will also have to speculate about who the possible culprit could be. This could result in a lot of mistrust amongst my circle of friends and work colleagues.

DID YOU KNOW?

Spirituality can help us to cope with pain, suffering and death.

- Does fame and chasing after material possessions define success?
- Is life more than possessions, career, and positions?
- Where does good honest life, ‘that seeks to serve rather than be served’ belong in modern society?

- Does it matter in the end if I live a good honest life? If we are all going to die, why not look after myself first and strive for self-comfort?
- Are there any consequences regarding the choices made in this life, is death not the end for the good and the bad?

An example of this is the question: What is a successful life? Take some time and discuss how people with different values will answer the following questions differently. Think about how these different answers will influence the way in which they find meaning in their lives.

5.2. HOW DO WE PREPARE FOR SUFFERING, PAIN AND DEATH?

South Africans hold a variety of worldviews with different levels of spirituality and a wide variety of values that affect the way they perceive life, and the ability to either accept or reject the healthcare provided for them. This variety of belief systems needs to be understood by both the client and the caregiver if the quality of care provided is to be meaningful.

Having a sick member of the family at home or at the healthcare facility presents uncertainty, and both the patient and the family need to be supported to cope with suffering and possible death of the family member. Quite often the caregiver may be the main source of support, empathy, and guidance.

Mr. Morero

Mr. Morero is an ex-teacher and lay preacher in the Pentecostal church in Soweto. He spends most of his time with members of his congregation and has assisted many people during times of grief and difficulty in their lives. When he became sick he was admitted to Baragwanath hospital and the doctors diagnosed him with Kaposi sarcoma and stage 4 AIDS. You are a community health care worker in his church.
How will you deal with him when you do a home visit and you see that he looks terminally ill?

5.3. COPING WITH DEATH AND DYING

The United Nations' declaration of the Rights of Dying include:
- The right to be treated as a living person right up until my death
- The right to take part in decisions about my own care
- The right not to die alone and without pain
- The right to die in peace and with dignity

The healthcare worker must aim to provide what the patient believes are his or her rights to make serious decisions regarding death and dying. These decisions include decisions such as their living will, continue treatment or abstain from treatment, stop feeding, start terminal sedation or commit suicide by an overdose.
This means that, ultimately, what is wrong and right hangs in the balance depending on values held by the patient and the healthcare worker.

5.4. HOW DO VALUES AND PERSONAL WORLDVIEWS AFFECT THE PRACTICE OF HEALTHCARE?

Lovemore Ramothobi

Lovemore is 15 years old and is attending her local high school. She has 2 brothers who are younger than her but they attend the same school. One of her younger brothers has been bullied by some of his classmates, who are bigger and stronger. Lovemore's boyfriend is helping to protect her small brother but he wants some 'rewards'. He puts pressure on her to have sex with him after school has closed but she is afraid to fall pregnant. A few months later she misses her period and becomes sick in the morning. She is afraid to tell her mother and when she tells her boyfriend he tells her to get an abortion. She finally decides to go to the clinic in another village and asks the nurse for help.
How would you deal with Lovemore when you are the clinic sister? How much should your own value system affect your response?

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1. The caregiver will hold a worldview. He or she should consider, examine and be sure of the worldview he or she embraces. This will influence the way the caregiver thinks and responds to different situations. It is important for the caregiver to feel confident and secure in his or her own worldview and to be able to apply effectively the principles and knowledge he/she was taught about healthcare within that worldview.
2. The patient or client will also hold a worldview, through which he/she will view what is happening in the situation he/she finds herself/himself in. The patient will interpret the management and treatment suggested by the caregiver through his/her worldview.
3. It is therefore important for both the caregiver and the patient to understand how the patient sees his/her illness and how the patient will understand the principles of management of the illness. This will affect all aspects of the ongoing relationship of the patient and the caregiver and it will impact strongly on the success or failure of the management.
4. Western Medicine is largely founded on evidence-based knowledge. This evidence base is constantly being added to, evaluated, considered, and re-considered. This fact may not be known or understood in the same way by the carer and by the patient/ client.
5. Doctors, professional nurses and healthcare providers are held accountable by their professional bodies to provide a certain level of service. This will include ethical behaviour, professional knowledge, application and understanding.
    - Accountability will be required by the professional bodies and to society as a whole.
    - These matters will also need to be understood and processed through the lens of the individual's worldview, which will have to be subject to the over-riding authority of the society and the state.

6. All health sciences training centres in universities in South Africa require their students to make a declaration at the commencement of the Health Science studies, that:
    - *They will not improperly divulge anything they may learn in their capacity as a*
    - *student of Health Science.*
    - *That in their relations with patients, colleagues and others they will conduct themselves with dignity as becomes a member of an honourable profession.*
    - *They declare their loyalty to the institution and will endeavour to promote its welfare and its reputation.*

7. All health science centres in South Africa require their students who graduate to make a declaration - the so-called Hippocratic Oath for doctors, the Nightingale Pledge for nurses and similar amended pledges of service like the Nurses' Pledge of Service that are binding on their conscience. (https://www.sanc.co.za/aboutpledge.htm, accessed 5-10-2020). Through these pledges, healthcare students pledge that:

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- they will exercise their profession to the best of their knowledge and ability for the safety and welfare of all persons entrusted to their care and for the health and wellbeing of the community;
- they will not knowingly or intentionally do anything or administer anything to their patients to hurt or prejudice them;
- they will not permit consideration of religion, nationality, race, politics or social standing to intervene between their duty and their patient;
- they will not improperly divulge anything they have learned in their professional capacity;
- they will at all times endeavour to defend their professional independence against improper interference;
- they will not employ any secret method of treatment, nor keep secret from their colleagues any method of treatment that they may consider beneficial; and
- in their relations with patients and colleagues, they will conduct themselves as becomes a member of an honourable profession.

This is an overall declaration made by all graduates of the Health Science Faculties of all universities. It forms the basis of their ethical behaviour in the practice of the health profession and will override all the worldviews, which must be subservient to the ethical practices of the healthcare professionals in South Africa.

8. At the end of life, as we know it, both patients and relatives need help to walk through the process of pain and grief. The health professional should:
    - encourage the patient to take care of unfinished business such as making a will;

- practice therapeutic listening - any struggles or regrets regarding unforgiveness towards others and God, then arrange appropriate support for this need; and
- maintain confidentiality.

DID YOU KNOW?

The WHO defines "Palliative care" as an approach that improves the quality of life of patients and their families facing the problems associated with life threatening illness, through prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. [153] [154]

Helping the patient deal with his/her own challenges will help to ease the emotional burden and help the patient to live with hope and may even prepare him/her to look forward to the next life without fear.

5

CONCLUSION

A healthcare worker who can help his/her patient in the journey of life, provides holistic care, and provides a meaningful perspective to life. He or she also contributes to the acceptance of the family and friends letting go of their loved one and start to bring closure to their loss and bereavement.

GROUP DISCUSSIONS

1. What stood out to you from this chapter?
2. What are your own personal values? What values do you share with your group? What values are different?
3. How do you think your values influence your healthcare practices?
4. Discuss situations in your own practice where you noticed a difference between your values and your patient's values? How did you handle the situation?

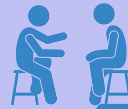
CHAPTER 6: RELIGION AND CULTURE

LUC KABONGO

WHAT ARE WE GOING TO DISCUSS?

In this chapter, I will discuss the following:
Firstly, the close relationship that exists between religion and culture. That religion is born and developed within a culture as well as catalyses the building of a culture.
Secondly, how religion should best be understood within the context it is practiced in.
Thirdly, how religion is a unifier of people from different cultures and backgrounds.
Fourthly, how a community is closely connected to religion and culture.

DID YOU KNOW?
Understanding and respecting a patient's culture and religion could improve a healthcare worker's competency to care well.



6

INTRODUCTION

Religion and culture are like two close relatives. They have always existed "in a close relation" to each other [79]. Religion seems to be a very important institution that gives the meaning of life to people of all cultures. It can be defined as "the belief in or worship of" an absolute or absolutes [80]. Villegas [81] says religion helps people to understand the "meaning" of life and the understanding of what happens beyond what we can see. Religion also sets the tone for rules of morality in societies. These rules consist of principles to live by and to guide life choices and behaviour. Since principles are part of the unseen (internalised), they are often connected to spirituality, which is also "unseen." Consequently, these rules of morality are often communicated via spirituality. This means that the latter expresses itself in a religion with its own rules and rituals. Ultimately, the latter become adapted and integrated into the local culture.

6.1. RELIGION IN CONTEXT

It is important to note that religion cannot be understood outside the context where it is practiced. The social, political, and economic realities can influence how religion is practiced or the principles of a certain religion are interpreted. For example, poor communities tend to be explicitly more religious than affluent ones. I live in a poor community with three local churches in my street. This number of churches is common in the community. Hospitals, clinics, and hospices also seem to be very fertile grounds where people are openly religious. Illness and death have a powerful way to remind human beings that they are not in control of everything and people need to trust in an entity that can take care of things they cannot control.
Religion is also a unifier of people from different backgrounds, cultures, and society as a whole. The current society teaches human beings to focus a lot on their uniqueness and individual identity which sometimes leads to disunity in society and in culture. Religion, in contrast, focuses on common issues. Hence, religion gives birth to communities of people.

Culture can be defined as “the ideas, customs and social behaviour of a particular people or society” [82]. It is the total way of life of people living in a certain location. Beyers [79] says that: “belonging to a particular religion implies belonging to a particular culture,” because religion always takes shape in a cultural context. Therefore, one of the best ways to understand a religion is to study the culture where it is expressed or where it originated from. Every year, many people go to Israel, Saudi Arabia, China, or India to deepen their understanding of Christianity, Judaism, Islam, Buddhism, and Hinduism respectively, for instance. This is why religion can also be seen as a cultural expression. Therefore, culture and religion live side by side in synergetic and cross-fertilizing ways.

Many people experience culture in a particular community they live in. Community is another keyword to this reflection. There is a connection between religion, community, and culture. Croucher, Zeng, Rahmani, and Sommier [80] define a community as “a group of people who share common activities or beliefs based on their mutual effect, loyalty, and personal concerns”. Affiliation with religious institutions forms communities. These communities form their own sub-cultures. The combination of these sub-cultures forms a culture. Therefore, a culture can be a by-product of religion. Different religious communities have sub-cultures that set them apart from others.

6.2. CULTURE BEFORE RELIGION

Throughout the world, religion is a powerful institution that influences culture. For instance, the pioneers of Christian evangelisation in Africa “imposed religion as an institution that came to shape culture” [83]. Through their influence, “religion became the deciding factor whether a cultural practice needed to survive or fall” [79]. The truth is that these pioneers brought Christianity to existing cultures. Beyers (2017) stresses that “culture has always preceded religion” [79]. Judaism and Christianity were born in the Jewish culture; Hinduism, in the Indian culture, Islam in the Arabic culture; and ancestral worships in different African cultures. It is, therefore, critical to be “respectful of culture in understanding its spiritual dynamics” if we hope to serve in ways that are meaningful and impactful [84].

Such a posture of respect and humility would not only bring holistic healing to patients but also pave the way for a smooth transfer of the caregiver’s spiritual principles and beliefs to patients. For instance, the organisation that I serve under, aims to serve, build relationships, and disciple people in the way of Jesus. Our bottom line should never “undermine a patient’s culture” [79]. It should instead challenge us to be learners of cultures so that the love of Jesus can be evident in our care and relationship building with a patient. Being a student of culture does not only empower caregivers to be effective in their approach to holistic healing, but it also makes patients and beneficiaries feel honoured because they will be better understood. There is a variety of ways to be “a student of culture such as by learning a local language, recruiting cultural mentors, reading existing literature about a particular culture and many other ways” [16]. Religion stands a chance to have a positive impact in a particular context if its adherents are faithful students of culture. That way religion can be a meaningful “cultural marker” [8].

6.3. RELIGION AS A CULTURAL MARKER

As mentioned earlier, religion found culture in a certain context and immersed in it.
To understand its impact, it is important to become a student of culture. Religion needs to be in tune with the heartbeat of culture so that it can be meaningful and impactful. It should guard itself against being corrupted by certain cultural habits. Christianity in Africa, for instance, is closely associated with a culture of individualism in a context that is mainly communal.
The concepts of personal salvation and blessing are emphasized, for example, in the "Evangelical and Pentecostal circles" [85].

6

This individualism is sometimes associated with the principles of monogamous marriages Christianity is known for although some of the respected people in the bible such as Abraham, Jacob, David, and Solomon were not monogamous. Many black African cultures are accepting of both monogamous and polygamous marriages. Religion has been involved as an accomplice in systems that promote cultures of oppression, greed, and corruption. It has also been involved in the growing culture that glamorizes wealth, pleasure and power, and makes little provision for sacrificial love, self-denial, and self-abnegation. In contrast, "authentic religion promotes sacrifice and self-denial" [84]. Religion should also affirm cultural identity. It creates an identity for its adherents which should help it spearhead the affirmation of a collective identity found in a culture. Franz Fanon [86] says that identity is what a person or people want. For instance, one of the things black Africans want and long for is to be recognised as of equal worth to others. The poor are a marginalised section of our society and they want to be dignified like other socio-economic groups. Religion can make a significant contribution to the restoration of people's identity. It can help affirm the fact that "true identity lies in discovering shared humanity" [87].

6.4. RELIGION AS UNIFIER

Religion can be a cultural marker by being a unifier. African cultures are well known for division and discrimination. The latter is done on a variety of grounds such as gender, age, place of origin, race, skin complexion or height. Religion seems to emulate such a culture in its day-to-day operations. Many religious institutions work against each other trying to impose themselves as the true religion. Sometimes, a particular religion is subdivided into different denominations. In local communities, we see many of these denominations exclude each other, although they may all be professing faith in one absolute. Christianity is sometimes accused of being patriarchal, for instance. Tanya van Wyk [88] says that for many decades, feminist theologians have been questioning "gender-exclusive language" in some translations of the bible and even in the ordinary language of Christians.

Yet, this gender-exclusive language is still used regularly in our communities or other formal forums. The regular use of such exclusive language has made many people internalise and normalise discrimination that has led to racism, gender-based violence, xenophobia, and prejudice within the church and outside of it. Religion could use its ability to unify a small community of people to be a tangible sign of unity through its interaction with culture.

DID YOU KNOW?

Feminist theology is the study of religion from a female perspective using reconstructionism [97]. They have also sought to reformulate traditional religions or to develop religions of their own [98]. It is aimed at the deconstruction of the patriarchy and male dominance in religion CITATION Ang07 \l 7177 [156], promoting female positions in religious organisations [98], and relaying the female lived experience as it relates to religion [155]

This interaction can be extended to traditional spiritual practices where religion could play the role of a reconciler. African cultures are known to be highly spiritual. The cause of everything good or bad is believed to be spiritual. The bad things are usually more emphasized than the good. Yagboyaju [84] says that "ordinary citizens are made to believe that demonic forces or spiritual attacks are behind illnesses, poverty and other misfortunes" one encounters in life. An over-emphasis on warfare or the power of demonic forces can sometimes be a way to avoid taking responsibility in shifting blame and scapegoating.

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It is very common to find a patient who blames their illness on a relative, neighbour, or colleague who supposedly practices witchcraft, while they might have willingly defaulted on the chronic medication healthcare professionals advised him/her to take daily. Such patients may even be spending money on consulting a traditional healer to find out who bewitched them. Many of such people live with fear and may even consult regularly traditional healers for protection "against witchcraft" [89]. Usually, their fear leads them to be very suspicious of others, to hatred, isolation, and even to the non-compliance to healthcare advice they receive. In many African cultures, witchcraft is seen as the likely cause for "ill-health, misfortune, accident or death" [90].

Unfortunately, religion sometimes serves as a platform for the perpetuation of the belief that any misfortune in life is caused by witchcraft. There are many Christian prophets in our communities who specialize in telling people why there is misfortune in their lives. Usually, a close person is accused of being the cause of the misfortune. Witchcraft and evil spirits are very recurring conversations we have with patients during home-based care visits. Many of our patients engage in these conversations because they long for healing. They, at the same time, seek protection so that nothing can stand in the way towards full recovery. We have learned to tell our patients that their peace of mind could be a positive contributor to their healing. We use our faith to encourage them to stop driving themselves crazy trying to understand who is bewitching them and how to protect themselves from them. We encourage them to have faith in God and release their warfare battles to God. We finally encourage them to focus on what they can control, which is to comply with healthcare professional recommendations about their health conditions.

Ms. Nkosi

Ms Nkosi is a 24-year-old woman who lives in one of the rural villages in Limpopo and is unemployed. She attended school and passed standard eight. She is bored and has some friends with whom she smokes dagga. When you meet her during a home visit she looks agitated and she does not trust you. She hears voices that tell her you are there to harm her and she looks afraid. The granny tells you that she becomes like this when she has been out with her friends and on occasion, she becomes violent when the granny gives her work to do. When you take a spiritual history, she tells you that she attends the Roman Catholic church and used to sing in the church choir.

What do you think is wrong with Ms. Nkosi and how would you approach her?

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The spiritual nature of African cultures has an influence on how Christians read the Bible. Adamo [91] says that for many Africans when they read the Bible the main questions they ask is "what does the text has to offer?" He uses Psalm 23 to show how many Africans use it as a Psalm of protection, provision, healing, and success. This example shows how African spirituality acknowledges that beliefs and practices touch on and inform every facet of their lives. Eskia Mphalele [92] once said: "When we seek moral guidance and inspiration and hope, somewhere in the recesses of our being, we grope for some link with those spirits". This is why it is very common to find a Christian who believes in the protective powers of their ancestors and venerates them. Potgieter and Van Rooyen [93] illustrate it in their research findings on mental health. They interviewed 94 psychiatric patients, the majority of whom were black Africans. The majority of the latter said that they were Christians, yet believed that keeping their ancestors happy through veneration or worship would bring full recovery and would protect them from getting sick again. They concluded that the healthcare worker's sensitivity to a patient's cultural and religious beliefs could enrich their therapeutic relationship.

Religion can penetrate culture and influence it so that quality of life can be improved. Research points out that "religion could promote healthier living and better decision-making regarding health and wellbeing" [80]. It is been proven that "religion has a positive effect on the treatment of cancer, religious attendance promotes healthier living, and people with HIV/AIDS often turn to religion for comfort as well" [94].

CONCLUSION

Culture and religion are in a close relation of cross-fertilisation. Such a relation could bring hope in a time of fear, despair, or anxiety such as the time when someone is ill and vulnerable. In Africa, faith-based organisations are providers of charitable work for the vulnerable and needy, "particularly given the widespread reality of failed states and collapsing government services" [95]. In this sense, religion has the potential to be a tangible sign of hope in cultures.

GROUP DISCUSSION

1. What stood out to you from this chapter?
2. How well do you distinguish your patients' religion from their culture?
3. What kind of culture is predominant in your community that sometimes has a negative impact on the health of its residents?

6

CHAPTER 7: DIFFERENT RELIGIONS AND FAITHS.

MARTIN BAC

WHAT ARE WE GOING TO DISCUSS?

In this chapter, we will discuss some of the different religions and faiths in South Africa. We will start by discussing the demographics of South African religions and the complexities defining religions and faith. Secondly, we will separately discuss African Traditional religions, Christianity, Hinduism, Islam, and Judaism.

INTRODUCTION

According to the 2013 General Household Survey, 84.2% of South Africans regard themselves as Christians, 5% identify with ancestral or traditional African religions, 0.2% identified as Jewish, 0.2% identify as atheistic or agnostic, 1% as Hindu and 2% identify as Muslims.[4] 5.5% did not identify with any religion and 1.6% did not specify. These percentages will differ a bit and depend also on the area where you are working.
The fact that people say they belong to a certain religion does not mean that they all share the same views, image of God, and follow the same doctrine and rituals.
Christians are divided into many different denominations: Protestant, Roman Catholic, Zionist, Shembe, Reformed, Evangelical, Anglican, Pentecostal, etc.
The way people express their faith results in many different forms of religion, each one with their own rituals, music, translation of the Scriptures and the way they fellowship.

DID YOU KNOW?

Africa is the second largest continent with one of the largest diversity between population groups.

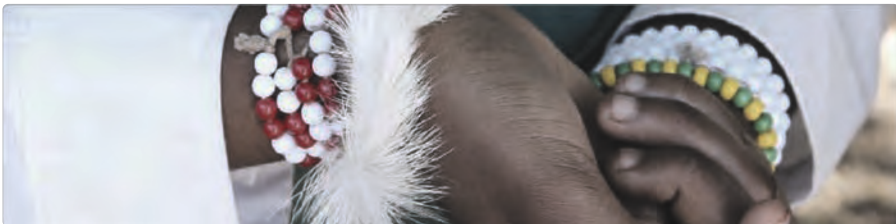
For example, one of the most commonly shared beliefs in Africa is a belief in a Supreme Being that sets the world in motion. Most religions on the continent have intermediaries to address the divine and these are treated with respect. However, these intermediaries differ from ancestral spirits, diviners, holy saints, prophets, or Jesus. Far from being a sacrifice of individual freedom, the existence of a faith community is accepted as indispensable for security and wholeness. In Africa, good health means much more than a healthy body, it includes harmony with God, the living dead and the universe.

4 https://culturalatlas.sbs.com.au/south-african-culture/south-african-culture-religion

7.1. AFRICAN TRADITIONAL RELIGIONS

The term traditional African religions encompass a large diversity of beliefs and belief systems. This can be expected since the continent is so large and the people so diverse. However, the majority of these religions have the following in common, to one extent or another:

- These religions are characterized by a belief in a Supreme Being, the Creator, and the source of all life.
- The ancestral spirits are the intermediaries and God is never far away but part of an African's thoughts and perceptions of the world. There is a relationship between the living and the dead of a family. The dead need to be respected and can help and protect the living ones.
- Disaster and misfortune are seen as a broken relationship with the ancestors and a family or whole community needs to perform certain rituals for the well-being of the ancestors and appease them.
- Nothing in life just happens and there must be a cause for an ailment or illness. The question is not which disease do I have but who caused it? A diviner can assist to find the cause and the cure for physical, mental, and spiritual problems.
- There is a general fear about evil spirits, malicious persons or losing our vital life force.
- Death is an accepted reality and is not feared because it does not end a life. If one dies, the person does not vanish but joins the departed in a state of collective immortality.
- The biomedical approach is insufficient and traditional medicines, rituals, and sacrifices might be needed to cure the person or assist in natural death. Sometimes patients want to go home before an operation in order to request the ancestors for protection and retention of life.
- African traditionalists want to burn African herbs in the ward because they believe that the herbs will remove the evil spirits from a patient.
- An unnatural death has serious implications and might disqualify the person as a potential ancestor [96].



7.2. CHRISTIANITY

Christianity is the world largest religion with about 3 billion believers but the teaching in the different Christian churches differ considerably. However, the central Christian belief is that the historic person of Jesus (Christ) of Nazareth (c. 4 BCE/c. 30 CE) is the Son of God [97] [98], who was sent to the world to be crucified for the sins of the whole world throughout the ages [99] [100]. The fundamental Christian beliefs confessed by the majority of Christian can be seen in the apostles' creed [101]:

I believe in God, the Father Almighty, Creator of Heaven and earth;
and in Jesus Christ, His only Son Our Lord, Who was conceived
by the Holy Spirit, born of the Virgin Mary, suffered under Pontius Pilate,
was crucified, died, and was buried.
He descended into Hell; on the third day He rose again from the dead;
He ascended into Heaven, and sitteth at the right hand of God,
the Father almighty; from thence He shall come to judge
the living and the dead. I believe in the Holy Spirit,
the holy Catholic Church, the communion of saints,
the forgiveness of sins, the resurrection of the body and life everlasting.

Additional core beliefs, doctrines, and practices include the following:

- Christians believe in a monotheistic, yet triune God (Holy Trinity), that consists of three persons, namely the Father, the Son, and the Holy Spirit [99].
- Most Christian believe in the concept of original sin (the fall), which states that the first human committed a sin by disobeying God, which resulted in (Genesis 3) a brokenness of the world and misery caused by diseases, epidemics, natural disasters, and war.
- One becomes a Christian when one repents one's sin, confesses Jesus Christ as Lord and Saviour, and believes with their whole heart that he is raised from the dead. This is the way to inherit eternal life after death. (Rom 10:9; 1 John 1-2)
- Important ceremonies are baptism, Holy Communion (Eucharist or Lord's supper) Holy Communion, and the fellowship of believers [99].
- It is very difficult to present a single opinion on ethical issues in healthcare and medicine because some of these are controversial such as abortion, blood transfusion, organ donation, and euthanasia.
- The approach to believers who are sick will vary from visiting them, offer a prayer, lay hands, minister the sacrament of the sick, or organise special healing services [96].

7.3. HINDUISM

Hinduism originated 4000 years ago in India. It has no fixed dogmas and is known for its tolerance. Similar to traditional African religion, Hinduism is an overarching term for religious beliefs in India and consequently encompasses a large diversity of beliefs and belief systems. The following is generally shared beliefs in Hindiusm:

- They believe in a great soul or spirit, called Brahman, which is omnipresent and omniscient.
- Every person has his or her own soul, called atman. When a person dies, the soul lives on and is reborn in a new physical body.

This reincarnation can happen repeatedly and keeps a soul trapped in a cycle of birth, death, and rebirth. The way a person lives can bring him/her closer to moksha or liberation when the soul joins with Brahman.

- Hindus believe in thousands of gods and goddesses, which each represent a different aspect of Brahman's power. Their most important gods are Brahma (creator), Vishnu (protector), and Shiva (destroyer).
- Worship varies among Hindus where one group may worship one particular god while others worship all the gods. Most Hindus have a small shrine at home and before entering the temple, they remove their shoes.
- Priests are given flowers, fruits, and sweets to offer to the gods.
- The most widely celebrated Hindu festival is Diwali or Deepawali where the triumph of good over evil is celebrated [96].

7

7.4. ISLAM

Followers of Islam are called Muslims. Islam means 'submission,' which signifies that a Muslim is a person who submits to the will of Allah. The following beliefs are central in Islam:

- Muslims believe that true success in this world and in the world to come can only be achieved by obeying Allah's commands.
- Peace can be achieved through obedience to God as taught by the prophet Muhammed.
- Muslims believe in Allah as the true God who created the world and in the prophets of which the prophet Muhammed is regarded as the most important.
- They believe in the divine revelations written in 104 books but the most important are: the Tawrat, given to Moses; the Zabur (Psalms), given to David; the Inji (Gospel) given to Jesus; and the Qur'an, given to the prophet Muhammed. The Qur'an is regarded as the final revelation replacing all other revelations from Allah to humanity.
- Muslims believe in angels, the last day of judgment, and they observe the five pillars on which their faith rests. These include: the declaration that there is no other God but Allah and the prophet Muhammed is his messenger; ritual prayers five times per day; the fast of Ramadan; almsgiving; and a pilgrimage to Mecca.
- Illness is not just a somatic problem but is seen in a psychosomatic context and suffering can cancel sins.
- Muslims believe in life after death. The death of a loved one is seen as a temporary separation and is actually the will of Allah.
- Prayer, ritual purification, and observing dietary requirements (halal) or fasting are all important aspects of Islam.

- Sensitivity to gender issues and cultural habits can prevent unnecessary problems. For example, female patients should be examined by female doctors and nurses [96].

DID YOU KNOW?

The word “somatic” comes from the Greek word - *sōma* (σῶμα), which means body. This is why somatic is used as an adjective for nouns that are related to the body.

7.5. JUDAISM

Judaism is the religion of the Jewish people and there is a strong sense of loyalty and support for each other irrespective of someone’s race. The following beliefs are central in Judaism:

- They believe that Abraham is the first Jew who was called by God 4000 years ago and lived in the Middle East.
- The Jews believe in one God and the Holy Scriptures or Tanakh which contains the Torah, Nevi’im, and the Ketuvim. The word Tanakh is actually an acronym combining the first letter from the names of each of these three main divisions.
- Jews can choose to worship on their own but usually pray with other Jews in a synagogue. The most important Jewish prayer is called the Shema. It begins:

Hear O Israel, the Lord is our G-d, the Lord is one.
Love the Lord your G-d with all your heart, and with all your soul,
and with all your might’ (Deuteronomy 6:9).

- The holy days are the Sabbath and Yom Kippur.
- In order to obey the covenant made by Abraham, the male child is circumcised on the eighth day after birth.
- At the age of thirteen, a Jewish boy is given a Bar Mitzvah and he must now obey all the Jewish laws.
- The sanctity of human life is of absolute and infinite value.
- Food restrictions are very strictly observed by orthodox Jews.
- When someone dies, the deceased is buried as soon as possible, often on the same day of death [96].

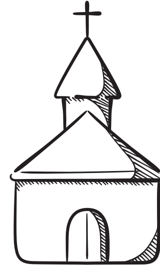
GROUP DISCUSSION

1. What stood out to you from this chapter?
2. If you identify as part of one of the above-mentioned religions, discuss whether you think the content is accurate? Notice how different members produce different answers.
3. Discuss some of the differences that you notice between the religions. How do you think this could influence health practices?
4. What other religions have you noticed in South Africa?

CHAPTER 8: THE ROLE OF THE CHURCH AND RELIGIOUS COMMUNITY IN HEALTHCARE

LUC KABONGO AND MARTIN BAC

WHAT ARE WE GOING TO DISCUSS?



In this chapter, we will discuss the following:
Firstly, what the main role of the Christian church is in society.
Secondly, that the Christian church was one pioneer of medical institutions in the world. Thirdly, how the Christian church involvement in healthcare was reduced and sometimes undermined, which is the current reality the South African society faces. Fourthly, how the church can be creative in remaining involved in matters of healthcare.

8.1. WHAT HISTORY SAYS

The Christian church's main role in society is to be a servant leader. This is a direct imitation of its head, Jesus. As a mission worker living and serving in a poor community, the passage of John 13:3-15 has helped me understand my role in society. In this passage, Jesus washes his disciples' feet to demonstrate that Christian leaders are expected to do the same. This passage, among many others, has taught Christians about the role of the church in society. Latvus [102] advises the church to be involved in works of charity as a way of showing selfless concern for the well-being of others. The church ought to be a messenger of tangible love in society. In the context of South Africa, the church has the privilege of also existing in vulnerable communities whose quality of life needs such care. Attie van Niekerk [103] says that "the church, by definition, is an organization that concerns itself with improving the quality of life" of everyone in the world. Jerry Pillay [104] reminds us that throughout its journey in the world, "the church of Jesus Christ has normally understood the transformation of society to be an essential part of its mission task." Indeed, history tells us that Christianity began by proclaiming through words and deeds the gospel of love and charity in caring for vulnerable people in society such as the sick, the widows, and the orphans.

DID YOU KNOW?

The adjective Greco-Roman refers to the combination of Greek and Roman culture that was prominent in the ancient Roman Empire.
We still see traces of this culture in our modern societies.

These followers were just imitating what they saw from Jesus, their mentor. The second section of the Bible called the New Testament shows how actions of mercy were a priority for the early church. Christians also took part in the Greco-Roman communities' public life through actions of mercy. In those communities, all Christians were required to financially contribute to the welfare of their society even while facing persecution from political leaders.
Their financial contributions were channeled towards ministries of mercy [105].

Even the era before Jesus describes the role of the church as that of a servant in society.

Don Mattera [106] says that such a rich history should continue to linger in our collective memory as "a weapon" that must be sharpened by the current church. In the area of healthcare, the Jewish customs based on the Torah describe the partnership between spirituality and healthcare. It shows how the priest was the person in the old Jewish laws who had to clean people of their sin and sickness. The priest brought sacrifices and prescribed the rituals for cleansing, for example, after menstruation, childbirth, or touching a dead person or animal carcass. Many Jewish laws captured the symbiotic relationship between spirituality and healthcare.

It had many instructions to prevent diseases. For example, people were told to dig a hole and bury their faeces outside the camp, wash their hands and cutlery frequently and put hyssop in the water. Boys were to be circumcised when they were 8 days old and when the chance of bleeding was the smallest. There are many more examples in the Old Testament that give guidance about what food can be eaten or forbidden for various reasons. Recently, discussions abound about whether or not people can and should eat the meat of all species of wild animals because of the risk of infections like COVID-19.

DID YOU KNOW?

The Christian church was at the forefront of starting hospitals and clinics around the world.

In the middle ages, monks provided basic health services in monasteries. They pioneered the first hospitals in Europe. From that time onwards, Christian institutions have founded more than 1200 hospitals and other healthcare facilities in Africa and Asia. A common thread in all these institutions was their person-centered approach. The clinical medicine the current era enjoys was not well developed at that time. Good compassionate care with basic hygiene, provision of food, and an environment where the sick person could recuperate was the most important measures that were taken. Many were inspired by the parable of the Good Samaritan who took care of the wounds of a perfect stranger in need and this has been the case for thousands of years.

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The mission nurses and doctors were mostly trained in the Western world but had a whole-person approach with an eye for the person who was ill and suffering. Medical work and interventions were often seen as a way to show love, win the trust of people, and open the door for the Gospel. Many priests and pastors developed programmes where healthcare, formal education, agricultural training, and food production were integrated and combined with preaching the Christian message of salvation. The individual salvation from sin, but also the transformation of the society and development of the country were the results.

Other religions too give prescriptions in the area of healthcare. Islam, for instance, has strict rules about what food can be eaten, the importance of fasting, and the washing of hands. The Zion Christian church asks its members to abstain from alcohol and smoking. It gives its sick people 'holy water' to cure their ailments. Most religions promote moderation and recommend avoiding indulgence in fatty foods and fast food. Many religions teach their followers to engage in safe sexual practices, promote monogamy, and having a functional family that is loving and safe for children. The church's role in dealing with physical diseases was greatly reduced by the time that scientific Western medicine developed and many medical schools regarded theologians and churches as ignorant with respect to the care of patients and healing of their illnesses.

The church's role in dealing with physical diseases was greatly reduced by the time that scientific Western medicine developed and many medical schools regarded theologians and churches as ignorant with respect to the care of patients and healing of their illnesses. The human being was regarded as a complicated and interesting 'machine' and by studying it carefully, doctors were able to fix many problems and even replace certain parts of the 'machine' by transplanting an organ. With the decline and change in the beliefs of large sections of the population in the Western world:

The ethical values changed dramatically and subsequently influenced medical practices and healthcare. It can be argued that currently human life is no longer regarded as sacred as it used to be in the middle ages. It can be terminated before or after birth or at the end of life if doctors feel that the quality of life is very poor. This has become a practice nowadays in many modern countries. For the past thirty years, voluntary euthanasia and physician-assisted suicide of adult patients have been common practice in countries such as the Netherlands and Switzerland.

Neonatal euthanasia was recently legalized in the Netherlands and the Groningen Protocol was developed to regulate the practice. Supporters claim compliance with the Groningen Protocol criteria makes neonatal euthanasia ethically permissible [107]. Other people advocate that what is technically possible and affordable should be done in order to save or preserve physical life. The argument is that if the quality of life has deteriorated to such an extent that the person becomes a burden to society or individuals, physical life can be terminated by a doctor.

The psychological and social causes for ill health has been largely neglected and only became more important once it became clear that clinical, reductionist medicine could not manage and cure many of the complaints presented to doctors. Examples of such social aspects of a person are hatred, bitterness, jealousy, broken relationships, guilt, shame, lack of finding meaning in life, and anger. For these problems, there are no technical or pharmaceutical solutions, let alone a vaccine.

DID YOU KNOW?

South Africa has many examples of faith-based groups that are actively responding to healthcare issues. (such as Rivoningo Care Centre hospice, Nazareth house, The Catholic Healthcare Association of Southern Africa, Holy Trinity in Braamfontein - to name a few). Discuss in your group what other support groups you are aware of?
Now discuss the benefit of healthcare systems collaborating with these groups.

In 1976 the World Health Organisation (WHO) met with the Christian Medical Commission in Geneva and they coined the term Primary Healthcare (PHC). Many medical missionaries and healthcare workers had first-hand experience that the Western type of medicine was insufficient to deal with the health problems in the developing world. They had developed their approaches, which often addressed the root causes of ill health, and these were not taught at medical schools in Europe or the USA. Based on the wealth of these experiences and on a strong conviction that basic healthcare is a human right, the PHC movement was accepted by nearly all countries in the world when they signed the Declaration of Alma-Ata in 1978.

In many countries, the mission hospitals have been taken over by the state, as was the case in South Africa. As a result, the medical missionaries went back to their countries of origin and doctors from other African countries and Cuba took their place. Ministries with practical actions of love and mercy in healthcare are still needed in many developing countries such as South Africa and should be prioritised by the church. The latter needs to be seen as practicing concrete gestures of care and love. Therefore, it needs to meet the needs of the vulnerable and act as a public servant.

For that to happen, it will require three major shifts [108]:

1.The church needs to prioritise meaningful community-based actions over its internal issues.

In South Africa, since the church is no longer involved in public healthcare facilities, it needs to look for new avenues to participate in addressing health needs in society. We will give several examples of how this has happened in the 21st century. In Amsterdam, the Netherlands, for example, churches started a non-governmental organisation (NGO) to address the problem of women trafficking and sex work in the city. In many cities in the world, churches have set up relief programmes for people who are homeless by providing food, shelter, basic healthcare, safe houses and training programmes. Many food banks have been set up to feed people who are unemployed and/or hungry.

When the HIV/Aids epidemic became a worldwide problem, many churches initially struggled with how to deal with this new disease, which affected mostly homosexual men and intravenous drug users. Once the epidemic became a predominantly heterosexual problem, many churches started running life skills programmes to address the problem of stigma and to promote abstinence, being faithful to one partner and using condoms (the ABC strategy). They also started support groups for people who are HIV positive. Substance use is a growing problem in the Netherlands. Churches started education programmes and detoxification clinics before the government developed its programme.

A good example is *De Hoop* where they help people with a range of addictions, teach them new skills and integrate them back into society. Prison ministry is another area where churches have become involved to address the psychosocial and spiritual needs of prisoners.

DID YOU KNOW?

PLHIV is an abbreviation for "People Living with HIV." We use this term instead of "HIV-positive people" because we want to refer to the people, to their agency, and not define them by their sickness, illness, disease, or situation.

Loneliness is a major problem in the west and this has been aggravated by the fact that many elderly people live alone. Churches have organised weekly meals for the elderly and single people in the community. During the COVID-19 pandemic, visits to old age homes and all elderly people were discouraged or forbidden. The church has developed a programme ('You are not alone') where people can phone a central office and tell them what their needs are.

This office contacts the nearest church and asks them to assist this person in their neighbourhood. The above-mentioned examples show the role the church could play in society in healthcare matters. Churches and Christian organisations have consistently asked for the medical and nursing schools to give greater priority to spiritual care and train healthcare professionals in assessing spiritual needs and how to address these.

Frank Sithole

Frank Sithole is a 25-year old man who lives on the streets in Pretoria and he is using heroine injections.
He has been spiking more frequently since a few months and he has lost a lot of weight. He gets clean needles from the COSUP programme and was tested for HIV about one year ago, although he claims that he was HIV negative.

When he reports at the clinic he is wasted and looks weak. Upon examination, he has signs of a chest infection with crackles in the right lung. He is referred to the local hospital where they diagnose pulmonary TB and his HIV test is positive. He is discharged on TB medication and as a CHW you meet him at the shelter. He is not able to work and has no food. His relatives live in Hammanskraal where his brother and sister-in-law stay.
How can you assist Frank and what needs to be done? How do Frank's choices in life conflict with your worldview? How can you manage your own tendency to judge patients' personal choices, especially when their health condition is a direct result of their choices?

In the Steve Biko academic hospital and several other hospitals in South Africa, there is an NGO called HospiVision which provides pastoral care and trauma counseling. They offer training for lay people in visiting the sick in their congregations as well as a debriefing for hospital staff.

2.The church needs to prioritise the training and equipping of ordinary people to be agents of their own hope.

The Christian spirituality stresses that all humans were created with equal worth and it is dignifying to equip everyone to be a builder of society in serving others. For this reason, a group of Christian doctors in consultation with the Christian Healthcare Alliance (various Christian healthcare organisations) and the South African National Department of Health (NDoH) prepared a document aimed at advising churches on the topic.

The document hopes to help run an awareness campaign to equip members in knowing that it is everybody's responsibility to promote and maintain the health of people. It also emphasises the point that if we want to improve the health of South Africans and increase disease prevention, much greater emphasis should be given to training ordinary people. This group points out that the Christian religion teaches how precious a healthy body and mind are, being accountable to God to look well after your body, and being part of a caring faith community that can help to cope with illness and aging.

3.The role of the church in society

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The church needs to show values of solidarity by contending for the poor and vulnerable. It also needs to be an agent of hope by practicing Ubuntu.
Ubuntu "places communal interests above those of the individual" and it encourages human interaction in the seeking of the common good [109].
The church would honour God if it collaborates with other stakeholders in building a loving and caring world where people will be the priority over anything else. Below are a few practical suggestions about how the church could play its part in this building process.

8.2. PRACTICAL SUGGESTIONS

A group of Christian medical doctors gives these suggestions that local churches or missionary teams could use as a way to play a proactive role in healthcare:

1. **Promotion of healthy living.**
   This could help reduce many lifestyle diseases, such as hypertension and diabetes. Simple interventions, such as the reduction of salt intake and the reduction of sugar, can have significant health benefits. The opposite could lead to risks of overweight and obesity, which could lead to strokes, heart attacks, and cancer. The Bible certainly teaches moderation when it comes to eating and drinking. Local clinic staff can also be invited to teach about healthy living in congregations.

2. **Taking care of the sick and the aged.**
   Most churches look after their sick members and visit them in the hospital or at home. Have you ever thought of extending this care to adopting a hospital ward or a clinic in your community? The aim of this is to be involved in rendering holistic patient care. This does not only involve spiritual care of patients but also supporting the nursing and medical staff to render optimal patient care and assisting in practical matters. Many churches give special attention to their healthcare professionals on 'Healthcare Sunday' in October every year. HospiVision [5] provides accredited training for church members in spiritual and pastoral care for the sick, their families, and healthcare workers, and the Healthcare Christian Fellowship (HCF) provides practical guidance for the project 'Adopt a Ward'.

Mrs. Mothwedi

Mrs Mothwedi is a 69-year-old widow who looks after 5 grandchildren of 3 different daughters. She is on old-age pension and 2 children get a child grant. The mothers of the children have all gone to look for work in Johannesburg and come home seldom.

They send small amounts of money at irregular intervals and the granny finds it difficult to feed all the children and pay school fees for the oldest child. She is on treatment for hypertension and diabetes mellitus at the local clinic and is an active member of the women's league of the Methodist church. When she reports at the clinic she complains about a loss of power in the left arm and she walks with difficulty. What do you suspect she has and how can you assist this lady?

3. **Community health workers and primary healthcare.**
   The government wants to improve healthcare for everybody and promote health at a household level. The plan is to train thousands of community health workers who will work in ward-based outreach teams (WBOTs). Community health workers can have a great impact in their community if they are compassionate, well-trained carers. Church members with an interest in the health and well-being of their community could apply for this training and in this way contribute to health promotion, early detection and prevention of disease by visiting and screening their community in their homes. Interested churches can visit the WBOT pilot project in Mamelodi. [6]

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5 www.hospivision.org.za / friend@hospivision.org.za / 012-3299492
6 www.youtube.com/watch?v=sQv-U7mk5MM.

4. **Dispensing of chronic medication.**
The government has approved a plan to dispense the medication for chronic patients via shops and local churches, especially in areas where there are mobile or no clinics. People with hypertension, diabetes, asthma, HIV/AIDS, and TB can get their medication every month from their local church if it has been registered with this Central Chronic Medicine Dispensing and Distribution Programme (CCMDD) programme. In this way, the church can make a very important contribution to the provision of medication to large groups of people who are on long-term and often lifelong treatment. If a patient's disease is well-controlled, they can ask their doctor for a prescription and collect the medication at a distribution point close to their home. It will save people a lot on transport money and time, as well as reducing the long queues in clinics and hospital outpatient departments. Three- or six-month check-ups will still happen at the clinic or hospital. The community health workers, nurses, or doctors in the congregation can combine this programme with health education and support groups.

5. **HIV/AIDS.**
HIV/AIDS has become a chronic disease, but treatment is possible for everybody who qualifies. The biggest challenge is to reduce the number of new infections. If your congregation is situated in an area where HIV infections are common, we recommend that your church forms a committee to look at combatting the spread of HIV. At the same time, there should be a plan to support infected and affected people by encouraging a healthy sexual lifestyle and faithfulness. This is of crucial importance for all pregnant women, but also for anyone sexually active. Early detection of HIV infection and timeous treatment prevents so much unnecessary suffering and loss of health, income, and even sometimes life. In 2015, all faith-based organisations were encouraged to become involved in the fight against HIV and the church has a wonderful opportunity to contribute. For more information on the role of the church and HIV, you can contact CABSA.[7] The SA National Aids Council (SANAC) is initiating a new programme for the youth called the Dreams Initiative.[8]

6. **Mother and child health.**
Compared with international standards, mother and child health in South Africa is severely below standard. Too many young children and mothers die of preventable diseases. Churches can encourage expectant women to attend antenatal clinics to have necessary health screens. They can also register for a new programme offering free guidance and advice to South African mothers called 'Mom Connect'.
The midwife at the antenatal clinic takes care of the registration. Monitoring the growth and development of all infants and children is one of the most important interventions, together with immunization against common infectious diseases. The role of the father is often neglected in improving mother and child health and should be promoted.

7 See www.cabsa.org.za
8 http://www.pepfar.gov/partnerships/ppp/dreams/index.htm/

7. **Recruiting young people to become healthcare workers.**
South Africa has a great need for young compassionate healthcare workers, especially in light of great shortages nationwide. The church can play an important role in encouraging young church members to consider a career in healthcare. Provincial Departments of Health give bursaries to bright young people to train as nurses, clinical associates, allied healthcare workers, or doctors. An example is The Exceptional Nurse (TEN)[9] campaign.

8. **Training your healthcare workers to integrate their faith into their work.**
Healthcare Fellowship (HCF), Christian Medical Fellowship (CMF), and HospiVision have an excellent tool, which can be used to train healthcare workers, doctors, and pastors to integrate the spiritual dimension into everyday healthcare practice in clinics, hospices, and hospitals. These organisations are very willing to come to your church or hospital to present a one-day Saline Process training session. It equips healthcare workers to address the spiritual needs of the patient better. The local committee is responsible for advertising the course and organizing a venue. They provide trainers and the training materials. See the HCF[10] or CMF[11] website for more details on the Saline Process training.

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They provide trainers and the training materials.
See the HCF or CMF website for more details on the Saline Process training.

9. **Support for healthcare workers.**
Many healthcare workers suffer from burn-out and fatigue due to the demands placed on them. They are sometimes also traumatized by exposure to suffering regularly. Churches are encouraged to reach out to health workers in general and refer those with special needs to HCF or CMF for counseling.
For churches who want to implement one of these projects and need help, they are invited to contact the Christian Healthcare Alliance at hcf@lantic.net or at CMF at office@cmf.org.za.

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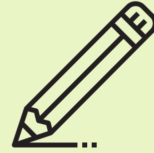
9 https://theexceptionalnurse.org.za/
10 https://www.hcfsouthafrica.co.za/
11 https://www.cmf.org.za/

Church has always played a significant role in healthcare. Our society still needs the church to remain a role player in healthcare in creative and meaningful ways. It is called to have a preferential leaning towards those who suffer and are vulnerable in society. Healthcare is such an area.



GROUP DISCUSSION

1. What stood out to you from this chapter?
2. Do you know a local church that is involved in community healthcare? If yes, what have you observed?
3. How would you encourage a local congregation to be involved in community healthcare?

8

CHAPTER 9: THE FIRST 1000 DAYS OF LIFE AND PARENTING, A CASE STUDY

EDITH MADELA-MNTLA AND PETER FARRANT

WHAT ARE WE GOING TO DISCUSS?

In the following chapter, we will be discussing how faith can influence the first 1000 days of life. We will start off by firstly, discussing what the research shows us about the relationship between faith and pregnancy. Secondly, we will look at a case study of the first 1000 days and parenting based on Christian/Biblical values. Thirdly, we will outline some parenting definitions. Lastly, we will discuss how children learn what they live.

INTRODUCTION

It is well known that people's worldviews and faith have an influence on maternal and child health. Some religions do not accept family planning, childhood vaccinations, or blood transfusions. These can all have a negative impact on maternal and child morbidity and mortality. In a number of studies in Africa, this was studied in greater depth. Cau, Sevoyan, and Agadjanian found in Mozambique that 'when the effects of affiliation to specific denominational groups are examined, only affiliation to the Catholic or mainstream Protestant churches and affiliation to Apostolic churches are significantly associated with improved child survival' [110].
Gyimah found in Ghana that 'At the bivariate level, children whose mothers identified as Muslim and Traditional were found to have a significantly higher risk of death compared with their counterparts whose mothers were identified as Christians' [111]. He also found that 'In general, Moslem and traditional women were less likely to use maternal health services compared with Christians' [112].

Have you seen differences between different religions' approaches to parenting? How they deal with pregnancy, childbirth and how they feed their babies?

How relevant is religion to our understanding of maternal health (MH) service utilization in sub-Saharan Africa? We ask this question mainly because, while the effect of religion on some aspects of reproductive health (e.g., fertility, contraception) has not gone unnoticed in the region, very few studies have examined the possible link with MH service utilization. Understanding this link in the context of sub-Saharan Africa is particularly relevant given the overriding influence of religion on the social fabric of Africans and the unacceptably high levels of maternal mortality in the region.

As African countries struggled to achieve their stipulated reductions in maternal and child mortality levels by two-thirds by 2015 as part of the Millennium Development Goals,

the need to examine the complex set of macro- and micro-factors that affect maternal and child health in the region cannot be underestimated. Using data from the 2003 Ghana Demographic Survey,[12] we found religion (measured by denominational affiliation) to be a significant factor in MH use. This is true even after they had controlled for socio-economic variables. In general, Moslem and traditional women were less likely to use such services compared with Christians. The findings are discussed with reference to our theoretical framework and some policy issues are highlighted. [113]

Baby Lerato

The mother of the baby Lerato of 10 months old brings the baby to the clinic with diarrhea for 2 days, the child is bottle fed and gets porridge and Nestum. The child is well nourished but weaned from the breast when it was 6 months old because the mother is HIV positive. Upon examination, the baby shows signs of mild dehydration and is still drinking the sugar-salt solution. The mother took the child to the sangoma the previous day and he gave the child an enema and put muti on the fontanel. You see that the mother is wearing a ZCC star and she is afraid that she will again lose her baby.
How will you deal with this mother and child?

Discuss the management and is there a spiritual component in this patient and how will you address this?

9.1. CASE STUDY FIRST 1000 DAYS AND PARENTING BASED ON BIBLICAL VALUES.

The World Health Organisation (WHO) was the first to highlight the importance of the first 1000 days of a baby's life. The 1000 days is categorised into three stages:

- 270 days of pregnancy;
- 365 days of baby's first year; and
- 365 days of baby's second year.

This is a unique period of opportunity when the foundations of optimum health, growth, and neurodevelopment across the life span are established.
Yet too frequently in developing countries, poverty and its attendant condition, malnutrition, weakens this foundation, leading to earlier mortality and significant morbidities such as poor health and more insidiously, substantial loss of neurodevelopment [114]. At least 200 million children living in developing countries fail to meet their development potential [115]. While the human brain continues to develop and change throughout life, the most rapid period of brain growth and its period of highest elasticity is the last trimester of pregnancy and the first two years of life [114].
So, what can we, as caregivers, do to help educate, encourage, support, and advise patients about these important matters?

DID YOU KNOW?
The book of Psalms is the longest book in the Bible?

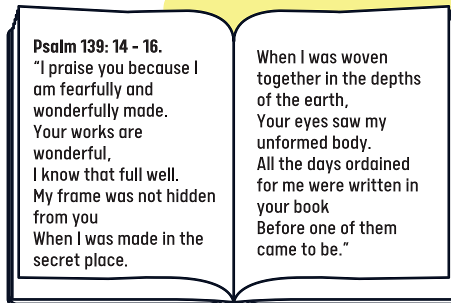
12 https://www.dhsprogram.com/pubs/pdf/FR152/FR152.pdf

From a Judeo-Christian perspective, it is important to understand that all babies are created by God. What are the important things that we as caregivers can do to help the baby and the parents benefit most from the first 1000 days of life?

1. Maternal nutrition before conception and during pregnancy is important to optimise.

2. Maternal health during the pregnancy (ANC visits), good food, no toxins (alcohol, tobacco, or any unnecessary drugs either prescription or non-prescription).

3. Maternal mental health and wellbeing is important.



4. Parenting: Caregivers must be responsive and form strong attachments with their babies so that they can grow and develop well intellectually, socially and emotionally. Fathers have an important role in promoting healthy, stable families. Functional families with loving, caring parents working together for the good of their families is vital for the good of all communities.

5. The child's growth in the first 1000 days is very important. Research in the COHORTS[13] study has shown:

- Pre-natal growth (growth in the uterus), which is assessed as birth mass is important. There are positive associations between adult height and schooling success. Bigger babies grow better and do better at school.
- Post-natal growth (growth after birth) - early (0-2 years) linear growth (length) relates to taller adult stature and improved school attainment. Whereas faster linear growth after 2 years (1000 days), is not strongly related to schooling. Therefore, focus on the first 1000 days is important.
- Post-natal growth in weight between 0 - 2 years does not seem to correlate strongly with risk for cardiometabolic disease. However, too rapid an increase in weight after 2 years is associated with risk for cardiovascular and metabolic disease. Therefore, focus on the first 1000 days is important.

6. Emotional wellbeing: The importance of bonding with the baby.

- The unborn baby can hear the parent's voice while in the uterus, so reading aloud and talking and singing to the baby is helpful and important.
- Skin-to-skin contact with both parents is important to help the baby bond with both the mother and father.
- Breastfeeding is vital for nutrition and growth and bonding reasons.
- Eye-to-eye contact provides meaningful communication at close range.
- Reading and singing to the baby help to establish the bond. Babies enjoy just listening to the conversation as well as the parent's descriptions of their activities and environments. Babies prefer human voices and enjoy vocalising in their first efforts to communicate.

[13] http://www.hsrc.ac.za/uploads/pageContent/87/presentationFirst1000days3mar2012.pdf

- Avoid television and screen time in the first 2 years of life. Thereafter, introduce a controlled and planned exposure with parental control and support. [116].
- Developing this close bond with both parents will lead to bonds being formed with other family and friends. This is also important to build up a support system for the family. "It takes a village to raise a child."
- The successful establishment of these primary bonds and basic trust assists the baby to establish healthy relationships later in life.
- It also assists the infant with his or her self-image, sense of self, and relationship style in later life.

7.Play and Intellectual Development.

- One-on-one interaction between the caregivers and the baby in the first 1000 days (and thereafter) form the basis for intellectual and psychomotor development in the baby.
- Reading, singing, looking at pictures, touching, feeling and experimentation by the baby under the caring, loving supervision of the mother, father or caregiver is an important and vital way of stimulating intellectual and psychomotor development.
- Allowing the baby to follow a moving object is an important tool to assist with visual development and communication.
- Talking to the baby and allowing the baby to vocalise in return is the beginning of communication and speech.
- Later the use of educational toys, books, and other tools assist with the complex development of gross motor and fine motor coordination.

9.2. SOME DEFINITIONS OF PARENTING:

1. Parenting or child rearing is the process of promoting and supporting the physical, emotional, social, and intellectual development of a child from infancy to adulthood.
2. Parenting is the raising of children and all the responsibilities and activities that are involved in it.

Parenting is a process and involves a wide number of aspects and stages which can be summarised as follows:

- Building strong foundations.
- Meeting children's needs.
- Setting boundaries.
- Teaching healthy relationships.
- Setting goals and long-term aims [117].

Good parenting involves a great deal of consistency and routine which gives children a sense of control. Good parenting focuses on developing independence in children. Therefore, the ultimate aim for parents is to become unneeded.

Good parenting involves a style that considers the child's age and stage of development.

9.3. PARENTING IS A GOD GIVEN RESPONSIBILITY.

The Judeo-Christian scriptures abound in teaching about parenting and the discipline of children.

- *"But Jesus called the children to him and said, 'let the little children come to me, and do not hinder them, for the kingdom of God belongs to such as those."* - Luke 18:16. This shows great responsiveness to children.
- *"Discipline your son, for in that there is hope. Do not be a willing party to his death."* - Proverbs 19:18.
- *"Do not withhold discipline from a child"* - Proverbs 23:13.
- *"Listen, my son, to your father's instruction, and do not forsake your mother's teaching. They will be a garland to grace your head and a chain to adorn your neck."* - Proverbs 1:18

Do you think that the pedagogical advices in Proverbs apply in the 21st century and are appropriate?

Other religions like Islam provide guidelines for their followers on parenting and stress the importance of building a strong relation with your child and role modelling good behaviour [118].

9.4. PARENTING IS INSTINCTIVE IN MOST LIVING CREATURES.

Consideration of nature will show very clearly that most living creatures provide in some way for their offspring.
Some birds make intricate nests, others are more casual with just a scrape in the ground or "two twigs across and a little bit of moss", but will feed, protect and teach their offspring to be self-sufficient in flying and feeding themselves in a few weeks.
Baboons and elephants are highly socialised, and it is fascinating to watch the care, nurture, and discipline of their young.

9

9.5. TRADITIONAL CULTURES:

Human traditional cultures show what happens when parenting is neglected.
The secular history of the Roman Empire and of Imperial Rome as a city is quite shocking in its revelation as to how infants and young children were treated. Infanticide was an acceptable practice to such an extent that the sewers of Rome became blocked by the bodies of newborn babies - especially girl babies. [119]. In 21st-century China, the practice of abortion for female fetuses is widely practiced. The unfortunate consequence of this practice is that today the male population exceeds females by approximately 50 million. A devastating number of men are thus without the possibility of finding a partner. This has also led to an enormous increase in human trafficking in China to provide sex slaves.[14]

14 Yeonmi Park, who fled from North Korea into China, tells the horrific story of how she was bartered as a sex slave until she finally managed to escape to South Korea, and eventually New York: *In Order to Live: A North Korean Girl's Journey to Freedom*

Child sacrifices were a regular occurrence in the Middle Eastern Countries as recorded by both secular historians and in Biblical references to Baal worship (Jeremiah 19:5), and to Molech worship (Leviticus 20:2).

The process of child rearing involves the promotion and support of their physical, emotional, social, and intellectual development to adulthood. It is the prime responsibility of parents to undertake this process. The traditional and God given place to do this is in the household. As healthcare providers, it is very important for us to get a good understanding of what sort of home, family, community, and culture we are dealing with in order to best guide and support our patients.

Children learn what they live
If a child lives with criticism - it learns to condemn.
If a child lives with hostility - it learns to fight.
If a child lives with ridicule - it learns to be shy.
If a child lives with shame - it learns to feel guilty.
If a child lives with tolerance - it learns to be patient.
If a child lives with encouragement - it learns to be confident.
If a child lives with praise - it learns to appreciate.
If a child lives with fairness - it learns to be just.
If a child lives with security - it learns to have faith.
If a child lives with approval - it learns to like himself.
If a child lives with friendship - it learns to find love.
If a child lives with acceptance - it learns to be himself.
CITATION Mol84 \l 7177 [151]

GROUP DISCUSSIONS

1. What stood out to you from this chapter?
2. Discuss whether you have noticed how faith influences the first 1000 days of life.
3. Think of your own faith/religion/spirituality. How does it influence the way you perceive parenthood?
4. Have you ever noticed how children learn more from doing and mimicry? Do you think this is less true for adults? Why?

CHAPTER 10: TRAINING HEALTHCARE PROFESSIONALS ON SPIRITUALITY

SOPHIA TEMBO AND ANGELINA SANDY

WHAT ARE WE GOING TO DISCUSS?

This chapter will discuss the challenges and guidelines of training healthcare professionals on spirituality. We will firstly discuss the need for and challenges of training healthcare workers in spirituality. Secondly, we will discuss the ethical elements of this type of training. Thirdly, we will discuss guidelines for training healthcare professionals and for approaching the topic. Lastly, useful resources will be provided.

AS A HEALTHWORKER.

Ethical practice requires you to follow seven rules:

1. Respect human dignity
2. Ensure informed consent
3. Protect privacy
4. Ensure confidentiality
5. Practice equity
6. Maximise benefits
7. Minimise harm

Remember:

Horizonal equity means people with the same needs should get the same attention. Vertical equity means people with greater needs should get more attention

INTRODUCTION

The need for integrating spirituality into healthcare is enormous but at the same time lacking because medical schools and health science faculties do not teach how students can do that. The World Health Assembly's palliative care guidelines state that all healthcare professionals have an ethical obligation to address all suffering of patients - physical, psychosocial, and spiritual. Yet some in the medical community think it "conflicts" with medical science and they feel that spirituality and faith are private matters that should not be raised during consultations.

Others will argue that to understand a patient better a more holistic approach is needed and in Family Medicine, the 3-stage assessment is taught to get a more comprehensive understanding of the patient's condition, fears, ideas, expectations, and context. This is the biopsychosocial model and this approach is very helpful to understand the patient and develop a management plan. The worldview and spirituality of people can have a big impact on the help-seeking behaviour of people and what they see as an appropriate and acceptable treatment.

Common examples are the acceptance of vaccinations, the use of family planning methods, male sterilisation, blood transfusion, avoidance of certain types of food, and the use of herbal or homeopathic medication. In this chapter, we will touch on some ethical and practical aspects of spirituality and give guidelines on how to train healthcare givers to incorporate spirituality in their daily work. Common reasons to avoid integrating spirituality in patient care is the lack of training, the fear that patients will ask questions the healthcare worker cannot answer, lack of confidence in her/his own worldview, lack of time, fear of people who will blame them,

and the fact that the clinical environment does not model how to do this. Another issue is the concern of whether it is ethical to explore people's deepest convictions and share your own experience and worldview.

DID YOU KNOW?

Ethical issues are closely related to worldviews and faiths.

10.1. THE ETHICAL ELEMENT

"Ethics is the science of moral conduct; it describes what an individual or a certain group of people is doing. It also prescribes what the individual or group should be doing. It attempts to answer the question what is right or wrong, good and bad, and how to achieve what is good." [120]

One of the reasons healthcare professionals may be hesitant to integrate spirituality into the practice of healthcare is the fear of violating ethical boundaries such as imposing their own faith on patients.

Spirituality is an inseparable aspect of humanity. It has been established in the previous chapters that spirituality in healthcare plays a significant role, both for healthcare professionals and patients. According to Herbert et al [121], illness raises questions regarding meaning and value, which can therefore be described as a spiritual event. The HIV/AIDS Care and Counselling study guide by Unisa states that, even when HIV-infected clients may in many cases shy away from directly touching on spiritual matters or may even be reluctant to discuss this with their priests, ministers, imams, or religious leaders, they nonetheless often have the burning needs to discuss spiritual matters" [122].

While it is evident that spirituality plays a huge part in healthcare, Herbet et al state that medical training falls short in preparing health professionals to help patients with the metaphysical needs of the illness [121]. While more health professionals are beginning to recognize that spirituality is a core patient need and has beneficial influences on health, some in the medical community think it "conflicts" with medical science. In the meantime, there is overwhelming evidence that spirituality has positive and negative impacts on the outcome of treatment [12]; [123].

Asking patients what is important and bringing meaning to life, is not a violation of any ethical boundaries. Spirituality is not a religion but can be the source that brings meaning, hope, and purpose. It also influences what type of healthcare is acceptable, the role of the family, ancestors or God play in these decisions. In a recent study in the Chris Hani Baragwanath Academic Hospital, it was found that offering spiritual care correlated with less pain, a lower dosage of morphine required to manage pain, less anxiety from family members and a higher percentage of deaths at home among the cancer patients [124].

10.2. GUIDELINE FOR TRAINING HEALTHCARE PROFESSIONALS IN SPIRITUALITY

The subjects of "How to take a Spiritual History" and "The 5w Approach to Spiritual Care Implementation" are covered in Chapter 11. These topics have a direct bearing on teaching the healthcare professional to integrate spirituality in the practice of healthcare. We will therefore focus on how the healthcare giver can be trained to practically apply spirituality in the workplace.

Several organisations have developed training courses to address the lack of training by healthcare training institutions and medical schools. Examples are the Saline Process by the International Health Service from a Christian worldview and a training course from a Buddhist worldview. Both courses pay a lot of attention to how healthcare professionals can address aspects such as anxiety, fear, guilt, bitterness, hope, peace, forgiveness, how to deal with death and dying, coping mechanisms, and how faith can play a role in dealing with these aspects.

As healthcare workers, we need to take responsibility of our own training. We should recognize and further develop 'blind spots' in our training, like spirituality.

THE SALINE PROCESS TRAINING COVERS THE FOLLOWING:

- Why is faith important in healthcare, what does science say?
- What are the opportunities and barriers?
- What is the role of the healthcare worker?
- What tools can you use?
- What are ethical considerations?
- Spiritual team
- Spiritual prescriptions

The Saline Process is based on a Christian worldview and values and will be used here as an example to illustrate how it prepares healthcare workers to deal with spiritual issues in a professional and ethical way. It addresses the question why it is difficult for some healthcare workers to integrate spiritual aspects into their practice and patient care. It shows how to recognize spiritual needs and explore them further in a manner that is respectful and ethical. The approach of the Saline Process can be summarised by the Five C's: Christ-like Character, Competence, Compassion, Communication and Courage.

THE FIVE C'S IN CHRIST-LIKE HEALTHCARE

Christ-like Character: healthcare givers need to imitate Jesus by living a life that is characterized by love, joy, peace, patience, kindness, goodness, faithfulness, gentleness, and self-control (Galatians 5:22-23). A person can achieve a Christ-like character by depending on God and not on his/her own abilities. When facing difficulties, one can draw on His strength based on the truth in His word. He is willing to be with us and see us through every difficult situation. A Christ-like character is one in which the fruit of the Spirit is visible.

Professional Competence: our patients desire to be treated by the best healthcare givers, who should meet this expectation. They need to serve the patients the best they can in terms of their profession. This means that they must make use of every opportunity to improve and sharpen their skills by reading material related to their profession and attending clinical updates. "Whatever you do, work at it with all your heart, as working for the Lord, not for men" (Colossians 3:23).

Compassion: this is an ingredient that is often lacking in a profession where it is so needed. Compassion deals with how one treats people. It speaks of kindness, willingness to accept and support patients and their relatives no matter their condition or what brought them to this point in their life. Healthcare givers need to regularly assess their own motives to see if they find themselves being harsh or judgmental. Compassion involves speech - what healthcare givers say to the patients and their relatives should be wholesome and helpful for building them up according to their needs. Compassion involves action - how healthcare givers treat the patients and their relatives should be the way they would expect others to treat them and their relatives.

Wise Communication: this is more than just the spoken words. It also involves tone, gestures, and body language. Messages are communicated by 7% words, 38% tone of voice, 55% gesture, and body language CITATION Alb68 \l 7177 [152].
Communication is listening to hear and understand what the patient is feeling and experiencing. Healthcare givers need to be silent and pay full attention to what the person is saying through their tone of voice, gestures, and body language.
They need to see whether the patient's words are reflected in his/her body language. Communication is asking the right questions. As healthcare givers ask questions, they need to do so with respect and without interrupting the patient while he/she is speaking. They should ask the right questions to clarify information or expand on the information already given. They should always depend on the Holy Spirit to guide them as they communicate with the patient.

Courage: this speaks about having a spirit of boldness and not being fearful. It means that as a healthcare giver you are able to stand up for a principle, a value, something you believe and hold close to your heart, even though others may be saying or doing something else. It takes courage to get started and keep going. Courage comes from knowing and understanding your calling: 'Why are you in the healthcare profession?' Is it a calling or is it 'just a job'? If it is a calling you will be able to persevere even when the odds are stacked up against you.
Courage also comes from the encouragement you get from others. This motivates you as a healthcare giver to go on, knowing that someone else is standing with you and urging you on. Courage also comes from knowing that God is on your side when you are walking in His will and doing the things, He wants you to do.

In addition to the Five C's, healthcare givers need to make each encounter they have with the patient a positive patient encounter. This can be achieved by providing a safe environment, the use of understandable words, allow for dialogue and discussion, and challenges the patient to take positive actions.

A safe environment is one in which patients will feel comfortable sharing their thoughts and feelings. It is one in which respect is shown and people are treated as equal, and the healthcare givers acknowledge the patients' beliefs without judgment.

Healthcare givers need to use words that would reflect their understanding of who the patient is in terms of his religion or worldview. They should allow for dialogue and discussion and take time to listen to the needs of the patients. Listening has therapeutic value for patients and provides the holistic care the patients deserve. The question that is often raised is how far healthcare workers can share their own faith with patients. Can they share a faith story, can they read from the Bible, or offer them a prayer? As a guideline one can say that this should be done with sensitivity, respect for the patient's worldview, and permission.

The healthcare worker is in a position of power compared with the patient who is sick and depending on the healthcare worker. This should never be used to coerce the patient to adopt another worldview. At the same time, it would be inappropriate to prescribe an antidepressant for a patient who is looking for meaning.

10.3. GUIDELINES FOR APPROACHING THE DISCUSSION OF SPIRITUALITY

Caring team members should be concerned about supporting the spirituality of the patients, as "spiritual pain and hunger will not always be expressed in religious words." It needs to be detected carefully. When there are spiritual issues specially trained people such as hospital chaplains, pastors, imams, and counselors need to become involved [125]. Healthcare givers must not wait for the patient to complain, they need to evaluate how the patient is doing and learn to anticipate the needs of the patient. When they realize that the patient is anxious, does not cope with bad news, has a low mood, lost hope, becomes aggressive, or does not respond to treatment further exploration is indicated. This will include psychosocial aspects such as concerns about work, family, or finances. But also, what gives meaning to the patient's situation, how does she/he experience the illness, what makes it difficult, and what brings hope. This can open opportunities for other interventions to complement the medical treatment.

"Most patients are willing to discuss spiritual matters if addressed with their permission, sensitivity, and respect." [126]

CONCLUSION

In this chapter, we briefly looked at the ethical and practical aspects of spirituality in healthcare.

We also looked at some guidelines in training healthcare givers in spirituality.

USEFUL RESOURCES

1. Centre for Spirituality and Healing, University of Minnesota http://www.csh.umn.edu/
2. Centre for Spirituality, Theology and Health, Duke University http://www.dukespiritualityandhealth.org/
3. Christian Medical and Dental Association http://cmdahome.org
4. Health Ministry Association http://www.hmassoc.org
5. America Medical Association Journal of Ethics www.virtuallmentor.org

GROUP DISCUSSIONS

1. What stood out to you from this chapter?
2. What kind of training have you received on spirituality?
3. What do you think is the biggest gap in your own understanding of spirituality?
4. What makes it difficult for you to bring spiritual matters into the conversation with patients?

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CHAPTER 11 SPIRITUAL CARE – SCREENING, IMPLEMENTATION AND TRAINING

DR ELLENORE MEYER & PROF WERDIE VAN STADEN

WHAT ARE WE GOING TO DISCUSS?

The benefits of incorporating spiritual aspects into personal healthcare have been related by several authors (e.g., [127]; [128]; [129]; [12]). These are possible positive effects, not only for patients, but also for their families, and could enhance perceived job satisfaction amongst the practitioners. This means that spiritual care of patients is considered a fundamental component of quality, compassionate healthcare.

This is especially true in the African context, where spirituality is seen as a vital component of whole-person care [130] [131].

In this chapter, we will discuss principles, practicalities, and tools for spiritual care. Firstly, we will discuss the 5W approach to spiritual care, and secondly, eight principles that guide spirituality in practice. Thirdly, we will look at the implementation of spiritual care, by discussing spiritual screening, history taking, and assessment. Lastly, we will discuss the intricacies of training others for spiritual care.

AS A HEALTHWORKER..

You are expected to treat what you know about people as confidential.
This means that

- You will not use what you know about people to embarrass them, or put them in danger or discriminate against them.
- You will be professional in you work.
- You are trustworthy and responsible.

11.1 THE 5W APPROACH

When a health professional or an interdisciplinary team adopts a holistic healthcare approach that incorporates spirituality, there are five key questions, referred to as the 5W Approach [132], which support the planning process. These questions provide a practical outline of what to consider when deciding on an approach suited to the individual practice.

In order to successfully implement quality spiritual care, it is important to conduct proper pre-planning and adopting an approach that is relevant to the individual health context.

11.2. ANSWERING THE 5W QUESTIONS FOR SPIRITUAL HEALTHCARE

The following sections describe possible answers to the 5W questions for spiritual healthcare. However, it is important for every team and each individual to answer these questions in the light of their unique context.

THE 5 W QUESTIONS ASK 'WHY? WHAT? HOW? WHO? WHEN?' IN ORDER TO PLAN FOR IMPLEMENTING SPIRITUALITY IN HEALTHCARE:

- **Why include spirituality in healthcare?**
- **What are we screening for?**
- **HoW should spiritual screening and history taking be conducted?**
- **Who should offer the spiritual care for a need identified?**
- **When should one refer for specialised care and to whom?**

11.2.1. Why include spirituality in healthcare?

- Patients report a need for spiritual care [133]; [134].
- The spiritual care of patients is considered a fundamental component of quality, compassionate healthcare [135].
- Culture and spirituality both have a significant impact on health-seeking behaviour and how patients want to receive healthcare when it is offered to them [136].
- The health practitioner has an opportunity to tend to the patient holistically by bringing into account the resources and issues in the patient's social, environmental and spiritual life.

11.2.2. What are we screening for?

- Monod et al [137] developed a tool that can assess the spiritual state of a patient by assessing four spiritual domains with a specific need linked to each domain. The spiritual domains include: transcendence, psycho-social identity, values and meaning. Spirituality can either be an asset or liability in the overall health of the patient and is not a homeostatic process as life events also influence one's spiritual state [138]; [139]. The goal of the spiritual enquiry is to identify a spiritual need that could be addressed, enquire about possible spiritual distress and its relation to the overall health of the patient, and identify possible resources that could improve well-being.

11.2.3. How should spiritual screening and history taking be conducted?

- Various spiritual screening tools are available (we will discuss a few, later in this chapter). Spiritual screening or history taking should be customised according to the needs of the patient in accordance with the practitioner's competence and clinical context that he/she offers services.
- After reading the section on spiritual screening, take some time to evaluate what method will be most suited for your own context.

11.2.4. Who should offer the spiritual care for a need identified?

- Spiritual care should be addressed within an inter-disciplinary team by the member most suited to do so.
- This is dependent on whether specialised spiritual care is readily available or not, whether one of the inter-disciplinary team members has established an ongoing and trusting relationship with the patient, and on the competence and skill of the health practitioner.

- All practitioners should be trained to address spiritual needs on a primary/essential care level, but also be comfortable enough about their own limitations and know when to refer.
- The spiritual care provider could be any one of the following [140]:
    - Physician
    - Nurse
    - Traditional healer
    - Chaplain
    - Psychologist or another mental health provider
    - Spiritual mentor
    - Social worker
    - Friends and family
    - Community Health Worker

11.2.5. When should one refer for specialised care and to whom?

- The spiritual care should be coordinated by the healthcare worker taking the lead on the patient's case. This does not, however, indicate that the health case manager should offer spiritual care.
- Spiritual care is best addressed when included as part of the overall healthcare plan. Holistic care requires a team approach where members of the healthcare team discuss the spiritual care plan as part of the treatment plan. This plan should include both the patient and family in such a manner that it enables meaning-making, finding hope and peace and transcendence with a sense of connectedness.
- Quality spiritual care includes timely referral to a spiritual counsellor or spiritual leader when appropriate.
- It also includes incorporating the patient's spiritual network and support system into the care plan.
- Referral for care is dependent on patient preference, practitioner competence and the availability of specialised spiritual care.

AS A HEALTHWORKER.

Think of your own example. Use the 5W approach and answer each question related to your practice. Use your answers to reflect on the rest of the chapter and update your response with what you learn as you read.

11.3. THE EIGHT PRINCIPLES TO GUIDE SPIRITUALITY PRACTICE

With the 5W approach in mind, we can discuss important aspects and perspectives on spiritual care.

This section describes eight principles for incorporating spiritual healthcare during a consultation. These principles for quality spiritual care serve as the foundation for an approach to incorporating spirituality into healthcare.

The eight principles form the basis for why spirituality in healthcare is important and how this should be addressed in an ethical and high-quality manner. The eight principals highlight the importance of including spirituality in the health consultation,

adopting a person-centric approach as well as the importance of creating a receptive environment that considers the spiritual needs of the patient within his/her personal context.

These eight principles that are used to frame and guide practice during the health consultation include:

- Spirituality should be part of the health consultation.
- An evidence-based approach that is ethically grounded should be followed.
- The practitioner should attend to his/her attitude during a spiritual health consultation.
- The practitioner should create a receptive environment that considers the spiritual needs of the patient within his/her personal context.
- A practitioner should adopt a person-centric approach.
- The practitioner should foster communication that suitably addresses spiritual health needs.
- The practitioner should be sincerely interested in the person and his/her spiritual needs (to achieve quality spiritual healthcare).
- The practitioner should co-mobilise spiritual resources that build resilience for the patient.

The depth and application of how spirituality is addressed in the health consultation will vary. Depending on the unique patient situation, one or all of these dimensions could be applicable to the consultation. Spiritual screening is very brief and usually takes place during a first consultation or could easily be concluded during the waiting period before the consultation. Spiritual history taking can be brief or extensive, and done prior to and/or during the consultation. Spiritual assessment over time is usually part of continuous or follow-up treatment.

11.4. Implementing of spiritual care

Using these 8 principles as a foundation, we will discuss the practical implementation of Spiritual Care. This starts by realizing that there are different levels of spiritual enquiry and learning to use different methods at the appropriate time, to achieve the desired results. Did you know that spiritual enquiry can be conducted at different levels? One can learn/apply different methods or levels of enquiry depending on the context.

AS A HEALTHWORKER.

Think of a scenario in which you would use one of the levels of spiritual inquiry mentioned above?

The inclusion of spirituality in the health consultation and treatment process requires three dimensions of enquiry:

- Spiritual screening
- Spiritual history taking
- Spiritual assessment.

Always remember - Spiritual screening or history taking should be customised according to the needs of the patient in balance with the practitioner's competence and clinical context that he/she offers services in.

11

11.4.1. Selecting a spiritual screening and history taking approach

The spiritual screening approach used could range from asking two questions to screen for and identify a spiritual need, to taking an in-depth spiritual history. Beyond the spiritual history, whether brief or thorough, lies the question of which member of the health professional team should address the spiritual needs and to what extent these should be addressed by a health professional before the patient is referred to a specialised spiritual carer. It is all about finding a method of taking the spiritual history that fits your time, practice, personality, and discipline.

It is recommended that practices should adopt an approach that combines a spiritual screening tool with an in-depth inquiry about the patient's narrative. This could entail using a short spiritual screening tool as part of your history whilst the patient is waiting, and spending more time during the consultation on needs that were identified beforehand. A spiritual history should include that the health professional explores with the patient a possible link between his/her perceptions of his own health and spiritual or emotional distress, and whether this could contribute to the patient's health or illness, including an exploration of possible patient spiritual stressors and resources.

11.4.2. Assessing and identifying spiritual distress

Taking a spiritual history or performing a spiritual screening during a clinical consultation includes assessing whether the patient is experiencing spiritual distress [141]; [142].
The CSI MEMO was developed by Koenig [142] to understand the role religion might play in a patient's life in coping with his/her illness or identifying whether it is a resource or a source of stress. De la Porte [131] argues that the patient narrative plays a vital role in empowering the patient in a multi-cultural context: "Not only do we have diverse cultures in society playing a role but also the 'culture' of the medical environment and healthcare. This environment has its own language, principles, and interpretative systems. Often patients experience that their own interpretive systems break down in this environment."

Various acronyms have been developed to help health practitioners to remember how to take a spiritual history. These include:

i. FICA

The FICA spiritual history tool [141] that stands for:
F: Faith and beliefs, **I: I**mportance of spirituality to the person,
C: Community for spiritual support, and **A: A**id in addressing spiritual needs.

ii. CSI MEMO

The CSI MEMO [142] consists of four questions:

1. Do religious or spiritual beliefs provide you with comfort or stress?
2. Do they influence medical decisions?
3. Are you a member of a religious or spiritual community?
4. Do you have any other religious or spiritual needs?

iii. SPIRIT

The SPIRIT tool [143] that enquires about a **S**piritual belief system, **P**ersonal spirituality, **I**ntegration into a spiritual community, **R**itualised practices and restrictions, **I**mplications for medical care, and **T**erminal event planning.

Fitchett and Risk CITATION Fit09 \l 7177 [146] describe a brief spiritual/religious tool for health practitioners that are too busy for a narrative inquiry or are unable to do an in-depth spiritual assessment. It asks a few simple questions that prompt one of three actions:

- Is there current spiritual distress? Refer for spiritual assessment if the answers indicate possible religious/spiritual struggle.
- Is there a need for spiritual care? Refer if spiritual care is requested by the patient upon questioning.
- No action if there is no indication of a spiritual struggle or no interest for spiritual care.

iv. FACT

The **FACT** spiritual tool [144] containing questions on:

F **F**aith (or beliefs) - What is your **F**aith or belief? Do you consider yourself a person of **F**aith? Or a spiritual person? What things do you believe give your life meaning or purpose?

A **A**ctive (or Available, Accessible, Applicable) - Are you currently Active in your faith community? Are you part of a religious or spiritual community? Is support for your faith Available to you? Do you have Access to what you need to Apply your faith (or beliefs)? Is there a person or support group whose presence and support you value at a time such as this?

C **C**oping (or Comfort, Conflicts, or Concerns) - How are you Coping with your medical situation? Is your faith (your beliefs) helping you Cope? Is your faith or beliefs providing you Comfort considering your diagnosis? Do any of your religious beliefs or spiritual practices Conflict (or have a potential impact) with medical treatment? Are there any particular concerns you have for us as your medical team?

T **T**reatment plan - If patients are coping well, then either support or encourage or reassess at a later date as the situation changes. If patients are coping poorly, then refer to an appropriate team member, discuss spiritual support that they can go to, and spiritual self-care methods that they could implement.

The FACT spiritual care tool offers more than a spiritual history, as it includes questions on how to conduct a spiritual assessment. This tool is intended for use by members of the interdisciplinary team, which could be a health professional (e.g. community health worker) or a spiritual leader (e.g. chaplain) [144]. FACT can be used successfully in a short first-visit patient consultation, as long as the health practitioner established beforehand that the patient is open to the intervention and has ensured that he/she is not overstepping any possible boundaries that the patient might have.

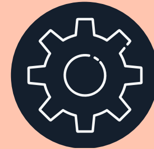
v. HOPE

The **HOPE** tool [145] looks at sources of **h**ope and meaning, **o**rganised religion, **p**ersonal spiritual **p**ractices, and **e**ffects on medical care.

The tools described above are not intended to be used as a checklist, but rather as an interview guide that should be used to facilitate a patient-centric conversation that can open a further discussion.
While these tools are valuable in helping practitioners to easily remember what to ask when enquiring about spirituality in the healthcare context, they don't necessarily guarantee that a meaningful discussion will be conducted.

AS A HEALTHWORKER.

Which of the above tools would be best suited for your practice?
Can you list three tools to conduct a spiritual history?
Choose a tool and try this out with a colleague or patient.
How would you respond to spiritual distress or a spiritual need?
Whom would you refer to and what recommendations will you make to the patient?



Before attempting to ask questions that are an important component of whom the person sees him/herself to be and the implications of these beliefs on the healthcare experience and the patient's journey, it is important to establish a rapport and trust that will enable an open and genuine conversation.

11.5. TRAINING THE TEAM FOR SPIRITUAL HISTORY TAKING

There is a gap in the training of health practitioners in the practical management of patients in the areas pertaining to the individual and contextual diagnosis. Puchalski, Vitillo, Hull, and Reller [135] advance the notion that spirituality should be integrated into routine clinical practice.

The list of competencies or behaviours that students and clinicians should demonstrate include:

- Incorporating and use of the patient's spiritual network and support system
- Performing a detailed spiritual history
- Spiritual screening (when appropriate)
- Ongoing assessment of a patient's spiritual distress
- Collaborating with a health team to manage the spiritual care
- Inviting patients to explore their own spirituality and inner life
- Responding appropriately to verbal and non-verbal signs of spiritual distress
- Timely referral to a spiritual counselor
- Respecting a patient's spiritual belief systems

Health practitioners from all disciplines should be trained on how to screen, take a spiritual history and integrate spiritual care into the treatment plan of patients from different spiritual beliefs and backgrounds. This should be part of undergraduate and ongoing professional training.

Any member of the health team should be able to conduct spiritual screening. Depending on circumstantial factors such as the time available, the relationship established, the nature of the distress, and the skill of the health professional, the health professional might take a brief or a full spiritual history and/or incorporate spirituality in the care plan, or refer the patient for specialised care.

AS A HEALTHWORKER...

Identify health team members in your practice or area of service that offer specialised spiritual care, with whom a collaborative patient management approach can be established.

The skill and art lie in matching the right spiritual screening and care tools to the individual patient, facilitated by the appropriate team member. The figure below depicts the three components of quality spiritual care in relation to each other [132]:

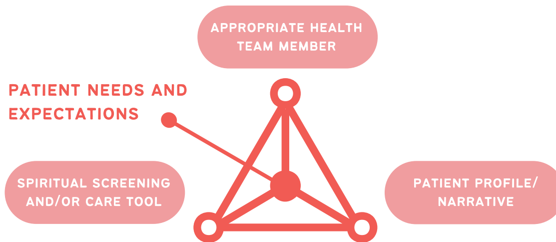
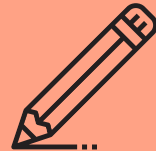


Figure 1: Three components to quality spiritual care [132]



Group discussion

1. What are the three dimensions of spiritual inquiry?
2. List and describe the three components of quality spiritual care?
3. Discuss the Fitchett and Risk's (2009) spiritual/religious tool [146].
4. How should spiritual screening and history taking be conducted? (Give an example at the hand of one of the tools described in this chapter)
5. As a health professional, after reading this chapter how would you describe an ethical and sound approach to spiritual care in practice?

APPENDIX TO CHAPTER 11

DR ELLENORE MEYER & PROF WERDIE VAN STADEN

Various practical tools have been developed based on the recommendations by both practitioners and patients [132]. These recommendations can assist in the adoption of an approach that will increase the success of implementing the spiritual care principles.
The recommendations for implementing spiritual care principles are described according to three categories:

1. General guidelines on applying the principles to spiritual care
2. 'How to do' from the perspective of the patient and practitioner
3. 'What to do' from the perspective of the patient and practitioner

1. GENERAL GUIDELINES ON IMPLEMENTING THE PRINCIPLES

The following points are overall guidelines to assess whether a principle is upheld in practice:

- Spiritual care should also be described for what 'it is not': Spirituality as part of a holistic care approach should not be offered as 'the quick fix' to all health problems.
- Incorporating spiritual care is person-centric when its focus is on the beliefs and preferences of the patient, whether or not the health professional agrees with it.
- Spiritual practices preferred by a patient should not be discouraged or dismissed by the health professional unless there is a clear medical indication that this could be to the detriment of the patient's health.
- The patient should also be aware that he has the right not to discuss spirituality as part of a consultation and care plan.
- The motivation for including a discussion on spirituality should be clearly communicated to the patient:
  - To assess possible resources/strengths and spiritual-emotional impediments to health
  - To offer an alternative treatment to be included as part of a holistic care plan.
- Exploring patients' spirituality and beliefs should be a process where the patient is given an opportunity to take the lead, make the call on how in-depth they want to discuss this, and also its importance to them personally, including the relevance and application thereof in the health context.
- The patient's personal narrative is just as important as the clinical history, and patients should be given the opportunity to explore this in a health context as part of history taking.
- Ethical principles include being non-judgemental and sympathetic, honest, congruent, genuine, respectful and sensitive to the patient's current needs and preferences with regard to expressing and addressing these needs. These should be adhered to at all times.

- Patients might be concerned about what the boundaries and limitations are when addressing their spiritual needs during a health consultation and treatment plan, and this should be discussed as part of spiritual care.
- Practitioner worldview or spiritual stance should not interfere with patient preference and should be dealt with carefully if ever shared.
- Respect for the patient's autonomy includes obtaining informed consent, honouring confidentiality and establishing a relationship of trust. These are important principles to adhere to as part of establishing a context for a meaningful discussion relating to spiritual needs and care
- Non-religious patients or patients that profess to be unsure about whether they consider themselves as spiritual, still profess a need to be cared for from an emotional and spiritual perspective that is supportive.

2. 'HOW TO DO' FROM THE PERSPECTIVE OF THE PATIENT AND PRACTITIONER

The following points are practical pointers for the health practitioner when incorporating spiritual care in practice:

- Patients want to have both a professional and a personal experience: For a patient to engage meaningfully on a spiritual level requires that the practitioner meet the patient as a human, allowing for vulnerability, connection, and open sharing. Patients want to feel that the health practitioner is genuine and honest.
- The health professional should be knowledgeable and skilled in his/her approach to offering spiritual care that is common to various cultures, religions, and spiritual beliefs. They should be able to offer such care in a professional manner that is of relevance to the specific patient and clinical context.
- Health professionals should be sensitive about patients' concerns regarding the healthcare worker's spiritual views and preferences and ensure these are not imposed on the patient.
- Practitioners should be open to varied patient responses and be sensitive to the patient's preference.
- A person-centric approach includes being sensitive and open to exploring the patient's beliefs, at a pace that is comfortable for the patient and in a framework that is acceptable to him/her, underscored by an attitude that comforts and supports the patient.
- The doctor must make enough time to listen to the patient and create an environment that feels safe and generates trust.
- The health professional should relate and integrate the spiritual component in a meaningful way to the patient assessment and treatment plan.

- Seeing the patient in his/her context includes seeing his/her abilities, family, dreams and goals, current needs and challenges, and how this health issue is influenced by his/her life story.
- A compassionate approach with good communication skills that enables the patient to explore his/her own spiritual-social resources that could improve his/her health and disease management should be sought and made part of a quality health consultation. During the patient interviews, this was stated to be preferred by many patients rather than asking direct questions related to their spirituality as an initial approach.
- The health professional and the patient do not have to share the same faith to share similar values or have a meaningful discussion on the value of spiritual care. Spirituality and adhering to principles that reflect quality care is still attainable. If practitioners keep the end goal in mind of assisting the patient to improved overall well-being within his/her system of belief and context, then this is readily achievable.
- End-of-life issues and fears relating to functionality when faced with a serious illness are often reported by patients as a definite need, although they will not necessarily voice this until asked about. Conversations about death, dying, making peace with one's own mortality, and having a care plan that enables the patient to feel in control as much as possible should be part of a spiritual care plan for patients that have a chronic condition.
- Spiritual resources that should be explored and utilised include meaning-making, self-acceptance, and peace. Practices that include mindfulness and self-awareness should be discussed as part of a treatment plan within an inter-disciplinary team approach to addressing patient needs. For patients living with a chronic illness, this should be included in the treatment regime as part of fostering transcendence and 'life beyond a diagnosis'
- The value of a focus on nutrition and other social practices and their link to mental and spiritual health should be explored as part of a holistic health approach for patients. Within the African context, traditional medical practices should also be discussed and how this could be incorporated into a care plan to accommodate the patient's needs and address the health problems effectively in a holistic manner.

These practical recommendations could serve as points for discussion within an inter-disciplinary team or individual tips for practical implementation.
They aim to make the healthcare worker aware of how to identify spiritual resources and support the establishment of positive spiritual and psychological features such as transcendence. The following points are practical recommendations on what to do in practice:

3. 'WHAT TO DO' FROM THE PERSPECTIVE OF THE PATIENT AND PRACTITIONER

1. Find a method of taking the spiritual history that fits your time, practice, personality, and discipline.

2. Combine a spiritual screening tool with an in-depth inquiry about the patient's narrative (this could entail using a short spiritual screening tool as part of your history while the patient is waiting, and spending more time during the consultation on needs that were identified beforehand).

3. Work and refer according to an interdisciplinary structure, and know which health team member to refer to when you have identified a need for specialist spiritual care. Spiritual health concerns or resources that could be unpacked to assist the patient cope during the treatment plan and future management should be addressed within a team and with the professional that is most competent and comfortable to address this.

4. Health practitioners from all disciplines should be trained on how to screen, take a spiritual history and integrate spiritual care into the treatment plan of patients from different spiritual beliefs and backgrounds. This should be part of undergraduate and ongoing professional training. Identify health team members in your practice or area of service that offer specialised spiritual care, with whom a collaborative patient management approach can be established.

5. Foster a person-centric, collaborative relationship with your patient that maximises patient autonomy and participation when it comes to addressing the needs of the patients and incorporating spiritual care in the health process.

6. The identification of spiritual health concerns and addressing them is not necessarily the responsibility of the same health professional. Finding the right tool to address the spiritual health needs are also patient-specific and could include prayer, cognitive behavioural therapy, lifestyle education, therapeutic touch, and traditional practices.

7. Incorporating spirituality into holistic healthcare should be practical and achievable for a patient. This should be linked to daily living in a natural way that is easily understood. Spirituality should be linked to one's lifestyle. Altering one's lifestyle requires the health professional to see the patient within a bigger context. This includes linking spirituality to daily rituals including sleep and relaxation, exercise and movement, nutrition and hydration, and how the patient manages his/her stress and fosters resilience, as well as how the patient expresses his/her spirituality within his/her relationships and networks.

CHAPTER 12: CONCLUDING REMARKS

SUZI MALAN

The original intent behind this book originated from the realization that all people have spiritual needs and awareness, and these tend to be ignored by most modern or Western medical practices. This book is intended as a supplement to the original handbook COPC - A Practical Training Guide because we realized there was a gap in the original material. We, therefore, combined our different strengths in a variety of disciplines to develop a tool that can equip community health workers, clinical associates, nurses, doctors, and even pastors and counselors to understand and respond to the many different spiritual perspectives their patients have. In this book, the authors tried to capture the overall essence of what spirituality is, how spirituality influences people's life and health decisions, and how any healthcare professional needs to interact with their patients' value systems and world views.

KEY MESSAGE OF THIS GUIDE

A patient is not just a biophysical entity, but the spiritual component of a patient is very real and a critical source to harness during any healing process.

Compiling this book was no easy task because spirituality, religion, culture, and their impacts on health are daunting topics each in itself. We sincerely hope the wide range of authors provided a richer platform for discussion, without seeming disconnected or fragmented. Even coming up with clear definitions of spirituality, religion, faith, and beliefs opened a variety of tunnels that one can drill into without reaching an overarching thematic endpoint.
The first chapters lay a theoretical foundation by providing a broad background to the essence of spirituality. Chapter 1 describes the terminology; how spirituality informs our worldviews; and how we find expression in different religious beliefs. The role of faith is a golden thread throughout the chapters because it plays such an important role in our expression of our inner spirituality.

The subsequent chapters focused on the connections between a person's spirituality and their physical and emotional health. The authors developed the connections between holistic care, compassion, and wellbeing. It was important to determine exactly what is regarded as a 'person' and to look at the history behind the strong link between faith and healthcare. Chapters five to eight unpacks the strong link between spirituality, religion, and beliefs through exploring the role of culture, different religions, and the role of the church in healthcare over centuries.

The final chapters brings to earth the ethereal and hard to define characteristic of spirituality and its influence on people's health and makes it practical to a healthcare professional.
We felt there was especially a need to include a chapter on parenting and the beginning of life as this is a very contentious area in people's religious beliefs, while also crucial to the foundations of humans starting out in life.

Chapter 10 provides very practical suggestions to educators and students of healthcare on how to approach spirituality and the ethics of healthcare. The final chapter and its appendix provide concrete tools to the difficult situations health professionals can come across. These include patients struggling with their own spirituality, or suffering from emotional trauma.
Since the book should provide guidance to this challenging aspect in healthcare, we have sprinkled practical questions and facts throughout the book and used real-life encounters by our authors to demonstrate some typical cases. These stories are very real and we hope to challenge the student and reader to question their own responses and reactions to patients' belief systems and struggles with their own spirituality.

The key message of the book is that a patient should be regarded and treated as a whole being, not purely from a biophysical perspective, but that their spiritual being is an extremely important source to harness during any healing process. The entire focus of the guide is to equip health professionals to better understand the spiritual component, to always respect all persons' spiritual backgrounds and worldviews, and to tread carefully throughout a patient's healing process and never lose sight of the healing power of faith and religion.

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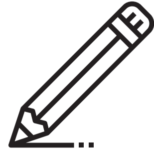

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