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Faith & Medicine Summit

Held on October 31st and November 1st, 2024 held at AIC Kijabe Hospital, Kenya.

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Abstract

The Faith and Medicine Summit, held on October 31st and November 1st, 2024, at AIC Kijabe, Kenya, brought together 55 participants from diverse healthcare sectors to explore the integration of spiritual care within the African healthcare context. The summit addressed the unique spiritual needs of patients, emphasizing a holistic approach to healthcare that encompasses physical, emotional, and spiritual dimensions. Key sessions included discussions on defining spiritual needs, understanding African theology of pain, suffering & evil, the importance of spiritual engagement for both patients and healthcare providers, spiritual care training and research, and institutionalization of spiritual care. Participants highlighted the necessity of culturally relevant training and institutional support to effectively incorporate spiritual care as standard healthcare practice. The summit concluded with a commitment to advancing spiritual care through collaborative efforts, research, and training.

Keywords: Faith and Medicine, Spiritual Care

Mission hospitals have been at the forefront of delivering modern healthcare (the science of medicine) and building capacity for Africa's healthcare workforce (teaching modern healthcare practices) for over a century. The impetus of mission efforts to bring modern scientific healthcare to the continent was framed within the call of Christ to (1) make disciples (Matt 28) and (2) love your neighbors (Matt 22). Since then, there has been growth in healthcare provision by people motivated by the Christian faith across the continent, and now it encompasses not only the provision of "just" healthcare but also quality healthcare and education.

Quality healthcare must be holistic. Whole-person and person-centered care is now considered a standard of care, including spiritual care. In mission hospitals, there is often an underlying assumption that healthcare workers should be competent in assessing and responding not only to a patient's physical needs but also to evaluating and addressing the spiritual needs of patients. This applies to all healthcare workers, regardless of primary or specialty care.

There are few data available describing the spiritual care needs of patients or the spiritual well-being of healthcare workers in Africa. The available data have been obtained using tools developed in the West and are based on Western assumptions. Modern medicine functions within a scientific framework that eschews anything that is metaphysical. Why has this been the case? We propose that the main reason is the fundamental difference in worldview: Modern medicine focuses on material causes through scientific inquiry and marginalizes anything religious. In doing so, modern medicine commonly epitomizes the fact/value and body/soul split present in Western thought. This dualistic perspective colors the assumptions about what causes both health and disease.

In contrast to this approach from the West, Africans tend to see causes of disease and health from a fundamentally relational and spiritual world view, while still embracing the benefits of scientific advances in healthcare. For patients from this perspective, "my child has a birth defect" or "I have cancer" is not only due to a chromosomal anomaly or a genetic predisposition but is also attributed to events (or curses), lack of harmony in the community, or the displeasure of the ancestors or spirits. The "strings" really controlling events lie beyond the physical/material realm. These contrasting worldviews have profound implications for one's understanding of spiritual care as well as health and human flourishing. The treatment plan is incomplete if these factors aren't explored and addressed.

FICA[1] (Faith, Importance, Community, Address in care) and HOPE[2] (sources of Hope, Organized religion, Personal spirituality, Effects on care) are two widely used spiritual assessment tools developed in Western contexts to help healthcare providers explore patients' spiritual needs. They provide a structured framework for discussing spirituality in clinical care. These survey questions have been validated using technical methods appropriate for health care and have many peer-reviewed publications. However, a gap has emerged, particularly in palliative care, where practitioners' recurrent comment was, "It makes sense in English, but not in Kiswahili." This entire construct becomes even more complicated as different ethnic groups with their unique perspectives are added. Various groups have mentioned similar challenges across other areas in Africa, suggesting that this is not only a "Kijabe" problem, but a "continental" challenge. Thus, Christian healthcare professional training bodies across the continent are asking what they can do differently to engage African patients and fellow workers fully with the truth and hope of the Gospel.

A first-of-its-kind summit was planned at AIC Kijabe Hospital from October 31, 2024, to November 1, 2024 in an attempt to begin exploring some of these questions. Fifty-five participants were drawn from different sectors—chaplains from various institutions, physicians and surgeons, nurses, allied health workers, a bioethicist, an apologist, among other specialties, making the summit much richer. The summit explored seven main questions. Ethics approval was not needed for this meeting; all participation was voluntary.

Session 1: What defines Spiritual Need within the lens of healthcare?

By Dr. Jeff Mailu and Dr. Mary Adam

This session began by exploring the complex and culturally rooted nature of spiritual needs within the African context. Spirituality in African societies is inseparable from daily life, where illness is often attributed not only to biological causes but also to spiritual or moral failings. For instance, many African preachers believed COVID-19 was God's judgment on the world. In some cases, the illness is thought to be caused by "someone." Additionally, the fear-power culture and the hierarchical structure within the community make it difficult to question healthcare providers, increasing the fear of the Supreme.

Given this context, what constitutes an African patient's whole-person need? Is it salvation of their soul? Is it the need to meet their

financial obligations? Is it reducing the stress associated with the illness? Or reconciliation for the woman facing early widowhood, poverty, or abandonment by her family? Is it the need for healing of the body? In our view, all these are whole-person needs. In this worldview, healing encompasses not only physical recovery but also the restoration of spiritual and relational harmony—what the Hebrew Bible refers to as shalom. These elements are interconnected and to be viewed through a holistic lens, requiring care that addresses the whole person—body, mind, and spirit. The numerous examples of Jesus healing by first forgiving sins before fully restoring the physical body reinforce the idea that spiritual restoration is integral to complete healing.

The group defined wholeness not only as physical well-being but as a state of peace and purpose that includes emotional stability and restored relationships with God, self, and others. Restoration toward this holistic state requires the involvement of healthcare providers who take time to understand their patients' spiritual and emotional contexts. We reflected on the limitations of conventional medical training, which often overlooks the spiritual dimension of care in addressing patients' needs and argues for a model that acknowledges and engages with patients' spiritual needs in a culturally respectful way. Support from family and faith communities, facilitated by a multidisciplinary team, is crucial to providing comprehensive, meaningful care.

Session 2: Africans' Theology of pain, suffering, and evil.

By Dr. John Njoroge.

This session examined African perspectives on pain and suffering through the lens of broader theological worldviews. It contrasts three categories: those who believe only God exists (e.g., Eastern religions), those who believe only the universe exists (e.g., atheistic materialism), and those who believe in both God and the universe (e.g., Christianity, Judaism, Islam).

There is no single, unified "African" culture; instead, the continent is home to numerous distinct communities. However, many of these communities share a similar worldview—one that centers on the belief in a Supreme Being who governs all aspects of life. Within this worldview, often with a fear culture, questioning God is uncommon, even in times of disappointment. Instead, people/communities seek to appease the Supreme Being through various means such as offering sacrifices, specific child-naming practices, and other rituals aimed at invoking divine mercy and favor.

Christianity, with which many African communities identify, acknowledges the existence of pain due to sin entering a once-perfect creation. It teaches that while suffering is real, God offers redemption and restoration through Christ. One implication for healthcare providers is the recognition that pain is multifaceted—physical, emotional, social, and spiritual. Western medical training often overlooks these dimensions, so caregivers must expand their understanding to support patients holistically. Prayer is central to many Africans' response to suffering, whether for healing, understanding, or alignment with God's will. However, disappointment with God can arise from unmet expectations or perceived divine silence, especially when influenced by prosperity theology that promises health and wealth here and now.

Session 3: Spiritual Engagement in the African Context

Prof Tom Obengo and Dr. Belyse Arakaza

Spirituality and spiritual engagement are not only what we do but also who we are. They are shaped by cultural contexts. African spirituality embodies profound human values, beliefs, and traditions. A patient's spiritual needs are often intertwined with their physical, emotional, and social needs. For example, one might assume an elderly sick person is primarily concerned about their health, only to discover, upon inquiry, that they are more preoccupied with the wealth they have yet to distribute.

Thus, effective spiritual care involves being fully present, listening actively, incorporating prayer and involving chaplains as part of a

multidisciplinary team. Recognizing spiritual needs requires sensitivity and attentiveness, as such discussions can be misinterpreted by patients if not approached thoughtfully. Tools like FICA exist, but they need to be adapted to fit the African cultural and linguistic context. Group and individual spiritual interventions, including communal prayers, bedside evangelism, and passive methods like media or art, are employed based on the patient's condition and the provider's capacity. Simple, compassionate questions such as "What matters to you?" or "What are your ideas, concerns and expectations?" are recommended as effective tools for initiating spiritual conversations with patients, emphasizing that the tone and intention behind the questions are just as important as the words themselves.

The key to spiritual engagement is cultural humility, which helps break initial communication barriers and allows patients to express their beliefs without judgment. The relational nature of African societies necessitates that providers understand the patient's background, sometimes adjusting language or approach to respect cultural nuances. Most patients, particularly in faith-based settings, value spiritual engagement from healthcare providers, with some viewing it as an expected part of care.

Session 4: Research Perspectives and Lessons learnt on Spiritual Care from the West

Dr. Michael Balboni

The session focused on lessons from Western research on spiritual care and its application within African contexts. It was emphasized that research should serve the patient rather than become an end in itself and cautioned against reducing spirituality to data, as science cannot capture the essence of God or the soul. The importance of maintaining pastoral wisdom and distinctly Christian spiritual care was highlighted, especially in secular or pluralistic medical environments. Dr. Balboni outlined four key domains of spiritual research: Human Flourishing, Christian Life, Suffering, and Religious & Spiritual Struggles—each with specific focus areas such as meaning, suffering intensity, and spiritual practices. He advocated for adapting Western tools for African settings and collaborating with African Christian experts to make research contextually relevant.

Group discussions revealed barriers to spiritual care in hospitals, such as cultural and language differences, lack of privacy, and denominational divisions. Facilitators included patient-initiated conversations and compassionate, trained staff. Effective spiritual care should be intentional, culturally sensitive, and focused on creating a nurturing environment of prayer and service. This care impacts non-spiritual outcomes, improving mental, emotional, and relational well-being by offering hope, peace, and community support. The group also cautioned against spiritual extremism and recognized the need for careful, trained engagement that meets patients' holistic needs without crossing ethical or theological boundaries.

Session 5: Training in Spiritual Care

Dr. Mfanelo Sobekwa

Dr. Mfanelo's session emphasized the vital role of pre-service training in spiritual care within healthcare, sharing poignant stories and research that illustrate the deep spiritual needs of patients, particularly in palliative care. One compelling story involved a terminal patient who, after being forgiven by his mother, exhibited a powerful spiritual response just before death, highlighting the significance of reconciliation at the end of life.

He mentioned findings from a study on cervical cancer patients that revealed high levels of physical and emotional suffering, spiritual confusion, and yet a strong desire for a deeper connection with God and the inclusion of spiritual care. Despite this, many healthcare providers felt unprepared to address these needs, as they have primarily been trained to focus on physical symptoms. This begs the question: how do we train healthcare providers to respond to such needs? Additionally, there is a call to shift

from viewing patients as a "hole," a defect, to seeing them as whole persons, embodying the African philosophy of Ubuntu—recognizing the humanity in one another.

The group discussions centered on the necessity of structured spiritual care training to build competence, shift cultural mindsets, and ensure that care is both doctrinally sound and practically effective. Good training should integrate communication, reconciliation, sociocultural understanding, and role modeling by leaders. It should be accessible, adaptable, embedded into everyday routines in the hospital, and inclusive of all healthcare staff. Suggested core competencies include compassion, honesty, teamwork, adaptability, spiritual discernment, and the ability to communicate the gospel. The group also stressed the importance of monitoring and evaluating spiritual care through contextually relevant tools, potentially integrated into electronic medical records, to ensure accountability and continual improvement. Collaboration between clinical and chaplaincy teams is essential for truly holistic patient care.

Session 6: Spiritual Engagement for the healthcare provider

Prof. Daniel Ojuka

This session focused on the healthcare provider and the need to strengthen their connection to God. Drawing from 1 John 1:1-4, the session emphasized that personal experiences with God—what has been "heard, seen, and touched"—are foundational for sharing spiritual care with others. Clinicians are encouraged to engage both as believers, rooted in obedience from love, and as physicians who often confront suffering compassionately. The session also introduced the "cycle of grace" versus the "cycle of works," advocating for a spiritual life based on God's unconditional acceptance rather than on performance. Emulating Christ through spiritual disciplines—such as prayer, solitude, and community—was discussed as essential for personal transformation and sustaining meaningful service.

Group discussions focused on practical strategies for integrating spiritual engagement amidst busy schedules. Key suggestions included prioritizing time wisely, securing institutional support, and fostering spiritual disciplines like prayer and Bible study. Colleague engagement was highlighted as a valuable support network for sharing, debriefing, and spiritual growth. The session also proposed components for a spiritual care curriculum, covering, amongst other topics, theology, communication, end-of-life care, and cultural awareness.

Session 7: How can spiritual care be institutionalized?

Dr Muthoni Magayu, Dr Chege Macharia, Rev Wilson Morogo, Rev Earnest Kioko

Session 7, a panel discussion, focused on institutional barriers and strategies for integrating spiritual care into healthcare systems. Key barriers identified include a lack of understanding among leadership regarding the importance of spiritual care, financial priorities overshadowing holistic care, structural gaps in training, and resistance from staff due to conflicting beliefs or a lack of engagement. To overcome these challenges, leadership modeling, staff training, open dialogue, and incentivizing spiritual care efforts were considered essential.

Suggestions for practical integration included establishing chaplaincy departments, allocating physical spaces for spiritual activities, including spiritual care as part of standard patient documentation, and creating opportunities for patients to request spiritual support. Institutions must clearly define and consistently communicate their mission to maintain focus and avoid mission drift, especially under financial pressures.

The panel underscored the critical role of leadership in institutionalizing spiritual care, from CEOs to board members. Supportive leadership can elevate spiritual care by modeling participation, ensuring resource allocation, and embedding spiritual care in the organization's core policies. Engaging religious institutions responsibly, managing partnerships

with clarity, and focusing on patient-centered care were highlighted as keys to sustainability. The conversation also addressed how to balance faith with the operational realities of healthcare, advocating for research to validate impact of spiritual care and proposing regulatory frameworks for chaplains. Ultimately, the session called for a culture where spiritual care is valued as essential, measurable, and deeply integrated into the healthcare experience.

Summary

The two-day conference was incredibly enriching, sparking conversations that many participants viewed as just the beginning of larger discussions on how to enhance the effectiveness of spiritual care. During the summit, attendees had the opportunity to outline their next steps both on an individual level and within their respective institutions. The majority of these action plans focused on exploring strategies to improve spiritual care provision, investing in training programs for spiritual care, and researching various aspects of spiritual care. It was evident that the conference served as a platform for attendees to come together and commit to advancing the field of faith and medicine for the benefit of those they serve, and to the glory of God.

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