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A culture-sensitive palliative pastoral care with a focus on the African context

Author:
Alfred R. Brunsdon[1]

Affiliation:
[1]Faculty of Theology, North-West University, Mahikeng, South Africa

Corresponding author:
Alfred Brunsdon,
Alfred.Brunsdon@nwu.ac.za

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This article engages the issue of a culture-sensitive palliative pastoral approach with the African context in mind. It contemplates palliative pastoral care from a dual-wisdom approach and denotes palliative pastoral care as an expression of Christian faith care towards patients and their relational networks, aimed at spiritual growth which enables meaning-making in the context of illness and possible loss. It also investigates the notions of illness, healing and dying in an African context and highlights the spiritual, systemic and communal nature of these concepts within African thinking. The implication for a culture-sensitive palliative pastoral approach is sought in the meaningful accommodation of these beliefs within the framework of Christian faith care. The coordinates of pastoral hospitality, an embodied pastoral care of presence, accommodation of the collective, the practice of respectful Christian discernment and inhabitation theology are suggested as some of the coordinates that could facilitate a culture-sensitive palliative pastoral approach.

Keywords: Pastoral care; Palliative care; Palliative pastoral care; Cultural-sensitive pastoral care, African context.

Introduction

Due to Europeans settling among indigenous African people, the southern tip of Africa developed into a multicultural context from the 17th century onwards. Through the history that ensued, South Africa developed into a truly multicultural context. Currently, the South African populace is known as the 'rainbow nation' in order to acknowledge its multicultural heritage and reality. Officially attributed to Archbishop Desmond Tutu (Buqa 2015:1), the typology of a 'rainbow nation' recognises that four major ethnic groupings constitute the South African population. This includes black people, Asian people, mixed race and white South Africans. Black South Africans, which denotes by far the largest segment of the South African society, are further sub-divided into more ethnic groups like the Xhosa, Batswana and Zulu people, creating yet further ethnic and cultural diversity.

Since the dawn of the new democracy in the mid-1990s, there has been growing acknowledgement that South Africa represents a context submerged in Western values, paradigms and epistemologies, despite of the fact that the majority of South Africans are of African descent. Subsequently, a new African consciousness has emerged that permeates to all levels of South African society. Discourses such as decolonialisation and Africanisation are currently at the forefront – even giving rise to reoccurring violent mass action, as disgruntled majorities are propagating for faster change in terms of the recognition of African values, culture, wisdom and ways of knowing.

Not least in the areas summoned to change, is that of higher education and training. Hence, institutions of higher learning have been grappling with the issue of realigning the content and outcomes of various disciplines to be contextual and true to the reality of the African context (Brunsdon & Knoetze 2014; Naidoo 2015). This article aligns with this discourse from a practical theological and pastoral framework aimed at contextualising current pastoral praxis to be more appropriate to the current, mainly African, South African context. It is specifically aimed at the African context, because of the lack of focus on African issues in pastoral care, while recognising the need of developing culture-sensitive approaches in diverse contexts.

Context, main research question, aim and objectives

The research hence departs from the current multicultural reality of South Africa where palliative care is provided in public spaces like hospices and hospitals as well as the private homes of patients. Patients in those settings are representative of all cultures, as are the members of the

multi-professional teams who provide such care. As the medical environment is a highly scientific and westernised one, need for theoretical reflection regarding cultural sensitivity exists to accommodate cultures like the African and others within these environments (Manda 2016:126). The reflection on this theme takes on the form of a dual-wisdom approach, probing African and Western sources to address the current reality of palliative pastoral care in a multicultural context like that of South Africa.

The main research question, which stems from this, relates to how culture-sensitive palliative pastoral care can be achieved, with a focus on the African context. The main aim is sought in the articulation of coordinates for a culture-sensitive palliative pastoral care, focused on the African context. In achieving this aim, several objectives are set. The article firstly engages with the issues of palliative and pastoral care from a phenomenological perspective. It also relates palliative care to the discipline of pastoral care in order to arrive at a definition of palliative pastoral care. The meaning of illness and dying is viewed from an African perspective, and then a synthesis of this information is made to present coordinates for culture-sensitive palliative pastoral care focused on the African context.

Palliative care

The World Health Organisation or WHO (2007) defines palliative care as:

> [*A*]n approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment, and treatment of pain and other problems – physical, psychosocial and spiritual. (p. 3)

Palliative care is thus concerned with so-called dread diseases, which threaten the lives of the affected and has consequences for their families and loved ones. It is not restricted to one particular disease like cancer, but includes conditions such as: 'HIV/AIDS, congestive heart failure, cerebrovascular disease, neurodegenerative disorders, chronic respiratory diseases and diseases of older people, among others' (WHO 2007:5).

According to Foley and Gelband (2001:3), palliative care concerns at least six skill sets, which includes communication, decision-making, the management of complications of the treatment and the disease, symptom control, psychosocial care of patients and their families and taking care of the dying. Two broad fields are visible within this spectrum, namely the management of the physical illness itself, and the facilitation of the spiritual and relational challenges that emanate from the specific disease. Palliative care is intrinsically linked to a multi-professional approach, which includes at least the participation of health practitioners like medical doctors, nursing staff, social workers and spiritual care providers.

In terms of the context of palliative care, there is a close historical association between palliative care and the hospice movement. Meier and Bowman (2017:74) relate the original hospice movement to religious orders of the Middle Ages who opened their doors to travellers in order to provide rest and shelter (hospice) and that evolved into safe havens for the ill, elderly and disabled. These were the forerunners of the modern hospice movement, which was established in the United Kingdom in 1967[1] from where it spread internationally during the decades that followed. Initially, palliative care and end of life care were treated as synonyms, which strengthened the close association between palliative care and the hospice environment. Currently, the general understanding of palliative care is no longer restricted to end of life care alone. It is seen as the 'support services throughout the illness continuum' (Reb 2003:35). Palliative care is at present deemed 'appropriate at any age, and at any stage in a serious illness, and can be provided concurrently with curative treatment' (Meier & Bowman 2017:74), with the main aim of providing patients and their loved ones relief of the symptoms and accompanying stress associated with illness.

Together with this broadening of the understanding of palliative care, the context in which palliative care is provided, has also been broadened to include hospitals and the homes of patients. Home-based palliative care has especially grown as a result of high medical costs and the preference of patients to be treated at home (Reb 2003:37). In African countries, such as Kenya and Uganda, there also seems to be a preference for home-based palliative care. This preference mainly relates to cultural attitudes and behaviour towards institutionalised care as well as the preference of African patients to die at home (Fraser et al. 2017:5).

Pastoral care

Although all compassionate care of humans towards one another can be described as pastoral in nature, there is a special bond between pastoral caregiving and the Christian tradition (Gerkin 1997:23). In so far as that the Christian tradition grounds caregiving towards fellow human beings in the shepherd motif found in the Old and New Testament (cf. Ps 23; Jn 10:10), pastoral care is particular to the Christian tradition (McClure 2012:269).

The motive for pastoral care is sought in God's love for his creation, which should be reflected in the conduct of his covenant people. In his classic summation of pastoral care, De Klerk (1978:2) states that God chose to reveal himself in the Old Testament as shepherd, based on his covenant love for the weak and vulnerable. Jesus Christ personified this metaphor in the New Testament and elevated empathy for those in need as benchmark for Christian faith and love (cf. Lk 10:30–37).

Pastoral care, as field within the theological discipline of Practical Theology, has over the years become specified in

1.The modern hospice movement is attributed to the visionary work of Dame Cecily Saunders who founded the first hospice in St. Christopher's in South London in 1967 (cf. 'How the hospice movement began', http://www.stlukes.co.za/hospice-movement/).

most tension fields of human experience and relations, aiding the faith of people who became disadvantaged or challenged in relation to the self or others. Understanding faith care as life care (Louw 2000:37; 2008:217), pastoral care is driven by the belief that maturity in faith is a key factor in the negotiation of existential life challenges. By facilitating and aiding faith maturity, pastoral care empowers believers to deal with and overcome life challenges. In this regard, pastoral care also facilitates the wisdom needed to accommodate and find answers to the challenges imposed by life (cf. Brunsdon 2015).

Pastoral care thus denotes a unique Christian approach to helping in that it involves both informal and specialised acts of care towards the other. These acts are based upon the love of God, aimed at building faith that empowers the fellow human being to conquer challenges and embrace a life abundant (cf. Brunsdon 2017:111).

The notion that pastoral care can be expressed in informal and specialised ways should be understood against the background of different distinctions that are visible in pastoral praxis. In this regard, De Jongh van Arkel (1995:197) states that pastoral care can be expressed as mutual care, pastoral care, pastoral counselling and pastoral therapy. The guiding principle in making these distinctions mainly depends upon the contexts in which pastoral care are exercised as well as the level of training the pastoral caregiver has. Within the faith community, mutual care of other Christians takes place spontaneously and without training as the members take care of one another by expressing love and care through simple gestures, such as showing interest in the personal wellbeing of one another. Pastoral care is qualitatively different, as it refers to a more formal interest and expression of Christian care. This can include house visitations by the elders of the congregation, visiting the sick, praying and ministering to them by Scripture reading. Although this does not require formal training, these actions are steered by a specific Christian ethos and may make use of the Scriptures, prayer and relying on the work of the Holy Spirit. It also relies on the basic knowledge of when the fellow human being is needing compassion and care. The last two distinctions of Van Arkel, viz. counselling and therapy, obviously implies certain levels of training. Counselling another implies a certain level of formal knowledge about a specific problem and the skills to address it, whereas therapy suggests specialised knowledge that will be applied systematically to a specific problem over a longer period. Hence, pastoral care can be spontaneous and informal, but also organised and highly formal or professional. It can have as only prerequisite the Christian love for one's neighbour, or it can require years of formal training at an institution of higher learning (cf. Brunsdon 2017:111).

These distinctions within the concept of pastoral caregiving accommodates persons without formal academic training to engage others pastorally in different settings like a congregational, hospital or home environment. Such engagement will be driven by the love of God as expressed in the shepherd motive seen in Scriptures. It will be aimed at providing consolation and hope through empathy towards the vulnerable through activities such as presence, acceptance, Scripture reading and prayer. If approached responsibly, it will be sensitive to the specific context and circumstances of the patients and their loved ones, as well as be respectful towards their culture and beliefs. Eberhard Hauschildt (2015:48) refers to such an approach as a 'general theory of pastoral care', which embraces at least three perspectives: that we are all human (and therefore all the same); that groups of people are different, and that each individual person is special.

Palliative pastoral care

As suggested, pastoral care is usually specified within a given tension field of the human experience. It thus finds expression in circumstances regarding personal, marital, family or any other situation of crises where people may require spiritual assistance and guidance. A preliminary definition of palliative pastoral care can thus denote it as pastoral caregiving in the specific circumstances that emanate from serious illness in any of the contexts where palliative care is provided.

The early definition of pastoral care by Clebsch and Jaekle (1964) seems to encompass much of what is meant by this definition:

> The ministry of the cure of souls, or pastoral care, consists of helping acts, done by representative Christian persons, directed toward the healing, sustaining, guiding, and reconciling of troubled persons whose troubles arise in the context of ultimate meanings and concerns. (p. 4)

It is argued here that serious illnesses especially have the capacity to bring people into the context of life's ultimate meanings and concerns. One of the main predicaments caused by a serious illness is that it detaches the affected from their normal being functions, which include the ability to work and to interact with well-known surroundings and loved ones. In many instances, this takes effect in a sudden fashion. This contradicts the postmodern feeling of everlasting vitality and the high value placed upon life in the present (cf. Collier 2003:729) in which illness and death are often denied, confronting people with life's ultimate meanings and concerns. This means that patients are forced to reconsider the meaning of life, relationships and death. This experience opens the opportunity for intervention in the form of palliative pastoral care.

According to Louw (2008:22), the existential crisis that usually results from illness should therefore not be understood as crisis alone; rather should it be considered as an opportunity for growth. This, however, calls for a reappraisal of the typical (Western) circular understanding of illness, where the only purpose of illness is to move back to health again. In such a circular understanding of illness, the whole cycle is vested in the capabilities of the medical team and medicine. Instead, a spiral understanding of illness is called for, which represents a qualitative understanding of illness. In such an

understanding the patients 'personal identity, growth potential and faith potential are decisive in their reaction to afflictions and the quality of their health' (Louw 2008:23). The desired reaction in this line of thinking concerns a change of attitude towards illness in so far as the patient perceives illness as an opportunity for spiritual growth, grounded in the belief that humans 'are able to bear suffering and pain meaningfully' (Louw 2008:24). In this regard, Louw draws on the insights of Flynn (1980:28–31) who articulated three phases of illness. During the acute phase, the patient experiences illness as the enemy and intruder. This is followed by a phase of understanding where insight and knowledge are obtained about the best way to cope with the illness. This is finally followed by a phase of obtaining the meaning of life, values and relationships.

The potential of patients to embrace this qualitative meaning of illness depends on some variables, that include maturity, faith, normative frames of reference, support systems and communication networks (Louw 2008:24).

Within this framework it now becomes possible to define palliative pastoral care more specifically as follows: Palliative pastoral care denotes the Christian faith care of patients and their relational networks within palliative contexts, aimed at the facilitation of spiritual growth, which enables meaning-making in the context of illness and possible loss.

Illness, healing and dying in an African context

The African cosmology makes provision for a profound spiritual understanding of life and death. Both life and death are regarded as gifts from the creator. 'Death, however, enjoys the incontestable advantage over life in that it is necessary, for it was not inevitable that life be given' (Zahan 1979:36). Life itself is thus a gift that should be nurtured until the inevitable becomes unavoidable.

Against this background, illness is not regarded in simple terms such as the analytical cause and effect approach of Western medicine, but as a phenomenon situated in a broader spiritual framework. Without eliminating pragmatic causes of illness altogether, spiritual beings are regarded as the most important agents causing illness (Westerlund 2000:152). This belief finds different expressions among different ethnic groups in the sense that illness can come from the 'sky', ancestors or from God himself (cf. Westerlund 2000:153, 159, 164). This belief is extended to witches and sorcerers as the physical agents who bestow ill fate and illness on victims. Even nature can deliver such ill fate through natural disasters such as earthquakes, famine or a locust invasion (Mbiti 1977:164).

When an enemy such as illness strikes, a central question within the Africans psyche relates to 'who' has caused such ill fate. Irrespective of how illness has befallen someone, for example malaria resulting from a mosquito bite, Africans would be adamant to establish by whom the illness was caused. This relates to the belief of dynamic universal powers at work and whose evil can be caused by witches and sorcerers on request of a disgruntled or jealous family member (Mbiti 1977:167; Oduyoye 1983:55). Illness and misfortune can also be sent from ancestors (Manda 2016:126). The importance of finding out who the cause of misfortune was, relates to the measures that can be taken to 'put right what has gone wrong, to heal, to cure, to protect, to drive away evil' (Mbiti 1977:169). If the anger of ancestors is the cause, rituals can be performed to appease them (Manda 2016:126); if the ill will of another person is the cause, traditional African medicine comes to the fore. Traditional African medicine is dispensed by the 'friends of society' who can include 'medicine men, herbalists, diviners, mediums, rain-makers and even rulers' (Mbiti 1977:170). Eventually, however, God is seen as the ultimate source of all medicine. In times of serious desperation, traditional African medicine and those who dispense them will be bypassed and God will be appealed to directly (Mbiti 1977:174).

The urge to find the cause of illness and to address it, is closely linked to the relational nature of Africans and their experience of life, which includes illness. An individual falling ill is thus never an isolated or individual matter, as the illness of one affects the systemic whole of the familial network. Even though Africans recognise that the physical suffering and pain of a specific disease can only be carried by the individual, individuality cannot obscure the communality engrained in African thinking and beliefs (cf. Githiga 2009:88.95). An individual remaining ill, extends the suffering of the familial network, and therefore the search for the cause of the illness will continue with great urgency, until a satisfying answer is discovered so that healing can be effective.

Just as illness itself is understood within a spiritual framework, so is the matter of healing. Within African beliefs and thinking about healing, the concept of power stands central (Long 2000:121). If illness is ascribed to evil spiritual causes, healing is sought in the restoration of the balance of power between good and evil powers. Good powers in this framework would refer to any source or medium that has the potential to heal. Because of the strong pragmatic inclinations regarding to what is deemed good powers, it would be more accurate to denote the spiritual framework of African healing as a spiritual-pragmatic model of healing. As 'the power to heal is good, many Africans feel little internal dissonance in seeking it wherever it may be found' (Long 2000:122).

Depending on the situation, Western medicine has long since become such a healing power used interchangeably or in tandem with traditional approaches (Manda 2016:135; Ngubane 1992:366; Thorpe 1991:123). Thus, Western medicine is sometimes seen as a point of departure for healing, but if it is not effective, Africans can revert seamlessly to traditional healing. This opposes the late Ugandan anthropologist Okotp'Bitek's prediction that African traditional beliefs regarding medicine would not survive the onslaught of modern reason (cf. Van Rinsum 2004:34), as many Africans practice this dual approach without reservation.

Within the more traditional approach, some of the most well-known sources of good powers are found in the following (cf. Long 2000:122):

- The person of the healer, especially if the healer is known as a good healer.
- Medicines that are infused with the powers of the healer.
- Charms through which healers channel powers to heal the illness.

These sources of power are usually complimented by symbols and rites through which the sources of evil are confronted or managed – or through which these powers are appeased (cf. Long 2000:123). Another important aspect of traditional healing is sought in reconciliation, as illness itself is holistically understood as the result of contaminated relationships. Reconciliation can be facilitated by several means such as confession, the sharing of meals, and even offering compensation. Central in this approach are the intermediaries of reconciliation that may include ancestral spirits, traditional healers, or elders (Long 2000:127). When good and evil powers are brought in balance, healing is believed to have taken place. However, when healing cannot be achieved, death becomes inevitable. In African thinking, death is not only seen as the important interface between the human and the spirit world, but also as 'a passage to a new level of existence … a transition to a new life … a return home' (Ikwuagwu 2007:90). Although death is perceived as the inevitable border to life, it is never seen as 'normal', except if it comes at an old age (Ikwuagwu 2007:91). In some strands of African beliefs such as that of the Yoruba of Nigeria where reincarnation guides thinking about death, the penalty of death is maybe less intense as people are believed to return to this 'life reincarnate in their descendants' (Pharrat1996:57). In general, however, death is regarded as the enemy of life, robbing humans of the vitality they need to fulfil their calling on earth (Nürnberger 2007:24). As a result, both its immanence and arrival are mourned heavily by those who remain behind. Mourning is expressed through extensive rituals that serve as coping mechanism for loved ones, but also to protect the survivors from the possibility of bad luck that is regarded as a strong possibility in the presence of death (Van Zyl 2009:182).

A culture-sensitive palliative pastoral approach with the African context in mind

In this section of the research the focus shifts to the coordinates of a culture-sensitive palliative pastoral approach with the African context in mind. The imagined context is that of Africans receiving palliative pastoral care from non-African Christians in settings like hospitals, hospices or in a home-care environment.

In the imagining of a culture-sensitive palliative pastoral approach, it will be important to articulate the basic difference in the understanding of illness, healing and dying between the Western and African worldviews – and to relate that to the meaning of palliative pastoral care before an attempt is made at suggesting coordinates for such an approach.

From the afore-going engagement with the concepts of illness, healing and dying in the African context, it is suggested that the main difference between the Western and African views is situated in the spiritual interpretation of these existential matters. The Western understanding is embedded in 'culture texts' like 'diagnosis of the disease, cure, medicine' and 'surgery' (cf. Ward 2015:178). These represent a mechanic, scientific and systemic understanding of illness that is not necessarily connected with spirituality. Subsequently, if modern westerners fall ill, they visit a medical practitioner who diagnose a specific condition by analysing a blood or tissue sample, or by evaluating visible symptoms. The symptoms are treated, or the organ, which has contracted the disease, is removed by surgical intervention and follow-up treatment is applied if necessary. Although emotional and spiritual reactions to medical intervention and treatment such as questions regarding the issue of theodicy, is regarded as normal, it is unlikely that modern westerners will seek spiritual reasons for the origin of a specific disease.

In an African worldview, the opposite is true. Illness is approached and understood within a spiritual and relational framework. Therefore 'sickness is seen as a need for restoration of relationships' (Ward 2015:178). This makes the experience of being ill a spiritual, existential and relational issue of which the spiritual, familial and social networks are immediately part. Within this understanding, intermediaries like the herbalist, traditional healers and elders of the community become part of the landscape, as they act as the restorers of affected relationships that are generally understood as the root cause of illness. These intermediaries also bring with them rituals and rites, which are instrumental in the process of healing and restoration.

This basic difference can be articulated in several ways, such as the individual vs. the communal, or the scientific vs. the spiritual – or even the analytical vs. the mystical. It should however be clear, that in an African understanding of illness, healing and dying, room is created for the collective, instead of only allowing for the individual. The most important practical consequence, which arise from this approach, is that culture-sensitive palliative pastoral care needs to embrace the communal nature of being ill within the African context. This communal nature of being ill must be integrated into culture-sensitive palliative pastoral care. The Christian faith care of patients and their relational networks within palliative contexts, must consequently be approached in such ways that it is respectful and accommodating of the tenets of African beliefs and practices regarding illness.

In the South African medical environment, some attempts have been made to bridge the gap between Western and African approaches, by considering the integration of traditional (African) healthcare practices with the general Western healthcare approach. This mainly rests on the reality

that an estimated 70% – 85% of the South African population depends on traditional African health practitioners to meet their medical needs (Summerton 2006:16). According to the same author, a surprising number (60%) of babies are delivered with the help of traditional healthcare workers. Although there are still much scepticism and reservations from the side of Western health protagonists (Summerton 2006:16), these statistics urge care providers to be serious about cultural accommodation in the healthcare environment, as culture-sensitive care is not only seen as a basic human right, but has also been shown to be conducive to healing and dignifying end of life transitions (cf. O'Brien et al. 2013).

In this spirit, pastoral caregivers should be equally committed to working towards the creation of culture-sensitive palliative pastoral care environments. This necessitates the articulation of coordinates that can work towards creating such environments.

Coordinates for a culture-sensitive palliative pastoral approach with the African context in mind

In articulating some of the coordinates for a culture-sensitive palliative pastoral approach with the African context in mind, the leading question of this article pertains to the meaningful accommodation of African cultural beliefs within palliative pastoral care environments. Although the task of the pastoral caregiver cannot be limited to the accommodation of cultural beliefs, as it includes a host of other challenges like the accommodation of the community and the management of relationships (cf. Magezi 2006), the focus here will be on the accommodation of cultural beliefs in the perceived multicultural context. This presents a creative challenge in so far as this environment is historically dominated by a Western pastoral understanding. It is with this challenge in mind, that the following coordinates are suggested.

Accommodating current contextual realities through pastoral hospitality

The actions of faith communities never take place in a vacuum, but it relates to real contexts. As such, pastoral caregiving always needs to be true to the specific context in which it takes place. Pastoral caregivers in the 21st century are without choice – and in the macro sense of the word – part of a globalised world. Globalisation has shrunk the world and brought different peoples and cultures in closer proximity than ever before.

As a result, Lartey (2015) comments:

> The concerns of pastoral counselling need not be narrowly parochial. Pastoral counselling in this day and age needs to rise above being merely an inner dialogue between persons of the same faith or attempts to recruit along faith lines. It needs to be broader than that. Anyone, regardless of religious tradition or the lack of it should find some benefit from the careful, thoughtful practice of pastoral counselling. (p. 69)

In the South African context, coming within closer proximity of other cultures, was further advanced by the dawn of the new democratic dispensation that favours a unitary, non-racial approach to nationhood. This challenged South Africans in the micro sense of the word to find 'the other' on all levels of society as previously segregated South Africans now share all spaces of being, whether in schools, universities, churches or hospitals.

Accommodating this unitary cultural reality calls for a cognitive recognition of this cultural convergence so that the pastoral praxis of faith communities can purposefully adjust and align to it. In this regard, the notion of Christian hospitality comes to mind as an important coordinate for culture-sensitive palliative pastoral care. Hospitality reminds of the Spirit-enabled Christian virtue of being able to show kindness, acceptance and warmth when welcoming guests or strangers as found in Hebrews 13:1–3 (Swinton & Mowat 2016:91). The purpose of hospitality is neither conformation nor proselytising, but rather about understanding and accommodating, providing a respectful and welcoming environment to those who have a different cultural and belief system than the personal.

An embodied pastoral care of presence

If the purpose of pastoral hospitality is neither conformation nor proselytising, one may wonder what the purpose of Christian pastoral care in palliative environments might be. In this regard, Graham (2017:3) remarks that a faithful Christian identity is in principle always performative. Thus, 'if theological values have any substance, they will exist in primary form as bodily practices – in activities of care … – and only derivatively as doctrines and concepts' (Graham 2017:3). Culture-sensitive palliative pastoral caregiving embodies the Christian message through presence, hence making Christ himself present. Being present and serving faithfully, is therefore another important coordinate for culture-sensitive pastoral care – as it has the potential to convey the Christian message without saying a word. This does not disqualify the pastoral caregiver of offering answers when asked for guidance and counsel (Col 4:6), but reminds of an important requisite for authentic pastoral care – that it does not rely on words alone, or as Bass and Dykstra (2008) remind:

> … the specific practices by which we respond to God's grace – practices such as prayer, forgiveness, and hospitality – bear knowledge of God, ourselves and the world that cannot be reduced to words. (p. 358)

Accommodating the collective

Another coordinate for culture-sensitive palliative pastoral care is embedded in the shift in focus from the individual to the collective. If the experience of being ill is indeed a spiritual, existential and relational issue of which the spiritual, familial and social networks are immediately part of, the horizons of the pastoral caregiver needs to widen accordingly to include not only the patient, but the

patient's relatives and his or her primary spiritual caregivers. Louw (2008:182) refers to 'group and community-centred counselling' which enjoy priority in multicultural settings above individual counselling reminiscent of a typical Western approach. A group-centred approach will prioritise contact with family members and the significant social networks in order to restore relationships as part of the healing. It will also respect and make room for the traditional spiritual caregivers as part of African's inclination towards traditional notions of healing.

Respectfully Christian: practising discernment

As indicated before, pastoral caregiving is in being a Christian way of providing care. Operating in diverse cultural settings does not make it less true. The coordinate offered here pertains to the art of being respectfully Christian in order to nurture a culture-sensitive palliative pastoral approach. Being respectfully Christian is probably best explained by the notion of discernment. The pastoral practice of discernment relates to the ability to 'adjudicate' circumstances in order to act appropriately (cf. Landes 2010:4). Within diverse cultural settings, it resonates well with the gift of knowing when to speak and when to listen (cf. Ja 1:19), which in turn relates to the 'true knowledge and perfect judgement' that depends on the growing love for which St. Paul prayed in Philippians 1:9. Practising discernment in culturally diverse settings will guide the pastoral caregiver as to when and how the Christian message of hope can be proclaimed. Not in a fashion that dismisses or diminishes the values and beliefs that lies at the core of the African being, while at the same time offering the transforming gospel of Christ when required to do so.

Inhabitation theology

Within the framework of this article, palliative pastoral care is denoted as the Christian faith care of patients and their relational networks within palliative contexts, aimed at the facilitation of spiritual growth that enables meaning-making in the context of illness and possible loss. In order to facilitate the palliative pastoral care described here, the last coordinate, which is suggested, relates to the trust bestowed upon the Holy Spirit as the true facilitator of spiritual growth, that will enable meaning-making in the context of illness and possible loss. Louw (2008:188) stresses the importance of inhabitation theology in multicultural pastoral work that relies on the Holy Spirit as transformational power in settings where the Christian message is conveyed. This challenges the pastoral caregiver on at least two levels. Firstly, to personally be a true vessel for the Holy Spirit, so that the Christian hope can be displayed through the person of the caregiver. Secondly, to entrust patients to the transforming power of the Holy Spirit that spiritual growth and meaning may be achieved at the cross-roads of illness and health.

Conclusion

This article engages the issue of a culture-sensitive palliative pastoral approach with the African context in mind. It departs from the multicultural reality of the current South African context, where people from different cultures engage one another in palliative settings. Contemplating palliative pastoral care from a dual-wisdom approach, denotes palliative pastoral care as an expression of Christian faith care towards patients and their relational networks, and the facilitation of spiritual growth enables meaning-making in the context of illness and possible loss. The article investigates the notions of illness, healing and dying in an African context and highlights the spiritual, systemic and communal nature of these concepts within African thinking that differs fundamentally from the analytical Western understanding. The implication for a culture-sensitive palliative pastoral approach is in the meaningful accommodation of these beliefs within the framework of Christian faith care. The coordinates of pastoral hospitality, an embodied pastoral care of presence, accommodation of the collective, the practice of respectful Christian discernment and inhabitation theology are offered as some of the coordinates that could help pastoral caregivers to achieve a culture-sensitive palliative pastoral approach.

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References

Bass, D. & Dykstra, C., 2008, *For life abundant: Practical theology, theological education, and Christian ministry*, Eerdmans, Grand Rapids, MI.

Brunsdon, A.R., 2015, 'Wisdom as outcome of the pastoral process: Reflections on a positive pastoral narrative approach', *In die Skriflig* 49(3), 8. https://doi.org/10.4102/ids.v49i3.1873

Brunsdon, A.R., 2017, 'Towards a pastoral care for Africa: Some practical theological considerations for a contextual approach', in S.P. van der Walt & N. Vorster (eds.), *Reformed theology today: Practical-theological, missiological and ethical perspectives*, pp. 107–122, AOSIS, Cape Town. https://doi.org/10.4102/aosis.2017.rtt47.07

Brunsdon, A.R. & Knoetze, J.J., 2014, 'Batho Pele (people first): Some ethical and contextual reflections on theological training in an African context', in M.A. Mokoena & I. Oosthuizen, (eds.), *Nuances of teaching learning and research: Research and publication book series*, vol. 3(1), pp. 261–280, Andcorck, Potchefstroom.

Buqa, W., 2015, 'Storying Ubuntu as a rainbow nation', *Verbum et Ecclesia* 36(2), 1–8, Article ID 1434. https://doi.org/10.4102/ve.v36i2.1434

Clebsch, W.A. & Jaekle, C.R., 1964, *Pastoral care in historical perspective: An essay with exhibits*, Prentice-Hall, Englewood Cliffs, NJ.

Collier, C.D.A., 2003, 'Tradition, modernity and postmodernity in symbolism of death', *The Sociological Quarterly* 44(4), 727–749. https://doi.org/10.1111/j.1533-8525.2003.tb00533.x

De Jongh van Arkel, J.T., 1995, 'Teaching pastoral and counseling in an African context: A problem of contextual relevancy', *The Journal of Pastoral Care* 49(2), 189–199. https://doi.org/10.1177/002234099504900208

De Klerk, J.J., 1978, *Herderkunde*, N.G. Kerkboekhandel, Pretoria.

Flynn, P.A.R., 1980, *Holistic health: The art and science of care*, Brady, Bowie, MD.

Foley, K.M. & Gelband, H. (eds.), 2001, *Improving palliative care for cancer: Summary and recommendations*, National Academy Press, Washington, DC.

Fraser, B.A., Powell, R.A., Mwangi-Powell, F.N., Namisango, E., Hannon, B., Zimmermann, C. et al., 2017, 'Palliative care development in Africa: Lessons from Uganda and Kenya', *Journal of Global Oncology* 4, 1–10. DOI: 10.1200/JGO.2017.010090

Gerkin, C.V., 1997, *An introduction to pastoral care*, Abingdon Press, Nashville, TN.

Githiga, J.G., 2009, *Initiation and pastoral psychology. Toward African personality theory*, 2nd edn., Evangel, Springfield, MO.

Graham, E.L., 2017, 'On becoming a practical theologian: Past, present and future tenses', *HTS Teologiese Studies/Theological Studies* 73(4), a4634. https://doi.org/10.4102/hts.v73i4.4634

Hauschildt, E., 2015, 'Intercultural pastoral care as a model for a theory of radically interactive pastoral care', in K. Federschmidt & D.J. Louw (eds.), *Intercultural and interreligious pastoral caregiving,* pp. 48–60, SIPCC, Düsseldorf.

How the hospice movement began, 2018, viewed 01 October 2018, from http://www.stlukes.co.za/hospice-movement

Ikwuagwu, O.A., 2007, *Initiation in African traditional religion*: *A systematic symbolic analysis with special reference to aspects of Igbo religion in Nigeria*, Echter, Würzburg.

Landes, S.D., 2010, 'Practicing discernment: Pastoral care in crisis situations', *The Journal of Pastoral Care & Counseling* 64(1), 1–9.

Lartey, E.Y., 2015, 'New perspectives and challenges for pastoral care and counselling in a globalizing world', in K. Federschmidt & D.J. Louw (eds.), *Intercultural and interreligious pastoral caregiving*, pp. 61–71, SIPCC, Düsseldorf.

Long, W.M., 2000, *Health, healing and kingdom: New pathways to Christian health ministry in Africa,* Regnum, Carlisle.

Louw, D.J., 2000, *A pastoral hermeneutics of care and encounter*, Lux Verbi BM, Wellington.

Louw, D.J., 2008, *Cura Vitae: Illness and the healing of life*, Lux Verbi BM, Wellington.

Manda, L.M., 2016, 'Africa's healing wisdom: Spiritual and ethical values of traditional healthcare practices', in R. Nicolsan (ed.), *Persons in community: African ethics in a global culture*, University of Kwazulu Natal Press, Scotsville, KY.

Magezi, V., 2006, 'Community healing and the role of pastoral care of the ill and the suffering in Africa', *In die Skriflig* 40(3), 505–521.

Mbiti, J.S., 1977, *Introduction to African religion*, Heinemann, London.

McClure, B., 2012, *Pastoral care*, in Miller-McLemore, B.J. (ed.), *The Wiley-Blackwell companion to practical theology,* pp. 269–278, Blackwell, Chichester.

Meier, D.E. & Bowman, B., 2017, 'The changing landscape of palliative care', *Generations – Journal of the American Society on Ageing* 41(1), 74–80.

Naidoo, M. (ed.), 2015, *Contested issues in training ministers in South Africa*, Sun Press, Stellenbosch.

Ngubane, H., 1992, 'Clinical practice and organization of indigenous healers in South Africa', in S. Feierman & J. Jansen, *The social basis of health and healing Africa*, pp. 366–375, University of California Press, Berkeley, CA.

Nürnberger, K., 2007, *The living dead and the living God: Christ and the ancestors in a changing Africa*, Cluster, Pietermaritzburg.

O'Brien, A.P., Bloomer, M.J., McGrath, P., Clarke, K, Martin, T., Lock, M., et al., 2013, 'Considering Aboriginal palliative care models: The challenges for mainstream services', *Rural and Remote Health* 13(2339), 1–10.

Oduyoye, M., 1983, 'The medicine man, the magician and the wise man', in E.A. Adegbola (eds.), *Traditional religion in West Africa*, pp. 55–72, Daystar Press, Ibadan.

Pharrat, J., (ed.), 1996, *The practice of presence: Shorter writings of Harry Sawyerr*, Eerdmans, Michigan, MI.

Reb, A.M., 2003, 'Palliative and end-of-life care: Policy analysis', *Oncology Nursing Forum* 30(1), 35–50.

Summerton, J.V., 2006, 'Western health practitioners' view about African traditional health practitioners' treatment and care of people living with HIV/AIDS', *Curationis* 15–23.

Swinton, J. & Mowat, H., 2016, *Practical theology and qualitative research*, 2nd edn., SCM, London.

Thorpe, S.A., 1991, *African traditional religions*, University of South Africa, Pretoria.

Van Rinsum, H.J., 2004, 'They became slaves of their definitions. Okotp'Bitek (1931–1982) and the European traditions in the study of African religions', in F. Ludwig & A. Adogame (eds.), *European traditions in the study of religion in Africa*, pp. 24–38, Harrassowitz Verlag, Wiesbaden.

Van Zyl, D.C., 2009, 'Appeased with death: Old Testament insights on life and death, for the church in Africa confronted by HIV/AIDS', *Scriptura* 100, 174–184. https://doi.org/10.7833/100-0-664

Ward, E.D., 2015, 'Cultural diversity in sickness and healing: The domain of caring in South African traditional cultures', in K. Federschmidt & D.J. Louw (eds.), *Intercultural and interreligious pastoral caregiving*, pp. 172–180, SIPCC, Düsseldorf.

Westerlund, D., 2000, 'Spiritual agents of illness', in J.K. Olupona (eds.), *African spirituality: Forms, meanings and expressions*, pp. 152–175, The Crossroad Publishing, New York.

World Health Organisation, 2007, *Palliative care – Cancer control knowledge into action: WHO guide for effective programmes*, World Health Organisation, Switzerland.

Zahan, D., 1979, *The religion, spirituality and thought of traditional Africa*, transl. K.E. Martin & L.M. Martin, The University of Chicago Press, Chicago, IL.